February 11, 2014

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Unacceptable Delays in Assignment of Home Health and Hospice Appeals to Administrative Law Judges

Dear Secretary Sebelius and Administrator Tavenner:

On behalf of nonprofit home health and hospice agencies, the Visiting Nurse Associations of America (VNAA) objects to significant delays in the assignment of provider requests for Administrative Law Judge (ALJ) hearings. In December 2013, the Office of Medicare Hearing and Appeals (OMHA) at the Department of Health and Human Services announced delays might be up to 28 months.

VNAA urges the Centers for Medicare and Medicaid Services (CMS) to work with OMHA to remedy this situation immediately. VNAA’s mission-driven home health and hospice providers require reimbursement for medically necessary care delivered to homebound and dying patients. Delays in the ALJ appeals process and Medicare Recovery Audit Contractors (RACs) reimbursements mean that reimbursement remains in recoupment and is not available to reimburse costs that have already been expended.

VNAA is a national trade association that supports, promotes and advocates for mission-driven, community-based home health and hospice providers. As safety net providers, VNAA members provide care to all patients regardless of their ability to pay or the severity of their illness and serve a mixture of Medicare, Medicaid, privately insured and charity care patients.

ALJ Delays Are In Direct Violation of Medicare Statute

Section 42 USC 1395ff(d)(1) [Social Security Act § 1869(d)(1)] requires the ALJs to conduct a hearing and issue a decision within 90 days of receipt of a request for hearing and outlines time requirements for the other levels of appeal. Delays of at least two years in granting an Administrative Law Judge (ALJ) hearing for an appealed claim are a direct violation of this statute. This is not a new problem, but it requires an immediate action.
Root Cause of ALJ Denials

Excessive and inappropriate denials of payment by RACs, under the direction of CMS, are a direct driver of the ALJ backlog. The expensive and duplicative cycle begins when RACs issue erroneous denials leaving home health and hospice agencies with no option other than pursuing costly and multiple appeals.

Denials frequently occur because of interpretation of language used by a physician to document a face-to-face encounter. CMS does not provide a standardized form or clear definition of requirement for a face-to-face encounter. Consequently, rejection of a claim by a RAC may be the result of a subjective decision on the adequacy of the physician documentation.

Another problem area is lack of definition for “skilled” services. A doctor may order the Medicare home health benefit only if a patient is homebound and requires medically necessary skilled care. CMS does not clearly define “skilled” service. Consequently, rejection of a claim may be the result of a subjective decision by a RAC.

For hospice, denials may occur because of a judgment that “the documentation does not support a six month terminal prognosis” despite that fact that two physicians made the determination and provided supporting documents.

In addition, providers repeatedly experience denials as the result of a minor omission or overlooked information. For example, a New Hampshire home health and hospice provider experienced a claim rejection by a RAC because a physician entered a date on two lines but overlooked a third line in the same document. A brief communication between the provider and the reviewer could resolve the error, rather than a resource intensive appeal process for both the provider and the government.

Lastly, a serious problem is the great variation in interpretation both within and among Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs). Providers do not understand why one claim is successfully paid and another denied, although in both instances the documentation met all the criteria. Providers in certain regions of the country experience multiple and aggressive audits, while providers in other regions do not.

Impact on Patients and Nonprofit Home Health and Hospice

The appeals process is resource and paperwork intensive for both providers and the federal government. The process of appealing a denial varies widely, but the cost always depletes funding that could go toward patient care. Providers report inconsistencies, errors and multiple additional documentation requests (ADR) during the appeals process coupled with cancellations of hearings by OMHA.
Here are examples of VNAA members’ experience with the appeals process:

- A provider in Connecticut reported receiving more 402 home health and hospice additional document requests (ADRs) with $1,163,239 in recoupment. In 2013, staff spent more than 2,704 hours of their time working on appeals.
- A provider in Georgia reported 135 ADRs with $300,000 in recoupment. In 2013, staff spent more than 600 hours of their time working on appeals.
- A provider in New Hampshire reported 214 ADRs with $470,000 in recoupment. In 2013, staff spent more than 978 hours of their time working on appeals.

Denials do not affect beneficiaries who already receive the Medicare home health or hospice benefit. However, they do have a negative impact the ability of a nonprofit provider to provide care in the future because of the cash flow problem. The impact is severe if there is a multi-level and exhaustingly long appeals process.

**VNAA Calls for Action**

VNAA calls for an immediate meeting between providers and officials at CMS and OMHA to resolve this issue. In addition, VNAA offers solutions below, along the same lines as offered by hospitals, which would mitigate the detrimental impact of federal mismanagement on home health and hospice agencies. These remedies include:

- Suspension of RAC audits until all levels of the determination and appeals process catch up with their current workloads. This would allow time for claims with audits in progress to work their way through the appeals process and minimize the number of claims added to the existing backlog.
- Postponement of recoupment of disputed funds until after the agency receives an ALJ determination.
- Enforcement of the RACs’ deadline to issue a decision on a claim by denying a RAC its contingency fee for any claim beyond deadline.
- Lowering of the RAC additional document request (ADR) limit to decrease the volume of claims that can potentially end up in the appeals system.
- Enforcement of statutory timeframes for appeals determinations. If an appeal is not heard within the required time period, a default judgment will find in favor of the provider.
- Immediate changes to systemic issues with the RAC audits process that lead to avoidable claim denials and appeals including a mechanism for reversal of erroneous denials outside the appeals process.
- Analysis of claims overturned at the ALJ level of appeal to determine patterns of erroneous decision making by RAC auditors.
Next Steps

VNAA is uniquely positioned in the home health and hospice arena and requests a meeting with OMHA and CMS representatives to further discuss this serious problem and potential solutions. VNAA is a trusted leader in the health care policy and regularly provides guidance on policy initiatives to the Medicare Payment Advisory Commission (MedPAC), Congress, the Centers for Medicare and Medicaid Services (CMS) and the Administration to address critical concerns in the home health and hospice services.

If you have questions regarding our concerns or proposed policy solutions, please feel free to contact me or Kathleen Sheehan, VNAA Vice President of Public Policy, at (202) 384-1456 or ksheehan@vnaa.org.

Sincerely,

Tracey Moorhead
President and CEO

cc:
Senator Ron Wyden, Chair, Senate Finance Committee
Senator Orrin Hatch, Ranking Member, Senate Finance Committee
Representative David Camp, Chair House Ways and Means Committee
Representative Sander Levin, Ranking Member, House Ways and Means Committee
Representative Fred Upton, Chair, House Energy and Commerce Committee
Representative Henry Waxman, Ranking Member, Energy and Commerce Committee