EXHIBIT 1

STATEMENT OF

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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 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.