

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 29, 2016

Submitted electronically: <http://www.regulations.gov>

Office of Medicare Hearings and Appeals
Department of Health and Human Services
Attn: HHS-2015-49
5201 Leesburg Pike, Suite 1300
Falls Church, VA 22041

Re: HHS-2015-49

Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures

Justice in Aging appreciates the opportunity to provide a response to the above referenced Notice of Proposed Rulemaking (NPRM).

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

We are sympathetic to the burden placed on OMHA as a result of the dramatic increase of appeals it is now required to handle and we appreciate that OMHA has prioritized beneficiary appeals as it grapples with the increase. Further, we agree that updating procedural regulations is valuable and helpful. However, as advocates for low income beneficiaries, including many who attempt to use the appeals system without professional representation, we urge OMHA to avoid any actions that could negatively affect the due process rights of these beneficiaries.

We have reviewed and fully endorse the comprehensive comments submitted by the Center for Medicare Advocacy. Our additional comments, set forth below, address four sets of concerns:

- The need for plain language regulations;
- Changes that would erode beneficiary protections including proposed changes in regulations related to timeframes for issuing hearing decisions and changes to default options for hearings;
- The absence of any discussion in the preamble and any proposed regulations that address the language and disability access obligations of OMHA under Section 1557 of the Affordable Care Act; and
- The need for OMHA to work with CMS to address underlying causes of the overload of appeals, which include the dismal record of Medicare Advantage and Part D prescription drug plans in handling internal appeals and the consequences of CMS's misguided observation status policies.

I. Plain language regulations

We are disappointed that, at a time when OMHA has undertaken a major rewrite of its regulations, it has not attempted to revise the regulations into plain language. We ask that the agency consider making

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the change. All parts of HHS, and particularly OMHA and CMS, work directly with millions of consumers who need to understand their benefits and their rights. The Social Security Administration and the Internal Revenue Service, two agencies with similarly significant consumer interface, have undertaken major revisions of their regulations using plain language. The benefits, particularly in the context of appeals, are evident. See, for example, the regulations for appeals of Social Security disability claims found at 20 C.F.R. 301 et seq., which are much more accessible for unrepresented beneficiaries and, for that matter, for anyone needing to use the appeals process. We urge HHS and particularly CMS to undertake similar revisions throughout. Recognizing, however, that a complete revision is a major task, we propose that appeals regulations are a good place to start.

II. Changes that would erode beneficiary protections

We wish to highlight two areas, decision deadlines found at Sections 405.1016 and 423.2016 and rights to videoconference hearings found at Section 423.2020, that are of particular concern from the beneficiary perspective.

Section 405.1016: Timeframes for deciding an Appeal of a QIC or an escalated request for a QIC reconsideration

OMHA proposes to revise the regulation at 42 C.F.R. § 405.1016(a) to remove the word “must” from the provision establishing the timeframe for ALJ decisions. Currently, the regulation states that “the ALJ *must* issue a decision, dismissal order, or remand to the QIC, as appropriate, no later than the end of the 90 calendar day period beginning on the date the request for hearing is received.” 42 C.F.R. § 405.1016(a). CMS proposes to revise this to state that the “ALJ or attorney adjudicator *issues* a decision, dismissal order, or remand to the QIC, as appropriate, no later than the end of the 90 calendar day period beginning on the date the request for hearing is received . . .” 81 Fed. Reg. at 43,864. This proposal is contrary to the plain language of the statute and a recent decision by the D.C. Circuit Court of Appeals. See *American Hospital Assoc. v. Burwell*, 812 F.3d 183, 190 (Feb. 9, 2016). Any language change that would have the effect of weakening the statutory requirement must be avoided. Particularly for low income beneficiaries who have no way to access needed health care or prescription drugs, the right to a timely decision, guaranteed by statute, cannot be diluted in any way.

Section 423.2016: Timeframes for deciding an appeal of an IRE reconsideration

Similar to the proposed change in 405.1016, we strongly object to the proposal to remove the requirement that an ALJ or Attorney Adjudicator *must* issue a decision, dismissal, or remand to the IRE within the statutory timeframe. This change would be very detrimental to beneficiaries given the current state of the appeals system.

Section 423.2020: Default hearing options

While we appreciate that OMHA has retained videoconferencing as the default option for unrepresented beneficiaries, we strongly oppose the proposal to make phone hearings the default for hearings sought by all others, unless an ALJ finds good cause for a videoconference or in-person appearance. There is no reasonable justification for this change and it will create a significant reduction in due process. Phone hearings do not take appreciably less time than videoconference hearings and do not afford the same level of communication. When parties can see one another and exhibits, communication is far better.

Videoconferences can be particularly valuable in facilitating communication when advocates have limited familiarity with the OMHA appeals process. It is our experience that many advocates who take on Medicare appeals for low income beneficiaries, though they may have years of experience in appeals of Medicaid and other benefit programs, have few occasions where they handle a Medicare case. This is true as well when attorneys from the private bar handle a case. The improved give-and-take available in a videoconference should be the norm unless a beneficiary or beneficiary's representative affirmatively expresses an alternate preference.

III. Addressing OMHA compliance with civil rights laws

Although the introduction to the NPRM makes it clear that the regulatory changes proposed are in response to changes in circumstances at OMHA, one important change that is neither noted nor addressed is the recent publication by the HHS Office of Civil Rights (OCR) of final regulations laying out language and disability access obligations for all entities covered by Section 1557 of the Affordable Care Act. See 45 C.F.R. Part 92. Those entities include HHS and all its elements. 45 C.F.R. §92.4. We are concerned that, throughout the NPRM, there was no discussion of how the OMHA intends to incorporate its disability and language access obligations into the modified procedures that it proposes. As OMHA is well aware, many beneficiaries who wish to appeal are either unrepresented or, even when they have assistance, that assistance is provided by family members or lay advocates that may come from the same language community and themselves have little familiarity with OMHA processes.

Viewing OMHA communications especially from the perspective of those unrepresented beneficiaries who either have limited proficiency in English or are persons with disabilities, we note:

- All communications from OMHA, since they concern rights to benefits, would qualify as “significant communications” requiring inclusion of the taglines and rights notices required by 45 C.F.R. § 92.8.
- When translations, oral interpretation, or information in alternate formats is required or requested, it is necessary that they be provided promptly since keeping an appeal on schedule can be of critical importance for those seeking access to health care. If, however, there is any delay in providing such assistance, beneficiary deadlines should be extended for the length of the delay.
- The Notice of Hearing discussed at Section 405.1022 of the proposed regulations is of particular importance. The hearing notice is complex, providing critical information about both the substance that will be addressed at the hearing and the procedures that must be followed. Failure to understand and act on the notice can be fatal to an individual's appeal. The fact that OMHA is required by Section 405.1022(d) to attempt to contact a beneficiary who has not acknowledged receipt of the notice attests to its importance. The hearing notice is exactly the kind of “long and complex” document that the HHS Office of Civil Rights had in mind when noting that a written translation may be necessary “so that an individual with limited English proficiency can refer back to or study it at a later date.” 81 Fed. Reg. 31376, 31416 (May 18, 2016).
- We note the excellent suggestion in the comments of the Center for Medicare Advocacy for an expanded appeals handbook to assist beneficiaries in navigating the process. If OMHA made an

up-front commitment of resources to such a handbook and to translating it into several major languages—as well as having it available in accessible formats—those steps would significantly reduce the need for individualized assistance and ultimately conserve OMHA resources.

IV. Addressing the root causes of the backlog

The long waits that beneficiaries have endured and continue to endure in having their appeals heard have, at their root, problems that are caused before any appeal reaches OMHA. While proposals here and elsewhere have largely been aimed at easing OMHA's backlog, it is necessary to pay attention to primary causes of the backlog. These include the failure of Medicare Advantage and Part D plans to operate internal appeals processes that genuinely review coverage decisions. CMS audits and enforcement actions have attempted to address the issue but the problem remains and systemic reform needs be considered. CMS hospital observation status policies also bear significant blame for backlog increases and desperately need revision. We urge that these processes take place before major changes are made that may further complicate and fragment the Medicare appeals process.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with the first name "Jennifer" and last name "Goldberg" clearly distinguishable.

Jennifer Goldberg
Directing Attorney