



By electronic submitted to: regulations.gov

February 16, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1653-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Request for Information Regarding the Awarding and the Administration of Medicare Administrative Contractor Contracts

Dear Sir or Madam:

The American Association for Homecare (AAHomecare) is pleased to have the opportunity to submit comments on the Medicare Program; Request for Information Regarding the Awarding and the Administration of Medicare Administrative Contractor Contracts (CMS-1653-NC). AAHomecare is the national association representing the interests of suppliers, manufacturers and distributors of durable medical equipment (DME), prosthetics, orthotics and supplies (collectively, DMEPOS). In light of our members' expertise and experience, AAHomecare is uniquely qualified to comment on the proposal.

We understand that CMS is interested in updating the MAC contracting process and is soliciting public comment on several questions regarding MAC incentives for exceptional performance and performance transparency. In the following section, AAHomecare responds to each questions posed by CMS in the proposal.

- 1. Do you have any concerns or suggestions related to development of a potential "award term" strategy and plan?*

AAHomecare is concerned that the current cost-plus-award-fee contract type is placing an inappropriate incentive on the MACs, essentially making the MACs focused on the bottom-line costs rather than performance. AAHomecare recommends CMS move away from the cost-savings program, as we believe this will be incentivizing the MAC to save money as the main priority instead of focusing on fairly and responsibly processing claims.

Contractors should be bidding on operational function with anticipated volumes. Government contractors should not be incentivized by financial reward as we are all responsible for guarding the Medicare Trust Fund and this would be an inappropriate use of these funds.

2. *Do you have any other suggestions for incentivizing and rewarding exceptional MAC performance?*

AAHomecare requests CMS to provide more information on what CMS considers 'exceptional performance.' CMS has a set of guidelines for contractors that have to be met. Since there are specific guidelines, how would exceptional performance be measured? MACs are educators and claim processors for the DMEPOS industry and therefore, there should be a high standard for knowledge and performance. Since MACs should be required to meet the standards outlined in an awarded contract, we believe MACs should be penalized for bad performance rather than being rewarded for what they have already agreed to when signing a contract. The DMEPOS industry is required to meet all Medicare standards when providing service with no incentives, we firmly believe the MACs should be treated accordingly.

Due to the vital role MACs play in the industry, when MACs do not perform at their best, it negatively impacts the entire industry. There are too many instances where MACs publish a clarification to a guideline or LCD and then retroactively apply it. This is a classic example of a MAC creating confusion and increased error rates while not performing in their contractual duties. MACs should not retroactively apply performance standards when making a clarification, as they should not need to make clarifications to begin with.

AAHomecare believes monitoring and reporting reopenings that are overturned, as well as redeterminations and reconsiderations would be more accurate than inter-rater reliability (IRR) assessments of the MACs. MACs should be penalized when claims are overturned at the Redetermination and Reconsideration level of appeal because the MACs should have processed the claims accurately the first time. In addition MACs are contractually required to function as educators and therefore DMEPOS suppliers should have been educated on Medicare requirements prior to providing a service to a Medicare beneficiary and submitting a claim.

We want to reiterate that MAC contractors have agreed to the terms and conditions of a government contract and they should not be rewarded for meeting them.

3. *Are there any specific metrics or evaluation criteria that would be valuable in measuring the level and quality of the service provided by a MAC?*

AAHomecare requests the CMS to afford the industry the opportunity to provide input on the metrics and criteria when the decision is made to create new guidelines. More specifically, MACs need to talk with DMEPOS suppliers on the accuracy of MAC staff in applying claims processing criteria and medical necessity guidance. For example, surveying DMEPOS suppliers post an interaction with MAC representatives can quantify the quality of customer service.

We believe there should be a measure for appeal overturn rate, transparency in MAC operational processes (examples are the changing of the CMN flag when an appeal is overturned and the overpayment process). CMS should have specific metrics and requirements for all

operational processes. These should be reported for each MAC and penalties should apply if they are not met.

4. *Are there any specific metrics or evaluation criteria that would be valuable in measuring the level and quality of the MAC's relationships (including education and outreach) with providers?*

AAHomecare would like to request more information on what the current measurements are and the process used by CMS to score the quality of MACs. In addition, are the current metrics weighted in overall scoring of a MAC?

Currently, DME MACs ask suppliers for feedback on their website. However, we do not believe satisfaction with a MAC website has much bearing on overall performance of the MAC. AAHomecare recommends that CMS specifically measure the 1-800-Medicare contractor in terms of accuracy and customer service to the beneficiary supplier community. When surveying suppliers, MACs should also identify areas where there are gaps in education materials related to coverage criteria and operational processes and ensure these gaps are filled.

There is also a need to measuring the Provider Outreach & Education (POE) departments in terms of visibility. These departments are supposed to be the front line of the DME MACs and many suppliers are not even aware of the roles they perform. Representatives should be visible to all suppliers and work geographically to assist.

There should be consistency between all the DME MACs on all processes from medical necessity requirements to operational processes. Without uniformity amongst the MACs, there is much confusion within the industry, especially for companies that operate nationally and have to work with multiple DME MACs.

5. *With regard to the MAC's quality and level of service and performance, what types or kinds of information should be published for public release?*

In the interest of government transparency, all information regarding quality, level of service and performance should be available publicly, including award fees. Here are some examples of information that should be available to the public:

- number of prepay audits by product category;
- accuracy of claim processing;
- number of appeals at each level;
- error rate;
- overturn rates on pre-pay and post-pay audits;
- number of claim denials in claim processing;
- number of claims denied in pre-pay and post-pay audits;
- overturn rates on reopening ;
- MAC goals and achievement rates.

6. *If we were to publish the results of the evaluation of a MAC's performance on our website, which types of metrics or information should be made available for public release?*

All information as listed above should be made publicly available.

In addition to the questions posed by CMS, AAHomecare would like to take the opportunity to share industry concerns in terms of the quality of performance by DME MACs. We believe a key component in improving MAC services will be to expand the technological capabilities. Electronic communication should be required and free to suppliers. EHR records should be open across the spectrum for all healthcare suppliers and providers taking care of a Medicare beneficiary. CMS should look into giving suppliers the ability to access all patient records. This type of access will improve communication between providers and suppliers, which will result in improved care for beneficiaries.

We also believe having clinical staff with current experience in the healthcare field would improve MAC performance. While there are clinical roles within various departments of a MAC, often they have not been in the field for many years and their interpretation of how current clinical processes and documentation works is not accurate. AAHomecare feels that this change would greatly improve the error rate.

AAHomecare is also concerned with the decrease from four DME MACs to two. Starting June of this year, CGS and Noridian will hold all of the DME MAC contracts. We are concerned that the consolidation amongst contractors concentrates too much control. CMS should ensure there are a minimum number of potential contractors to bid on the contracts. If the challenge is the limited number of participants for the contract awards, additional consideration should be given to the entire process.

In summary, AAHomecare does not support CMS' proposal to reward MACs for good performance and would like to see additional industry input on MAC guidelines. MAC performance measurements should be available to the public and penalties should be applied for poor performance.

Thank you again for the opportunity to submit these comments. We would be happy to meet with you to discuss these issues in more detail as needed.

Sincerely,



Kimberley S. Brummett, MBA
VP for Regulatory Affairs