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25 HLR 1511

***Medicare***

## HHS, Hospital Group to Pitch Solutions to Medicare Appeals Backlog


*By Eric Topor*

Oct. 13 — The Medicare appeals process is likely to get a judicial shove in the coming weeks when a federal district court decides what action should be taken to alleviate the backlog of over 760,000 appeals of Medicare claim denials and rectify a system that one health-care attorney characterized as "clearly out of control and broken."

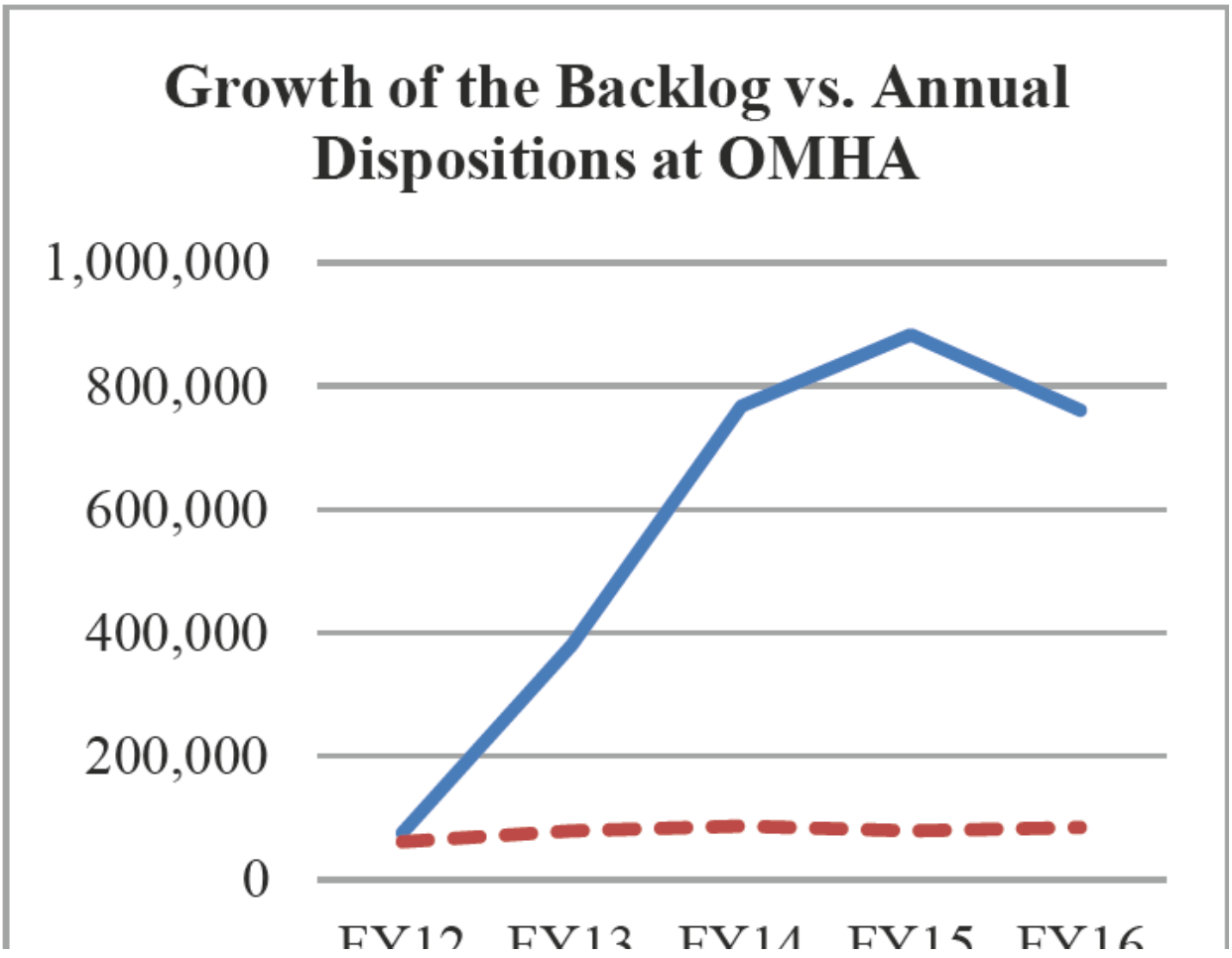
The U.S. District Court for the District of Columbia is presiding over litigation between the American Hospital Association and the health and human services secretary over the federal agency's failure to adjudicate Medicare claims appeals in the statutorily prescribed 90-day period.

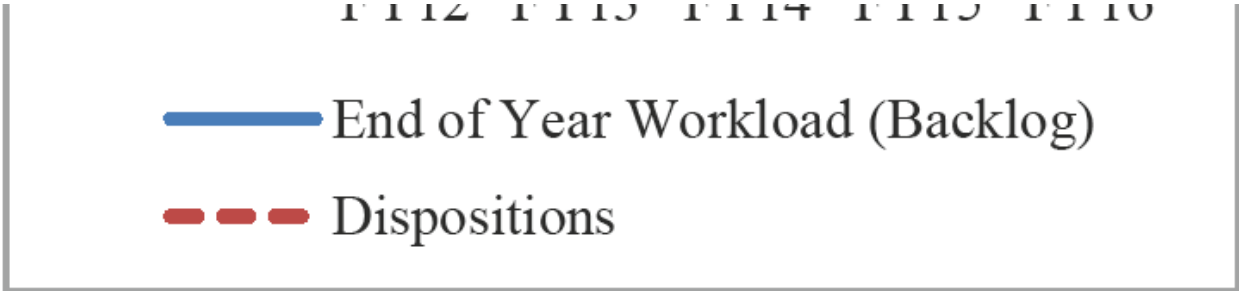
The two sides will submit proposals to fix the problem to Judge James E. Boasberg, starting with the AHA's motion for a requested court order due on Oct. 14, and the Health and Human Service's own proposal due Nov. 4.

Boasberg rejected the HHS's plea for more time to fix the problem on its own in a Sept. 19 ruling (*Am. Hosp. Ass'n. v. Burwell*, 2016 BL 307248, D.D.C., No. 14-cv-851, 9/19/16) (25 HLR 1382, 9/22/16).

### Snapshot

- HHS, hospital trade group will propose solutions to 760,000 Medicare claim appeals backlog
- Medicare attorneys say changes to RAC program, mass settlements should be part of solution






Source: HHS

Bloomberg BNA talked to attorneys who represent hospitals and other providers experiencing the sharp increase in the number of Medicare claim denials and frustration with a review process that stretched to 848 days on average as of fiscal year 2016. During that time, crucial Medicare reimbursements for services long since provided were waylaid.

A common thread from all sides working to fix the problem and bring the HHS back into compliance with the law is that changes to the recovery audit contractor (RAC) program are necessary. The parties disagree, however, on how aggressive those changes must be.

**The ALJ Appeal Backlog**

Medicare appeals at the administrative law judge level (where providers can first present medical expert testimony supporting their claims) must be completed within 90 days according to statute (42 U.S.C. §1395ff(d)(1)(A)). The ALJs are part of the Office of Medicare Hearings and Appeals (OMHA) within the HHS.

The RAC program, which pays audit contractors on a contingency fee basis to identify and collect improper Medicaid claims payments, was created by statute and was expanded nationwide in 2009. The advent of the RAC claim review process coincided with the increase in Medicare appeal rates to levels that exceeded what the HHS was capable of reviewing. The AHA places much of the blame for the backlog on the RAC program and alleged mass denials of valid Medicare claims by RAC contractors. It has requested a court order—called a writ of mandamus—that would require the HHS to make certain modifications to the RAC program.

The AHA also cited the RAC compensation model, which pays RACs a contingency fee based on the amount of reimbursement denials, as a cause of improper Medicare claim denials.

The HHS acknowledged in a report that the increase in Medicare claim denials by RACs has "contributed to the increased workload" at the ALJ level of appeals.

***"The quick fix here is to impose a moratorium on the RAC audit process until order can be restored."***

***Kenneth Marcus, Honigman Miller Schwartz and Cohn LLP, Detroit***

However, the HHS also said that the increase in overall Medicare beneficiaries—beginning with the start of the baby boomer generation's enrollment in 2011—is a significant factor in the creation of the backlog, with non-RAC appeals increasing by 316 percent from FYs 2010 to 2015.

**RAC Changes Must Come**

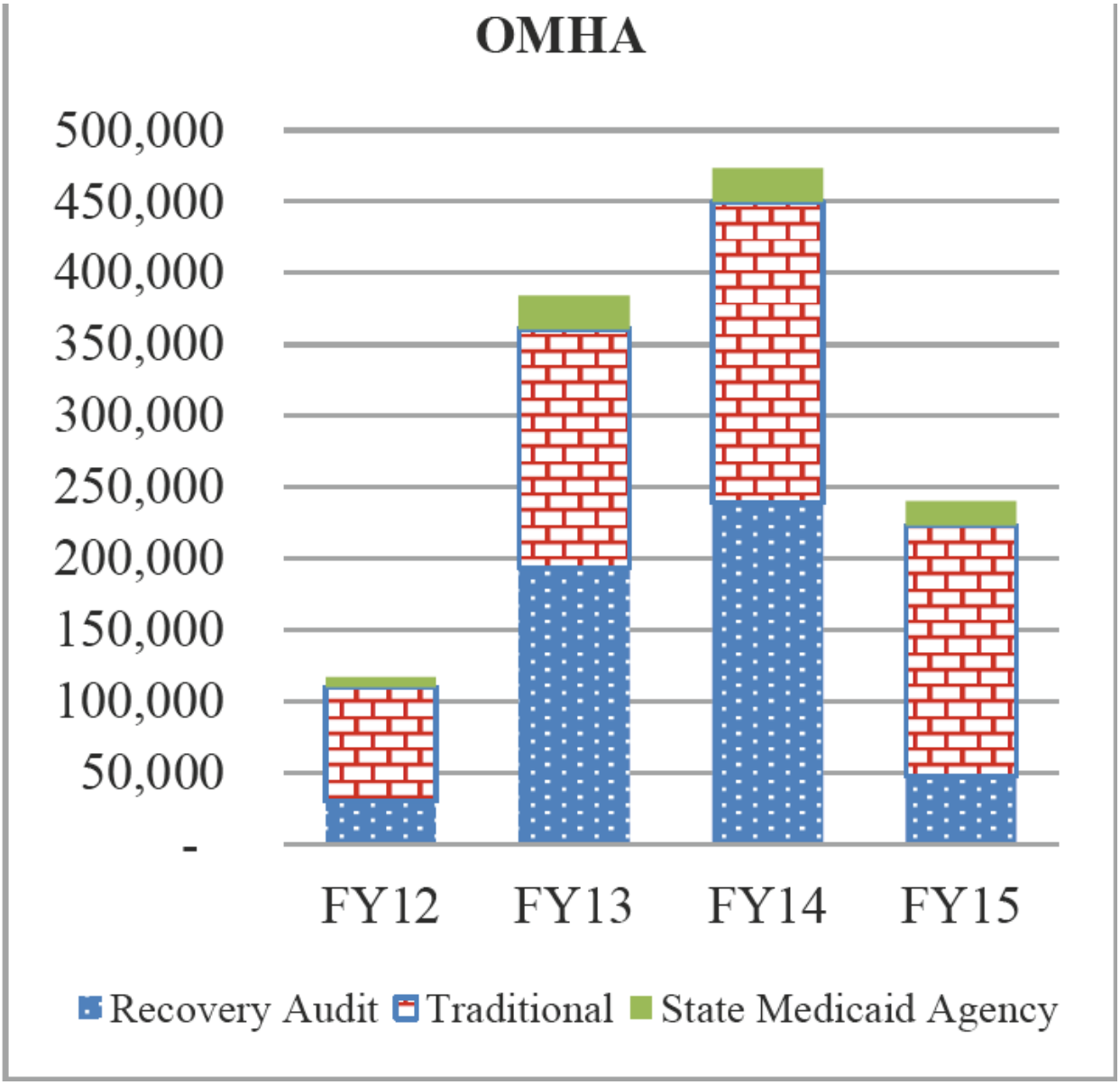
Boasberg said the HHS's three proposed changes to the RAC program gave him "particular pause," in his order denying the HHS's request for a one-year stay in litigation. Boasberg criticized the proposed RAC changes as only affecting 7 percent of the total number of RAC appeals despite the fact that they make up 31 percent of total pending ALJ appeals.

Boasberg said the HHS has "substantial discretion" over the RAC program, suggesting that he expects that more aggressive RAC reform must be part of the government's plan to remedy the backlog. The HHS is due to submit its brief against judicial mandamus on Nov. 4, in which the secretary presumably will propose her own plan of action beyond what has already been suggested.

"The quick fix here is to impose a moratorium on the RAC audit process until order can be restored," Kenneth Marcus, with Honigman Miller Schwartz and Cohn LLP in Detroit, told Bloomberg BNA. Marcus, who represents hospitals in Medicare and Medicaid payment appeals, said the Centers for Medicare & Medicaid Services "had a duty to expand the capacity to conduct the clearly foreseeable steep increase in appeal volume" in structuring the RAC program.

The idea of a moratorium was echoed by Mark D. Polston, a partner in King & Spalding's health-care practice in Washington. He noted that a partial moratorium on RAC reviews of certain inpatient claims was initiated by the HHS in November 2015.

That review limitation brought some criticism from Senate Finance Committee Chairman Orrin Hatch (R-Utah) who said the limitation would lead to an increase in improper Medicare payments.




Source: HHS

Polston told Bloomberg BNA that the RACs are private contractors that bid on a particular business model and could pursue their own remedies against the government in the face of an expanded moratorium, including breach of contract lawsuits, if the RAC program changes lead to fewer claim reviews and reduced RAC recovery payments.

Polston said the CMS "feels like it's in a pinch if it pulls back" on RAC audits, but added that a federal court mandamus order directing aggressive changes to the RAC program "might give [the CMS] a lot of cover" to enact something as politically controversial as an expanded RAC review moratorium.

**Contingency Fee Criticism**

Amy O. Garrigues, a shareholder at Hall, Render, Killian, Heath & Lyman LLP in Morrisville, N.C., told Bloomberg BNA there "absolutely" must be a change in the RAC contingency fee-based payment structure. Garrigues said the contingency fee pay leads to "highly technical denials, or aggressive pursuit of any way to deny a claim, and going after the really high dollar value claims."

Garrigues gave the example of inpatient rehabilitation hospital claims, which she said were denied by RACs "en masse, because it leads to a higher payment."

That example was supported by an amicus brief submitted to the court by the Fund for Access to Inpatient Rehabilitation, which included survey results showing there were $234 million in Medicare claims from 249 rehabilitation hospitals, covering claims between 2010 and 2015. The survey indicated that 80.2 percent of RAC-denied cases involving rehabilitation hospitals were ultimately overturned, and 86.8 percent of total reimbursement amounts denied by RACs were overturned on appeal.

**Additional Possible RAC Reforms**

Joseph D. Glazer, principal of The Law Office of Joseph D. Glazer PC in Princeton, N.J., told Bloomberg BNA that the HHS should enact reforms "that discourage the RACs from trying to recoup claims that are meritorious." Glazer, who specializes in hospital law, said those reforms could include scrutinizing individual RACs that have the highest percentages of overturned claim denials, rewarding RACs with lower percentages of overturned claim denials, and penalty provisions.

Polston said that Boasberg's Sept. 19 order "is clearly telling [the HHS] that the RAC program must take a backseat now to these [90-day] statutory deadlines." Polston also said the contingency fee pay structure could be altered to withhold RAC fees until after a claim denial has been upheld by an ALJ to guard against "sloppy" denials and give RACs "some skin in the game."

Polston also said the court could require the CMS to review the criteria RACs use, which Polston said the CMS doesn't necessarily look at. "They don't look at [the RACs'] review criteria," Polston said of the CMS, "and they don't have any sense as to whether [the RACs] actually comply with Medicare's rules."

**Enhanced Settlement Process**

In 2014 the CMS settled approximately 260,000 pending ALJ appeals involving denials of inpatient hospital admission claims at 68 percent of Medicare reimbursement amounts claimed. Garrigues said that type of settlement program could be expanded to all claim types. That "would be the most efficient use of resources to clear out" the current backlogged claims and CMS could then "move forward" with other program changes, she said

Polston echoed the idea of "an off ramp out of the appeals system when appropriate for settlement purposes," and "empowering people at the administrative level with the authority to settle cases."

Polston said he has had conversations with HHS staff about expanding the settlement program to rehabilitation hospital appeals, but the problem the agency has encountered is coming up with appropriate settlement valuations across other large claim types. The inpatient admissions settlements in 2014 involved a "narrow question," and the agency could justify a 68-cents-on-the-dollar settlement to thousands of hospitals, he said.

Polston said for other large groups of claims denials that could cover different claims, providers and care settings, the CMS would have to "justify the settlement internally." Polston noted that "[n]ot all of [the pending appeals] are terrible cases for the government, and not all of them are terrible cases for the plaintiffs." Finding an appropriate valuation for a mass settlement offer is critical for the CMS because it has a responsibility to protect public Medicare funds, he said.

Despite the difficulty, Polston said he thinks the CMS should identify several other appeal issues where "they see significant litigation risk, and identify the volume of those, how they impact the system," and offer providers some type of mass settlement. Polston said the rehabilitation hospital claims were a prime candidate for mass settlement offers, adding that the CMS "could probably get rid of those in short order."

**Court-Imposed Milestones**

Boasberg criticized the HHS's enacted and proposed reforms to the Medicare appeals process and the RAC program. Even combined, they won't be sufficient, by the HHS's admission, to actually reduce the number of backlogged Medicare claims going forward, he said.

Glazer said one component of the court's ultimate order to the HHS might be to set milestones for backlog reduction at specified time periods, or face more significant court intervention.

Glazer said court-imposed milestones would be a way for Boasberg to prod the HHS toward finding a concrete solution to the backlog, without directing the agency to perform specific actions, something courts are loathe to do in general. An expanded settlement program of the HHS's own design could be one method of meeting those milestones, Glazer said, and one that "doesn't require a tremendous commitment of agency resources."

Glazer said that Boasberg is unlikely to order specific changes or reforms imposed on the appeals process or the RAC program unless he believes "the agency is not at all serious about solving the problem."

Polston said Boasberg would likely order the secretary to consider and evaluate specific changes to the appeals process and the RAC program if he continued to see a lack of progress in reducing the backlog.

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**For More Information**

The court's Sept. 19 opinion is at http://src.bna.com/iHd.



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