



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

January 14, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Significant Delay in Assignment of Hospital Appeals to Administrative Law Judges

Dear Ms. Tavenner:

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) is writing to express our strong concern regarding the Office of Medicare Hearings and Appeals' (OMHA) December 2013 letter announcing that it has temporarily suspended assignment of most new requests for Administrative Law Judge (ALJ) hearings for at least 24 months.

Delays of at least two years in granting an ALJ hearing for an appealed claim are not only unacceptable, they are a direct violation of Medicare statute that requires ALJs to issue a decision *within 90 days of receiving the request for hearing*. Further, this is not a new problem; prior to OMHA's suspension of appeals assignments, ALJs were not adhering to their statutory deadline.

Excessive inappropriate denials by Medicare Recovery Audit Contractors (RACs) are a direct driver of the ALJ backlog. Hospitals have been put in an untenable position in which the nearly unfettered ability of RACs to churn out erroneous denials forces them to pursue appeals in order to receive payment for medically necessary care, while the inability of OMHA to manage the appeals process within the timeframes required by the Social Security Act holds that payment hostage. **While we recognize that the Centers for Medicare & Medicaid Services (CMS) and the OMHA are independent entities within the Department of Health & Human Services, we urge CMS to work with OMHA to remedy this situation immediately. In addition, we offer solutions below that would help mitigate the detrimental impact on hospitals, including postponing recoupment for appealed claims until after the hospital receives an ALJ determination, and enforcing the statutory timeframes to issue appeals decisions.**

AVOIDABLE RAC DENIALS STRAIN THE APPEALS SYSTEM

Erroneous RAC denials force hospitals to shoulder the significant administrative burden of pursuing appeals in order to receive payment for the medically necessary services they



provide to Medicare beneficiaries. Hospitals participating in AHA's quarterly RACTrac survey have seen a nearly 30-fold increase in RAC denials since 2010. Hospital appeals have also grown exponentially in that time – average appeals per hospital increased from around 17 in 2010 to more than 300 in 2013. As a result, hospitals have an increasing amount of funds at stake in the appeals process – the total value of appealed hospital claims through September 2013 neared \$1.5 billion.

According to the RACTrac survey, hospitals have won nearly 70 percent of the claims for which the appeals process has been completed. These numbers speak to the inaccuracy and abandon with which RACs deny claims. Since hospitals win nearly 70 percent of these appeals, a significant amount of the denied payments are ultimately returned to them. Unfortunately, the appeals process has been moving at an increasingly slow pace. Over 70 percent of the overall RAC denials that have been appealed by hospitals since the program began are still pending in the appeals process. This is primarily due to the backup at the ALJ level. Specifically, 94 percent of hospitals participating in RACTrac reported experiencing at least one delay longer than the statutory 90 days that ALJs have to issue a determination after receiving an appeal. However, other delays in the process are contributing to the problem. For example, 66 percent of hospitals participating in RACTrac reported receiving notification from a Qualified Independent Contractor (QIC), which hears the second round of appeals, that it cannot make a decision within the 60 days required by statute. **It is clear that the RAC program and the resulting volume of inappropriate claim denials are putting significant strain on the appeals process. And hospitals are bearing the financial burden with over a billion dollars caught in a broken appeals process that takes several years to issue a final determination.**

We understand that the substantial delays in the appeals system are one reason that CMS has attempted to clarify, through its two-midnight policy, when it is appropriate to admit a patient as an inpatient rather than to treat them on an outpatient basis. The effects of this controversial policy on the appeals system have yet to be seen. However, it will certainly not have an effect on the almost half a million cases OMHA stated are already in its backlog. **Action must be taken to address this problem now.**

CMS MUST ACT TO MITIGATE THE NEGATIVE IMPACT ON HOSPITALS

While the AHA urges CMS to work with OMHA to develop a lasting solution to the appeals backlog, we also suggest a number of actions CMS could take to mitigate the negative impact on hospitals. **Suspension of RAC audits until all levels of the determination and appeals process catch up with their current workloads would be the most straightforward solution, particularly since the next round of RAC contracts has not yet been finalized.** This would allow time for claims that have already been audited to work their way through the appeals process and minimize the number of claims that will be added to the existing backlog. The AHA also suggests the following policy changes, which would help alleviate the significant burden this broken system imposes on hospitals:

- **When a hospital appeals to the ALJ level, CMS should not recoup the disputed funds until after the hospital has received an ALJ determination.** When a provider pursues an appeal, it must choose whether to keep the disputed funds during the appeals process or to allow them to be recouped immediately. If a provider keeps the funds and ultimately loses the claim, it must remit the funds plus interest to CMS. This currently occurs after

the hospital loses at the second (QIC) level of appeal, even if the hospital appeals the QIC determination to the ALJ level. Because of the delays at all levels of the appeals process, but particularly at the ALJ level, hospitals currently face the prospect of waiting years from when CMS initially recoups the disputed funds to when the appeal is fully adjudicated and the funds are returned to the hospital. Again, according to RACTrac data, hospitals have been highly successful at winning overturned denials through the appeals process. Thus, hospitals are seeing a significant amount of their cash flow recouped and essentially held hostage to the appeals system. Given the fact that hospitals must now wait years before their claims will be heard by an ALJ – and that they historically have been highly successful at the ALJ level – CMS should allow hospitals that choose to pursue their appeal rights to retain payment for denied claims until the ALJ has made a determination.

- **CMS should enforce the statutory timeframes within which appeals determinations must be made by entering a default judgment in favor of the provider if an appeal has not been heard within the required time period.** Hospitals that miss appeals deadlines lose their right to further pursue the claim through the appeals process. However, the only remedy that currently exists for hospitals when the contractors or ALJs miss their appeals deadlines is to escalate the claim to the next level of appeal. This is effectively no remedy at all, since significant backups exist at all levels of the appeals process. Leveling the playing field between hospitals and contractors/ALJs is warranted.
- **CMS should address systemic issues with the RACs that lead to avoidable claim denials and appeals and provide a mechanism for erroneous denials to be reversed outside the appeals process.** Hospitals have reported a number of unnecessary problems with RAC audits that lead to avoidable appeals. For example, hospitals may utilize a pre-appeal discussion period to provide the RAC with additional information and plead its case for reversal of the denial; if the RAC agrees, it can reverse its own decision, allowing the hospital to avoid an appeal. Hospitals have reported problems with the discussion period, however, such as receiving a favorable decision from the RAC, which it then does not communicate to the Medicare Administrative Contractor (MAC), resulting in issuance of a demand letter – after which, the denial may only be overturned by an appeal. In addition, hospitals have experienced widespread problems submitting documentation to RACs in response to an additional documentation request (ADR) and having the RAC state that it did not receive the documentation – even though the hospital has confirmation of delivery. Similarly, many hospitals have reported that the RACs do not always send ADRs to the hospital’s identified contact, which delays receipt by the appropriate person and may cause the hospital to inadvertently miss the deadline to provide documentation. The end result of both scenarios is that the RAC denies the claim for lack of documentation (a so-called “technical denial”) and, again, the hospital must appeal in order to have the technical denial overturned. Finally, a number of hospitals have reported that RACs are denying inpatient claims for procedures on the inpatient-only list, asserting that the services should have been delivered in the outpatient setting. This is a blatant misapplication of CMS regulations, but hospitals’ only recourse is to appeal the denial. CMS should address these unacceptable, yet systemic RAC issues as part of its oversight of the RAC program. Further, CMS should provide a mechanism by which a clearly erroneous or “technical” denial may be reversed by a contractor without forcing the hospital to pursue an appeal.

Ms. Marilyn Tavenner

January 14, 2014

Page 4 of 4

- **CMS should lower the ADR limit to decrease the volume of claims that can potentially end up in the appeals system.** RACs may request up to 400 records from a single hospital (600 for high-volume hospitals) every 45 days, and their contingency fee payment structure incentivizes them to pull – and deny – as many claims as possible. However, RACTrac data show that over 50 percent of the complex reviews completed by RACs do not identify an overpayment. When considered with the high rate at which hospitals win overturn of RAC denials, this indicates that RACs are inaccurate at both identifying claims for review and, as stated above, denying claims. Requiring RACs to request fewer medical records would force them to improve the accuracy with which they select claims for review. In addition, it may encourage them to conduct a more thorough review that results in an accurate determination up front, avoiding the need for an appeal.
- **CMS should enforce the RACs' deadline to issue a decision on a claim by denying a RAC its contingency fee for any claim for which it has missed its deadline.** Hospitals spend a significant amount of time and money to respond to ADRs in a timely fashion, as failure to comply results in denial of the claim. However, nearly 40 percent of hospitals participating in RACTrac report that their RAC failed to meet the 60-day deadline to issue claim determinations. This indicates that RACs are requesting more claims than they have the ability to process within the timeframe required by their contracts – and unnecessarily clogging up the appeals system.

The AHA appreciates your attention to this issue and urges you to address it immediately. If you have questions regarding our concerns or proposed policy solutions, please feel free to contact me or Melissa Jackson, AHA senior associate director for policy, at (202) 626-2356 or mjackson@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

Cc: Kathleen Sebelius, Secretary, Department of Health & Human Services