

# MEDICARE MISMANAGEMENT PART II: EXPLORING MEDICARE APPEALS REFORM

---

---

## HEARING

BEFORE THE  
SUBCOMMITTEE ON ENERGY POLICY,  
HEALTH CARE AND ENTITLEMENTS  
OF THE  
COMMITTEE ON OVERSIGHT  
AND GOVERNMENT REFORM  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

JULY 10, 2014

**Serial No. 113-148**

Printed for the use of the Committee on Oversight and Government Reform



Available via the World Wide Web: <http://www.fdsys.gov>  
<http://www.house.gov/reform>

U.S. GOVERNMENT PRINTING OFFICE

91-226 PDF

WASHINGTON : 2014

---

For sale by the Superintendent of Documents, U.S. Government Printing Office  
Internet: [bookstore.gpo.gov](http://bookstore.gpo.gov) Phone: toll free (866) 512-1800; DC area (202) 512-1800  
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

DARRELL E. ISSA, California, *Chairman*

JOHN L. MICA, Florida	ELLJAH E. CUMMINGS, Maryland, <i>Ranking</i>
MICHAEL R. TURNER, Ohio	<i>Minority Member</i>
JOHN J. DUNCAN, JR., Tennessee	CAROLYN B. MALONEY, New York
PATRICK T. MCHENRY, North Carolina	ELEANOR HOLMES NORTON, District of
JIM JORDAN, Ohio	Columbia
JASON CHAFFETZ, Utah	JOHN F. TIERNEY, Massachusetts
TIM WALBERG, Michigan	WM. LACY CLAY, Missouri
JAMES LANKFORD, Oklahoma	STEPHEN F. LYNCH, Massachusetts
JUSTIN AMASH, Michigan	JIM COOPER, Tennessee
PAUL A. GOSAR, Arizona	GERALD E. CONNOLLY, Virginia
PATRICK MEEHAN, Pennsylvania	JACKIE SPEIER, California
SCOTT DESJARLAIS, Tennessee	MATTHEW A. CARTWRIGHT, Pennsylvania
TREY GOWDY, South Carolina	TAMMY DUCKWORTH, Illinois
BLAKE FARENTHOLD, Texas	ROBIN L. KELLY, Illinois
DOC HASTINGS, Washington	DANNY K. DAVIS, Illinois
CYNTHIA M. LUMMIS, Wyoming	PETER WELCH, Vermont
ROB WOODALL, Georgia	TONY CARDENAS, California
THOMAS MASSIE, Kentucky	STEVEN A. HORSFORD, Nevada
DOUG COLLINS, Georgia	MICHELLE LUJAN GRISHAM, New Mexico
MARK MEADOWS, North Carolina	<i>Vacancy</i>
KERRY L. BENTIVOLIO, Michigan	
RON DeSANTIS, Florida	

LAWRENCE J. BRADY, *Staff Director*

JOHN D. CUADERES, *Deputy Staff Director*

STEPHEN CASTOR, *General Counsel*

LINDA A. GOOD, *Chief Clerk*

DAVID RAPALLO, *Minority Staff Director*

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

JAMES LANKFORD, Oklahoma, *Chairman*

PATRICK T. MCHENRY, North Carolina	JACKIE SPEIER, California, <i>Ranking</i>
PAUL GOSAR, Arizona	<i>Minority Member</i>
JIM JORDAN, Ohio	ELEANOR HOLMES NORTON, District of
JASON CHAFFETZ, Utah	Columbia
TIM WALBERG, Michigan	JIM COOPER, Tennessee
PATRICK MEEHAN, Pennsylvania	MATTHEW CARTWRIGHT, Pennsylvania
SCOTT DESJARLAIS, Tennessee	TAMMY DUCKWORTH, Illinois
BLAKE FARENTHOLD, Texas	DANNY K. DAVIS, Illinois
DOC HASTINGS, Washington	TONY CARDENAS, California
ROB WOODALL, Georgia	STEVEN A. HORSFORD, Nevada
THOMAS MASSIE, Kentucky	MICHELLE LUJAN GRISHAM, New Mexico

# CONTENTS

---

Hearing held on July 10, 2014 .....	Page 1
WITNESSES	
Ms. Nancy J. Griswold, Chief Administrative Law Judge, Office of Medicare Hearings and Appeals, U.S. Department of Health and Human Services	
Oral Statement .....	4
Written Statement .....	7
APPENDIX	
Office of Medicare hearings and appeals chart, submitted by Chairman Lankford .....	38
Questions for the record answered by Judge Griswold .....	40
Oct. 28, 2014 letter to Rep. Maloney from Judge Griswold .....	41
July 9, 2014 letter to Rep. Lankford from Proper Payments .....	42
Statement for the record by OIG of HHS .....	45



## **MEDICARE MISMANAGEMENT PART II: EXPLORING MEDICARE APPEALS REFORM**

**Thursday, July 10, 2014**

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE, AND  
ENTITLEMENTS,  
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,  
*Washington, D.C.*

The subcommittee met, pursuant to call, at 2:13 p.m., in Room 2154, Rayburn House Office Building, Hon. James Lankford [chairman of the subcommittee] presiding.

Present: Representatives Lankford, Gosar, Woodall, Massie, Meadows, Speier, Norton, Duckworth and Lujan Grisham.

Staff Present: Molly Boyd, Deputy General Counsel and Parliamentarian; Katelyn E. Christ, Professional Staff Member; Linda Good, Chief Clerk; Meinan Goto, Professional Staff Member; Mark D. Marin, Deputy Staff Director for Oversight; Emily Martin, Counsel; Laura L. Rush, Deputy Chief Clerk; Andrew Shult, Deputy Digital Director; Sarah Vance, Assistant Clerk; Jaron Bourke, Minority Director of Administration; Aryele Bradford, Minority Press Secretary; Una Lee, Minority Counsel; and Michael Wilkins, Minority Staff Assistant.

Mr. LANKFORD. Good afternoon. We apologize for a little bit of delay. We'll have additional delays in the moments ahead. Ms. Speier and I both were on the floor doing some debate on the current bill that's on the floor, appropriations bill. The votes, we understand, will be called for that in the next 15 to 20 minutes. So what I'm going to try to accomplish is an opportunity for us to be able to go through some of our opening statements, get us established. When votes are called, we'll recess for a short period of time, then we'll come back and finish up with questions.

This is the Energy Policy, Health Care and Entitlements hearing on Medicare and Mismanagement Part II: Exploring Medicare Appeals Reform. The chair is authorized to declare a recess of the committee at any time.

I'd like to begin this hearing by stating the Oversight Committee mission statement. We exist to secure two fundamental principles: First, that Americans have the right to know that the money Washington takes from them is well spent; second, Americans deserve an efficient, effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights.

Our solemn responsibility is to hold government accountable to taxpayers, because taxpayers have the right to know what they get

from their government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

This conversation is, as I mentioned already, the second part of a two-part conversation about how things are going. We have multiple different entities that have a significant backup. They're waiting through the appeals process, some of them for years in the appeals process, healthcare providers, hospitals, individuals that do not have a large cash flow and individuals and businesses that do.

So the issue today is why does that exist, how do we actually resolve this, what are the fixes that are needed legislatively, and what can we take care of right now?

I'd like to yield additional time to Mr. Meadows from North Carolina, who has been very, very involved in this process as well.

Mr. MEADOWS. Thank you, Mr. Chairman, and thank you for your leadership on this particular issue. And really this comes down and boils down to people, and what we have to do is make sure that as government agencies that we do the very best we can to go after waste, fraud and abuse, which the chairman has so eloquently articulated, yet at the same time make sure that the rule of law, in fairness to everyone, is upheld.

And right now I think that there is great question—and not singling you out, Ms. Griswold, because I've had some great conversations with really folks within the ALJ. There seems to be a very compassionate desire to fix the problem, and so that's what we're looking for here today.

My other concern, though, and I think the concern of the American people, is this whole process in terms of when we go after waste, fraud and abuse, if we cast such a wide net, then we're taking the decisionmaking away from doctors, healthcare providers, hospitals, many people who make their decisions who are trained, who go to years of training to do that, and we're transferring that decisionmaking capability because of reimbursements to—actually to a bureaucrat.

For me, I have a lot more trust in the nurse or the doctor that cares for me than I do somebody that works here in Washington, D.C. I think that polls would show that to be the fact as well. So what I'm looking for specifically, and it will be difficult, I know, because you're all part of an agency, but there's this wall of separation that somehow goes up that the American people don't understand, that they all see you part of HHS or part of CMS, and yet you have a wall, CMS has a wall.

What I need to do is have as much finger pointing as possible to say this is what will solve it, knowing that I'm not asking you to throw anybody under the bus. As the chairman pointed out, we're looking for legislative fix, for appropriations that need to be done so that we can help this to quit being a problem, and so we can obey the law the way that it is written.

And so I thank the chairman, and I yield back.

Mr. LANKFORD. Thank you, Mr. Meadows.

I would like to ask unanimous consent to conserve for the record a chart giving disposition outcome rates that was given to us by the Office of Medicare Hearings and Appeals just last night. I'd like

to be able to add this to the record and be able to share with all individuals that are here as well.

I'd like to now recognize the distinguished ranking member, the gentlelady from California Ms. Speier, for her opening statement.

Ms. SPEIER. Mr. Chairman, thank you for holding the hearing, and I want to thank the Chief Judge Griswold for appearing before us today on this important issue.

You know, I think we can all agree that Medicare providers are entitled to have their claims administered fairly, efficiently and without undue delay so that they can focus on their core mission of providing care to our Nation's seniors. If they are billing incorrectly, they deserve to know sooner than later. Unfortunately, that is not the situation facing providers today.

Medicare providers appealing payment decisions made by contractors are waiting on average 387 days to have their claims adjudicated by the Office of Medicare Hearings and Appeals. For providers submitting new claims, the wait could be as long as 28 months just to have an appeal assigned to an ALJ. The current claims backlog at OMHA is unacceptable and unsustainable. OMHA must make significant changes in how it does business. I look forward to hearing from the chief judge about the initiatives that OMHA is implementing to approve efficiency and alleviate the backlog.

But I also want to remind my colleagues that the claims backlog is a problem that Congress created. Congress has required CMS appropriately to be increasingly vigilant in detecting and reducing the amount of waste, fraud and abuse in the \$600 billion Medicare program that covers 51 million beneficiaries. This emphasis on program integrity is critical both to the health of our Nation's seniors and to the protection of our taxpayer dollars, but this increased scrutiny has not been coupled with additional funds to address the influx of claims and appeals that have resulted.

With the Medicare Prescription Drug Act, Congress created the Medicare Administrative Contractors, the Zone Program Integrity Contractors, and the Recovery Auditor Contractors pilot program. In 2010, the RAC program was made permanent and expanded nationwide. All of these contractors conduct audits of Medicare providers. Each of these contractors have increased the number of claims being audited for payment accuracy in recent years. According to a 2013 GAO study, the volume of contractor postpayment claims reviews increased by 55 percent between 2011 and 2012.

More audits means, obviously, more appeals. That is an inevitable result of the additional program integrity functions that we here in Congress have asked CMS to implement. Yet Congress has not provided OMHA with more funding for more judges to adjudicate claims, so when we wring our hands about the number of days that these providers have to wait, we have to wring our hands and look directly at ourselves.

Despite the sixfold increase in the number of appeals since 2006, the number of ALJs at OMHA has remained relatively constant. In 2007, OMHA received 20,000 RAC claims. In 2013, OMHA received 192,000 RAC claims, yet received no additional funding to handle this workload. I joined a number of my colleagues on both sides of

the aisle in sending a letter to the Secretary of HHS citing concerns about the RAC program and expressing the need for reform.

But it's also important to note that RACs have led to the exposure of many questionable billing practices, such as billing for hospital readmissions on the same day with the same diagnosis; durable medical equipment items delivered, but never ordered by a physician; hospital claims coded with illness a patient did not possess; and excessive units of medication ordered, especially where the billed dose would be harmful or lethal to the patient who received it.

We may need to consider reforms to the RAC program that reduces the administrative burden of RAC audits on providers, but we must also ensure that we preserve the central program integrity functions of the RACs who performed the critically important, congressionally mandated function of reducing improper payments in the Medicare program.

Finally, an important part of reducing the burden on providers is ensuring that appeals from adverse RAC determinations are adjudicated in a timely manner. Congress must do its part by ensuring that OMHA's budget request is fully funded. We have to give OMHA the resources commensurate with the workload that we have asked them to perform.

And with that, I yield back.

Mr. LANKFORD. Members will have a requisite 7 days to submit additional statements if they choose to add statements for the record.

Ms. Griswold, you are the sole individual in this hearing today, and we are grateful that you are here. Pursuant to all committee rules, all witnesses are sworn in before they testify. If you'd please stand, raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth and nothing but the truth, so help you God?

Ms. GRISWOLD. I do.

Mr. LANKFORD. Thank you.

Let the record reflect the witness answered in the affirmative.

You, of course, may be seated.

Ms. Griswold is the Chief Administrative Judge at the Department of Health and Human Services Office of Medicare Hearings and Appeals, and we are very grateful that you are here to be able to have this conversation. To allow time for discussion, we'd ask you to limit your oral testimony to 5 minutes. Of course, your written testimony we've already received will be a part of the permanent record as well. We have not called votes yet, so we're not in a hurry at this point, so I'm grateful to be able to receive your testimony. You may begin.

**STATEMENT OF NANCY J. GRISWOLD, CHIEF ADMINISTRATIVE LAW JUDGE, OFFICE OF MEDICARE HEARINGS AND APPEALS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Ms. GRISWOLD. Chairman Lankford, Ranking Member Speier and members of the subcommittee, I want to thank you for the invitation to discuss the workloads of the Office of Medicare Hearings

and Appeals, or what we call OMHA. OMHA administers the nationwide Medicare administrative law judge hearing program and is responsible for conducting the third level of review of Medicare appeals. In order to ensure that OMHA's adjudicators have decisional independence from CMS, OMHA was established as a separate agency within the Department of Health and Human Services and reports directly to the Secretary. Accordingly, we operate under a separate appropriation, and we are both functionally and physically separate from CMS.

Between fiscal years '11 and '13, what had previously been a gradual upward trend in appeal receipt levels took an unexpectedly sharp turn, and OMHA experienced an overall 545 percent increase in our appeals. The rise in the number of appeals resulted both from increases in the number of beneficiaries utilizing covered services, and also from the expansion of OMHA's responsibility to include the adjudication of appeals resulting from new audit workloads undertaken by CMS, including the nationwide implementation of the Recovery Audit Program. There have also been increases in Medicaid State agency appeals.

We are pleased that OMHA's 2014 enacted funding level has allowed for the hiring of 7 additional teams, bringing OMHA's adjudication capacity to 72,000 appeals per year; however, this capacity pales in comparison to the adjudication workload. In fiscal year '13 alone, OMHA received 384,151 appeals; and in fiscal year '14, receipt levels through July 1 are approximately 509,124 appeals.

As a result, OMHA had over 800,000 appeals pending on July 1 of 2014. Although ALJ team productivity has more than doubled from fiscal year '09 through '13, OMHA has been receiving approximately 1 year's worth of appeals every 4 to 6 weeks, driving adjudication time frames to their current high of 387 days.

OMHA recognizes the need to adjudicate appeals with greater efficiency. By the end of the fiscal year, we will release a manual which utilizes best practices to standardize our business process. We are using information technology to convert our process from paper to electronic, an effort which will culminate in its first release in the summer of 2015.

We have also developed a template system which simplifies the work of our staff by providing standardized fillable formats for routine word processing. OMHA also proposed and former Secretary Sebelius established a departmental interagency work group, which conducted a thorough review of the appeals process and developed additional initiatives that both OMHA and CMS are currently implementing.

On June 30, OMHA posted on its Web site two new options for appellants. The first allows appellants to have their claims adjudicated using statistical sampling and extrapolation methods. The second option for appellants uses alternative dispute resolution techniques during a facilitated settlement conference.

Finally, OMHA has redirected the efforts of its senior attorneys to assist in the prioritization of beneficiary appeals. Any beneficiary who believes their case is not receiving priority consideration at OMHA may contact us directly at Medicare.Appels@HHS.Gov or at our toll-free number, 855-556-8475.

Although OMHA is functionally and organizationally separate, I can provide a general outline of initiatives that are being undertaken at CMS. These include beginning global settlement discussions involving similarly situated appellants, requiring the new recovery auditors to offer providers and suppliers a 30-day discussion period, allowing for recovery audit payment only after a qualified independent contractor has determined that an overpayment exists, issuing a proposed rule requiring prior authorization for certain durable medical equipment, and requiring prior authorization for two particular Part B services under CMS' demonstration authority.

Although the Department is working to address the backlog and the number of prospective appeals within current resources and authorities, the initiatives that I've discussed today will be insufficient to close the gap between workload and resources at OMHA. Although all workloads at OMHA have experienced rapid growth, a significant portion of the increase is a consequence of the Department's effort to implement legislation designed to combat Medicare fraud and to reduce improper payments.

The Department is committed to crafting solutions which will bring these efforts and the resulting appeal workload into balance. We look forward to working with this committee and with our stakeholders to develop and implement these solutions.

I thank you for your time and concern.

[Prepared statement of Ms. Griswold follows:]

**STATEMENT OF  
NANCY J. GRISWOLD  
CHIEF ADMINISTRATIVE LAW JUDGE  
OFFICE OF MEDICARE HEARINGS AND APPEALS**

**ON  
“OFFICE OF MEDICARE HEARINGS AND APPEALS  
WORKLOADS”**

**BEFORE THE  
UNITED STATES HOUSE COMMITTEE ON OVERSIGHT &  
GOVERNMENT REFORM  
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE &  
ENTITLEMENTS**

**JULY 10, 2014**

**U.S. House Committee on Oversight & Government Reform**  
**Subcommittee on Energy, Health Care & Entitlements**  
**Hearing on Office of Medicare Hearings and Appeals Workloads**  
**July 10, 2014**

Chairman Lankford, Ranking Member Speier and members of the Subcommittee, thank you for the invitation to discuss the workloads at the Office of Medicare Hearings and Appeals (OMHA). 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 hearing program for Medicare claims and entitlement appeals under sections 1869 and 1155, of the Social Security Act (the Act). OMHA ensures that Medicare beneficiaries, and the providers and suppliers that furnish items or services to Medicare beneficiaries, as well as Medicaid State Agencies, have a fair and impartial forum to address disagreements with Medicare claim determinations. This includes determinations related to Medicare eligibility and entitlement, as well as income-related premium surcharges made by the Social Security Administration (SSA). In addition, OMHA provides hearings on appeals of coverage determinations made by Medicare Advantage Organizations, health maintenance organizations, competitive medical plans, and Part D plan sponsors under sections 1876(c)(5)(B), 1852(g)(5), and 1860D-4(h) of the Act.

The Medicare claims appeals process consists of four levels of administrative review within HHS, and 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 Administrative Law Judges. Subsequent reviews are conducted at the fourth level of appeal within the Departmental Appeals Board (DAB), and at the fifth level by the federal district courts.

The 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. The first level is the reconsideration level conducted by the SSA. The second level of review is administered by OMHA and is conducted by Administrative Law Judges. Subsequent reviews are conducted at the third level of appeal within the DAB and at the fourth level by the federal district courts.

The Department 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 Administrative Law Judge hearing

function of the Medicare claims and entitlement appeals process from the SSA to the Department of Health and Human Services. OMHA was established to improve service to appellants and to reduce the 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 and Improvement Act of 2000 (BIPA) (Pub. L. 106-554). In order to ensure that OMHA's adjudicators would have decisional independence from CMS, OMHA was established as a separate agency within the Department of Health and Human Services, 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:

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

With this mix of work at the expected levels, OMHA was for the most part able to meet the 90-day time frame that Congress contemplated for most appeals. However, starting in FY 2010, OMHA began to experience an upward trend in the number of requests for hearings and delays in the average processing times for appeals.

From FY 2011 thru FY 2013, the upward trend in receipt levels took an unexpectedly sharp turn and OMHA experienced an overall 545% growth in appeals (from 59,600 in FY 2011 to 384,151 in FY 2013). This rise in the number of appeals resulted both from increases in the number of beneficiaries utilizing services covered by Medicare (CMS now processes more than one billion claims annually) and from the expansion of OMHA's responsibility to adjudicate appeals resulting from new audit workloads, including the nationwide implementation of the Recovery Audit Program in 2010. The Recovery Audit Program, established by Congress, has been very successful, returning billions in improper payments to the Medicare Trust Fund. Only 7% (99,492) of the 1.419 million Recovery Auditors claims identified as overpayments were challenged and overturned on appeal as published in the Centers for Medicare and Medicaid Services (CMS) FY 2012 Report to Congress. There have also been increases in Medicaid State Agency (MSA) appeals of Medicare coverage denials for beneficiaries enrolled in both Medicaid and Medicare. Although ALJ team productivity (dispositions per ALJ) more than doubled from FY 2009 through FY 2013 (from an average of 534 dispositions per ALJ team per year in FY 2009 to 1260 in FY 2013), the magnitude of these increases 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 387 days (as of June 30, 2014).

OMHA has been able to maximize its productivity by supporting each of its ALJs with assigned 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 ALJ teams on board. Under the 2014 continuing resolution, OMHA's funding level supported 65 ALJ teams. OMHA's 2014 enacted funding level allowed for the hiring of 7 additional teams, who will report on August 25, 2014. This will bring OMHA's adjudication capacity to approximately 72,000 appeals per year. However, this capacity pales in comparison to the adjudication workload. In FY 2013 alone, OMHA received 384,151 appeals, and in FY 2014 receipt levels through July 1 are approximately 509,124 appeals. Weekly appeal levels have ranged between 10,000 and 16,000 throughout FY 2014. As a result, OMHA had over 800,000 appeals pending on July 1, 2014. At current receipt and adjudication capacity levels, OMHA's Central Operations, which is the focal point for all incoming appeals, is receiving one year's worth of appeals every four to six weeks.

Due to the rapid and persistent influx of appeals, OMHA's four field offices faced significant challenges in their ability to safely store the high number of files pending hearing. As a consequence, OMHA began deferring its requests for case files from the lower appeal levels, and deferred the assignment of most requests for hearing to an Administrative Law Judge (ALJ), until they could be accommodated on an ALJ's docket. The decision to defer assignment of appeals was a management decision related to the geography of case storage and did not cause any additional delays in the hearing and decision of appeals. Although the assignment of most appeals has been deferred under this process, appeals filed by beneficiaries, our most vulnerable appellants, comprise less than 2% of our workload and continue to be given priority assignment to ALJs. In February, 2014, OMHA began to assign a limited number of non-beneficiary appeals to judges who were able to accommodate additional appeals on their dockets. Throughout this time, OMHA has continued to conduct hearings and issue decisions on appeals already assigned.

Recognizing the impact the growing workload would have on our appellant community and the need for transparency with regard to its growing workloads, OMHA held an Appellant Forum on February 12, 2014, to inform stakeholders of its operating status. Over 800 individuals attended the forum either in person or by webinar. In addition to presentations by OMHA, both CMS and the DAB presented information concerning their workloads and processes. OMHA's next Appellant Forum is tentatively scheduled for October 29, 2014, and will be formally announced on our website in the near future.

In the face of dramatically increasing workloads, OMHA recognizes the need to deliver high quality and timely decisions on benefits and services to the Medicare community with greater efficiency. By the end of the fiscal year we will release our adjudicative business process manual, which will utilize best practices to standardize our business processes. We are using information technology to convert our process from paper to electronic. This effort will culminate in the first release of our Electronic Case Adjudication Processing Environment (ECAPE) in the summer of 2015. We have also developed a Medicare Appeals Template System (MATS), which simplifies the work of our staff by providing standardized fillable formats for routine word processing.

Recognizing the gravity of its workload challenges, OMHA proposed and former Secretary Sebelius established a departmental interagency workgroup in 2013, which included leaders from each of the three agencies involved in the Medicare appeals process (CMS, OMHA, and DAB). This interagency group conducted a thorough review of the appeals process and developed a series of initiatives that both OMHA and CMS are implementing to reduce the current backlog of pending appeals and the number of appeals that reach OMHA.

As a result of this cross-component cooperation and the assistance we have received from departmental leaders, OMHA is now implementing a number of pilot programs. On June 30, OMHA posted on its website two new options for appellants seeking resolution of their appeals. The first allows appellants to have their claims adjudicated using statistical sampling and extrapolation. This initiative facilitates resolution of large numbers of claims based upon resolution of a statistically valid sample. The second new option for appellants uses alternative dispute resolution techniques during a facilitated settlement conference conducted by OMHA attorneys who have been trained in mediation techniques. OMHA will be monitoring the performance of these pilots and, if successful, will roll them out nationally as funding allows. Finally, to bolster the processing of beneficiary appeals as our first priority, OMHA has redirected the efforts of its senior attorneys to assist in the prioritization of these appeals. Any beneficiary who believes their case is not receiving priority consideration at OMHA may contact us directly by e-mail at [Medicare.Appeals@hhs.gov](mailto:Medicare.Appeals@hhs.gov) or at OMHA's toll free number, 855-556-8475.

OMHA is, by Congressional design, functionally and organizationally separate from CMS and its review processes. I understand, however, that in addition to the initiatives OMHA has undertaken to mitigate workload challenges, CMS also has taken a number of steps intended to substantially reduce the number of appeals submitted to OMHA. While CMS would be in the best position to address the specifics of those initiatives, I can provide a general outline. These initiatives include: a) beginning global settlement discussions involving similarly-situated claimants; b) under the new fee for service recovery audit contracts, requiring the new Recovery Auditors to offer providers and suppliers a 30-day discussion period to allow an opportunity for resolution before the Recovery Auditor refers a claim to the Medicare Administrative Contractor for collection; c) under the new fee for service recovery audit contracts, allowing for payment only after CMS' Qualified Independent Contractor (QIC) has made a determination supporting the recovery auditor's determination of an overpayment; d) issuing a proposed rule requiring prior authorization for certain durable medical equipment frequently subject to overutilization; and e) using CMS's demonstration authority to require prior authorization for two particular Part B services.

OMHA is privileged to have an extremely dedicated workforce of both Administrative Law Judges and staff who remain committed to processing Medicare appeals in both a quality and timely fashion. While the Department is working to address the backlog and the number of prospective appeals with current resources and authorities, the initiatives discussed today are

insufficient to close the gap between workload and resources at OMHA. Although all workloads at OMHA have experienced rapid growth, a significant portion of the increase is a consequence of the Department's efforts to implement legislation designed to combat Medicare fraud and reduce improper payments. The Department is committed to bringing these efforts and the resulting appeal workload into balance. With that goal in mind OMHA continues to work with departmental leaders to develop comprehensive solutions to its growing workloads and we also look forward to working with this committee and our stakeholders to develop and implement these solutions.

Mr. LANKFORD. The chair recognizes Dr. Gosar for questioning.

Mr. GOSAR. Thank you, Mr. Chairman.

Ms. Griswold, can you walk us through the five levels of Medicare appeals process?

Ms. GRISWOLD. Yes. The first two levels are conducted at CMS. They are administered by CMS and CMS' contractors. The third level is at the Office of Medicare Hearings and Appeals and is conducted by administrative law judges. The fourth level is at the Medicare Appeals Council, which is part of the Departmental Appeals Board and is also a separate agency within Health and Human Services. And the final level is with the Federal district courts.

Mr. GOSAR. Gotcha.

Can you describe the different types of appeals heard by the ALJs?

Ms. GRISWOLD. Yes. We hear both Part A and Part B appeals under Medicare, and we also hear the Part D appeals. This was part of our original charge, the prescription drug appeals. We hear IRMAA appeals. We hear appeals on entitlements. We also hear the Part C Medicare Advantage appeals.

Mr. GOSAR. In percentages of those, what do you hear more often, most often in those appeals for ALJs?

Ms. GRISWOLD. Well, it varies. In recent years we have heard a significant number of appeals under Part A, which are the acute care hospital—the acute hospital appeals.

Mr. GOSAR. And does that happen, would you say, 30, 40, 50 percent of the time in the ALJ workload?

Ms. GRISWOLD. I can get you that number. Hold on just 1 minute.

Mr. GOSAR. I mean, trends really help you out trying to figure out what the problem—you know, being a healthcare provider, I mean, you always look at trends about what's happening, so that gives you kind of a workload basis of which to delegate resources to.

Ms. GRISWOLD. Most of our recovery audit appeals have been Part A, and so you can kind of use that as a gauge. In 2014, 41.2 percent—oh, I'm sorry. I have the wrong number there; 54.2 percent to date were recovery audit appeals, and those are predominantly those Part A appeals.

Mr. GOSAR. Part A.

So according to HHS Office of Inspector General, in 2010, 56 percent of the appeals were decided as fully favorable to the appellants, a reverse previous lower-level decision. What is the current rate?

Ms. GRISWOLD. All right. And are you asking about the RAC decisions, the RAC appeals, or just overall—

Mr. GOSAR. Just overall.

Ms. GRISWOLD. —overall OTRs? All right.

In 2014, the fully-favorable OTR rate for the fiscal year to date is 19.3 percent.

Mr. GOSAR. Gotcha.

Now, has OMHA conducted an analysis on what factors are really driving this backlog? I mean, you made mentions of three of them, but I'd like to be a little bit more specific.

Ms. GRISWOLD. Yeah. There are a number of things. All of our workloads are going up. We attract what we call our traditional workload, which is, you know, the Part A/B workload. We also have been tracking the RAC workload, and we've tracked the dual-eligible or Medicaid and Medicare beneficiary workload. All three of those have been going up. The traditional workload has been driven largely partly by demographics. I mean, there are just more beneficiaries on the rolls who are utilizing more services.

It has also been driven by increases in CMS' audit efforts, Zone Program Integrity Contractors' identification of improper payments. Anything that results in more denials at lower levels is going to result in more appeals at the ALJ level.

Of course, the Recovery Audit Program is the one that gets a lot of attention. It was a new program in 2010, so it was a startup, and the increase in receipts in that program was, of course, dramatic. That occurred primarily at our level between 2011 and 2013 is when we saw the largest spikes in that workload. We've also seen increases in this dual-eligible workload, beneficiaries that are eligible for both Medicare and Medicaid, and those workloads have gone up as well.

Mr. GOSAR. I thank you.

I yield back, Mr. Chairman.

Mr. LANKFORD. Ms. Speier and I are going to reserve our questions until after the voting time, so the chair would like to recognize Mr. Meadows for his questioning.

Mr. MEADOWS. Thank you, Mr. Chairman.

Ms. Griswold, is it not true that the efficiency of your adjudicators has actually increased? You're handling more cases per adjudicator on an annual basis; is that not true?

Ms. GRISWOLD. It is true, yes. We're very proud of our—

Mr. MEADOWS. All right. So you're actually more efficient by 20 percent if you really look at the real numbers, that you're adjudicators are actually being a lot more efficient than they've ever been before?

Ms. GRISWOLD. Well, and since 2009, our adjudicators have actually doubled their productivity.

Mr. MEADOWS. Right. And so if we look at that, this is not a problem of an administrative law judge just sitting back eating bonbons?

Ms. GRISWOLD. No.

Mr. MEADOWS. Okay. All right.

Ms. GRISWOLD. We have a very dedicated workforce.

Mr. MEADOWS. I think we can both agree on that.

At this particular point, and you've done your homework, you've looked at the previous hearings, would you say an estimate under our current rates right now based on the estimates of potential backlog of 1 million cases, I guess, was in the budget assessment that we got, that that is an 8- to 10-year backlog to adjudicate them based on current staffing and workload efficiency?

Ms. GRISWOLD. I think if you do the simple math, which is, you know—

Mr. MEADOWS. I'm a simple guy, so simple math, you know.

Ms. GRISWOLD. —workforce divided by adjudicators, you know, of course that is the number you come up with. It does not, however,

take into account the efficiencies that we are putting in place, the initiatives both at CMS and within our pilot programs.

Mr. MEADOWS. So granted, you've got the—I saw the guy smiling, so he's part of your efficiency thing there. And I see that, and so I'm encouraged by that.

You are familiar with the fact that the law says that you're required to have a 90-day turnaround. That's the law. That is the law.

Ms. GRISWOLD. Yes, that is—the statute envisions a 90-day processing time.

Mr. MEADOWS. Yeah. And you're also familiar with the fact that the intent of Congress was to have that 90-day turnaround?

Ms. GRISWOLD. Yes. I—

Mr. MEADOWS. Okay. Because—go ahead.

Ms. GRISWOLD. No, I was just going to say, I think that's part of why OMHA—if you look back at the legislative history, that's part of why we were established in the first place was to deal with processing delays in Medicare cases that existed at Social Security.

Mr. MEADOWS. And you are familiar with the fact that you—because the intent of Congress is that, that there is a law out there that authorizes you to take moneys from other trust funds to do three things: hire additional administrative law judges, provide additional training, and increase the staff of the Department Appeals Board, those three things. You are familiar with that?

Ms. GRISWOLD. I think you're talking about the reprogramming authority.

Mr. MEADOWS. Well, it's Public Law 108–173, subtitle D, if your counsel would like to look at it. I mean, I've got a copy of it. But with that, even the budget requirement or request that you guys have made, I guess, require for additional seven units; is that correct?

Ms. GRISWOLD. Our fiscal year '14 enacted level allows for seven additional ALJs.

Mr. MEADOWS. So what are we doing on 2015?

Ms. GRISWOLD. The President's budget—

Mr. MEADOWS. Yeah.

Ms. GRISWOLD. —for 2015 would give us an additional 17 teams.

Mr. MEADOWS. Right. So I've done the simple math based on the President's budget and based on where we are, and does that get you to 90 days?

Ms. GRISWOLD. No.

Mr. MEADOWS. Okay. Does it get you to less than 3 years? The answer is no.

Ms. GRISWOLD. Well, the initiatives—I want to qualify that. If we're talking about given current authorities and current funding, then the answer is no.

Mr. MEADOWS. Well, your request. It's the President's request. So your request, at this particular point how many years would somebody have to wait for justice?

Ms. GRISWOLD. I think it is—

Mr. MEADOWS. 5.3 years?

Ms. GRISWOLD. I think it is impossible at this point to really pin down how long they will have to wait.

Mr. MEADOWS. Okay.

Ms. GRISWOLD. We are—you know, we do the math as, I think, an outside limit.

Mr. MEADOWS. All right. Well, let me close with this, then: How many businesses have to go out of business before we start abiding by the law?

Ms. GRISWOLD. The 90-day timeframe that's envisioned by Congress—

Mr. MEADOWS. Ninety-day law. It is law. I can give you a copy. Ninety-day law.

Ms. GRISWOLD. I also have to point out, and it is in the statute, we recognize that, there is, however, a safety valve in that statute as well, which I need to point out, which is the right to escalate claims. And I think that also envisioned—

Mr. MEADOWS. So we just moved the 10-year backlog up to number four or number five? That won't work either. I mean, I've looked at their budgets.

Ms. GRISWOLD. That is what the statute envisions.

Mr. MEADOWS. Okay.

Ms. GRISWOLD. The interesting thing in this, though, is that people have chosen not to escalate. This year we had 152 requests to date, which I believe indicates that providers and suppliers are still finding value in our ALJ hearing process and choose to remain in the queue.

Mr. MEADOWS. So your recommendation is for all those that are watching here today to escalate their claims if they're in this 10-year backlog? I can't imagine you would say that.

Ms. GRISWOLD. No, it is an option for them.

Mr. MEADOWS. Okay. All right.

I yield back. I thank the patience of the chair.

Mr. LANKFORD. Ms. Griswold, we're going to take a recess. The votes have been called, and so we're headed that direction, and we will recess until the conclusion of the votes. The votes, I would estimate, are going to take somewhere around 30 minutes, maybe a little bit longer to be able to go through, and then we will reconvene at that time.

Ms. GRISWOLD. Great.

[recess]

Mr. LANKFORD. I apologize for the delay there with the votes. We do not expect votes to interrupt us. Since we're voting about—9 o'clock is our next vote series. If we're still meeting in our hearing at that time, this would be not a good sign. So we don't anticipate that as well. But I do apologize, that 30-minute delay ended up being about an hour and 20 or so before it was all said and done.

We will go back and forth here to be able to process through questions. Ms. Speier, if you're okay with the number that's here, I'm okay if we just start opening up questions, and we'll just start to formally go through this.

Ms. Duckworth, is that all right with you?

So we'll kind of turn clocks off. We'll start addressing questions, and I have no particular order on that. That way, if you want to be able to interrupt during the questioning time, you're free to be able to do that to be able to get a follow-up question to any statement that's made.

Ms. Griswold, what that will do is that changes our format some. It won't change yours. We typically do a very structured 5-minute time during our first round; our second round of questioning, it's a more open process where any Member can ask a question at any time. Just so if you make a statement, the Member that asked you the question is not limited to the one that does the follow-up. Is that fair enough?

Ms. GRISWOLD. Absolutely.

Mr. LANKFORD. And so we'll just open this up to more conversational style.

Ms. GRISWOLD. I'm just answering questions, so—

Mr. LANKFORD. Great. It doesn't change, I guess, what's happening on your side of the dais very much at all. It just changed a little bit on our process.

I do have a question on the numbers that you submitted to us on the recovery audit appeals work, percent increase in the non-recovery, I should say. I want to be able to go through a couple of these with you.

You list out on the disposition outcome rates fully favorable, partially favorable, unfavorable, remanded, dismiss and other. Can you give us a quick definition on what that means to the provider for each of those in the process that happens?

Fully favorable, obviously they've overturned the previous two, it comes back to them; partially favorable, there's a little bit of a change, and I'd like some definition there; unfavorable, basically they lost entirely the previous two. They're going to appeal, then, to the fourth level at that point.

Ms. GRISWOLD. Right.

Mr. LANKFORD. Give us partially favorable, what that means, remanded, dismiss and other.

Ms. GRISWOLD. Yeah. Partially favorable, our appeals consist generally of a number of claims that will be submitted with each appeal, and so a partially favorable decision would say that some of these claims are payable, and some of these claims are not payable. And so that would be what that is.

Mr. LANKFORD. So fully favorable, if a provider comes in, and they've got 10 different cases in front of you, they want all 10 of those. It may be another one that's another provider comes in, they bring in 10 cases, they want 7 of them or 2 of them or whatever it may be. So we don't know if they want 1 of those or 10 of those in that case, correct?

Ms. GRISWOLD. Exactly.

Mr. LANKFORD. Okay. So unfavorable, they lost all of them?

Ms. GRISWOLD. Right.

Mr. LANKFORD. And tell us about remanded and dismissed.

Ms. GRISWOLD. The remanded, we do have some authority to send cases back to the lower level or to the QIC if there is information that we need from them and that information is only available to—you know, from CMS and its contractors. And so we can do some limited remands.

Mr. LANKFORD. Okay. With Part A, that seems to be a very high percentage that's actually being remanded and coming back. Do we know what happens then? Once they go back down to the second level, what occurs?

Ms. GRISWOLD. Well, actually, with most of these, they have come back to us, and this large number was related to the Part A/B policy issue, which was resolved by CMS through rulemaking, and so those are coming back to us.

Mr. LANKFORD. Okay. So help us understand the order there. When you're talking about it's coming back to us, that meant it went to the fourth level, it came back to you?

Ms. GRISWOLD. Yes.

Mr. LANKFORD. What does that mean? So talk us through how that happens.

Ms. GRISWOLD. Well—

Mr. LANKFORD. Because this is a very high number here. You're talking about as many are remanded as are found fully favorable, partially favorable and unfavorable combined.

Ms. GRISWOLD. Yes. And in these cases, many of the judges decided to remand them. You know, they're basically questions about whether or not claims would be paid as inpatient claims under Part A, or whether they would be paid as outpatient claims under Part B. That was, you know, the basic issue. And so in order to get—many of the judges felt they needed additional information in order to make that decision, and they sent these claims back to the lower level to get that information.

What has happened as a result of CMS' rulemaking and—these cases are actually going to be coming back to us. And I think they have come back to us.

Mr. LANKFORD. Okay. So they're remanded, you got the additional detail, it's now coming back to you. How does that show up in our statistics here of what we're trying to see? What we're trying to evaluate is what's really happening in these cases. When a very high percentage of remand and dismiss, it's hard to be able to tell what's really going on.

Ms. GRISWOLD. Well, and we don't double count them. I think that's the important thing. They don't recount into our receipt levels when they do come back to us, you know, because they're not fully disposed of. The cases are still—still need an adjudication at our level. And so when they come back to us, we adjudicate them within the process, and then we would send them on. They either get paid, or, you know, they don't get paid, and many of them will get appealed.

Mr. LANKFORD. Okay. So I'm still trying to track this. They've gone through the first two levels with CMS.

Ms. GRISWOLD. Yes.

Mr. LANKFORD. They come to you?

Ms. GRISWOLD. Yes.

Mr. LANKFORD. There's not the information you need to deal with inpatient, outpatient, whatever that may be. You're remanding it back to CMS?

Ms. GRISWOLD. Yes.

Mr. LANKFORD. They're getting additional information, and then it comes back to you again?

Ms. GRISWOLD. Yes, that's right.

Mr. LANKFORD. Okay. So there's now, one, two, three, four, five levels so far. Excuse me, five different events within the first three levels.

Ms. GRISWOLD. Five hand-offs.

Mr. LANKFORD. Right. They're come back to you again?

Ms. GRISWOLD. Yes.

Mr. LANKFORD. And then I should look at this remand that is sent back, it would be basically this same percentage between fully favorable, partially favorable and unfavorable, then? You would expect that, because you're saying it's not double counted.

Ms. GRISWOLD. No, it's not a double count.

Mr. LANKFORD. Right. That's what I'm saying. But when it comes back to you again, I should expect it to be something similar to this percentage that's coming back? I'm trying to find out what happens when it's remanded. Are they more likely to be found favorable or unfavorable when it comes back after being remanded?

Ms. GRISWOLD. I don't think that—the remand doesn't predispose it to any sort of disposition when it comes back. When it comes back to us, we adjudicate it as all other claims, and, you know, we'll have a hearing on it and make a decision.

Mr. LANKFORD. So this is somewhere around 60 percent—just Part A—around 60 percent, 65 percent being found fully favorable when they're coming to you. I should expect if they're remanded, it's about the same percentage coming back again.

Ms. GRISWOLD. Yeah.

Mr. LANKFORD. That once they're remanded, and they get through that—so basically if they are very, very persistent in Part A at least, pretty good chance they're going to be found fully favorable.

Ms. GRISWOLD. I think if the percentages hold true, then you can use those percentages to say what will happen with the remands when they come back.

Mr. LANKFORD. Okay. And that's approximately how long? Because, again, getting to you the first time, they have consumed 3 years in the process. Then it gets remanded, it goes back to CMS, they handle it in 3 months, whatever it may be, and then they're waiting back in line again. That may be another 3 or 4 years to get back in line to get to you. So a remand is an incredible amount of time.

Ms. GRISWOLD. It's my understanding that these cases are really already back with us, that they were sent back in bulk, and so these are already back in the hearing queue. So, but as far as how long that took, that's a number I'll need to get back with you on.

Mr. LANKFORD. That's what we're trying to figure out, because the remand is a new number that we're trying to track based on what we got last night on this. I'm trying to figure out if it's 3 years to get to you and get a decision; it gets remanded, goes back, and they're back in the queue again, so now we're up to 6 years minimum to get fully through all five of those steps.

Ms. GRISWOLD. I believe—I will check on this for you and clarify it, but I believe that they retain their spot in the hearing queue when they are remanded.

Mr. LANKFORD. Okay. So once CMS makes the decision, they're right back to you again quickly?

Ms. GRISWOLD. And they're right back into the queue where they were when they left us, because we haven't given up jurisdiction of the claim, you know. We've sent it back for some more informa-

tion, but it's still with us. And generally it would come back to the same judge who had it when it was sent, when it was remanded.

Mr. LANKFORD. Okay.

Ms. GRISWOLD. This was—this year was an aberration. You can—you know, it was a very, very high number.

Mr. LANKFORD. Right.

Ms. GRISWOLD. And we're not seeing that in subsequent years, and we didn't see it in previous years.

Mr. LANKFORD. Okay. And you feel that's because of the whole issue about inpatient, what's inpatient, what's outpatient, that was unique to this year?

Ms. GRISWOLD. Correct. Correct.

Mr. LANKFORD. Is it still with the two-midnights rule and all of that?

Ms. GRISWOLD. Yes. Yes.

Mr. LANKFORD. What a fun rule. That's gone really, really well. The hospitals love it.

Ms. GRISWOLD. Well, we're waiting to see what impact it will have at our level. We have not seen the impacts of that rule at our level yet.

Mr. LANKFORD. I have yet to find a fan of that rule, by the way, anywhere. And that seems to be one of those issues that doctors in hospitals raise consistently saying, this affects our decision-making. That wasn't your decision. I'm not blaming you. But I would expect there would be quite a bit coming at you because there's a tremendous amount of frustration around that particular rule, and—

Ms. GRISWOLD. Well, and I think this is something that we are watching and need to watch. We need to continue to see what the appeal rates are in this Part A and Part B inpatient/outpatient arena.

Mr. LANKFORD. Let me ask two more quick questions on this, then I want to be able to share this time, as well. The "dismissed" and "other."

Ms. GRISWOLD. Yeah, the dismissals are cases where, for one reason or another, usually it's because the appellant hasn't properly filed their request for hearing, or perhaps they have abandoned their request for hearing in the process by not showing up for hearing and that sort of thing, and so the cases are dismissed at our level. That is a final disposition of those unless they appeal that dismissal to the Medicare Appeals Council.

Mr. LANKFORD. So that is an unfavorable sitting out there, but it's basically an unfavorable based on the individual didn't show up, didn't file, didn't complete their process. They started the process, but didn't complete it.

Ms. GRISWOLD. Correct.

Mr. LANKFORD. But the previous decision would still stand, which was unfavorable?

Ms. GRISWOLD. That's correct. The QIC decision becomes the final decision.

Mr. LANKFORD. Okay. What is an "other"? This sounds like "present" on our dais.

Ms. GRISWOLD. The other, I will actually—oh, okay. Escalations. It would include escalations to the Medicare Appeals Council. As

I mentioned, we have about 152 of those. Occasionally we have an expedited access to judicial review, but those are very, very rare.

Mr. LANKFORD. Okay. Thank you.

Ms. SPEIER. Thank you.

I'm still a little flummoxed by this remanded number. I just added up the fully favorable, the partially favorable and the unfavorable and came up with the number 21,846, which is 9 from this 21,855. So this remanded number that you say get back in the queue, are they getting back in the queue in FY '13, or are they getting back in the queue in FY '14?

Ms. GRISWOLD. I believe that they came back in FY '13 or early fiscal year '14 right about the time that CMS Administrator Tavenner issued, you know, her rulings on this.

Ms. SPEIER. But since the number is so close, and maybe that's just part of the aberration, that would mean that virtually every one of these cases was remanded because there was inadequate information?

Ms. GRISWOLD. No, these are not—it's not a cumulative number. I understand that they are close to the same amount, but the remands are exclusive of this fully favorable, partially favorable and unfavorable. It's a separate category.

Ms. SPEIER. Okay. So it's a separate category, which would mean that we're not talking—we're talking about close to 50,000 just in Part A if you take all of these numbers and add them together, give or take?

Ms. GRISWOLD. Yes.

Ms. SPEIER. Okay. All right. Let me ask you this: ALJs don't have medical training, correct?

Ms. GRISWOLD. No, as a general rule, they don't. I don't know whether there are any who actually have dual certifications, medical and legal, but they are attorneys who have been selected off an OPM register.

Ms. SPEIER. Now, because they don't have medical training, they are somehow trying to determine whether or not a procedure was appropriate or not appropriate, correct?

Ms. GRISWOLD. Reasonably—medically reasonable and necessary, yes.

Ms. SPEIER. So is that system flawed just at the outset?

Ms. GRISWOLD. Well, we have some extensive training for them that is conducted. When they come onboard, we do a training session for them that goes over very much of this, but lawyers are involved in medical/legal issues in many, many areas.

Ms. SPEIER. But they're advocating typically for one side or another and not judging whether something is appropriate medical procedure or not, whether someone really needed this procedure. It's more of a philosophical question. I don't—I mean, we obviously have engaged in this for a long period of time. I just find it somewhat odd that in the end there are attorneys like you and me who have been trained a certain way, but don't know whether this was an appropriate urology procedure or not.

Ms. GRISWOLD. Well, but in essence, what they're doing is making a judicial decision that is based on the evidence that's presented to them. And, you know, in our setting, that includes the written record, the documentary evidence, and generally during the

course of a hearing also some explanation of medical necessity from either a provider or supplier of the services. And so that is—you know, that's kind of the way this system is set up for us to be able to rely on the opinions of—

Ms. SPEIER. I'll let you read your note so you can respond.

Ms. GRISWOLD. Yeah. Essentially it's the same thing that I've been saying, you know, that we look at the record to determine whether the standards for coverage have been met.

Ms. SPEIER. So I think we're all troubled by the fact that 54 percent, at least that's the record that we have heard, of the appeals in Part A are sustained. Now, you said earlier that the figure for the first part of this year is less than half that that are fully favorable, but fully and partially, to me, need to be lumped together. What is the figure for 2014 for fully and partially favorable?

Ms. GRISWOLD. I don't have a percentage for that.

Ms. SPEIER. Could you get that for us, though?

Ms. GRISWOLD. I certainly can.

Ms. SPEIER. Okay. So here is the dilemma I see. Fifty-four percent of the appeals are sustained. So in the medical profession, if you've got a better than 50/50 chance of being sustained, you're going to appeal. So your volume is going to continue to increase as more and more providers recognize that, hey, this is a pretty good—your odds are really good here. And when you have an ALJ who is looking at a set of circumstances, is not a physician, but is trained, and is looking at, well, you know, from my perspective as someone who is, you know, not in the profession, it could be a close call. The procedure has been performed. It's not like there hasn't been a service that has been actually provided in most of these circumstances. So you're going to err in favor of saying, okay, we're going to sustain this appeal.

Ms. GRISWOLD. Yes.

Ms. SPEIER. So at some point I wonder whether we're going to have diminishing returns here. That's more of a provocative question, rhetorical question at this point. But I do think that the construct probably should urge us to think about whether it's the way we should be doing these appeals.

Ms. GRISWOLD. Uh-huh.

I would like to clarify one thing here, which is that the percentages you're looking at are on the recovery audit appeals. And the reversal rates on those appeals have been higher than the general reversal rate for the agency, which—you know, if it includes all appeals. So for 2014, and, again, the numbers I have are fully favorable decisions, but it was just 19.3 percent.

The numbers have been—I'm sorry, that was fully favorable OTRs, and I keep going to that number. I will get you a number on the reversal.

Ms. SPEIER. Now, the other thing I've been told is that when CMS actually is present at these hearings, that the decisions are not sustained, but the CMS representative is oftentimes not present. So that suggests to me, again, that we have a system that isn't properly—isn't operating properly, because we want fairness across the entire spectrum.

So if one provider shows up, has their appeal, and the CMS person shows up and it's not sustained, but another provider shows

up, same sort of circumstance, but the CMS person is not there and it is sustained, we're not providing equal protection under the laws.

Ms. GRISWOLD. Uh-huh. Let me—the CMS, what we have found, and there is very limited data on this, and it does come from CMS, but when there is CMS participation at the hearing, the reversal rate does go down. And—

Ms. SPEIER. By how much; do we know?

Ms. GRISWOLD. I think it was about 6 percent, if I remember correctly. It was from about 46 percent. It was only over a few months of data that we have. I'll get you the exact numbers, but from about 46 percent down to 40 percent. Yeah, 40 percent.

And as far as the reversal rates go, if I could, I've got that number now which is on the dispositions, the overall favorable rate in '14 is 35.2 percent. We have been doing a number of things which have been designed to bring our policy interpretations in line across all levels and to develop some consistency in adjudication. Part of that is training, and we have had—approximately 20 training sessions have been delivered by CMS, their doctors and their policy experts to the administrative law judges since 2010.

And so what you will see if you look at the historical data is that the reversal rates have actually been going down. They were at a high in 2010, 55.5 percent fully favorable, and that is now down to 35.2 percent.

Mr. LANKFORD. Why?

Ms. GRISWOLD. I think that the training efforts have—you know, have a lot to do with that.

Mr. LANKFORD. So you have a better quality of decision? Because they're dealing with every case in front of them having to make a decision.

Ms. GRISWOLD. Yes.

Mr. LANKFORD. So the question is the cases coming to you, they either made better decisions at a lower level, or there's something that's happened at the ALJ level with better training that you're making better decisions, and the decisions earlier you were finding people fully favorable more often than what would be consistent with policy.

Ms. GRISWOLD. Or that joint training leads to better consistency among adjudication levels.

Mr. LANKFORD. Well, that still would mean that at some point you've got some people making fully favorable decisions that should have been partially or unfavorable. If you're saying better training has fixed that, that would say there was an issue at some point that we were doing too many fully favorable or partially favorable.

Ms. GRISWOLD. I don't think I would go so far as to say it has fixed it, you know, but I would say that it has improved it.

Mr. LANKFORD. Has changed.

Ms. GRISWOLD. And I think the goal is, you know, as Congresswoman Speier points out, the goal is to have the case paid; if it is a validly payable claim—

Mr. LANKFORD. Yes.

Ms. GRISWOLD. —to have it paid at early as possible and keep them from reaching the ALJ level.

Ms. DUCKWORTH. Mr. Chairman, may I add a little to this?

Mr. LANKFORD. Sure you can.

Ms. DUCKWORTH. I just want to touch on this. Is there training coming from you, the ALJ, back down to CMS, feedback back to CMS? And is CMS accepting that at the RAC audit? And I'm going to use an example that's happening in the orthotics and prosthetics industry where after an artificial limb is made and delivered to the patient, the claim is being denied by RAC audits because the actual words "patient is an amputee" does not appear in the physician's notes. But the words "patient requires artificial limb or prosthesis" appear, and the Medicare history includes payment for the surgeon to conduct a limb amputation.

Ms. GRISWOLD. Uh-huh.

Ms. DUCKWORTH. And so many of these denials could be eliminated if when they get to—and then these are, you know, getting reversed at ALJ.

Is there feedback going back down to the CMS saying, look, just because the exact words does not appear in the surgeon's note that the patient is an amputee doesn't mean that you deny these, because if you look, it says that the physician is saying they need a prosthetic, and we paid them to amputate a limb.

And so are you in CMS and the RAC audits looking at different records? Are you—because, you know—I—

Ms. GRISWOLD. No. I mean, as a general—as a general rule, we review the same record. Now, there are some exceptions to that. There's a good cause exception which allows additional evidence to be presented at the ALJ level. But we are supposed to be deciding things on the same record.

What does change significantly is the fact that we do have a hearing. And so at our level we are able to, you know, question the provider/supplier, receive some explanation, and then make a decision. That becomes part of the evidence that's in front of us.

Ms. DUCKWORTH. But my understanding is that the auditors are not allowed to consider the O&P professional's notes, but those notes are considered part of the physician's record, and they show up under the physician's record. So the O&P, the person who makes the artificial leg, his notes—the RAC auditors are not allowed to look at his notes. They only look at the physician's note. But when you look at the physician's note, you look at the entirety, which includes the person—the prosthetist's notes.

Is there feedback coming from you to CMS to allow their RAC auditors and the lower levels to say you need to look at the prosthetist's notes, because you're pushing these people into the system? And it's ridiculous when someone is being—you know, something as simple as "patient is an amputee" is missing from a record from a guy that we paid already to have his leg amputated.

Ms. GRISWOLD. Yes. And we do have regular meetings with CMS and with their appeals group within CMS. I think those happen on a weekly basis? Weekly basis. And when we identify a trend, we would bring that up at those meetings, or if it was significant trend, I would bring it up with Marilyn Tavenner. I'm not aware of the specific instance that you are describing.

Ms. DUCKWORTH. Oh, it's more than one. We have 100 orthotists and prosthetists in this country who have gone out of business waiting to be reimbursed and have gone out of business, and so it's

more than one. And I am sure that we can get you a lot of those examples.

Mr. MEADOWS. Yes.

Ms. GRISWOLD. You know, as we become aware of them, I think that's part of the, you know, part of the issue. Our judges are individual adjudicators, and so we have to become aware that there is a trend. And when we do, we have those feedback loops in place, and we have—we are able to do that.

Ms. DUCKWORTH. How do you spot a trend? Do you have a system in place at the ALJ level to figure out, to find those trends? And I think Mr. Meadows, my colleague from—

Mr. MEADOWS. Well, I just want to reiterate what the gentleman from Illinois was talking about. She's exactly right, and this is not just unique to her particular group that is—told her. I mean, we've got physicians—we've got physicians who literally go through step one and step two that have complete records.

And it has to go to you before you look and say, oh, gosh, it's a complete record, and they've waited how many months or years to find it. And it's crazy stuff, Ms. Griswold. I mean, you know, she's given that. I got examples. I mean, after this last hearing, we started hearing from all over the country from claims that were denied because the date instead of being at the top was at the bottom. Or the physician, you know, had signed his name in this spot, and they weren't taking—I know we can't fix stupid, but it seems like that that's what we've got to do here, because it's just, I mean, a reasonable person would do this.

And you talk about trends. I don't know how you define trends, because you've got adjudicators that are adjudicating across the OMHA system. So what one adjudicator is seeing as a trend in his or her jurisdiction, it doesn't work. And so I just—I appreciate the gentleman yielding. I'll yield back.

Mr. LANKFORD. Go ahead.

Ms. DUCKWORTH. I just have one final thing, and that is as you go to meet with the newly confirmed Secretary Burwell, I was hoping that you would consider having a conversation with her about granting the same kind of relief from RAC audits that was being granted to hospitals under Part A, through the work under the two-midnight rule, to Part B providers like those in orthotics and prosthetics. If we're going to grant it to hospitals under Part A, I think that we need to consider granting it under Part B, especially since there is a halt to the hearings at this point.

Thank you, Mr. Chairman.

Ms. GRISWOLD. I'll certainly convey that.

Mr. LANKFORD. Ms. Lujan Grisham, would you want to jump in? Go ahead.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman.

And at the risk of piling on now in the last couple of comments and statements, I have the same concern. I applaud that you've introduced new initiatives so that your productivity is better, but now we're minimizing; my information says that, you know, the average hearing is now 2 hours, and given the complexities—although we haven't talked about the complexities, we've talked about the easy stuff—I'm not sure gets addressed. And while I know that given that we now have an incredible backlog, and we

are struggling with this, it's time to do more than just sort of figure out the steps, how we're touching these cases, how we're cross-communicating, what the training looks like. We have to maybe do something up front, and the up front is nobody on this committee, and I daresay no one in Congress, is willing to tolerate waste, abuse and fraud. We want you, everyone in the system, to do everything you can not just to minimize it; eradicate it.

But these are clearly administrative issues. And while I do, I expect providers to be as administratively competent as they can, I can't with consistency, and I'm a lawyer, even read a Medicare EOB. Given that, the likelihood that you make mistakes, simple; the form says put the date at the bottom, but that form was updated this year, I've got 200,000 forms from last year, and instead of throwing those away, we're just going to—and no one pays attention to that.

And the fact that we are doing this under a waste, fraud and abuse context, and I think that's important, but we're closing these businesses who aren't getting paid, and there's a lot of small providers. And again, I know that you've heard all this, and we appreciate it, and I agree with my colleagues, I want fairness. I—just because you're a big provider, I don't think that a big hospital system should have to wait and be penalized in this fashion.

But what's critical in a rural and frontier State like mine in New Mexico, that means that an entire community in a place like Gallup, where in one of—in my district in Tarrant County, there aren't any providers, there aren't any durable medical equipment providers, there aren't any small oncology providers. There are none. You have zero access. And we don't even have the right tools or strategies to recreate these practices.

So I'm really interested as a result of understanding now the situation between how they're adjudicated, what your initiatives are, how you're trying to manage these cases, I feel—I appreciate the weekly meetings, but I would encourage you to go back to Ms. Tavenner and the Secretary and be really clear, at least some of these comments—and I think it seems to me like we're all on the same page on the subcommittee—that we've got a problem on the front end.

So we do want updates, I do, I want information about what you're doing on the back end. And I want to be careful that people feel like because it's cumbersome, that they can win on an appeal even when there might be a material problem. But I think the bulk of these cases and the reason that you now have half a million cases coming to you on appeal is because they are administrative issues that don't come anywhere close to fraud, waste and abuse, and we need to deal with that issue sooner than later.

And I don't know that you—is a comment to make back except that my expectation is that you'll take this urgency back, because we are—with all the work we've done to maximize access, this effort is minimizing it to the highest degree, and it has a chilling effect on our patient populations.

Ms. GRISWOLD. I would certainly take that back. And, you know, if there is a positive that is coming out of this situation, I think it is that the Department is viewing this workload more holistically. Although there are three separate agencies, CMS, OMHA,

and the Departmental Appeals Board and Medicare Appeals Council, that work with these workloads, the Department is taking an active role in trying to resolve things. And so I will take your concerns back. I certainly share them.

I would also say I was very pleased when I came here to OMHA to be part of an agency that had for the most part met its 90-day time frames. You know, as an administrator myself, I find the delays very troubling and unacceptable. You basically have here, though, a workload and capacity problem at our—

Ms. SPEIER. And can we get to that for a moment, because, I mean, we can sit here and complain for hours, and nothing's going to change, because the addition of 17 new ALJs, talk about the simple math that my good friend Mr. Meadows had referenced. There's 500,000 appeals that will be backlogged by the end of this year. You divide that by 1,220, and you're working at optimal levels, and I don't know that you can do any more than that, and, frankly, I don't know that we would want you to do more than that, because giving less than 2 hours to every case is probably unfair and would be slipshod. That would suggest that we would need 410 new ALJs if we wanted to get rid of that backlog in a year, 410, and you have asked for 17, or you have been given 17.

So we're basically saying to all the providers out there, suck it up. Excuse my language, but that's basically what we're saying to them. We're saying that we don't—we're not willing to deal with this backlog in the reality that it—we're putting blinders on, we're going to add a few more, and cross our fingers and hope that with a few new reforms that you put in place, that it's going to—but it's not going to reduce it to the extent that we're not going to be back here next year with the same discussion.

So how would you comment to that?

Ms. GRISWOLD. Well, there are several things. One—

Mr. LANKFORD. Ms. Griswold, I'm sorry to interrupt. Can you pull your microphone a little bit closer to you?

Ms. GRISWOLD. Sure.

Mr. LANKFORD. Thank you.

Ms. GRISWOLD. You know, there are several funding issues here, and, in my mind, one of the primary ones has to do with the Recovery Audit Program and the recovery audit legislation. I think when Congress passed the legislation for the program, it was envisioned that that program would be self-funding out of recoveries, but the legislation actually provides that the administrative costs of CMS will be covered. That does not include the administrative costs or the—of OMHA or the administrative costs of the Departmental Appeals Board. So what we have basically had in that regard is a workload that came in on us that was basically unfunded.

So I think that's part of the problem, and it's a part of the problem that I think does have a solution. And so if I were queen for a day—

Ms. SPEIER. Yes. What would you—

Ms. GRISWOLD. —you know, that would be one of the simple fixes that I think would be possible.

Ms. SPEIER. Meaning what? Fix the—

Ms. GRISWOLD. To in some way be able to—

Ms. SPEIER. Properly fund.

Ms. GRISWOLD. —properly fund the—fund OMHA, and I'll put in a plug for my sister agency, the Departmental Appeals Board, so that the recovery audit appeals that come to the last two levels are funded at—the administrative costs are funded out of the program as they are at the lower two levels.

Ms. SPEIER. So is there enough money that is recovered by the RACs to pay for all of the levels of appeal?

Ms. GRISWOLD. Yes. I think that there is, yes. And, you know, this is based on CMS' reports on the recoveries that are coming from that program. So that is one part, I think, of the solution.

There's some other things as well. We're doing these two pilots. One involves alternative adjudication models, you know, using a settlement conference facilitation. If that pilot is successful, I think we need to look at some things like that as well.

Mr. LANKFORD. Is that being piloted in a geographic location or with a certain type of file?

Ms. GRISWOLD. It's being piloted at the Office of Medicare Hearings and Appeals. There's no geographic location. It's being done with Part B, I believe—yeah, Part B claims right now. And there's a certain time period where we are offering these facilitated settlement conferences. CMS has agreed—

Mr. LANKFORD. Give us an example of what that means.

Ms. GRISWOLD. Well—

Mr. LANKFORD. Real-life terms.

Ms. GRISWOLD. Well, real-life terms, it is just—it was put on our Web site on June 30th, so it's a very new program, and we're waiting to see how appellants respond to it. But the theory is that an appellant will be able to come in and ask for a settlement conference with an attorney who is at OMHA. CMS would provide someone there with settlement authority who would be able to discuss the merits of the claim and possibly resolve them short of them having to stay in the queue and go to hearing. That is the theory.

While that is going on, they do not lose their place in the hearing queue, so they would still remain there, but we're hopeful that this will allow us to resolve some of the pending claims.

You know, this is a two-part problem. There are the pending claims that we have; there are also the receipts that are coming in. This piece of the solution is designed to deal with the pending cases that are already with us.

Mr. LANKFORD. So is it your assumption it's the slam-dunk cases that are going to come at that settlement process? Go back to Mr. Meadows' statement about a signature's in the wrong spot, and they walk in and say, it's not at the top, it's at the bottom, it's right here. Is it your assumption it's going to be that kind of stuff coming at you, or what is your assumption coming at you with the settlements? And are the settlements for a lesser amount than fully paid, or is it fully paid so they're at a faster process to full payment?

Ms. GRISWOLD. Well, you know, I think it depends. Like most settlement conferences, it's going to be probably a little bit of give and take. That would be my anticipation. But if it's something that we can, in that—the course of what's really a prehearing conference with an attorney, point out a simple error, a technical error

or something like that in these claims, then, you know, it is potential, it is possible that they would be fully paid. We just—we have to wait and see how that would work.

Ms. SPEIER. So this alternative dispute resolution would be valuable to providers in particular if it was a decision that was going to be made swiftly.

Ms. GRISWOLD. Yes. We are——

Ms. SPEIER. So that becomes the appeal.

Ms. GRISWOLD. We're trying to find ways——

Ms. SPEIER. No pun intended.

Ms. GRISWOLD. —of resolving claims within our pending workload more quickly than we can get them to an ALJ. And we're trying to do that given our current authorities.

Right now the way the statutory scheme is structured, an appeal cannot get out of step three, it cannot leave OMHA without action by an ALJ. So what this would do, there would be this agreed-upon settlement, both parties would sign, and the judge would then dismiss the appeal. So the agreement becomes the resolution of the claims.

Mr. LANKFORD. So is that listed in the chart that you gave us as a dismissal, long term——

Ms. GRISWOLD. It would end up being——

Mr. LANKFORD. —or is that—it ends up being favorable or fully favorable or——

Ms. GRISWOLD. It would be a—it would probably be a dismissal, but right now we're just tracking them separately as a settlement resolution.

Mr. LANKFORD. Okay.

Ms. SPEIER. How about the other alternative is this global settlement discussion concept, which claimants that have very similar kinds of cases would all be invited to come in and participate in a global settlement, but they could choose not to, I gather; is that correct?

Ms. GRISWOLD. This is an initiative that is one of CMS' initiatives, and I have to admit that my knowledge on this is limited, but, you know, it's my understanding that it would be a global settlement.

Ms. SPEIER. So that would happen before it even got to you?

Ms. GRISWOLD. I think it also contemplates—they're also looking at claims that are pending at all levels of the process.

Ms. SPEIER. So we really haven't seen it operational yet?

Ms. GRISWOLD. No, we have not. It's an initiative that is still pending.

Ms. SPEIER. Okay.

Mr. LANKFORD. Okay. So I know you're communicating back and forth with CMS, and CMS is part of the issue, and I get that, that's not you, that you're in these regular conversations. When we're getting to an attorney, helping them to try to do a type of presettlement, what you're talking about, before it gets to an ALJ, that's really something that they would have rather had with CMS and to get this done a long time ago, to face-to-face with someone there, resolve this, or to be able to get on the phone and everybody looks at the same document and tries to resolve this. If they're simple, straightforward cases, they just want this resolved. If they are

a physical therapist that is trying to take care of his practice as well as trying to do all the paperwork, he does not need one more thing to do to try to chase all this stuff down. Just to be able to leave and go do a hearing and to be in that process, or to hire outside counsel is well beyond what they want to be able to do. They just want resolution of simple things.

How could a process like what you're experimenting with work in a CMS so it never gets to you? We're still trying to figure out how do we prevent the backlog.

Ms. GRISWOLD. Right. And I think among CMS' initiatives, you will see mention of a discussion period, particularly with regard to recovery audit, and I think that that could be helpful in resolving these claims at the lower level.

Mr. LANKFORD. But that's not something—

Ms. GRISWOLD. I don't know—

Mr. LANKFORD. —you're aware that they do? That's something they're discussing, but that's not something that they do currently?

Ms. GRISWOLD. I really can't speak to that. I don't know to what extent they have a discussion period right now.

Okay. I am informed that it's optional right now in the RAC cases, recovery audit cases.

Mr. LANKFORD. But at the CMS level, they can do some sort of discussion as well?

Ms. GRISWOLD. I think so, but I'll have to check on that. I'd rather get back or have CMS get back to you on that.

Mr. LANKFORD. I understand. I understand. I don't want to push you outside and try to answer for them. We're just trying to do some fact gathering as well.

Ms. GRISWOLD. I understand.

Mr. LANKFORD. Because, again, we come down to the issue of they just want resolution.

Ms. GRISWOLD. Absolutely.

Mr. LANKFORD. And once the RAC contractor grabs it, files it, lays it out there, they lose contact with them, and now they're fighting with someone else. And really their fight is first with the RAC folks they can't get to anymore because it's too late. They've made their decision, and they've filed it. And then the RAC auditor is trying to figure out—playing the percentages, literally, that if they grab 10 or 15, they know they're going to get 3 or 4 of these at least get paid, and they get paid a percentage of each of them. So it's a whole different game for them.

But for the provider, our issue all along is if it's fraud, it's fraud, and we ought to bust them. If it's a good provider, this should not be harder. These are the folks we need on our team and that the American people need rather than hurt.

Ms. GRISWOLD. I fully agree, and I think that identifying not just Medicare fraud, but also improper payments is an important piece of this puzzle. But what we have done, I guess, in the zealous efforts to implement Congress' intent in that regard, it's gotten out of balance, and what we need to do is restore that balance at this point between the fraud efforts and the appeal rights. And so I'm—you know, I have spoken with the Secretary on these issues, and I know she's committed to restoring that balance.

Ms. SPEIER. You know, I had a RAC in my district that was creating a great deal of discomfort for one of the hospital providers in my district, and it was also a hospital that was under a lot of financial pressure to just keep its doors open. And my experience with that particular situation suggests that more than anything else, the provider wants to know what's going to be approved.

Now, they could have, in fact, have been unbundling services that, you know, would allow for more reimbursement. I don't remember the elements of it. Sometimes, you know, the providers are in a bind and are looking for ways to upcode or to unbundle services. So we need to be smart about this and not appear to be taking one side or another. Everyone should be treated the same. But it's so important for there to be some certainty, and some finality, and some timeliness to these decisions.

And this backlog, I keep coming back to this backlog, because we're not getting anywhere near addressing that even with all of these new proposals that haven't even been tested really. So I still think that we've got to do—whether we hire temporary ALJs for a period of 1 year and deal with this backlog, otherwise we haven't really accomplished much.

Ms. GRISWOLD. And just to address that, there are very, very limited authorities for hiring temporary ALJs, and this is statutory under the Administrative Procedures Act. Really, there are two ways. You can try and get a loan—a judge on loan from another agency. Most agencies have their own backlogs.

Ms. SPEIER. It's true.

Ms. GRISWOLD. And when we went forward requesting loaner judges in April, we did not get any. So the other way is to hire judges who have retired, and they're called rehired annuitants, senior ALJs. Those individuals are also on a list that's maintained by OPM. They can be hired for a couple of years and then let go. Beyond that, an ALJ appointment is, you know, essentially a life appointment except for removal for good cause after a hearing before the MSPB.

Ms. SPEIER. So how large is this list of retired ALJs?

Ms. GRISWOLD. How many were there? Nine—it's probably around 100. It's not a tremendously long list, you know, but we do have that. We requested it in April, because we do think that temporary capacity is a part of this solution to deal with the backlog.

Now, when you get to—when you're talking about projected receipt levels, I do think we need to be appropriately staffed for what we anticipate to be coming in, you know. So I don't know if that's helpful, but ALJs are nonprobationary. When you hire them under the APA, there's no probationary period, there are no performance reviews, and they can't receive awards. So those are kind of the things that make them different from other government employees.

Mr. MEADOWS. If the gentlewoman would yield, I want to follow up, because they're hitting on precisely the point and why it's so incredibly important that you're here today, but it really is about what's coming to you and how do we address that.

The bigger concern that I have is is even if you hired your hundred, it would still be shy, based on my simple math, of what's going to happen, because this doesn't stop today. It's growing expo-

nentially every day. I think it's 1,500 appeals, at least, a week. Is that correct?

Ms. GRISWOLD. It has been as high as 16,000 appeals a week.

Mr. MEADOWS. A week, yeah.

Ms. GRISWOLD. But it has been down slightly at the beginning of this year to 11,000. We're trying to figure out where the plateau is going to be.

Mr. MEADOWS. Well, I guess—I was told by Jonathan Blum before he left that there was a policy change within CMS that was initiated—and maybe numerous policy changes—but there was a policy change between 2011 and 2012 that dealt with the way that they start to refer these to you. Part of it's RAC, but part of it was—and that he needed a legislative fix. Now, my question to him was, if it was a policy change, why do you need a legislative fix?

But what I'm concerned about is what changed in 2011 or 2012 to make this number grow that you're getting when we're not seeing payments, miss—the payments, improper payments, actually go down? So we've seen no progress in terms of improper payments, and yet we've got this huge problem on our hands, and we're not saving any money.

Ms. GRISWOLD. Uh-huh.

Mr. MEADOWS. So what changed in 2011 or 2012? And I'll yield back to the chairman, let you answer.

Ms. GRISWOLD. Okay. Well, the big thing was the recovery audit, of course. You know, we've talked about that. That was initially a pilot program in 2009-ish. You know, we saw I think it was four States. And that—

Mr. MEADOWS. But that was an act of Congress. He indicated it was a policy within their agency that—I don't know if—

Ms. GRISWOLD. It's probably—I mean, there was—and it was probably around that time period where there was a focus on identifying improper payments. That's not tracked as part of our—you know, we track the recovery audit separately.

Mr. MEADOWS. Right.

Ms. GRISWOLD. But CMS' efforts to identify improper payments, the ZPICs, Zone Program Integrity Contractors, and the others, you know, Zone Program, who are really looking at fraud issues, and there was also a coding initiative and some other things like that, but any time there are efforts at CMS' level that result in a denial of more claims, then at our level there is going to be an increase in appeals.

Mr. MEADOWS. But that's my point. It didn't change the improper payments. I mean, they may have done that, and it may have been well intentioned, but we are still—actually, they increased, if you look at the numbers. You can go on there. We had a hearing yesterday, and so that's fresh in my mind.

But I'll yield back. I want to thank the ranking member and the chair for their leadership on this and their graciousness to allow me to be included.

Ms. GRISWOLD. And if I could—

Mr. LANKFORD. Right.

Ms. GRISWOLD. Could I go back to one issue that you raised earlier, which I think I have finally kind of grasped what the question may have been, and that has to do with our appropriation and how

that is handled? And, of course, as you pointed out, the Medicare Modernization Act did contain language which would authorize to be appropriated funds that would, you know, cover an increase in adjudicators as needed.

Having said that, though, that appropriation still has to be approved, and it does have to go through our Department's appropriation process. So I just wanted to point that out.

I would also say with regard to our general appropriation that, you know, we do know we've been living in challenging budgetary times. And in the past 5 years, the President's budget has actually only been approved for us in 1 of the 5 years. So requests that we have gone forward with, even though they'd be somewhat modest, have really only been approved this year, and so we appreciate that, and we're trying to do what we can with the money that's been appropriated to us.

Ms. SPEIER. So—and that was approved because it was part of the omnibus bill?

Ms. GRISWOLD. Oh, was it part of the omnibus bill?

Ms. SPEIER. Why was it approved this year and—

Ms. GRISWOLD. I don't know whether it was part of an omnibus bill or what it was part of, but I do know that we received President's budget this year. I'm sorry.

Ms. SPEIER. So is there any other statutory authority you think you need or could use?

Mr. LANKFORD. Or solutions that you would propose?

Ms. GRISWOLD. Yeah. You know, I think that there are a number of things that are going to be coming through the appropriate legislative process that we're looking at. I think the two that I've highlighted from our perspective will provide us with the greatest ability to handle our workloads and to expand the way that we adjudicate claims at OMHA.

There are some additional things that are being considered that—you know, through the Departmental Work Group that I know will be coming up through the proper legislative channels.

Mr. LANKFORD. When will you evaluate the settlement process? It obviously just started June the 30th, so it's just starting. When is the target date for your initial evaluation? Is it a year? Is it 6 months?

Ms. GRISWOLD. No. We're looking at a 6-month evaluation.

Mr. LANKFORD. Okay. Can you put us on a calendar reminder and 6 months from now send it to this committee as well—

Ms. GRISWOLD. Certainly.

Mr. LANKFORD. —so we get a feel for that also?

Ms. GRISWOLD. And we're tracking a number of metrics with that from which we'll judge the success of the program. We'd be happy to include you in that.

Mr. LANKFORD. Okay. Please do. This committee is obviously very interested in that.

Ms. SPEIER. Mr. Chairman, I don't have any further questions. I just want to thank Ms. Griswold for being so attentive to our questions and for sitting around for an hour and a half while we went and voted. And thank you for your service to—

Ms. GRISWOLD. Thank you.

Ms. SPEIER. —our country.

Ms. GRISWOLD. I thank you for your interest in this issue. It's certainly one near and dear to our hearts as well.

Mr. LANKFORD. Well, it's near and dear to a lot of people in our district that not only want to deal with the fraud and waste, and the loss, and the improper payments, which is important to everyone, including everyone on this dais, but also to providers that absolutely firmly, intensely hate the RAC audit process. And when they go through it, and there is a signature in the wrong place or a date in the wrong spot, and they just want to get it resolved, it now takes 3 years to get it resolved at times. So it goes from their frustration about RAC to the frustration about getting an obvious solution that doesn't help any of us. So finding alternative solutions like what you're proposing on the settlement process, that they could go through that process, if they don't like it—is what it sounds like to me, if they don't like what happens in the settlement, they still are in the queue to be able to resolve. Is that correct, or do they leave?

Ms. GRISWOLD. No. They are absolutely in the queue.

Mr. LANKFORD. Okay.

Ms. GRISWOLD. And there's nothing mandatory about that—

Mr. LANKFORD. Right.

Ms. GRISWOLD. —settlement process. You know, at any point, they can exit the process.

Mr. LANKFORD. They just want an answer. So that's very important—

Ms. GRISWOLD. And they're entitled to an answer.

Mr. LANKFORD. They are.

Ms. GRISWOLD. I realize that.

Mr. LANKFORD. They are. So that's a key thing, so if you're working on processes to do that, thank you. Continue to press, and if there are ways that we can help in the process, because, as Mrs. Speier has mentioned, bringing on more ALJs is not going to solve this. There's no way you're going to get 400 more ALJs, so there has to be another solution into this to be able to determine how do they get answers.

Part of this, we understand well, is on CMS. You should not have the number get to you that is getting to you. So if you have a—and I'm looking at these percentages, and I know we've kicked around numbers on it, but let me just mention this one other number on it. When I look at the percentages, I pull out the remanded, because those are coming back; that's a different number. I pull out dismissed, because they're not even getting to you, that's not there. And the other I can pull out.

When I look at that fully favorable and partially favorable just for Part A, and I'm aware of the other numbers, that's showing a 65 percent either a fully favorable or partially favorable resolution for them if they get to you. That's telling me the job is not getting done on the CMS side.

You should not have that high of a percentage of overturn getting to you. There's something being missed. So part of the issue is we've got to press on CMS to get some of these things resolved before they ever get to you so you don't have a backlog this high. Just statistically you shouldn't have a 65 percent overturn rate to be able to get to you. So that's not on you, but I'm just saying pub-

licly there are issues on the previous two that we've got to get resolved in the days ahead.

Any other comments?

Thank you as well for spending the day, and we apologize for the long delay in the middle of a recess.

With that, we are dismissed.

Ms. GRISWOLD. Thank you.

[Whereupon, at 5:05 p.m., the subcommittee was adjourned.]



## **APPENDIX**

---

MATERIAL SUBMITTED FOR THE HEARING RECORD

Percent increase in non-Recovery Audit appeals work.

From 2012 to 2013, the number of appeals unrelated to the Recovery Audit program increased from 86,419, to 191,046 — an increase of approximately 121%. The number of claims involved in those appeals increased from 260,883 to 459,871 — an increase of approximately 76%.

Disposition outcome rates.

## By Appeals (FY13 Dispositions)

	Fully Favorable	Partially Favorable	Unfavorable	Remanded	Dismissed	Other
Part A	12,574	1,659	7,613	21,855	9,650	21
Part B (non-DME)	7,924	804	3,798	647	3,512	46
Part B (DME)	14,009	1,557	7,368	1,024	5,646	32
Other	613	94	1,457	165	983	6
% of Total	34%	4%	20%	23%	19%	0%

## By Claims (FY13 Dispositions)

	Fully Favorable	Partially Favorable	Unfavorable	Remanded	Dismissed	Other
Part A	14,286	3,207	13,489	22,771	14,780	23
Part B (non-DME)	28,732	13,396	26,137	10,834	18,585	761
Part B (DME)	23,303	5,285	13,410	1,795	12,754	262
Other	614	94	1,460	166	983	6
% of Total	29%	10%	24%	16%	21%	0%

Percent of cases decided fully favorable on the record (without a hearing)

In FY13, approximately 20,604 decisions were issued "on the record" and were fully favorable, out of a total of approximately 59,470 decisions that were issued, which represents 35% of the FY13 decisions issued. (A decision may be issued on the record if the evidence in the hearing record supports a finding in favor of the appellant on every issue, per 42 C.F.R. §§ 405.1038(a); 423.2038(a).)

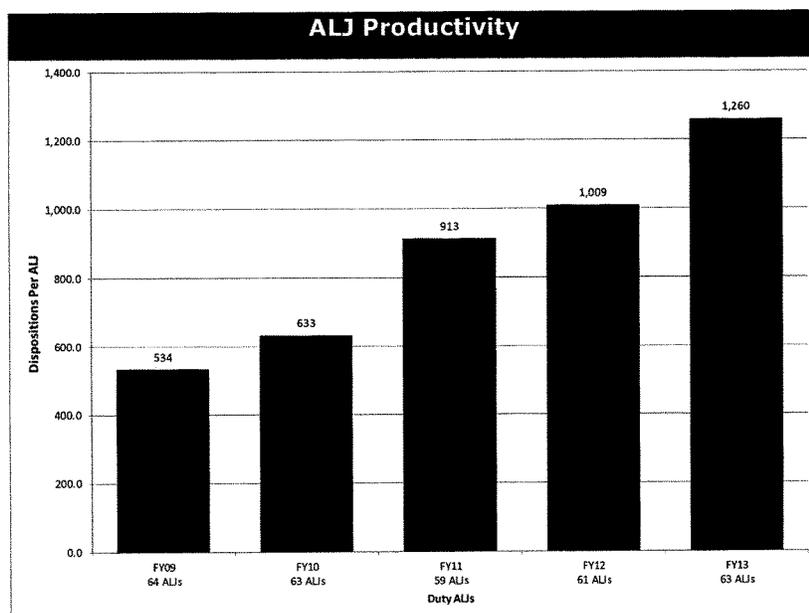
Percent breakdown in appeal receipts between Part A and B

## FY13 Receipts / Part Breakdown

	Appeals	% of Total	Claims	% of Total
Part A	256,434	66.8%	299,078	45.7%
Part B (non-DME)	88,966	23.2%	185,095	28.3%
Part B (DME)	34,913	9.1%	166,539	25.4%
Other	3,838	1.0%	3,868	0.6%

Number of hours per disposition, per ALJ

OMHA does not keep a statistic on the number of hours per disposition. However, there was an observation that in FY12 and FY13, the number of dispositions per ALJ averages to 2 hours or less per disposition. The average dispositions per ALJ are listed below:



Represents cases decided in listed fiscal year no matter what year case was received.  
Excludes remands and combined appeals.

Run Date: July 7, 2014

Forum transcript.

An official transcript of the February 12, 2014, OMHA forum was not prepared.

The presentation slide deck (126 slides) is available on the OMHA website, at:  
[http://www.hhs.gov/omha/omha\\_medicare\\_appellant\\_forum\\_presentations.pdf](http://www.hhs.gov/omha/omha_medicare_appellant_forum_presentations.pdf)

Question for Ms. Griswold  
Chief Administrative Law Judge  
Office of Medicare Hearings and Appeals  
U.S. Department of Health and Human Services

Question from Congresswoman Maloney  
Subcommittee on Energy Policy, Health Care and Entitlements  
Committee on Oversight and Government Reform

Hearing on:  
“Medicare Mismanagement Part II: Exploring Medicare Appeals Reform”

---

1. For years, the Centers for Medicare and Medicaid Services were engaged in successful demonstration projects with New York, Massachusetts, and Connecticut, which utilized sampling and arbitration processes to efficiently and impartially resolve Medicaid versus Medicare payment coverage disputes for home health services. In fact, for federal fiscal years 2000-2010, the New York State project resulted in \$1.66 billion in gross recoveries for the Medicaid program.

Unfortunately, this demonstration project has been discontinued resulting in a claim-by-claim manual appeal process has resulted in an increase in the number and circumstances of denials which are being manually adjudicated that requires providers to gather volumes of paperwork for thousands of cases rather than focusing on working with patients. With the termination of the demonstration project, a backlog of appeals began to form in 2012 in which more requests for hearings were being filed than could be adjudicated. The Office of Medicare Hearing Appeals (OMHA) has recently announced that it temporarily suspended the assignment of most new requests for Administrative Law Judge (ALJ) hearings as of July 15, 2013 due to the agencies existing workload. OMHA has suggested that assignments of most new requests for hearings to an ALJ may be delayed for up to 24 months. In New York State alone there have been over 60,000 claims in various states of appeal because of a complicated 5 step appeal process.

While it is clear that OMHA is trying many new initiatives to reduce the appeal backlog, the previously tested demonstration project system has not been suggested. Consideration of a reinstated demonstration project could help resolve many of the backlog issues. With this in mind, will you agree to work with New York State on potentially reinstating the demonstration project to ensure fair and equitable Medicare coverage for home health services?



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of Medicare Hearings and Appeals  
Office of the Chief Judge  
1700 North Moore Street, Suite 1800  
Arlington, VA 22209  
(703) 235-0635 Main Line  
(703) 235-0700 Facsimile

October 28, 2014

The Honorable Carolyn B. Maloney  
Committee on Oversight and Government Reform  
Subcommittee on Energy Policy, Health Care and Entitlements  
2157 Rayburn House Office Building  
Washington, DC 20515

Dear Representative Maloney:

Thank you for your inquiry following my appearance before the Committee on Oversight and Government Reform's Subcommittee on Energy Policy, Health Care and Entitlements on July 10, 2014, at the hearing entitled, "Medicare Mismanagement Part II: Exploring Medicare Appeals Reform." The text of your question is attached for your convenience.

The Office of Medicare Hearings and Appeals (OMHA) is a component of the Department of Health and Human Services, but operates separately from the Centers for Medicare & Medicaid Services (CMS). As your question indicates, CMS conducted a demonstration project to resolve Medicaid and Medicare payment disputes for services provided to dually enrolled beneficiaries. It is my understanding that the demonstration discussed in the question was operated solely by CMS and accordingly, I have asked CMS to follow up with you on your question.

OMHA has been working closely with CMS on a number of initiatives to address the backlog and will continue to do so as new initiatives emerge. Thank you for your continued interest in improving the Medicare appeals process.

Sincerely,

Nancy J. Griswold  
Chief Administrative Law Judge

Enclosure

CC: The Honorable James Lankford, Chairman  
Subcommittee on Energy Policy, Health Care and Entitlements  
The Honorable Jackie Speier, Ranking Minority Member  
Subcommittee on Energy Policy, Health Care and Entitlements  
Jim Esquea, Assistant Secretary for Legislation (via e-mail)  
Department of Health and Human Services  
Sarah Vance, Assistant Clerk (via e-mail)  
Subcommittee on Energy Policy, Health Care, and Entitlements



July 9, 2014

The Honorable James Lankford  
 United States House of Representatives  
 Chairman, House Oversight & Government Reform  
 Subcommittee on Energy Policy, Health Care & Entitlements  
 2157 Rayburn HOB  
 Washington, D.C. 20515

Dear Chairman Lankford,

Our coalition appreciates the opportunity to contribute recommendations on ways to improve the Medicare appeals system. In advance of the subcommittee's hearing on this topic and in support of our coalition's mission to eliminate improper payments, I want to offer insight into the current challenges facing the Recovery Audit Contractor (RAC) program with regard to Medicare appeals, as well as suggestions for reform.

#### **Evolution of the Most Successful Integrity Initiative in Medicare History**

According to the Department of Health and Human Services (HHS) FY2013 Agency Financial Report, Medicare loses more money to waste than any other federal program and, since 2011, the rate of improper payments has risen steadily from 8.6% to 10.1%.<sup>i</sup> In addition, in FY2013, providers overbilled Medicare by \$45.6 billion.<sup>ii</sup>

In 2003, Congress mandated the creation of a program to combat rampant Medicare waste. Over the course of a three-year period, the Recovery Audit Contractor (RAC) pilot program returned over \$900 million in overpayments to the Medicare Trust Fund and nearly \$38 million in underpayments to healthcare providers. As a result of the program's overwhelming success, in 2006, Congress mandated the Department of Health and Human Services (HHS) to institute the national RAC program. In 2009, the Centers for Medicare and Medicaid Services (CMS) implemented the permanent RAC program to identify improper payments and recover misused taxpayer funds. Since then, RACs have recovered over \$8.9 billion, while reviewing less than 2% of Medicare records from any given provider.

#### **Challenges Posed by the Medicare Appeals System**

Despite the RAC program's strides, ongoing delays and operational issues in the Medicare appeals process are impeding the program's ability to protect taxpayers and seniors from widespread waste in Medicare.

Providers can appeal RAC findings up to five times, with Administrative Law Judges (ALJs) overseeing the third level of appeals. According to the HHS Office of Inspector General, the Medicare appeals system is ripe for reform. In 2012, an OIG investigation found that due to "wide interpretation" of Medicare policy, overturn rates among ALJs ranged from 18-85%.<sup>iii</sup> In 2013, this inconsistency led to a surge in "frequent filers" – providers that appeal every single audit. According to the Office of Medicare Hearings and

Appeals (OMHA) this trend, along with an increase in Medicare beneficiaries and in state Medicaid agency activity resulted in a massive backlog of cases. In December 2013, OMHA suspended all ALJ assignments until the judges can work through the backlog of cases, which will take approximately two years. Providers and integrity contractors agree that these delays tie up critical resources, undermine Medicare integrity and threaten long-term access to care.

**Recommendations for Medicare Appeals Reform**

In an effort to limit the impact of these developments on seniors, providers and contractors, our coalition recommends taking several steps to alleviate the Medicare appeals backlog and improve appeals process overall:

1. **Implement OIG recommendations.** Our coalition echoes the recommendations included in the November 2012 OIG report, *Improvements are Needed at the Administrative Law Judge Level of Medicare appeals*, including but not limited to:
  - a. Improve compliance training to promote consistency among judges at all levels of appeal.
  - b. Identify unclear Medicare policies and proactively clarify and communicate their intent to all judges.
  - c. Standardize case files to ensure judges have access to the same information across all levels of appeal.
  - d. Implement modest appeal-filing fee to discourage “frequent filers” from unnecessarily clogging the system.
  - e. Implement quality assurance measures to ensure ALJs are accurately interpreting Medicare policy.
  - f. Facilitate greater participation by CMS and integrity contractors in ALJ hearings.
2. **Improve hearing notifications.** A recovery auditor’s presence at an ALJ hearing has a dramatic impact on the hearing outcome. Reports from individual contractors show judges uphold RAC determinations up to 80% of the time, when the contractor is present. Unfortunately, many times integrity auditors are not able to participate in hearings because they are not given timely, if any, notice. Therefore, we recommend improving OMHA hearing notification procedures to ensure contractors are made aware of upcoming hearings, and given ample time to plan for and attend if necessary.
3. **Implement OMHA reporting requirements.** Providers frequently cite inaccurate or inflated rates of success at overturning RAC determinations at the ALJ level of appeal. According to CMS, only 7% of all RAC determinations are overturned on appeal. To reduce confusion and promote the use of accurate data, our coalition recommends implementing an OMHA reporting requirement. Providing updated data regarding pending cases, overturn rates and case volume would increase transparency among all Medicare stakeholders.
4. **Expand OMHA resources.** OMHA attributes three factors to its increasing workload: CMS’ expansion of integrity programs, more active state Medicaid agencies and an increase in Medicare beneficiaries. Despite these developments, OMHA resources have remained constant. Due to this disparity, contractors, providers and beneficiaries are waiting 329 days on average for a case to be processed, according to OMHA. Our coalition recommends expanding OMHA resources to allow the agency to hire additional judges and expedite other system enhancements.

Improving Medicare integrity requires balance. The solutions offered above would provide immediate relief to the appeals backlog and foster transparency among all Medicare stakeholders. Following this hearing, our coalition urges the committee to relay the importance of reforming the Medicare appeals systems to program administrators. Furthermore, our coalition supports having an ongoing, open dialogue with all Medicare stakeholders about strategies to improve Medicare integrity overall.

On behalf of program integrity contractors and the nearly 50 million seniors who rely on Medicare every day, thank you for your consideration and for your efforts to improve oversight of our nation's marquee healthcare program.

Sincerely,



Rebecca  
The

Reeves  
American Coalition for Healthcare Claims Integrity

<sup>1</sup> The Department of Health and Human Services, FY2013 Agency Financial Report, December 2013, Page 15: <http://www.hhs.gov/aftr/2013-hhs-agency-financial-report.pdf>

<sup>2</sup> The Department of Health and Human Services, FY2013 Agency Financial Report, December 2013, Page 161: <http://www.hhs.gov/aftr/2013-hhs-agency-financial-report.pdf>

<sup>3</sup> Department of Health and Human Services Office of Inspector General, Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals, November 2012, Page 14. <https://oig.hhs.gov/oig/reports/oci-02-10-00340.pdf>



Statement for the Hearing Record:

Office of Inspector General  
U.S. Department of Health and Human Services

Hearing Title:  
“Medicare Mismanagement Part II: Exploring Medicare Appeals Reform”

House Committee on Oversight and Government Reform  
Subcommittee on Energy Policy, Health Care and Entitlements

July 10, 2014  
2154 Rayburn House Office Building  
2 p.m.



Statement for the Hearing Record:

Office of Inspector General  
 U.S. Department of Health and Human Services  
 Hearing Title: "Medicare Mismanagement Part II: Exploring Medicare Appeals Reform"  
 House Committee on Oversight and Government Reform  
 Subcommittee on Energy Policy, Health Care and Entitlements

---

Chairman Lankford, Ranking Member Speier, and other distinguished Members of the Subcommittee, thank you for inviting the U.S. Department of Health and Human Services (the Department) Office of Inspector General (OIG) to submit a statement for the hearing record about OIG's recommendations to prevent Medicare improper payments and improve the Medicare appeals system.

OIG's mission is to protect the integrity of Department programs and operations and the health and welfare of the people they serve. OIG has recommended numerous actions to advance this goal. The Department has implemented many of OIG's recommendations, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In fiscal year (FY) 2013, OIG reported estimated savings of more than \$19 billion resulting from legislative and regulatory actions supported by OIG recommendations. However, more remains to be done. In March 2014, OIG issued its *Compendium of Priority Recommendations (Compendium)*,<sup>1</sup> which highlights additional opportunities for cost savings and program and quality improvements. Implementing these recommendations could result in billions of taxpayer dollars saved and more efficient and effective programs to better serve beneficiaries.

As you requested, this statement provides select recommendations to prevent and reduce improper payments and summarizes OIG's work addressing the Administrative Law Judge (ALJ) level of the Medicare appeals system.

#### **CMS Needs To Better Ensure That Medicare Makes Accurate and Appropriate Payments**

Overall, improper Medicare payments cost taxpayers and beneficiaries about \$50 billion a year.<sup>2</sup> Medicare fee for service, the largest program, reported an error rate of 10.1 percent (\$36 billion) in FY 2013. OIG's audits and evaluations have identified opportunities to reduce Medicare improper payments for specific program areas and services. From our recently issued *Compendium*, priority recommendations to prevent and reduce improper payments include:

- Address wasteful Medicare policies and payment rates for clinical laboratories, hospitals, and hospices.

---

<sup>1</sup> Office of Inspector General's *Compendium of Priority Recommendations*; available at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

<sup>2</sup> *Department of Health and Human Services FY 2013 Agency Financial Report*, available at <http://www.hhs.gov/afi/2013-hhs-agency-financial-report.pdf>.

- Improve controls to address improper Medicare billings by community mental health centers, home health agencies (HHAs), and skilled nursing facilities.
- Detect and recover improper Medicare payments for services to incarcerated, unlawfully present, or deceased individuals.
- Improve monitoring and reconciliation of Medicare hospital outlier payments.
- Ensure that Medicare Advantage Organizations are implementing programs to prevent and detect waste, fraud, and abuse.
- Improve controls to address questionable billing and prescribing practices for prescription drugs.

### **CMS Should Maximize Recovery of Improper Payments and Better Address Payment Vulnerabilities To Prevent Improper Payments**

The ultimate goal is preventing improper payments entirely. However, the reality is that Medicare pays billions of dollars improperly each year. CMS must maximize the recovery of overpayments identified by its contractors and others. It is also paramount to prevent the recurrence of improper payments by identifying why they occurred and improving program safeguards accordingly.

#### *Maximize Recovery of Overpayments*

OIG has uncovered numerous impediments to maximizing the recovery of overpayments. For example, as of February 29, 2012, 2,004 HHAs still owed CMS a total of approximately \$408 million for \$590 million in overpayments that the agency identified for these HHAs between 2007 and 2011. CMS could have recovered at least \$39 million between 2007 and 2011 if it had required each HHA to obtain a \$50,000 surety bond.<sup>3</sup>

CMS's challenges in recovering overpayments are not limited to home health agencies. OIG examined overpayments in "currently not collectible" status – a classification that CMS uses for overpayments in which the provider has not made a repayment for at least 6 months.<sup>4</sup> In FY 2010, CMS reported that \$543 million in overpayments had been newly designated as "currently not collectible." However, CMS had limited information to track most of these overpayments in its accounting system. For those it did track, virtually all went uncollected. According to contractors, inaccurate provider contact information delays or prevents some overpayment demand letters from reaching providers. Expanding the types of provider identifiers used to offset overpayment could improve debt recovery efforts, particularly for providers with multiple Medicare national provider identifiers.

<sup>3</sup> *Surety Bonds Remain an Unused Tool To Protect Medicare From Home Health Overpayments*; available at <http://oig.hhs.gov/oei/reports/oei-03-12-00070.asp>.

<sup>4</sup> *Medicare's Currently Not Collectible Overpayments*, OEI-03-11-00670, June 2013; available at <http://oig.hhs.gov/oei/reports/oei-03-11-00670.pdf>.

These challenges echo earlier OIG findings that the vast majority of overpayments identified by CMS's program integrity contractors went uncollected. Further, CMS did not adequately track information on these overpayments and their collection status.<sup>5</sup>

CMS contracts with Recovery Auditors (RACs) to identify Medicare improper payments for recovery (in cases of Medicare overpayments) or return (in cases of Medicare underpayments). OIG reviewed the RAC program for the Medicare fee-for-service program in 2010 and 2011.<sup>6</sup> RACs audits identified improper payments totaling \$1.3 billion in FYs 2010 and 2011. These audits resulted in about \$768 million recovered from providers and about \$135 million in payments returned to providers.

*Better Address Vulnerabilities To Prevent Improper Payments*

In addition to using RAC audits to recover overpayments, CMS uses them to identify vulnerabilities and develop corrective action plans to prevent future improper payments. Vulnerabilities have included, for example, billing for services or supplies on behalf of deceased beneficiaries. By June 2012, CMS reported that it had taken corrective actions to address most of the vulnerabilities it had identified from the 2010 and 2011 RAC audits. These corrective actions were not considered closed, however, because CMS had not yet evaluated their effectiveness, a key step in its process. Thus, it is not clear to what extent these corrective actions have prevented improper payments from recurring.

CMS has missed opportunities to address improper payment vulnerabilities identified by its program integrity contractors. In 2011, OIG found that CMS had resolved or taken significant action on only about a quarter of the vulnerabilities that its program integrity contractors had reported in 2009.<sup>7</sup>

Key OIG recommendations to CMS to maximize recovery of improper payments and address payment vulnerabilities include:

- Implement the surety bond requirement for HHAs.<sup>8</sup>
- Improve tracking and monitor the status of overpayment collections
- Expand the types of provider identifiers used to recover overpayments.
- Address program vulnerabilities identified by contractors in a timely manner.
- Evaluate the effectiveness of corrective actions.

<sup>5</sup> *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010; available at <http://oig.hhs.gov/oei/reports/oei-03-08-00030.pdf>.

<sup>6</sup> *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, September 2013; available at <http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf>.

<sup>7</sup> *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500, December 2011; available at <http://oig.hhs.gov/oei/reports/oei-03-10-00500.asp>.

<sup>8</sup> In January 1998, CMS promulgated a final rule requiring each HHA to obtain a surety bond in the amount of \$50,000 or 15 percent of the annual amount paid to the HHA by Medicare, whichever is greater. However, this regulation remains unimplemented.

### The Medicare Appeals System Faces Many Challenges

The administrative appeals system is an essential component of the Medicare program. Appeals decisions affect providers, beneficiaries, and the Medicare program as a whole. It is imperative that the appeals system be efficient, effective, and fair.

The system has experienced an unprecedented surge of appeals over the past several years. According to the Office of Medicare Hearings and Appeals (OMHA), the number of appeals reaching ALJs—the third level of appeals—doubled from FY 2012 to 2013.<sup>9</sup> Further, OMHA estimates that its backlog will reach a million claims by the end of this fiscal year. A concerted effort by all key players—including OIG, the Centers for Medicare & Medicaid Services (CMS), OMHA, and Congress—is needed to address this issue and to maintain the integrity of the appeals system.

#### *A small percentage of providers account for a large number of appeals*

Our work in examining appeals in FY 2010 showed that Medicare providers make up the vast majority—85 percent—of appellants at the ALJ level of appeal.<sup>10</sup> State Medicaid agencies filed 3 percent of appeals and beneficiaries filed the remaining 11 percent. Four State Medicaid agencies filed at least 50 appeals each; 2 of these filed more than 500 appeals each.

Moreover, 2 percent of providers that appealed accounted for nearly one-third of all ALJ appeals. Specifically, 96 providers were frequent filers that filed at least 50 appeals each; 1 provider filed over 1,000 appeals. These providers were twice as likely as others to file appeals regarding medical supplies, such as wheelchairs. During interviews, ALJ staff raised concerns that some providers appeal every payment denial and may have incentives to appeal because a favorable decision is likely.

Of the 40,682 appeals that ALJs decided in FY 2010, 39 percent were Part A; 31 percent were Part B; 22 percent were related to durable medical equipment, prosthetics, orthotics, and supplies; and the remaining were primarily Parts C and D.

#### *For over half of appeals, ALJs decided fully in favor of appellants*

In FY 2010, ALJs reversed prior-level decisions and decided fully in favor of appellants for 56 percent of appeals.<sup>11</sup> In comparison, Qualified Independent Contractors (QICs)—the second level of appeals—decided fully in favor of appellants for only 20 percent of appeals. At the ALJ level, appellants were most likely to receive favorable decisions for Part A hospital appeals (72 percent) and least likely for Parts C and D appeals (18 percent and 19 percent, respectively).

<sup>9</sup> Department, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015, OMHA*.

<sup>10</sup> OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012. Our work was completed before the recent surge in appeals, but remains relevant to understanding and addressing the current challenges. <https://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>

<sup>11</sup> We did not examine the appropriateness of these decisions.

*Differences between ALJ and prior-level decisions were due to different interpretations of Medicare policies and other factors*

Several factors led to ALJs' reaching decisions that were different from those in the prior level of appeals. We found that ALJs tended to interpret Medicare policies less strictly than did QICs. In addition, ALJ and QIC staff commonly noted that some Medicare policies are unclear. Many ALJs noted that unclear policies lead to more fully favorable decisions for appellants and to more variation among adjudicators.

ALJs and QICs also differed in the degree to which they specialized in Medicare program areas and in their use of clinical experts. In contrast to QICs, ALJs do not have medical directors and clinicians on staff. Several ALJ staff said ALJs tended to rely on testimony and other evidence from treating physicians.

*The favorable rate varied widely by ALJ*

In addition to finding variation between the two levels of appeals, we found variation among ALJs. In particular, the fully favorable rate for appellants ranged from 18 to 85 percent among the 66 ALJs.

Frequent filers received fully favorable rates at different rates from different ALJs. For example, a supplier with close to 600 appeals received fully favorable decisions from 1 ALJ 7 percent of the time and from another ALJ 100 percent of the time.

According to many ALJ staff, different philosophies among ALJs contribute to the variation in fully favorable rates. They said that given the same facts and the same applicable Medicare policy, some ALJs would make decisions that are favorable to appellants, while others would not.

*CMS participation in ALJ appeals is limited*

CMS may choose to participate in ALJ appeals. In FY2010, CMS participated in 10 percent of ALJ appeals. This participation involved providing testimony or submitting position papers. CMS rarely chose to be a party. When CMS participated, the ALJs were less likely to decide fully in favor of the appellant. Overall, 44 percent of ALJ decisions were fully favorable to appellants when CMS participated. In contrast, 60 percent of ALJ decisions were fully favorable when CMS did not participate. The role of CMS participation was most striking with appeals involving medical supplies; the appellant was about half as likely to receive a fully favorable decision when CMS participated.

CMS and ALJ staff noted several benefits of CMS participation. Most CMS staff cited an improved relationship between the two agencies, and many ALJ staff noted that CMS often provided needed information.

*Current practices regarding appeals documents are highly inefficient*

Most CMS and ALJ staff noted that the requirements for accepting new evidence at the ALJ level are open to wide interpretation. ALJs may accept new evidence only if the appellant had good cause for waiting until the ALJ level of appeals to submit it. Most ALJ staff said that they usually accept new evidence when it is submitted. Nearly all CMS staff reported that the ALJs' acceptance of new evidence reduced the efficiency of the appeals system.

In addition, both CMS and ALJ staff identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case file at the QIC level; these problems created inefficiencies in the appeals system. Because the QICs' case files are almost entirely electronic and ALJs primarily accept only paper case files, the QICs must convert the files to paper format before sending to the ALJs. Most staff noted that this process is resource intensive and prone to error.

**Further Action Is Needed To Ensure That the Medicare Appeals System Works Efficiently and Effectively**

ALJs decide tens of thousands of appeals each year. These decisions are critical to providers and beneficiaries and affect the Medicare program as a whole. Our findings highlight a number of inconsistencies and inefficiencies in the appeals process. Together, they demonstrate that OMHA and CMS must take action to improve the appeals system, while maintaining ALJs' independence.

Key recommendations to OMHA and CMS include:

- Identify and clarify Medicare policies that are unclear and are interpreted differently. Unclear policies can lead to inconsistencies between ALJs and QICs and among ALJs. At least annually, CMS and OMHA should identify policies that are unclear and are interpreted differently by soliciting input from CMS contractors and ALJ staff and by analyzing appeals data.
- Develop and coordinate training on Medicare policies. OMHA and CMS should work together to develop and provide training on Medicare policies to ALJ and QIC staff. Coordinated training will help ensure that knowledge of Medicare policies is consistent at the second and third levels of appeal.
- Provide more guidance to ALJs regarding the acceptance of new evidence. Current regulations regarding the acceptance of new evidence provide little guidance and only one example of good cause. OMHA and CMS should revise these regulations to include additional examples as well as factors for ALJs to consider when determining whether there is good cause.
- Standardize case files and make them electronic. To improve the efficiency of the appeals process, OMHA and CMS should make case files more consistent across the various levels of appeal. Finalizing and enforcing a Memorandum of Understanding should be a first step toward

standardization of the content and the organization of case files. In addition, OMHA should accelerate its Electronic Records Initiative to transition from paper to electronic files.

- Continue to increase CMS participation in ALJ appeals.  
Given the benefits cited by both agencies, CMS should continue to increase its participation in ALJ appeals. CMS should establish participation guidelines and incentives for each type of contractor and should track the results of its participation.
- Implement a quality assurance process to review ALJ decisions.  
The range of fully favorable rates among ALJs raises concerns about whether all ALJs are applying Medicare policies in accordance with regulations. OMHA should implement a quality assurance process that includes, for example, reviewing a sample of ALJ decisions and, when needed, providing ALJs with additional training.

Ensuring that the Medicare program works well for beneficiaries, taxpayers, and providers is of paramount importance. An appeals system that is effective, efficient, and fair is critical to accomplishing this goal. This requires a concerted effort by a number of key players, including OMHA, CMS, providers, OIG, and Congress. It also requires a commitment to implementing innovative solutions to improve the appeals process and to evaluating and refining these reforms over time. Such actions are essential for protecting Medicare beneficiaries and the Medicare Trust Funds.

#### **Conclusion**

OIG is responsible for oversight of about 25 cents of every Federal dollar. Unfortunately OIG's mission is challenged by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. Since 2012, we have closed over 2,200 investigative complaints because of lack of resources. We expect to reduce our Medicare and Medicaid oversight by about 20 percent by the end of this FY. Yet the Department estimated that Medicare and Medicaid outlays would grow by about 20 percent from 2012 to 2014. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect the Medicare and Medicaid programs, beneficiaries, and taxpayers.

Thank you for your interest and support and for the opportunity to discuss some of our work.