UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, *et al.*, Plaintiffs, v. ERIC D. HARGAN, in his official capacity as ACTING SECRETARY OF HEALTH AND HUMAN SERVICES, Defendant.	Civil Action No. 14-cv-00851 (JEB)

DECLARATION OF SHERRI G. MCQUEEN

I, Sherri G. McQueen, declare as follows:

1. I am the Director of the Financial Services Group (FSG) within the Office of Financial Management (OFM) of the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS or Department). I have held this position since April 5, 2015. Among my duties at HHS, I have responsibility for CMS' debt collection activities, provider and health plan audit and reimbursement operations, banking services, settlements, and coordination of benefits functions. I have also served as the FSG Deputy Director and Director of the Division of Medicare Benefits Coordination. Prior to joining CMS in 2008, I worked over 19 years in the private sector for one of the largest health insurers in the New York metropolitan area.

2. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

3. Since 2014, CMS, in collaboration with other parts of the Department, has undertaken a variety of administrative settlements to reduce the volume of pending Medicare appeals pending at the Office of Medicare Hearings and Appeals (OMHA) through settlement. Specifically, CMS has (1) implemented a settlement program for hospitals, known as the Hospital Appeals Settlement process (HASP), *see infra* ¶7, (2) participated in the Office of Medicare Hearings and Appeals (OMHA) Settlement Conference Facilitation (SCF) process, *see infra* ¶¶ 8-9, and (3) engaged in discussions with external stakeholders representing Inpatient Rehabilitation Facilities (IRFs) to explore settlement, *see infra* ¶ 10. Despite the opportunities available, however, some appellants with appeals in the OMHA backlog have chosen not to participate.

4. CMS is now implementing a new low-volume appellant settlement program (LVA) to resolve appeals filed by appellants with fewer than 500 appeals (that is, 499 or fewer appeals) pending at OMHA where the total billed amounts per appeal are $9,000 or less, *see infra* ¶ 11a.

5. Also, OMHA is expanding the SCF process to make it available to more appellants, and CMS will participate in that expanded process. *See infra* ¶ 11b; Griswold Decl. at ¶ 15.

6. Many appellants—or groups of appeals—were ineligible for HASP or SCF because they did not meet the criteria for participation. This includes many appellants comprising a significant portion of the backlog that have program integrity issues, such as active False Claims Act investigations encompassing a wide range of alleged improper practices, past and ongoing civil and criminal investigations by federal and state authorities, evidence of past program abuse, revocation of billing privileges, and Medicare payment suspensions. These

program integrity issues have precluded or significantly constrained any efforts to reach settlements with such appellants to further reduce or eliminate the OMHA backlog. Further details regarding the specific program integrity concerns applicable to particular providers are provided in a declaration of George G. Mills, which I understand is being submitted ex parte to the Court in this case. CMS anticipates that certain appellants will be ineligible for both the LVA and the expanded SCF process for similar program integrity reasons.

7. Hospital Appeals Settlement Process (HASP): Through HASP, providers willing to withdraw their appeals were given a partial payment of the net allowable amount (2014 – 68% and 2016 – 66%). CMS has executed settlements with over 2,400 hospitals under HASP, resulting in the removal of an estimated 380,212 appeals pending at OMHA:

a. In August 2014, CMS made available to hospitals an opportunity to administratively resolve appeals of certain inpatient hospital claim denials related to whether the medical record supported the patient being admitted as an inpatient (vs outpatient), which the hospital industry began appealing in significant numbers in 2013. When this process was announced, inpatient status appeals represented a large portion of the appeals pending at OMHA. Under this process, hospitals received timely partial payment of the disputed claims at a settlement rate of 68% of the net allowable amount for those claims in exchange for withdrawing a pending appeal or not further appealing the claim, or both. HASP enabled the Department to reduce the appeals pending at OMHA by resolving a large number of homogeneous claims in a short period. It also allowed hospitals to obtain prompt and efficient payment for rendered services, and it enabled all parties and the Department to avoid litigation risk and the costs of litigation

and adjudication associated with continued appeals. This initial round of the HASP removed an estimated 323,492 appeals from the OMHA docket for 2,022 providers.

b. On September 28, 2016, CMS announced that it would allow eligible providers who failed to avail themselves of the original settlement initiative a renewed opportunity to settle their patient status claims currently under appeal using the HASP. On November 3, 2016, CMS announced a settlement rate of 66% of the net allowable amount for those claims, which was slightly reduced from the 68% provided in the 2014 HASP to account for administrative costs to the Department to continue the appeals process for cases of appellants who chose not to avail themselves of the original settlement. At the time this option was presented, the Department estimated that an additional 95,000 appeals could be removed from the appeals pending at OMHA through allowing hospital participation in HASP for inpatient status claims another time. Unfortunately, only 56,720 appeals from 220 providers who had participated in 2014 HASP an additional 392 unique providers were removed from the OMHA backlog as a result of this renewed settlement option.

c. The Department estimates that there are between 40,000 and 50,000 potentially eligible inpatient status appeals where the hospitals chose not to participate in either of the HASP opportunities. Of those, the Department estimates that approximately 7,000 appeals were flagged for program integrity concerns, which means that an additional estimated 33,000 to 43,000 appeals could have been removed from the OMHA backlog had those providers chosen to participate.

d. Appeals resolved through the HASP were based on a unique set of circumstances that are generally not applicable to other appeals in the backlog. These

inpatient status settlements involved a very large homogenous universe of claims denied for the same reason, which were resolved on a global, rather than on a case-by-case, basis. Specifically, the settlements only involved appeals of patient status claims, which are determinations that otherwise medically necessary services should have been furnished on an outpatient basis, rather than on an inpatient basis. In these cases, some payment was appropriate for services; the issue was whether services would be paid as inpatient or outpatient services, which are paid at different rates and include coverage of different services. Appeals eligible for the settlement did not involve medically unnecessary services, but rather necessary services where the record did not support the inpatient admission that was billed by the provider. This is in contrast to the majority of appeals that are denied because an item or service is not a covered Medicare benefit or was determined to be not reasonable and necessary.

8. Settlement Conference Facilitation (SCF) with State Medicaid Agencies (SMAs): Under SCF, OMHA staff facilitates settlement conferences between CMS and appellants, and in determining settlement offers, CMS considers the following factors: (1) the type of item or service at issue, (2) the governing policy regarding the item or service at issue, (3) the cost to the Department for adjudicating the appeals at issue, (4) a sample of provider's claims, and (5) the provider's historical overturn rate on appeal.

9. To date, settlements have been reached with 56 appellants, including SMAs, to resolve over 69,000 appeals through SCF. The most notable agreements were reached with SMAs in Connecticut, New York, and Massachusetts after extensive negotiations. Those three SMAs were among three of the highest volume appellants at OMHA. Each one agreed to resolve their pending appeals at OMHA or at the Medicare Appeals Council (the Council) in

exchange for partial payment at a negotiated percentage of the net allowable amount. Each SMA also agreed to additional measures to resolve or reduce the number of new appeals through the summer of 2018, which will have a significant effect on incoming appeals as these SMAs pursue Medicare payment for services for beneficiaries eligible for both Medicare and Medicaid at a high rate. These settlements will remove approximately 54,000 appeals from OMHA. The Department estimates that they will result in a reduction of approximately 9,000 new appeals being filed at OMHA.

10. Inpatient Rehabilitation Facility (IRF) Settlement Talks: CMS is engaging in settlement discussions with members of the American Medical Rehabilitation Providers Association (AMRPA) and the Fund for Access to Inpatient Rehabilitation (FAIR), which have indicated that they represent a significant number of IRFs. These settlement discussions remain ongoing. If settlement talks are successful, and appellants agree, as many as 15,000 IRF appeals could be removed from the backlog.

New Settlement Initiatives

11. After the new leadership of the Department began onboarding earlier this year, they assessed administrative options for further reducing the OMHA backlog and helped identify and develop two new or expanded settlement initiatives. They are meant the help the two general types of providers with appeals in the OMHA backlog: the vast majority of providers who have comparatively few appeals with low dollar amounts, and the small group of appellants with a large number of appeals with higher dollar amounts:

a. Low Volume Appellant Option (LVA): The Department has developed a new settlement initiative for appellants with low appeal volumes who may not have been eligible

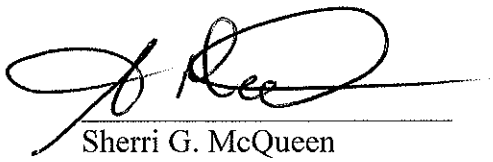
for other settlement initiatives. The Department estimates that approximately 80% of appellants with appeals in the OMHA backlog, with a corresponding 166,000 appeals, which is approximately 30% of the OMHA backlog, could be eligible for this initiative. LVA will be available to appellants with fewer than 500 eligible appeals (that is, 499 or fewer eligible appeals) pending at OMHA or the Council where program integrity concerns are not apparent. An eligible appeal has a billed amount of $9,000 or less and was filed with OMHA or the Council on or before November 3, 2017. Eligible appellants, many of whom were not previously eligible for other settlement initiatives, may enter into an administrative agreement with CMS to receive 62% of the net allowed amount of all of their eligible appeals in return for withdrawing all of their pending appeals. This settlement initiative would be limited to appeals pending as of November 3, 2017 to prevent appellants from flooding the Medicare appeals process with new appeals that appellants would have not otherwise pursued in hopes of receiving a settlement.

In developing LVA, CMS reviewed historic ALJ overturn rates in conjunction with costs of adjudication. The Department projects that the LVA will save Trust Fund dollars because it will enable the Department to avoid adjudication costs, *i.e.*, the cost of collecting the claim, and to mitigate the Department's litigation risk. The Department set the appeal threshold, maximum billed amount, and payment percentage to maximize the projected cost avoidance of the initiative. If all eligible providers were to resolve their eligible claims for LVA, HHS would pay out an estimated $131 million, but at a net savings of over $166 million.

b. Expansion of SCF Option: The Department will be expanding the SCF option for most appellants not eligible for LVA based on their volume of pending appeals that do not have apparent program integrity concerns. *See* Griswold Decl. ¶ 15.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on November 3, 2017 in Baltimore, Maryland



Sherri G. McQueen