



**American Hospital  
Association**

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April 6, 2007

Submitted electronically to:  
Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services

***RE: Request for Information (RFI) related to Request for Proposal (RFP) #1 under the Cycle 2 Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Procurements.***

Dear Ms. Norwalk:

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 the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) related to the Cycle 2 Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Statement of Work (SOW).

## **GENERAL COMMENTS**

Hospitals will be integral customers of the MACs, and a significant proportion of hospital revenue will depend on these contractors operating in a timely and judicious manner. Section 911 of the *Medicare Modernization Act of 2003* requires the Secretary of the Department of Health and Human Services (HHS) to consult with providers of services on MAC performance requirements and standards, and we appreciate the opportunities that hospitals and other providers have had in contributing to this process. With the advent of competitive procedures for the selection of MACs, we believe that such provider input is critical.

The AHA encourages CMS to include providers in the contractor selection and renewal process. Furthermore, to address any serious problems with the selected MACs, providers also should be permitted to provide formal mid-contract reviews of their performance. We are concerned about the introduction of competitive procedures for the selection of the MACs, as it is likely that some contractors will bid so low that they may not be able to adequately perform at the level that HHS and providers require. Hospitals have had first-hand experience with contractors who submit "low-ball" bids and then



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cannot do their job adequately in the Medicaid program, where competitive bidding often is used to select contractors. Therefore, hospitals should have input on both the selection and termination of MACs. We also ask CMS to do everything within its authority to ensure that MACs are accountable to the agency and providers for the services they provide. It is critical that the selected contractors understand how hospitals and health care systems function, and that their employees have excellent communication skills. In addition, given that each defined A/B MAC jurisdiction will include several states, CMS must ensure that the chosen contractor is able to maintain a significant local presence. This includes the ability to work within different time zones, availability and accessibility within typical hospital administrative hours of operation, and the ability to conduct face-to-face meetings and teleconferences with individual hospitals, or groups of hospitals, on a regular basis.

## **SPECIFIC COMMENTS**

### **C.5.1.8.2 Consolidation of Local Coverage Determinations**

Hospitals have serious concerns regarding how the numerous local coverage determinations (LCDs) will be consolidated in the transition to MACs, and how providers will be informed of these changes. It is important that providers be informed in a timely manner to avoid confusion about whether a particular service will be covered by Medicare. Concerns include questions about which policy will govern if conflicting LCDs for a Medicare-covered service are in place across fiscal intermediaries (FIs) contained within a single MAC jurisdiction, and if there are LCD policy conflicts between carriers (i.e., physician policies) and FIs (i.e., hospital policies) in a single MAC jurisdiction.

As with any other complex change, provider acceptance in consolidating LCDs largely will depend on the way in which consolidation is carried out. For instance, whether providers and subject matter experts will be consulted in consolidating the LCDs; how “least restrictive” will be defined; how providers will be informed of the changes; and whether providers will be given adequate time to incorporate the changes into their practice.

The AHA is pleased that CMS has partially addressed these concerns by requiring that contractors select the least restrictive LCD, and that this could mean no policy is selected if one or more states within the jurisdiction have no LCD on the particular topic. We also are supportive of CMS’ proposal to require that a MAC notify the affected provider community at least 45 or more days prior to the policy change date.

However, we remain concerned that CMS is neither requiring MACs to involve the provider community in the selection of least restrictive policies nor requiring them to conduct a formal Contractor Advisory Committee (CAC) notice and comment revision process, as specified in Chapter 13 of the Program Integrity Manual (PIM), until the

consolidation process is final. Allowing providers to weigh-in results in a more reasonable policy and promotes acceptance of the revised policy. For example, we understand that Noridian, the Jurisdiction 3 MAC, posted the consolidated LCDs on their Web site for provider comment prior to the final consolidation of policies and this resulted in a better level of understanding and acceptance among providers.

To address these concerns, we recommend that CMS require:

- the CACs to engage in a formal notice and comment process for the proposed consolidated LCDs, as required in the Chapter 13 of the PIM; and
- that the MAC inform implementation stakeholders, such as hospital associations, of this opportunity for comment so that they may disseminate the information to their members within the state.

Another potential complication in the consolidation of LCDs involves chain providers. Under C.5.4.12 Chain Provider Organizations, chain providers with CMS-approved, single-MAC status will bill through the MAC whose boundaries include the chain's home office. LCD policy conflicts that may arise when services are performed in a hospital that is part of a chain with single-MAC status by a physician who bills through a different MAC are not addressed in the SOW. It does not make sense to apply different coverage policies for a Medicare service to physicians and hospitals simply because the hospital happens to be part of a chain provider. This places chain hospitals at risk for incurring expenses for non-covered services provided by physicians whose own services are covered by Medicare. We recommend that CMS work with the selected MACs and chain providers to identify and resolve these types of potential conflicts.

#### **C.5.1.9 Implementation of Stakeholder Communication**

We are pleased that the introductory paragraph in this section now identifies hospital associations as implementation stakeholders. We urge CMS also to include hospital associations in the Background section. Like medical societies and medical-specialty groups, state, local and regional hospital associations are an important conduit of information between Medicare and individual hospitals, and should be included in the overall Communication Project Plan required under this section, as well as all stakeholder communications and meetings.

#### **C.5.1.10 Implementation Meetings**

The SOW describes the flow of implementation meetings, starting with a jurisdiction kickoff to be held within 30 days after the contract is awarded, followed by individual segment kickoff meetings held within 10 days after the scheduled implementation start date of the segment. Given Medicare's tremendous financial importance to hospitals and health systems, it is understandable that these stakeholders would be keenly interested in the opportunity to receive frequent and regular updates on the transition to the MAC in their jurisdiction. For that reason, we strongly recommend that segment meetings be held both prior to and after the implementation start date for each segment to ensure that all

parties fully understand the transition process and have the opportunity to have questions answered.

#### **C.5.4.12 Chain Provider Organizations**

We are pleased that the SOW allows a chain provider organization, upon CMS approval, to receive single-MAC status. However, we also believe that there should be a mechanism for a chain with entities in many A/B jurisdictions to consolidate into a smaller number of MACs instead of a single MAC. For a chain provider organization that includes multiple kinds of providers – hospitals, freestanding imaging centers, physician offices, etc. – there should be a mechanism to allow some entities to stay with the local MAC while others migrate to the MAC of the chain’s home office.

We also seek clarification on how chain providers that currently report to a single FI will be managed in the coming stages of the MAC transition. If a chain hospital is in a jurisdiction that is transitioning to a MAC, but the chain’s home office is not in that jurisdiction, may the chain hospital continue to report to the FI it has been using, or must it transition to the contracted MAC in its jurisdiction? We recommend that CMS expeditiously provide instructions on how a chain organization may convert to a single MAC to avoid the need for multiple transitions for chain hospitals.

#### **C.5.2.6 Provider Cost Reports and Appeals and C.5.11.3 Cost Reporting and Reimbursement Payment Policy**

With regard to the handling of cost report audits and appeals that overlap the transition from one MAC to another, we are pleased that the draft SOW, at C.5.2.6, requires that outgoing contractors transfer all open and closed cost reports, appeals and audit documentation, and any other pertinent files/records, to the new MAC. However, we ask CMS to clarify that this same transfer process will occur during the initial transition from the outgoing FIs to the MACs. This will help ensure that the rights of hospitals are protected. For example, under the current process, if a cost report is filed with an outgoing FI close to the end of its contract, it could be a year before the cost report is scheduled for an audit. The appeal process then could take several years to resolve. We are concerned that the outgoing FI may not be able to continue to provide these services for the time period required to move from the audit to the completion of the appeal process due to inadequate staffing, or the fact that it may no longer be in business. In addition, we recommend that there be consideration and allowance for delays in the transfer of documents that could cause the hospital to miss deadlines for filing position papers for appeals.

#### **C.5.5 Provider Enrollment**

The SOW includes several standards for provider initial enrollment and changes in enrollment information, including timeliness and correctness standards, and standards related to revocations and appeals. We are concerned that the MACs are inheriting a provider enrollment system that includes rigid and complex requirements and, as a result, is already tremendously backlogged. Hospitals regularly express frustration with the slowness and complexity of the provider enrollment system. It is not uncommon for it to

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take over six months for a hospital to enroll a physician in the Medicare program and receive a billing number. Until then, none of the services the physician provides under Medicare can be billed.

This backlog has gotten worse in the last year due to the many changes CMS has made to the provider enrollment process. This includes CMS Transmittal 134, issued on March 1, 2006, which significantly changed the enrollment process, making it more complex and cumbersome, and provided Medicare contractors with an extended time frame for processing enrollment applications. For instance, contractors have to process only 80 percent of enrollment applications within 60 days of receipt. Prior to that date, carriers were required to process 90 percent of these forms within 60 days. Further, the transmittal requires carriers to process 99 percent of these applications within 180 days, instead of the 90-day time frame in effect prior to March 1, 2006.

In addition, the implementation of the provider enrollment final rule published in the April 21 *Federal Register – Medicare Program: Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment* – will further increase the workload of Medicare contractors when it is implemented. For example, all providers and suppliers will be required to complete the applicable *CMS 855 Medicare Health Care Provider/Supplier Enrollment Application* at least once, and enrollment information must be updated and validated every five years.

This new regulation will impose massive new requirements on both Medicare contractors and providers that will, unfortunately, overlap the time frame for transition to MACs. Hospitals are concerned that these additional requirements on MACs, who will already be overextended due to transition responsibilities, will impede their ability to process and approve enrollment applications and issue billing numbers for new Medicare providers in a timely manner.

As a result, we urge CMS to take whatever reasonable steps it can to streamline the provider enrollment process to improve the ability of current contractors and the MACs to process enrollment applications more quickly. Some examples of changes that we believe could be made include:

- Expedite the implementation of an electronic provider enrollment process (Web/Internet based). This will eliminate the contractor as a middle-man and significantly reduce processing time and costs associated with establishing an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) system.
- Loosen the requirement for original signatures (PIM, Chapter 10, Section 4.15 “Certification Statement”). This requirement results in additional mailing, costs and administrative time.
- Eliminate the requirement that a contractor must send a pre-screening letter requesting the provider submit, in writing, information missing from the application, even if this information is clearly available elsewhere on the form or in the supporting

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documentation (PIM, Chapter 10, Section 3.1 “Pre-Screening Process”). An example would be if the provider neglected to furnish its zip code but the zip code is clearly indicated on a supporting document.

- Clarify that the requirement to report “managing employees” is intended to apply only to high-level administrators with direct responsibility for the overall management of the facility (i.e., president/CEO, medical director, director of nursing) and *not* to the typically large number of hospital employees who have some daily management responsibility for departments or services within the hospitals (i.e., cardiac rehabilitation department, purchasing manager, etc.). If CMS continues to require hospitals to report changes in information about all of these lower-level managers and supervisors, CMS Form 855 revisions will be filed far more frequently.

In addition, we recommend that CMS strictly track and enforce its standards for contractors’ timeliness and responsiveness in processing provider enrollment applications.

The AHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Roslyne Schulman, senior associate director for policy, at (202) 626-2273 or [rschulman@aha.org](mailto:rschulman@aha.org).

Sincerely,

Rick Pollack  
Executive Vice President