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August 29, 2016

Office of Medicare Hearings and Appeals
Department of Health and Human Services
Attention: OMHA-2015-49
5201 Leesburg Pike
Suite 1300
Falls Church, VA 22041

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

NOTE: In the correspondence that follows, AHCA is specifically commenting on Precedential final decisions of the Secretary; Attorney Adjudicators; Amount in controversy required for an ALJ hearing; and Sending copies of a request for hearing and other evidence to other parties to appeal.

To Whom It May Concern:

The American Health Care Association (AHCA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) proposed rule, *Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures*, 81 *Federal Register* 43,790 (July 5, 2016). AHCA is the nation's leading long term care organization. AHCA and its membership of over 13,000 non-profit and proprietary centers are dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly and disabled citizens who live in nursing care centers, assisted living communities, subacute centers and centers for individuals with intellectual and developmental disabilities. The vast majority of our members are skilled nursing facilities (SNFs) that participate in the Medicare program, and thus they have a direct interest in changes to the Medicare appeal process.

As CMS describes in its proposed rule, the Office of Medicare Hearings and Appeals (OMHA) has experienced such a significant and sustained increase in its appeal workload that it can no longer meet the statutory requirements enacted by *The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA). BIPA requires an Administrative Law Judge (ALJ) to conduct, conclude and render a decision in a Medicare hearing appeal within 90 days from the date an appellant has timely filed a request. The *Social Security Act* (SSA), Section 1869(d)(3) also states that if an ALJ is unable to render a decision by the end of the specified timeframe, the appellant may then request review by the Departmental Appeals Board (DAB). Subsequently, if the DAB does not render a decision within 180 days, the appellant may then seek judicial review.

These remedies are of little practical value to SNFs, who are being substantially impacted by the current OMHA backlog and delays. For example, ALJ decisions consistently lead to higher rates of reversals for SNF claims denials. Requiring SNFs to wait the average of 819 days for an ALJ decision[1] to have improperly denied claims overturned place SNFs at an unfair financial disadvantage. Under CMS' current rules, once an appeal is at the ALJ level recoupment can no longer be avoided; and, depending upon the alleged overpayment, the recoupment may have a significant impact on a provider's cash flow. Furthermore, any unpaid amount stemming from an overpayment continues to accrue a high interest rate while the recoupment is processing. Additionally, the unpaid debt is often referred to one or more collection agencies, requiring the SNF to spend money and devote resources in order to dispute any such referred debt.

For the above reasons, AHCA recommends that CMS relax its approval process for SNF payment plans while a SNF awaits an ALJ hearing. Further, CMS should be prohibited from making a debt referral which exists because of the Medicare appeals backlog and should waive any further interest on the principal under a SNF payment plan and only impose interest later on any amount later adjudicated as an overpayment.

Within the SNF environment, under both Medicare Parts A and B, there are significant backlog of claims appeals at OMHA. Most significantly, under the Part B outpatient therapy Manual Medical Review (MMR) program, improper recovery auditor (RA) activities created numerous appeals. By way of background, *The American Taxpayer Relief Act of 2012* (ATRA) extended a provision from *The Middle Class Tax Relief and Job Creation Act of 2012* (MCTRJCA) that established the therapy cap exceptions process and established the MMR program for outpatient therapy services exceeding $3,700. Under the SSA, Section 1833(g), CMS is required to make a decision about whether or not therapy services are covered within 10 business days from receipt of a request for review.

In April 2013, the RAs began conducting prepayment MMR reviews of SNF claims at or above the $3,700 threshold in California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas; and post payment reviews in

[1] U.S. Government Accountability Office (GAO), *Medicare Fee-For-Service: Opportunities Remain to Improve Appeals Process*, GAO-16-366, May 2016.

all other states. Unfortunately, these reviews started with RA Additional Document Requests (ADRs), that were overly burdensome and greatly exceeded what could reasonably be considered necessary to determine whether or not outpatient therapy services were medically necessary. SNFs that sent in medical records were required to do so by fax or mail, and in many instances, RAs denied claims citing that they never received the records that providers sent to them, despite provider proof of receipt. In other cases, RAs did not submit decisions to Medicare Administrative Contractors (MACs) in a timely manner at which time the MAC systems auto-denied the claims. Providers were not provided a discussion period and were instructed that their only recourse was to appeal the improper denial. Many of these appeals received "rubber stamp" denials at the first two levels of appeal. For SNFs who did receive RA "finding[s]" letters, there was insufficient rationale for denials, making the Medicare appeals process even more difficult. These problems were widespread and had huge repercussions for SNF residents, as well as severely limiting providers' cash flow, particularly for facilities in the 11 prepayment review states.

The Protecting Access to Medicare Act of 2014 (PAMA) added a 1-year extension to the therapy cap exceptions process and the associated MMR program through March 31, 2015. Subsequently, *The Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) further extended the outpatient therapy cap exceptions process and a modified MMR program through December 31, 2017.

In February 2016, CMS announced (via a website update) that the Supplemental Medical Review Contractors (SMRCs) (not the RAs) are now responsible for the MMR program reviews. Regrettably, with the extension of the MMR program and a new national CMS contractor now involved, AHCA anticipates that SNFs will continue to have to appeal inappropriate claims denials and be faced with significant delays.

AHCA is concerned that the OMHA delays are affecting not only the third level of the Medicare appeals process; but also every other level of the Medicare appeals process, resulting in significant financial hardship for both beneficiaries and providers. Although we are encouraged that CMS is working to align regulatory inconsistencies, we are concerned that CMS' proposed rule will not significantly improve or eliminate the current backlog. We encourage CMS to think more broadly, and to work with key legislators and stakeholders to take the proper steps to make some more meaningful changes to the current Medicare appeals process.

Below please find AHCA's comments to the few major changes suggested in the proposed rule.

A. PRECEDENTIAL FINAL DECISIONS OF THE SECRETARY

In the proposed rule, CMS would allow some decisions from the Medicare Appeals Council (Council) to establish precedent that decision-makers at the lower levels of the Medicare appeals process would have to follow. Specifically, new 42 C.F.R. § 401.109 would introduce precedential authority to the Medicare claim and entitlement appeals

process; grant authority to the Chair of the DAB to designate a final decision of the Secretary issued by the Council as precedential; and require notice of precedential decisions to be published in the *Federal Register*, and the decisions themselves to be made available to the public.

AHCA agrees that if this proposal is based strictly on issues of law, the Council's decisions are entitled to precedential deference by other lower level adjudicators in the Medicare appeals process. Cases that reach the Council level of review have already gone through four levels of review, and they are more likely to be the cases of most importance to beneficiaries and providers. When other parties have advocated their position and the Council has fully considered an issue, it makes sense for others parties to have the benefit of the prior decisions and accord them precedential deference, similar to that which a district court accords to the other district courts within the same circuit. AHCA believes this proposal, if limited narrowly on issues of law, would help to focus issues for appeals and streamline subsequent decisions. AHCA believes, however, that designating certain decisions as precedents would have little influence in decreasing the current backlog.

While AHCA supports limited precedential deference, we are concerned that many of the current cases making their way through the appeals process are based on RA determinations and are too fact-specific to offer reliable precedential value. Further, AHCA is concerned there are no clear criteria for how the Council Chair will determine the precedential decisions. Finally, AHCA is concerned with how precedential decisions will be implemented by CMS – the proposed rule is unclear regarding the process and AHCA can foresee Medicare contractors inconsistently applying precedential decisions. **Until the criteria are better outlined, AHCA cannot endorse these sections of the proposed rule.**

B. ATTORNEY ADJUDICATORS

In the proposed rule, CMS would allow senior attorneys (*e.g.*, attorney adjudicators) to handle some of the procedural matters that routinely come before the ALJ. Specifically, the proposed rule would revise 42 C.F.R. §§ 405, 422, 423, to allow attorney adjudicators to issue: a) decisions when a decision can be issued without an ALJ conducting a hearing; b) dismissals when an appellant withdraws his or her request for an ALJ hearing; and c) remands for information that can only be provided by CMS or its contractors or at the direction of the Council. CMS also would allow attorney adjudicators to conduct reviews by a Qualified Independent Contractor (QIC).

Any decision or dismissal issued by attorney adjudicators could be reopened and/or appealed in the same manner as equivalent decisions and dismissals issued by ALJs. The rights associated with an ALJ appeal (*e.g.*, time frame, escalation option, right of appeal to the Council, etc.) also would extend to any appeal adjudicated by attorney adjudicators. Even in situations where attorney adjudicators are assigned to adjudicate a request for an ALJ hearing, that hearing request could still be reassigned to an ALJ for an oral hearing if the attorney adjudicator determines that a hearing is necessary to render a decision.

AHCA is concerned that attorney adjudicators will do little to alleviate the significant OMHA backlog created by the RAs and SMRCs under the MMR process, as these matters would generally be outside attorney adjudicator's jurisdiction. Further, even though CMS specifically "note[s] that attorney adjudicators would receive the same training as OMHA ALJs"[2], attorney adjudicators may not possess the same level of expertise and experience as ALJs in adjudicating Medicare appeals and SNFs may not receive decisions consistent with the quality of ALJ decisions. **AHCA would like to know more about the current ALJ training and CMS' proposed timeline for hiring and training attorney adjudicators before it can support these proposed changes.**

Additionally, it is unclear from the proposed rule whether these attorney adjudicators will be solely designated from current staff or newly hired by CMS. If the former, AHCA wonders whether this reallocation of tasks would only create another backlog for other appeal-related tasks. **AHCA recommends that CMS seek additional funding to retain additional ALJs for the third and fourth level of appeal.**

If CMS determines to move forward with attorney adjudicators despite AHCA's concerns, we recommend that CMS consider at the very least using the supplementary OMHA staff already working with the ALJs in the research, hearing and decision-making processes, and who have worked for those ALJs for a minimum of a least one year with respect to Medicare payment and coverage issues.

C. AMOUNT IN CONTROVERSY REQUIRED FOR AN ALJ HEARING

In the proposed rule, CMS would calculate the amount in controversy (AIC) for ALJ hearings based on the Medicare allowable amount rather than the billed charges. Specifically, the proposed rule would revise 42 C.F.R. §§ 405.1006, 405.976(b)(7), 423.1970, 422.600(b), and 478.44(a), to establish that provider claims appeals would be based on the published Medicare fee schedule, and would use the actual amount charged to the individual as the basis for the AIC, rather than the Medicare allowable amount (*e.g.*, the maximum amount of the billed charge deemed payable for the item or service) for the items/services being appealed. The proposed rule also establishes exceptions to this revision if a claim is not priced pursuant to a fee schedule.

AHCA agrees with CMS statement that "[d]ue to the pricing methodology for many items and services furnished by providers of services, such as …SNFs, at the present time an allowable amount is not easily discerned or verified with existing CMS…tools…. Therefore, we are proposing…to continue using the provider's or supplier's billed charges as the basis for calculating the AIC [for SNFs]." **AHCA supports the proposed continued use of SNF billed charges as the basis for calculating the AIC.**

Related to the amount in controversy issue, we note that currently, in too many instances, claims determinations from a single audit are segregated into multiple overpayment

[2] *Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures*, 81 Fed. Reg. 43,795 (July 5, 2016).

demands that increase the administrative burden not only to SNFs but also to CMS. This contractor practice of segregating the claims determinations, oftentimes with different decision dates creates situations where SNFs have been unjustly denied an opportunity to appeal certain claims because the amount in controversy for an individual claim is too low to meet the AIC or is too low to justify the expense of an appeal…while the different decision dates may prevent the provider the opportunity to combine the individual claims to satisfy the minimum AIC threshold. **AHCA recommends that the agency prohibit MACs from segregating claims that stem from the same audit or investigation by the MAC, RA or Zone Program Integrity Contractor (ZPIC).**

D. SENDING COPIES OF A REQUEST FOR HEARING AND OTHER EVIDENCE TO OTHER PARTIES TO APPEAL

In the proposed rule, CMS would incorporate portions of current 42 C.F.R. § 405.1014(b)(2) into 42 C.F.R. § 405.1014(d), which would require the appellant to send a copy of the request for a hearing to all other parties, and any failure to comply would halt the ALJ's 90 calendar day adjudication deadline until all the parties to the QIC reconsideration received notice of the requested ALJ hearing. Any additional materials necessary for an appellant to complete a request also would require copies be sent to all other parties. Evidence that a copy of the request for hearing or a copy of submitted evidence summary, was sent would include: 1) certifications that a copy of the request for hearing or request for review of a QIC dismissal is being sent to the other parties; 2) an indication, such as a copy or ''cc'' line on a request for hearing or review, that a copy of the request and any applicable attachments or enclosures are being sent to the other parties, including the name and address of the recipients; 3) an affidavit or certificate of service that identifies the name and address of the recipient and what was sent to the recipient; or 4) a mailing or shipping receipt that identifies the name and address of the recipient and what was sent to the recipient. Further, if an adjudication time frame applies, it would not begin until evidence that the request, materials, and/or evidence was received. Lastly, if an appellant does not provide evidence, within the time frame provided, to demonstrate that the request, materials, and/or evidence was sent to all other parties, the appellant's request for hearing or review would be dismissed.

AHCA strongly opposes this proposed provision as it would only promote more paperwork and delays and would result in unnecessary confusion for many of the beneficiaries receiving these notifications. For example, under the current regulations, an ALJ hearing request may be made in a simple one-page filing which can easily be sent to each beneficiary whose claim is included in the appeal. The proposed regulations would significantly increase the extent of the filing which would increase costs for reproducing and sending a copy to each beneficiary. Even with a simple appeal filing, a number of beneficiaries call in response to receiving the letter to inquire about the appeal. If the appeal filing is more extensive, those calls will require more time to answer all of the questions the beneficiary has about the appeal. As noted above, many of the SNF claims are overturned at the ALJ hearing, a hearing in which beneficiaries do not participate. It is unfair to place such an administrative burden on a SNF for claims in which the denials are not upheld during the hearing. **AHCA recommends, as an**

alternative approach, that CMS consider a policy that would require provider notice to the beneficiary of the outcome of a hearing but only for claims in which the denial has been upheld by the ALJ.

E. **STATEMENT OF WHETHER THE FILING PARTY IS AWARE THAT IT OR THE CLAIM IS THE SUBJECT OF AN INVESTIGATION OR PROCEEDING BY THE OIG OR OTHER LAW ENFORCEMENT AGENCY WHEN REQUESTING AN ALJ HEARING OR A REVIEW OF A QIC DISMISSAL**

The proposed rule revises 42 C.F.R. 405.1014(vii) by requiring a request for an ALJ hearing or a review of a QIC dismissal to include "a statement of whether the filing party is aware that it or the claim is the subject of an investigation or proceeding by the HHS Office of Inspector General or other law enforcement agencies."

AHCA opposes this proposed provision as it is overly broad, burdensome, and potentially prejudicial to providers. AHCA does not see the relevance in providers being required to disclose active investigations, particularly those from other law enforcement agencies unaffiliated with HHS. To the extent there is an active investigation from HHS, the burden should be on the government to develop efficient interagency procedures to obtain such information related to such investigation. Further, there is significant concern that this information may be used prejudicially by an ALJ or attorney adjudicator at a hearing where the result or cause of any such investigation may be completely unrelated to the issue at hand.

AHCA also notes that in certain circumstances those filing an appeal on behalf of provider may not be aware of any active investigations or proceedings, particularly in a large SNF chain setting. To the extent CMS moves forward with this requirement, **AHCA recommends that CMS provide clarity and safeguards with respect to the request and submission of such information.**

On behalf of our members, AHCA thanks you for the opportunity to submit these comments regarding the significant OMHA backlog and the proposed rule. If you have specific follow-up questions to these comments, please contact Dianne De La Mare at 202-898-2830 or email at ddmare@ahca.org.

Sincerely,

Mike Cheek, AHCA
Sr. V.P., Finance Policy & Legal Affairs