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News for North Carolina Hospitals
from the Health Law Attorneys of Poyner Spruill LLP

North Carolina's Medicaid RAC Program – Don't Let Your Guard Down

by Chris Brewer and David Broyles

With Section 6411(a) of the Patient Protection and Affordable Care Act (ACA) and the Final Rules found at 42 CFR Part 455, the Recovery Audit Contractor (RAC) program has been expanded to the North Carolina Medicaid program, sending a strong message to hospitals that the government's focus on program integrity will be around for a long time.

A main reason for the expansion seen in Section 6411(a) of the ACA was the government's self-proclaimed, though questionable, success with the Medicare RAC program. That program saw total payment corrections from FY 2010 to FY 2012 reach nearly $1.5 billion, of which nearly $1.3 billion was attributed to overpayments to providers. In 2011, CMS had estimated that the Medicaid RAC program would bring net savings of approximately $2.1 billion over a five-year period, with estimated net savings to the program in fiscal years 2015 and 2016 of $580 million and $630 million, respectively. Why is this important? If for no other reason, it tells hospitals that they should keep a close watch on the continued growth and development of the Medicaid RAC program. Although hospitals throughout North Carolina have not seen a great deal of activity in this area since contractor HMS was awarded the Medicaid RAC II contract over two years ago, current trends clearly indicate increased activity in the area of program integrity and recoupment of improper payments.

Regardless of the number of Medical Record Request letters or Tentative Notice of Overpayment letters seen by hospitals across the state, the structure of the program implemented in 2011 continues to leave the authority with the states to determine the criteria, processes and structure of the Medicaid RAC programs. In its recent passage of the Appropriations Act of 2014, Session Law 2014-100 (Appropriations Act), the N.C. General Assembly has provided several additional tools and powers designed to increase and strengthen the Medicaid RAC enforcement activity in the Division of Medical Assistance (DMA), the agency with oversight over the Medicaid RAC program. Subpart XII-H of the Appropriations Act contains the following mechanisms applicable to the Medicaid RAC program and the Medicaid appeals process:

- Section 12H.22 stresses the need for a comprehensive program integrity contract and mandates that DMA issue a request for proposals no later than June 30, 2015, including certain procedures and requirements for a single contract to perform six program integrity functions, two of which are RAC and prepayment review.
- Section 12H.26(b) amends N.C.G.S. 108C-5 to add a new subsection allowing DMA to utilize a contractor to send notices directly to providers.
- Section 12H.27(a) amends N.C.G.S 108C-12(d) to place the burden of proof on the petitioner in Medicaid appeals (provider or applicant) from an adverse determination.
- Section 12H.27(b) amends N.C.G.S. 108A-70.9B to require that the Office of Administrative Hearings (OAH) dismiss the contested case of a Medicaid recipient if the recipient accepts an offer of mediation and fails to attend without good cause. Previously nothing in that statute could restrict the right of a recipient to a contested case hearing related to contested Medicaid cases.

The points outlined above should be clear signals to hospitals that North Carolina is committed to the continued buildup and success of the Medicaid RAC program, to heightened enforcement related to program integrity generally, and to a pro-agency stance in the notice and appeals process for Medicaid cases.

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A Primer on Medicare Requirements for Physician Supervision of "Incident to" Services

by Wilson Hayman

Services provided by a physician's auxiliary staff that are "incident to" the physician's services are paid under the physician fee schedule at a higher rate, as though the physician had personally furnished the services. However, Medicare rules governing physician supervision of "incident to" services continue to present challenges for hospitals and physicians who seek to bill for the services of such personnel acting under physician supervision.

Medicare Part B reimburses services and supplies that are provided under a physician's supervision either as hospital outpatient services or as by a physician office or clinic. The term "incident to" is defined in the Medicare regulations and manuals, but different requirements apply to "incident to" services in each setting.

This article addresses only Medicare requirements and policies applicable to physician supervision for "incident to" services. Different requirements and policies regarding physician supervision may apply to other government programs such as Medicaid and to private insurance plans.

Hospital Outpatient Services

For hospital outpatient services, "incident to" services are those therapeutic services furnished by a hospital or critical access hospital (or those under arrangement with a hospital) on an outpatient basis by auxiliary personnel, pursuant to the order and supervision of a physician or non-physician practitioner. The term "non-physician practitioner" for this purpose means a clinical psychologist, licensed clinical social worker, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife.

To be reimbursed under Medicare Part B as "incident to" a physician's or other practitioner's personal services, hospital outpatient services and supplies must meet all the following requirements:

- Services and supplies must be therapeutic (not merely for diagnostic purposes) and furnished to outpatients incident to the services of physicians or non-physician practitioners, as defined. These may include drugs and biologicals that are not usually self-administered, if furnished "incident to" a physician's or practitioner's services.
- Services must be furnished by the hospital or under arrangement with a hospital. These may include clinic services, emergency room services, and observation services.
- Services must be furnished as integral, though incidental, parts of the physician or non-physician practitioner's professional service in the course of treating an illness or injury.
- Services must be furnished in the hospital or a department of the hospital that has a provider-based status.
- Services must be furnished under the direct supervision of a physician or non-physician practitioner, or under such other appropriate level of supervision as is designated by CMS, and in accordance with state law and all additional requirements (see further discussion below).

Levels of Physician Supervision for Services Delivered to Hospital Outpatients

Although CMS requires direct supervision by an appropriate physician or non-physician practitioner for the provision of all therapeutic services to hospital outpatients, CMS may assign certain hospital outpatient therapeutic services as requiring either general supervision or personal supervision. Non-physician practitioners (as defined above) may provide the required supervision of services in accordance with state law and any other requirements. The physician or practitioner must have the knowledge, skills, ability, and privileges to actually perform the clinical service or procedure. In addition:

- If direct supervision is required for services furnished in the hospital, this term means the physician or other practitioner must be "immediately available" to furnish assistance and direction, but need not be present in the room when the procedure is performed. Although CMS has not defined "immediate availability" in this context, it would not include a supervisory physician or practitioner who is performing another procedure or service that he or she could not interrupt. However, a supervising physician or practitioner may furnish direct supervision from a physician office or other location that is not on the hospital campus where the services are being furnished, as long as the physician or practitioner remains immediately available.

- Pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation must be directly supervised by a doctor of medicine or doctor of osteopathy.
- For non-surgical extended duration therapeutic services (NSEDTS), which can last a significant period of time and have a substantial monitoring component typically performed by auxiliary personnel, Medicare requires at least direct supervision by a physician or appropriate non-physician practitioner during the initiation of the service. When the patient is stable, this may be followed by general supervision at the discretion of the supervising physician or practitioner.
- "General supervision" means the services are furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the service or procedure.
- A table listing services that may be furnished under general supervision and those defined as non-surgical extended duration therapeutic services (NSEDTS) is available on the OPPS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.
- "Personal supervision" means the physician must be in attendance in the room during the performance of the service or procedure.

Physician Office or Physician-Directed Clinic Services

For all settings other than a hospital or skilled nursing facility, including services provided by a physician office or physician-directed clinic, Medicare Part B pays for services and supplies that are considered to be "incident to" the services of a physician or non-physician practitioner if they are rendered at that location without charge or are included in the physician's bill. In those settings, the services and supplies must meet all the following requirements:

- The services or supplies are integral, though incidental, to the physician's or practitioner's professional service covered by Medicare Part B. Each service provided by auxiliary personnel does not need to be accompanied by a personal professional service of the physician, but the physician must perform an initial service and then provide subsequent services that reflect the physician's active participation and management of the course of treatment.
- The services and supplies are furnished incident to the physician's or other practitioner's services, are commonly furnished by the physician in the course of providing services and are included in the physician or practitioner's bills, and represent an expense to (i.e., are purchased by) the physician or billing entity. Services may not be "incident to" if payment can be made under a separate benefit category listed in 42 USC § 1395x(s) (§ 1861(s) of the Social Security Act), such as diagnostic tests and certain vaccines.
- Unlike the supervision required for outpatient services discussed above, the services and supplies provided by auxiliary personnel in a private practice setting must be furnished under the direct supervision of a physician. "Direct supervision" in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure, but the physician does not need to be present in the room when the procedure is performed.
- The supervising physician may be either an employee, leased employee or independent contractor of the legal entity that bills and receives payment for the services or supplies, but the physician must have a legal relationship with the entity that satisfies the requirements for a valid reassignment.
- In some medically underserved areas, the direct physician supervision requirement does not apply to certain discrete individual or intermittent services when provided to homebound patients by auxiliary personnel who meet all applicable state requirements. The service must be an integral part of the physician's service but may be performed under general physician supervision by personnel who are employed by the physician or physician-directed clinic. Such services include, among others, injections, EKGs, therapeutic exercises, the insertion and changing of catheters, and certain educational services. "General supervision" means the service must be performed under the physician's overall supervision and control, but the physician need not be physically present at the patient's residence. All other "incident to" requirements must be met. If, however, the service is covered as a home health service, the patient is eligible for home health benefits, and the service could be provided on a timely basis by an available agency, then it should be provided by the home health agency, and postpayment review will ensure that physicians and clinics do not perform a substantial number of these services.

Shared/Split E/M Services

When an evaluation and management (E/M) service in an office or clinic setting is a "shared/split encounter" between a physician and a non-physician practitioner, the service may be considered and billed as "incident to" if it meets all the "incident to" requirements. If those requirements are not met, the service must be billed under the non-physician practitioner's billing number, with payment from the physician fee schedule at the appropriate level.

In contrast, an E/M encounter shared by a physician and non-physician practitioner in a hospital inpatient, outpatient or emergency department setting may be billed under the physician's billing number only if there was a face-to-face encounter between the physician and the patient. "Incident to" rules do not apply to shared

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Hospital Options for Unused Long Term Care Beds

by Todd Hemphill

A number of hospitals in North Carolina have skilled nursing beds in their bed inventory. According to the Proposed 2015 State Medical Facilities Plan (SMFP), 1,652 of the 45,724 (or approximately 4 percent) of the licensed nursing home beds in North Carolina are located in hospitals. In addition, critical access hospitals in rural areas typically have swing beds capable of being used for both acute care patients and those requiring skilled care.

While the use of swing beds in the critical access hospital setting has remained a viable economic model, utilization of hospitals' traditional nursing home beds has decreased due to a shift in the manner in which hospitals are reimbursed for care provided to persons qualifying for long term care health services. Ten hospitals in North Carolina, having a total of 290 licensed nursing home beds in their inventory, reported zero occupancy in their most recent License Renewal Applications.

At the same time, traditional nursing homes located in the same counties may actually be at high utilization. However, because the hospital-based nursing home beds in a county are at low utilization, the SMFP methodology may not identify a need for additional nursing home beds in that county. In fact, both the 2014 SMFP and the Proposed 2015 SMFP identify a need for no additional nursing home beds. Thus, there are no nursing home beds identified as being needed in North Carolina for the next 18 months.

Many providers may believe that developing new beds under the N.C. State Health Coordinating Council (SHCC) need determination methodology provides the only opportunity for growth. However, there are other options. The Certificate of Need (CON) law permits two providers to jointly file a CON application to relocate beds from one facility to another.

Hospitals seeking to rid themselves of unneeded nursing home beds may enter into agreements with nursing homes to effectuate such a transfer. This transfer of beds can occur within the same county regardless of the SMFP need determination. In addition, providers may relocate beds to a contiguous county, so long as the proposal would not result in a deficit of licensed beds in the county that would be losing the beds, or a surplus of beds in the county gaining the beds, as reflected in the SMFP.

This type of transfer requires a two-step process. First, the hospital and the nursing home must jointly file a CON application to relocate the hospital's beds to the nursing home site. The beds can be moved to an existing wing of the nursing home building, or to a new wing constructed on the nursing home site.

After the CON application is approved and the beds are developed, licensed and certified, the nursing home provider may acquire the hospital's interest in the beds. This can be done by obtaining an exemption from the CON Section. In order to obtain the exemption, the nursing home must send a letter to the CON Section advising the section of its intent to enter into a purchase agreement with the hospital.

Because of the lack of need in the SMFP and the value of additional nursing home beds, nursing home providers are willing to pay a significant amount of money for the right to acquire these beds. They also typically will cover all the costs associated with the CON application and the exemption request. Thus, the hospital's expenditures in this type of transaction are typically limited to its costs associated with the negotiation of the transaction.

North Carolina is now the 10th largest state in the U.S., and one of the fastest-growing states in the over-65 population category. Despite the absence of "new" nursing home beds in the annual SMFP, the state's nursing facility industry is expanding. This growth presents an opportunity for hospitals to recoup some of the cost of operating nursing home beds that are no longer needed in the hospital's bed inventory.

Please feel free to contact our health law team if you are considering this type of transaction. We have a great deal of experience in this area, both in following the steps discussed above to obtain CON Section approval of the transaction and in negotiation and preparation of the asset transfer documents.

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NC's Medicaid RAC Program

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What does all of this mean for North Carolina hospitals about the Medicaid RAC program? While it is too early to predict with any certainty, one warning is clear—**do not let your guard down**. Even though Medicaid RAC activity has not been at high levels within our State to date, the signs point to a heightened focus by DMA and Health Management Systems (HMS), the Medicaid integrity contractor for North Carolina, and an active future for the Medicaid RAC program. As we will continue to do with our contacts statewide and regionally, hospitals should monitor daily activity to identify red-flag areas and billing patterns that may place them on the Medicaid RAC program's radar screen.

One essential tool in this monitoring is communication between hospitals and other providers to assess developing trends and to coordinate measures taken to avoid vulnerability in identified enforcement areas. This communication would include focusing on such areas as certain target diagnostic-related groupings, readmissions, and inappropriate setting determinations, to name but a few. This coordinated approach tracks the collaboration seen for years among the various federal and state agencies active in the arena of program integrity and enforcement. A consistent, coordinated approach is a best practice that will help prepare and position hospitals to respond effectively to future challenges – and it might even keep a relatively straightforward billing or processing error or overpayment from leading to an allegation of fraud, waste or abuse.

Finally, hospitals must have an action plan in place well in advance of the dreaded notice from the Medicaid RAC. Hospitals should know their appeal rights, responsibilities, duties, and deadlines for responses. For all the reasons outlined above, the state has clearly placed the burden on hospitals to be focused from day one when faced with an adverse determination. Whether a hospital is reviewing compliance policies and procedures, formulating best practices, deciding to fight a tentative decision at the reconsideration level, or appealing an adverse determination to an Administrative Law Judge (ALJ) in OAH, involvement of experienced legal counsel as a part of the hospital's team is an important, if not essential, component.

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Primer on Medicare Requirements

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E/M encounters in those settings. CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 178, Change Request 2321 (May 14, 2004); Medicare Carriers Manual, Part 3, Claims Process, Transmittal 1776, Change Request 2321 § 15501 (Oct. 25, 2002).

General Rules Applicable to "Incident to" Services Provided in Either Setting

Auxiliary Personnel

The term "auxiliary personnel" has been interpreted for purposes of "incident to" services as including not only the typical medical office personnel such as RNs, LPNs, medical assistants, technicians, and therapists, but also medical professionals such as mid-levels, RNs, LPNs, medical assistants, and even other physicians (see discussion below). Mid-levels are separately covered and can be paid by Medicare for services performed personally without direct physician supervision. In order for their services to be covered as "incident to," at least in the office setting, they must be directly supervised by the physician as an integral part of the physician's personal service. Pub 100-02, Chapter 15, § 60.2. All auxiliary personnel must meet state licensing requirements, and services and supplies must be furnished in accordance with state law.

Another Physician Providing "Incident to" Services

Some may not realize that a physician, as opposed to other auxiliary personnel, may also bill as "incident to" another physician's services, if those services meet the requirements of the Medicare "incident to" regulations. This may be helpful if a new physician needs to provide Medicare-reimbursed services before the effective date of his or her enrollment with Medicare. The new physician may bill using the supervising physician's NPI, and the new physician would not be identified on the claim for services. Of course, the supervising physician would be held liable for all services, and it is recommended that the supervising physician sign off on all services notes and reports for the new physician.

Hospitals would be well advised to pay close attention to these rules, and the varying requirements according to practice setting, when they utilize "incident to" billing to maximize practice revenues.

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Medicaid Reform – House Bill 1181, the Medicaid Modernization Act

by Jillian DeCamp and Tom West

With about 2.3 million North Carolina residents receiving Medicaid services for at least part of 2013, Medicaid reform is a top priority for the General Assembly. The significant funding allocations required to supplement the appropriated budget over the past three years have reduced the confidence of many legislators in the Department of Health and Human Services' (DHHS) ability to accurately predict Medicaid costs. As a result, the N.C. House of Representatives and the N.C. Senate have proposed radically different plans they each believe would hold providers accountable for meeting budget and quality care goals while providing "whole-person care" to North Carolina Medicaid recipients, who include the state's low-income, disabled and pregnant patients, and young and old residents. With no resolution in the current short session, the question remains whether the transition will be to a plan using both provider-led and non-provider-led capitated health plans or solely provider-led plans, and whether that transition and plan will be under the supervision of DHHS or a separate Department of Medical Benefits (DMB).

Medicaid reform has been in the news most of 2014, after DHHS's initial proposal to bring in for-profit managed care companies to run the state's Medicaid program met tremendous opposition from the health care provider community. The agency subsequently changed its proposal to instead use accountable care organizations (ACOs) to provide care to North Carolina Medicaid recipients. The N.C. House's original plan would have followed DHHS's lead in part and restructure the Medicaid system using ACOs. In House Bill 1181 (HB 1181), filed May 21, 2014, by Representatives Nelson Dollar, Marilyn Avila, Justin Burr, and Donny Lambeth, the House stated its intent "[i]nstead of paying for medical services on a purely fee-for-service basis that merely rewards volume and intensity of services, the state can redesign payment and care coordination models to reward advances in quality and patients' health outcomes" and hold "providers accountable for meeting budget targets and quality goals." While transitioning to "more prevention-focused" care, they would also integrate care "across physical, behavioral, and long-term care domains." In the original House plan, DHHS would establish a Medicaid ACO Program, modeled after the federal Medicaid Shared Savings Program found in 42 C.F.R. Part 425, that would utilize shared savings and losses with providers as incentives to meet budget targets.

One month later, with the support of the Governor, the House changed course and proposed moving to a provider-led capitated health plan model, in a House Committee Substitute originating in the House Committee on Health and Human Services. The stated goals of the revised legislation were to: (1) provide budget predictability, (2) slow the rate of cost growth, (3) achieve cost savings through efficient reductions in programmatic costs, (4) create more efficient administrative structures, (5) improve health outcomes for the state's Medicaid population, and (6) require provider accountability for budget and program outcomes. The plan was to be implemented for the majority of the Medicaid population by July 1, 2020, beginning with sharing limited risk with providers that would increase over time. The plan in this substitute bill proposed that DHHS would lead the transition and report to the General Assembly on the status of implementation in March of 2015.

A third version came out of the House Committee on Appropriations as another committee substitute. The only substantive change between it and the previous version was to create a study of "issues related to the development of a demonstration pilot to test the feasibility of single payments to an entity that would cover the full array of Medicaid services for Medicaid recipients with intellectual and developmental disabilities." This third version of HB 1181 passed out of the House on July 2, 2014, with unanimous and bipartisan support, 113-0.

The Senate has demanded more radical changes to the current program and desires greater and more direct control over Medicaid expenditures. Led by Senators Ralph Hise and Louis Pate, this plan was first proposed as a Senate Committee Substitute for HB 1181 and reported favorably on July 17, 2014, in the Senate Committee on Rules. The Senate plan, which is now the sixth edition of HB 1181, would have established by September 1, 2014, a new Department of Medical Benefits (DMB) to oversee the transition to multiple

provider-led and non-provider-led health plans (described by critics as "private for-profit managed care companies"), instead of oversight by DHHS and the Division of Medical Assistance (DMA). The Senate plan included the following goals or features:

- Create competition among multiple provider-led and non-provider led health plans as a way to reduce costs, improve quality, and increase patient satisfaction.
- DMB would commence capitated health plans and phasing in full risk for provider-led plans over two years, transitioning the state entirely to full risk provider-led plans by July 1, 2018.
- Include mechanisms to provide incentives for personal accountability for patients' health choices and outcomes, and ways to identify and refer Medicaid patients for further beneficial and appropriate services and programs.
- DMB's board would be comprised of seven members, including experts in the administration of large health delivery systems, public assistance, managed care, health insurance, large business leadership, and an actuarial fellow with experience in health insurance. The Secretary of DHHS would sit on the board but would serve as an ex-officio, non-voting member.

The Senate passed the sixth edition of HB 1181 out of the chamber on July 28, 2014, by a vote of 29 to 17, almost entirely along party lines. On July 30, 2014, the House rejected the Senate plan, again voting with unanimous and bipartisan support, 106-0.

The General Assembly has adjourned *sine die*, but it may return before the 2015 session scheduled to begin in late January 2015 if three-fifths of the members of each house vote to do so. Section 11(2) of Article II of the North Carolina Constitution. The more likely scenario for the General Assembly to return would be for a special session called by the Governor, as is permitted "on extraordinary occasions, by and with the advice of the Council of State," pursuant to Section 5(7) of Article 3 of North Carolina Constitution.

Although neither the House nor the Senate has appointed conference committee members to negotiate a resolution concerning their sharply differing versions of HB 1181, the General Assembly remains committed to Medicaid reform. The Appropriations Act of 2014, Session Law 2014-100, signed by the Governor on August 7, 2014 (Act), included the following provisions regarding plans for Medicaid reform:

- Under Subpart XII-H, DMA (Medicaid), Section 12H.1, the Act states that "[i]t is the intent of the General Assembly to continue to work toward the details of Medicaid reform during a special session in November 2014."
- Section 12H.19 of the Act repeals the payment per member per month to Community Care of North Carolina (CCNC) appropriated in the Appropriations Act of 2013, stating "[i]t is the intent of the General Assembly that the structure of per member per month (PMPM) payments or other payments to providers participating in Community Care of North Carolina (CCNC) programs be considered as a part of any Medicaid reform plan for the state."
- Section 12H.20A requires DHHS and DMA to include in all its contracts containing Medicaid-related or N.C. Health Choice-related provisions a clause that allows its cancellation without cause and upon 30 days' notice. All contracts entered into on or after August 7, 2014, will be deemed to include that provision whether or not it actually appears in the contract.

The two houses of the N.C. General Assembly have remained at odds throughout the past short session concerning a solution to the consistent problems with North Carolina's Medicaid program. Hospitals, other providers and consumers remain watchful as to whether an agreement will be reached either in November or in the 2015 legislative session, what form it will take, and whether the resolution can begin to solve the difficult issues facing that program.

Tom West and Jillian DeCamp are members of our Legislative and Regulatory Group. They are both regular contributors to our Regulation & Reality Blog found at www.ncgovrelations.com. You may reach Tom at 919.783.2897 or twest@poyners.com and Jillian at 919.783.1027 or jdecamp@poyners.com.

Our Health Law Group Expands

On June 1, 2014, the boutique health care law firm Bode Hemphill, LLP joined Poyner Spruill, bringing our health law team to 14 members. Ken Burgess, health law practice group leader, said, "We are extremely pleased to have Todd Hemphill, Matt Fisher, David Broyles, as well as their assistant, Janet Plummer join our law firm. Todd and his team have ably served their clients and are recognized as leaders in their field. Merging their significant skills and talents with the health law professionals of Poyner Spruill will enable us together to expand the array of legal services available to our health care clients." To get to know Todd, Matt and David, please visit our website and read their full bios.

Hospitals File Lawsuit Over Medicare ALJ Hearings Delays

by Chris Brewer

Over 460,000 appeals requesting hearings before an ALJ were pending in the Office of Medicare Hearings and Appeals (OMHA) at the end of 2013 with 15,000 new appeals being submitted each week. At the beginning of 2014, OMHA suspended any further assignments of appeal requests by providers for a period of up to 28 months. The suspension applies to cases received by OMHA after July 15, 2013. The tremendous increase in appeals is directly related to the expanded number of Medicare contractors reviewing claims and the expanded volume of claims reviews.

The moratorium by OMHA prompted the American Hospital Association (AHA) to sue DHHS on May 22, 2014, to force the Secretary of HHS to meet deadlines required by statute for reviewing denials of Medicare claims. In its lawsuit and its recently filed Motion for Summary Judgment, AHA asserts that providers may wait up to five years to complete four levels of administrative appeals. Federal regulations require the ALJ hearing appeals to be completed within 90 days following the date the request is received by OMHA. If this timetable is not met, the only remedy available is escalation to the Departmental Appeals Board (DAB) where similar delays are common. If the DAB does not decide the appeal within 180 days, escalation is allowed to the Federal District Court. These remedies are of little practical value to providers. HHS requested and the Court granted an extension to respond to AHA's Summary Judgment Motion until September 11, 2014. Updates regarding this lawsuit are available on the AHA website (www.aha.org).

The delays have hurt providers in many ways. ALJ reviews have consistently led to high rates of reversals of claim denials. In addition, Medicare providers are impacted by the contained accrual of interest and withholding of alleged overpayments during the expected 30 months they must wait for an appeal to be assigned and heard by an ALJ.

HHS and OMHA have taken only marginal steps to address the problem. Provider reviews by Recovery Auditors (RA) were suspended at the end of February, 2014. When the RA audit program resumes with new contractors, new guidelines will be in place that are designed to reduce the number of claims reviewed and to facilitate resolution of audit findings at the contractor level. The new contracts are expected to contain RAC program changes that CMS announced in February, including requiring auditors to wait 30 days to allow for a discussion before sending claims to the Medicare Administrative Contractors for collection. Under the new contracts, RACs will also be expected to confirm receipt of a discussion request within three days. CMS believes this will result in the filing of fewer administrative appeals. RACs will also have to wait until providers have moved through the second level of appeals before collecting their contingency fee, as well. The new contracts are also expected to change how many documents RACs may request for claims, and to adjust document request limits based on providers' denial rates.

CMS has also initiated a "Settlement Conference Facilitation Pilot," which is an alternate dispute resolution process designed to bring the appellant and CMS together to discuss the potential of a mutually agreeable resolution for claims appealed to the Administrative Law Judge. These and other actions by OMHA to assist providers impacted by the delays are described on its website (www.hhs.gov/omha), including "best practice" guideline tips for providers filing hearing requests.

On Friday, August 29, 2014, Medicare announced an offer to settle hundreds of thousands of hospital appeals relating to reimbursement for short-term care. The settlements could potentially result in payments to hospitals of several hundred million dollars. The proposed settlement offers hospitals a little more than two-thirds of the amounts they contend they are owed. Thousands of hospitals have filed appeals challenging the amount they should receive for treating patients whose hospital stays were one or two days, contributing to the backlog of appeals and resulting delays at the ALJ level. The link to the post from the CMS website in its "updates" dated August 29, 2014, is www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.

Notwithstanding these measures, the moratorium on assigning cases for hearing remains in place and the backlog continues to grow. As AHA alleges in its lawsuit, "OMHA has admitted it that is not meeting statutory deadlines and will not be able to do so any time the near future."

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