G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

June 30, 2005

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

Subject: *Medicare: Concerns Regarding Plans to Transfer the Appeals Workload from SSA to HHS Remain*

Medicare—the federal health insurance program that covers the nation's elderly and disabled—annually processes over 1 billion medical claims for services provided to beneficiaries. The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), administers the Medicare program with the assistance of its claims administration contractors. These contractors are charged with processing and paying claims that are properly submitted and that are for medically necessary and covered services. The contractors also deny payment for claims considered invalid, incomplete, or otherwise improper. Medicare beneficiaries and providers have the right to appeal denied claims through a multilevel administrative process that includes a decision by an administrative law judge (ALJ). In fiscal year 2004, CMS's contractors denied over 158 million Medicare claims, about 5 million of which resulted in the initiation of appeals. In the same year, about 113,000 denied claims were appealed to ALJs.

Two federal agencies—HHS and the Social Security Administration (SSA)—play a role in resolving Medicare appeals, but neither agency manages the entire process. In recent years, the Medicare appeals process has been the subject of widespread concern because of poor coordination between HHS and SSA and the time it takes to resolve appeals. In December 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) was enacted. It mandated appeals reform, including stricter time frames for processing Medicare appeals. Additional changes were required 3 years later by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MMA mandated that SSA transfer its Medicare appeals workload to HHS, between July 1, 2005, and October 1, 2005—in effect, consolidating Medicare appeals within a single federal agency.

In October 2004, we noted that transferring the Medicare appeals workload from SSA to HHS posed a complex challenge, requiring careful preparation and precise implementation of many interrelated tasks.[1] We also reported that the plan that HHS and SSA jointly developed to transfer this workload lacked sufficient detail on how the transfer would be accomplished. We concluded that the absence of this information seriously jeopardized a successful and timely transition and threatened to compromise service to appellants.

In light of our concerns, you asked us to monitor the transfer of the appeals workload from SSA to HHS. Specifically, our objectives were to (1) assess the agencies' progress in preparing to implement the transfer and (2) determine how HHS spent funds appropriated for transferring the appeals workload from SSA to HHS and related activities in fiscal year 2004 and the first half of fiscal year 2005.

To address these matters, we followed up on the steps taken to address weaknesses cited in our October 2004 report. We obtained documentation on the transfer and discussed this information with HHS and SSA officials. We also examined relevant laws, regulations, policies, and procedures concerning the transfer of SSA's Medicare appeals workload to HHS. In addition, we reviewed the budget assumptions and documentation related to spending on transfer-related activities—including reimbursements to SSA and CMS's implementation of BIPA reforms—and interviewed HHS, CMS, and SSA budget officials on these matters. We performed our work from October 2004 through June 2005, in accordance with generally accepted government auditing standards.

We recognize that the implementation of the plan to transfer the Medicare appeals function from SSA to HHS is at a critical and dynamic stage. This report provides a snapshot of that progress as of May 26, 2005.

In summary, we found that, although HHS and SSA have taken steps to prepare for the required transfer of the appeals function as required by MMA, some of the concerns we cited in our October 2004 report continue. With the July 1, 2005, implementation of the transfer plan quickly approaching, we identified three areas of concern.

- First, ensuring sufficient appellant access to hearings will be challenging. HHS has severely limited access to in-person hearings by establishing 4 hearing offices, in contrast to the 141 maintained by SSA. HHS will have to make special arrangements to obtain hearing space in other locations to ensure that appellants have adequate and timely access to in-person hearings. Despite its heavy reliance on videoconferencing (VTC) technology, HHS has not provided convincing evidence that appellants generally consider VTC hearings an adequate substitute for in-person hearings. HHS also faces a complex logistical task in arranging for thousands of VTC hearings, but has not estimated its needs based on SSA's recent hearing experience or another

[1] See GAO, *Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants,* GAO-05-45 (Washington, D.C.: Oct. 4, 2004).

reasonable surrogate. Instead, HHS plans to tap these resources on an as-needed basis, providing little assurance that VTC hearings can be scheduled and completed within the stricter time frame.

- Second, HHS is facing tight time frames to hire and train ALJs to hear Medicare appeals. HHS has not yet hired its Chief ALJ, and, although 23 individuals have accepted offers to fill the 49 open positions for ALJs who are expected to hear appeals, HHS's hiring and training timetable is extremely ambitious and provides little margin for error.

- Third, HHS continues to face operational challenges that have not yet been resolved, such as implementing its new Medicare appeals case-tracking system at all levels of the appeals process.

We are also concerned that, with such an enormous task still in front of it, HHS has not developed a specific contingency plan for processing appeals if for some reason it does not meet its October 1, 2005, deadline.

We also reviewed HHS's spending on the transfer of the appeals function and related activities in fiscal year 2004 and the first half of fiscal year 2005. We found that for fiscal year 2004, HHS spent less than it had been appropriated for transfer-related activities and SSA appeals processing. Furthermore, HHS spent slightly more than half of its fiscal year 2005 appropriation during the first two quarters of the fiscal year. Enclosure I contains briefing slides that elaborate on our findings.

We provided SSA and HHS with a draft of this report for comment. In its written comments, SSA did not indicate whether it agreed or disagreed with the information we presented in our report. However, SSA stressed its commitment to successfully transferring the appeals workload to HHS, while maintaining service to appellants. SSA also updated the information contained in our draft, most notably, that it submitted a plan to the Office of Management and Budget on June 1, 2005, for completing its pending Medicare appeals workload. SSA commented that it would have between 3,000 to 5,000 Medicare claims pending on October 1, 2005—the date the transition is to be completed. Furthermore, SSA did not provide written assurance as to when these appeals would be completed.

HHS also provided written comments and stated that it generally agreed with the report's contents and described its most recent progress in preparing for the transfer of the appeals function. However, HHS suggested that our report contained two inaccuracies. First, HHS took issue with our statement that it had not provided convincing evidence that appellants generally consider VTC hearings an adequate substitute for in-person hearings and concluded that our statement was based on a faulty premise. HHS said that the applicable statutory provision does not include any specific requirements regarding the form that hearings must take and that the only requirement is that they comport with due process. However, our concern extends beyond legal requirements and encompasses a variety of reasons why appellants may be uncomfortable with VTC hearings. For example, beneficiary appellants may be intimidated by the unfamiliar technology or may be concerned that a lack of personal

contact with the ALJ may put them at a disadvantage. It is this type of information—the beneficiary appellants' perspective on the use of VTCs as opposed to in-person hearings—that HHS has not provided. Second, HHS said that our statement that those appealing to the ALJ level have a right to an in-person hearing is inaccurate. We recognize that the provision of the act governing hearings, which was enacted in 1939, does not specify the form they must take,[2] but until 2003 the regulations did not contemplate VTC hearings.[3] When SSA amended these regulations in 2003 to facilitate the use of VTC hearings, no changes were made to preclude or significantly burden an appellant's choice of an in-person hearing.[4] We revised our wording to reflect that appellants may choose an in-person hearing.

Both SSA and HHS provided technical comments, which we incorporated as appropriate. (See enclosure II for a copy of SSA's comments and enclosure III for a copy of HHS's comments.)

- - - - -

We provided your staff with the information contained in this report on May 26, 2005. As discussed with your staff during that briefing, we agreed to issue this report to you containing the information we provided. As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of HHS, the Commissioner of SSA, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please call me at (312) 220-7600. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Geraldine Redican-Bigott, Enchelle Bolden, Helen Desaulniers, Shirin Hormozi, Barbara Mulliken, and Craig Winslow made key contributions to this report.

Leslie G. Aronovitz
Director, Health Care

Enclosures -- 3

---

[2]Social Security Act Amendments of 1939, ch. 666, sec. 201, § 205(b), 53 Stat. 1360, 1368 (codified as amended at 42 U.S.C. § 405(b) (2000).

[3]20 C.F.R. §§ 404.929 and 404.936 (2002).

[4]68 *Fed. Reg.* 5,210, 5,218 (codified at 20 C.F.R. §§ 404.929 and 404.936(d) and (e) (2004)).

GAO Briefing

MEDICARE: Concerns Regarding Plans to Transfer the Appeals Workload from SSA to HHS Remain

Briefing to the Staff of the Senate Committee on Finance

May 26, 2005

1

MEDICARE: Concerns Regarding Plans to Transfer the Appeals Workload from SSA to HHS Remain

- Introduction
- Objectives
- Scope and Methodology
- Results in Brief
- Background
- GAO Findings

2

Introduction

- The Medicare appeals process has been the subject of widespread concern in recent years because of the time it takes to resolve appeals of denied claims.
- Two federal agencies play a role in deciding Medicare appeals, but neither agency manages the entire four-level administrative appeals process. The Department of Health and Human Services (HHS) is responsible for overseeing the Medicare program, including managing three levels of the appeals process. However, the Social Security Administration (SSA), formerly an agency within HHS, has continued to hear appeals at the third level in the process, despite the fact that it became an independent agency in 1995.

3

Introduction

- To help expedite the adjudication of appealed claims, the Congress passed two laws:
  - The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which established stricter time frames for processing Medicare appeals.
  - The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated transfer of SSA's Medicare appeals function to HHS. As a result, all levels of the administrative appeals process will reside within a single federal agency.

4

Introduction

- Our October 4, 2004, report, *Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants* (GAO-05-45), noted that transferring the Medicare appeals function from SSA to HHS posed a complex challenge, requiring careful preparation and precise implementation of many interrelated tasks. We found that the plan developed by SSA and HHS to transfer the Medicare appeals workload lacked sufficient details. We concluded that the absence of specific information on how the transfer would be implemented seriously jeopardized a successful and timely transition and threatened to compromise service to appellants.

5

Objectives

We were asked to

1. assess the progress in preparing to implement the transfer of the Medicare appeals function from SSA to HHS and

2. determine how HHS spent funds appropriated for transferring the appeals workload from SSA to HHS and related activities in fiscal year 2004 and the first half of fiscal year 2005.

6

Scope and Methodology

- To perform our work, we
  - followed up on steps the agencies have taken to address weaknesses cited in our October 2004 report, obtained documentation on transfer activities, and discussed this information with HHS and SSA officials;
  - examined laws, regulations, policies, and procedures relevant to the transfer of the Medicare appeals workload; and
  - reviewed the budget assumptions and documentation related to the allocation and spending of appeals transfer funds, and interviewed budget officials from HHS and SSA.
- We performed our work from October 2004 through June 2005, in accordance with generally accepted government auditing standards.

7

Results in Brief

- HHS and SSA are taking steps to prepare for the transfer of the Medicare appeals workload by October 1, 2005, as required by MMA. However, we are concerned that HHS's approach for accomplishing the remaining key tasks follows an ambitious schedule that leaves little margin for error. Our concerns focus on HHS's ability to maintain sufficient appellant access to hearings, meet critical resource needs, and resolve operational issues.

- In FY 2004, HHS spent $59.5 million of the $77 million appropriated for the transfer of the appeals function and related activities. In FY 2005, HHS was appropriated $81 million for the transfer and related activities and an additional $49.6 million to reimburse SSA for hearing Medicare appeals. HHS spent slightly more than half of these funds through the first two quarters of the fiscal year.

8

Background

- Medicare covers a variety of health care services including inpatient hospital care, physician services, and diagnostic tests. In addition, as a result of MMA, beneficiaries will be able to participate in Medicare's new, voluntary prescription drug benefit, beginning in January 2006. Like other denied claims, denied prescription drug claims will also be subject to appeal.

- The Centers for Medicare & Medicaid Services (CMS), an agency within HHS, is responsible for administering the Medicare program, with assistance from its claims administration contractors. These contractors are charged with processing and paying claims that are properly submitted and that are for medically necessary and covered services.

9

Background

- Medicare's claims administration contractors are also charged with identifying and denying claims that are invalid, incomplete, or improper. For example, a claim may be denied if a beneficiary received services that were medically unnecessary or not covered by Medicare, or if the deadline for filing claims had been exceeded.

- In FY 2004, over 158 million Medicare claims were denied and about 5 million were appealed to the first level in the process. That same year, about 113,000 denied claims were appealed to the third level of the process, where administrative law judges (ALJs) hear and decide appeals. An appeal may consist of more than one denied claim.

10

Background

- The administrative appeals process consists of four levels:
    - CMS's claims administration contractors resolve appeals at the first two levels.
    - ALJs from SSA hear and decide appeals at the third level of the process. At this level, appellants may choose an in-person hearing.
    - The Medicare Appeals Council, within HHS's Departmental Appeals Board, resolves appeals at the fourth level.
- Appellants who are dissatisfied with decisions reached at one level in the appeals process may submit their appeal to the next level.

11

Background

- Until FY 2004, the President's budget submission to Congress included a request for SSA to be provided with funds to process Medicare appeals. However, the FY 2004 submission requested that HHS be provided with funds to process appeals, instead of SSA. SSA subsequently entered into an agreement with HHS to hear appeals, and Congress appropriated funds to HHS to pay SSA for its work.
- HHS budgeted $50 million in both fiscal years 2004 and 2005 to reimburse SSA for adjudicating Medicare appeals.

12

Background

- MMA specified that the ALJ function be transferred from SSA to HHS no earlier than July 1, 2005, and no later October 1, 2005. MMA also directed SSA and HHS to develop a plan detailing how the transfer would take place and specified that certain elements be addressed. Among other things, the plan was to
    - provide for an appropriate geographic distribution of ALJs throughout the United States;
    - identify steps for hiring ALJs and training them about Medicare law and regulation;
    - establish appropriate staffing levels, considering the current and anticipated appeals workload;

13

Background

- address the feasibility of conducting hearings using videoconferencing (VTC) technologies; and
- establish management tools, including specific regulations to govern the appeals process, a timetable for accomplishing the transfer, and a case-tracking system to facilitate the maintenance and transfer of data across all levels of the appeals process.

14

Background

- In response to MMA's mandate, SSA and HHS jointly developed the required transfer plan. The plan provides that, beginning July 1, 2005—3 months before the mandatory transfer date established by MMA—all Medicare appeals that otherwise would have been sent to SSA will instead be sent to HHS for adjudication, with one exception: Appeals related to Medicare's managed care claims will be sent to HHS beginning September 1, 2005. This approach was designed to enable SSA to concentrate on completing its pending Medicare appeals workload from July 1, 2005, through September 30, 2005. This strategy was also intended to permit HHS to fully assume the Medicare appeals hearing function on October 1, 2005, without inheriting a pending workload from SSA.

15

Background

- CMS published procedures and guidance on implementing statutory changes to the appeals process resulting from both BIPA and MMA in an *Interim Final Rule with Comment Period* in March 2005. As a result, additional changes to the appeals process will include
  - replacing the claims administration contractors who resolve the appeals at the second level of the process with a new type of contractor, called qualified independent contractors (QIC) and

16

Background

- meeting the requirements for faster resolution of appeals:

  QICs will have to resolve appeals in 60 days, compared with the current 120-day requirement for the hearing officers at the claims administration contractors.

  HHS ALJs will have to resolve appeals within 90 days. SSA ALJs currently have no time limit but, between October 2004 and March 2005, took an average of 295 days to resolve appeals.

These changes were implemented for some QICs on May 1, 2005, and will be fully implemented when the remaining QICs become operational on January 1, 2006.

17

Background

- In our October 2004 report, we recommended that, to facilitate the transfer of SSA's ALJ workload to HHS, the Secretary of HHS and the Commissioner of SSA should, among other things,
    - identify where staff and hearing facilities—including VTC equipment—are needed;
    - develop an approach to ensure that ALJs and support staff can be hired and adequately trained; and
    - prepare a detailed project plan that includes key elements essential to the transfer of the ALJ function from SSA to HHS, including contingency plans for appeals to be decided, if the transfer is not completed by October 1, 2005.

18

GAO Findings

Objective 1: Preparations to Implement the ALJ Transfer Plan

- Since we issued our October 2004 report, HHS and SSA have made progress in completing tasks necessary to facilitate the transfer of the ALJ workload from one agency to the other. However, as of May 26, 2005, some of the recommendations we made in that report had not been fully addressed.

19

GAO Findings

Objective 1: Preparations to Implement the ALJ Transfer Plan

- Specifically, since the issuance of our October 4, 2004, report, we have identified three ongoing concerns related to the implementation of the ALJ transfer plan:

  1. Maintaining Sufficient Appellant Access to Hearings
     - reliance on widespread use of VTC hearings
     - in-person hearings result in waiver of the statutory 90-day deadline
  2. Meeting Critical Human Resource Needs
  3. Resolving Operational Issues
     - delay in fully implementing appeals case-tracking system
     - lack of contingency planning

20

GAO Findings

Objective 1: Preparations to Implement the ALJ Transfer Plan: Maintaining Sufficient Appellant Access—Reliance on Widespread Use of VTC Hearings Raises Concerns

As of October 4, 2004

- HHS reported it would locate the central office in the Baltimore/Washington area and planned to develop a process to identify other hearing office locations.

As of May 26, 2005

- HHS will locate a central hearing office in Arlington, VA; and three other hearing offices in Miami, FL; Cleveland, OH; and Irvine, CA. The Arlington site will also function as a hearing office. HHS stated that having a small number of offices is cost-effective and will enable it to open them quickly. HHS noted it may later need to realign this structure on the basis of workload experience. (See fig. 1.)

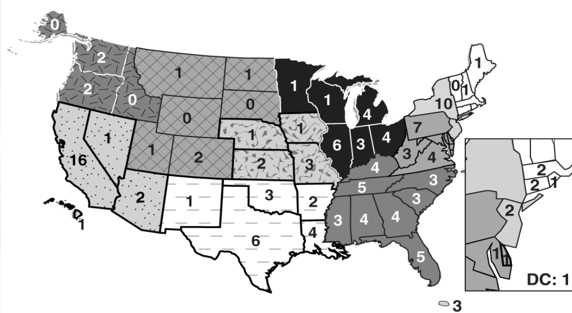
21

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

Figure 1: Distribution of SSA's and HHS's Hearing Offices

Distribution of SSA's 141 Hearing Offices

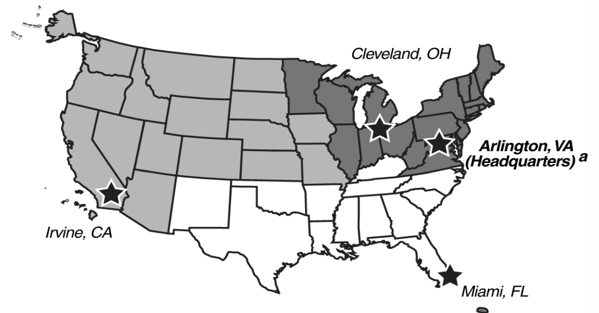


Workload per SSA Region for FY 2004

- Region I: 4,641 cases processed
- Region II: 5,940 cases processed
- Region III: 4,283 cases processed
- Region IV: 24,183 cases processed
- Region V: 5,397 cases processed
- Region VI: 7,774 cases processed
- Region VII: 1,776 cases processed
- Region VIII: 1,194 cases processed
- Region IX: 8,014 cases processed
- Region X: 641 cases processed

Source: SSA.

New HHS Hearing Offices



- States covered by Miami, Florida
- States covered by Irvine, California
- States covered by Cleveland, Ohio

Source: GAO.

[a] The Arlington, VA office will be smaller than the other three hearing offices. It will serve the Washington, DC metro area and also assist in processing cases for other regions as needed.

22

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

As of October 4, 2004

- HHS indicated it planned to rely heavily on VTCs but had not determined the proportion of appellants willing to conduct hearings using this technology. Several ALJs told us that beneficiaries are often uncomfortable using VTC facilities and prefer in-person hearings. HHS said it would study how best to employ VTCs in the hearing process.

As of May 26, 2005

- HHS expects most appellants to use VTCs. According to HHS, about 90 percent of appellants are providers, many of whom are familiar with VTCs, and are represented by law firms with their own VTC equipment. HHS stated that some ALJs and beneficiaries will still travel to hearing locations. CMS's rule does not address whether appellants would be paid for travel, but HHS said it will issue guidance on this by the time its ALJs begin hearing appeals.

23

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

As of October 4, 2004

- HHS did not provide information on the number of hearings it expected to conduct in-person and by VTC.

As of May 26, 2005

- HHS estimates that its ALJs will receive 42,000 Medicare appeals in FY 2006, excluding appeals resulting from the new prescription drug benefit. HHS acknowledged that it does not have a reliable projection of future appeals associated with this new benefit but believes that the number will be small. HHS noted that not all appeals require hearings. It estimates about three-quarters of appeals received will result in hearings.

24

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

As of October 4, 2004

- HHS did not specify its VTC needs, including the number of sites needed or the location of anticipated VTC sites.

As of May 26, 2005

- HHS said it cannot precisely specify its equipment needs but will have 31 VTC facilities in its 4 hearing offices. It may also use VTC facilities in its 10 regional offices. HHS also told us it has access to VTC facilities in 503 cities nationwide. This includes access to sites operated by (1) private vendors that have existing federal contracts and (2) SSA, which will give HHS access to VTC facilities in 69 of its locations.

25

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

As of October 4, 2004

- CMS is testing a Web site for beneficiaries to access their claims information. HHS planned to study the feasibility of using this Web site for electronic filing of appeals.

As of May 26, 2005

- CMS is conducting its test for a limited population and may expand participation over the next 2 years. There is no timetable, however, for when it may be possible for appeals to be filed electronically.

26

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

GAO Observations

- While HHS provided a rationale for choosing its four locations that it believes is cost-effective, the number of hearing sites dedicated to HHS's use for in-person hearings will be greatly reduced. HHS will have to make arrangements to schedule hearings elsewhere on an as-needed basis to ensure that appellants granted in-person hearings have reasonable and timely access to them.
- In addition, although HHS told us that most providers and attorneys are familiar with VTC technology, it has not shown that these appellants or beneficiaries generally consider VTC hearings an adequate substitute for in-person hearings.

27

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

GAO Observations (continued)

- HHS faces a complex logistical task in arranging for thousands of VTC hearings that may be required to resolve appeals within the statutory 90-day deadline. However, HHS has indicated that it cannot determine the number of hearings it will hold by VTC, and, as a result, it has not calculated how many hearings it can conduct using its equipment and VTC facilities available from private vendors and SSA. While it is understandable that HHS cannot anticipate the locations where it will need to conduct VTC hearings with great precision, it has not developed estimates of its VTC needs based on SSA's recent hearing experience or another reasonable surrogate to help it address this overwhelming task. Instead, HHS plans to tap these resources as needed, providing little assurance that VTC hearings can be scheduled and completed in a timely manner.

28

GAO Findings

Objective 1: Reliance on Widespread Use of VTC Hearings Raises Concerns

GAO Observations (continued)

- While HHS is studying the feasibility of using CMS's beneficiary Web site for electronic appeals submissions, it will not be available to beneficiaries in the short-term.

29

GAO Findings

Objective 1: Preparations to Implement the ALJ Transfer Plan: Maintaining Sufficient Appellant Access—In-Person Hearings Result in Waiver of the Statutory 90-day Deadline

As of October 4, 2004

- HHS said that its regulations would also address the use of VTCs in lieu of in-person hearings.

As of May 26, 2005

- Under CMS's rule, appellants who request and show good cause for in-person hearings may, with management approval, be granted one. But such requests will constitute waiver of the statutory 90-day requirement for a decision. Although HHS said it will revise the rule to clarify that there will be no waiver when requests are denied, appellants granted in-person hearings will lose the benefit of any deadline.

30

GAO Findings

Objective 1: In-Person Hearings Result in Waiver of the Statutory 90-day Deadline

GAO Observations

- The rule does not provide clear standards for appellants to show good cause when requesting in-person hearings. It also does not include any deadlines for scheduling such hearings or deciding these appeals. This may most affect the 10 percent of appellants who are beneficiaries—as opposed to providers represented by law firms—and who may not be familiar with VTCs or have easy access to VTC facilities.

31

GAO Findings

Objective 1: Preparations to Implement the ALJ Transfer Plan: HHS Faces Challenges in Meeting Critical Human Resource Needs

As of October 4, 2004

- HHS stated that it was working with the Office of Personnel Management (OPM) to expedite the hiring of at least 50 ALJs.

As of May 26, 2005

- HHS plans to hire 54 ALJs—a Chief ALJ, 4 managing ALJs, and 49 ALJs who will hear appeals. Offers have been accepted for all 4 managing ALJ positions. One of the managing ALJs is currently serving as the acting Chief Judge. In addition, offers have been accepted for 23 of the 49 positions for ALJs who will hear Medicare appeals. HHS plans to hire half of its ALJs by mid-June 2005 and the other half by late July 2005.

32

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

As of October 4, 2004

- HHS said that, in addition to relying on workload and staffing data from SSA, it would conduct its own additional analysis to develop its workload forecasts and staffing needs.

As of May 26, 2005

- HHS maintains that 54 ALJs will be a sufficient number to manage the anticipated appeals workload within its statutory 90-day deadline. It based this on SSA's staffing data and discussions with SSA officials. HHS said that it expects to be very efficient, which will enable it to resolve appeals more quickly than SSA. HHS will also set aggressive processing standards for hearing offices and plans to monitor their performance.

33

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

As of October 4, 2004

- HHS had not determined how it would distribute its ALJ positions.

As of May 26, 2005

- HHS determined that it will place a Chief ALJ and 4 ALJs in its Arlington office and 15 ALJs in each of the other 3 locations. In addition, each of HHS's 4 hearings offices will be headed by a managing ALJ.

34

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

As of October 4, 2004

- In addition to working with OPM to obtain ALJs, HHS was also relying on OPM for assistance in hiring support staff.

As of May 26, 2005

- According to HHS, offers have been accepted for each of the 4 hearing office manager positions. HHS also plans to hire half of its support staff—including 85 attorneys—by mid-June 2005 and the other half by late July 2005. Seventeen attorneys have accepted positions, and 63 offers are outstanding. HHS noted that its appeals workload will not be at full strength on July 1, 2005, and that more staff will be added following the transfer.

35

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

As of October 4, 2004

- HHS stated it would consider Medicare expertise as a factor in hiring its ALJs. However, OPM's registry of ALJ applicants does not indicate whether they have Medicare expertise.

As of May 26, 2005

- HHS stated that many of the individuals who have accepted ALJ positions are SSA employees with Medicare experience, but said it could not supply precise information until a later date. HHS also emphasized that MMA did not require that it hire ALJs with Medicare expertise—only that HHS consider this as a factor in the hiring process.

36

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

As of October 4, 2004

- HHS reported that it had contracted with HHS University—its internal training unit—to analyze training needs, oversee the development of training materials, and schedule classes.

As of May 26, 2005

- HHS plans to begin training the first group of newly hired ALJs and support staff in mid-June 2005. Three weeks of training will be provided, including 3 days devoted to Medicare law. In addition, those beginning careers as ALJs will attend 2 weeks of training at the National Judicial College in mid-July 2005. HHS stated that the majority of training will be conducted before ALJs hear cases.

37

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

GAO Observations

- With about 5 weeks remaining before implementation of the transfer plan is due to begin, HHS has not yet hired a Chief Judge. Although a managing ALJ is currently acting as Chief Judge, and, according to HHS, has authority to develop policies and make key human resource decisions, we believe that the delay in hiring a permanent Chief Judge is less than ideal. The uncertainty that inherently accompanies an acting status, in our view, adds to the complexities associated with an already challenging task and makes a smooth transition more difficult.

38

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

GAO Observations (continued)

- HHS has assured us that it will be ready to begin implementing the transfer on July 1, 2005, as planned. However, we are concerned with HHS's tight schedules for hiring and training staff. HHS's hiring and training timetables are ambitious and provide little margin for error. A delay in meeting either schedule could affect the agency's ability to begin hearing appeals on time or resolving appeals within the required statutory 90-day deadline.

39

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

GAO Observations (continued)

- While not an MMA requirement, the hiring of ALJs with Medicare expertise would help facilitate a successful transition, as cases may be resolved more expeditiously by ALJs already familiar with Medicare law. However, it is unclear whether the majority of ALJs that HHS will be able to ultimately hire will have such expertise. Other than providing 3 days of initial Medicare training, HHS has not specified how it plans to cultivate this expertise among its ALJs and other professional staff who have little or no Medicare experience.

40

GAO Findings

Objective 1: HHS Faces Challenges in Meeting Critical Human Resource Needs

GAO Observations (continued)

- Although HHS expects to have a sufficient number of ALJs to manage its workload and also plans to operate more efficiently than SSA, we remain skeptical, given an anticipated workload of 42,000 appeals in FY 2006. Assuming that one-quarter of these appeals do not require hearings, HHS ALJs will still need to complete, on average, about 3 appeals a day in order to manage this workload. Moreover, any administrative or logistical difficulties—such as the inability to arrange for VTC access at key times or obtain necessary case files—could hamper HHS's ability to resolve appeals in a timely manner.

41

GAO Findings

Objective 1: Preparations to Implement the ALJ Transfer Plan: Resolving Operational Issues—Delays in Fully Implementing New Appeals Case-Tracking System

As of October 4, 2004

- HHS's incremental approach to implementing its newly developed appeals case-tracking system—intended to correct existing system incompatibilities between all four levels of the process—seemed reasonable. However, initial plans to test the functionality of the system with QICs did not occur in the summer of 2004, as planned.

As of May 26, 2005

- Full implementation of the new system is delayed. HHS tested the system at the QIC and ALJ levels in April 2005 and said it is ready to be implemented at those two levels. However, it was to be available at the first level of the appeals process by June 2005. HHS reports that this will not occur but stated that it will consider the feasibility of expanding the system to the first level in FY 2006.

42

GAO Findings

Objective 1: Delays in Fully Implementing New Appeals Case-Tracking System

GAO Observations

- HHS's appeals case-tracking system was intended to facilitate the maintenance and transfer of case-specific data throughout the four levels of the appeals process and to correct long-standing case management problems. However, it is now scheduled to be implemented only at the second and third levels. HHS is reconsidering its implementation at the first level and also has not indicated when it will be used to track appeals at the fourth level of the process.

43

GAO Findings

Objective 1: Preparations to Implement the ALJ Transfer Plan: Resolving Operational Issues—Lack of Contingency Planning

As of October 4, 2004

- HHS stated that it would address contingencies as needed but did not provide details on the specific steps that might be taken.

As of May 26, 2005

- HHS stated that its plan to begin transferring the ALJ workload on July 1, 2005—3 months before MMA's deadline—will allow the agency sufficient time to address potential problems.

44

GAO Findings

Objective 1: Lack of Contingency Planning

As of October 4, 2004

- HHS reported having a mechanism to continue using SSA ALJs after the mandatory transfer date, if necessary.

As of May 26, 2005

- HHS mentioned, among other things, the MMA and the Economy Act, as possible bases for a mechanism to allow SSA ALJs to continue hearing Medicare appeals if the transfer is not fully accomplished on time. However, HHS and SSA have not developed plans for using a specific mechanism or formalized an agreement for completing SSA's pending workload.

45

GAO Findings

Objective 1: Lack of Contingency Planning

As of October 4, 2004

- SSA ended FY 2004 with about 28,700 pending Medicare appeals. SSA estimated it would need to resolve about 74,900 Medicare appeals cases by the end of FY 2005 to finish its Medicare appeals workload. This includes the 28,700 cases pending at the end of FY 2004 and about 46,200 new cases it expected to receive in FY 2005.

As of May 26, 2005

- SSA's pending workload has increased. As of late April 2005, SSA had 30,918 pending appeals cases—about 2,200 more than were pending when the fiscal year began. While SSA is committed to completing this workload, it acknowledged that it is unlikely that it will be able to do so by the October 1, 2005, transfer deadline.

46

GAO Findings

Objective 1: Lack of Contingency Planning

GAO Observations

- HHS indicates that it is on schedule for completing the transfer by MMA's October 1, 2005, deadline and that beginning the transfer on July 1, 2005, will provide sufficient time to address potential problems. However, if significant problems develop, HHS has not formulated a specific contingency plan to resolve them.
- SSA and HHS have not formalized an agreement that outlines SSA's commitment to complete its pending Medicare workload after the transfer date. As a result, there is little assurance that SSA will not ultimately transfer this workload to HHS.
- Without preparing for SSA to continue hearing Medicare appeals, HHS provides little assurance that disruption to the process can be avoided, should it be unable to begin hearing such appeals on time.

47

GAO Findings

Objective 2: HHS Spending on the Appeals Transfer and Related Activities

- HHS spent a little over three-quarters of the funds appropriated for the transfer of the appeals function and related activities in FY 2004. HHS has spent slightly more than half of the funds appropriated for the transfer and related activities in the first two quarters of FY 2005.

48

GAO Findings

Objective 2: HHS Spending on the Appeals Transfer and Related Activities

- HHS spent only $59.5 million of the $77 million appropriated for the appeals transfer and related activities in FY 2004. This lower spending was due to, among other things, HHS's reimbursing SSA $37.5 million for hearing appeals—substantially less than the $50 million HHS had originally budgeted.

- In FY 2005, the appropriation for the appeals transfer and related activities was increased to $81 million. In the first two quarters of FY 2005, HHS spent $47.6 million on appeals activities. In addition, another $49.6 million was appropriated to reimburse SSA for continuing to adjudicate Medicare appeals. HHS paid SSA $24.8 million for adjudicating appeals in the first two quarters of FY 2005. (See table 1.)

49

GAO Findings

Objective 2: HHS Spending on the Appeals Transfer and Related Activities

Table 1: FY 2004 and FY 2005 Budget Requests, Appropriations, and Actual Spending (Dollars in millions)

Activity	FY 2004 requested	FY 2004 appropriated	FY 2004 spent	FY 2005 requested	FY 2005 appropriated	FY 2005 spent as of 03/31/05
Program management						
QIC implementation	$65.0	$11.0	$2.0	$65.0	$65.0	$10.2
Coverage determinations	3.0	3.0	0.0	3.0	3.0	0.0
Program management of the Medicare appeals system	11.0	11.0	7.0	3.0	3.0	3.0
ALJ appeals	50.0	50.0	37.5	50.0	49.6	24.8
Start-up funds for appeals transfer	0.0	0.0	8.5	8.0	8.0	29.9
Intragency agreement (IAA) with Departmental Appeals Board	0.0	0.0	0.3	0.0	0.0	0.0
IAA with HHS General Counsel for MMA activities	0.0	0.0	0.6	0.0	0.0	0.0
Total program management	**$129.0**	**$75.0**	**$55.8**	**$129.0**	**$128.6**	**$67.9**
MMA						
Case-tracking system	N/A	2.0	3.7	N/A	2.0	4.5
Total MMA	**N/A**	**$2.0**	**$3.7**	**N/A**	**$2.0**	**$4.5**
Grand total	**$129.0**	**$77.0**	**$59.5**	**$129.0**	**$130.6**	**$72.4**

Source: HHS.

Notes: Amounts include funds spent by HHS and CMS, an agency within HHS. N/A = not applicable.

50

Comments from the Social Security Administration

SOCIAL SECURITY

The Commissioner

June 15, 2005

Ms. Leslie G. Aronovitz
Director, Health Care – Program
Administration and Integrity Issues
U.S. Government Accountability Office
Room 5-A-14
441 G Street NW
Washington, D.C. 20548

Dear Ms. Aronovitz:

Thank you for the opportunity to review and comment on the draft Government Accountability Office (GAO) correspondence "MEDICARE: Concerns Remain Regarding Plans to Transfer the Appeals Workload from SSA to HHS" (GAO-05-703R).

First and foremost, I wish to reiterate my commitment to making the Social Security Administration's (SSA) transfer successful and to maintaining service to appellants throughout the process. The draft correspondence correctly notes that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) transfers authority from SSA to the Department of Health and Human Services (HHS) for the Medicare appeals hearings function, effective October 1, 2005. However, in the event that it is necessary, SSA and HHS have identified a mechanism for HHS to continue to use SSA Administrative Law Judges to adjudicate Medicare appeals after the statutory date of transfer.

Enclosed are detailed comments and suggestions we have on the draft correspondence. If you have any questions, please have your staff contact Ms. Candace Skurnik at (410) 965-4636.

Sincerely,

Jo Anne B. Barnhart

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

COMMENTS ON THE GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT CORRESPONDENCE "MEDICARE: CONCERNS REMAIN REGARDING PLANS TO TRANSFER THE APPEALS WORKLOAD FROM SSA TO HHS" (GAO-05-703R)

We appreciate the opportunity to comment on the GAO draft correspondence concerning the transfer of the Medicare appeals workload from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS).

SSA recognizes there are considerable challenges remaining in the effort to transfer the Medicare appeals workloads to HHS. While much of the responsibility for addressing these challenges rests with HHS, SSA will continue to work with them to accomplish an orderly transition of this workload.

For example, SSA and HHS have jointly studied opportunities for sharing video-teleconferencing (VTC) sites. SSA and HHS are developing options that will allow HHS access to our VTC sites in a variety of locations to help meet HHS' needs. SSA plans to permit the use of its VTC sites to the extent that it will not interfere with SSA workloads, and in a manner which will not inconvenience SSA claimants. SSA will continue to provide data regarding its experience in processing Medicare appeals to assist HHS in estimating their VTC and Medicare appeals hearing workload needs.

As to the specific findings, we offer the following comments.

Page 50: As of May 26, 2005, SSA's pending workload has increased. As of late April 2005, SSA had 30,918 pending appeals cases – about 2,200 more than were pending when the fiscal year began. While SSA is committed to completing this workload, it acknowledged that it is unlikely that it will be able to do so by the October 1, 2005, transfer deadline.

We offer the following updated Medicare appeals workload information for the month of May 2005:

Medicare pending: 30,879 cases
Medicare receipts: 9,620 cases
Medicare dispositions: 9,659 cases

The pending Medicare workload in May continues to be higher than it was at the beginning of the fiscal year. However, the total pending at the end of May 2005 is more than 10,000 cases below the same time last year and Medicare dispositions are far ahead of the pace issued in 2004 (more than 6,500 cases ahead of last year at this time). And as of June 2005, more than half of all of the pending Medicare cases at SSA (52 percent) are either scheduled for a hearing or ready to be scheduled for a hearing.

2

We remain committed to processing all Medicare cases pending with SSA as of September 30, 2005, including remanded cases issued by SSA that are received through September 30, 2005. We anticipate that between 3,000 and 5,000 Medicare cases will be pending in SSA as of October 1, 2005, but we will be able to more precisely assess both the number and when the pending workload will be completed after the flow of most new receipts ends on June 30, 2005.

Page 51: SSA and HHS have not formalized an agreement that outlines SSA's commitment to complete its pending Medicare workload after the transfer date. As a result, there is little assurance that SSA will not ultimately transfer this workload to HHS.

SSA submitted a contingency plan to OMB on June 1, 2005, under which SSA has committed in writing to processing to completion all those Part A and B appeals received by June 30, 2005, and all those Part C appeals received by August 31, 2005. While we intend to execute an MOU which will discuss any necessary details about this and other aspects of the transfer, we believe that the plan submitted to OMB sufficiently formalizes the commitment we gave in our response to GAO on this same point on April 14, 2005. Also, we have recently agreed with HHS to process remanded cases decided by SSA that are received in SSA through September 30, 2005. Further, SSA will process remands on cases decided by SSA that are received from October 1 through December 31, 2005, for which a hearing is not required.

SSA is committed to complete the processing of Medicare cases for which we have responsibility pursuant to these arrangements. Until the pending Medicare workload is completed, the necessary infrastructure will remain in place to ensure that the workload is completed. For example, SSA will continue to operate the Medicare management workgroup which is responsible for managing and monitoring the Medicare workload in SSA. Also, SSA's Medicare screening unit will continue in operation to provide assistance in processing the workload.

Page 51: Without preparing for SSA to continue hearing Medicare appeals, HHS provides little assurance that disruption to the process can be avoided, should it be unable to begin hearing such appeals on time.

SSA is prepared to continue to hear new Medicare appeals, if necessary. While we are processing the remaining Medicare cases pending in SSA, we will continue to maintain the infrastructure needed to receive and process new Medicare appeals, if needed.

Technical comments

Page 13: Like other denied claims, denied prescription drug claims will also be subject to appeal.

The right to appeal does not depend on the fact that the claim was denied. The sentence should state that "Individuals who are dissatisfied with the determination made on their

claim may appeal the determination." This change would make the language consistent with that on the bottom of page 15 of the report.

Page 15: ALJs from SSA hear and decide appeals at the third level of the process. At this level, appellants have the right to an in-person hearing.

The phrase "in-person" should be deleted, since the statute does not specify whether or not the hearing has to be "in-person." See, e.g. section 1869(d) of the Act (referring to a hearing by an administrative law judge).

Page 19: In response to MMA's mandate, SSA and HHS jointly developed the required transfer plan. The plan provides that, beginning July 1, 2005 – 3 months before the mandatory transfer date established by MMA—all Medicare appeals that otherwise would have been sent to SSA, will instead be sent to HHS for adjudication.

The statement should be revised to reflect that the Transfer Plan provides that all Medicare appeals will be sent to HHS beginning July 1, 2005, except Part C, which will be sent to HHS beginning September 1, 2005.

Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 1 6 2005

Ms. Leslie G. Aronovitz
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO's) draft correspondence entitled, "MEDICARE: Concerns Remain Regarding Plans to Transfer the Appeals Workload from SSA to HHS" (GAO-05-703R). The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Acting Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft correspondence in our capacity as the Department's designated focal point and coordinator for U.S. Government Accountability Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT CORRESPONDENCE ENTITLED "MEDICARE: CONCERNS REMAIN REGARDING PLANS TO TRANSFER THE APPEALS WORKLOAD FROM SSA TO HHS" (GAO-05-703R)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the U.S. Government Accountability Office's (GAO's) draft correspondence, which was prepared as a follow up to GAO's earlier report entitled, "MEDICARE—Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants" (GAO-05-45), published October 4, 2004.

Section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that responsibility for the functions of administrative law judges (ALJs) who hear Medicare appeals under Title XVIII of the Social Security Act (the Act) be transferred from the Social Security Administration (SSA) to HHS not earlier than July 1, 2005, and not later than October 1, 2005. It also required SSA and HHS to submit a report to the Congress (the Transfer Plan) by April 1, 2004, providing a plan for the transfer of this responsibility. GAO was mandated to evaluate that plan and report to the Congress, which it did in GAO-05-45.

Following release of that report, GAO was asked to monitor the transfer of the appeals workload and update the Congress. This draft correspondence recognizes, on page 2, that "...the implementation of the plan to transfer the Medicare appeals function from SSA to HHS is at a critical and dynamic stage. This report provides a snapshot of that progress as of May 26, 2005."

While HHS generally agrees with most of the statements made by GAO in the slide presentation that constitutes the draft correspondence, there are several issues that HHS would like to clarify or update, and would also like to supply additional information regarding steps taken since the snapshot was taken on May 26, 2005.

Video Teleconferencing

The MMA mandated that the Transfer Plan explore the feasibility of conducting ALJ hearings using teleconference or videoconference technologies. HHS will fulfill this obligation by improving the hearings process and expanding access to ALJs through the use of video teleconference (VTC) hearings. The use of VTC hearings will allow prompt hearings in order to ensure that decisions will be rendered within the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)-mandated timeframe, and create more access points than SSA currently provides through its offices. HHS is achieving these improvements in access through office locations established as "coordinating hubs" or field offices, rather than through Department-owned buildings to which appellants must travel.

This technology is now commonly used in the medical community with patients (telemedicine), and in courtrooms throughout the country. SSA has introduced VTC hearings successfully and has been expanding their use each year. VTC equipment is widely available and used extensively throughout the United States. It is prevalent not only in the legal realm, but also in the healthcare arena and other areas where spanning geographic distance to meet the needs of customers (e.g. appellants, patients) is critical and time-sensitive. The very positive feedback from SSA on their implementation of VTC supports user acceptance of VTC for use in hearings.

In addition, VTC equipment is widely available in law firms. According to the 1999 Report from the Office of Inspector General (http://oig.hhs.gov/oei/reports/oei-04-97-00160.pdf) the appeals process is no longer a process predominately for individual beneficiaries, but rather a provider/supplier dominated process. This report states that in excess of 90 percent of all appellants are providers, suppliers, or hospitals, many of whom use private law firms that already have their own VTC equipment.

The VTC equipment for each of the HHS, Office of Medicare Hearings and Appeals (OMHA) hearing rooms has been specified and ordered. Delivery and installation is on time for hearings.

HHS has also identified VTC resources available from SSA, HHS Regional Offices, other organizations, and private vendors and is establishing relationships and procedures for using these VTC resources. HHS and SSA are developing a Memorandum of Understanding giving HHS access to 69 of SSA's VTC sites for an SSA estimate of approximately 9,000 hearings a year. SSA has continued to assure HHS that they wish to cooperate in supporting availability of their VTC equipment, in compliance with the mandates of the MMA. In addition, HHS has conducted test-hearing scheduling and is developing a database of all VTC sites for use in scheduling hearings. HHS anticipates continuing to build the VTC network of resources over the first year of operation, expanding access to appellants even further.

HHS privacy officials were involved in the specifications for the VTC equipment and the encryption for compliance with the Privacy Act. Additionally, HHS' information technology and VTC experts were involved in the preparation of the specifications for the equipment with privacy as an essential criterion. HHS has been in contact with VTC providers and has verified that VTC services are regularly used for depositions and other confidential matters and that the VTC providers have private rooms and secured networks to assure privacy.

The VTC equipment includes not only the capability to transmit the picture and sound of the video teleconference, but also state-of-the-art digital audio recording capability, with automatic back up recordings of the hearings. This surpasses the past practice of audio recordings, which were frequently not backed up and often lost or misplaced, causing a significant remand and rework workload.

HHS believes that access to ALJ hearings for appellants will be as good or better than the current access under SSA. Not only will access be available via VTC at SSA VTC sites, OMHA offices, HHS regional offices, and many other locations throughout the country, but

also beneficiaries will continue to be able to request, and in appropriate circumstances, obtain in-person hearings.

Finally, HHS would like to take this opportunity to correct several items that it believes to be factually or legally inaccurate, as follows:

GAO mentions in two places in the draft correspondence (pages 3 and 31) that *"HHS has not provided convincing evidence that appellants generally consider VTC hearings an adequate substitute for in-person hearings."*

Although this statement is intended to convey GAO's opinion regarding HHS' efforts to plan for the transition of the ALJ function, HHS believes that this opinion is based on a faulty premise. Pursuant to the Social Security Act (the Act) at section 1869(b)(1)(A), parties are entitled to a hearing "to the same extent as is provided in section 205(b)." The Act does not include any specific requirements regarding the form the hearing must take. Rather, the only requirement is that the hearing process comport with due process. Thus, HHS is required only to show that VTC hearings are consistent with the requirements of due process. As HHS has previously advised, in many cases a hearing conducted by telephone or VTC will comport fully with the requirements of due process. Furthermore, ALJs, with the concurrence of the Managing Field Office ALJ, are permitted to schedule an in-person hearing when there are special or extraordinary circumstances that would make a VTC hearing inappropriate, or when an appellant shows good cause to grant a request for an in-person hearing. Thus, HHS believes that the use of VTC hearings is consistent with the requirements of due process.

On page 15 of the draft correspondence, GAO includes the following statement regarding the hearing procedures that are applied by the SSA ALJs currently responsible for hearing Medicare appeals: *"At this level, appellants have the right to an in-person hearing."*

HHS believes that this statement is legally inaccurate. Although all appellants have the right to a hearing, the Act does not specify the form that the hearing must take. Accordingly, as was previously noted, HHS believes that it may be appropriate in many cases for hearings to be held by telephone or VTC. HHS believes that the statement by GAO is intended to indicate that under existing SSA regulations, all parties may request an in-person hearing, and that such a request will constitute good cause for scheduling an in-person hearing.

Waiver of 90-day Timeframe

Although the *Interim Final Rule with Comment Period* (IFC) (70 FR 11420) provided that appellants may request an in-person hearing, it inadvertently indicated that the request would constitute a waiver of the 90-day BIPA timeframe for conducting the hearing and rendering a decision. A Correcting Amendment has been drafted and will be published in the Federal Register prior to the opening of the HHS ALJ offices clarifying that the mere request by a party for an in-person hearing does not relieve the ALJ of the 90-day hearing and decision-making timeframe requirement. Rather, waiver of the 90-day hearing and decision-making timeframe requirement results only after the ALJ has granted the request for an in-person hearing. Although the timeframe will be waived, HHS will make every effort to process these appeals in the most expeditious manner possible.

3

Hiring and Staffing

Hiring is proceeding on a daily basis to staff the OMHA Field Offices. The administrative staff and half of the ALJs and their direct reports will be hired and training began on June 13, 2005. The remaining half of the ALJs and their direct reports will be hired and will begin training toward the end of July. This two-phased hiring plan is based on the commitment from SSA that HHS will not inherit a pending workload from SSA. The workload therefore will steadily increase from zero percent of full workload the morning of July 1, 2005, to 100 percent of the workload 90 days later (September 30, 2005), which is one full cycle for processing cases. During the first half of the 90-day cycle of case processing, only half of the staff are necessary to process the cases received. Therefore, the second half of the staff will be trained and begin hearing cases approximately half way through the 90-day cycle. This two-phase hiring plan allows for staff to be trained, be available to hear cases, and appropriately uses taxpayer dollars to align the hiring of staff with the need to begin hearing cases.

The attached chart depicts the hiring results as of June 14, 2005.

Based on these staffing numbers, HHS is confident that it has a sufficient number of ALJs to manage the Medicare hearings workload. Based on the information provided by SSA in its Caseload Analysis Report (CAR), in fiscal year (FY) 2003, SSA was able to dispose of 78,005 docketed items, of which 48,971 were Medicare hearings, using 46.18 ALJs. In FY 2004, SSA disposed of 64,082 docketed items, of which 31,223 were Medicare hearings, using 37.55 ALJs. Based on these numbers, HHS clearly can accommodate the anticipated case receipts with its workforce of ALJs.

As mentioned in an earlier submission, HHS has hired an Acting Chief Judge to oversee the implementation of the Transfer Plan. Judge Perry Rhew was appointed to be the Managing Administrative Law Judge for the Cleveland OMHA in March 2005. On April 22, 2005, the Office of the Assistant Secretary for Administration and Management appointed Judge Rhew to be the Acting Chief Administrative Law Judge of the OMHA. This appointment conveyed all the rights, authority, and responsibility of the Chief Judge to Judge Rhew.

Since his appointment, Judge Rhew has led the selection and hiring of the ALJs and other staff for OMHA, directed policy development for the appeals process, and overseen the finalization of training plans and facilities development. Prior to Judge Rhew joining HHS, he was the Acting Chief Administrative Law Judge for the SSA Cleveland Office of Hearings and Appeals, where he streamlined operations and made changes that made the office more efficient, increased overall productivity, and personally mentored six new judges.

Judge Rhew is a dynamic, experienced leader, and is a veteran of the Medicare appeals process at SSA. He was selected to be the Acting Chief ALJ because of his talent at hiring and leading judges and staff, his passion for ensuring a fair and timely hearing process, and his excitement about the opportunities for efficiencies in the Medicare appeals system. Judge Rhew has the full confidence of Secretary Leavitt and the entire HHS leadership.

4

Training

The training has been designed as a 5-week program, with all staff, including judges, receiving 3 weeks of training. New judges receive an additional 2 weeks of training designed exclusively for HHS' new judges by the National Judicial College. The first half of the staff will receive 2 weeks of training from June 13 to June 24, 2005, and the second half of the staff will receive the same 2 weeks of training from July 24 to August 5, 2005. All staff will receive 1 week of training from August 8 to August 12, 2005. In addition, new judges will receive 2 weeks of training at the National Judicial College from July 11 to July 22, 2005.

Training specific to Medicare law will be provided for 3 days at both sessions and will include the following topics:

Medicare entitlement and enrollment
Medicare coverage process
Payment of claims
Overview of the appeals process – Parts A and B
Limitations on judicial review in the Medicare program: Concepts of
exhaustion and "channeling"
The Medicare Advantage Program (Part C)
Part D

In addition, other training is provided encompassing an entire week of training specific to the Medicare appeals workload, including:

Appeal case flow walk-through
Appeal field office workflow process
Consolidation and aggregation
Case management
Procedural issues
Amount in controversy
Use of expert witnesses
Substantive issues
Death of the beneficiary
Lessons from the SSA experience
The merits – issues SSA commonly encountered
Part A – hospital, skilled nursing facility, home health care, partial hospitalization
Part B – assignment, aggregation, Durable Medical Equipment, equipment, overpayment
Multiple beneficiary cases
Medicare Advantage
BIPA
Conduct of Medicare hearing
Medicare decision writing
VTC tools and management

5

In addition to the above training, new judges will receive 2 weeks of training designed exclusively for Medicare ALJs, including mock Medicare hearings using VTC.

The training curriculum is designed to be Medicare-specific and will enable the Medicare ALJs to render fair, impartial, and informed decisions. As is the case with any Federal judge, if an issue arises in which the Medicare ALJ is not an expert, he or she will quickly acquire the knowledge necessary to hear the case and render a decision, as judges do by training and education.

Medicare Appeals System (MAS)

The Medicare Appeals System (MAS) as planned will eventually encompass all five levels of appeals, beginning with the Affiliated Contractors and ending at the Federal District Court level. However, for cost and efficiency reasons, the MAS is being developed and deployed incrementally. MAS testing took place from April 11 through April 22, 2005, prior to the Qualified Independent Contractor (QIC) implementation. The MAS was fully functioning when the QICs began processing cases on May 1, 2005, consistent with the requirement of the BIPA statute.

The MAS will be available for appeals to the new HHS ALJ hearing offices when they begin hearing appeals on July 1, 2005. Although there has never been a commitment to implement the MAS at the 55 contractors that conduct first level appeals, each of whom has its own data system, as planned, CMS is looking into the feasibility and cost-effectiveness of making the MAS available to these contractors under a future increment, most likely in conjunction with implementation of the Medicare contractor reform initiative.

Spending for FY 2004 and FY 2005

There are two primary reasons why HHS spent only $59.9 million of the $77 million appropriated in FY 2004 for the full Medicare appeals process.

First, at the time of the appropriation, $11 million of the $77 million was appropriated to CMS for QIC implementation (BIPA section 521). This amount assumed phase-in of Part A and Part B QICs would begin in FY 2004. HHS and CMS subsequently made a business decision to align the phase-in of QICs with the planned transfer of the appeals function from SSA to HHS on July 1, 2005. Had both Part A and Part B QICs been in place at the time OMHA become operational on July 1, the ability of the new OMHA to hear cases forwarded from QICs within the BIPA time frames would have been comprised. Thus, HHS and CMS made a business decision to gradually phase-in QICs, with Part A QICs (the smaller workload) becoming operational on May 1, 2005, and Part B QICs becoming operational January 1, 2006. Since OMHA will be gradually ramping up to full capacity from July 1 to October 1, 2005, this phased-in QIC approach ensures that OMHA is positioned to accommodate the cases forwarded by Part A QICs within the 90-day BIPA time frame. As a result of this business decision, CMS only spent $2 million of the $11 million for QIC implementation in FY 2004.

Second, at the time of the appropriation, $3 million of the $77 million was appropriated to CMS for local coverage decision and national coverage decision appeals, per section 522 of

6

BIPA. This caseload has yet to materialize at the levels originally assumed, and as such, the appropriated money was not spent for this activity.

HHS would also like to clarify why in FY 2004 it only reimbursed SSA $37.5 million of the $50 million appropriated for the ALJ-level of Medicare appeals. In FY 2004, HHS and SSA operated under a Memorandum of Understanding (MOU), whereby HHS would reimburse SSA $1,000 per unit of service. Unit of Service was defined in the MOU as "the adjudication of request(s) for hearing on one or more claims involving one or more beneficiaries that are properly disposed of by a single decision or dismissal. Request(s) for hearing may involve multiple units of service and be assigned multiple docket numbers only when a beneficiary's claim or claims require unique findings of fact and/or application of the law to fact, e.g., individual medical necessity determinations." Through its diligent enforcement of this unit of service reimbursement methodology, HHS reimbursed SSA $12.5 million less than the $50 million appropriated. A portion of this $12.5 million, $4.3 million, was used to advance Medicare appeals activities within HHS, most notably, critical start-up funding for the new OMHA. The remainder, $8.2 million, was used by CMS for one of its most mission-critical functions, claims processing; actual claims in FY 2004 exceeded estimates assumed in the appropriation by 32 million. It should be emphasized that none of this $12.5 million lapsed.

Finally, HHS would like to make a clarification regarding the spending table found on page 54 of the GAO draft correspondence. Nearly all of the funding on this table is CMS spending (not HHS as the title indicates), with the exception of the ALJ Appeals line. The ALJ Appeals line —funds used to reimburse SSA for processing ALJ appeals prior to the transfer—has different sources of funding for FY 2004 and FY 2005. In FY 2004, the $50 million was appropriated to CMS, who then entered into an MOU to reimburse SSA for this work. However, in FY 2005, Congress appropriated $49.6 million (post-recission) for this same purpose within HHS's General Departmental Management (GDM) appropriation, not CMS's appropriation, as the table on page 54 would imply.

Pending SSA Workload

Consistent with the Transfer Plan, SSA has committed to completing all appeals received by it prior to July 1, 2005, with no backlog.

Other Clarifications

HHS would like to make the following clarifications to statements in the draft correspondence:

On page 20 of the draft correspondence, GAO states that, *"CMS published procedures and guidance on implementing statutory changes to the appeals process resulting from both BIPA and MMA in an Interim Final Rule with Comment Period on March 8, 2005."*

HHS would like to note that although the interim final rule with comment period (IFC) appeared in the Federal Register on March 8, 2005, the IFC was actually published on March 1, 2005.

7

Also on page 20 of the draft correspondence, the statement is made that the IFC includes the following change: *"Replacing the claims administration contractors who resolve the appeals at the second level of the process with a new type of contractor called qualified independent contractors(QIC) ... "*

At the present time, in the Part B appeals process, second level appeals are handled by a carrier fair hearing officer. Currently, there is no carrier fair hearing under Part A. The new QICs will be responsible for resolving appeals at the second level of the process under Part A and Part B.

On page 21 of the draft correspondence, GAO states that: *"QICs will have to resolve appeals in 60 days, compared to the 120-day requirement for the claims administration contractors."*

HHS believes the reference to claims administration contractors is inaccurate and potentially confusing. The current 120-day requirement applies to carrier fair hearing officers under the existing Part B appeals process.

Conclusion

HHS appreciates GAO's thoughtful consideration of the progress made in preparing to implement the transfer of the Medicare appeals function from SSA to HHS and welcomes the opportunity to review and comment on the resultant draft correspondence. As the slides noted, the implementation of the Transfer Plan is at a critical and dynamic stage, and HHS is pleased to be able to offer this additional information and updates.

8

HHS Office of Medicare Hearings & Appeals (OMHA) Hiring Status
as of Tuesday evening, June 14
Note: Hiring statistics are subject to change on a daily basis

	FOR JUNE 13 TRAINING				FOR JULY 24 TRAINING				TOTAL OMHA			
Positions In Process	Selected To Date /1	Accepted To Date /2	Planned Target /3	Diff: Plan Vs Hired	Selected To Date /1	Accepted To Date /2	Planned Target /3	Diff: Plan Vs Hired	Selected To Date /1	Accepted To Date /2	Planned Target /3	Diff: Plan Vs Hired
Chief ALJ /4	0	0	0	0	0	0	0	0	0	0	1	-1
Supervisory ALJs	29	19	24	-5	17	6	25	-19	46	25	49	-24
Senior Attorneys	7	7	7	0	n/a	n/a	n/a	n/a	7	7	7	0
Attorneys	29	28	36	-8	22	15	42	-27	51	43	78	-35
Paralegals	23	21	24	-3	15	11	28	-17	38	32	52	-20
Docket Clerks	9	7	11	-4	n/a	n/a	n/a	n/a	9	7	11	-4
Hearing Clerks	23	23	24	-1	15	4	28	-24	38	27	52	-25
Program Analysts	2	2	4	-2	n/a	n/a	n/a	n/a	3	3	4	-1
Staff Assistants	3	2	3	-1	n/a	n/a	n/a	n/a	3	2	3	-1
Office Automation Assistants	3	3	4	-1	n/a	n/a	n/a	n/a	3	3	4	-1
Total, In Process	**128**	**112**	**137**	**-25**	**69**	**36**	**123**	**-87**	**198**	**149**	**261**	**-112**
Positions On-Board /5												
Managing ALJs	4	4	4	0	n/a	n/a	n/a	n/a	4	4	4	0
Hearing Office Managers	4	4	4	0	n/a	n/a	n/a	n/a	4	4	4	0
Program Analysts	2	2	2	0	n/a	n/a	n/a	n/a	2	2	2	0
Emerging Leader	1	1	1	0	n/a	n/a	n/a	n/a	1	1	1	0
Total, On-Board	**11**	**11**	**11**	**0**	**n/a**	**n/a**	**n/a**	**n/a**	**11**	**11**	**11**	**0**
Total, In Process + On-Board	**139**	**123**	**148**	**-25**	**69**	**36**	**123**	**-87**	**209**	**160**	**272**	**-112**

/1 Selected = HHS has identified an individual to whom a position will be offered, and we either are checking references, made an offer, or are awaiting acceptance.
/2 Accepted = HHS's Human Resources office has contacted the individual with an official job offer, the individual has accepted, and a start-date has been identified.
/3 Planned Target = Goal for the number of staff on-board by the time of the designated training. This is not a minimum number required to be operational.
/4 Judge Rhew, the Cleveland Managing ALJ, was designated Acting Chief Judge on April 22.
/5 In addition, Nancy Thompson serves as Director of the Office of Medicare Hearings & Appeals Transition (OMHAT).

(290423)

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548

PRINTED ON RECYCLED PAPER