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26 HLR 421

Medicare

Medicare Appeals Backlog Targets Unattainable, HHS Says

By Eric Topor

The HHS won't hit annual Medicare appeals backlog reduction targets mandated by a federal court order and projects the total backlogged appeals will top 1 million in late 2021 (*Am. Hosp. Ass'n v. Price*, D.D.C., No. 14-cv-851, *status report* 3/6/17).

The projection of Medicare appeals pending at the administrative law judge level was included in the agency's first status report to the U.S. District Court for the District of Columbia, which in December 2016 ordered the agency to report every 90 days on its progress in hitting the annual reduction targets. The court ordered the Department of Health and Human Services to reduce the 658,000 pending Medicare provider claim appeals at the time by 30, 60, 90 and 100 percent at the end of 2017, 2018, 2019 and 2020, respectively (25 HLR 1739, 12/8/16).

Snapshot

- HHS projects pending Medicare claim appeals will increase annually, contrary to court order
- Agency cites lack of funding to stem appeals backlog increase; attorney says RAC program changes would help

The HHS said in its March 6 status report that it projects pending appeals (now at 667,326 as of March 5) to increase through the end of every fiscal year through 2021, given current Medicare appeals rates and agency funding levels. While the HHS notes that the pace of anticipated appeals filings has reduced slightly, the agency claimed its administrative efforts to facilitate greater appeals resolutions have been stymied by lack of funding, the government-wide hiring freeze and lack of settlement interest from appealing providers hoping further court action will lead to more lucrative recoveries.

Kenneth Marcus, a partner with Honigman Miller Schwartz and Cohn LLP in Detroit, told Bloomberg BNA that "the court's ability to require the agency to comply with the reduction targets is limited," adding that there was some truth to the HHS's argument that it was hampered by insufficient resources to comply with the law. Marcus, a Bloomberg BNA health-care advisory board member whose practice focuses on Medicare and Medicaid payment issues, suggested that the court might consider "an injunction halting all further [recovery audit contractor] audits until a meaningful appeals process is established."

Exhibit 1: MEDICARE APPEALS BACKLOG STATUS UPDATE
Projections with Impact of Taking Administrative Actions
Data as of 12/31/2016 (through Quarter 1 of FY 2017)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Beginning workload balance	669,281	687,382	714,347	788,493	882,437
New receipts	162,939	172,040	193,459	214,494	228,081
Disposition by ALJ hearing	(76,000)	(88,000)	(88,000)	(88,000)	(88,000)
CMS hospital settlement	(36,000)	(27,000)	-	-	-
OMHA settlement conferences	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)
On-the-Record adjudication	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)
Senior ALJ program	(750)	(750)	(750)	(750)	(750)
Statistical Sampling (administrative actions under current authorities and budget)	(4,000)	(5,000)	(5,000)	(5,000)	(5,000)
QIC Demonstration - resolution of appeals pending at OMHA	(16,088)	(17,325)	(18,563)	(19,800)	-
Settlement conference facilitation for State Medicaid Agencies	(5,000)	-	-	-	-
Recovery Audit program contract modifications (non-add - item results in lower 'New receipts')	*(1,163)*	*(2,237)*	*(4,920)*	*(5,368)*	*(5,591)*
Prior Authorization (administrative actions)(non-add - item results in lower 'New receipts')	*(40,220)*	*(45,205)*	*(51,755)*	*(39,995)*	*(39,995)*
QIC Demonstration - appeals resolved before reaching OMHA (non-add - item results in lower 'New receipts')	*(3,795)*	*(4,410)*	*(5,025)*	*(5,640)*	*0*
Administrative Actions Impact Total	**(68,838)**	**(57,075)**	**(31,313)**	**(32,550)**	**(12,750)**
Cumulative Pending - With Current Actions Taken	**687,382**	**714,347**	**788,493**	**882,437**	**1,009,768**

Source: HHS

The American Hospital Association (AHA), the lead plaintiff, and other providers have repeatedly cited the recovery audit contractor (RAC) program's overly aggressive Medicare claim denials as the primary reason for the HHS's failure to issue ALJ decisions on claim appeals within 90 days as required by statute. The HHS has argued during the litigation that the number of RAC appeals has declined significantly since fiscal year 2014, with some statistical support, though it expects its intended RAC program modifications to result in fewer than 6,000 additional appeal resolutions annually.

A provider appealing a Medicare claim denial faced an average wait of 848 days as of FY 2016 before an ALJ heard the appeal and issued a decision. The HHS filed an appeal notice of the district court's order to the U.S. Court of Appeals for the District of Columbia Circuit on Feb. 1. The HHS declined to comment on the litigation and the AHA didn't respond to Bloomberg BNA's request for comment on the status report.

Administrative Actions and Setbacks

The HHS detailed a number of the administrative actions it has taken to increase the pace of Medicare appeals processing at the ALJ level, including: claim settlements with hospitals, RAC modifications, on-the-record hearings in lieu of full ALJ hearings, statistical sampling initiatives and settlement negotiations with state Medicaid agencies.

The report also noted that the agency has adjusted its anticipated ALJ appeals resolution capacity downward from 92,000 annually to 76,000 for FY 2017, and then rising to 88,000 annually thereafter. HHS Acting Assistant Secretary for Financial Resources and Acting Chief Financial Officer Norris Cochran said in a declaration attached to the report that the higher appeal resolution estimate was tied to anticipated higher funding levels which weren't approved by Congress, though Cochran said the Trump administration "has shown serious concern for the Court's mandamus order" and the agency was seeking an exemption from the hiring freeze.

Cochran also noted certain setbacks that have blunted the agency's administrative actions to remedy the ALJ backlog. These included the aforementioned decrease in interest by hospitals in settling appeals claims, lower- than-anticipated interest and funding levels for on-the-record hearings and a failure to reach a settlement agreement with one state Medicaid agency in particular that has a large number of pending claim appeals.

Cochran repeated an HHS assertion made to Judge James E. Boasberg continually during litigation that it simply doesn't have the funding to adequately resolve the number of incoming appeals on the merits, without violating its statutory duty to protect the Medicare program against payment of nonmeritorious claims. Boasberg has rejected that argument in past decisions, noting that the agency's obligation to resolve ALJ claim appeals within 90 days is also imposed by the Medicare statute.

Hogan Lovells US LLP represents the AHA. The Department of Justice represents the government.

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For More Information

The status report is at http://src.bna.com/mN9.

Cochran's declaration is at http://src.bna.com/mOP.

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