STATEMENT OF

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ON

"CREATING A MORE EFFICIENT AND LEVEL PLAYING FIELD: AUDIT AND APPEALS ISSUES IN MEDICARE"

BEFORE THE

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Hearing on "CREATING A MORE EFFICIENT AND LEVEL PLAYING FIELD: AUDIT AND APPEALS ISSUES IN MEDICARE"

Office of Medicare Hearings and Appeals

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Chairman Hatch, Ranking Member Wyden, and Members of the Committee, thank you for the opportunity to discuss proposals for creating a more efficient process for Medicare appeals. The Office of Medicare Hearings and Appeals (OMHA), a staff division within the Office of the Secretary of the U.S. Department of Health and Human Services (HHS), administers the nationwide Administrative Law Judge (ALJ) hearing program for Medicare claims and entitlement appeals under sections 1155, 1869, 1876, 1852, and 1860D, of the Social Security Act (the Act). OMHA is charged with providing a fair and impartial forum in which Medicare beneficiaries, and the providers and suppliers that furnish items or services to Medicare beneficiaries, as well as Medicare Advantage Organizations and Medicaid State Agencies, are able to resolve disagreements with Medicare claim determinations.

BACKGROUND

Three separate agencies within HHS are charged with administering the four levels of administrative review of Medicare claims appeals within HHS. There is a fifth level of review with the federal district courts after administrative remedies within HHS have been exhausted. The first two levels of review are administered by the Centers for Medicare & Medicaid Services (CMS) and conducted by Medicare contractors. The third level of review is administered by OMHA and is conducted by ALJs. Subsequent reviews are conducted at the fourth level of appeal within the Medicare Appeals Council, which is within the Departmental Appeals Board (DAB), and at the fifth level by the federal district courts. In addition to Medicare claims appeals, individuals may appeal a determination by the Social Security Administration (SSA) that they are not entitled to Medicare benefits. This Medicare entitlement appeals process consists of three levels of administrative review and a fourth level of review with the federal district courts after administrative remedies have been exhausted.

HHS established OMHA in June, 2005, pursuant to section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173) (MMA), which required

the transfer of responsibility for the ALJ hearing function of the Medicare claims and entitlement appeals process from the SSA to HHS. OMHA was established to improve service to appellants and to reduce the then average 368-day waiting time for a hearing decision that appellants experienced with SSA to the 90-day time frame for issuing dispositions established in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554).

In order to make certain that OMHA's adjudicators would have decisional independence from CMS, OMHA was established as a separate agency within HHS, reporting directly to the Secretary. Accordingly, OMHA operates under a separate appropriation and is both functionally and fiscally separate from CMS.

At the time OMHA was established, Congress envisioned that OMHA would receive the same mix of work which had been handled by SSA:

- Claim and entitlement appeals workload from the Medicare Part A and Part B programs;
- Coverage appeals from the Medicare Advantage (Part C) program;
- Appeals of Income Related Monthly Adjustment Amount (IRMAA) premium surcharges assessed by SSA, and
- A new workload of appeals from the Medicare Prescription Drug (Part D) program.

With this mix of work at the expected levels, OMHA was initially able to meet the 90-day time frame that Congress contemplated for most appeals coming before the new agency. However, starting in Fiscal Year (FY) 2010, OMHA began to experience an upward trend in the number of requests for hearings being filed, which resulted in longer average processing times for appeals.

Although it is impossible to assign any single cause to the rapid growth in Medicare appeals, it is possible to identify a number of probable contributing factors. In 2010, OMHA began to take on new workloads, including appeals that result from the Recovery Audit program, which Congress established in 2006 and expanded nationwide beginning in 2010. While the program has led to more appeals as providers exercised their right to a hearing, the program has also reduced improper payments and returned significant dollars to the Medicare Trust Funds. During these same years, OMHA also experienced a concurrent growth in its traditional workload. Between FY 2009 and FY 2014 OMHA's traditional workload increased 543%. In FY 2011 and FY 2012, OMHA also noted an increase in the number of appeals filed by Medicaid State Agencies (MSAs) related to treatment for beneficiaries dually enrolled in both Medicare and Medicaid. Finally, Medicare enrollment has grown as the Baby Boom generation becomes Medicare-eligible. Recent increases in SSA disability adjudications have also resulted in the

influx of larger numbers of younger disabled individuals becoming eligible for Medicare benefits. This increase in the number of beneficiaries utilizing Medicare services may be resulting in a higher universe of potential disputes.

Although ALJ team productivity (dispositions per ALJ team) has more than doubled from FY 2009 through FY 2014 (from an average of 472 dispositions per ALJ team per year in FY 2009 to 1,049 in FY 2014),[1] the magnitude of the increase in workload has exceeded OMHA's ability to adjudicate incoming appeals within the 90-day time frame that Congress contemplated for most appeals. As a result of the significant disparity between workload and capacity, adjudication time frames have increased to their current level of 572 days (as of February 28, 2015), and will continue to increase until receipt levels and adjudication capacity are brought into balance.

In an effort to mitigate the impact of increased wait times on individual beneficiaries, who we believe to be our most vulnerable appellants, OMHA implemented a prioritization policy to ensure that appeals filed by beneficiaries are assigned to ALJs and heard as quickly as possible. These beneficiary-initiated appeals comprise approximately 1% of all appeal requests OMHA receives, but often concern emergent issues such as requests for pre-service authorization. As a result of this prioritization policy, the average time to decision for beneficiary appeals has improved. In February 2015, we estimated that the average time to decision for beneficiary appeals decreased from 244.6 days in FY 2013 to 125.0 days in FY 2014 (this calculation does not include Part D expedited appeals, which operate on a much shorter (10-day) time frame).

Over the past five years, OMHA has worked to maximize its productivity by supporting each of its ALJs with enhanced processing teams consisting of attorneys and other support staff. This has allowed each ALJ to focus on hearing and deciding appeals—functions which can only be performed by ALJs. However, OMHA's adjudication capacity is still limited by the number of funded ALJ teams. Under the 2014 continuing resolution, OMHA's funding level supported 65 ALJ teams. Enacted funding increases in FY 2014 and FY 2015 have allowed for the hiring of 12 additional ALJ teams, bringing OMHA's adjudication capacity to 77,000 appeals. This funding also enabled OMHA to open its fifth field office in Kansas City, the first additional office since OMHA opened its doors in 2005. However, even this additional capacity pales in comparison to

[1] These numbers do not include dismissals or remands. When dismissals are included, the disposition numbers are 551 per ALJ team per year in FY 2009 and 1,505 per ALJ team per year in FY 2014. The dismissal numbers were higher than normal in FY 2014 due to appellants withdrawing Part A appeals to avail themselves of a then-new option for rebilling of hospital services under Part B and a single appellant's withdrawal of a significant number of appeals as the result of a negotiated court settlement. However, these levels do not represent a sustainable disposition capacity for the agency.

the adjudication workload. In FY 2013 alone, OMHA received approximately 384,000 appeals, and in FY 2014, approximately 474,000 appeals were received.

In the face of dramatically increasing workloads, the Department recognized the need to deliver high quality and timely decisions on benefits and services to the Medicare community with greater efficiency, and under Secretary Burwell's leadership the Department has undertaken a three-pronged strategy to improve the Medicare Appeals process: 1) Take administrative actions to reduce the number of pending appeals and to appropriately resolve claims at earlier levels of the appeals process; 2) Request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; and 3) Propose legislative reforms that provide additional funding and new authorities to address and mitigate the appeals volume. The FY 2016 Budget includes a comprehensive legislative package of seven proposals aimed both at helping HHS process a greater number of appeals and facilitating the appropriate resolution of appeals at earlier levels of the process. The FY 2016 Budget also requests additional resources to enhance OMHA's capacity to process appeals.

Administrative Actions to Reduce the Number of Pending Appeals and Appropriately Resolve Appeals at Earlier Levels of the Appeals Process

OMHA has taken the following administrative actions:

- ***Leveraging Information Technology to Increase Efficiency***–OMHA's ALJ Appeal Status Information System (AASIS) was released in December of 2014, and increases the accessibility of basic information related to appeal status by implementing a searchable database, which appellants can access through OMHA's website. Electronic Case Adjudication and Processing Environment (ECAPE) is OMHA's most ambitious electronic initiative and will convert our business process from paper to electronic over the next two years. ECAPE is planned as a three phase implementation with the first release tentatively scheduled for early spring of 2016. In anticipation of the movement from paper files to electronic records, OMHA has entered into a scanning contract, which will allow conversion of existing paper appeal files into electronic format. OMHA has also developed a Medicare Appeals Template System (MATS), which simplifies the work of our staff by providing standardized fillable formats for routine word processing.
- ***Judicial Education Training***—In July 2010, OMHA implemented mandatory yearly training for ALJs, and expanded the program to include other members of the adjudication staff in 2012. These sessions provide consistent training to adjudicators on policy issues related to Medicare appeals and routinely involve collaborative training

using policy experts from OMHA, CMS, and the DAB. Special sessions have also included participation from the HHS Offices of the Inspector General and General Counsel. This joint training has been designed to increase decisional consistency between adjudicators at all levels of appeal. Since implementation of this joint training, the rate at which OMHA ALJs reverse decisions from lower levels of appeal has decreased from 63.2 percent in 2010 to their current rate of 43.0 percent, reflecting a more consistent application of policy at all levels.

- ***In Service Training Days*** were added to the training curriculum at OMHA in 2013 to provide critical adjudicatory and administrative training to all employees simultaneously via video-teleconference.
- ***OMHA's Quality Assurance Program*** assesses adjudicatory compliance with procedural requirements and adjudicative norms, identifies trends (both procedurally and substantively) encountered in the adjudication of Medicare appeals and disseminates the lessons learned as part of OMHA's continuing education program. Although OMHA recognizes that decisions of the Medicare Appeals Council are not precedential, we have implemented an enhanced, searchable database of decisions by the Medicare Appeals Council for use by our adjudicators.
- ***Settlement Conference Facilitation Pilot*** uses alternative dispute resolution techniques to resolve multiple appeals filed by a single appellant without hearing. OMHA attorneys, who have been trained in mediation techniques, facilitate a settlement conference between an individual appellant and CMS representatives.
- ***Statistical Sampling Pilot*** allows appellants with qualifying appeals to choose to have their claims adjudicated using statistical sampling and extrapolation and would allow for the resolution of large numbers of claims based upon resolution of a statistically valid sample.
- ***OMHA Case Processing Manual (OCPM)*** incorporates best practices in case processing and establishes a standardized business practice in all our field offices. The phased release of this manual started in February, 2015.

Just to highlight one of the administrative initiatives listed above, OMHA has implemented the Settlement Conference Facilitation Pilot using existing staff, budget, and regulatory authorities. Although new to the Medicare appeals process, mediation is a common means of resolving disputes throughout the judicial and administrative processes of government. To date, OMHA's settlement conference facilitators have resolved over 1,000 appeals during this extremely limited pilot. This represents the average productivity of an entire ALJ team working for a full year. It is also important to note that because these appeals are resolved by settlement of the underlying dispute, there is no possibility of further appeal to the DAB.

Request New Resources to Invest at All Levels of Appeal to Increase Adjudication Capacity and Implement New Strategies to Alleviate the Current Backlog

The 2016 President's Budget recognizes that even after efficiencies have been obtained through the administrative actions discussed above, significant additional funding will be required in order for OMHA to handle the number of appeals reaching the third level.

The 2016 President's Budget funds increases in adjudication capacity at OMHA by increasing its current budget of $87.3 million to $270 million. The President's Budget proposes three sources for this funding—$140 million from OMHA's discretionary appropriation, $125 million from recoveries resulting from the Recovery Audit program, and $5 million (estimated) from new filing fees. The latter two funding mechanisms are dependent upon passage of legislation which is included in the President's Budget. This additional funding would provide for the addition of 119 new ALJ teams and 82 Medicare Magistrates and increase OMHA's yearly adjudication capacity from 77,000 appeals per year to approximately 278,000 appeals per year. The President's Budget assumes that appeal process reforms in the nature of those listed below will be enacted which will allow OMHA to implement alternative adjudication models at lesser cost and to receive partial funding of its administrative costs from recovery audit reimbursements and filing fees. The President's Budget also assumes that reforms will slow the growth in the rate of appeals reaching OMHA.

Propose Legislative Reforms that Provide Additional Funding and New Authorities to Address the Appeals Volume

The significant increase in adjudication capacity at OMHA is dependent upon the enactment of the appeal reforms contained in the President's Budget.

- ***Provide Office of Medicare Hearings and Appeals and Departmental Appeals Board Authority to Use RA Collections.*** This proposal would expand the Secretary's authority to retain a portion of Recovery Audit (RA) program recoveries for the purpose of administering the recovery audit program and will allow RA program recoveries to fully fund the appeals process for RA related appeals at the OMHA and the DAB.

- ***Establish a Refundable Filing Fee.*** This proposal would institute a refundable per claim filing fee for providers, suppliers, and Medicaid State Agencies, including those acting as a representative of a beneficiary, at each level of appeal. Appeals filed by beneficiaries or representatives of beneficiaries other than providers, suppliers, and Medicaid State Agencies would be exempt from the fee. Fees will be returned to appellants who receive a fully favorable

determination. Under current law, there is no administrative fee paid to the adjudicating entity for filing an appeal. A filing fee would encourage those who frequently file to more carefully assess the merits of their appeals before filing.

- ***Sample and Consolidate Similar Claims for Administrative Efficiency***. This proposal would allow the adjudication of large numbers of appeals through the use of sampling and extrapolation techniques without appellant consent. Additionally, this proposal would authorize the consolidation of similar appeals into a single administrative appeal at all levels of the appeals process for purposes of adjudicative efficiency. This provision would also require that all appeals that were included within an extrapolated overpayment or were consolidated previously would remain a part of the extrapolated or consolidated file on appeal.

- ***Remand to Redetermination Level upon Introduction of New Evidence***. This proposal would require remand of a Medicare appeal to the first level of review at CMS when new documentary evidence is submitted into the administrative record at the second level of appeal or above. The proposal would include exceptions to mandatory remands if the basis for the submission is that new evidence was provided to the lower level adjudicator but erroneously omitted from the record, or an adjudicator denies an appeal on a new and different basis than earlier determinations. This proposal provides a strong incentive for all evidence to be produced early in the appeals process and to ensure the same record is reviewed and considered at the second and subsequent levels of appeal.

- ***Increase Minimum Amount in Controversy for ALJ Adjudication of Claims to Equal Amount Required for Judicial Review.*** This proposal would increase the minimum amount in controversy required for adjudication by an ALJ to the Federal district court amount in controversy requirement ($1,460 in 2015). It would also clarify the circumstances under which claims can be aggregated to meet the amount in controversy limit.

- ***Establish Magistrate Adjudication for Claims with Amount in Controversy Below New ALJ Amount in Controversy Threshold.*** This proposal would allow OMHA to use attorney adjudicators to resolve those appeals that meet the current ALJ amount in controversy threshold ($150 in 2015) but fall below the amount currently required to file an appeal in federal district court ($1,460 in 2015), reserving ALJs for development of a record in more complex cases involving higher amounts in controversy, which have the potential for appeal to federal district court. Decisions of a Medicare Magistrate could be appealed to the DAB, but would not meet the amount in controversy required to be appealable to federal district court.

- ***Expedite Procedures for Appeals with No Material Fact in Dispute.*** This proposal would allow OMHA to issue decisions without holding a hearing when there is no material fact in dispute and the decision is governed by a binding authority. These cases include, for example, appeals in which Medicare does not cover the cost of a particular drug or the ALJ cannot find in favor of an appellant due to binding limits on authority. This proposal would increase the efficiency of the Medicare appeals system and result in faster adjudications of appeals at the ALJ level of appeal.

Interdependency of Proposals

The President's Budget maximizes adjudication capacity at OMHA by incorporating appeals process reforms that allow for the utilization of less expensive adjudication models for some appeals. For example, OMHA estimates that the proposed Medicare Magistrate program would fund the adjudication of approximately 82,000 appeals annually at a cost of $27 million. Funding the same 82,000 appeals using the existing ALJ process would be almost twice as expensive at $52 million. Full implementation of the Medicare Magistrate program is dependent upon two legislative proposals currently in the President's Budget—the Increase Minimum Amount in Controversy and the Medicare Magistrate proposal. Similarly, if authorizations are not passed allowing OMHA to receive reimbursement for the administrative costs of adjudicating recovery audit appeals and to institute filing fees, its available resources would be cut in half and its projected disposition capacity would be similarly reduced.

CONCLUSION

OMHA is privileged to have an extremely dedicated workforce of both ALJs and staff who remain committed to processing Medicare appeals that are both timely and reflect the highest quality of decision making. The Department continues to work to address the backlog of pending appeals and to appropriately resolve disputed claims at earlier levels of the appeals process. However, it has become apparent that administrative initiatives which are possible within current budget authority and the existing statutory framework are insufficient to close the gap between workload and resources at OMHA. The Department is committed to bringing these efforts and the resulting appeal workload into balance and believes that the proposals contained in the 2016 President's Budget will provide additional authorities which will enable us to begin to restore that balance. With that goal in mind, OMHA continues to work with departmental leaders to develop comprehensive solutions to its growing workloads and looks forward to working with this committee and our stakeholders to develop and implement these solutions.