December 5, 2014

Nancy 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

***RE: OMHA-1401-NC: Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim Appeals***

Dear Ms. Griswold:

The American Health Care Association (AHCA) appreciates the opportunity to respond to the Office of Medicare Hearings and Appeals (OMHA) request for information at *Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim Appeals*, 79 *Federal Register* 65660 (November 5, 2014). AHCA is the nation’s leading long term care organization. AHCA and its membership of over 12,000 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.

As OMHA describes in its request for information, the Agency has experienced such a significant and sustained increase in its appeal workload that it can no longer meet the statutory requirements in 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. Further, the *Social Security Act* (SSA), Section 1869(d)(3) 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 the specified timeframe, the appellant may then seek judicial review. Despite these BIPA and SSA requirements, the OMHA delays are affecting every subsequent level of the Medicare appeals process, resulting in significant financial hardship for both beneficiaries and providers.

AHCA applauds OMHA for its efforts in reaching out to stakeholders through hosting forums and vetting possible solutions to the ever-growing Medicare appeals backlog problem. However, we are disappointed that the Centers for Medicare and Medicaid Services (CMS) offered only the acute care hospitals an opportunity to receive a partial payment from the agency if they withdrew certain appeals (*e.g.,* related to inpatient status). Many of these pending appeals seem to stem from overly aggressive Medicare Recovery Auditor Contractors (RACs) determinations that beneficiaries are designated as hospital inpatients when they should have been outpatients. Amid a massive backlog of hospital inpatient claims appeals at OMHA, CMS is now giving acute care hospitals the opportunity to withdraw their pending Medicare appeals to obtain a “timely partial payment” of 68 percent of their disputed claims’ net allowable amount. Skilled nursing facilities (SNFs) would like the same opportunity to receive a partial payment if they voluntarily choose to withdraw certain appeals.

Within the SNF environment, we too are seeing a significant backlog of claims appeals at OMHA, resulting from improper RAC activities in implementing the outpatient therapy manual medical review (MMR) program. By way of background, the American Taxpayer Relief Act (ATRA) extended a provision from the Middle Class Tax Relief and Job Creation Act (MCTRJCA) that established a MMR process for outpatient therapy services exceeding $3700. Under the SSA, Section 1833(g), CMS must make a decision about whether or not therapy services are covered within 10 business days from receipt of a request for review.

Effective April 1, 2013, the RACs became responsible for conducting prepayment review of claims at the $3700 threshold in California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas; and postpayment reviews in all other states. Within the MMR program, the RACs began requesting Additional Document Requests (ADRs) for their reviews 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 some instances RACs were claiming that they never received the records that providers sent to them. For SNFs who did receive “findings” letters from the RACs, there was insufficient rationale for the denials, making the Medicare appeals process even more difficult. These problems were widespread and had huge repercussions for care center patients, as well as severely limiting cash flow, particularly for the SNFs in the 11 prepayment review states.

On April 1, 2014, President Obama signed into law the *Protecting Access to Medicare Act of 2014*, which added another 1-year extension to the current therapy cap exceptions process and the associated MMR program. Unfortunately, with the extension of this program, the aforementioned RAC problems continue, and SNFs are forced to appeal the many inappropriate denials. For this reason AHCA respectfully requests that OMHA discuss this matter with CMS, and encourage that agency to allow SNFs the same opportunity to receive a partial payment from CMS if they withdraw certain appeals relating to the MMR program.

AHCA also encourages OMHA to consider recently released legislation, *Hospital Improvements for Payment Act of 2014*, Subtitle C – Appeals, Section 107, *Retrospective Non-Hospital Solutions to Address Problems in the Medicare Appeals Process***,** as it searches for solutions to the substantial ALJ backlog. AHCA agrees in concept with the proposed provisions requiring the US Department of Health and Human Services (HHS) Secretary to implement the two described processes to help alleviate the current problems. However, we also have recommendations for improvements.

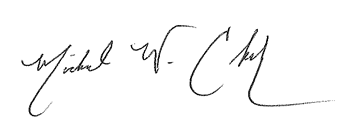
First, AHCA recommends that the provisions be extended beyond Part B claims to include non-hospital Part A claims. For example, although SNF Prospective Payment Claims (PPS) claims do not represent a significant portion of the ALJ appeals backlog, that impact may be very significant to the individual SNF that has numerous claims stuck in the appeals process. These providers should be afforded the same appeals alternative options afforded to inpatient hospitals and providers of Part B services.

Second, AHCA recommends that the first sentence of the proposed language in (j)(i) on page 54 regarding the voluntary settlement option be revised from “The Secretary *may*…” to “The Secretary *shall*…” Providers under this provision should be afforded the same appeals alternative options afforded to inpatient hospitals.

Under Section 108, Prospective Solutions to Address Problems in the Medicare Appeals Process, AHCA supports all of the proposed provisions to address numerous problems in the appeals process including those related to improved data collection requirements, the establishment of a comprehensive electronic system for filing and managing appeals by July 1, 2015, and the posting of information on pending appeals and determinations within 6 months or enactment.

On behalf of our members, AHCA thanks you for the opportunity to submit these comments regarding the significant backlog at OMHA. 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](mailto:ddmare@ahca.org).

Sincerely,



Mike Cheek

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