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August 26, 2016

The Honorable Nancy J. Griswold
Chief Administrative Law Judge
Office of Medicare Hearings and Appeals
Department of Health and Human Services
Attention: HHS-2015-49
5201 Leesburg Pike, Suite 1300
Falls Church, VA 22041

RE: HHS-2015-49, Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures, July 5, 2016.

Dear Judge Griswold:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit comments in response to the Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals' (OMHA) proposed changes to address the Medicare claim and entitlement appeals workload and backlog at the Administrative Law Judge (ALJ) level.

We appreciate that HHS acknowledges the gravity of the appeals backlog, which has resulted in hospitals experiencing delays of up to several years before receiving an ALJ hearing. However, we are skeptical that the changes to the appeals process proposed in this rule will do more than scratch the surface of the problem. In fact, as OMHA itself stated in a blog post accompanying the release of this proposed rule, *if* the proposals in this rule *and* proposed funding increases and other administrative changes in the president's fiscal year 2017 budget are implemented, the agency may achieve the elimination of the appeals backlog – by 2021. **This projection is striking because it signals to providers with claims already delayed in the appeals process that they may expect to wait five more years before these claims can be resolved.** Further, this projection is contingent on factors outside of the agency's control, since the changes OMHA cites as necessary would require enactment of legislative changes.

The most recent statistics released by OMHA show that the average appeals processing time was 935.4 days in the third quarter of fiscal year (FY) 2016 – an increase of 75 days from the prior quarter and 140 days since the beginning of the fiscal year. **This is movement in the wrong**

direction, and it is clear that merely tweaking the appeals system will not adequately address the problem.

Our skepticism about the effectiveness of the proposals in this rule springs from their failure to address directly the underlying cause of the appeals workload and backlog – excessive inappropriate denials of claims by Medicare contractors, and specifically the Recovery Audit Contractors (RACs). In fact, HHS consistently has downplayed the role of the RAC program in driving the backlog. **Nonetheless, preventing the flood of inappropriate claim denials – which force providers to refund payments for medically necessary services provided to Medicare beneficiaries and then appeal in order to recoup the funds that are due them – is a critical component of an effective and permanent solution to the appeals backlog. While we understand that reforming the RAC process is not within OMHA's direct control, we urge it to continue to share relevant data with the Centers for Medicare & Medicaid Services (CMS) and HHS, members of Congress, providers and other stakeholders to illustrate the continuing contribution of the RAC denials to the workload burdens of the ALJs and the growing backlog of appeals.**

In addition, we urge HHS to use its authority to manage the RAC program to identify and implement controls that would limit those contractors' ability and incentive to inappropriately deny claims. Specifically, we continue to urge the following reforms:

- Allow providers to delay recoupment of disputed payments until the appeal has been decided by an ALJ, and change the "clock" for interest on denials upheld by the ALJ so that interest does not start to accrue until the ALJ determination has been made.

- Eliminate application of the one-year filing limit to rebilled Part B claims. When a Part A claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was determined not reasonable and necessary (so-called "patient status" claims), the hospital should be able to submit a subsequent Part B claim for the services provided as long as the Part B claim is submitted within 180 days of a final determination. This would allow hospitals to pursue their appeal rights and receive a final determination on the Part A claim before rebilling under Part B. CMS has attempted to address this issue by limiting certain contractors to auditing patient status claims within six months of the date of service in order to give providers time to rebill denials. However, this effectively addresses the problem only if contractors stick to their own required timeframes for review – timeframes that they frequently violate.

- Limit RAC approval for auditing issues to a particular, defined time period instead of approving them indefinitely, as current practice permits. In addition, a senior CMS official should be designated to be accountable for approval of audit issues. After the issue's audit time period has run out, RACs would stop auditing that issue. CMS then would analyze the audit results and provide education to providers in that jurisdiction, if warranted. Under this policy, a RAC would need to seek new approval from CMS to audit for that same issue, but would have to wait a certain defined time period to allow providers to incorporate education before requesting new approval.

- Codify *in regulation* CMS's assertion in the preamble of the FY 2014 inpatient prospective payment system final rule that Medicare contractors are limited to determining whether an inpatient stay is medically necessary based on the medical documentation available at the time the admission decision was made. "[T]he decision to admit should be based on and evaluated in respect to the information available to the admitting practitioner at the time of the admission" (78 Fed. Reg. 50495, 50952 (Aug. 19, 2013)).

In addition, we offer comments below on specific proposals in this rule.

TIMEFRAME FOR DECIDING AN APPEAL

OMHA proposes to amend 42 C.F.R. § 405.1016, which states that "the ALJ must issue a decision, dismissal order, or remand to the [Qualified Independent Contractor], as appropriate, no later than the end of the 90 calendar day period beginning on the date the request for hearing is received." Specifically, OMHA proposes to delete the "must," arguing that "must" should be reserved for absolute requirements" and that the 90-day timeframe is not such a requirement since statute provides appellants a right to escalate claims to a higher level of appeal if the timeframe is not met.

The AHA opposes this proposal and rejects the agency's reasoning, which is too clever by half. We disagree with the agency's characterization that the statute merely "envisions" that appeals will be adjudicated within that timeframe. In fact, the statute **mandates** that appeals be adjudicated within 90 days, and federal courts – both the D.C. Circuit and District Courts – have ruled that the statute requires that ALJs complete a hearing and issue a decision within 90 days. Escalation is not an alternative to the "must." Rather, as the courts articulated, it is a remedy of which providers may avail themselves *only after* OMHA has violated the requirement to satisfy the "must." Eliminating the regulatory reference to the statute's mandate cannot – and most certainly does not – eliminate the mandate itself. Further, it undermines the currently clear duty owed to appellants by OMHA's adjudicators.

DESIGNATION OF PRECEDENTIAL DECISIONS BY THE DEPARTMENTAL APPEALS BOARD (DAB)

OMHA proposes to grant authority to the chair of the DAB to designate certain final Medicare Administrative Council decisions as precedential. **The AHA has strong concerns about this proposal, particularly regarding the lack of detail on how the DAB chair would select which decisions should constitute precedent.** Without further detail, including criteria for selecting precedential decisions, it is difficult to evaluate the merits of this proposal, but easy to speculate how it could harm appellants if the process favors decisions that are beneficial to CMS. We urge OMHA to table this proposal while it gathers additional stakeholder feedback, and provide more details on a proposed process through future notice-and-comment rulemaking.

ATTORNEY ADJUDICATORS

OMHA proposes to institute attorney adjudicators to dispose of issues that do not require an ALJ hearing, thus potentially freeing ALJs to conduct hearings and decide appeals on the merits.

Specifically, the attorney adjudicators would be able to issue decisions when regulation does not require an ALJ hearing; dismiss a case when an appellant withdraws a request for hearing; or remand for additional information that can only be provided by CMS or its contractors, or when the Medicare Administrative Council directs remand.

While the AHA agrees that attorney adjudicators could help dispose of certain matters that do not require ALJ attention, we strongly urge the agency to establish criteria to ensure that attorneys designated as OMHA adjudicators have significant knowledge of and experience in applying Medicare regulations. As a recent federal circuit court noted, "Medicare is, to say the least, a complicated program" (*Caring Hearts Personal Home Services Inc. v. Sebelius*, 2016 WL 3064870 at *3 (10th Cir. May 13, 2016)). If attorney adjudicators are to be an effective limited alternative to ALJs, it is imperative that they receive sufficient training that ensures their familiarity with this complex body of law.

Further, we oppose OMHA's proposal to revise 42 C.F.R. § 405.1038(a) to limit the ability of ALJs (or proposed attorney adjudicators) to issue decisions without a hearing when the record supports a fully favorable finding for the appellant. The agency proposes that an ALJ or attorney adjudicator may not make a decision on the record if CMS or its contractor has elected to become a party to the appeal. We anticipate that this proposal would significantly weaken the effectiveness of attorney adjudicators in addressing the backlog by reducing the number of appeals that they could decide on the record, thus avoiding an unnecessary ALJ hearing. This is because CMS contractors – and, specifically, the RACs, who due to their profit motive are incentivized to defend their denials from appeal – increasingly are electing to participate as parties. In fact, CMS has used the RACs' scope of work to encourage their participation in the appeals process. OMHA's proposal could result in CMS contractors electing to become a party even in cases where the record clearly supports a favorable decision for the appellant-provider, in order to force an avoidable hearing so that the contractor can attempt to justify a denial that is inappropriate on its face. The record includes the information available to the contractor at the time it made its decision; if it is clear to an impartial adjudicator, such as an ALJ or the proposed attorney adjudicators, that the information available to the contractor and present in the record does not support upholding the denial, the contractor should not have the chance to chase its inappropriate denial further into the appeals process.

We thank you for the opportunity to provide input on this proposed rule, and look forward to continued discussion on ways to address the appeals backlog, including reform of the audit process to prevent inappropriate denials that necessitate avoidable appeals. If you or your team have any questions or would like to discuss further, please contact Melissa Myers, senior associate director for policy, at mmyers@aha.org or (202) 626-2356, or Lawrence Hughes, assistant general counsel, at lhughes@aha.org or (202) 626-2346.

Sincerely,

/s/

Ashley Thompson
Senior Vice President, Public Policy Analysis and Development