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in the news

Health Care

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HHS Proposes Rules to Eliminate Backlog … in 5 Years

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On June 28, 2016, the U.S. Department of Health and Human Services (HHS) released a series of regulatory changes in the Notice of Proposed Rule Making (NPRM) designed to curtail the massive backlog of Medicare claim appeals. Specifically, the proposed changes would revise the appeal procedures at the Administrative Law Judge (ALJ) level as well as alter procedures at the Centers for Medicare and Medicaid Services (CMS) and Medicare Appeals Council (Council) levels for certain matters affecting the ALJ level. HHS contends that these reforms will help defray the number of pending appeals by encouraging resolution of cases earlier in the appeals process.

HHS intends for this proposed rule to operate in conjunction with a series of legislative actions and funding requests outlined in the Fiscal Year (FY) President's Budget Request. Should this three-prong strategy gain traction, "[HHS] estimates that the backlog of appeals could be eliminated by FY 2021." These proposed changes follow a recent report published by the Government Accountability Office (GAO) stating the appeals backlog would likely persist despite HHS initiatives. The GAO report also recommended four actions to improve the completeness and consistency of the appeals data used by HHS and to promote the efficient resolution of repetitive claims. **To be assured consideration, all comments must be received by the OMHA no later than 5:00 PM EST on August 29, 2016.**

Key Takeaways:

- If implemented, the proposed changes would vest the Chair of the Department Appeals Board (DAB) with the power to designate certain Council decisions as precedential.

- The proposed changes would also expand the current decision-maker

taxonomy. In addition to ALJs, new *attorney adjudicators* would absorb limited responsibilities at the third level of HHS appeals.

The following commentary examines some of the significant changes the proposed reforms would bring and considers how the appeals process would function if the proposed regulatory changes, legislative actions, and budgetary requests take effect.

- **Precedential Decisions.** HHS recommends designating select Council decisions as precedential to provide more consistency in decisions across all levels of appeal, reduce the resources required to render decisions, and possibly reduce appeal rates by providing clarity to appellants and adjudicators. All precedential decisions would be published in the Federal Register and would only gain precedential deference after being made available to the public. Giving precedential weight to Council decisions gives rise to further considerations. First, it will likely be necessary for providers appealing claims to seek legal counsel earlier in the appeals process. Also, allocating interpretive responsibilities to Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) is likely to result in misapplication of the precedence because the claims adjudicators do not have legal training. HHS recognizes this issue and proposes as a solution that, "In the limited circumstances in which a precedential decision would apply to a factual question, the decision would be binding where the relevant facts are the same and evidence is presented that the underlying factual circumstances have not changed since the Council issued the precedential final decision."

- **Attorney Adjudicators**. To alleviate the ALJ caseload, HHS proposes expanding OMHA's available adjudicator pool by allowing attorney adjudicators to review QIC dismissals, decide appeals for which a decision can be issued without a hearing, issue remands to CMS contractors, and dismiss requests for a hearing when an appellant withdraws the request. ALJs would still possess the sole authority to conduct hearings and issue rulings pursuant to those proceedings. Moreover, appellants would still have the right to a hearing. The proposed change would require attorney adjudicators to be "licensed attorney[s] employed by the OMHA with knowledge of Medicare coverage and payment laws." HHS has taken steps to ensure attorney adjudicator decisions would further appellants' procedural rights. For instance, attorney adjudicators would be able to decide if an appellant(s)' request for claim aggregation involved the delivery of similar or related services, but only an ALJ could determine if the claims failed in this respect. Additionally, while an attorney adjudicator could decide an appellant had good cause for missing a deadline, only an ALJ could issue an adverse finding. It should also be noted that HHS's other proposed changes – specifically, revisions concerning the amount in controversy calculation and new requirements for hearing requests – could divert an increased number of appeals to attorney adjudicators as these reforms will likely increase the number of QIC dismissals.

- **Revise the Amount-in-Controversy Calculation.** The current amount-in-controversy (AIC) figure is calculated according to the actual amount charged to the beneficiary for the items or services in question (commonly referred to as billed charges). HHS proposes changing the calculation by replacing the billed charges variable with the Medicare allowable amount for items and services with a published Medicare fee schedule or published contractor-priced amount. Typically, the Medicare allowable amount represents 80 percent of the billed amount, but can fall as low as 30 to 40 percent depending on the item or service. HHS contends this change would more closely align the AIC with the actual amount in dispute. However, this provision could potentially prevent many appeals from reaching ALJs, and thus effectively limiting providers who do not meet the new AIC to a two-level appeals process. HHS's legislative proposal recommending the minimum amount in controversy reflect the amount required at the federal

court level of appeal would exacerbate this problem if codified.

- **CMS Involvement in Hearings.** HHS aims to simplify hearing proceedings when CMS or its contractors are involved by limiting the number of CMS officials that can participate in, or be a party at, a hearing. According to the proposed changes, if multiple CMS officials or contractors file to be a party at the hearing, only the first entity to file its election after notice of the hearing has been issued may serve in this capacity. All other entities will be designated as participants and cannot provide oral testimony during the hearing. If neither CMS nor its contractors file to be a party to the hearing, but multiple officials file to be participants, only the first entity to file its election after notice of the hearing has been issued may provide oral testimony. All participants barred from contributing to the oral hearing may still submit position papers and written testimony for the ALJ's review.

- **Create Process Efficiencies**. HHS has recommended a series of measures to eliminate procedural inefficiencies currently encumbering OMHA officials and appellants. These reforms include allowing ALJs to vacate their own dismissals and to conduct hearings over the telephone regardless of whether special or extraordinary circumstances exist. HHS has also included revisions which would require appellants to provide more information on what they are appealing and who will be attending a hearing. Specifically, providers requesting a hearing would have to include a statement addressing whether they are aware that they or the claim is subject to an investigation by the HHS Office of Inspector General and the amount in controversy figure applicable to the disputed claim. Appellants who disagree with how HHS conducted a statistical sample or extrapolation must also assert their reasoning within the request for a hearing. Increasing the stringency for appellant hearing requests and requiring the appellants to submit copies of these materials to all parties could result in increased rates of MAC and QIC dismissals as governed by §405.942(b)(2-3). Consequently, appellants might be deprived of a hearing or have to expend unnecessary resources to have a dismissal reopened.

- **Address Stakeholder Concerns and Regulations Clarifications.** HHS has taken modest steps to remedy some of the many frustrations voiced by stakeholders. These efforts include establishing an adjudication time frame for cases remanded from the Council and providing more specific rules for what constitutes good cause for new evidence to be admitted at the ALJ level of appeal. HHS has also attempted to streamline the language and clarify terms in the current regulations to aid in readability and reduce confusion.

For More Information

For questions regarding this information, please contact the author, a member of Polsinelli's Health Care practice, or your Polsinelli attorney.

- R. Ross Burris, III | 404.253.6010 | rburris@polsinelli.com
- Raymond J. Lindholm | 404.253.6004 | rlindholm@polsinelli.com
- Cybil G. Roehrenbeck | 202.777.8931 | croehrenbeck@polsinelli.com

To contact a member of our Health Care team, click here or visit our website at www.polsinelli.com > Services > Health Care Services > Related Professionals.

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The Polsinelli Health Care practice represents one of the largest concentrations of health care attorneys and professionals in the nation. From the strength of its national platform, the firm advises clients on the full range of hospital-physician lifecycle and business issues confronting health care providers across the United States.

Recognized as a leader in health care law, Polsinelli is ranked no. 1 for largest health care practice in Hospitals & Health Systems and Health Information & Technology and no. 2 as second largest health care practice overall by *American Health Lawyers Association* (*AHLA Connections, June* 2016). The firm is also nationally ranked by *Chambers USA* (2016) and nationally recognized for the best client relationships in the health care industry (*BTI*, 2016). Polsinelli's attorneys work as a fully integrated practice to seamlessly partner with clients on the full gamut of issues. The firm's diverse mix of attorneys enables our team to provide counsel that aligns legal strategies with our clients' unique business objectives.

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Polsinelli is an Am Law 100 firm with more than 800 attorneys in 19 offices, serving corporations, institutions, and entrepreneurs nationally. Ranked in the top five percent of law firms for client service*, the firm has risen more than 50 spots in the past five years in the Am Law 100 annual law firm ranking. Polsinelli attorneys provide practical legal counsel infused with business insight, and focus on health care, financial services, real estate, intellectual property, mid-market corporate, and business litigation. Polsinelli attorneys have depth of experience in 100 service areas and 70 industries. The firm can be found online at www.polsinelli.com. Polsinelli PC. In California, Polsinelli LLP.

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