



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 31 2014

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter sharing concerns about the Centers for Medicare & Medicaid Services' (CMS) hospital settlement offer and the backlog of appeals at the Office of Medicare Hearings and Appeals (OMHA). As you know, I'm very interested in working closely with Congress to resolve this situation as soon as possible.

The Department of Health and Human Services (HHS) established a Departmental interagency workgroup in 2013 to address the Medicare appeals backlog. The workgroup includes leaders from the three agencies involved in the Medicare appeals process: CMS, OMHA, and the Departmental Appeals Board. HHS conducted a thorough review of the appeals process and developed a series of initiatives, including the pursuit of settlements, that both OMHA and CMS are implementing to reduce the current backlog of pending appeals and the number of appeals that reach OMHA. I was pleased to learn of the interest expressed by the Members of your Committee as well as the staff when this information was shared with you last summer.

One of the ways that HHS chose to address these matters was to offer health care providers and HHS a clear path forward through settlements. On August 29, 2014, HHS announced that, for claims denied based on inappropriate inpatient status for dates of admission before October 1, 2013, CMS is offering an administrative agreement to hospitals willing to withdraw pending appeals in exchange for partial payment (68 percent) of the denied inpatient claim. This offer was announced as soon as CMS was prepared to process settlement requests. Knowing the importance of this issue to your Committee, we alerted you prior to the posting of the settlement parameters on the CMS website, and prior to it being announced in the media.

CMS believes this settlement, offering global resolution of providers' appeals, is in the best interest of the government and hospitals. This settlement is intended to ease the administrative burden for all parties. The settlement offers an opportunity for the government to reduce the pending appeals backlog by resolving a large number of homogeneous claims in a short period of time. In addition, the settlement offers an opportunity for hospitals to obtain payment now for rendered services, rather than waiting a considerable amount of time with the associated risk of not prevailing in the appeals process.

Before this announcement, CMS took steps to minimize claim denials and prevent future appeals that would add to the backlog. For example, CMS Ruling 1455-R (issued March 13, 2013) expanded billing for Part B services. This provided an opportunity to resolve these types of appeals, but only a limited number of hospitals participated. Additionally, the fiscal year 2014 Hospital Inpatient Prospective Payment System Final Rule (issued in August 2013) clarified the inpatient admission policy for Medicare Part A payment and allows providers to rebill for medically necessary Part B services. HHS expects these changes to result in fewer appeals going forward.

The appeals eligible for this settlement do not involve claims for which the services furnished have been determined to be medically unnecessary. Instead, the eligible appeals involve determinations that otherwise medically necessary services should have been furnished on an outpatient, rather than inpatient basis. The majority of eligible claims were denied on a postpayment basis, resulting in overpayment determinations. HHS is offering this settlement pursuant to our compromise authority under the Social Security Act, including sections 1102, 1815, 1871, and 1893, as implemented by regulations at 42 CFR sections 401.601, 401.613, and 405.376 (which reference the Federal Claims Collection Act), and the common law.

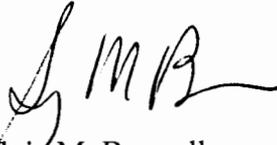
HHS determined 68 percent was an appropriate settlement offer based on our knowledge of the types of claims at issue and the associated value of the services performed. As your letter noted, MedPAC has found that the comparable average inpatient reimbursement can vary compared to the average outpatient reimbursement depending on the services provided. For instance, the MedPAC report you cited in your letter found that a drug-eluting stent procedure's outpatient reimbursement averaged 72 percent of the inpatient reimbursement. Therefore, in determining the appropriate settlement offer, HHS examined the denied amounts, the tendency of hospitals to appeal decisions, and the vulnerability that hospitals and CMS face throughout the appeals process. While the percentage was based on known data, HHS also considered other factors such as services that may have been provided during the inpatient stay for which no Part B reimbursement is allowed and other savings measures that both the government and hospitals may achieve.

HHS considered and addressed beneficiary effects by offering hospitals an amount that represents full and final satisfaction of the claim. Health care providers are required to refund coinsurance and deductible amounts collected for denied claims if the provider is determined liable under section 1879 of the Social Security Act. In this proposed offer, each eligible claim was denied by a Medicare contractor. Therefore, beneficiaries should have received refunds. These claims will remain as denied, and hospitals may not rebill beneficiaries. I am committed to ensuring that the backlog of appeals does not adversely affect Medicare beneficiaries. OMHA continues to prioritize beneficiary appeals so that their hearing requests are handled as expeditiously as possible.

HHS has made extensive outreach efforts regarding this settlement offer, including posting detailed information on the CMS website and conducting a National Provider call. Additionally, CMS established an email address where questions can be submitted to facilitate communication with the provider community. Questions submitted to that mailbox are responded to and posted to the CMS website so all providers can see the answers. I believe these actions safeguard the best interests of Medicare beneficiaries, health care providers, and the government. For these reasons, we will continue to pursue settlements as well as other options to responsibly resolve the backlog of appeals.

I appreciate your interest in these important issues and would be pleased to provide additional details. I look forward to working with the committee towards our mutual goal of strengthening Medicare for beneficiaries and providers. Please do not hesitate to contact me with any further thoughts or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'SMB', with a long horizontal flourish extending to the right.

Sylvia M. Burwell