American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

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Submitted Electronically

Hon. Nancy J. Griswold
Chief Administrative Law Judge
Office of Medicare Hearings and Appeals
Department of Health and Human Services
Attention: OMHA-1401-NC
1700 N. Moore Street, Suite 1800
Arlington, VA 22209

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) request for information on current and additional potential initiatives to address the Medicare claim and entitlement appeals workload and backlog at the Administrative Law Judge (ALJ) level.

We understand that in an effort to address the current backlog crisis, OHMA recently expanded its adjudicatory capacity – in particular through the opening of a new field office in Kansas City, Mo. – and announced plans to standardize its business process and deploy new information technology systems for case filing and tracking that the agency expects to create efficiencies in case handling. However, these efforts fail to address directly the underlying cause of the appeals workload and backlog – excessive inappropriate denials of claims by recovery audit contractors (RACs). In particular, improper denials of short inpatient hospital stays have swollen the number of ALJ appeals. OMHA's current pilot programs aimed at reducing the existing huge appeals backlog offer at best only a temporary fix for backlogged cases while raising a number of questions and concerns for any hospital potentially interested in participating.

Fundamental reform of the RAC process is at the heart of an effective and permanent solution to the appeal backlog problem and will enable hospitals to get timely administrative review that clearly is required by the Medicare statute. 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 leadership at the Centers for Medicare & Medicaid Services (CMS) and HHS, members of Congress, and providers and other

stakeholders to illustrate the continuing contribution of the RAC denials to the workload burdens of the ALJs and hence the growing backlog of appeals.

RAC PROCESS REFORMS SHOULD BE IMPLEMENTED IMMEDIATELY

Excessive inappropriate RAC denials have forced hospitals to appeal significant numbers of them, and the influx of appeals for these inappropriate denials has broken the Medicare appeals process. The biggest driver of this willful conduct by RACs is the contingency fee structure because it incentivizes them to issue inappropriate denials with impunity. If RACs were assessed a financial penalty for making inappropriate denials, it would lessen these strong financial incentives and promote more appropriate and accurate assessments by the RACs.

Additional administrative changes that would enhance audit accuracy and reduce burden on hospitals and the appeals system include:

- Codifying in regulation CMS's assertion in the preamble of the fiscal year 2014 inpatient prospective payment system final rule that the RACs 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).

- Eliminating 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, 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 appeals rights and receive a final determination on the Part A claim before rebilling under Part B.

- Limiting RAC approval for auditing approved issues (such as inpatient short stays) 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, RACs must stop auditing that issue. CMS then would analyze the audit results and provide education to providers in that jurisdiction, if warranted. A RAC would need to seek new approval from CMS to audit for that same issue, but must wait a certain defined time period to allow providers to incorporate education before requesting new approval.

THE LACK OF CRITICAL OPERATIONAL INFORMATION DISCOURAGES HOSPITAL PARTICIPATION IN THE OMHA-ESTABLISHED PILOTS

OMHA's Settlement Conference Facilitation Pilot, which provides an alternative dispute resolution process applicable only to Medicare Part B claims, would not be generally applicable to most hospital appeals. The Statistical Sampling Pilot, under which a provider would agree to allow OMHA to adjudicate a group of appeals using a statistical sampling methodology, has

more direct relevance for most hospital appeals. Given the number of claims required by the pilot and the limited timeframe to which it applies, it is unclear how many hospitals would have enough claims pending at the ALJ level to qualify to use statistical sampling. Hospitals also question whether OMHA's resources would allow it to process requests for participation in the program in a timely and accurate way.

In addition, important questions and concerns about the operation of the Statistical Sampling Pilot remain unanswered, including:

- **Use of Extrapolation:** In the materials it has published on the pilot, OMHA states that a "Medicare contractor" will extrapolate the ALJ's decision on the sample set of claims to the larger universe of claims from which the sample was drawn. The contractor will then forward the results to the Medicare Administrative Contractor to effectuate the decision. It is not clear which Medicare contractor would perform the extrapolation. **The AHA would strongly oppose CMS's use of RACs to extrapolate the ALJ's decisions, given the significant financial incentives the RACS have to increase hospital claim denials.**

  In addition, OMHA provides no details on how the extrapolation will be conducted – for example, whether it will extrapolate results based on number of claims or payment amounts denied. Further, though participating hospitals will have the chance to challenge the statistical sampling model via expert testimony at the ALJ hearing, it is unclear whether or how hospitals will be able to challenge whether the extrapolation is performed correctly.

- **Part B Rebilling:** OMHA states that the ALJ cannot extrapolate the amount that a hospital would receive if it submits denied Part A admissions for rebilling under Part B. Although OMHA does not directly address whether hospitals would have a right to rebill denied Part A admissions that were part of a universe of claims, it seems impossible from a practical perspective that hospitals would be able to do so. Therefore, use of statistical sampling for denials of Part A admissions may result in hospitals forgoing their ability to receive any payment for those claims.

- **Effect of Withdrawing Consent:** Hospitals will be able to withdraw consent for participation in statistical sampling until the ALJ has issued the pre-hearing conference order. However, once a hospital withdraws consent, it is not clear whether appeals that would have been subject to statistical sampling will remain in queue for hearing by an ALJ or if they will go to the back of the line.

Although marginal improvements to the Statistical Sampling Pilot may make it more attractive for some hospitals, it nevertheless remains an inadequate substitute for a timely ALJ hearing and decision on inappropriately denied claims. It is at the ALJ stage of the Medicare administrative appeals process where hospitals are entitled to independent and objective review of their claims and, not surprisingly, historically have had the greatest rate of success in overturning inappropriate RAC denials. ALJ hearings provide hospitals the opportunity to present testimony based on clinical factors that are critical to accurate decisions in denial of complex claims. At the hearing, hospitals can demonstrate the credibility and veracity of their claims through the oral

testimony of clinicians, and this gives the ALJ a meaningful way in which to judge a claim's legitimacy. Moreover, hospitals can respond to questions posed by the ALJ in real-time and explain the written materials in the record. This simply cannot occur through a paper hearing and demonstrates that an oral hearing before an ALJ is critical.

Given the importance of preserving the integrity and ensuring the timely functioning of the ALJ appeals hearing process, we believe the focus of efforts to address the Medicare claim and entitlement appeals workload and backlog at the ALJ level should return to, and remain on, ensuring that RAC denials truly represent improper payments. And, that requires making fundamental reform of the RAC process an immediate priority within HHS. Implementation of the recommendations we outlined above would ensure that fewer hospitals need to appeal inappropriately denied claims to the ALJ level, reducing the influx of appeals at the front-end and preventing further growth of the appeals backlog.

Please direct any questions to Melissa Jackson, senior associate director for policy, at mjackson@aha.org or (202) 626-2356, or Lawrence Hughes, assistant general counsel, at lhughes@aha.org or (202) 626-2346.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis and Development