



Charles N. Kahn III
President & CEO

December 3, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, DC 20201

Re: CMS-4174-P; Medicare Program: Changes to the Medicare Claims and Medicare Prescription Drug Coverage Determination Appeals Procedures; 83 Fed. Reg. 49513 (Oct. 2, 2018)

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) *Medicare Program: Changes to the Medicare Claims and Medicare Prescription Drug Coverage Determination Appeals Procedures Proposed Rule* (Proposed Rule).

The FAH commends CMS for its goals, as stated in the Proposed Rule, of streamlining the Medicare appeals process, increasing consistency in decision-making, improving efficiency for both appellants and adjudicators, and clarifying processes and adding provisions for increased assistance for unrepresented beneficiaries. As a general matter, the FAH supports the changes identified in the Proposed Rule. We believe, however, that CMS should consider additional measures that would address the significant inefficiencies, procedural problems, and administrative burdens that arise as a result of the massive backlog of appeals that continues to exist at the Office of Medicare Hearings and Appeals (OMHA).

The U.S. Department of Health and Human Services (HHS) has identified the backlog of appeals as "a matter of significant concern" and made the adoption of "measures that are designed to reduce the backlog and improve the overall Medicare appeals process" an agency priority.¹ Given this priority and CMS goals in the Proposed Rule, we would like to offer recommendations, many of which the FAH has previously made, on the types of administrative actions that would improve the Medicare appeals process and reduce the appeals backlog. The FAH, therefore, urges CMS to consider our recommendations, which are compiled in the attached synopsis titled *Key Recommendations, Improve Medicare Appeals Process and Reduce Backlog*.

The FAH appreciates your consideration of our comments and recommendations on the efforts being undertaken by CMS to provide regulatory and administrative relief for appellants and adjudicators. We remain ready to work with CMS on these important initiatives. Should you have any questions, please contact me or my staff at (202) 624-1500.

Sincerely,



¹ CMS, *Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Determination Appeals Procedures*, 82 *Fed. Reg.* 4974, 4977 (Jan. 17, 2017).



KEY RECOMMENDATIONS
IMPROVE MEDICARE APPEALS PROCESS AND REDUCE BACKLOG

- **Offer voluntary claims settlement process:** Based on the successful outcome of the Hospitals Appeals Settlement that CMS offered in 2014 and 2016 to reduce the Medicare appeals backlog, we recommend that the Agency similarly offer a voluntary claims settlement process for various other Medicare claims in the appeals backlog.
- **Delay QIO referrals to RACs by one year:** Recovery Audit Contractors (RACs) will conduct patient status reviews for providers that have been referred by a Quality Improvement Organization (QIO) as exhibiting persistent noncompliance with Medicare payment policies. We are concerned that this RAC activity will materially increase overall appeals volume, in particular appeals of patient status denials. We urge CMS to delay such RAC involvement by at least one year. This will provide an opportunity for the QIOs to fully transition into their new claims review role and better understand the review and appeals process, while removing incentives for the RACs to deny claims that often are overturned on appeal at the ALJ level and ultimately increase the appeals backlog. We also urge CMS to exercise oversight of RAC activities to prevent incentives for inappropriate claims denials.
- **Limit scope of RAC/QIO review:** Going forward, the scope of RAC or QIO review should exclude any medical necessity determinations for which there is documentation of the exercise of physician judgment. Medical necessity determinations, including patient status designations, are complex clinical decisions that require physician judgment based on the facts and circumstances present at the time the decision is made. In particular, patient status determinations are subjective in nature and made in real time by physicians with the best interests of patients in mind. Yet, these decisions have been subject to intense scrutiny by the RACs, and significantly contributed to the steep increase in the appeals backlog, with a substantial number of these very same RAC decisions being overturned at the ALJ level.
- **Delay RAC payment and recoupment until after ALJ level:** Medicare contractors should not be permitted to recoup payments from hospitals, or payments due under another enrollment under the same legal entity, until after a RAC denial is upheld by an ALJ. Similarly, RACs should not be paid until a final ALJ determination is made upholding their denial. Often, the first two levels of the Medicare claims appeal process do not afford a fair and impartial review of the merits of Part A. Based upon Office of Medicare Hearings and

Appeals' (OMHA) data, the overturn rate for Part A denials at these lower levels is very low (when removing missing documentation cases). In contrast, the overturn rate at the ALJ level has been far higher, which confirms the view that ALJs provide the first level of real oversight and objectivity to scrutinizing denials.

We appreciate that CMS has undertaken RAC reforms, such as establishing that RACs cannot receive a contingency fee until after the second level of appeal is exhausted. However, our experience is that RAC denials often are upheld at the first two levels of appeal. Therefore, delaying the RAC contingency fee only until after the second level of appeal likely will not provide adequate incentives for the RACs to limit inappropriate denials, which are backlogging the appeals system.

- **Require Medicare contractors to address technicalities before denying a claim:** Often, Medicare contractors deny claims for simple non-substantive technicalities, such as a missing signature. CMS should ensure that contractors timely engage in discussion with providers to efficiently address these technicalities before denying a claim.
- **Require physician review of Medicare contractor patient status and medical necessity reviews:** We appreciate that CMS now requires RACs to have a Contractor Medical Director and encourages RACs to have a panel of specialists available for consultation. We urge CMS to exercise oversight to ensure that the RACs utilize this panel of specialists. Further, these standards also should be applied to all Medicare contractor denials.
- **Prohibit RAC/QIO denials upon missed deadlines:** CMS should enforce RAC and QIO deadlines to issue claims decisions and prohibit RACs and QIOs from issuing determinations for claims when a RAC or QIO misses its deadlines for those claims.
- **Penalize RACs for high denial overturn rate:** RACs should be subject to a financial penalty when their post-payment denials are overturned on appeal at a significant rate at the ALJ level. Again, we appreciate that CMS now requires RACs to maintain an overturn rate of less than 10 percent at the first level of appeal, and a 95 percent accuracy rate. It is premature, however, to determine the impact of these reforms. As discussed above, our experience is that RAC denials often are upheld at the first two levels of appeal, and maintaining an overturn rate of 10 percent at the first level of appeal may not be effective. Instead, the overturn rate requirement should apply at the ALJ level where most appeals are overturned.
- **Require transparency of QIO/Medicare contractor claims review standards and guidelines, audit protocols and audit tools:** QIOs and other Medicare contractors often provide inconsistent reviews. CMS should require greater transparency regarding claims review guidelines that CMS provides to Medicare contractors. And, CMS should require its contractors to develop and follow audit protocols (setting forth the applicable statutes, regulations, manual guidance, coverage determinations, etc. under which each claim determination will be made) and utilize audit tools (providing objective scoring to reflect errors). This would not only enhance transparency but also provide clarity regarding contractor review standards and ensure standardization for consistent determinations. CMS

provision of review guidelines and QIO and Medicare contractor sharing of audit protocols and audit tools also would facilitate providers in submitting more compliant claims up front, which would reduce unnecessary claims denials.

- **Require transparency for rationale of claims denials:** CMS should require MACs and Qualified Independent Contractors (QICs) to be transparent in the rationale for denying a claim and should provide in writing the specific regulation or other requirement that is the basis for denial of a claim. Often, claims are denied even though the records submitted demonstrate compliance with the applicable regulations or other requirements. If providers have more information regarding the basis for the denial, they can provide more targeted information so that the case can be closed or settled earlier in the appeals process. Additionally, if a MAC or QIC is required to consult the applicable regulations or other requirements, it may cause the reviewer to reconsider the denial and allow the claim, thereby settling the case earlier in the process, and ensuring that an appropriate standard has been applied.
- **Require robust MAC claims review:** CMS should instruct MACs to review all materials submitted for an appeal of a claims denial and actually render an independent decision regarding the claim (as occurs at the ALJ level), rather than simply reviewing the RAC's or other Medicare contractor's report and claims decisions. MACs should be cautioned to view a contractor audit that has an extremely high error rate with skepticism. This would allow a more robust review, which could result in more accurate determinations of claims at the MAC level.
- **Require more education for MAC appeals/allow option to begin appeal at QIC level:** CMS should require greater education for MACs regarding appeals. To the extent that appeals have more robust review at the QIC second level of appeal, it is due to greater education at the QIC level. CMS also could consider allowing the option for providers to appeal directly to the QIC level, rather than beginning at the MAC level of appeal, especially since MACs have already made the initial denial determination.
- **Provide Incentives for MACs to resolve appeals:** CMS could create financial incentives for the MACs to resolve appeals at the MAC level, if appropriate.
- **Extend timeframe for hospital appeals recoupment:** After receiving an initial demand letter for payment, upon denial of a Medicare claim, providers have 120 days to request a redetermination of the denial. Recoupment of payment for the denied claim can be put on hold only if the provider submits the appeal within 30 days. This timeframe should be extended to 59 days, as this would allow providers more time to develop and submit a more robust and complete appeal, which would promote an improved appeals process that could result in better outcomes at lower levels of appeal.
- **Consolidate Medicare contractor appeals:** When a Medicare contractor conducts an audit and requests that claims in the audit be denied, the MAC should be required to issue only one determination with regard to the claims denials so that there is a singular appeal. Too often, MACs divide the results from a probe audit into several determinations. If the MAC fails to

issue a single determination, providers should be able to consolidate appeals that originate from a single audit. Consolidation also should be permitted when there is a prepayment probe and claims are denied for a similar reason. When MACs issue individual denials for each claim, and each appeal is individually processed and heard, this causes unnecessary burden, time and expense for CMS, the Medicare appeals process, and providers. Finally, providers should be permitted to consolidate appeals at the ALJ level to provide a more efficient docket.

- **Address additional provisions in the January 2017 Medicare appeals process final rule:** Under the Medicare appeals process final rule issued in January 2017, when a provider requests an ALJ hearing or review of a QIC dismissal, the provider must submit a copy of the request and related materials to all involved parties. This would include each Medicare beneficiary who is a part of the appealed claim, which may involve a substantial number of beneficiaries. This could create perverse incentives for MACs to deny claims inappropriately, on the basis that providers may have less incentive to request an ALJ appeal due to the increased burden of submitting the appeals request and related materials for each beneficiary. While this may appear to promote a decrease in the number appeals, it likely would have the opposite effect. When MACs and other Medicare contractors have incentives in the claims review process that result in inappropriately denied claims, this creates a spiral effect of increasing provider incentives to appeal claims. There should be alignment of appropriate incentives for all parties to the Medicare appeals process. (Notably, when CMS appeals a claim to the ALJ level, the Agency is not required to provide the same beneficiary notice and related materials, and there should be parity in this process.)

In contrast, under the Medicare appeals process final rule, the MACs are now required to attend the ALJ appeal hearing. It is critical that CMS oversee and monitor this requirement, as it could create incentives for more robust MAC review at lower levels of appeals. If so, this could positively impact the appeals process and reduce the number of appeals.