Federation of American Hospitals®

Charles N. Kahn III
President & CEO

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The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals.

We appreciate the opportunity to comment on the Chairman's Mark of the *Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015*. The FAH commends the Committee for its leadership efforts in developing legislation to implement certain reforms to the Medicare appeals program. Further, we appreciate the thoughtful process the Committee has undertaken to develop these reform policies, including engaging with the FAH and other stakeholders over a number of months. We applaud the legislation as a positive step in addressing an overly-burdened Medicare appeals process, and look forward to working with the Committee to include additional provisions that improve the process further.

The bill contains various provisions to provide the resources needed to adequately respond to appeals. For example, the legislation would provide increased resources to the Office of Medicare Hearings and Appeals and the Departmental Appeals Board to conduct activities related to reviews, hearings and appeals, along with additional HHS staff (Medicare Magistrates) with expertise in the Medicare issues under appeal. The legislation also would promote transparency and consistency in applying the Medicare review guidelines to appeals, and would provide assistance through a

Medicare Ombudsman in resolving complaints about the Medicare appeals process, with recommendations for improvement.

Further, the legislation is aimed at providing some important relief in addressing the Medicare appeals backlog that has accrued in large part due to financial incentives in current law for the Recovery Audit Contractors ("RACs") to reach a conclusion that an inpatient admission was not justified. This is problematic because the RAC decision often is rendered multiple years after the date of service, at a point in time when hospitals can no longer rebill under Part B for the denied Part A claim. Therefore, hospitals have every incentive to continue with the appeal process, especially when a very high percentage of RAC denials are overturned at the Administrative Law Judge ("ALJ") level of appeal. The legislation seeks to stem this tide by limiting the RAC look back period regarding patient status reviews, which would allow providers time to rebill a denied Part A claim under Part B. It also would base permitted audit activity on a provider's error rate, while additional document requests ("ADRs") would be linked to a review entity's accuracy rate.

Although we see promise in many of these provisions, we are concerned about the funding needed to implement them, and we would strongly object to any cuts to hospitals' payments to pay for any component of the legislation.

Since 2010, more than $140 billion in cumulative cuts have been imposed on hospitals. These continued cuts jeopardize the ability of hospitals to deliver the care seniors expect and deserve, and the health care security all Americans count on hospitals to provide. The cuts that hospitals must already absorb contribute to record-low Medicare hospital margins, projected by MedPAC to reach negative nine percent this year. While we welcome legislation to address the Medicare appeals process, further cuts to Medicare hospital payments would be counter-productive by threatening access to care

We also are concerned that certain provisions in the bill could exacerbate the current problems with Medicare appeals. For example, remanding appeals to the redetermination level, with the introduction of new evidence, potentially could delay the appeals process even further. While understanding the desire to address the administrative burden on the Office of Medicare Hearing and Appeals, we are concerned about any proposals that would effectively lengthen the time period that providers would experience to complete the appeals process.

While certain provisions in the bill may be well intended, many of them address the Medicare appeals process on the "back-end" in terms of creating ALJ reform. We urge the Committee, however, to consider critical recommendations for strengthening the legislation as it proceeds with "front-end" reforms aimed at reforming the Medicare contractor and RAC review process. For example, the Committee should consider reforming the RAC contingency fee provisions in existing law that create a financial incentive for RACs to deny an inpatient admission claim, separate from the merits of the claim.

A number of other provisions also could improve the process, as specified in brief below, and we are happy to discuss these provisions further with the Committee as consideration of the legislation continues:

- The scope of RAC reviews should exclude any medical necessity matter involving physician judgment.

- ADRs should be limited to those where the likely appeals can be resolved by ALJs within 90 days of receipt.

- Payments to hospitals should not be recouped until after a final resolution of an ALJ appeal confirming an overpayment.

- RAC denials should be reviewed and approved by a physician on staff at a RAC before being issued to a provider.

- CMS should implement an exception to the timely filing requirement which permits hospitals to opt for a Part B payment remedy when faced with a post-payment redetermination which occurs beyond one year from the date of the original claim.

- CMS should enforce the RAC deadlines to issue claims decisions and prohibit RACs from making denials when deadlines are not met.

- RACs should be subject to a financial penalty when their post-payment denials are overturned on appeal at a significant rate.

- CMS should seek regular stakeholder input with regard to RAC activities.

- CMS should enforce the statutory timeframe within which appeals determinations must be made by entering a default judgment for the hospital or beneficiary if an appeal is not heard within the required timeframe.

- Hospitals should not be required to wait for ALJ acknowledgment letters of hospital dismissals of Part A appeals before seeking Part B payment, and should not be required to recode and rebill the claims as Part B claims.

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We thank you for this open and transparent process which allows the hospital community to weigh in on these critical issues, and look forward to working with the Committee to improve the legislation. Please do not hesitate to contact me should you have any questions.

Sincerely,



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