American Hospital Association

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November 20, 2007

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS–1399–GNC; Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance During Fiscal Year 2008 (Vol. 72, No. 189), October 1, 2007.

Dear Mr. Weems:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) notice on the performance evaluation criteria and standards it will use for its contract fiscal intermediaries (FIs) and carriers.

The proposed criteria and standards should provide the necessary framework for CMS to oversee and evaluate these influential contractors to ensure accurate and fair execution of Medicare statutes, regulations and guidelines. However, the success of these proposed standards ultimately depends on CMS' enforcement. We encourage CMS to proactively and rigorously enforce these performance standards and to respond to problems in a timely and comprehensive manner.

The AHA has long-standing concerns with FI performance related to the medical necessity review function. We fully support the need for CMS to conduct medical necessity reviews to ensure that the Medicare program pays only for clinically appropriate services. However, we urge CMS to exercise stronger oversight to ensure that contractors' medical necessity reviews comply with CMS' own program integrity, coverage and appeals rules. As we have expressed in comment letters on numerous inpatient rehabilitation facility local coverage determinations (LCDs) issued by FIs, we are concerned that FIs are unilaterally narrowing national Medicare coverage criteria and issuing proposals that are neither evidence based nor consistent with

standard medical practice. These practices violate CMS' national program integrity and coverage guidelines. CMS must actively monitor its contractors to prevent such practices, which ultimately restrict access for patients who meet medical necessity standards.

In 2007, the AHA and United BioSource Corporation collected medical necessity review data from 72 inpatient rehabilitation facilities in 20 states. As part of the study, we examined LCDs issued by nine FIs, including TriSpan, Mutual of Omaha, BlueCross BlueShield of Georgia, Cahaba Government Benefit Administrators, and First Coast Service Options, as well as four of the five FIs that have consolidated under National Government Services, including AdminiStar Federal, Inc., United Government Services, Associated Hospital Services and Anthem Health Plan of New Hampshire. FIs initially denied payment for an alarming 80 percent of inpatient rehabilitation hospital bills reviewed, withholding more than $25 million in Medicare payments. Sixty-three percent of denied bills were overturned after completing the appeals process, resulting in nearly $6 million returned to hospitals. The report, "Limiting Access to Inpatient Medical Rehabilitation: A Look at Payment Denials for Medicare Patients Treated in Inpatient Rehabilitation Facilities," is attached for your review.

To discourage inappropriate behavior, CMS should require FIs to meet key performance measures, just like providers. This should result in more thorough and accurate medical necessity reviews that lower the administrative burden on providers. More precise medical necessity review by FIs would cut the administrative red tape required by appeals, which take an average of 18 months to adjudicate and divert hospital resources away from patient care.

CMS and providers expect a higher rate of accuracy and quality from FIs. CMS must use its FI performance review process to ensure that FIs begin to meet these expectations – even if it means penalizing FIs that do not meet CMS performance criteria. These same high performance standards and penalties also should apply to other CMS contractors conducting medical necessity reviews.

It is unclear why these performance criteria took effect on October 1 – two months prior to the completion of the public comment period on November 30. For this and other policies that are circulated for public comment, CMS should release the proposal for review within a time frame that allows the agency to consider and respond to public input ***prior to*** implementation of the proposal.

Thank you for considering our input on FI performance pertaining to medical necessity reviews. If you have questions or need further information, please contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

SSM HEALTH CARE

November 27, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Att: CMS-1339-GNC Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments on "Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance During Fiscal Year 2008" (Federal Register, Vol. 72, No. 189, page 55775)

Gentlemen:

Multiple efforts at submitting these comments electronically on the internet having met with application errors, our comments are herewith submitted in writing.

Background:
Sponsored by the Franciscan Sisters of Mary and based in St. Louis, Missouri, SSM Health Care (SSMHC) is one of the largest Catholic systems in the country. The system owns, manages and is affiliated with 20 acute care hospitals and two nursing homes in four states: Missouri, Illinois, Wisconsin and Oklahoma. More than 5,000 affiliated physicians and 24,000 employees work together to provide a wide range of services, including rehabilitation, pediatrics, home health, hospice, residential and skilled nursing care. Our health-related businesses include information systems and support services such as materials management and home care. SSMHC also owns an interest in Premier Medical Insurance Group Inc., one of Wisconsin's largest health maintenance organizations.

Criteria and Standards for Fiscal Intermediaries:
Payment Safeguards: One of the criteria set forth in the proposed regulation is "Payment Safeguards" which includes Medical Review, Overpayments, Provider Enrollment and Audit & Reimbursement. Unquestionably, payment safeguards are essential to a fiscally sound reimbursement program. SSM Health Care would propose that the criterion for Payment Safeguards also include requirements that activity in the area of payment safeguards be conducted across the spectrum of providers for whom a given FI is responsible. For example, while it may be wise, from a cost-benefit point of

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view, to begin medical reviews or audits with those providers having the largest number or largest dollar value of claims, once an issue has been identified (if legitimate) in terms of inappropriate eligibility, inaccurate procedure coding, etc., other providers should also be reviewed by the FI to determine if the error is a widespread issue. Otherwise, patients who have been identified as ineligible for certain services will simply seek treatment by other (possibly smaller) providers, and the overall Medicare system may continue to make inappropriate payments--albeit to different providers. Often payments identified as ineligible for reimbursement are due to misunderstandings across a particular sector of the industry. Failure by the FI to follow up with other providers will not truly safeguard payments and will merely allow some providers to continue to serve and be reimbursed for the treatment of patients for whom other providers have been denied reimbursement.

Similarly, the payment safeguards should ensure that all FIs are applying the same reimbursement eligibility standards so that some providers are not suffering from overly restrictive interpretations by one FI and other providers are experiencing a windfall from less restrictive FIs--who may actually be operating in the same geographical area.

For example, a recent study by the United BioSource Corporation and the American Hospital Association (see http://www.aha.org/aha/content/2007/pdf/071003rehablcd.pdf) revealed that, in the summer of 2007, out of 2,200 claims for inpatient rehabilitation services at 72 inpatient rehabilitation facilities, 80% were denied by the fiscal intermediary. Out of 652 claims that were appealed, 63% of the denials were overturned on appeal.

There is something inherently wrong with a process that results in such a high rate of reversals on appeal. The oversight and evaluation of performance of the FIs by CMS should identify and eliminate such errors and disparities in reviewing claims.

(In accordance with the instructions, an original and two copies are provided.)

Yours truly,

DAVID S. DURBIN
Corporate Public Policy Manager
SSM Health Care