Charles N. Kahn III
President & CEO

December 15, 2011

BY ELECTRONIC MAIL

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-9989-P
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Medicare Fee-For-Service Prepayment Medical Review: Emergency Clearance Request (CMS-10417) 76 Fed.Reg. 76737

Dear Ms. Tavenner:

The Federation of American Hospitals ("FAH") is the national representative of approximately 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching short-stay community hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, cancer, and long-term care hospitals, which provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment to the Department of Health & Human Services ("HHS") regarding the emergency review of the information collection for Medicare Fee-For-Service Prepayment Medical Review.

The FAH and its member hospitals are strongly committed to and share CMS's goal of protecting the Medicare trust fund and reducing the payment error rate. The FAH questions, however, the efficacy of prepayment complex medical review for services delivered in a hospital setting as a means to achieve that goal. Only one legitimate reason seems to exist for any type of prepayment review – if the ability to adjust a provider's future payments to account for disallowances was in question. Because virtually all hospitals are stable, ongoing operations, however, Medicare

contractors can always audit after payment has been made and make appropriate adjustments against future payments. The characteristic stability and permanence of the hospital institutional setting distinguishes it from other suppliers and providers that CMS may appropriately subject to prepayment review.

It is also important to note that prepayment reviews substantially stretch out the payment period and negatively affect hospital cash flow, which is increasingly vital in light of the mounting financial pressures and thin operating margins (negative for Medicare) under which hospitals struggle. Cash flow concerns combined with the fact that hospitals experience a high rate of success in appealing payment denials makes it clear that prepayment review for hospitals should be the exception, rather than the rule.

At a minimum, CMS must ensure that the scope of prepayment review of hospital claims is limited and carefully targeted to circumstances in which contractors demonstrate with detailed data analysis the "likelihood of sustained or high level of payment error." Along those lines, contractors must be reasonable and transparent about the analytic methods and standards applied to determine whether the "likelihood" threshold has been breached, and they must afford the provider an opportunity to review and refute the findings. All MACs and RACs should routinely provide reason codes whenever they conduct a review.

The FAH also asserts that high-dollar value alone is insufficient grounds to broadly target a specific service – that there must a demonstrable connection to the "likelihood" standard above. In addition, the FAH opposes across-the-board prepayment reviews of certain MS-DRGs, as they do not properly distinguish providers who make significant investments in safeguards and are clearly committed to compliance with all coverage, coding and documentation requirements. Permitting its contractors to apply the prepayment edits only to those providers whose data suggests a problem is an appropriate and efficient way to reinforce CMS's policy goals without creating widespread unreasonable and unwarranted regulatory and paperwork burdens on the entire industry.

Regarding the conduct of contractors, in situations in which an NCD or an LCD for a specific service does not exist, contractors need to make clear precisely what records they seek to satisfy documentation requirements. In addition, to ensure fair, accurate, and efficient complex medical review, it is imperative that contractors only use well-qualified personnel to complete this difficult and often judgmental work. Further, the FAH believes that it would be instructive for both providers and the program if certain information were made public such as the percentage of charts reviewed and the selection criteria. This transparency will help improve program accountability and provider trust that prepayment review is applied equitably.

From a process standpoint, in light of the current ability of MACs to conduct prepayment review where program vulnerabilities are identified, as well as the existence of the other organizations that conduct post-payment auditing of claims, it is unclear why CMS feels compelled to seek emergency clearance on this notice. The purported need for emergency clearance results in a limited public comment period, and thus is not likely to produce a sufficient record of public feedback on the burden of this very significant data collection activity.

The FAH submits the following specific questions and comments regarding the information collection request and the burden on hospitals associated with prepayment medical review.

- As noted by the supporting statement, Medicare contractors already have the ability to conduct prepayment review of claims in order to protect the Medicare trust fund from vulnerabilities. Other than expanding the volume of pre-payment review from

approximately 1.2 million claims per year to 2.7 million claims per year, what change in policy/practice is this request implementing?

- Is the increase in prepayment review volume to be focused on providers where data analysis and/or a probe or sample review indicates program vulnerabilities, or is broader application of prepayment review contemplated? To the extent broader application is contemplated, how would providers and/or particular services be selected for prepayment review?

- The supporting statement indicates that prepayment review "may delay payment slightly." Is CMS contemplating relaxing the prompt payment provisions currently in place, under which MACs have 60 days to make a determination (per the Claims Processing Manual).

- How will the expanded prepayment review be coordinated with other existing prepayment and post-payment reviews (e.g. RAC, ZPIC, MACs sending demand letters for the RAC) to eliminate confusion, avoid unnecessary and duplicative reviews and ensure that consistent standards of review are applied.

- The supporting statement indicates that "CMS will also pilot prior authorization." Although providers are familiar with prior authorization requirements in the context of commercial managed care contracts, the introduction of prior authorization requirements in the Medicare fee-for-service arena is a significant policy change more appropriately addressed through statutory changes or formal notice and comment rulemaking.

- The supporting statement estimates the average time for a provider to respond to medical records requests to be 30 minutes, at an average hourly rate of $16.83, and a loaded rate of $33.66. This equates to $90.1 million per year allocated to providers and suppliers nationwide. To the extent this expanded prepayment review is not focused on potentially problematic providers, some of these costs may unfairly be borne by compliance-minded providers who would otherwise not be subjected to prepayment review and its related costs.

Thank you for the opportunity to provide these comments. If you have any questions or need further information, please contact me, Jeff Micklos, or Steve Speil of my staff. We would welcome an opportunity to discuss them with you.

Sincerely,