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The Medicare Appeals Crisis: Why Mediation is the Medicine

Michelle Ellis*

I. INTRODUCTION

From the United States' first federally financed health care program in 1798,¹ to recent Affordable Care Act changes, the country has borne considerable directional shifts in health law policies to meet the demands of an advancing society. While typically such transformative demands call for government intervention, sometimes it is the government intervention itself that triggers transformative demands.

Today's Medicare program stands at the forefront of the surging federal debate on health care reform. In 2014, Medicare spending accounted for 14% of the federal budget.² Medicare currently insures 55 million Americans³—15% of the population.⁴ By 2037, it is expected to account for the health care of 80 million people.⁵ As the demographic wave of baby-boomers become eligible for Medicare in the first half of the twenty-first century and as the recession-induced boost in Social Security Disability Insurance elevates the number of Americans now qualifying for Medicare,⁶ the tremendous growth rate necessitates major changes in the federal budget regarding how and what the program provides. This inevitable Medicare

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1. Rick Ungar, *Congress Passes Socialized Medicine and Mandates Health Insurance in 1798*, FORBES (Jan. 17, 2011), <http://www.forbes.com/sites/rickungar/2011/01/17/congress-passes-socialized-medicine-and-mandates-health-insurance-in-1798/>.

2. *The Facts on Medicare Spending and Financing: Overview of Medicare Spending*, THE HENRY J. KAISER FAM. FOUND. (July 24, 2015), <http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/>.

3. *Id.*

4. Megan Multack & Claire Noel-Miller, *Who Relies on Medicare? Profile of the Medicare Population*, AARP PUB. POL'Y INST., (Jan. 2014), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2014/who-relies-on-medicare-fact-sheet-2014-AARP-ppi-health.pdf.

5. Mark Trumbull, *Taming Medicare Costs: What are the Options?*, D.C. DECODER (Apr. 2, 2013), <http://www.csmonitor.com/USA/DC-Decoder/2013/0402/Taming-Medicare-costs-What-are-the-options>.

6. Philip Moeller, *Here's What You Need to Know About the Serious Backlog of Medicare Appeals*, PBS NEWSHOUR (May 6, 2015), <http://www.pbs.org/newshour/making-sense/serious-backlog-medicare-claims-appeals/>.

expansion has already begun to overwhelm the federal financing mechanisms that support it, and although such transformative demands have sparked various forms of government intervention, such as establishing Medicare Recovery Audit Contractors (RACs), this recent government intervention has actually aggravated the problems surrounding Medicare,⁷ calling for drastic changes in order to prevent the collapse of one of the most important federal programs for American citizens. Though modestly explored in the Medicare arena, alternative dispute resolution is emerging as the optimal forum for resolving these recent coverage disputes.

This article will explore how unmeritorious RAC-reversals recently polluted the Medicare appeals process, and how this has led to a crisis for both providers and the United States Department of Health & Human Services (HHS). Furthermore, this article will consider the lack of available remedies and narrow measures taken by HHS, and will instead advocate for mediation as the best means of easing the backlog. While the delays also directly affect Medicare beneficiaries, this article will limit its discussion to the backlog in relation to providers and suppliers.

II. THE MEDICARE PROGRAM

Congress established the Medicare program in 1965 in an effort to provide health insurance primarily to individuals sixty-five years and older.⁸ Although the objective of this federal program is to ensure that beneficiaries have access to health care,⁹ “the Medicare program does not cover all health care expenses.”¹⁰ Title XVIII, also known as the Medicare Act, grants the federal government authority to determine what medical services are provided to beneficiaries and to accordingly award and deny reimbursements to medical providers.¹¹ Medical “providers” typically include hospitals, home health agencies, outpatient rehabilitation facilities, skilled nursing facilities, and hospices.¹² The Medicare statutes and regulations strictly

7. *RAC Auditing Reform is Essential to Fix Urgent, Critical Problems*, AM. HOSP. ASS'N (2014), www.aha.org/content/14/issuebrief-rac.pdf. (“The influx of appeals of RAC denials has broken the Medicare appeals process.”).

8. Social Security Act, Title XVIII, Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. §§ 1395-1396v).

9. *Id.*

10. Medicare Program: Changes to the Medicare Claims Appeal Procedures, 67 Fed. Reg. 69,312, 69,313 (proposed Nov. 15, 2002) (to be codified at 42 C.F.R. pt. 405).

11. 42 U.S.C. § 1395ff (2014).

12. Medicare Program: Changes to the Medicare Claims Appeal Procedures, 67 Fed. Reg. at 69,336.

define the parties who may appeal a determination of denied coverage and provide lengthy procedural guidelines for such process.¹³

A. Four-Step Appeals Process

When medical providers furnish services to a Medicare patient, they submit a reimbursement claim to a Medicare Administrative Contractor (MAC), who then conducts an initial evaluation of the claim.¹⁴ These government contractors are responsible for processing Medicare claims and appropriately reimbursing medical providers who have furnished covered medical care to Medicare beneficiaries.¹⁵ Upon review, MACs either pay or deny the medical provider's claim for reimbursement.¹⁶ If dissatisfied, a provider may return a denied claim to the MAC again, and is entitled to a redetermination within sixty days.¹⁷ A provider may then appeal the MAC's decision to a Qualified Independent Contractor (QIC), who is likewise required to issue a decision within the statutory sixty-day time period.¹⁸ These first two levels of review have been characterized as "a little more than rubber stamps" due to the fact that less than 5% of coverage denials are actually reversed at those levels.¹⁹

The Office of Medicare Hearings and Appeals (OMHA) oversees a third level of review, which allows providers to request a hearing before an

13. See 42 C.F.R. § 422.578 (2004) (limiting the right to appeal to parties of an organization determination); 42 C.F.R. § 422.566 (2004) (defining "parties to an organization determination").

14. 42 U.S.C. § 1395ff(a)(2)(A) (2014). CMS contracted with an entity called Medicare Administrative Contractors (MAC) to serve as the "fiscal intermediary" for claims under this statute. See *Medicare Contracting Reform to Replace Carriers and Fiscal Intermediaries*, AM. ACAD. OF PHYS. MED. & REHAB. (2015), <https://www.aapmr.org/practice/resources/regulatory/Pages/Medicare-Contracting-Reform-Replace-Carriers-Fiscal-Intermediaries.aspx>.

15. 42 U.S.C. § 1395kk-1(a)(4)(A) (2015).

16. *Id.* § 1395kk-1(a)(4)(A)-(B).

17. *Id.* § 1395ff(a)(3)(C)(ii) (2014).

18. *Id.* § 1395ff(c)(3)(C)(i).

19. Daniel Hettich, *Medicare Beneficiaries Sue HHS Over 489-Day Backlog in ALJ Appeals*, KING & SPALDING HEALTH HEADLINES (Sept. 2, 2014), <http://www.kslaw.com/library/newsletters/HealthHeadlines/2014/0902/article5.html>. "Despite the overwhelming likelihood of failure at these first two levels, their completion is a necessary condition to obtaining review at the ALJ level." Complaint for Declaratory, Injunctive, and Mandamus Relief at 6, *Lessler v. Burwell*, No. 3:14-cv-01230 (D. Conn. Aug. 26, 2014), <http://www.medicareadvocacy.org/wp-content/uploads/2014/08/00083998.pdf> [hereinafter *Lessler Complaint*] (noting the one exception for ALJ review when the statutory adjudication period for reconsideration has expired without a decision).

Administrative Law Judge (ALJ).²⁰ This stage is particularly important to providers, suppliers, and beneficiaries because it is the only level of review where parties have the right to an independent adjudicator and to a live hearing—namely, the opportunity to call witnesses.²¹ Moreover, at the ALJ level, “denial of coverage is generally reversed at least half the time.”²² By statute, Congress has directed that the ALJ must hold the hearing and render a decision within ninety days.²³ If still dissatisfied, a provider may appeal to the Departmental Appeals Board (DAB), where the Medicare Appeals Council appointed by the Secretary of HHS will review the ALJ’s decision and offer a decision within ninety days.²⁴

A “fifth” constructive level of review includes an escalation option, where providers have the right to escalate their claims to federal courts if the claim meets a certain amount in controversy, and if the providers have exhausted all administrative remedies within HHS.²⁵ However, if their claim does not meet the amount in controversy requirement for escalation or the administrative remedies are delayed by a surge in appeals, then providers have no choice but to wait it out.²⁶

20. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 931(b)(2), 117 Stat. 2066, 2398 (2003) (“The Secretary shall assure the independence of administrative law judges . . . In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from [CMS].”)

21. Hettich, *supra* note 19. “Only the third level, the administrative law judge (ALJ) level, provides the right to an oral hearing before the adjudicator, including witness testimony, allows a beneficiary to present his or her case with more than written evidence and argument, and provides the only opportunity for meaningful review.” *Lessler Complaint*, *supra* note 19, at 1. Beneficiaries may submit new evidence for the ALJs to consider *de novo* based on the Medicare statute and regulations, “unlike the contractors and QICs who rely on less formal and more restrictive guidelines and directives.” *Id.* at 7.

22. Hettich, *supra* note 19.

23. 42 C.F.R. § 405.1016(a) (2010).

24. 42 U.S.C. § 1395ff(d)(2) (2014); 42 C.F.R. § 405.1108(a) (2005).

25. 42 C.F.R. § 405.1132 (2010); 42 C.F.R. § 405.1100(d) (2010). Because the Medicare statute states that a claimant “may” escalate an appeal to the MAC’s, CMS has interpreted “may” as exempting OMHA from the ninety-day deadline. Amy Lerman & Robert Wanerman, *OMHA’s Second Medicare Appellant Forum Reveals Some Forward Momentum but No Simpler or Quick Solutions for Medicare Administrative Appeals Backlog*, EPSTEIN BECKER GREEN: HEALTH CARE AND LIFE SCI. ALERT (Nov. 6, 2014), <http://www.ebglaw.com/publications/omhas-second-medicare-appellant-forum-reveals-some-forward-momentum-but-no-simple-or-quick-solutions-for-medicare-administrative-appeals-backlog/>. CMS claims that the Medicare statute contemplates the possibility that not all claims at the ALJ or DAB levels will be decided within ninety days, and thus merely provides a remedy for those claims, not time restraints imposed on every claim. *Id.*

26. 42 C.F.R. § 405.1132(b); 42 C.F.R. § 405.1006(c) (2010); Medicare Appeals: Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2014, 78 Fed. Reg. 59702-01, 59703 (Sept. 27, 2013).

B. Post Payment Review by RACs

In theory, all levels of the Medicare administrative review process should be completed within about one year; however, in recent practice, the pipeline has become so clogged with appeals at the ALJ level that pursuing a claim extends far beyond the timeframes established by the Medicare Act.²⁷ It all started when Congress introduced a RAC for the purpose of recouping Medicare “overpayments.”²⁸ Since 2009, the first two levels of reimbursement review, which are governed by the Centers for Medicare and Medicaid Services (CMS), have utilized these third-party contractors to conduct an additional level of post-payment review.²⁹ The RACs had jurisdiction over all providers that fell within their designated geographical scope, despite the practice area.³⁰ This program subjected formerly paid reimbursement determinations to future auditing and reversals by RACs—including those claims dating as far back as three years.³¹ Though first introduced as a check to ensure the honesty and accuracy of provider-claims,³² the RACs have proven to be a very effective force for CMS,

27. Hall Render, *Health Law Year in Review: Here's What Happened in 2014 as We Launch into 2015*, HALL RENDER BLOG (Jan. 7, 2015), <http://blogs.hallrender.com/blog/health-law-year-in-review-heres-what-happened-in-2014-as-we-launch-into-2015-2/>.

28. *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012: FY 2012 Report to Congress as Required by Section 1893(h) of the Social Security Act and Section 6411(c) of the Affordable Care Act*, CTRS. FOR MEDICARE & MEDICAID SERVS., at iv-v, 26-27, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf (last visited Oct. 21, 2015) [hereinafter *Recovery Auditing in Medicare and Medicaid for FY 2012*].

29. *Medicare Improper Payment Review: Recovery Auditor Contractors (RAC)*, AM. C. PHYSICIANS, http://www.acponline.org/running_practice/payment_coding/medicare/pay_review_rac.htm (last visited Oct. 21, 2015).

30. *Health Care Alert: The Changing Landscape of Medicare's RAC Program: Auditing Announcements You May Have Missed*, STRADLEY RONON (Mar. 21, 2014), <http://www.stradley.com/insights/publications/2014/03/health-care-alert-march-2014the-changing-landsca>. In 2014, CMS created an audit team to exclusively review claims from home health, hospice, and durable medical equipment providers under the rationale that “a specialized RAC will develop expertise and efficiently audit this subset of providers.” *Id.*

31. *Id.*; *Statement of Work for the Medicare Fee-for-Service Recovery Audit Program*, at 9, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/090111RACFinSOW.pdf> (last visited Oct. 21, 2015).

32. *Recovery Auditing in Medicare and Medicaid for FY 2012*, *supra* note 28, at 26-27.

recouping \$36 billion in “improper” fee-for-service payments in 2013.³³ But at some point, this scheme transcends efficiency, and precipitates disaster.

Most commonly, RACs overturn payments for inpatient coding when the RAC determines that the provider could have furnished appropriate care on an outpatient hospital basis.³⁴ In making these sorts of determinations, RACs are questioning the medical judgment of health care providers and denying claims for services that qualify for the most expensive reimbursements. Interestingly, RACs are paid based on the amount of reimbursements that they recover by reversing “improper” payments to providers,³⁵ incentivizing the contractors to maximize reversals, including legitimate claims. In a 2013 study by the American Hospital Association (AHA), hospitals reported that when they appealed RAC denials, they were overturned 72% of the time, and as of a March 30, 2015 survey, hospitals reported appealing 45% of all RAC denials.³⁶

Not surprisingly, many providers blame the RAC program for the surge of unprocessed appeals. Before the implementation of RACs in 2009, there were 35,831 appeals at the ALJ level.³⁷ In just four years, the number of appeals to ALJs has increased nearly tenfold, reaching 384,151 appeals in

33. *Senate Committee Urges CMS to Refine Audit Procedures to Prevent Improper Payments, Reduce Provider Burden*, NELSON MULLINS (Aug. 5, 2014), <http://www.nelsonmullins.com/newsletters/cms-urged-to-refine-audit-procedures>.

34. *CMS RAC Status Document: Status Report on the Use of Recovery Audit Contractors in the Medicare Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., at 12 (Feb. 2008), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/2007RACStatusDocument.pdf>. Afraid of being denied inpatient payments for short stays, hospitals often keep patients longer than necessary in order to guarantee reimbursement for the necessary outpatient services. *Render, supra* note 27. Consequently, outpatients sustain greater out-of-pocket costs than if they had been admitted as inpatients. *Id.* CMS has recently attempted to clarify inpatient coding standards by establishing the “Two-Midnight Rule,” which provides that when a physician anticipates the patient-stay to cross at least two midnights and admits the patient on such basis, then inpatient admissions is appropriate. *Id.*

35. *Senate Committee Urges CMS to Refine Audit Procedures to Prevent Improper Payments, Reduce Provider Burden*, *supra* note 33.

36. *Results of AHA RACTrac Survey, 1st Quarter 2013*, AM. HOSP. ASS’N RACTRAC, at 55 (June 1, 2013), <http://www.aha.org/content/13/13q1ractracresults.pdf>; *Results of AHA RACTrac Survey, 4th Quarter 2014*, AM. HOSP. ASS’N RACTRAC, at 33 (Mar. 30, 2015), <http://www.aha.org/content/15/14q4ractracresults.pdf> (stating that of the 88,705 completed appeals reported, 69% were overturned in favor of the provider). Similarly, in an April 2015 hearing before the U.S. Senate Finance Committee, Senator Hatch testified that at least 60 percent of appeals are found in favor of defendants, and questioned how initial decisions are being made and whether providers are facing undue burdens. Wachler & Associates, P.C., *Senate Finance Committee Examines Medicare Appeals Backlog*, WACHLER & ASSOC. HEALTH LAW BLOG (May 19, 2015), <http://www.wachlerblog.com/2015/05/senate-finance-committee-examines-medicare-appeals-backlog.html>.

37. *Important Notice Regarding Adjudication Timeframes*, Office of Medicare Hearings and Appeals, U.S. DEP’T HEALTH & HUMAN SERVS. (Apr. 29, 2015), http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.

2013.³⁸ The ALJs have not been able to keep up with this dense volume of appeals, dealing with a 300% increased workload from 2012 to 2013.³⁹ Of the 363,889 appeals filed in 2013, only 79,374 were actually decided.⁴⁰ The backlog appeared to worsen during the beginning of 2014, with OMHA receiving more than 15,000 appeals per week.⁴¹ Consequently, 800,000 claims remain stagnant at the ALJ level, as providers wait an average of 547 days to find out if they will be paid for services already rendered to Medicare beneficiaries.⁴² The total value of the RAC-denied claims languishing at this level remains well over \$1 billion,⁴³ which includes individual providers with payments up to \$200 million locked-up in the process.⁴⁴

This delay within the four-step administrative appeals process is postponing medical provider's appeal adjudications years beyond the timeframe prescribed by Congress. While the ALJs' overall productivity more than doubled from 2009 to 2013,⁴⁵ the volume of the increased workload seriously defeated OMHA's capacity to timely adjudicate incoming appeals. As of July 2014, it took an average of 489 days for an ALJ to issue a decision.⁴⁶ Not only does such delay plainly violate the statutes, but it also contradicts the very purpose of the Medicare appeals

38. *Id.*

39. *Medicare Appellant Forum*, OFFICE OF MEDICARE HEARINGS AND APPEALS, at 9 (Feb. 12, 2014), http://www.hhs.gov/omha/omha_medicare_appellant_forum.html. See also Rich Marotti, *A Report and Analysis on the OMHA Medicare Appellant Forum and the Suspension of ALJ Hearings for Medicare Providers* (Feb. 12, 2014), http://www.americanbar.org/publications/aba_health_resource/2013-14/april/omha_medicare.html.

40. *Medicare Appellant Forum*, *supra* note 39.

41. *Id.* As of February 2014, OMHA received more than 15,000 appeals per week, totaling 377,900 appeals. *Id.* Only 87,266 were decided at that time. *Id.* Of note, sources have reported a span of twenty to twenty-four weeks before OMHA entered new appeals onto its docket, prompting a notice to claimants stating: "If 22 weeks have not lapsed since you submitted your Request for Hearing, do not resubmit your request." Moeller, *supra* note 6.

42. *Office of Medicare Hearings and Appeals Workloads: Hearing Before the United States H. Comm. on Oversight & Gov't Reform, Subcomm. on Energy Policy, Health Care & Entitlements*, 113th Cong. 3 (2014) (statement of Chief Judge Nancy J. Griswold) [hereinafter *Griswold Statement*], <http://oversight.house.gov/wp-content/uploads/2014/07/CMS-Griswold-OMHA-Final.pdf> (reporting over 800,000 unprocessed appeals as of July 1, 2014.) [<http://perma.cc/B48Z-PBVG>]; James Swann, *Medicare Appeals Backlog Could Be Reduced by Restructuring Process*, *Senator Says*, BLOOMBERG BNA (Apr. 29, 2015), <http://www.bna.com/medicare-appeals-backlog-n17179925933/>.

43. *Results of AHA RACTrac Survey, 4th Quarter 2014*, *supra* note 36, at 20.

44. *Senate Committee Urges CMS to Refine Audit Procedures to Prevent Improper Payments, Reduce Provider Burden*, *supra* note 33.

45. *Griswold Statement*, *supra* note 42.

46. Hettich, *supra* note 19.

process.⁴⁷ Without proper adjudications, hospitals cannot recover the Medicare reimbursement to which they are entitled for claims that were improperly denied.

C. *Effect of the Current Moratorium*

In December 2013, OMHA announced a temporary moratorium, suspending the assignment of most new provider requests for an ALJ hearing.⁴⁸ During the anticipated two-year-suspension,⁴⁹ OMHA stated that it intends to work through the backlog of 357,000 claims that were previously assigned to the sixty-five ALJs.⁵⁰ Once the moratorium is lifted, providers will still have to wait for the actual hearing and rendering of an ALJ decision on their claims.⁵¹ For providers, this means they must repay charges that were initially reimbursed by Medicare, knowing their appeal will not be decided at the ALJ level for as long as five years. Because Medicare beneficiaries make up 16% of the population, and 40% of those beneficiaries are living with three or more chronic conditions, such delay is devastating to hospitals that seriously rely on this Medicare reimbursement.⁵² As of June 2015, the moratorium has only further polluted the backlog with over 870,000 pending appeals, depriving hospitals of funds, and leaving them deeply out-of-pocket for services already rendered to their

47. Letter from Donald May, Exec. Vice President of Payment & Healthcare Delivery Policy, AdvaMed, to Kathleen Sebelius Secretary, Dep't of Health & Human Servs., and Marilyn Tavenner, Administrator of CMS, at 1 (Mar. 27, 2014), <http://advamed.org/res/472/office-of-medicare-hearing-and-appeals-decision-to-suspend-assignment-of-new-request-for-administrative-law-judge-hearings-for-adjudication-of-appeals>. OMHA delays alone have far exceeded the total compliance time prescribed for all five levels of review. Moeller, *supra* note 6.

48. Debra A. McCurdy, *Medicare Appeals Backlog Prompts Hold on New Provider Appeals*, HEALTH INDUS. WASH. WATCH, (Jan. 27, 2014), <http://www.healthindustrywashingtonwatch.com/2014/01/articles/other-hhs-developments/medicare-appeals-backlog-prompts-hold-on-new-provider-appeals/>.

49. *Lessler Complaint*, *supra* note 19, at 17 (“[W]ith the current backlog we do not expect general assignments to resume for at least 24 months”).

50. Memorandum from Nancy Griswold, Chief Administrative Law Judge, Dept. of Health & Human Servs., to OMHA Medicare Appellants, at 1 (Dec. 24, 2013), http://www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/letter_to_medicare_appellants_from_the_calj.pdf [hereinafter Griswold, *Moratorium Memorandum*].

51. Complaint for Declaratory, Injunctive, and Mandamus Relief at 3, *Baxter Reg. Hosp. et al. v. Sebelius*, No. 14-cv-851 (D.D.C. filed May 22, 2014), <http://www.aha.org/content/14/140522complaint-appeals.pdf> [hereinafter *Baxter Complaint*].

52. Megan Multack & Claire Noel-Miller, *Who Relies on Medicare? Profile of the Medicare Population*, AARP PUB. POL. INST., (Jan. 2014), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2014/who-relies-on-medicare-fact-sheet-2014-AARP-ppi-health.pdf. For example, even a single “health system/appellant may comprise more than 100 hospitals.” Steven Greenspan, *Frequent Filers: Scapegoats for the Appeals Backlog?*, RAC MONITOR (June 17, 2015), <http://www.racmonitor.com/rac-enews/1846-frequent-filers-scapegoats-for-the-appeals-backlog.html>.

patients.⁵³ Smaller providers may face bankruptcy, while larger providers will experience disruptions to cash flow.⁵⁴ Overall, the appeals backlog is obstructing funds that should be dedicated to sustaining the hospital infrastructure necessary to provide quality patient care.

Providers are outraged by the backlog and moratorium. Ninety-eight organizations sent a letter to Chief ALJ Nancy Griswold “urg[ing] OMHA to develop a comprehensive solution to the Medicare appeal backlog problem” because “the numerous appeals requirements, actual costs of filing appeals and often lengthy delays undermine the ability of physicians to deliver patient-centered care.”⁵⁵ Health care professionals expressed concerns that the moratorium is creating harm for both patients and providers, and only “perpetuates the backlog that eliminates the statutory schedule of appeal reviews.”⁵⁶ One hundred eleven members of Congress signed a letter issued to Secretary Sebelius, asking her to consider dedicating additional resources to help resolve the backlog and to implement reforms, such as restructuring the RAC process and providing more transparent mechanisms of informing providers of errors so that they can be avoided in the future.⁵⁷

D. Recent Litigation

The moratorium has also prompted several high-profile lawsuits, including a federal class action suit filed by the Center for Medicare Advocacy (CMA) on behalf of five Medicare beneficiaries, requesting a court order requiring the Secretary of HHS to clear the massive backlog of ALJ appeals.⁵⁸ Similarly, the AHA filed suit against the Secretary of HHS in federal district court, seeking a writ of mandamus ordering the secretary to process their administrative appeals in accordance with statutory deadlines.⁵⁹ One plaintiff stated that Medicare accounts for 55% of its gross

53. Greenspan, *supra* note 52; *see, e.g.*, *Am. Hosp. Ass’n v. Burwell*, 76 F.Supp.3d 43 (D.D.C. 2014).

54. Marotti, *supra* note 39.

55. Letter from the American Medical Ass’n et al., to Nancy Griswold, Chief ALJ, Office of Medicare Hearings & Appeals (Feb. 12, 2014), <http://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-HHS-MedicareAppealsBacklog-021214.pdf>.

56. Letter from Donald May, *supra* note 47.

57. Marotti, *supra* note 39.

58. Hettich, *supra* note 19; *Lessler Complaint*, *supra* note 19, at 2. On behalf of themselves and the nationwide class of other Medicare beneficiaries harmed by the backlog, plaintiffs challenged the administrative review process as a violation of the Medicare statute and the Due Process Clause of the Fifth Amendment. *Id.*

59. *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43, 45 (D.D.C. 2014).

revenue, leaving \$7.6 million worth of appeals pending in the appeals process—\$6.6 million of which at the ALJ level.⁶⁰ Another plaintiff, Baxter Regional Medical Center, claimed that it has so much tied up in the appeals process that it cannot afford to replace a failing roof over its surgery department, purchase new beds for its intensive care unit, engage in basic upkeep of its facilities, or purchase necessary capital items.⁶¹ Furthermore, as a result of the delays, some rehabilitation facilities have been “‘forced to avoid admitting certain types of patients’ . . . due to uncertainty about timely reimbursement.”⁶² Plaintiffs contend that because of the nexus between these economic consequences and basic human welfare, it is crucial that HHS promptly find a solution to reduce the backlog.⁶³

Under the rationale of *In re Barr Labs., Inc.*,⁶⁴ the court recently dismissed AHA’s summary judgment motion on jurisdictional grounds, stating, “while [the] Court sympathizes with Plaintiffs’ plight, for the time being the waiting game must go on.”⁶⁵ In light of HHS’s higher and competing priorities,⁶⁶ the D.C. Circuit found that HHS’s delay in processing administrative appeals was far from ideal, but not so egregious to warrant intervention and therefore the court lacked proper subject matter jurisdiction.⁶⁷ Because Congress is well aware of the problem, and Congress and the Secretary are the proper agents to resolve it, the court declined the invitation for judicial intervention, characterizing such as either an “empty

60. Complaint at 5, *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43 (D.D.C. 2014) (No. 14 Civ. 851), 2014 WL 2532049 [hereinafter *AMA Complaint*].

61. *Id.* at 4.

62. *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43, 52 (D.D.C. 2014).

63. AHA argued that the ultimate consequences for health services and facilities “weigh[] in favor of compelling agency action based on unreasonable delay.” See *Muwekma Tribe v. Babbit*, 133 F. Supp. 2d 30, 39 (D.D.C. 2001); *Air Line Pilots Ass’n v. Civil Aeronautics Bd.*, 750 F.2d 81, 86 (D.C. Cir. 1984) (determining that the “consequences of non-intervention” factor weighed in favor of relief when an agency failed to timely adjudicate claims for unemployment-assistance payments).

64. *In re Barr Labs. Inc.*, 930 F.2d 72, 75 (D.C. Cir. 1991) (rejecting a petition for mandamus against the Food and Drug Administration for immediate resolution of generic drug applications after the FDA consistently violated statutory deadlines by almost 500 days, resulting in fewer resources for other aspects of health care). *Barr Labs* found that the court had no basis for “reordering agency priorities,” and that “[t]he agency is in a unique – and authoritative – position to view its projects as a whole, estimate the prospects for each, and allocate its resources in the optimal way.” *Id.* at 76. “Such budget flexibility as Congress has allowed the agency is not for [the Court] to hijack.” *Id.*

65. *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43, 45 (D.D.C. 2014).

66. *Id.* at 51-53. “Competing priorities” is merely one of the six non-dispositive factors from *Telecomms. Research & Action Ctr. v. FCC*, 750 F.2d 70, 79 (D.C. Cir. 1984). *Id.* Evaluating the totality of the circumstances in this case, the court also weighed other *TRAC* factors including: (1) failure to comply with statutory deadlines, (2) consequences of non-intervention, and (3) bad faith. *Id.*

67. *Id.* at 45.

gesture” or “judicial overstepping.”⁶⁸ However, the court left open the possibility that the case later shift in the plaintiff’s favor, should HHS and Congress fail to adequately address the overflow of appeals.⁶⁹

E. Lack of Alternative Remedies

The D.C. Circuit’s recent refusal to grant the mandamus is certainly a temporary relief to HHS, but the cautionary closing remarks of the judge still places pressure on HHS to swiftly implement changes. And furthermore, the *Burwell* plaintiffs are considering appealing the dismissal.⁷⁰ This leaves us all, including HHS, wondering, what now? Chief ALJ Griswold has conceded that the wait times for ALJ hearings are unacceptable,⁷¹ however providers have not been offered a comprehensive solution.

Although appellants have the right to escalate their claims to a MAC if the ALJ does not meet the ninety-day requirement, like OMHA, MAC is not meeting its statutory deadline for making decisions.⁷² CMS itself warned providers that, “escalating would deprive the appellant of an oral hearing . . . cause the forfeiture of the ninety-day deadline for the MAC’s decision-making, and . . . result in a less well developed record.”⁷³ Essentially, OMHA is aware that such is not a viable option for providers. It is not surprising that very few providers are opting for this escalation option—as exemplified by the mere nineteen escalations that MACs received from OMHA in fiscal year 2014.⁷⁴

In response to the federal court alternative, providers contend that escalating their claims to federal court is both costly and disadvantageous because the court would only have access to the limited record and determination by the QIC or the MAC without an unbiased, independent ALJ’s finding of fact and conclusions of law.⁷⁵ In addition to an

68. *Id.* at 55.

69. *Id.* at 56.

70. Ayla Ellison, *Court Dismisses AHA’s Case Over Rejected Inpatient Payments*, BECKER’S HOSP. CFO, (Sept. 18 2014), <http://www.beckershospitalreview.com/finance/court-dismisses-aha-s-case-over-rejected-inpatient-payments.html>.

71. *AMA Complaint*, *supra* note 60, at 12.

72. *Lessler Complaint*, *supra* note 19, at 18; Medicare Appellant Forum, *supra* note 34. Like OMHA, the MAC is “unlikely to meet the ninety-day deadline for issuing decisions in most appeals.” *Id.*

73. Hettich, *supra* note 19.

74. *Lessler Complaint*, *supra* note 19, at 18-19 (calculating the 2014 fiscal year through February 2014).

75. *AMA Complaint*, *supra* note 60, at 10.

undeveloped record, “hospitals must weigh the cost of federal court litigation against the total possible recovery,”⁷⁶ which when considering the low amount in controversy requirements, expected recovery can be minimal. In many cases hospitals would pay more to litigate their case than they could even recover from the Medicare claims.⁷⁷ Even if some appellants were willing to sacrifice their right to an ALJ hearing by escalating to a MAC or federal courts, “escalation was not intended to be and could not be a wholesale solution for thousands of appellants.”⁷⁸

So what kind of solution exists, if any? Funded through its own appropriation,⁷⁹ HHS remains under tight budgetary constraints and competing priorities. At this time it lacks the adequate resources to redeem the necessary momentum to handle the mass production of appeals. As a step in the right direction, OMHA and HHS established a departmental interagency workgroup comprised of leaders from CMS, OMHA, and DAB to conduct a thorough review of the appeals process and develop initiatives that OMHA and CMS can employ to streamline the appeals process.⁸⁰ In a Request for Information, OMHA also sought public-input regarding its initiatives to reduce pending appeals and requests for hearings at the ALJ level, as well as “suggestions for additional initiatives which could be undertaken at OMHA to address the appeals workload.”⁸¹ Though not a “cure-all” solution to the appeal disaster, one non-traditional forum—alternative dispute resolution—stands out as an innovative approach to addressing the backlog while attending to the concerns of the providers.

II. INTEGRATING MEDIATION IN RESPONSE TO THE BACKLOG

The initial levels of the appeal-review process are designed as a power-based conflict resolution method where parties are simply awarded or denied reimbursement through the unilateral decision of the reviewer. Distinguishably, alternative dispute resolution—and particularly mediation—promotes effective communication of the party’s positions and

76. *Id.* at 16.

77. *Id.*

78. *Lessler Complaint*, *supra* note 19, at 18.

79. *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43, 54 (D.D.C. 2014).

80. *Griswold Statement*, *supra* note 42. OMHA reported 800,000 unprocessed appeals as of July 1, 2014. *Id.* The departmental interagency initiatives are discussed in Part II(C) of this article. *See infra*.

81. Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim Appeals, 79 Fed. Reg. 214, 65661 (Nov. 5, 2014). OMHA submitted a request for information issued in the November 5, 2014 Federal Register. *Id.*

encourages settlement negotiations through a more collaborative lens.⁸² Providers are currently employing a more distributive approach, focusing primarily on financial alternatives to rectify the appeals situation. For example, the plaintiffs in *Burwell* contend that the Secretary of HHS could avail herself of funds within HHS to hire more ALJs, seek greater appropriations for OMHA, terminate the RAC program, or simply “reprogram” funds.⁸³ Instead, providers should be capitalizing on alternative dispute resolution as a more promising, integrative approach, which if applied in conjunction with other structural changes, could ease the current dilemma and support a more feasible appeals process for the future.

Although in terms of success rate, arbitration is considered 100% successful, surveys reveal an actual success rate⁸⁴ of about 80%.⁸⁵ In the instant case, OMHA would be asking parties to agree to accommodations due to the dysfunctions of the Medicare appeal system—a system with setbacks beyond the control of providers. Modifying an established, yet faulty, appeals process and forcing providers into a different binding, non-collaborative decision would be an arbitrary exercise of Medicare’s power. Thus, under the particular circumstances of the backlog, arbitration is not the best forum, and OMHA should focus on integrating mediation as the primary conflict-resolution method.

A. *Advantages of Mediation*

There are several distinctive advantages of mediation that, if properly implemented, could offer remedies to providers stranded at the ALJ level. For one, merely as a matter of system design, a non-stakeholder brings confidence in the mediation process itself because, unlike the MAC representatives or the QIC that usually oversees the appeals, the neutral mediator is neither an employee of OMHA nor a designated provider-representative.⁸⁶ Rather, a trained and disinterested third-party typically assists in the mediation’s communication process, which allows the parties to more effectively understand the controversies and come to an agreement

82. R. Wayne Thorpe, *Effective Use of Mediation and Arbitration in Health Care Disputes*, BLOOMBERG L. REP. (2011), <http://www.jamsadr.com/files/Uploads/Documents/Articles/Thorpe-Healthcare-Disputes-Bloomberg-2011.pdf>.

83. *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43, 54 (D.D.C. 2014).

84. Referring to the satisfaction of both parties.

85. Garylee Cox, *The Appropriate Arena for ADA Disputes: Arbitration or Mediation?*, J. C.R. & ECON. DEV. 591, 594 (1995).

86. Phyllis E. Bernard, *Mediating with an 800-Pound Gorilla: Medicare and ADR*, 60 WASH. & LEE L. REV. 1417, 1421 (2003) [hereinafter Bernard, *Medicare and ADR*].

through their respective self-determinations. Because mediation would integrate providers directly into the process, it may empower providers to more readily reach a result. Unlike a typical black-and-white written appeal where providers are simply given a brief reason why the claim was or was not overturned, mediation tends to lead to settlements that all parties are genuinely, and lastingly at peace with, much because they were a part of both the process and the outcome.⁸⁷ By opening dialogue between providers and OMHA representatives, the parties could identify shared values, acknowledge the relative strengths and weaknesses of their positions, and clarify poorly managed expectations so that future services can be adapted to meet the underlying needs of both parties. Mediation would engage OMHA in conversations directly with providers, encouraging representatives to actually listen to providers' current practices, challenges, and concerns. This may also provide helpful instruction to parties, particularly those who submit large amounts of Medicare claims, because it may offer a more holistic understanding of how to handle multiple appeals and mitigate similar types of disputes with future claims. This is especially important to providers because their post-backlog claims continue to pool while they await the adjudication process. In time, OMHA and providers would save the resources and time it currently spends entertaining denied claims, and instead preserve such costs for future claims through the more informed knowledge gained by the mediation process.

In regards to efficiency, a mediator can facilitate swift resolution at materially reduced costs and with a greater finality than disputes in the judicial or appeal-review systems.⁸⁸ Some parties believe the informality of mediation, namely the absence of procedural and evidentiary rules, promotes candid communication and problem solving that leads to efficiency.⁸⁹ Though some describe health care mediation as "labor-intensive" and "burdensome" for both parties,⁹⁰ fighting multiple appeals or simply waiting years for a claim to be addressed is far more oppressive. Considering the circumstances, providers with a more urgent need for a remedy should at least have an option to monitor and address their claims until the ALJs can regain control over their dockets. Because of the limited number of ALJs

87. Dan Simon, *5 Reasons It's Hard for Mediators to Support Self-Determination*, INST. FOR THE STUDY OF CONFLICT TRANSFORMATION (Nov. 10, 2014), <http://www.transformativemediation.org/2014/11/10/5-reasons-hard-mediators-support-self-determination/>. Active participation in both the process and outcome separates mediation from other forms of conflict resolution. For example, "[i]n mediation, the mediator controls the process, the parties control the outcome. In arbitration, the parties control the design of the process and the arbitrator controls the outcome. In litigation, the court controls both the process and the outcome." Cox, *supra* note 85, at 594.

88. Thorpe, *supra* note 82.

89. Bernard, *Medicare and ADR*, *supra* note 86, at 1431.

90. *Id.* at 1432.

available to resolve the magnitude of stagnant claims, this alternative dispute resolution option would allow providers to appeal certain Medicare claims decisions in a timely manner, and would successfully alleviate the workload of ALJs. Additionally, a mediation settlement is typically memorialized into a binding contract that is enforceable in court under traditional contract law principles.⁹¹ If the parties reach a settlement, the finality of the mediation agreements would reduce the need to resort to ALJ, DAB, QIC, and federal court escalation, and thus reduce the exorbitant volume of appeals at those levels.

Fortunately, the positions and circumstances surrounding this backlog make appellants and OMHA optimal adversaries for employing this alternative dispute resolution method. Mediation works best “when providers are sophisticated, institutional entities with legal representation present at the negotiations, principles of law are not central to resolving the dispute, perceptions of facts are more important than the law, and personal credibility and trustworthiness are essential to the use of a flexible approach in resolving the dispute.”⁹² Here, the providers most affected by the backlog consist of institutionalized hospitals and health agencies that are likely to present competent legal representation at mediation. Medicare appeals can be driven by the factual details surrounding a hospital’s perception of the service versus Medicare’s perception of its necessity. Thus, these circumstantial types of appeals are well suited for mediation. In addition, providers are more likely to trust the attending OMHA representative if presented the opportunity to discuss the party’s adverse positions and come to a mutual the appeals process,⁹³ and although many would prefer to interact directly with ALJ’s, considering the circumstances, a qualified mediator may still be an attractive option for providers who wish to have an opportunity for that real-time dialogue and accelerated results.

B. Potential Mediation Program Structure

OMHA could reconfigure the appeals process to include alternative dispute resolution in a variety of ways, however it is still wise to preserve the overall appellate body. It is important to note that mediation is merely a suggestion for easing the number of appeals, and it should be combined with concurrent efforts to reconfigure the process—perhaps most importantly, in

91. Edna Sussman & Conna A. Weiner, *Striving for a “Bulletproof” Mediation Settlement Agreement*, 33 ALTERNATIVES TO HIGH COST LITIG. 49, 60 (April 2015).

92. Bernard, *Medicare and ADR*, *supra* note 86, at 1438.

93. Lerman, *supra* note 25.

conjunction with RAC-program changes.⁹⁴ That being said, mediation would prove to be a powerful tool for both OMHA and providers.

One option, as discussed above, would be for OMHA to adopt a completely voluntary method of readdressing denied claims, where providers would enter the mediation entirely at their sole discretion. Although this model would guarantee that parties are committed and likely to reach a settlement, it would be difficult for OMHA to recruit a significant number of appellants willing to voluntarily enter, and thus this model would only make a small dent in the massive backlog. In the alternative, OMHA could place dollar limits mandating alternative dispute resolution, at least at some level. Many health care professionals seem to believe that matters of \$50,000 or less are most likely to be negotiated since it is difficult to justify pursuing disputes of that size in light of the high cost of case-preparation and federal court litigation.⁹⁵ Generally, people are most likely to settle cases “when larger dollar amounts are at stake and there is room for both sides to give something and still leave the negotiations satisfied with what they take.”⁹⁶ This feature is unique to mediation because, in a standard Medicare appeal, one party leaves satisfied and the other the “loser.” By mandating mediation among a significant number of claims, OMHA could ensure that neither side of the dispute is viewed as “weaker” for accepting mediation over pursuing litigation or weathering the ALJ delay. Instilling this power balance would hopefully ease compliance among parties and positively impact the backlog. It is also important to note that “mandating” mediation at some level does not force parties into an agreement; rather it forces parties into a *conversation* about an agreement. With that in mind, it would be important that both voluntary and mandated parties to a mediation maintain their position at the ALJ level so that they can enter mediation without coercion or pressure.

C. OMHA's Pilot Program

OMHA apparently agrees that mediation may be the predominant solution to the delays, recently announcing its plans to launch a mediation pilot program of its own.⁹⁷ Providers were pleased to hear that OMHA is in

94. Potential RAC-program changes include: curtailing the number of RACs, modifying how the RACs are paid, creating disincentives for overturned claims later reversed on appeal, requiring providers to pay a fee for each claim appealed to discourage non-meritorious appeals, and transitioning to electronic submission of documents.

95. Phyllis E. Bernard, *Empowering the Provider: A Better Way to Resolve Medicare Hospital Payment Disputes*, 49 ADMIN. L. REV. 269, 340 (Jan. 1997), available at http://works.bepress.com/cgi/viewcontent.cgi?article=1018&context=phyllis_bernard [hereinafter Bernard, *Empowering the Provider*].

96. *Id.* at 340.

97. Lerman, *supra* note 25 (stating that the pilots launched in July 2014).

the process of developing programs to help combat the appeals workload, one of which being the “facilitated settlement conference” conducted by OMHA attorneys who have been trained in dispute resolution techniques.⁹⁸ The facilitated settlement conference is basically a mediation confined to particular terms and conditions created by OMHA, but generally, it follows a mediation model.⁹⁹ The conference is offered to providers with at least twenty Medicare Part B appeals filed in 2013 that are still awaiting an ALJ assignment, or with a value of services totaling at least \$10,000.¹⁰⁰ In order to request a settlement conference, providers must include all the same types of claims at the ALJ level.¹⁰¹

Just as a mediator would serve as a neutral third-party, the facilitator in the proposed conference facilitation would not make official determinations on the merits of a claim at issue, nor would they serve as a fact-finder, like an ALJ would.¹⁰² The settlement conference program sets forth a standard voluntary agreement, where a facilitator will draft a settlement document reflecting the agreement, and the appellant and CMS sign the document during the conference session.¹⁰³ The program specifies that by reaching a settlement agreement, an appellant’s request for an ALJ hearing is then dismissed.¹⁰⁴ And if the mediation does not lead to a mutually agreeable

98. Statement by Nancy J. Griswold, *supra* note 42. A “Statistical Sampling Initiative” is also being offered as part of the pilot program, which consists of using statistical sampling to draw a random sample of claims and extrapolating the sample results to that large volume of claim disputes at the ALJ level. Jessica Gustafson & Abby Pendleton, *(Partial) Relief in Sight: CMS Proposes Settlement of Pending Inpatient Hospital “Status” Appeals*, AMERICANBAR.ORG (Oct. 2014), http://www.americanbar.org/publications/aba_health_resource/2014-2015/october/partial.html. CMS has also agreed to pay any hospital that withdraws pending appeals a partial payment (68%) of the net allowable amount. *Id.*

99. *Settlement Conference Facilitation*, U.S. DEPT. OF HEALTH & HUMAN SERVS., http://www.hhs.gov/omha/OMHA%20Settlement%20Conference%20Facilitation/settlement_conference_facilitation.html (last visited Nov. 15, 2015) (“The settlement conference facilitator uses mediation principles to assist the appellant and CMS in working toward a mutually agreeable resolution.”) *Id.*

100. Steven Meyerson, *HHS Pilots Alternatives to Medicare Appeals Bottleneck*, ACCRETIVE HEALTH BLOG, (Aug. 5, 2014), <http://accretivehealth.com/hhs-pilots-alternatives-to-medicare-appeals-bottleneck/>.

101. *Id.*

102. Debra McCurdy, *HHS “Settlement Conference Facilitation” Pilot Provides Alternative to ALJ Hearing*, HEALTH INDUS. WASH. WATCH (July 25, 2014), <http://www.healthindustrywashingtonwatch.com/2014/07/articles/other-health-policy-developments/other-hhs-developments/hhs-settlement-conference-facilitation-pilot-provides-alternative-to-alj-hearing>.

103. *Id.*

104. Chuck Buck, *Mixed Reviews Greet Settlement Conference Facilitation Pilot*, RAC MONITOR (July 17, 2014), <http://racmonitor.com/rac-ews/1697-mixed-reviews-greet-settlement-conference-facilitation-pilot.html>.

resolution during the conference, then the claims are placed back into the ALJ assignment waitlist in the same position that it was originally placed.¹⁰⁵ Chief ALJ Nancy Griswold stated that “OMHA will be monitoring the performance of th[e] pilots and, if successful, will roll them out nationally as funding allows.”¹⁰⁶

But so far, OMHA is seeing underwhelming participation and success in the program. In a 2014 survey, only 2% of respondents eligible for one of the pilot programs planned to participate, 7% firmly did not plan to use it at all, and 50% were undecided.¹⁰⁷ In a subsequent follow-up poll, 3% of eligible respondents reported that they planned to use the pilots, while 16% did not wish to take advantage of the alternative.¹⁰⁸ So what is it about the conference’s design that is troubling providers?

D. Challenges of the Proposed Pilot Program

Unfortunately for OMHA, most providers are not taking advantage of the facilitated settlement conference alternative for a variety of reasons. First, by the program’s own terms, many providers remain excluded from participating—and stunted participation raises skepticism about the impact-potential of implementing this form of mediation. As the program stands now, the proposed settlement conference is limited to such a small subset of appeals, mainly Medicare Part B claims appealed at the ALJ level,¹⁰⁹ but not hospitals’ inpatient medical necessity claims.¹¹⁰ Medicare Part A, C, D, and several other types of appeals are simply not eligible for the process.¹¹¹ Furthermore, providers are discouraged by the extensive requirements that at least twenty claims or \$10,000 worth of appeals must be pending assignment to an ALJ, or if fewer, each individual claim is less than \$100,000.¹¹² In addition to the types of Medicare claims accepted, these requirements preclude an even larger volume of providers from participating in the process. As a result, the program lacks the force to have an immediate or drastic impact on the backlog.

It is also fair that providers question whether OMHA’s resources will allow it to process their requests for participation in the program in a timely

105. Lerman, *supra* note 25.

106. *Griswold Statement*, *supra* note 42.

107. Meyerson, *supra* note 100.

108. *Id.*

109. *Inside CMS: OMHA Mediation Pilot Puts CMS, Part B Providers Together To Resolve Appeals*, INSIDE HEALTH POL’Y (July 11, 2014), <http://medicareintegrity.org/inside-cms-omha-mediation-pilot-puts-cms-part-b-providers-together-to-resolve-appeals>.

110. *Id.*

111. *Id.*

112. Meyerson, *supra* note 100; Buck, *supra* note 104.

and accurate manner given their preoccupation with the current claims in the appellate process. If participants agree to save OMHA administrative costs and essentially shift responsibility back to providers, then in return, providers are going to expect faster progress than that of a standard appeal. As discussed above, parties engaging in mediation are looking for swift resolution at materially-reduced costs and with greater finality—and the facilitated settlement conference is no exception.

Moreover, the proposed pilot program states that the settlement conference facilitator will be an employee of OMHA,¹¹³ which although a separate agency from CMS, is a component of the HHS Office of the Secretary. In mediation, it is essential that safeguards protect the neutrality of the alternative dispute resolution intervention.¹¹⁴ But here, the closely related interests of the mediator (or in this case, the “facilitator”) and their employer likely raise provider-concerns regarding conflicts of interest and whether providers will actually be heard in the conference. The impartiality of the mediator is a crucial element of mediation, setting the non-adversarial tone for the discussion and empowering the parties to trust in the process. Without a neutral third-party, the process is broken by perceived power imbalances and a lack of autonomy. And without equal footing, coercion may infiltrate the structure of the mediation.¹¹⁵ One alternative dispute resolution critic warns that in these types of negotiations, “consent is often coerced; . . . although dockets may be trimmed, justice may not be done.”¹¹⁶ Though caustic, it is plausible that by employing OMHA’s own attorneys to mediate the conferences, these negotiations may dupe providers into settling for inequitable compromises.¹¹⁷

This power imbalance is only heightened by the likelihood that most providers voluntarily engaging in the conference are doing so because they are financially pressed. In the context of this mediation setting, they are considered the “poorer party.” A poorer party may be induced to

113. Meyerson, *supra* note 100.

114. *Impartiality in Mediation*, THE MEDIATION PRAC. (May 1, 2014), <http://www.mediationpractice.ie/resources/item/impartiality-in-mediation>.

115. Bernard, *Medicare and ADR*, *supra* note 95, at 1428.

116. *Id.*

117. Perhaps it would be best to appoint a neutral third-party with a comprehensive understanding of the technicalities of the appeal. For example, Thomas Naughton, a QIC, suggested that the appeals backlog could be reduced by establishing a support unit for ALJs capable of providing expertise on RAC audits, utilizing subject matter experts like nurses, physicians and certified coding specialists to help resolve disputes. James Swann, *Medicare Appeals Backlog Could Be Reduced by Restructuring Process, Senator Says*, BLOOMBERG BNA (Apr. 29, 2015), <http://www.bna.com/medicare-appeals-backlog-n17179925933/>.

expeditiously settle notwithstanding a belief that they are receiving less now than if they awaited actual judgment on the appeal.¹¹⁸ Additionally, the poorer party may be forced to settle simply because they do not have the resources¹¹⁹ to allocate towards waiting-out the backlog or financing litigation, particularly when the value of the appeal is limited.

OMHA's settlement conference specifies that in choosing to enter settlement with CMS, the provider must give-up all future appeal rights.¹²⁰ Because multiple claims for the same service are required to be held at a group hearing,¹²¹ providers are placed at a serious disadvantage. In other words, the provider must bundle all like-services together and mediate every one of those claims in the aggregate—so either “win big or lose big.”¹²² Considering the latent power imbalance discussed above, if a provider chooses this settlement conference option and settles for a loss on the group of claims, even if coerced, they forfeit all future appeal rights on every claim contained within the group—which is never a good move.¹²³

Luckily for OMHA, all of the aforementioned faults can be recast in terms of procedural technicalities and design. However, OMHA still faces enveloping challenges in applying mediation to this appeals setting. It will be difficult to streamline settlement decisions across such a diverse range of claims, parties, and mediators. Particularly because these mediations are not adjudicated by a specialized and neutral ALJ, parties need assurance that the facilitated settlement conference will carry substantial predictability and uniformity. The institutionalized mediation scheme must allow providers to reasonably rely on its predictability so that they can make realistic plans in their best interest.

IV. CONCLUSION

On a macro-scale, the backlog has strained providers by depriving them of the funds that supplement their ability to provide quality patient services. With the rise of baby-boomers reaching Medicare-qualification age and increased Medicare access via Social Securities Disability Insurance, the

118. Bernard, *Medicare and ADR*, *supra* note 95, at 1429.

119. *Id.*

120. Buck, *supra* note 104.

121. Andrew B. Wachler et al., *Recently Unveiled Pilot Programs Provide Alternative Methods for Resolving Medicare Claim Appeals*, AM. BAR ASS'N HEALTH ESOURCE (Aug. 2014) http://www.americanbar.org/publications/aba_health_esource/2013-14/august/pilot_programs.html. “[T]he Settlement Conference Facilitation request must include all of the provider’s eligible claims for the same item or service regardless of whether the claims were included in separate ALJ hearing requests (i.e., providers may not submit a [Settlement Conference Facilitation] request for some eligible claims and proceed to the ALJ hearing for the remaining eligible claims).” *Id.*

122. Buck, *supra* note 104.

123. *Id.*

upturn in appeals is unlikely to wane any time soon. OMHA's budget was increased from \$69 million to \$82.3 million over the past 2014-2015 fiscal year.¹²⁴ In the U.S. Senate Finance Committee's April 2015 hearing to address the Medicare appeal backlog, ALJ Nancy Griswold claimed that the boost in resources was still not enough.¹²⁵ On February 2, 2015, President Obama released his fiscal year 2016 budget proposal, which proposed to award over \$1 trillion to HHS¹²⁶ and increase OMHA's budget by \$300 million¹²⁷ for the purpose of ensuring the Medicare program's integrity without placing undue burdens on providers.¹²⁸ This proposal would solicit exorbitant amounts of taxpayer dollars towards only a partial solution to the backlog, while holding a burden on providers to pursue a frustrating appeal process. Indeed, the funds would enable OMHA to hire a greater number of ALJs to handle the appeals.¹²⁹ However the circumstances require a far more comprehensive remedy than merely throwing \$1 trillion at the problem. Considering the economical value of mediation, these funds could instead be more effectively allocated to a modified version of OMHA's Facilitated Settlement Conference at only a fraction of the cost of bolstering the original program design. Perhaps even at the initial level of appeals, alternative dispute resolution could streamline access to subsequent appeal levels. OMHA should be employing mediation, not just money, to mitigate the disastrous number of stagnant appeals at the ALJ level, while leaving taxpayer funds to other health care and federal expenditures that lack such a pragmatic alternative.

The settlement conference at least invites providers to engage with OMHA in a non-binding, open environment, which is a comparable alternative to the live ALJ hearing so adored by providers. Although the pilot program is far from perfect, it is after all, a "pilot" project and can be subjected to modification or termination at any time. It is clear that providers are weary of the program as it stands now, however if OMHA modified the facilitated settlement conference to capitalize on some of the benefits of standard mediation practices, such as neutral third-party

124. *Senate Finance Committee Examines Medicare Appeals Backlog*, WACHLER & ASSOC. HEALTH L. BLOG (July 22, 2015), <http://www.wachlerblog.com/2015/05/senate-finance-committee-examines-medicare-appeals-backlog.html>.

125. *Id.*

126. The proposal designated over 85% of HHS's budget to CMS programs. Lauren Gennett & Allison Kassir, *Deducing Health Care Policy Priorities from 2016 Budget*, LAW360 (Feb. 18, 2015), http://www.kslaw.com/imageserver/KSPublic/library/publication/2015articles/2-18-15_Law360.pdf.

127. Wachler, *supra* at 124.

128. Gennett, *supra* note 126.

129. *Id.*

mediators, mandated assignments, and broadened inclusion of additional Medicare claims, mediation could be just the dose of medicine the appeals crisis needs.