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December 3, 2018

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4174–P
P.O. Box 8013
Baltimore, MD 21244–1850

***Re: AHCA Response to Medicare Program; Changes to the Medicare Claims and Medicare Prescription Drug Coverage Determination Appeals Procedures. Federal Register, Vol. 83, No. 191, October 2, 2018. CMS-4174-P***

Dear Administrator Verma:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,600 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. Each day, our members provide essential housing and health care services to residents in over 1.05 million skilled nursing facility (SNF) beds and more than 247,000 assisted living beds.

With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

We appreciate the opportunity to comment on the proposed changes to the Medicare appeals procedures to help streamline the appeals process and reduce administrative burden on providers, suppliers, beneficiaries and appeals adjudicators. In the following pages you will note that we support most of the proposed revisions. However, we identified a small number of proposed changes that we believe are problematic and we offer recommended approaches to address our concerns.

If you have questions about any of our comments, please contact Daniel Ciolek at (302)740-7888.

Sincerely,

Daniel E. Ciolek, PT, MS, PMP
Associate Vice President, Therapy Advocacy

## 1. Summary Table: AHCA Comments Related to Proposed Regulations

**Note: Bold text in table indicates AHCA detailed comments are in subsequent pages**

| Subsection Within Section II of NPRM | AHCA Position |
|---|---|
| A. Removal of Requirement That Appellants Sign Appeal Requests (§§ 405.944, 405.964, 405.1112, and 423.2112) | Support |
| B. Change to Timeframe for Vacating Dismissals (§§ 405.952, 405.972, 405.1052, and 423.2052) | Support |
| C. Technical Correction to Regulations To Change Health Insurance Claim Number (HICN) References to Medicare Numbers (§§ 405.910, 405.944, 405.964, 405.1014, 405.1112, 423.2014, and 423.2112) | Support |
| D. Removal of Redundant Regulatory Provisions Relating to Medicare Appeals of Payment and Coverage Determinations and Conforming Changes (§§ 423.562, 423.576, 423.602, 423.604, 423.1970, 423.1972, 423.1974, 423.1976, 423.1984, 423.1990, 423.2002, 423.2004, 423.2006, 423.2014, 423.2020, 423.2044, 423.2100, and 423.2136) | Support |
| **E. Change to Timeframe for Council Referral (§ 405.1110 and § 423.2110)** | **Concerns Detailed Below** |
| F. Technical Correction to Regulation Regarding Duration of Appointed Representative in a Medicare Secondary Payer Recovery Claim (§ 405.910) | Support |
| G. Technical Correction to Actions That Are Not Initial Determinations (§ 405.926) | Support |
| H. Changes To Enhance Implementation of Rule Streamlining the Medicare Appeals Procedures (§§ 405.970, 405.1006, 405.1010, 405.1014, 405.1020, 405.1034, 405.1046, 405.1052, 405.1056, 423.1014, 423.1990, 423.2002, 423.2010, 423.2016, 423.2032, 423.2034, 423.2036, 423.2052, and 423.2056) | |
| **H.1. Amount in Controversy (AIC) (§ 405.1006)** | **Concerns Detailed Below** |
| **H.2. Submissions by CMS and CMS Contractors (§§ 405.1010 and 405.1012)** | **Oppose as Detailed Below** |
| H.3. Extension Requests (§§ 405.1014 and 423.2014) | Support |
| **H.4. Notice of Hearing (§ 405.1020)** | **Oppose as Detailed Below** |
| H.5. Request for an In-Person or Video Teleconference (VTC) Hearing (§§ 405.1020 and 423.2020) | Support |
| H.6. Unlabeled section right column of p. 49521 (§ 405.1052) | Support |
| **H.7. Remanding a Dismissal of a Request for Reconsideration (§§ 405.1056,405.1034, 423.2034, and 423.2056)** | **Oppose as Detailed Below** |
| H.8. Notice of a Remand (§ 405.1056) | Support |
| H.9. Requested Remands (§ 423.2056) | Support |
| H.10. Other Technical Changes | Support |

## 2. Detailed AHCA Comments Related to Section II – Provisions of the Proposed Regulations – By Sub-Section

### E. Change to Timeframe for Council Referral (§ 405.1110 and § 423.2110)

**Summary of CMS Proposal**

- CMS currently has inconsistent timelines as to when CMS or its contractors must respond to an OMHA decision or dismissal to refer a case to the Medicare Appeals Council. Some regulatory provisions refer to the timeline starting on the date of issue from OMHA, while other provisions refer to the date that CMS or its contractors received the notice from OMHA.
    - **Proposed Change**: To standardize the start date of the referral timeline for CMS or its contractors to respond to an OMHA decision. Specifically, CMS is proposing to revise the Council referral timeframes in §§ 405.1110(a) and (b)(2) and 423.2110(a) and (b)(2), and proposing to add §§ 405.1110(e) and 423.2110(e) so that the timeframe in all regulatory provisions would begin on the date that CMS or its contractor received the OMHA decision In addition, new language would be added to further standardize the requirement by applying a '5-day mailing presumption' standard determine the date that CMS or its contractor received the OMHA decision (unless there is evidence to the contrary).

Therefore, the timeframe for CMS or its contractors to submit a Council referral would be extended 5 days as compared to current policy under §§ 405.1110(a) and (b)(2) and 423.2110(a) and (b)(2).

**AHCA Comment**

While we agree with the concept of standardizing the timeframe for CMS or its contractors to refer a case to the Council, this proposal to add another 5 days to the timeframe for CMS and its contractors' response timeline would further erode the rights of appellants to obtain a timely resolution of a Council-level appeal that represents a substantial dollar amount.

- ***AHCA recommends that CMS delay implementation of these proposed revisions to the timeline for Council referrals in § 405.1110 and § 423.2110 until the Agency has resolved the current appeals backlog that already exceeds statutory timelines.***

### H. Changes To Enhance Implementation of Rule Streamlining the Medicare Appeals Procedures

**(§§ 405.970, 405.1006, 405.1010, 405.1014, 405.1020, 405.1034, 405.1046, 405.1052, 405.1056, 423.1014, 423.1990, 423.2002, 423.2010, 423.2016, 423.2032, 423.2034, 423.2036, 423.2052, and 423.2056)**

### H.1. Amount in Controversy (AIC) (§ 405.1006)

**Summary of CMS Proposal**

- The AIC for the ALJ level of appeal is computed as the amount the provider or supplier bills for the items or services in the disputed claim, reduced by any Medicare payments already made or awarded for the items or services, and further reduced by any deductible

and/or coinsurance amounts that may be collected for the items or services. § 405.1006(d)(1).

- There are a number of exceptions to the AIC calculation, including: (1) when the appeal involves an identified overpayment, the AIC is the amount specified in the demand letter; and (2) when the appeal amount involves an overpayment based on statistical sampling, the AIC is the total amount of the estimated overpayment determined through extrapolation, as specified in the demand letter. § 405.1006(d)(4).

- When CMS created these two exceptions, it failed to account for the possibility that the overpayment amount specified in the demand letter might change throughout the administrative appeals process (it could go up or down). CMS or the MAC may also revise the overpayment amount after a discussion period, which may result in a revised demand letter. However, CMS and MACs do not always issue demand letters.

    - **Proposed Change**: Revise § 405.1006(d)(4) to state that: (1) when an appeal involves an identified overpayment, the AIC is the amount of the overpayment specified in the demand letter, or the amount of the revised overpayment if the amount originally demanded changes as a result of a subsequent determination or appeal; and (2) in extrapolation cases, the AIC is the total amount of the estimated overpayment, as specified in the demand letter, or as subsequently revised.

**AHCA Comment**

Currently, CMS and MACs do not always issue demand letters when the alleged overpayment amount changes.

- ***AHCA recommends that, under the § 405.1006 Amount of Controversy regulations as a threshold matter, MACs should be required to issue revised demands whenever a decision is made on appeal that would increase or decrease an alleged overpayment. Additionally, CMS should clarify what happens when no demand letter is issued. Is the AIC the number in the original demand?***

**H.2. Submissions by CMS and CMS Contractors (§§ 405.1010 and 405.1012)**

**Summary of CMS Proposal**

- If CMS/contractor wants to participate in ALJ proceedings *before* receiving of a notice of hearing, or when notice of hearing is not required, it must give written notice to the parties who were sent a copy of the reconsideration notice, and to the assigned ALJ or attorney adjudicator (or, if not assigned, to a designee of Chief ALJ). § 405.1010(b)(1). However, CMS believes that, in its current form, this rule does not apply to reconsideration requests escalated from the QIC to OMHA without notice of reconsideration having been issued. CMS states that potential parties to a hearing should receive notice of CMS's/contractor's intent to participate and address reconsideration escalations.

    - **Proposed Change**: Revise § 405.1010(b)(1) to require that, for escalated request for reconsideration, notice of intent to participate be sent to any party that filed a request for reconsideration or was found liable for the services at issue subsequent to the initial determination.

- **Proposed Change**: Revise § 405.1010(c)(3)(ii)(A), which currently requires CMS/contractor to send position papers or written testimony submitted before receipt of a notice of hearing to parties who were sent a copy of the reconsideration notice, to require such copies be sent to parties who must be sent the notice of intent to participate in accordance with § 405.1010(b)(1).

In summary, this revision is to address situations in which the QIC has not issued a decision and, therefore, cannot participate in a hearing. CMS proposes to revise § 405.1010(b)(1); for escalated requests for reconsideration, notice must be sent to the party that filed the reconsideration request (or is found liable after the initial determination).

- If CMS/contractor elects to participate *after* a hearing is scheduled, it must give written notice of its intent within 10 calendar days "*after receiving notice of hearing*." § 405.1010(b)(3)(ii). CMS believes this is inconsistent with § 405.1012(a)(1), which requires CMS/contractor, when electing to be a party to a hearing, to send written notice of such intent within 10 calendar days "*after the QIC receives the notice of hearing*," as notices of hearing are sent to QIC in accordance with § 405.1020(c). To make these two requirements/timelines consistent, and to give CMS flexibility to choose another contractor (other than a QIC) to receive notices of hearing, CMS proposes revising § 405.1020(c)(1). Simultaneously, CMS proposes revising §§ 405.1010(b)(3)(ii) and 405.1012(a)(1) to make them consistent with the revised § 405.1020(c)(1).

  - **Proposed Change**: Revise § 405.1020(c)(1) to provide greater flexibility to CMS to designate another contractor, other than QIC, to receive notices of hearing under § 405.1020(c)(1).

  - **Proposed Change**: Revise §§ 405.1010(b)(3)(ii) and 405.1012(a)(1) to provide that written notice of intent to participate or intent to be a party be submitted no later than 10 calendar days after receipt of notice of hearing by the QIC *or another contractor designated by CMS to receive the notice of hearing*.

- If CMS/contractor elects to participate, it has 14 days from election (if no hearing scheduled) or 5 days prior to hearing (if hearing scheduled) to submit a position paper or written testimony. § 405.1010(c)(3)(i). Although an ALJ can extend the 5-day timeframe, CMS recognizes that the regulatory text is unclear as to whether the ALJ or attorney adjudicator can extend the 14-day timeframe.

  - **Proposed Change**: Clarify that § 405.1010(c)(3)(i) allows ALJ or attorney adjudicator to extend 14-day timeframe.

  This rule authorizes ALJ to grant additional time for CMS/contractor to submit a position paper or written testimony. CMS believes this regulation may be unclear as to whether the ALJ's discretion also applies to the 14-day period to submit a position paper or written testimony when no ALJ hearing has been scheduled. CMS's intent was to apply this discretionary extension in both circumstances and proposes to clarify that intent.

- If CMS/contractor elects to be a party to the hearing, it must send written notice of such intent to ALJ and to "the parties *identified in* the notice of hearing. § 405.1012(b). CMS believes this is inconsistent with § 405.1012(b)(2), which states that such notice be sent to the ALJ and "the parties *who were sent a copy of* the notice of hearing."

- **Proposed Change**: Revise § 405.1012(b) by replacing "identified in the notice of hearing" with "who were sent a copy of the notice of hearing."

- CMS inadvertently states it is revising § 405.1012(b)(2). There is no paragraph (b)(2); however, paragraph (b) appears to have the same language CMS proposes to revise.

- ALJs *and* attorney adjudicators are currently authorized to determine whether CMS's/contractor's election to be a party to a hearing is invalid. § 401.1012(e)(1). Because § 401.1012 only permits CMS/contractor to make election *after* the QIC receives notice of hearing, and only an ALJ can schedule and conduct a hearing, CMS wants to remove the "or attorney adjudicator" language.
  - **Proposed Change**: Revise § 405.1012(e)(1) to replace the phrase "ALJ or attorney adjudicator" with "ALJ."

**AHCA Comment**

We believe these proposed changes significantly undermine QIC accountability. The QIC that rendered the decision appealed to the ALJ should be a party to the hearing. Also, CMS's desire to have "greater flexibility" to select another contractor, other than the QIC, is problematic. CMS should not be able to cherry pick a contractor months after-the-fact, just before a scheduled hearing. This would waste time, add an unnecessary layer of complexity, and prejudice providers by allowing CMS to "surprise" them shortly before a hearing. There is a database that the QIC can access and readily see when a hearing is scheduled.

Note, the definition of "Contractor" is "an entity that contracts with the Federal government to review and/or adjudicate claims, determinations and/or decisions." § 405.902. The only contractors that should be allowed to participate in a hearing are those that were involved with the claims, determinations, and decisions on appeal. CMS suggests it will identify a notice contractor to disseminate notices, which is concerning. We also note that, although not raised in the Proposed Rule, the 5-day window for contractors to submit arguments is too short to permit appellants a full and fair opportunity to review and address new issues.

- ***AHCA opposes the proposed policy changes to §§ 405.1010(b)(3)(ii) and 405.1012(a)(1) to permit CMS to select a contractor other than the QIC that rendered the decision appealed to the ALJ.***

**H.4. Notice of Hearing (§ 405.1020)**

**Summary of CMS Proposal**

- Currently, § 405.1020(c)(1) requires that notice of hearing be sent to:
  - All parties that filed an appeal or participated in the reconsideration;
  - Any party who was found liable for the service at issue after the initial determination or may be found liable based on a review of the record;
  - The QIC that issued the reconsideration; and
  - CMS or a contractor that elected to participate in the proceedings under § 405.1010(b) or that the ALJ believes would be beneficial to the hearing.
- CMS is concerned that this rule does not account for reconsideration requests that are escalated from QIC to OMHA without a reconsideration decision being issued. CMS

wants to ensure the QIC (and other CMS contractors who receive notice of scheduled hearings through the QIC) receives notice of all scheduled hearings.

- **Proposed Change**: Revise § 405.1020(c)(1) to require that notice be sent to the QIC that issued the reconsideration or from which the reconsideration request was escalated.

- **Proposed Change**: Revise § 405.1020(c)(1) to state, in part, that the notice of hearing may instead be sent to another contractor designated by CMS to receive it.

In summary, CMS proposes: (1) to require notice of the hearing be sent to the QIC that issued the reconsideration or from which the request for reconsideration was escalated; and (2) for CMS to have the flexibility to designate another contractor, instead of the QIC, to receive such notice.

**AHCA Comment**

AHCA requests further clarity of the role of the alternative contractor that CMS proposes to designate to receive notices of hearing. Like our concerns related to the proposed changes in H.2. above, CMS's proposal raises the concern of last minute appointments/designation of contractors by CMS, which can unfairly prejudice providers. The contractor that rendered the decision appealed should be a party to the hearing, not a third-party that was not previously involved in the appeal.

- ***AHCA opposes the proposed policy change to § 405.1020(c)(1) "to state, in part, that the notice of hearing may instead be sent to another contractor designated by CMS to receive it" until CMS clarifies that this party cannot be a substitute for the contractor that rendered the decision being appealed.***

**H.7. Remanding a Dismissal of a Request for Reconsideration (§§ 405.1056,405.1034, 423.2034, and 423.2056)**

**Summary of CMS Proposal**

- An ALJ or attorney adjudicator can remand to the QIC in the following cases:

  - If the ALJ or attorney adjudicator requests an official copy of a missing redetermination or reconsideration for an appealed claim in accordance with § 405.1034, and the QIC or another contractor does not furnish the copy within the timeframe specified within § 405.1035, the ALJ or attorney adjudicator may remand directing the QIC or other contractor to construct the record or, if it is not able to do so, initiate a new appeal adjudication. § 405.1056(a)(1);

  - If the QIC does not furnish the case file for an appealed reconsideration, the ALJ or attorney adjudicator may issue a remand directing the QIC to reconstruct the record or, if not able to do so, initiate a new appeal adjudication. §405.1056(a)(2); and

  - If the ALJ or attorney adjudicator determines that a QIC's dismissal of a request for reconsideration was in error, the ALJ or attorney adjudicator will remand the case to the appropriate QIC. § 405.1056(d).

In Summary, this provision would expand remands to the QIC if the notice of dismissal or case file cannot be obtained from the QIC for FFS and Part D. Importantly, with the exception of remands where the ALJ or attorney adjudicator determines that a QIC's dismissal of a request for reconsideration was in error, remands are subject to review by the Chief ALJ or designee.

- CMS recognizes that, by restricting the bases for remand under (a)(1) and (a)(2) to appeals of reconsiderations, it inadvertently made those reasons unavailable for remands of requests for review of the dismissal of a reconsideration request under § 405.1056(d).

    - **Proposed Change**: Revise § 405.1056(d) by:

        - Reassigning the existing paragraph (d) as paragraph (d)(1); and

        - Adding paragraph (d)(2) to state that an ALJ or attorney adjudicator may also remand a request for review of a dismissal in accordance with the procedures in paragraph (a) of the section if an official copy of the notice of dismissal or case file cannot be obtained from the QIC.

        - Corresponding revisions will be made to § 423.2056(d) for Part D enrollees.

- Additionally, CMS believes that the above changes require two additional revisions. First, §§ 405.1056(g) and 423.2056(g), which discuss reviews of remands by Chief ALJ or designee, state that review of remand procedures is not available for remands issued under §§ 405.1056(d) and 423.2056(d), which are more akin to determinations than purely procedural mechanisms. However, the proposed (d)(2) would be procedural.

    - **Proposed Change**: Revising §§ 405.1056(g) and 423.2056(g) by replacing references to (d) to (d)(1), so remands under (d)(2) would be subject to the review remand procedures in (g); and

    - **Proposed Change**: Revise §§ 405.1034(a)(1) and 423.2034(a)(1) to provide that the request for information procedures ion these paragraphs apply to (1) requests for official copies of redeterminations and reconsiderations; **and** (2) official copies of dismissals of requests for redetermination or reconsideration.

**AHCA Comment**

Remands delay the resolution of appeals, and there is no limitation on the number of remands. Providers unduly suffer "ping pong" fates. A fundamental requirement for providers is maintaining records in support of claims, or else no reimbursement is paid. The same standard should be applied to CMS and its contractors. If CMS or its contractors cannot maintain appropriate records, then an adverse finding should be reversed.

- ***AHCA opposes the regulatory changes proposed in H.7 as they further reduce CMS contractor accountability for recordkeeping and timely documentation submission while placing additional burdens and delays on resolution of appellant appeals. These proposed regulation changes would increase, rather than decrease the appeals backlog.***