

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

STEPHEN LESSLER, et al.,

Plaintiffs,

v.

SYLVIA MATHEWS BURWELL, Secretary of
Health and Human Services,

Defendant.

No. 3:14-cv-1230 (JAM)

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

I, Nancy J. Griswold, pursuant to the provisions of 28 U.S.C. 1746, declare:

1. My name is Nancy J. Griswold.
2. I am the Chief Administrative Law Judge for the Office of Medicare Hearings and Appeals ("OMHA") at the U.S. Department of Health and Human Services ("HHS").
3. OMHA Administrative Law Judges ("ALJs") issue agency decisions on appeals of, among others, determinations by Qualified Independent Contractors ("QICs") and Quality Improvement Organizations ("QIOs") on claims for benefits under the Medicare fee-for-service program.
4. OMHA, a staff division within the HHS Office of the Secretary, administers the nationwide ALJ hearing program for Medicare claims appeals under 42 U.S.C. §§ 1395ff and 1320c-4. OMHA ensures that Medicare beneficiaries, and the providers and

suppliers that furnish items or services to Medicare beneficiaries, as well as Medicaid State Agencies (MSAs) that have made payment or may be liable for services furnished to beneficiaries who are enrolled in both Medicare and Medicaid, have a fair and impartial forum to address disagreements with Medicare claim determinations.

5. In addition to Part A and Part B claim determination appeals, OMHA is a forum for appeals of Medicare eligibility, entitlement, and income-related premium surcharges made by the Social Security Administration (SSA); organization determinations on coverage made by Medicare Advantage Organizations, health maintenance organizations, and competitive medical plans under 42 U.S.C. §§ 1395mm and 1395w-22; and coverage determinations on prescription drug coverage made by Part D plan sponsors under 42 U.S.C. § 1395w-104.
6. The Medicare claims appeals process for beneficiary claims generally 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 ALJs. 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. See 42 CFR 405.900–405.1140.
7. The Medicare appeals process for a beneficiary's continuation care is somewhat different, generally consisting of three levels of administrative review within HHS, and a fourth level of review with the federal district courts after administrative remedies within HHS have been exhausted. The first level is the reconsideration level conducted by a QIO.

The second level of review is administered by OMHA and is conducted by ALJs.

Subsequent reviews are conducted at the third level of appeal within the DAB and at the fourth level by the federal district courts. See 42 CFR 478.10–478.48.

8. HHS established OMHA in June 2005 pursuant to section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173) (MMA) which required the transfer of responsibility for the ALJ hearing function of the Medicare claims and entitlement appeals process from the SSA to HHS. OMHA was established to improve service to appellants and to reduce the 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 HHS, reporting directly to the Secretary. Accordingly, OMHA operates under a separate appropriation and is both functionally and fiscally separate from CMS.
9. At the time OMHA was established, Congress envisioned that OMHA would receive appeals of:

Medicare Part A and Part B claim denials reviewed by a QIC, and Medicare provider discharges that are reviewed by a QIO;

Medicare Advantage Organization (Part C) determinations reviewed by an independent review entity or a QIO;

Prescription Drug Plan Sponsor (Part D) coverage determinations reviewed by an independent review entity; and

Medicare entitlement and premium determinations reconsidered by SSA.

10. 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 appeals of Medicare Part A and Part B QIC reconsiderations. 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.
11. 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 increased auditing activity to protect the Medicare Trust Funds, including the nationwide implementation of the Recovery Audit Program in 2010. The Recovery Audit Program, established by Congress, has been very successful, returning billions of dollars in improper payments to the Medicare Trust Fund. There have also been increases in MSA appeals of Medicare coverage denials for beneficiaries enrolled in both Medicaid and Medicare, when the MSA has made payment or is liable for the services if they are not covered by Medicare. Although ALJ productivity (dispositions per ALJ) more than doubled from FY 2009 through FY 2013 (from an average of 534 dispositions per year in FY 2009, to 1260 in FY 2013), the magnitude of these increases in appeals has exceeded OMHA's ability to adjudicate incoming appeals within the 90-day time frame that Congress contemplated for appeals of Medicare Part A and Part B QIC reconsiderations. As a result of the

significant disparity between workload and capacity, adjudication time frames have increased to an overall average of 407 days in FY14 (as of August 31, 2014).

12. Recognizing that increasing time frames to obtain a decision could have significant implications on the most vulnerable appellant population that OMHA serves, Medicare beneficiaries, OMHA began prioritizing the processing of beneficiary appeals in July 2013, and established a mail-stop for beneficiary-specific appeals in February 2014, to ensure they are quickly identified and assigned to an ALJ for hearing. These measures have resulted in an average processing time of 109 days for requests filed by beneficiaries in FY2014, according to data available in the Medicare Appeals System (MAS), the OMHA case management and tracking system, as of October 1, 2014.
13. In addition to these measures for beneficiary appeals, OMHA has been able to maximize its productivity overall 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 that can only be performed by ALJs. However, OMHA's adjudication capacity is ultimately limited by the number of ALJs and support staff (ALJ teams). 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 ALJ teams, who reported for duty on August 25, 2014. This brings 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, OMHA had received approximately 509,124 appeals through July 1, 2014. The number of appeal requests filed each week has 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 is receiving one year's worth of appeals every four to six weeks.

14. Due to the rapid and persistent influx of appeals, by July 2013, OMHA's field offices faced significant challenges in their ability to safely store the large number of physical files associated with appeals pending hearing, and each ALJ team had an estimated two years' worth of appeals currently assigned to them. As a consequence, with the exception of appeals filed by beneficiaries, OMHA began deferring assignment of requests for hearing to an ALJ, until an ALJ's docket could accommodate the additional work and the team could manage the physical case files. 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. In February 2014, OMHA began to assign a limited number of non-beneficiary appeals to ALJs 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 to ALJs.
15. 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. OMHA is also pursuing a transition from the current paper adjudication process to a fully electronic process, with the first phase expected in the summer of 2015, and automating notices and routine correspondences to further increase productivity.
16. 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 HHS 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.

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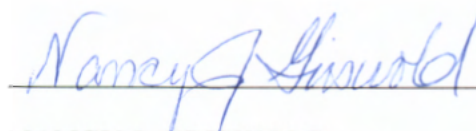
20.

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21.

22. Based upon the data available in MAS as of October 1, 2014, there were 2518 beneficiary-initiated appeals pending at the ALJ level. Of those 2518 appeals, 1409 were subject to the statutory 90-day time frame provided for at 42 U.S.C. § 1395ff(d)(1), after which escalation rights are available.

23. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.



NANCY J. GRISWOLD

Executed on October 9, 2014, in Arlington, Virginia.