December 5, 2014

Nancy Griswold
Chief Administrative Law Judge
Office of Medicare Hearings and Appeals
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted Electronically via www.regulations.gov

RE: OMHA-1401-NC Request for Information; Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim Appeals

Dear Judge Griswold:

The American Orthotic & Prosthetic Association (AOPA), founded in 1917, is the largest national orthotic and prosthetic trade association with a national membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss, or limb impairment resulting from a chronic disease or health condition. These include patient care facilities, manufacturers and distributors of prostheses, orthoses and related products, and educational and research institutions.

AOPA commends the OMHA for its efforts to date to address the exponential increase in the number of ALJ hearing requests and its willingness to work with appellants and stakeholders on the development of new and creative strategies to reduce the delays and backlog. The simple truth remains, however, that without significant changes to the Medicare Recovery Audit Program, the OMHA simply does not have the funding or the administrative resources to significantly reduce the delays. Rather, they continue to grow at an exponential rate.

We are pleased to offer the following suggestions on how the Office of Medicare Hearings and Appeals may address the substantial growth in the number of requests for administrative law judge (ALJ) hearings that are being filed by Medicare providers, suppliers, and beneficiaries as well as the growing backlog of pending cases.

1. Recovery Audit Contractor (RAC) Activities Must be Re-Focused

As stated in the request for information published in the Federal Register, the exponential increase in requests for Medicare ALJ hearings began in fiscal year 2012 and continued into fiscal years 2013 and 2014. This is the same timeframe in which claim denials generated by RAC audits entered the Medicare appeals system. The exponential increase of claim denials as a result of RAC activities must lead to questions regarding the nature of the claim denials themselves. Are the RAC programs truly protecting the Medicare program and its beneficiaries or are they simply exploiting technical errors in claim submissions that result in unnecessary claim denials and inappropriate collection of contingency fees by the RAC contractors?

Companies and the certified/licensed health care providers who comprise the prosthetics and orthotics profession have been hit extremely hard by RAC audits. For the small businesses (average total revenue of about $1 million) that comprise our profession, the size of these audit payment denials has been very large, and the devastation of the excessively long waits to secure an ALJ hearing on cash flow has been debilitating, forcing well over 100 O&P businesses across the country to close, reducing access to care for both Medicare beneficiaries and private sector patients alike. Generally, O&P businesses have experienced a very high rate of success once these cases reach the ALJ, approximately 90+%. Unfortunately, as a result of the unacceptable delays in getting cases to the ALJ hearing stage, many times the damage has been done and businesses have been forced into bankruptcy and closure.

AOPA supports efforts to curb waste, fraud, and abuse but believes that the RAC contractors have gone beyond reasonable efforts to identify these activities to the detriment of legitimate providers and suppliers who provide medically necessary services to Medicare beneficiaries who require these services to maintain healthy and productive lives. AOPA believes that the RAC process must be reviewed and refined to better represent its original purpose, protection of the Medicare program and its beneficiaries.

2. CMS Should Offer Orthotic and Prosthetic Providers the Opportunity to Voluntarily Settle Claims that are Awaiting an ALJ Hearing Using a Statistically Valid Extrapolation Process

In 2014, CMS offered hospital based providers an opportunity to enter into an administrative agreement whereby CMS would provide timely partial payment for any claims that the provider agreed to voluntarily withdraw from the appeals process. Hospital based providers who agreed to participate in this program would be reimbursed at 68% of the net allowed amount of any claims withdrawn from the appeals process.

AOPA believes that the extension of this administrative agreement to orthotic and prosthetic providers using a statistically accurate extrapolation process to determine an equitable partial payment percentage could significantly reduce the number of orthotic and prosthetic claim appeals awaiting docketing for an ALJ hearing. This process must be voluntary, meaning that individual providers would be given the opportunity to accept the administrative agreement and partial payment or reject it and continue the appeal process.

The fundamental point on this issue, and of our comments here, is that the federal statutory promise of a final ALJ decision within 90 days is being violated massively and inexcusably, to the detriment of the entire Medicare system, and aggressive steps must be taken to remedy this violation of the law, precipitated by the combined outcome of failures by HHS, CMS, and OMHA. For small business health care providers like O&P facilities, the upfront recoupment and long delays in getting to an ALJ hearing translate into huge cash flow problems which have forced well over 100 orthotic and prosthetic patient care facilities to close their businesses, costing jobs in the community and reducing beneficiary access to care. Therefore, it is imperative that OMHA and HHS urgently and expeditiously find ways to reduce the huge and growing cases and long wait times for having our cases reach the ALJ hearing. AOPA urges you to follow the precedent and practice already adopted with respect to hospital RAC appeals. HHS/CMS initiated a settlement offer that was extended to the hospitals, to settle outstanding claims at 68 cents on the dollar, and about 110,000 claims were disposed of. OMHA should work in conjunction with HHS/CMS to assure that this outreach is not selectively limited to hospitals alone, but that a parallel settlement offer is accorded to the large number of O&P facilities who also have Medicare appeals claims in line waiting for an ALJ hearing. Based on the higher success rate of orthotic and prosthetic claims when they reach the ALJ, the settlement offer for O&P claims should be at 87 cents on the dollar.

There is Congressional support for this type of action in the form of proposed legislation sponsored by Rep. Kevin Brady (R-TX), who currently serves as Chair of the Health Subcommittee of the House Ways and Means Committee. The proposed legislation would require that CMS create a voluntary process under which an appellant in an ALJ appeal regarding denied payments for Medicare Part B claims would be provided an opportunity to resolve the claim through extrapolation of the results of a review decision on a statistically valid sample of claims for the same or similar services. CMS would be required to establish this process within 90 days of enactment of the legislation, and in order to use the extrapolation process, appellants would need to provide notice to CMS of their intent to avail themselves of the process within 60 days after CMS establishes the process.

Bringing these claims to a prompt and equitable settlement would both reduce the backlog of claims awaiting an ALJ hearing AND would alleviate the enormous cash flow pressures on companies struggling to stay alive, and delivering patient care. The incomparable cash flow constraints these claim denials currently impose, with delays long beyond the statutory period, threaten the very survival of these businesses.

3. OMHA Should Overturn Claim Denials that Cannot be Scheduled for an ALJ Hearing Within 90 Days of a Hearing Request

AOPA believes that if the statutory requirement for an ALJ to "conduct and conclude a hearing and render a decision on such hearing" within 90 days of the receipt of a hearing request cannot be met, the ALJ should issue a default judgment in favor of the appellant. While AOPA understands that OMHA has simply been overwhelmed by the exponential increase in hearing requests in the last several years, the statute remains intact and judgment should be made in favor of the appellant.

4. Needed, Coordinated Actions by HHS, CMS and OMHA

In light of the blatant violations of the ninety (90) day statutory mandate for an ALJ decision, CMS should shift the timing of the recoupment on claims from the current time frame, which allows recoupment following a unfavorable reconsideration decision by the Qualified Independent Contractor (QIC), to after a decision is rendered by the ALJ. Suspending recoupment until after the ALJ decision may actually save government funds because the rate of interest which the federal government pays is in excess of its borrowing rate on the high percentage of cases that are held in favor of the provider at the ALJ level. At a minimum, the shift in recoupment should be extended until the 90 day statutory time frame for a final ALJ decision is restored.

For many reasons, AOPA strongly opposes OMHA's continued delay in assigning new ALJ hearings, most notably because it represents yet an additional violation of the Medicare statute and implementing regulations which stipulate that ALJs must schedule and conduct a hearing and issue a final decision within 90 days of the date when the appeal is filed. The current, unprecedented delay in assigning new ALJ hearings serves to exacerbate the current untenable situation where providers go out of business due to cash flow nightmares because OMHA and CMS remain complicit with pervasive violation of the statute.

We note also, and support the language in H.R. 5083 (Rep. Ellmers, R-NC) that would preclude inclusion of any audit claims in calculating the provider's error rate before the

claim has come to conclusion via an ALJ decision. CMS' failure to observe such limitation creates a horrible, unsustainable situation where appeals that are unheard by an ALJ provide a false statistic, which triggers more unjustified audits (on the false assertion that the provider has a very high error rate), and more cases requiring an appeal to already overburdened ALJs for decision.

AOPA agrees with the O&P Alliance comments stating that if ALJs fail to hear an appeal and render a decision within the 90-day statutory period, that appeal should be overturned automatically. As Rep, Duckworth (D-IL) stated in questioning at separate hearings of both Judge Griswold, and Deputy CMS Administrator Agrawal in July, if you can't meet the statute in delivering a hearing and decision, CMS must "give the money back to the providers."

AOPA recommends a renewed "pause" in new pre-payment and RAC audits. In its plan to transition from four RAC auditors for DMEPOS to a single contractor, CMS invoked a pause in new audits. This is one major way to help cure the current backlog—limit new cases until the 90-day statutory limit is restored. Unfortunately, CMS subsequently reversed directions and re-authorized new RAC audits by the four existing RACs while finalizing the new RAC contract. OMHA and CMS are violating the law, and in recognizing that indisputable fact, CMS needs to invoke the palliative step of re-instituting a "pause" in new audits until such time as OMHA and CMS can find a means to restore compliance within this 90-day legal deadline.

5. OMHA Must be Funded at a Level that Supports its Increased Workload

The conversation during both of the OMHA appellant forums held within the last year focused on the exponential increase in OMHA workload over the past three years resulting in the backlog that we are faced with today. While AOPA applauds OMHA for recognizing the problem and taking some limited steps in the direction of remedying it, OMHA has not gone nearly far enough. Two facts are quite clear: (1) the statutory promise of a 90-day decision is being routinely and continuously violated, and (2) there are simply not enough ALJs to hear the pending cases. Increased funding of OMHA will allow the creation of additional field offices and additional ALJs that will be able to conduct hearings. Additional financial resources to permit expedited staff hiring is imperative.

Congress authorized HHS to transfer sufficient funds from the Medicare Part A and Part B trust funds to hire the ALJs and support staff necessary to comply with the statutory 90-day deadline. This, and other steps, must be invoked to increase availability of resources to OMHA and assure restoration of fairness and compliance with the law. The objective is clear and mandatory. HHS, CMS and OMHA must collectively take

serious steps to limit the number of audits, help remedy the huge cash-flow problems created by the monies the federal government holds for unduly long periods because of the case backlog, and release resources needed to restore the balance and to bring an end to the regrettable denial of timely provider due process through the failure to satisfy their statutory obligation to deliver a final ALJ decision within 90 days. Without a significant increase in the number of ALJs available to hear new cases, the backlog will only continue to grow.

Conclusion

AOPA supports, in large measure, the current OMHA efforts to address and reduce the backlog of Medicare claim appeals that are awaiting a hearing before an ALJ and believes that OMHA is making efforts to provide appellants with timely and equitable appeal decisions. Current efforts, however, are simply not enough. Not only is the backlog not being reduced, it continues to grow at an exponential rate.

AOPA appreciates the opportunity to provide suggestions on how OMHA can reduce the backlog through its own resources as well as resources provided by external sources.

Sincerely,

Thomas F. Fise
Executive Director