DEPARTMENT OF HEALTH AND HUMAN SERVICES

[OMHA-1401-NC]

Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim Appeals

AGENCY: Office of Medicare Hearings and Appeals (OMHA), HHS.

ACTION: Request for Information.

SUMMARY: This request for information solicits suggestions for addressing the substantial growth in the number of requests for hearing being filed with the Office of Medicare Hearings and Appeals, and backlog of pending cases.

DATES: The information solicited in this notice must be received at the address provided below, no later than 5:00 p.m., eastern standard time (e.s.t.) [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: In commenting, refer to "OMHA-1401-NC" at the top of your comments. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. We will not accept comments submitted after the comment period.

You may submit comments in one of two ways (to ensure that we do not receive duplicate copies, please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments to *www.regulations.gov*. For new users, you can find instructions on how to submit comments by selecting "Are you new to this site?" at *www.regulations.gov*, then selecting "How do I submit a comment?" For those familiar with *www.regulations.gov*, you can search "OMHA-1401-NC" and select "Comment Now!"

If you are submitting comments electronically, we strongly encourage you to submit any comments or attachments in Microsoft Word format. If you must submit a comment in Portable

Document Format (PDF), we strongly encourage you to convert the PDF to print-to-PDF format or to use some other commonly used searchable text format. Please do not submit the PDF in a scanned or read-only format. Using a print-to-PDF format allows us to electronically search and copy certain portions of your submissions.

2. *U.S. Mail or commercial delivery.* You may send written comments to the following address ONLY: Office of Medicare Hearings and Appeals, Department of Health and Human Services, Attention: OMHA-1401-NC, 1700 N. Moore St., Suite 1800, Arlington, VA 22209.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

Viewing comments: Comments received from members of the public (including comments submitted by mail or commercial delivery) will be made available for public viewing in their entirety on the Federal eRulemaking portal at *www.regulations.gov*. Information on using *www.regulations.gov*, including instructions for accessing agency documents, submitting comments, and viewing the docket, is available on the site under "Are you new to the site?"

Privacy Note: Because comments will be made available for public viewing in their entirety on the Federal eRulemaking portal, commenters should exercise caution and only include in their comments information that they wish to make publicly available.

FOR FURTHER INFORMATION CONTACT: Jason Green, by telephone at 1-703-235-0124, or by e-mail at *jason.green@hhs.gov* (comments will not be accepted at this e-mail address). If you use a telecommunications device for the deaf (TDD) or a text telephone (TTY), call the Federal Relay Service (FRS), toll free, at 1-800-877- 8339.

SUPPLEMENTARY INFORMATION:

I. Background

The Office of Medicare Hearings and Appeals (OMHA), a staff division within the Office of the Secretary of the U.S. Department of Health and Human Services (HHS), administers the nationwide Administrative Law Judge hearing program for Medicare claim, organization and coverage determination, and entitlement appeals under sections 1869, 1155, 1876(c)(5)(B), 1852(g)(5), and 1860D-4(h) of the Social Security Act. OMHA ensures that Medicare beneficiaries and the providers and suppliers that furnish items or services to Medicare beneficiaries, as well as Medicare Advantage Organizations (MAOs) and Medicaid State Agencies, have a fair and impartial forum to address disagreements with Medicare coverage and payment determinations made by Medicare contractors, MAOs, or Part D Plan Sponsors (PDPSs), and determinations related to Medicare eligibility and entitlement, and income-related premium surcharges made by the Social Security Administration (SSA).

The Medicare claim, and organization and coverage determination appeals process consists of four levels of administrative review within HHS, and a fifth level of review with the Federal 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 for claim appeals, by MAOs and an independent review entity for Part C organization determination appeals, or by PDPSs and an independent review entity for Part D coverage determination appeals. The third level of review is administered by OMHA and conducted by Administrative Law Judges. The fourth level of review is administered by the HHS Departmental Appeals Board (DAB) and conducted by the Medicare Appeals Council. In addition, OMHA and the DAB administer the second and third levels of appeal, respectively, for Medicare eligibility, entitlement and premium surcharge reconsiderations made by SSA; a fourth

level of review with the Federal courts is available after administrative remedies within HHS have been exhausted.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554), which added section 1869(d)(1)(A) of the Social Security Act, provides for an Administrative Law Judge to conduct and conclude a hearing and render a decision on such hearing within 90 days of the date a request for hearing has been timely filed. Section 1869(d)(3) of the Social Security Act states that, if an ALJ does not render a decision by the end of the specified timeframe, the appellant may request review by the Departmental Appeals Board. Likewise, if the Departmental Appeals Board does not render a decision by the end of the specified timeframe, the appellant may seek judicial review. OMHA was established in July 2005 pursuant to section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173), which required the transfer of responsibility for the Administrative Law Judge hearing level of the Medicare claim and entitlement appeals process from SSA to HHS. OMHA was expected to improve service to appellants and reduce the average 368-day waiting time for a hearing decision that appellants experienced with SSA.

OMHA serves a broad sector of the public, including Medicare providers, suppliers, and MAOs, and Medicare beneficiaries, who are often elderly or disabled and among the nation's most vulnerable populations. OMHA currently administers its program in five field offices, including those located in Miami, Florida; Cleveland, Ohio; Irvine, California; Arlington, Virginia; and the recently established field office in Kansas City, Missouri. OMHA uses video-teleconferencing (VTC), telephone conferencing, and in-person formats to provide appellants with hearings.

At the time OMHA was established, it was envisioned that OMHA would receive the claim and entitlement appeals workload from the Medicare Part A and Part B programs, and organization determination appeals from the Medicare Advantage (Part C) program, as well as coverage determination 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 able to meet the 90-day adjudication time frame.

However, in recent years, OMHA has experienced a significant and sustained increase in appeals workload that has compromised its ability to meet the 90-day adjudication time frame. In addition to the expanding Medicare beneficiary population and utilization of services across that population, the increase in appeals workload has resulted from a number of changes in the Medicare claim review and appeals processes in recent years, including:

- Medicaid State Agency (MSA) appeals of Medicare coverage denials for beneficiaries dually enrolled in both Medicare and Medicaid. These appeals were previously addressed through a demonstration project that employed an alternative dispute resolution process to determine whether the Medicare or Medicaid program would pay for care furnished to the dually enrolled beneficiaries. The demonstration project ended in 2010, and the MSA appeals entered the standard administrative appeals process, increasing appeals workloads throughout the Medicare claim appeal process, including at OMHA.

- The fee-for -service Recovery Audit (RA) program (also known as the Recovery Audit Contractor program), which was made permanent by section 302 of the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432). Appeals from the RA program began to enter the administrative appeals process at the CMS contractor levels in fiscal year 2011. In fiscal year

2012, OMHA began receiving hearing requests related to the RA program that exceeded projections.

- CMS has implemented a number of changes to enhance its monitoring of payment accuracy in the Medicare Part A and Part B programs, which have increased denial rates and likely contributed to increased appeals. For example, based on recommendations from the HHS Office of Inspector General (OIG), in 2009, CMS tightened its methodologies related to how it calculates the Medicare payment error rate, with a view towards improving provider claims documentation and compliance with Medicare's billing, coverage, and medical necessity requirements. In addition, Medicare Administrative Contractors (MACs) initiated a series of focused medical review initiatives, which increased the overall number of denied claims. CMS also initiated efforts to eliminate payment error and fraud based on Executive Order 13520 and the Improper Payments Elimination and Recovery Act of 2010 (Pub. L. 111-204), resulting in additional denied claims and the identification of overpayments.

With the increase in overall claim denials, the administrative appeals process has experienced an overall increase in appeal requests. At OMHA, the more than anticipated workload increase in appealed claims resulted in a backlog of appeals (that is, appeals that cannot be heard and decided within the adjudication time frame) starting in fiscal year 2012, with a 42% increase from fiscal year 2011 in the number of claims appealed to OMHA. In fiscal year 2013, the number of claims appealed to OMHA more than doubled from fiscal year 2012, with a 123% increase, further contributing to the backlog of cases and resulting in a substantial increase in the adjudication time frame. The increase in appealed claims from the RA program was particularly high in fiscal year 2013, with a 506% increase in appealed RA program claims compared to

fiscal year 2012 appealed claims from the RA program, versus a 77% increase in appealed claims not related to the RA program during that same period of time.

In 2013, CMS issued an Administrator Ruling (published on March 18, 2013, 78 FR 16614) and finalized new rules (published on August 19, 2013, 78 FR 50495) designed to clarify criteria for new (fiscal year 2014) Medicare Part A inpatient hospital admissions, which comprised the disputed issues in a majority of RA program appeals, and to clarify policies at issue in appeals of inpatient claim denials under the existing rules. In addition, CMS expanded the scope of alternative Part B services that could be billed if a Part A inpatient admission was denied and, as part of the ruling, for a limited time allowed hospitals to submit Part B claims for those services beyond the one-year claim filing deadline. Separately, CMS also suspended most RA program audits of Part A inpatient hospital admissions under the new inpatient admission criteria (commonly referred to as the two-midnight rule), which was effective for inpatient claims with admission dates on and after October 1, 2013, in order to offer providers time to become educated on the two-midnight rule. The suspension of audits for new admissions was extended for claims with dates of admission through March 31, 2015, pursuant to section 111 of the Protecting Access to Medicare Act of 2014 (Pub. L. 113-93). CMS is also making improvements to the RA program that are designed to increase the accuracy of RA determinations and to reduce the burden on providers as well as the number of payment denials that providers and suppliers appeal.

OMHA also took measures to mitigate the effects of the workload increase at the Administrative Law Judge level. One of the immediate measures taken was to ensure that processing of the relatively small numbers of beneficiary-initiated appeals was prioritized. For the remaining cases, OMHA has deferred assignments of new requests for hearing until an

adjudicator becomes available, which will allow appeals to be assigned more efficiently on a first in/first out basis as an Administrative Law Judge's case docket is able to accommodate additional workload.

On February 12, 2014, OMHA hosted a Medicare Appellant Forum (see OMHA's Notice of Meeting, published on January 3, 2014, 79 FR 393). The Medicare Appellant Forum was conducted to provide the appellant community with an update on the status of OMHA operations; relay information on a number of OMHA initiatives designed to mitigate the backlog in processing Medicare appeals at the Administrative Law Judge level of the administrative appeals process; and provide information on measures that appellants could take to make the administrative appeals process work more efficiently at the Administrative Law Judge level. In addition, CMS and the DAB participated in the forum and shared information on operations at their respective appeals levels. A second OMHA Medicare Appellant Forum was held on October 29, 2014 (see OMHA's Notice of Meeting, published on October 23, 2014, 79 FR 63398). As conveyed at the forums, HHS is committed to addressing the challenges facing the Medicare claim and entitlement appeals process, and has implemented initiatives and continues to explore additional measures to address the workload increase and reduce the backlog of appeals.

Since the February Medicare Appellant Forum, OMHA has implemented two pilot programs to provide appellants with meaningful options to address claims at the Administrative Law Judge level of appeal, in addition to the existing right to escalate a request for appeal when the adjudication time frame is not met. OMHA is providing appellants with an option to use statistical sampling during the Administrative Law Judge hearing process, which will enable appellants to obtain a decision on large numbers of appealed claims based on a sampling of those

claims. OMHA is also providing appellants with an option for settlement conference facilitation, which will provide appellants with an independent OMHA facilitator to discuss potential settlement of claims with authorized settlement officials. Additional information on these two pilots can be found on OMHA's website, http://www.hhs.gov/omha.

In addition to these initiatives, OMHA continues to pursue new case processing efficiencies and an electronic case adjudication processing environment (ECAPE) to bring further efficiencies to the appeals process.

II. Request for Information

OMHA is seeking input from the public on the current initiatives being undertaken at the Administrative Law Judge level, as well as suggestions for additional initiatives which could be undertaken at OMHA to address the Medicare claim and entitlement appeals workload and backlog at the Administrative Law Judge level. Input is sought on the following topics and questions:

- Are there suggestions related to the current initiatives for addressing the increased workload and/or backlog of appeals at the Administrative Law Judge level that comply with current statutory authorities and requirements?
- Are there other suggestions for addressing the increased workload and/or backlog of appeals at the Administrative Law Judge level that comply with current statutory authorities and requirements?
- Are there any current regulations that apply to the Administrative Law Judge level of the Medicare claim and entitlement appeals process that could be revised to streamline the adjudication process while ensuring that parties to the appeals, as defined at 42 C.F.R. § 405.902

and § 405.906, are afforded opportunities to participate in the process and are kept apprised of appeals related to claims submitted by them or on their behalf?

(Catalog of Federal Domestic Assistance Program No. 93.770, Medicare—Prescription Drug Coverage; Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 30, 2014

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Nancy J. Griswold,

Chief Administrative Law Judge,

Office of Medicare Hearings and Appeals

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