

ADDRESSING THE MEDICARE APPEALS BACKLOG

by  
Kelly L. Davis

A capstone project submitted to Johns Hopkins University in conformity with the requirements  
for the degree of Master of Arts in Public Management

Baltimore, Maryland  
April, 2017

© 2017 Kelly L. Davis  
All Rights Reserved

## **ABSTRACT**

When a Medicare provider is denied payment for a Medicare claim, the provider can appeal the decision to a five-level appeals system. However, the backlog of appeals at the third level of appeal is so large that statutory timeframes for decisions are not being met, and a federal judge has ordered the U.S. Department of Health and Human Services to clear the backlog by 2021. This capstone evaluates the issues causing and prolonging the backlog, offers a policy solution to address these issues, and analyzes the effectiveness, efficiency and administrative and political feasibility of the proposed solution.

Advisor: Professor Paul Weinstein

## TABLE OF CONTENTS

Action-Forcing Event .....	1
Statement of the Problem .....	1
History .....	4
Background .....	9
Policy Proposal.....	17
Policy Authorization Tool: Bill to Amend an Existing Law.....	17
Policy Implementation Tool: Increased Funding .....	18
Policy Implementation Tool: Fees .....	19
Policy Analysis.....	20
Increased Funding for OMHA .....	20
Refundable Filing Fees and High Overturn Rate Fees .....	26
Political Analysis .....	29
Increased Funding for OMHA.....	29
Refundable Filing Fee .....	33
High Overturn Rate Fee.....	37
Recommendation.....	39
Curriculum Vita.....	41

## **Memorandum to the President: Addressing the Medicare Appeals Backlog**

**TO:** Senator Orrin G. Hatch, Chairman, Committee on Finance, United States Senate

**FROM:** Kelly Davis

**DATE:** April 19, 2017

**SUBJECT:** Addressing the backlog in the Medicare appeals system

### **Action-Forcing Event**

In early December 2016, a federal judge ordered the U.S. Department of Health and Human Services (HHS) to clear the backlog of Medicare appeals by 2021.<sup>1</sup> The order is part of a lawsuit the American Hospital Association (AHA) filed against HHS and in response to a June 2016 Government Accountability Office (GAO) report that found that from fiscal years (FY) 2010 to 2014 the number of appeals had increased greatly causing appeals decisions to be made past the 90-day statutory timeframe.<sup>2</sup>

### **Statement of the Problem**

The problem of the Medicare appeals backlog is two-fold: the current structure of the system encourages providers to appeal every claim denial in hopes of an overturn decision and the Office of Medicare Hearings and Appeals (OMHA) does not have the funds needed to clear the current backlog. The backlog of Medicare appeals at the third level of the five-level Medicare appeals system is so large that the 90-day statutory deadline for appeals decisions is not being met, leaving appellants waiting two to three times the legal amount of time to receive an appeals

---

<sup>1</sup> Baxter, Amy. "Judge: Medicare Appeals Backlog Must Be Cleared by 2021." *Home Health Care News*. Accessed December 7, 2016. <http://homehealthcarenews.com/2016/12/judge-medicare-appeals-backlog-must-be-cleared-by-2020/>.

<sup>2</sup> United States. Government Accountability Office. *Medicare Fee-For-Service: Opportunities Remain to Improve Appeals Process*. By Kathleen M. King, Lori Achman, Todd Anderson, Susan Anthony, Christine Davis, Julianne Flowers, Krister Friday, Shannon Legeer, Amanda Pusey, Lisa Rogers, Cherie Starck, and Jennifer Whitworth. GAO-16-366. <http://www.gao.gov/assets/680/677034.pdf>.

decision and therefore tying up funds that providers and/or recovery audit contractors (RAs) should be paid out. HHS attributes this backlog to many factors, including a growing Medicare population, lack of an increase in funding, increased program oversight and an appeals system that encourages providers to appeal claim denials in an attempt to have these denials overturned when the appeal reaches the third level of the appeals system. Unlike the first two levels of appeal, at the third level, an Administrative Law Judge (ALJ) holds a hearing on the appeal, allowing providers to make the case for their billing decisions instead of relying solely on Medicare policy and billing documents to make a ruling.

Adding to the issue, the federal judge's ruling that HHS must clear the backlog of Medicare appeals at the third level of appeal by 2021 puts a timeline on a process that HHS believes to be impossible to meet even with additional resources.<sup>3</sup> At the end of fiscal year 2015, the backlog at the third level sat at more than 880,000 claims while the ability to review cases was at only 75,000 claims per year.<sup>4</sup>

In May 2014, the AHA filed a lawsuit against HHS alleging that the Department's appeals process was too cumbersome and did not deliver appeals decisions within the statutory timeline of 90 days. The lawsuit pointed to the third level of appeal, in which an ALJ hears the case at OMHA, housed within HHS, as the largest contributor to the backlog.<sup>5</sup>

OMHA saw an increase of 442 percent in denied claims appeals between FY2010 and FY2015; and in FY2015, 3.7 million claims decisions were appealed. By the end of FY2015, OMHA was receiving 365 days' worth of appeals every 18 weeks and there was a backlog of 884,017 appeals. HHS stated that even without additional appeals entering into the system, it would take 11 years to clear the backlog.<sup>6</sup>

---

<sup>3</sup> "Judge: HHS must eliminate its Medicare appeals backlog—by 2021." *Advisory Board*, December 12, 2016. Accessed January 13, 2017. <https://www.advisory.com/daily-briefing/2016/12/12/medicare-appeals-backlog>.

<sup>4</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

<sup>5</sup> *American Hospital Association v. U.S. Department of Health and Human Services* (United States District Court For The District Of Columbia May 22, 2014).

<sup>6</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

According to HHS, while the number of appeals grew, the level of funding did not. HHS attributed the backlog of appeals to four factors: an aging population; changes to coverage and payment rules; an increase in state Medicaid agency appeals; and, increased programs put in place to crack down on improper payments within the program, such as the Recovery Audit Contractor (RA) Program. As the number of claims filed increased and oversight of Medicare billing increased, the number of appeals providers filed also increased; however, funding for the most overwhelmed level of appeals – the ALJ level – remained largely the same. According to HHS, funding allocated by Congress to the appeals system was not proportional to the increase in workload. In FY2016, the total number of cases OMHA could clear was approximately 85,000.<sup>7</sup>

HHS attributes the inability to clear the backlog to two factors: lack of filing fees and low limit on the minimum dollar amount – or amount in controversy (AIC) – needed to reach the ALJ level. Both HHS and the Council for Medicare Integrity (CMI), a coalition advocating for proper Medicare billing, believe the lack of filing fees removes the barrier for entry for a provider to appeal all denied claims in the hopes of reaching the ALJ level in which the ALJ does not have to rule according to Medicare billing policy. HHS also points to the very low AIC for an appeal to make it to the ALJ level – only \$150 needs to be in controversy for review. HHS found that companies have begun to specialize in filing Medicare appeals and are “fueling increases in filing appeals.” For example, five providers “filed 51 percent of the appeals at the ALJ level in the first quarter of FY2015.” According to HHS, “this suggests that some providers find repetitive appeals good business practice.”<sup>8</sup>

Medicare providers are mostly affected by this backlog, as HHS prioritizes appeals filed by beneficiaries and hears those cases first.<sup>9</sup> Medicare providers, represented by the AHA in the lawsuit, believe that post-payment reviews by RAs question medical judgment and that appealing

---

<sup>7</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

<sup>8</sup> *Ibid.*

<sup>9</sup> *Ibid.*

claims is sound business practice as providers report that claims denials are often overturned during the appeals process. Further, providers claim that billions of dollars in Medicare reimbursements are tied up in the appeals process and that the backlog is leading to providers' inability to provide patient care without these funds. A plaintiff represented by the AHA in the lawsuit claimed it was unable to purchase a new roof, new beds for its Intensive Care Unit, and other necessities due to the funds it believed it should have received but that were tied up in the appeals process.<sup>10</sup>

## History

### *Contributors to the Backlog*

In FY2010, Congress expanded efforts to audit Medicare claims for accuracy and without changing the entitlements Medicare beneficiaries received. Due to these increased efforts and an increase in the number of beneficiaries eligible for the program, the number of appeals filed in response to claims decisions increased greatly. In particular, the number of appeals filed at the third level, in which an ALJ from OMHA reviews the judgement, increased by 936 percent from FY2010 to FY2014. However, as the number of appeals increased, the level of funding at OMHA did not, only increasing by 16 percent during this time.<sup>11</sup> In FY2016, OMHA had the capacity to review 92,000 appeals, but there were 658,307 appeals pending at the ALJ level.<sup>12</sup> Between FY2010 and FY2014, the GAO found that at the third level of appeal, 96 percent of appeal decisions were made outside of the statutory timeframe of 90 days.<sup>13</sup>

HHS attributed the increase in appeals to “increases in the number of beneficiaries;

---

<sup>10</sup> American Hospital Association v. U.S. Department of Health and Human Services (United States District Court For The District of Columbia May 22, 2014).

<sup>11</sup> *MEDICARE FEE- FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office, Washington, DC: U.S. Government Accountability Office, 2016. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.

<sup>12</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

<sup>13</sup> *MEDICARE FEE- FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office Washington, DC: U.S. Government Accountability Office, 2016. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.

updates and changes to Medicare and Medicaid coverage and payment rules; growth in appeals from State Medicaid Agencies; and national implementation of the Medicare fee-for-service Recovery Audit (RA) Program.”<sup>14</sup> In 2010, Congress expanded the RA Program to all 50 states. RAs reviewed Medicare claims after they were paid to ensure they were billed according to Medicare policy; and, they identified short, inpatient stays as a commonly misbilled claim. Hospitals fought many of these overturns, resulting in an increase of 2,000 percent in the number of these claims appealed to the OMHA level.<sup>15</sup>

HHS stated that although the RA Program has “contributed to the increasing workload, between fiscal year 2010 and fiscal year 2015, OMHA’s traditional workload (non-RA related, non-State Medicaid Agency appeals) increased 316 percent.”<sup>16</sup>

#### *AHA vs. Burwell*

On May 22, 2014, the AHA filed a lawsuit against HHS alleging there was a backlog of more than 460,000 appeals at the ALJ level by the end of 2013 and the average wait time for a hearing was 16 months. At the same time, HHS announced a moratorium on assigning appeals at the ALJ level for at least two years. By February 12, 2014 there were 15,000 new claims filed weekly. The AHA estimated that the Medicare providers would have to wait up to five years for a claim decision to make its way through the first four levels of appeal, even though the statutory timeframe for this process is one year.<sup>17</sup>

The case, in which the AHA was suing to force HHS to meet statutory timeframes, was dismissed in December 2014 by the federal District of Columbia District Court which ruled that

---

<sup>14</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

<sup>15</sup> *MEDICARE FEE- FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office. Washington, DC: U.S. Government Accountability Office, 2016. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.

<sup>16</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

<sup>17</sup> *MEDICARE FEE- FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office. Washington, DC: U.S. Government Accountability Office, 2016. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.



Congress and HHS should address the problem, not the court system. The AHA appealed the judge's decision and on February 9, 2016, a federal appeals court reversed the decision and sent the case back to the lower court.<sup>18</sup>

In September 2016, a federal judge denied HHS' request to postpone proceedings until September 30, 2017, because the judge believed the plan HHS outlined to address the problem was inadequate.<sup>19</sup>

In October 2016, the AHA issued a motion for summary judgement requesting a writ of mandamus and provided solutions to fix the appeals backlog, including offering a settlement to qualified providers, fining RAs who have high rates of overturns in the appeals process, and allowing providers to keep the Medicare claim payments until the appeals decision is final.<sup>20</sup>

The AHA's request was granted in December 2016, ordering HHS to clear the appeals backlog by the end of 2020. On December 15, 2016, HHS filed a Motion to Reconsider, arguing that the court's timeline would force HHS to pay claims appeals without regard to merit; however, the court denied this request on January 4, 2017.<sup>21</sup>

### *CMS' Efforts Thus Far*

CMS has made many attempts to reduce the backlog, and the factors causing the backlog, by deploying pilot projects, clarifying Medicare policies, making changes to the RA Program, and offering providers settlements.

In October 2013, CMS placed a moratorium on RA reviews beginning in February 2014, stopping all reviews until the next round of RA contracts were issued. However, in June 2015, CMS canceled the procurement for the new RA contracts and allowed the current RAs to begin to

---

<sup>18</sup> Topor, Eric. "Court Orders Second Look at Worsening Medicare Appeals Backlog." *Bloomberg BNA*, February 10, 2016. Accessed January 27, 2017. <https://www.bna.com/court-orders-second-n57982067169/>.

<sup>19</sup> "Court Denies HHS Wish to Delay Medicare Appeals Backlog Case." *RevCycleIntelligence*, 2016. Accessed January 27, 2017. <http://revcycleintelligence.com/news/court-denies-hhs-wish-to-delay-medicare-appeals-backlog-case>.

<sup>20</sup> *American Hospital Association v. Sylvia Mathews Burwell*, No. 1:14-cv-00851-JEB (UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA October 14, 2016).

<sup>21</sup> *American Hospital Association v. Sylvia Mathews Burwell*, No. 1:14-cv-00851-JEB (UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA January 4, 2017).

review a limited number of issues through July 31, 2016, when the new procurement would begin. As part of this restart, CMS modified the RA contracts and shortened the “lookback” period for RA reviews from three years to six months from the date of service.<sup>22</sup>

Further, CMS and Congress placed a moratorium on RA reviews of claims for short, inpatient stays between October 1, 2013 and December 31, 2015. In October 2015, CMS instructed another contractor, Quality Improvement Organizations (QIOs), to conduct short, inpatient hospital reviews instead of the RAs. The QIOs were only to refer a claim to the RAs if there was evidence of repeated misbilling.<sup>23</sup>

OMHA also created the settlement conference facilitation pilot in June 2014, in which providers that met certain criteria could enter into a settlement to receive 68 percent of the value of their claims if they dropped their appeals. The agency paid \$1.47 billion to settle 346,000 claims with 2,022 hospitals.<sup>24</sup> In November 2016, CMS offered another settlement of 66 percent payment to acute care hospitals and critical access hospitals for pending appeals at the third and fourth levels of the appeals system that were centered on short, inpatient stays occurring prior to October 1, 2013. If the providers accept the settlement, they will have to drop the appeal. The settlement process began on December 1, 2016 and will run through January 31, 2017.<sup>25</sup>

In July 2014, OMHA began its statistical sampling pilot, in which the agency decided more than one appeal from the same provider by using “statistical sampling and extrapolation.” However, as of August 2015, only one provider agreed to participate in the pilot. One year later, OMHA began its senior attorney pilot, in which a provider could have its appeal reviewed by a senior attorney who would provide a recommendation to an ALJ for a decision. As of March

---

<sup>22</sup> *MEDICARE FEE-FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office. Washington, DC: U.S. Government Accountability Office, 2016. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.

<sup>23</sup> *Ibid.*

<sup>24</sup> “CMS Offers 66% Settlement to Reduce Medicare Appeals Backlog.” *RevCycleIntelligence*, November 7, 2016. Accessed January 25, 2017. <http://revcycleintelligence.com/news/cms-offers-66-settlement-to-reduce-medicare-appeals-backlog>.

<sup>25</sup> Ellison, Ayla. “CMS makes offer to clear Medicare appeals backlog: 6 things to know.” *Becker's Hospital CFO*, November 4, 2016. Accessed January 25, 2017. <http://www.beckershospitalreview.com/finance/cms-makes-offer-to-clear-medicare-appeals-backlog-6-things-to-know.html>.

2016, 671 appeals had been decided through the program and HHS was considering an expansion.<sup>26</sup>

In the first half of 2016, HHS released a “three-pronged strategy” to reduce the Medicare appeals backlog. The strategy included: “invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; take administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process; and propose legislative reforms that provide additional funding and new authorities to address the appeals volume.”<sup>27</sup> HHS stated that the funding in the President’s Budget and the three-pronged approach could reduce the appeals backlog to 240,000 by FY2018 and would be eliminated by FY2019. HHS stated that without these changes, the number of appeals pending at the third level will be more than 1.5 million by the end of FY2021; and, with only administrative changes and no funding in the President’s Budget, the projected backlog at OMHA will be 900,000 by FY2021.<sup>28</sup>

On June 28, 2016, HHS issued a Notice of Proposed Rulemaking (NPRM) on changes to the Medicare appeals system. HHS proposed increasing the number of OMHA adjudicators, increasing consistency in judgments, and streamlining the appeals process.<sup>29</sup>

In FY2016, OMHA was appropriated 20 percent more funding, which allowed the Office to hire 15 new ALJs. However, OMHA stated that it was still not enough funding to fix the backlog.<sup>30</sup> In the FY2017 President’s Budget, HHS requested \$142.6 million more than the FY2016 budget of \$107.4 million, which would bring total funding to \$250 million and allow OMHA to increase its capacity to hearing 120,000 appeals each year and put in place five new

---

<sup>26</sup> *MEDICARE FEE- FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office. Washington, DC: U.S. Government Accountability Office, 2016. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.

<sup>27</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

<sup>28</sup> *Ibid.*

<sup>29</sup> “HHS Proposes Changes to Medicare Reimbursement Appeals Process.” *RevCycleIntelligence*, July 1, 2016. <http://revcycleintelligence.com/news/hhs-proposes-changes-to-medicare-reimbursement-appeals-process>.

<sup>30</sup> *MEDICARE FEE- FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office. Washington, DC: U.S. Government Accountability Office, 2016. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.

field offices. The Budget also included legislation that would fund RA-related appeals with improper payment dollars identified by the RAs, establish a refundable filing fee to appeal a claim decision, allow OMHA to make a ruling without a hearing if there is “no material fact” in dispute, increase the minimum AIC for the third level of appeal to \$1,560, send claims back to the first level of appeal if new evidence is introduced, and allow the Secretary to use statistical methods to consolidate related appeals and make a ruling on them.<sup>31</sup>

### *Congressional Actions*

In December 2015, the Senate Committee on Finance passed<sup>32</sup> the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM Act).<sup>33</sup> The AFIRM Act, which had not been enacted into law as of January 10, 2017, proposed strategies to alleviate the burden of the Medicare appeals process. A few of these strategies included increasing funding for OMHA by \$125 million; increasing the minimum AIC limit to \$1,560; sending appeals back to the first level of appeal if new evidence is introduced; allowing OMHA to issue decisions without holding a hearing when “there are no material issues of fact in dispute”; allowing for the consolidation of related appeals; conducting yearly training sessions for OMHA adjudicators; and shortening the “lookback” period for RA reviews from three years to six months.<sup>34</sup>

## **Background**

All key players, including Senator Ron Wyden, Chief ALJ Nancy Griswold, the AHA and its members, the White House, and CMI, agree there should be legislation to address the Medicare appeals backlog. The controversy comes into play when discussing the cause of the

---

<sup>31</sup> *HHS Primer: The Medicare Appeals Process*. Issue brief. U.S. Department of Health and Human Services. Accessed January 13, 2017. <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>.

<sup>32</sup> S. Rep. No. 114-177 (2015).

<sup>33</sup> AUDIT & APPEALS FAIRNESS, INTEGRITY, AND REFORMS IN MEDICARE ACT OF 2015, S. S. 2368, 114th Cong. (2015).

<sup>34</sup> S. Rep. No. 114-177 (2015).

backlog, how to address it and how to fund resources to clear up the existing backlog.

### *U.S. Congress*

The Senate Finance Committee has jurisdiction over health programs under the Social Security Act, which includes Medicare. Senator Ron Wyden (D-OR) serves as the ranking member of this committee and has shown a keen interest in finding a solution for the Medicare appeals backlog. Because Wyden is the ranking member on the committee, his buy-in on the proposal policy to fix the backlog is critical.

At a 2015 hearing, “Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare,” Wyden voiced his concerns about the rising number of appeals at the third level of appeal, highlighting that at the time of the hearing there had been a “ten-fold jump in only two years” in the number of appeals at OMHA. Further, he discussed the capacity of OMHA to address these appeals, explaining that as the number of appeals increased, the number of ALJs to hear the cases has not.<sup>35</sup>

Wyden’s main concerns included Medicare’s mandate to serve seniors as well as Congress’s responsibility to ensure taxpayer dollars are not being wasted. He stated at the hearing that although most Medicare providers are billing according to Medicare policy, “there is a small number that has figured out a way to really hotwire the system, to just game it.”<sup>36</sup>

Wyden pointed to two solutions that could address these concerns: the establishment of a refundable filing fee and the possibility of allowing a different group of hearing officers, aside from the ALJs, to review appeals that are “less complicated and contested.”<sup>37</sup>

In December 2015, Wyden and Senator Orrin G. Hatch (R-UT), chairman of the Senate

---

<sup>35</sup> *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong. (2015) (statement of Senator Ron Wyden, Ranking Member, U.S. Senate Committee on Finance).

<sup>36</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>37</sup> *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong. (2015) (statement of Senator Ron Wyden, Ranking Member, U.S. Senate Committee on Finance).

Finance Committee, introduced the AFIRM Act, a bipartisan bill that would streamline the appeals process in order to expedite appeals decisions. This bill was passed by the Senate Finance Committee, but has not gone any further.<sup>38</sup>

In 2014, Representative Kevin Brady, a Republican and Chairman of the House Ways and Means Health Subcommittee, introduced the Hospital Improvements for Payment (HIP) Act, which proposed many changes to the Medicare program, including changes to how Medicare pays for short, inpatient hospital stays. Appeals of audits of this particular issue contribute to a large percentage of the backlog at the ALJ level. The bill also proposed changes to the RA Program, including changing the look-back period for audits and increasing oversight.<sup>39</sup>

In 2015, Brady also voiced concern about the settlement offer HHS gave to hospitals to clear up a portion of the backlog. He emphasized the need for HHS to state what statutory authority allows it to take such measures and expressed hesitation in allowing appeals to be settled without review of the merits of the cases.<sup>40</sup>

At a 2015 Congressional hearing, Senate Minority Leader Charles Schumer, a Democrat, discussed his concerns about the increase in state Medicaid appeals filed and the subsequent delay in receiving an appeals decision as well as the decrease in favorable decisions made at the ALJ level – from 26 percent in 2008 to 16 percent in 2010. However, when HHS conducted a pilot project to see the difference between ALJ decisions and those by other hearing officers, the hearing officers granted favorable decisions in 69 percent of cases. Schumer believes state Medicaid agencies are “excluded” from some of the administrative review options, including sampling and mediation and suggested OMHA conduct another demonstration model in the state of New York to try to remedy the issue in that state. Schumer also asked OMHA to clarify its

---

<sup>38</sup> United States. U.S. Senate. Committee on Finance. *The Audit & Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) Act of 2015*. June 3, 2015. Accessed February 1, 2017. <https://www.finance.senate.gov/imo/media/doc/AFIRM%20Act%20Background.pdf>.

<sup>39</sup> House Ways and Means Committee. Subcommittee on Health. “Brady Unveils Discussion Draft to Improve Hospital Issues in the Medicare System.” News release, 2014. Accessed March 6, 2017. <https://waysandmeans.house.gov/brady-unveils-discussion-draft-to-improve-hospital-issues-in-the-medicare-system/>.

<sup>40</sup> *Ibid.*

plan to clear the Medicare appeals backlog and prevent it from occurring again in the future.<sup>41</sup>

*Chief Administrative Law Judge (ALJ) Nancy Griswold*

As the Chief ALJ at OMHA, Nancy Griswold is responsible for overseeing the ALJs at the third level of the Medicare appeals process. She has testified on numerous occasions about the backlog at the ALJ level as well as what OMHA is doing to address it. Because she is a leader at the organization and reports directly to the HHS Secretary, Griswold's support for the proposed policy is crucial for not only its passing, but also its implementation.

At a 2015 Senate Finance Committee hearing, Griswold described a two-pronged problem: the capacity for reviewing the number of appeals filed and deterring providers from filing claims without merit. She identified possible contributors to the appeals backlog, including increased appeals resulting from RA audits, increased appeals from Medicaid state agencies, an increase in the number of Medicare beneficiaries, and changes to the disability eligibility under the Social Security Act.<sup>42</sup> However, at a 2013 hearing she also emphasized the importance of the RA Program in reducing Medicare waste, stating that the program "has been very successful, returning billions in improper payments to the Medicare Trust Fund."<sup>43</sup>

Griswold pointed to the lack of capacity to hear the mounting number of appeals, which has led to appeals decisions being made in an average 572 days, much longer than the statutory timeframe of 90 days. Even still, OMHA has increased productivity of the ALJs by providing them with support staff. However, the number of these teams is still below what is necessary to meet the capacity needed for the current appeals backlog.<sup>44</sup>

---

<sup>41</sup> House Ways and Means Committee. Subcommittee on Health. "Brady Questions HHS Medicare Appeals Settlement." News release, September 16, 2014. Accessed March 6, 2017. <https://waysandmeans.house.gov/brady-questions-hhs-medicare-appeals-settlement/>.

<sup>42</sup> United States. U.S. Senate. Committee on Finance. *The Audit & Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) Act of 2015*. June 3, 2015. Accessed February 1, 2017. <https://www.finance.senate.gov/imo/media/doc/AFIRM%20Act%20Background.pdf>.

<sup>43</sup> *Statement Of Nancy J. Griswold Chief Administrative Law Judge Office Of Medicare Hearings And Appeals On "Office Of Medicare Hearings And Appeals Workloads" Before The United States House Committee On Oversight & Government Reform Subcommittee On Energy Policy, Health Care & Entitlements*, 114th Cong. (2014) (testimony of Nancy J. Griswold).

<sup>44</sup> *Ibid.*

In her testimony, Griswold described the actions taken by OMHA and HHS to address the backlog, but she emphasized the need for increased funding to create new ALJ teams and Medicare Magistrates. Griswold went further stating the committee should consider allowing OMHA to use funds collected by RAs to fund the review of RA-related claims; establishing a refundable filing fee to deter meritless claims from being appealed, excluding those appeals filed by beneficiaries; consolidating similar claims to be decided upon using statistical sampling and extrapolation, improving OMHA efficiency; requiring appeals that introduced new evidence to go back to the first level of the appeals system for review; increasing the minimum AIC for appeals to enter the ALJ review, with those claims that fall under the AIC to be decided by Medicare Magistrates; and allowing OMHA to make a ruling on an appeal without a hearing if there is “no material fact in dispute.”<sup>45</sup>

### *Medicare Providers*

The AHA, which represents 5,000 member hospitals and health care systems and 43,000 individual members, has voiced its concern about the Medicare appeals backlog, filing a lawsuit against HHS for OMHA’s inability to meet statutory timeframes for appeals decisions at OMHA.

The AHA and its members, including those who filed the 2014 lawsuit, are opposed to post-payment reviews by the RAs, claiming they cause a significant burden on the providers and lead to a backlog in the Medicare appeals process. At the time of initial filing of the lawsuit, RAs could look at 2 percent of any provider’s claims dating back three years. Providers claimed that the RAs question medical judgment and cause burden on the provider, harming the care the patient receives. They pointed to the payment structure of the RAs, a contingency fee, as the cause for so many claim decision overturns in post-payment reviews, believing that RAs are incentivized to deny claims in order to make more money. AHA claimed that “aggressive and

---

<sup>45</sup> *Statement Of Nancy J. Griswold Chief Administrative Law Judge Office Of Medicare Hearings And Appeals On “Office Of Medicare Hearings And Appeals Workloads” Before The United States House Committee On Oversight & Government Reform Subcommittee On Energy Policy, Health Care & Entitlements, 114th Cong. (2014) (testimony of Nancy J. Griswold).*



widespread auditing activity by the RAs” has led to an increase in the number of hospital claims. AHA self-reported that in the first quarter of 2013, 72 percent of claim decisions were overturned in the first three levels of appeals.<sup>46</sup>

Providers claim that the backlog is causing financial burden on hospital systems across the country. Providers believe funds that are tied up in the appeals system could be used for patient care or hospital necessities. The lawsuit claims “HHS’s delay in meeting the statutory Medicare claim appeal deadlines thus presents a serious threat to hospitals nationwide and their ability to continue to provide quality patient care while maintaining financial viability.”<sup>47</sup>

AHA points to the lack of remediation by HHS as a cause for the lawsuit. Prior to filing the lawsuit, AHA claims to have sent a letter to CMS asking it to work with OMHA to fix the backlog. Additionally, the American Medical Association (AMA) and 98 other organizations sent a letter to Chief ALJ Nancy Griswold asking her to implement a solution for the backlog. Further, the Advanced Medical Technology Association (“AdvaMed”) wrote of the issue of the moratorium and its influence on the backlog in a letter to HHS Secretary Kathleen Sebelius and the CMS Administrator.<sup>48</sup>

In July 2016, in response to HHS’s proposed changes at OMHA, AHA blamed HHS for not reining in the RAs, which they claimed caused the backlog by forcing providers to appeal claims after unfair RA audits. AHA denied that the proposed changes would help without first reforming the RA Program and suggested HHS limit the RAs’ ability to deny Medicare claims. AHA proposed HHS allow providers to keep Medicare funds until after the ALJ hears the case; establish timeframes for issues RAs can review and prohibit review of those issues once the timeframe has expired.<sup>49</sup>

---

<sup>46</sup> American Hospital Association v. U.S. Department of Health and Human Services (United States District Court For The District Of Columbia May 22, 2014).

<sup>47</sup> Ibid.

<sup>48</sup> Ibid.

<sup>49</sup> "RE: HHS-2015-49, Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures, July 5, 2016." Ashley Thompson to The Honorable Nancy J. Griswold. August 26, 2016. In American Hospital Association. August 26, 2016. Accessed February 1, 2017. <http://www.aha.org/advocacy-issues/letter/2016/160826-cl-hhs2015-49-medicareadvantage.pdf>.

*Council for Medicare Integrity (CMI)*

CMI is a nonprofit advocacy organization representing the RAs. CMI states that the RA Program is crucial to curbing Medicare waste, with RAs identifying more than \$10 billion in overpayments in the past eight years.<sup>50</sup> This group is key to getting buy-in from the companies that perform the RA audits as it represents the interests of those groups.

In November 2016, CMI issued a statement urging Congress to pass the AFIRM Act, stating that it would “ensure active steps are taken to address the backlog.” In the statement, CMI argued that some Medicare providers intentionally appeal all claims denials in the hope that it will reach the ALJ level and be overturned due to ALJs’ “broad discretion” because they do not have to rule according to Medicare policy. CMI blamed the current backlog on the actions of a few providers that government reports have called “frequent filers” and cited Griswold’s testimony that “51 percent of appeals filed in 2015 were filed by the same five appellants” to support this position.<sup>51</sup>

Further, in a separate press release, CMI elaborated on the cause of the appeals backlog, denying hospitals’ claims that RAs are responsible for the influx of appeals. CMI cited an issue brief from HHS that stated that the RA “program simply was not, and is not, the primary source of the [Medicare appeals] backlog.” The release went on to share data from HHS showing RA-related appeals only accounted for 9.3 percent of all OMHA appeals filed in FY2016 and 14.1 percent filed in FY2015, and that state Medicaid agency appeals account for a large number of appeals in the backlog.<sup>52</sup>

Although CMI supports passage of the AFIRM Act, the group suggests “additional safeguards” to deter meritless appeals, including a refundable filing fee as suggested by Griswold

---

<sup>50</sup> Council for Medicare Integrity. "Council for Medicare Integrity Urges Congress to Pass AFIRM Act." News release, November 14, 2016. MedicareIntegrity.org. Accessed 2017. <http://medicareintegrity.org/council-for-medicare-integrity-urges-congress-to-pass-afirm-act/>.

<sup>51</sup> Ibid.

<sup>52</sup> Council for Medicare Integrity. "HHS: Recovery Auditors Not Responsible for Medicare Appeals Backlog." News release, November 17, 2016. MedicareIntegrity.org. Accessed February 1, 2017. <http://medicareintegrity.org/hhs-recovery-auditors-not-responsible-for-medicare-appeals-backlog/>.

and Wyden; requirements for providers to file a claim within three months of the service; Congressional mandates that ALJs must rule according to Medicare policy; and consolidation and expedition of claims with no material facts in dispute.<sup>53\</sup>

### *Center for Medicare Advocacy*

In a 2016 letter to OMHA, the Center for Medicare Advocacy, a nonprofit law firm that advocates for fair access to Medicare on behalf of its beneficiaries and State Medicaid agencies, described “significant trends in appeals that negatively affect beneficiaries” and discussed the need for policymakers to address the “primary causes of the backlog,” including increased audits of Medicare providers. The Center voiced concerns about the length of time beneficiaries had been waiting for an appeals decision at the ALJ level, stating that the backlog caused by the increase in auditing has led to beneficiaries “having to wait far beyond the 90-day statutory timeframe for a hearing” and although beneficiaries can accelerate the claim to the next level of appeal once the timeframe has expired, that is not fair to the beneficiaries who have the most success at the third level of appeal.<sup>54</sup>

Although HHS has prioritized patient appeals since 2014, reviewing those cases before those filed by providers or Medicaid state agencies, in 2016 the Center still described beneficiaries waiting beyond the statutory limit for appeals decisions.<sup>55</sup>

### *The Obama Administration*

President Obama’s Budgets for 2016 and 2017 included proposals aimed at reducing the Medicare appeals backlog. Specifically, the budgets included funding for OMHA to establish a

---

<sup>53</sup> Council for Medicare Integrity. "Council for Medicare Integrity Urges Congress to Pass AFIRM Act." News release, November 14, 2016. MedicareIntegrity.org. Accessed 2017. <http://medicareintegrity.org/council-for-medicare-integrity-urges-congress-to-pass-afirm-act/>.

<sup>54</sup> Center for Medicare Advocacy. (2016, August 29). Center Comments on Proposed Rule that Would Significantly Alter the Medicare Administrative Appeals Process [Letter to Office of Medicare Hearings and Appeals, Department of Health & Human Services].

<sup>55</sup> Konrad, Walecia. "Need to appeal your Medicare claim? Get in line." *CBS News*, July 1, 2016. Accessed March 10, 2017. <http://www.cbsnews.com/news/need-to-appeal-your-medicare-claim-get-in-line/>.

refundable filing fee, send claims back to the first level of appeal when new evidence is introduced, increase the threshold for the minimum AIC for the ALJ level of appeals, establish a Medicare Magistrate system to review those claims that fall below the AIC threshold, and expedite cases in which no material fact is disputed. In FY2016, the Office of Management and Budget (OMB) estimated these proposals would impact the budget by an increase in \$1.27 billion from FY2016-2025.<sup>56</sup>

## **Policy Proposal**

The problem of the Medicare appeals backlog is two-fold: the system does not have safeguards in place to prevent a future backlog of claims at the third level of appeals and OMHA does not currently have the authority or resources to clear the existing backlog at the ALJ level.

## **Policy Authorization Tool: Bill to Amend an Existing Law**

The proposed legislation, the Medicare Appeals Reform Act of 2017, builds upon the suggestions put forth in the AFIRM Act and the FY2017 President's Budget. The legislation would amend title XVIII of the Social Security Act<sup>57</sup> to ensure OMHA has the appropriate resources and authority to hear appeals and to ensure only those appeals with merit reach the ALJ level. This legislation would apply only to appeals submitted by Medicare providers and Medicaid state agencies, not by individual Medicare beneficiaries.

In order to enact this legislation, Congress will vote on and pass the bill to amend the Social Security Act. Once this bill is passed, Congress will direct HHS, CMS, and OMHA to implement the policies.

---

<sup>56</sup> Office of Management and Budget. (2015). *Fiscal Year 2016 Budget of the U.S. Government* (Publication No. ISBN 978-0-16-092678-5). Retrieved March 17, 2017, from U.S. Government Publishing Office website: <https://www.gpo.gov/fdsys/pkg/BUDGET-2016-BUD/pdf/BUDGET-2016-BUD.pdf>

<sup>57</sup> Pub. L. 89-97, 89th Cong. (1965) (enacted).

The proposed legislation would change the process of appeals mainly at the third level of appeal, the ALJ level overseen by OMHA.

### **Policy Implementation Tool: Increased Funding**

#### *Increase resources for OMHA*

As suggested in the AFIRM Act,<sup>58</sup> for FY2018, OMHA would receive \$125,000,000. According to OMHA's FY2017 budget justification, this would allow OMHA to expand its ALJ teams from 92 teams to 193 teams, which would allow 101,000 cases to be reviewed per year.<sup>59</sup> This amount would come from the RA recoveries and would be allocated each FY until 2021 to allow OMHA to meet the deadline set by the federal judge.

#### *Raise the threshold for the amount-in-controversy (AIC)*

As described in the AFIRM Act, beginning in FY2018, the AIC would be raised to be equal to that of the fifth level (judiciary level) of appeals. This means that a claim would need to be valued at least \$1,500, depending on the threshold set for the FY to receive a hearing from an ALJ. If a claim reaches the third level of appeal but does not meet the AIC, the claim would be reviewed by a separate group of hearing officers, the Medicare Magistrates, described below.

#### *Establish a Medicare Magistrate review system*

As proposed in the AFIRM Act, if a claim does not meet the AIC for a hearing by an ALJ, the claim would be reviewed by a Medicare Magistrate without a hearing. A Medicare Magistrate would be a licensed attorney with expertise in Medicare law and would be subject to the same rules of law as the ALJs. The Medicare Magistrate would review those claims that are valued at less than \$1,500 (depending on the threshold set for the FY) and render a decision on

---

<sup>58</sup> S. Rep. No. 114-177 (2015).

<sup>59</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

the appeal. In its FY2017 budget justification, OMHA estimated that establishing this system would allow OMHA to review 75,000 more cases per year. This would involve hiring a team of 100 Medicare Magistrates, which is estimated to cost \$27 million annually.<sup>60</sup> This system would be paid for out of the funds allocated to OMHA by Congress.

### **Policy Implementation Tool: Fees**

#### *Establish a refundable filing fee for all levels of appeal*

Building upon the request of CMS in the FY2017 President's Budget, beginning in FY2018, a refundable filing fee would be required in order to file an appeal at any level of the system. If the claim decision is overturned, the filing fee would be returned to the provider with interest. OMHA has estimated this will result in approximately \$5 million in revenue annually.<sup>61</sup> This policy proposal builds upon that number, requiring the fee to be equal to 10 percent of the value of the appealed claim.

#### *Establish a high overturn rate fee*

Beginning in FY2018, if an RA has an overturn rate at any level of appeals above 10 percent, the RA's contingency fee level would be cut in half. For example, if an RA receives 10 percent of any given overpayments recovered, the new rate would be 5 percent. Based on the current overturn rate of more than 10 percent, the current recovery amount of approximately \$360 million, and the average contingency fee of 10.75 percent,<sup>62</sup> it is estimated that this proposal will result in savings of at least \$10 million if current levels remain.

---

<sup>60</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

<sup>61</sup> *Ibid.*

<sup>62</sup> Centers for Medicare and Medicaid Services. *Recovery Auditing in Medicare Fee-For-Service for Fiscal Year 2015*. Report. Washington, DC, 2016.

## **Policy Analysis**

To address the two-fold problem of the Medicare appeals backlog – the increasing number of appeals being filed combined with the lack of resources for OMHA to clear the current backlog of appeals at the ALJ level – the proposed bill would amend title XVIII of the Social Security Act<sup>63</sup> to ensure OMHA has the appropriate resources and authority to hear appeals and to ensure only those appeals with merit reach the ALJ level. The proposal includes increased funding to OMHA to be used by the Office to implement programmatic changes as well as create a new review system for select appeals, and fees for both Medicare providers and RAs if they abuse the system or deny claims excessively.

To determine if this proposal will accomplish its goal, below is an analysis of each part of the proposal, looking at estimated effectiveness, costs and benefits, equal treatment of parties, and feasibility.

### **Increased Funding for OMHA**

*Will increased funding eliminate the appeals backlog by 2021 and prevent future backlogs?*

To address the current issue of the appeals backlog and allow OMHA to meet the deadline to clear the backlog by 2021, the proposal suggests increased resources to OMHA in order to expand ALJ teams from 92 to 193, raise the threshold for the AIC and establish a Medicare Magistrate system to review claims that do not meet the new AIC without a hearing.

OMHA believes that with additional funding, it will be able to increase adjudicatory capacity by 178,000 claims per year. This increase would be due to an expansion of ALJ teams from 92 to 193 teams, which would increase the claims reviewed per year by 101,000 as well as the implementation of the proposed Medicare Magistrates system, which would review approximately 75,000 claims per year.<sup>64</sup>

---

<sup>63</sup> Pub. L. 89-97, 89th Cong. (1965) (enacted).

<sup>64</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

It is important to look at similar situations to determine if the increased level of funding will be effective in reducing the current backlog. In FY2010, the Social Security Administration (SSA) was facing a backlog of nearly 1 million cases. In order to reduce this backlog, the SSA was appropriated funding in 2009 and 2010 to increase staffing to handle these cases and implement procedural changes in the appeals process. SSA was successful in decreasing the backlog of appeals to 698,000 by FY2013; however, because it did not receive any additional funding after 2010, it was not able to decrease the backlog to its goal of 525,000. The lack of funding caused the staffing to decrease as SSA was not able to replace employees who left the agency, resulting in similar levels of staffing in 2013 as that of 2008, before the funding was allocated.<sup>65</sup>

In addition to setting up the ALJ teams and Medicare Magistrate system, OMHA will need to take 6-12 months to train the teams on the new system and to educate providers on the new AIC rules and how the programmatic changes will affect existing appeals in the backlog.<sup>66</sup> There is not proof that OMHA will be able to effectively train the new teams and providers on the programmatic changes in such a short amount of time. In fact, the SSA saw a decrease in productivity at the ALJ level when it implemented rules intended to strengthen the quality of appeals decisions.<sup>67</sup> Further, this lost time spent on training both staff and providers may delay the increase in adjudicatory capacity, inhibiting OMHA from reaching its statutory deadline.

At a 2015 Congressional hearing, a representative from MAXIMUS Federal Services, a CMS contractor involved in the second level of the appeals process, detailed how its organization also faced a backlog of appeals in 2012. This contractor received added resources allowing it to more than quadruple its staff and create specialized teams to handle specific appeals. The backlog

---

<sup>65</sup> *The Social Security Administration's Progress in Reducing the Initial Disability Claims Backlog*. Report no. A-07-13-13073. Office of the Inspector General, Social Security Administration. Washington, DC, 2014.

<sup>66</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

<sup>67</sup> *The Social Security Administration's Efforts to Eliminate the Hearings Backlog*. Report no. A-12-15-15005. Office of the Inspector General, Social Security Administration. Washington, DC, 2015.



was eliminated in just a few months and it has not returned.<sup>68</sup> This example illustrates how a similar level of appeal within the Medicare program was able to address its backlog through additional resources, hiring staff and creating specialized teams, as proposed in this policy.

In order to ensure OMHA is able to not only expand ALJ teams and create a Medicare Magistrate system but also sustain these positions, Congress would need to allocate funding each FY through 2020 and possibly for years past this deadline. As illustrated in the SSA and MAXIMUS case studies described above, without increased funding OMHA may not be able to meet its legally mandated deadline. Further, without funding past FY2020, with the same level of appeals being filed each year, the backlog may once again appear because OMHA would not have the resources to sustain the increased capacity. This notion is supported by SSA's increase in appeals once the increase in funding was no longer allocated to the agency. In 2015, the SSA Office of Inspector General released another report that found that due to budget constraints, the SSA was not able to hire enough ALJs and the backlog had since increased to 1 million claims.<sup>69</sup>

*Will the additional changes be worth the increased costs?*

To examine the efficiency of increased funding to OMHA to implement programmatic changes, we can do a cost/benefit analysis to determine the costs for the proposed changes and compare them to the benefits.

---

<sup>68</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>69</sup> *Ibid.*

Estimated Annual Spending (FY2018, FY2019, FY2020)		
Action	Cost	Benefit
Expanded ALJ teams	Salary: \$47,975,000/year x3 <sup>70</sup> Administrative: \$41,713,000/year x3 <sup>71</sup> Total: \$89,688,000/year x3	+101 ALJ teams +101,000 claims reviewed/year x3 +110% adjudicatory capacity +436 FTE (full time hours worked by one employee) / year x3  (Benefits detailed in FY2017 budget justification <sup>72</sup> )
Change in AIC/ Creating Medicare magistrates program	\$27 million/year x3 <sup>73</sup>	+100 magistrates +123 FTE/year +75,000 claims reviewed/year x3  (Benefits detailed in FY2017 budget justification <sup>74</sup> )
<b>Total</b> (FY2018, FY2019, FY2020)	\$350 million <sup>75</sup>	+101 ALJ teams +100 magistrates +528,000 claims reviewed +1,677 FTE +\$17.8 million saved in interest fees <sup>76</sup>

<sup>70</sup> Determined by taking the total salary costs as estimated in the FY2016 President's Budget (*Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2015.) divided by the total number of ALJ teams proposed in the FY2016 President's Budget (\$475,000/ALJ team), multiplied by the proposed number of ALJ teams (101) in the FY2017 President's Budget (*Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.)

<sup>71</sup> Determined by taking the total operating, administrative and rent costs as estimated in the FY2016 President's Budget (*Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2015.) divided by the total number of ALJ teams proposed in the FY2016 President's Budget, multiplied by the proposed number of ALJ teams (101) in the FY2017 President's Budget (*Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.)

<sup>72</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

<sup>73</sup> Ibid.

<sup>74</sup> Ibid.

<sup>75</sup> Determined by taking the estimated salary costs plus estimated administrative costs multiplied by the number of years in the proposed funding time period (three years, FY2018-2020)

<sup>76</sup> *MEDICARE FEE- FOR-SERVICE Opportunities Remain to Improve Appeals Process*. Report no. GAO-16-366. U.S. Government Accountability Office. Washington, DC. May 2016. Accessed January 25, 2017. <http://www.gao.gov/assets/680/677034.pdf>.

Reviewing the above chart, we can see that with the increased funding, OMHA will see an increase in adjudicatory capacity of 528,000 claims from FY2018 to FY2020, the deadline for OMHA to clear the appeals backlog.

The analysis also shows the introduction of the Medicare Magistrate program will allow 75,000 claims to be reviewed per year at half of the cost of the current cost for ALJs to review those cases (\$27 million/year versus \$66 million/year,<sup>77</sup> respectively).

Additionally, with increased funding, OMHA will be more likely and able to meet statutory deadlines for rendering appeals decisions. The GAO found in 2016 that from FY2010-2015, CMS paid \$17.8 million in interest to Part A and B providers due to decisions made outside of the statutory timeframe. Specifically, 75 percent of this interest was paid out in 2013 and 2014, when wait times for appeals decisions began to grow at a faster rate.<sup>78</sup> If the proposal provides the funding necessary to eliminate the backlog and reduce the wait time for appeals decisions, it will also eliminate the costs associated with paying interest to providers during the wait times outside of the statutory timeframe.

Because this funding would come from RA recoveries, which averaged \$359.7 million in FY2015,<sup>79</sup> additional funding from the program and from Congress would not be necessary to cover the costs of these programmatic changes. The funds would come directly from the RA Program recoveries, which have been blamed for the increase in appeals filed in the first place. However, this means that \$125 million, or \$375 million total, will not be returned to the Medicare Trust Funds each year. If RA recoveries remain at the current level, then nearly one-third of recoveries will not be returned to the Medicare Trust Funds.

---

<sup>77</sup> Determined by taking 75 percent of the total cost of ALJ teams reviewing 101,000 claims as determined by the FY2016 President's Budget (*Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2015.

<sup>78</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2015.

<sup>79</sup> *National Program Total Corrections*. Issue brief. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Washington, DC, 2016.

*Does OMHA have the administrative capacity to implement proposed programmatic changes?*

According to OMHA's own reports to Congress, with additional funding, the agency will be able to implement the programmatic changes without additional authority. The funding will allow OMHA to hire additional resources needed to meet the needs of the appeals system, increasing the adjudicatory capacity by 528,000 claims over the next three years. The proposal would build upon the existing structure of the appeals system by expanding the ALJ teams and CMS can use its regulatory authority to change the rules of the AIC at the third level of appeal and implement a Medicare Magistrate system. The biggest roadblock to the feasibility of this proposal is the need for Congress to appropriate funds from RA recoveries to OMHA to be used for these programmatic changes.<sup>80</sup> The proposed funds include operational costs associated with expanding ALJ teams and creating the Medicare Magistrates system.

Even with additional resources OMHA may need to implement an education campaign to train new ALJs and Medicare Magistrates. With questions existing on the effectiveness of the current training of ALJs, including reports detailing the variance in decisions made at the ALJ level,<sup>81</sup> there is no substantive evidence that OMHA's current administrative staff would be capable of training new ALJ teams or Medicare Magistrates, the latter of which has not been done before in the Medicare program.

However, programs already exist to train and educate these new ALJs. Since 2010, OMHA has offered the Judicial Education Symposium (JES), which provides continuing education to ALJs on an annual basis. OMHA also provides a week-long training program for all new hires and educates them on Medicare policy and the appeals process. OMHA also provides an "InService" program on a monthly basis, in which it offers seminars and training to current ALJs. OMHA reports a "significant change in the rate at which ALJs reverse decisions from

---

<sup>80</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

<sup>81</sup> AUDIT & APPEALS FAIRNESS, INTEGRITY, AND REFORMS IN MEDICARE ACT OF 2015, S. S. 2368, 114th Cong. (2015).

lower levels of appeal” and due to these program, the rate has decreased from 63.2 percent in 2010 to 43 percent in 2015. In addition to these training programs, OMHA provides the OMHA Case Processing Manual, which formalizes agency policy and is updated as policy changes.<sup>82</sup> Because this process already exists, it is reasonable to conclude that OMHA has the administrative capacity to educate new ALJs and the Medicare Magistrates.

It is also necessary to consider the feasibility of educating Medicare providers that are filing or have filed appeals on the new structure of the OMHA level, including the new AIC threshold and the Medicare Magistrates system. CMS has implemented education programs in the past on Medicare policies and what would constitute a Medicare claim to be denied.<sup>83</sup> However, many claims decisions are still being denied by RAs and providers are still filing many appeals of those decisions.

### **Refundable Filing Fees and High Overturn Rate Fees**

*Will the refundable filing fee and the high overturn rate fees lessen the number of appeals filed?*

A refundable filing fee would deter those providers who file an appeal every time a claim decision is overturned from filing an appeal without merit. If the appellant is victorious in the appeals process, the filing fee would be refunded to the appellant. This fee is similar to that of the appeals process with private insurers, such as Blue Cross Blue Shield of North Carolina, which charges a filing fee based on the value of the claim in dispute.<sup>84</sup>

Because there would be a deterrent to filing appeals without merit, those providers that the federal government has termed “frequent filers” or those that appeal every claim in the hopes

---

<sup>82</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>83</sup> *MLN Matters® Article 2015 Index Through December 2016*. Issue brief. Centers for Medicare and Medicaid Services. 2016. Accessed 2017. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2015-2016MLNMattersArticlesIndex.pdf>.

<sup>84</sup> “BlueCross BlueShield of North Carolina.” Provider Appeals - Level II | BCBSNC. Accessed February 23, 2017. <http://www.bcbsnc.com/content/providers/appeals/LevelIIProviderAppeals.htm>.

of getting in front of a judge that will overturn the claim decision would be less able or likely to file an appeal.<sup>85</sup>

This filing fee would also generate additional funding to support the appeals process. However, there would need to be provider education on the amount of the fees, when they apply, and what needs to happen for the provider to get a refund. This could be an added cost. Although OMHA has estimated the filing fee to generate \$5 million in funding for OMHA,<sup>86</sup> it is difficult to predict how many claims decisions will be overturned or upheld on appeal and therefore difficult to make an accurate prediction of the funds OMHA will receive from this proposal.

The high overturn rate fee is a penalty on RAs that have a rate of more than 10 percent of claims decisions overturned at the ALJ level. The penalty will be a reduction of 50 percent of the RA's contingency fee for the following FY. For example, if an RA receives 10 percent of the value of each improper payment it identifies and it has a high overturn rate at the ALJ level of appeal, the contingency fee will be reduced to 5 percent for the following FY. This proposal will improve the quality of RA decisions when reviewing Medicare claims because if the claims are overturned at the third level of appeal, not only will the RA have to return the contingency fee resulting from the claim decision,<sup>87</sup> but may also face the greater penalty of a contingency fee reduction for the following year.

If an RA is hit with a high overturn rate fee, that means 50 percent of what it would have kept as a contingency fee will be returned to the Medicare Trust Funds. However, imposing such a steep penalty on an RA may lead to a slower decision time when evaluating post payment claims, which will then result in less recoveries. With less recoveries, there will be less funding available from recoveries to fund other portions of this proposal and less money will be returned

---

<sup>85</sup> *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*. Report no. OEI-02-10-00340. Office of the Inspector General, U.S. Department of Health and Human Services. Washington, DC, 2012. 5.

<sup>86</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2015.

<sup>87</sup> *Recovery Auditing in Medicare Fee For-Service for Fiscal Year 2015 Report*. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Washington, DC, 2016.

to the Medicare Trust Funds. Returning wasted funds to the Medicare Trust Funds is the purpose of the RA Program as outlined by Congress.<sup>88</sup>

*Will the proposed fees be worth the result?*

To determine the possible costs and benefits associated with the proposed fees, it is possible to analyze a cost/benefit analysis to get a better understanding of the outcome of the proposal.

Estimated Annual Impact of Proposed Fees		
Action	Cost	Benefit
Refundable Filing Fee	-Education to providers -Refund of filing fee -Unpredictable funding per year	+\$5 million +Less meritless appeals filed +Less appeals entering backlog
High Overturn Rate Fee	-Possible decrease in overpayments identified -Less money returned to Trust Funds -Less money available to fund OMHA programs	+50% of contingency fee returned to Medicare Trust Fund per claim decision +Less meritless claims filed +Less appeals filed +Decrease in refunds to providers +Decrease in interest paid to providers

The refundable filing fee is estimated to generate \$5 million in revenue for OMHA, which OMHA has proposed to use toward implementing and sustaining programmatic changes.<sup>89</sup>

The refundable filing fee is meant to deter an increase in meritless appeals at no cost to OMHA and with the potential to increase funds to the organization.

<sup>88</sup> *Recovery Auditing in Medicare Fee For-Service for Fiscal Year 2015 Report*. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Washington, DC, 2016.

<sup>89</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2015.

However, if most appeals are overturned throughout the process, the estimated increase in funds from the filing fee will be returned to the appellants with interest, which would be an increased cost for the program.<sup>90</sup>

As discussed in the section above, a high overturn rate fee may have unintended consequences. Although it will likely lead to a decrease in the number of claims decisions overturned on appeal, it may also result in less recoveries. With less recoveries, there will be less funding available from recoveries to fund other portions of this proposal and less money will be returned to the Medicare Trust Funds. Returning wasted funds to the Medicare Trust Funds is the purpose of the RA Program as outlined by Congress.<sup>91</sup>

However, if providers are paying a refundable filing fee and the overturn rate is lower than 10 percent, then less than 10 percent of all filing fees will be refunded, lowering the amount paid to providers by not only the value of the filing fee but also the interest that would need to be paid to a provider. This would allow OMHA to keep more funding for programmatic changes and implementation.

## **Political Analysis**

In order to ensure the proposal will be passed in Congress, the viewpoints of each of the key stakeholders must be considered in regard to each section of the proposal.

## **Increased Funding for OMHA**

Key stakeholders, including representatives from OMHA, the Senate Finance Committee, the White House and the Medicare provider community have all voiced support for increased funding to OMHA to expand capacity to review appeals at the ALJ level and establish a Medicare

---

<sup>90</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2016*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2015.

<sup>91</sup> *Recovery Auditing in Medicare Fee For-Service for Fiscal Year 2015*. Report. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Washington, DC, 2016.



Magistrate system. In general, Medicare providers are not behind the change in the AIC threshold in that they believe it may prohibit some providers from receiving a fair hearing. The statements from each stakeholder are provided below.

#### *OMHA*

Chief ALJ Nancy Griswold has repeatedly called for increased funding to OMHA to implement programmatic changes. At a 2015 Congressional hearing,<sup>92</sup> she detailed proposals in the President's Budget to increase funding to the organization in order to expand the number of ALJ teams available to adjudicate cases. Griswold pointed to the record number of appeals received by OMHA, but to too few resources to be able to handle the incoming claims. Griswold noted the urgency of expanding the ALJ teams in order to increase capacity, stating she is "keenly aware of the impact that these delays are having" and urged Congress to support the proposals for increased funding in the Budget, emphasizing their ability to double capacity at OMHA. Griswold pointed to the slight increase in funding in FY2014 and FY2015 and how it allowed OMHA to hire some additional resources, however more are needed. She emphasized that "administrative initiatives alone are insufficient" to address the backlog and Congressionally-allocated funding is necessary.

With this increase in funding, Griswold explained, OMHA would be able to not only expand ALJ teams, but change the AIC threshold and implement the Medicare Magistrate system in order to reduce the number of appeals required to be reviewed in a hearing before an ALJ. The Medicare Magistrates would review claims for less cost than the ALJs and would review those claims that fall below the new AIC. Griswold argued that ALJs are the only officers than can prepare documents for review at the fourth level of appeal, in which the AIC is much higher, and that if the claim cannot reach the fourth level due to AIC, it makes sense to have a different

---

<sup>92</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

hearing officer review that claim at a lower cost to OMHA.

*U.S. Congress*

Senator Wyden, a Democrat and ranking member of the Committee, has stated the need for increased resources at OMHA on numerous occasions. At a 2015 Congressional hearing, he detailed the number of appeals received by the organization compared with its resources, commenting, “It’s no wonder that the appeals system is buckling under its own weight” and explaining that while the number of appeals has increased, the number of hearing officers had not changed since 2011. He stated further, “Simple math makes it quite clear that this [current level of] capacity falls severely short” and that “within [OMHA’s] current resources, it sounds as though many [initiatives aimed at reducing the backlog] have been exhausted.” Wyden also championed the idea of the Medicare Magistrate system, stating that it would “leave the more complicated and difficult cases to administrative law judges.”<sup>93</sup>

At the same hearing, Senator Orrin Hatch, the Republic Chairman of the Senate Finance Committee, recognized the steps OMHA had taken to address the backlog with its current resources. He did not go so far as to endorse any proposal but he did reassert his commitment to make the appeals process work more efficiently.<sup>94</sup>

Senators Wyden and Hatch introduced the AFIRM Act, which included increased funding to OMHA to enact a number of administrative and process changes that would help alleviate the backlog. Because this proposal is based on this Act, which included this recommendation, it is likely the senators would support the proposal.

Senator Robert Casey, a Democrat, also pledged his support for increased resources for OMHA, stating “I am a great believer that resources matter, especially when you can very

---

<sup>93</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>94</sup> *Ibid.*

specifically focus on what resources would be used for”<sup>95</sup> such as the proposals outlined in this policy proposal.

In 2015, Representative Brady disagreed with HHS’ settlement offer to hospitals to clear up a portion of the backlog. He questioned the agency’s statutory authority to take such measures and expressed concerns with settling appeals without review of the merits of the cases.<sup>96</sup>

In 2015, Senator Schumer voiced his support for a pilot project that allowed a group of hearing officers, instead of ALJs, to review Medicaid state agency appeals. He asked that this pilot be expanded into New York state, a similar idea as the establishment of the Medicare Magistrate system.<sup>97</sup>

#### *The White House*

The White House has made fighting waste, fraud and abuse within Medicare as well as reducing the number of appeals coming into OMHA priorities in both 2016 and 2017.<sup>98</sup>

Beginning in 2016, the President’s Budget included funding to reduce improper payments, use RA recoveries to fund process changes at OMHA, increase the AIC at the third level of appeal and establish a Medicare Magistrates system to review those claims at OMHA that do not meet the AIC. The Obama administration has continuously asked for this funding.

#### *Medicare Providers*

In a letter to the Senate Finance Committee, the National Association for Home Care and Hospice stated that “OMHA should increase its resources to handle the level of demand and

---

<sup>95</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>96</sup> House Ways and Means Committee. Subcommittee on Health. "Brady Questions HHS Medicare Appeals Settlement." News release, September 16, 2014. Accessed March 6, 2017. <https://waysandmeans.house.gov/brady-questions-hhs-medicare-appeals-settlement/>.

<sup>97</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>98</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

establish alternative dispute resolution processes to resolve some appeals.”<sup>99</sup>

However, a representative from the AHA has stated that this proposal, as submitted in the AFIRM Act, does not go far enough to address the real cause of appeals – the RAs.<sup>100</sup>

#### *Center for Medicare Advocacy*

When discussing the changes to the AIC, the Center for Medicare Advocacy, which represents the interests of Medicare beneficiaries and Medicaid state agencies, voiced concerns that providers who do not reach the AIC would not receive a fair hearing and instead be subject to review by a Medicare Magistrate, who may have less experience than an ALJ. They also emphasized the confusion that could come with a new set of regulations and rules regarding this step of the appeals process.<sup>101</sup> The Center also raised concerns about the Medicare Magistrates system, calling it a “stopgap measure” and stating more ALJs would be a better use of the resources.<sup>102</sup>

### **Refundable Filing Fee**

#### *Medicare Contractors Involved in the Appeals Process & OMHA*

At a 2015 Congressional hearing, a representative from a Medicare Administrative Contractor, which handles claims at the first level of appeal, suggested the Committee consider implementing a refundable filing fee as first proposed by Senator Wyden. She believed this type of fee would discourage providers from filing meritless claims while also funding additional resources in the appeals system. She also pushed for the Committee to consider providing education to Medicare providers who continue to submit appeals incorrectly or who continue to

---

<sup>99</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>100</sup> Jaffe, Susan. "HHS Proposes To Streamline Medicare Appeals Process." *Kaiser Health News*, June 29, 2016. Accessed March 10, 2017. <http://khn.org/news/hhs-proposes-to-streamline-medicare-appeals-process/>.

<sup>101</sup> *June 2015 – Reforming Medicare’s Appeals System & Other Issues*. Issue brief. Center for Medicare Advocacy. 2015. Accessed February 23, 2017. <http://www.medicareadvocacy.org/june-2015-reforming-medicares-appeals-system-other-issues/>.

<sup>102</sup> Jaffe, Susan. "Medicare’s Efforts To Curb Backlog Of Appeals Not Sufficient, GAO Reports." *Kaiser Health News*, June 10, 2016. Accessed March 10, 2017. <http://khn.org/news/medicares-efforts-to-curb-backlog-of-appeals-not-sufficient-gao-reports/>.

submit appeals after many unfavorable decisions. Further, she encouraged the Committee to consider penalizing Medicare providers who abuse the system by removing them from the Medicare program.<sup>103</sup>

At the same hearing, Griswold pointed to the flood of new appeals coming in, bringing up the fact that “51 percent of appeals have been filed by five appellants since 2015” as cause to implement a refundable filing fee. She argued that this would encourage providers to be “a little more discriminating” when filing appeals at the third level and “impact the number of cases coming in.” Griswold explained that OMHA continually finds that some Medicare providers do not even review the reason their claims were denied and just simply submit appeals on every claim. When the appeal is set to go before an ALJ, sometimes these providers withdraw their appeal just before the hearing, “after considerable resources have already been devoted to processing the appeal, supporting the conclusion that they gave the claims only a cursory review prior to appealing.” Griswold stated that “OMHA believes a refundable filing fee would be the most reliable measure to discourage this behavior.” She pointed out that beneficiaries would be exempt from this fee.<sup>104</sup>

A representative from the contractor responsible for reviewing claims at the second level of appeal, MAXIMUS Federal Services Inc., agreed that a small percentage of appellants are responsible for a majority of appeals and that “providers are engaging high-powered law firms to represent them at ALJ hearings” and if they continue to appeal the cases to the resource-strapped ALJ level, their chances of “winning are greater because [they] have the resources to get behind this and make sure [they] win it.”<sup>105</sup>

CMI, which represents the RAs, believe providers wrongly blame the RAs for unfair auditing and appeal a majority of claims in hopes of receiving a different outcome at the third

---

<sup>103</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>104</sup> *Ibid.*

<sup>105</sup> *Ibid.*

level of appeal. The organization supports the idea of a refundable filing fee as a way to make sure providers who appeal are “putting some skin in the game.” The Council pointed to an OIG report that called providers who appeal every decision “frequent filers” stating that these providers need to be deterred from filing frivolous appeals.<sup>106</sup> CMI argued that RAs are penalized when a claim is overturned on appeal because they must give back their contingency fee and it is only fair that providers also be penalized for abusing the system. Further, the Council believes that ALJs do not rule according to Medicare policy, which is why providers appeal in the hopes of reaching that level.<sup>107</sup>

### *U.S. Congress*

At a 2015 Congressional hearing, Senator Wyden, a Democrat, championed the refundable filing fee proposal, stating that a small number of providers have “figured out a way to really hotwire the system.”<sup>108</sup> He urged the Committee to support the proposal in order to protect the seniors whose cases need to be heard and to deter those providers who have a ton of resources and automatically appeal every case in the hopes of favorable decision or settlement.<sup>109</sup>

Senator Michael Bennet, a Democrat, echoed this statement bringing up the OIG report that found two percent of providers are responsible for one-third of all appeals. Bennet emphasized the Committee’s responsibility “to protect taxpayer dollars from exploitation by the few who are bogging down the system for their own financial gain.”<sup>110</sup>

Senator Debbie Stabenow, a Democrat, voiced concerns over the implementation of a refundable filing fee, believing that if the fee is put in place, all of the financial burden for filing

---

<sup>106</sup> Berklan, James. "Providers suffering Medicare appeals backlog — at their own hand?" *McKnight's*, April 29, 2015. Accessed February 23, 2017. <http://www.mcknights.com/daily-editors-notes/providers-suffering-medicare-appeals-backlog-at-their-own-hand/article/411714/>.

<sup>107</sup> Stein, Michelle. "Chief ALJ: Refundable Filing Fee Could Reduce New Appeals." *Inside Health Policy*, April 28, 2015. Accessed February 27, 2017. <https://insidehealthpolicy.com/daily-news/chief-alj-refundable-filing-fee-could-reduce-new-appeals>.

<sup>108</sup> Berklan, James. "Providers suffering Medicare appeals backlog — at their own hand?" *McKnight's*, April 29, 2015. Accessed February 23, 2017. <http://www.mcknights.com/daily-editors-notes/providers-suffering-medicare-appeals-backlog-at-their-own-hand/article/411714/>.

<sup>109</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>110</sup> *Ibid.*

an appeal is placed on the Medicare providers and there is no deterrent for RAs to deny claims even if there is no reason to do so.<sup>111</sup>

### *Medicare Providers*

The Orthotic and Prosthetic Alliance has voiced concerns over the implementation of a refundable filing fee, doubting that such a fee would have an impact on clearing the backlog and preventing it from occurring again in the future. It posited that the fee would only serve to “erect additional financial barriers between potential appellants and their right to due process.” The organization does not support the idea that a fee is in place at all, but also explained it does not believe making the fee refundable is an acceptable way to try to make a fee fair to the provider community because many providers appeal due to “significant financial harm they experience when Medicare claims are denied and the funds are recouped.” It argued that this fee would only further this financial harm and it would create a barrier in the provider’s right to due process. Further, the organization argued that smaller entities and those who receive a high amount of RA audits would be more affected by the fee than others.<sup>112</sup>

The AHA is also opposed to a refundable filing fee. The association pointed to the financial and time burden on the provider when participating in the appeals process and that many providers cannot afford to file legitimate appeals even without the filing fee. The organization also believes that the filing fee may have a very minor impact on the number of appeals filed, and that it does not address the cause of the backlog, which providers blame on the RAs and their auditing practices.<sup>113</sup>

---

<sup>111</sup> Stein, Michelle. "Chief ALJ: Refundable Filing Fee Could Reduce New Appeals." *Inside Health Policy*, April 28, 2015. Accessed February 27, 2017. <https://insidehealthpolicy.com/daily-news/chief-alj-refundable-filing-fee-could-reduce-new-appeals>.

<sup>112</sup> “*Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*”, 114th Cong. (2015) (testimony of American Hospital Association).

<sup>113</sup> *Ibid.*

### *The White House*

In both FY2016 and FY2017,<sup>114</sup> the President's Budget included a recommendation to create a refundable filing fee. This illustrates the president's support for the fee in order to create a barrier to entry for those providers that are filing meritless claims.

### **High Overturn Rate Fee**

Although it has never been directly proposed to Congress, statements from key stakeholders reveal how this proposal may be received by Congress.

### *Medicare Providers*

The AHA places the blame for the backlog on the RAs and what AHA has called overzealous auditing practices. The AHA questions how some claim denial decisions are being made the RAs and believes that the high rate of reversals in the appeals system shows that providers are put under financial burden at the start of the appeals process, whereas RAs have no risk in denying a Medicare claim because there is no penalty for a high rate of overturns on RA-related claims in the appeals process.<sup>115</sup>

The AHA has suggested in the past that RAs with a high overturn rate should see reduced payments in order to incentivize them to make claims decisions correctly in the first place. AHA stated, "This reform would curb overzealous RAs and create a level playing field for both RAs and providers in addressing incorrect payments."<sup>116</sup>

The American Medical Association has also proposed a similar fee structure in the past, suggesting that RAs who abuse their auditing power should be penalized and that these RAs

---

<sup>114</sup> *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*. Report. Office of Medicare Hearings & Appeals, U.S. Department of Health and Human Services. Washington, DC, 2016.

<sup>115</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>116</sup> "Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare", 114th Cong. (2015) (testimony of American Hospital Association).



should have to pay provider costs in the event of a successful appeal.<sup>117</sup>

### *Medicare Contractors Involved in the Appeals Process & OMHA*

At a 2015 Congressional hearing, a representative from a Medicare Administrative Contractor, which handles claims at the first level of appeal, explained that RA-related claims jumped from 7 percent in 2011 to 63 percent in 2013.<sup>118</sup>

### *U.S. Congress*

Senator Debbie Stabenow, a Democrat, emphasized the need to “get ahead of this on the front end” and that the reversals in the appeals process show that the RA Program needs to be reformed. She believes that because RAs operate on a contingency fee basis, they have little risk in denying claims in the first place.<sup>119</sup>

At a 2015 Congressional hearing, Senator Wyden, a Democrat, encouraged the Committee to consider how to prevent a large number of appeals in the first place, stating that the Committee needs to determine how to make sure RAs get the claims decisions “right in the first place.”<sup>120</sup>

Representative Brady would likely support increased funding to OMHA for these changes as he has identified the backlog as a concern previously when he introduced a bill in 2014 aimed at monitoring the accuracy of RAs,<sup>121</sup> which this proposal aims to do.

---

<sup>117</sup> Showalter, J. Stuart. "Medicare appeals process worries providers and CMS alike." *Healthcare Financial Management*, September 1, 2014.

<sup>118</sup> U.S. Congress, Senate, Committee on Finance, *Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare*, 114th Cong., 1st sess., 2015.

<sup>119</sup> Ibid.

<sup>120</sup> Ibid.

<sup>121</sup> House Ways and Means Committee. Subcommittee on Health. "Brady Unveils Discussion Draft to Improve Hospital Issues in the Medicare System." News release, 2014. Accessed March 6, 2017. <https://waysandmeans.house.gov/brady-unveils-discussion-draft-to-improve-hospital-issues-in-the-medicare-system/>.

## **Recommendation**

The bottom line is that there is a huge backlog at the OMHA level of appeals, one so great that it will continue to grow without intervention by Congress. HHS has taken the steps it can administratively to address the backlog, but without creative thinking on the part of lawmakers, OMHA will not be able to meet the deadline of 2021 to clear the backlog, which was set by a federal judge in December 2016.

Because the proposal uses a combination of increased funding and fees for abuse of the system, it treats every participant in a fair manner, with both providers paying fees for filing meritless claims and auditors getting a reduction in compensation for overturning claims without merit. Providers continuously complain about overzealous auditing, and auditors and OMHA both complain about providers appealing every claim denial in an attempt to game the system. This proposal gives OMHA the resources it needs to make process changes and holds both auditors and providers accountable for their parts in creating the backlog in the first place.

Because many members of Congress have voiced support, at least in part, for a number of these proposals, the bill should be able to pass and be implemented. This proposal was based on some recommendations in the AFIRM Act, which already passed the Senate Finance Committee, a good sign that this new bill would be well-received. Members on both sides of the aisle as well as in House and the Senate have held hearings on the issue and recognized the need to reduce the backlog, stop it from occurring again in the future, conduct oversight of Medicare integrity and lessen the burden on hospitals.

A cost/benefit analysis of each section of the proposal – increased funding and levying fees – shows that the benefits outweigh the cost. The amount of funding currently lost due to settlements and interest would be eliminated if the appeals backlog is cleared. Because the increased funding to OMHA would come directly from RA recoveries, it would not require Congress to find funds or pull funding from one program to fund another. The money is already within the agency, and with congressional authorization, HHS can reroute those funds to address

this issue.

Consumer and provider groups have voiced concern about the increase in AIC and the creation of the Medicare Magistrates program. They believe that it will take away from a beneficiary's or provider's right to due process. To ease these groups into the idea that this would actually benefit them in terms of reducing the costs and time burdens that go into filing an appeal, I suggest we begin a pilot program immediately in which randomly selected claims are routed into this new system. This pilot program could exist for one year, and if an appellant is unhappy with the outcome of the pilot, they will be able to refile an appeal in the existing system and be moved to the top of the list in order to minimize the already extremely long wait time. Using the results of this pilot, in one year OMHA can either decide to implement it permanently or scrap the idea. One major benefit of this proposal is that Medicare Magistrates would cost OMHA substantially less money to review and decide on the same number of claims. It would reduce the number of cases the ALJs had to review and lessen their burden on all involved.

Another downside involves the redirection of RA recoveries from the Medicare Trust Funds to OMHA to implement these procedural changes. The point of the RA Program is to recover waste and return it to the Trust Funds in order to prolong the life of the program. If RA recoveries are instead used to fund administrative programs, those dollars are not increasing the solvency of the program. However, the appeals backlog is costing OMHA administrative costs in the form of time, money, and interest. Clearing the backlog would, in the long run, allow these RA recoveries to go toward the Trust Funds. Further, increased funding from the refundable filing fees and reduction in contingency fees paid to those RAs that have a high overturn rate would fill in some of the gaps in funding lost from redirecting the RA recoveries to OMHA.

My recommendation is to move forward with this proposal to address the dire need to reduce the appeals backlog as soon as possible. The benefits far outweigh the challenges in the long run and, if successful in clearing the backlog, will satisfy all parties involved in the appeals process.

## **Curriculum Vita**

Kelly Davis was born in La Jolla, CA and raised in Jacksonville, FL. She earned her Bachelor of Science in Public Relations from University of Florida and is a candidate for her Master of Arts in Public Management at Johns Hopkins University.