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GAO

Report to Congressional Committees

October 2004

MEDICARE

Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants

GAO-05-45

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Highlights

Highlights of GAO-05-45, a report to the Senate Committee on Finance, the House Committee on Energy and Commerce, and the House Committee on Ways and Means

Why GAO Did This Study

The Medicare appeals process has been the subject of widespread concern in recent years because of the time it takes to resolve appeals of denied claims. Two federal agencies play a role in deciding appeals—the Department of Health and Human Services (HHS) and the Social Security Administration (SSA). Currently, neither agency manages and oversees the entire multilevel process. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress mandated that SSA transfer its responsibility for adjudicating Medicare appeals to HHS between July 1, 2005, and October 1, 2005. In addition, it directed the two agencies to develop a transfer plan addressing 13 specific elements related to the transfer. GAO's objective was to determine whether the plan is sufficient to ensure a smooth and timely transition.

What GAO Recommends

GAO recommends that the Secretary of HHS and the Commissioner of SSA take steps to complete a substantive and detailed transfer plan that includes contingency provisions. HHS, with one exception, and SSA generally agreed with the recommendations. HHS stated the recommendation to develop contingency plans for four elements was unnecessary. GAO believes a contingency plan for each congressionally mandated element would best ensure a smooth and timely transition.

www.gao.gov/cgi-bin/getrpt?GAO-05-45.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600..

What GAO Found

Transferring the Medicare appeals workload from SSA to HHS requires careful preparation and the precise implementation of many interrelated items. The transfer is mandated to take place no later than October 1, 2005. SSA and HHS have stressed their commitment to ensuring a successful transfer of the administrative law judge (ALJ) level of the Medicare appeals process, and both agencies have emphasized that they are continuing to further develop details of the plan. Although the plan generally addresses each of the 13 elements mandated by MMA, it omits important details on how each element will be implemented. Furthermore, the plan overlooks the need for contingency provisions, which could prove to be essential, should critical tasks not be completed in a timely manner. GAO believes that this essential information is needed to facilitate a smooth and timely transfer. Its absence makes it unclear how the transfer plan will be implemented and threatens to compromise service to appellants.

Completeness of Medicare Appeals Transfer Plan

Plan elements mandated by MMA	Characteristics of the transfer plan: Addresses MMA requirements	Contains detailed information	Includes contingency plan
1. Transition timetable	●	○	○
2. Workload	◒	○	○
3. Cost projections and financing	◒	◒	○
4. Regulations	●	○	○
5. Feasibility of precedential authority	●	●	○
6. Geographic distribution	◒	○	○
7. Access to ALJs	●	○	○
8. Shared resources	◒	○	○
9. Case tracking	●	●	●
10. Hiring	●	○	○
11. Training	●	○	○
12. Independence of ALJs	◒	○	○
13. Performance standards	●	○	○

● This aspect of the plan is complete

◒ This aspect of the plan is partially complete

○ This aspect of the plan is incomplete

Source: GAO analysis of Medicare appeals transfer plan and supporting information.

Contents

Abbreviations

ALJ	administrative law judge
BIPA	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
DAB	Departmental Appeals Board
HHS	Department of Health and Human Services
MAC	Medicare Appeals Council
MAS	Medicare Appeals System
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
OHA	Office of Hearings and Appeals
OPM	Office of Personnel Management
QIC	qualified independent contractor
SSA	Social Security Administration

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United States Government Accountability Office
Washington, DC 20548

October 4, 2004

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

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

In fiscal year 2003, Medicare—the federal health insurance program that serves the nation's elderly and disabled—processed over 1 billion claims submitted by providers on behalf of the beneficiaries they serve. The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is responsible for administering the Medicare program. With assistance from 46 claims administration contractors, CMS is charged with identifying and denying health care claims that are invalid, incomplete, or otherwise improper. Medicare beneficiaries and providers have the right to appeal denied claims. In fiscal year 2003, the Medicare program denied about 136 million claims, or about 13 percent of all claims submitted. Of these denied claims, more than 5 million were appealed.

Medicare appeals are resolved through an administrative process consisting of multiple levels of review through several entities. The process allows appellants who are dissatisfied with decisions at one level to appeal to the next level. The entities tasked with resolving appeals are referred to as "appeals bodies." HHS is responsible for implementing and

overseeing the Medicare appeals process. It includes using CMS's claims administration contractors that consider appeals of denied claims, administrative law judges (ALJ) from another federal agency—the Social Security Administration (SSA)—who adjudicate appeals, and the Medicare Appeals Council (MAC) within HHS's Departmental Appeals Board (DAB), which reviews decisions made by the ALJs.

SSA was an agency within HHS until 1994, when it was separated from HHS and became an independent agency. Despite its removal from HHS, SSA's Office of Hearings and Appeals (OHA) continued to hear, or "adjudicate," Medicare appeals. Although still a participant in this process, OHA's primary mission is to resolve Social Security appeals. Its Medicare workload is relatively small, representing about 11 percent of the appeals it heard in fiscal year 2003. As a consequence, most of OHA's ALJs have greater expertise in Social Security matters than in Medicare. Because of their separate and distinct missions, and for the sake of administrative simplicity, HHS and SSA have contemplated transferring OHA's Medicare appeals workload from SSA to HHS for years, but an agreement between the two agencies on specific details of the transfer was never reached.

The Medicare appeals process has been the subject of widespread concern. Last year we reported that there has been poor coordination among the appeals bodies, which has affected their abilities to effectively manage the process.[1] We also found that management by two federal agencies—HHS and SSA—with neither agency managing and overseeing the entire process, has complicated the appeals bodies' attempts to streamline the process. The appeals bodies have also been criticized for the length of time it takes them to render decisions, particularly SSA's OHA and HHS's MAC.

In the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress mandated that SSA transfer its responsibility for adjudicating Medicare appeals to HHS, with the result that all levels of the process would reside within a single federal agency.[2] MMA specified that the transfer be completed not earlier than July 1, 2005, and not later than October 1, 2005. The law also required that SSA and HHS develop a plan for transferring the work and specified 13 elements

[1]See GAO, *Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities*, GAO-03-841 (Washington, D.C.: Sept. 29, 2003).

[2]Pub. L. No. 108-173, § 931, 117 Stat. 2066, 2396.

that were to be addressed in that plan.[3] MMA directed SSA and HHS to submit the transfer plan to GAO for evaluation no later than April 1, 2004. Our objective was to evaluate this plan[4] to determine whether it is sufficient to facilitate a smooth and timely transition.

To do our work, we assessed how well the plan addressed the specific requirements set out in MMA and interviewed officials at HHS and SSA responsible for developing the plan. We also reviewed laws and regulations relevant to the transfer. To learn more about the plan's implications, we interviewed ALJs who currently adjudicate Medicare appeals at OHA and judges at the MAC who review appealed OHA decisions. We also met with other officials at OHA, DAB, and CMS and representatives from two beneficiary advocacy groups to discuss the implications of the transfer plan. To learn more about HHS's ability to hire new ALJs, we spoke with officials from the Office of Personnel Management (OPM). We interviewed officials from the Office of Management and Budget to learn about the costs associated with the transfer and related budgetary matters. Representatives from the Association of Administrative Law Judges—the union representing ALJs—and the American Bar Association submitted written comments regarding the transfer plan, which we considered. Finally, we analyzed available information and other materials supporting the assumptions on which the plan is based, to determine their validity and to evaluate the appropriateness of the plan's strategies. We performed our work from March 2004 through September 2004 in accordance with generally accepted government auditing standards.

Results in Brief

Transferring the Medicare appeals workload from SSA to HHS poses a complex challenge that requires careful preparation and the precise implementation of many interrelated tasks. Although the plan generally addresses each of the 13 elements mandated by MMA, it does not fully address 5 of them. For example, while MMA mandated that the plan address cost projections and financing by including funding levels required

[3]The 13 elements were transition timetable, workload, cost projections and financing, regulations, feasibility of precedential authority, geographic distribution, access to ALJs, shared resources, case tracking, hiring, training, independence of ALJs, and performance standards.

[4]The Secretary of Health and Human Services and the Commissioner of Social Security, *Report to Congress: Plan for the Transfer of Responsibility for Medicare Appeals* (March 2004).

for fiscal year 2005 and subsequent fiscal years, the plan only contains information for fiscal year 2005. In addition, we found that the plan lacks detailed information for 11 of the 13 elements, making it difficult to understand how the transfer will be accomplished. For example, the plan contains insufficient information concerning the timing of the transfer, such as a detailed schedule or project plan to ensure that critical tasks are accomplished. Other elements of the plan required by MMA—including the development of new regulations to guide the appeals process and critical operational matters—have not been thoroughly addressed. Moreover, issues that establish the foundation for many other transfer activities—such as the geographic distribution of ALJs—have not been resolved. Finally, ambiguous details concerning plans for hiring and training ALJs, developing appropriate performance standards, and safeguarding their decisional independence leave it unclear exactly how these important components of the transfer will ultimately be accomplished. The scarcity of detailed information regarding specific dates, duties, and decisions prevents a full assessment of the plan's elements and the absence of contingency plans, should elements not be completed in a timely manner, threatens to compromise service to appellants.

We are recommending that the Secretary of HHS and the Commissioner of SSA take steps to help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, including the completion of a substantive and detailed transfer plan that includes contingency plans. HHS, with one exception, and SSA generally agreed with the recommendations. HHS stated the recommendation to develop contingency plans for four elements was unnecessary. We believe a contingency plan for each congressionally mandated element would best ensure a smooth and timely transition. The agencies also noted new efforts to facilitate the transfer of Medicare appeals to HHS. Although these efforts might have merit, we had no opportunity to evaluate them.

Background

Medicare's fee-for-service health care program consists of two parts—A and B. Part A covers inpatient hospital, skilled nursing facility, hospice, and certain home health services. Part B covers physician services, diagnostic tests, and related services and supplies. Medicare providers, on behalf of their beneficiaries, can appeal denied claims for services. Currently, there are four levels of administrative appeal (see fig. 1). Appeals for denied Part A and Part B Medicare claims currently follow

similar, but not identical, paths. At the first level of appeal, the process is the same for both Part A and Part B denials. The Medicare claims administration contractor[5] reexamines the claim along with any additional documentation provided by the appellant. At this level, in general, only written materials are reviewed; however, Part B appellants may request telephone hearings. If the appellant of a Part B claim is dissatisfied with a decision at the first level, he may proceed to the second level of review, conducted by the Medicare contractor. At this stage, the file is once again reviewed, including any additional documentation submitted by the appellant, and a hearing may be conducted. However, there is no comparable second level of review by Medicare contractors of Part A appeals.[6]

Appellants of both Part A and Part B denied claims who remain dissatisfied with the decisions rendered by Medicare contractors may appeal to the third level—SSA's OHA—where appeals are adjudicated by ALJs.[7] At this level, appellants have the option of attending a hearing conducted by telephone, by videoconference, or in person. OHA's ALJs adjudicated the appeal of about 122,000 Medicare claims in fiscal year 2003. Should appellants also be dissatisfied with the ALJ's decision, they can appeal to the MAC. The MAC's adjudication is the fourth and final level of the administrative appeals process. It is based on a review of OHA's decision; the MAC does not conduct hearings. Appellants who have had their appeals denied at all levels of the administrative appeals process have the option of appealing to a federal district court.

In addition to preparing for the transition of SSA's appeals workload, HHS continues to plan numerous administrative and structural changes

[5]In addition to processing and paying claims, the claims administration contractors currently administer the first level of the Part A appeals process and the first two levels of the Part B appeals process.

[6]Currently, appellants whose Part A appeals are denied by Medicare contractors at the first level, and who wish to continue to appeal their denied claims, proceed directly to the third level of the administrative appeals process—SSA's OHA.

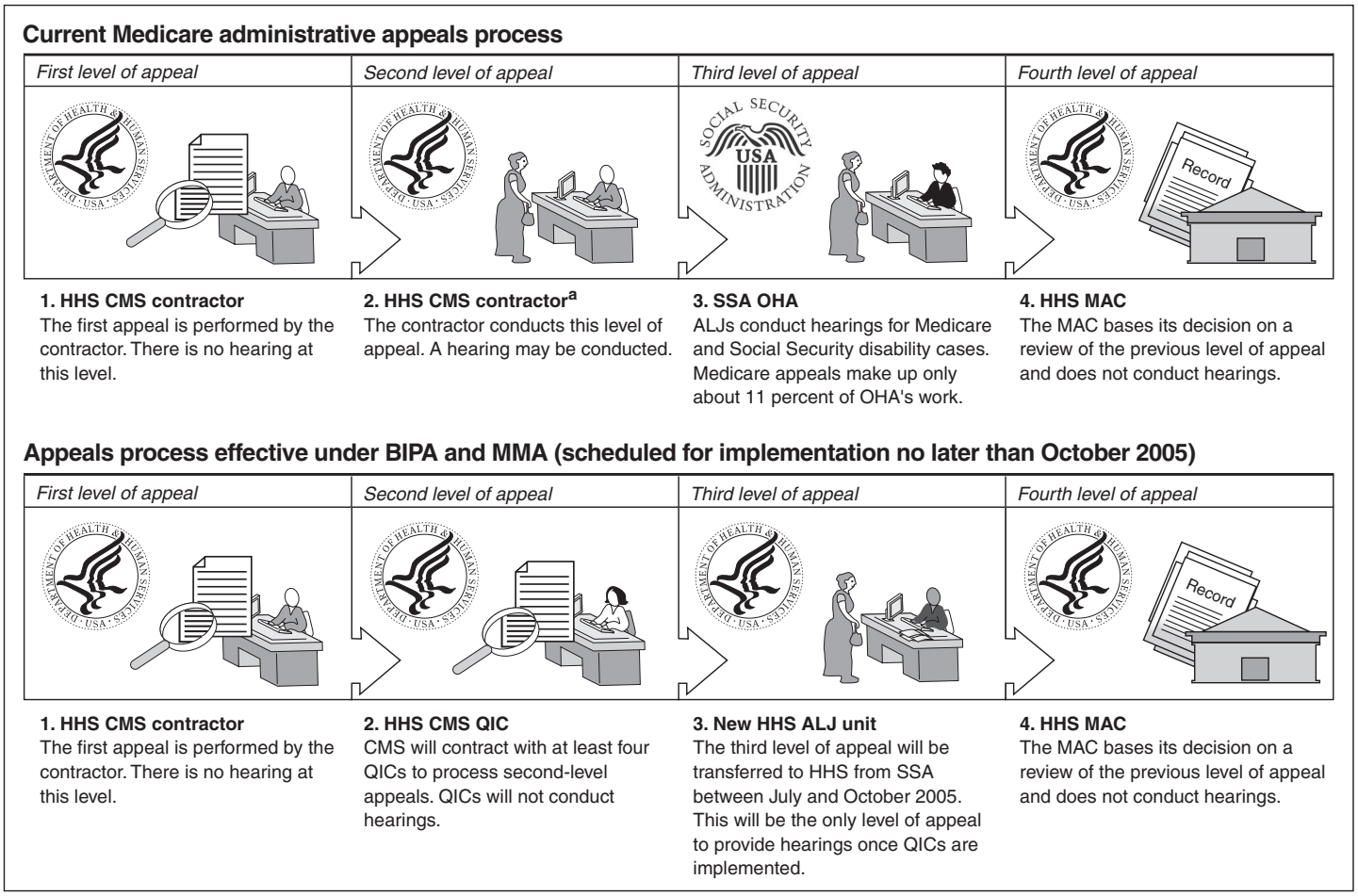
[7]OHA employs most—about 1,000—of the 1,300 ALJs who are employed by the federal government. Because OHA's primary mission is to adjudicate Social Security disability appeals, its resources are largely devoted to these matters. Although it does not have a dedicated corps of ALJs for Medicare appeals, it has a cadre of 34 ALJs with significant Medicare hearings experience. However, few of these ALJs adjudicate Medicare appeals exclusively. Other ALJs may also have Medicare experience, to varying degrees. As a result, some Medicare appeals are randomly assigned to ALJs who may not be familiar with Medicare statutes and program rules.

required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[8] Most of these changes have not yet been implemented, including the finalization of new regulations. Among other things, BIPA mandated shorter time frames; expedited procedures for processing Medicare appeals at all levels; and the establishment of new contractors, known as qualified independent contractors (QIC). Contracts for QICs have not yet been awarded, but once QICs become operational, they will provide a new second level of adjudication for Part A appeals and replace the existing second level of the appeals process for Part B claims.

As noted earlier, figure 1 shows the appeals bodies that are currently involved in Medicare appeals. It also shows those that will be responsible for resolving Medicare appeals once BIPA has been fully implemented and OHA's workload has been transferred to HHS.

[8]Pub. L. No. 106-554, app. F, § 521, 114 Stat. 2763A-463, 2763A-534.

Figure 1: Current and Future Medicare Administrative Appeals Process



Source: GAO.

[a]The second level of the current appeals process is relevant for Part B appeals only. At present, there is no comparable second level of appeals for denied Part A claims. Appellants whose Part A claims have been denied by the claims administration contractor may continue to appeal their claims by submitting them to OHA.

The transfer of the appeals workload from SSA to HHS is not a new proposal. As early as 1988, while SSA was still a part of HHS, discussion regarding the transfer of this function was already under way and, throughout the years, the development of potential transfer plans and strategies has continued. Discussions were active as late as 2003, culminating in SSA's decision not to seek funding for Medicare appeals in its fiscal year 2004 budget request. Instead, HHS requested and received funding to cover the cost in its fiscal year 2004 budget. Under a

reimbursable agreement with CMS, SSA will continue to hear Medicare appeals until September 30, 2005.

In response to MMA's mandate to transfer the workload, SSA and HHS created an interagency team that drafted the required transfer plan. The team has continued to meet to deliberate various aspects of the plan and discuss its implementation. Representatives from both agencies have stressed their commitment to ensuring a successful transfer of the Medicare appeals process from SSA to HHS. The plan indicates that HHS will begin to exercise adjudicative authority for Part A and Part B ALJ appeals that are received on or after July 1, 2005. The plan notes that this schedule is being adopted so SSA may concentrate on reducing its pending workload between July 1, 2005 and September 30, 2005 and to permit HHS to prepare for and begin conducting ALJ hearings.

According to MMA, the plan is required to provide information regarding 13 key elements. For purposes of this report, we have grouped these elements into six broader categories—timetable, scope of work, adjudication guidance, operational matters, staffing, and oversight. Table 1 lists these six categories and related elements and identifies the act's requirements for each element.

Table 1: MMA Requirements for the Transfer Plan by Category

Category and related elements	MMA requirement
(A) Timetable	
(1) Transition timetable	A timetable for the transition.
(B) Scope of work	
(2) Workload	The number of ALJs and support staff required now and in the future to hear and decide Medicare appeals in a timely manner, taking into account current and anticipated claims volume, appeals, the number of beneficiaries, and statutory changes.
(3) Cost projections and financing	Funding levels required for fiscal year 2005 and subsequent years to carry out the functions transferred under the plan.
(C) Adjudication guidance	
(4) Regulations	The establishment of specific regulations to govern the appeals process.
(5) Feasibility of precedential authority	The feasibility of developing a process to give MAC decisions, addressing broad legal issues, binding precedential authority.
(D) Operational matters	
(6) Geographic distribution	The steps that should be taken to provide for an appropriate geographic distribution of ALJs throughout the United States to ensure timely access.
(7) Access to ALJs	The feasibility of (a) electronically filing appeals to the ALJ level and (b) conducting hearings using video- or teleconferencing technologies.
(8) Shared resources	The steps that should be taken to enter into arrangements between HHS and SSA to share office space, support staff, and other resources, with appropriate reimbursement.
(9) Case tracking	The development of a unified case tracking system that will facilitate the maintenance and transfer of case-specific data across both the fee-for-service and managed care components of the Medicare program.
(E) Staffing	
(10) Hiring	The steps that should be taken to hire ALJs, taking into account their Medicare expertise and appropriate geographic distribution, and to hire support staff for ALJs.
(11) Training	Training for ALJs regarding Medicare laws and regulations.
(F) Oversight	
(12) Independence of ALJs	The steps that should be taken to ensure the independence of ALJs through placement of ALJs in an administrative office organizationally and functionally separate from CMS and its contractors, and providing that ALJs report to, and be under the general supervision of, the Secretary of HHS, but not report to, or be subject to supervision by, another officer of HHS.
(13) Performance standards	The appropriateness of establishing performance standards for ALJs with respect to timeliness of decisions, taking into account applicable requirements.

Source: GAO analysis of Section 931 of MMA.

Incomplete Transfer Plan Lacks Sufficient Detail to Ensure a Smooth and Timely Transition

We found that HHS's and SSA's plan is too vague to serve as a blueprint for the transfer's implementation. We evaluated the plan's 13 elements, mandated by MMA, and grouped them into six categories to evaluate whether the plan was sufficient to ensure a smooth and timely transition. We found that in virtually every category, the information contained in the plan, as well as documentation provided to us in the course of our work, lacked sufficient detail to ensure that HHS will achieve a smooth and timely transfer. Further, the lack of detail and the fact that some aspects of the plan have not yet been finalized raise serious questions as to whether HHS and SSA have considered the breadth of challenges inherent in the transfer. Our review suggests that the plan's deficiencies, if not corrected, may compromise service to appellants. (App. I contains a summary evaluation of our analysis of the plan.)

Category A: Essential Milestones and Contingency Strategies Not Included in Transition Timetables

Element 1: Timetable

Transferring SSA's annual workload of appeals—about 122,000 claims in fiscal year 2003—to HHS requires the development of many interrelated components. For example, deciding where ALJs should be geographically located affects hiring and training plans and the need for office space. Because the transfer date is approaching, many of these activities must be completed simultaneously so that HHS can ensure that service to appellants will not be disrupted. With the exception of the development of a case tracking system, the plan contains few milestones for completing tasks. Some of the few dates that are mentioned merely reflect the MMA-imposed deadlines between July 1, 2005, and October 1, 2005, without noting interim milestones. For example, there are no milestone dates associated with the vital tasks of producing training materials for newly hired ALJs or locating office space for ALJs to conduct hearings. Other elements of the plan are addressed without ever mentioning dates, such as the ensuring of independence for ALJs and the establishment of performance standards for them. Moreover, the plan does not assign responsibility to any group, office, or individual to perform the necessary tasks to execute key elements of the plan. In our view, the level of complexity associated with the transfer would warrant the development of a detailed schematic outlining all of the steps that need to be taken, as well as the corresponding dates for completing these steps, to ensure that the plan could be successfully executed. In response to our inquiries, the transfer team reported that it did not prepare a project plan nor could it supply information about ambiguous or absent milestones. Without specific milestones, HHS does not have a management tool for

determining whether the general dates contained in the plan can be met as scheduled.

The transfer plan also lacks a contingency component, to be used in the event that something prevents the transfer from occurring as scheduled. Given the importance of having a system in place for adjudicating appeals, we view this as a considerable oversight. Failure to successfully implement even one element of the plan, such as the development of a geographic distribution plan to ensure appellants appropriate access to ALJs throughout the country, could derail the transfer. Although this is a critical element of the plan, there is no contingency provision. HHS officials maintained that they are confident the transfer will be executed in a timely manner, eliminating the need for a contingency plan. However, they indicated that if necessary, they could renew their reimbursable agreement with SSA to adjudicate Medicare appeals for another year. In contrast, SSA officials emphasized to us that responsibility for all Medicare appeals will pass, under MMA, to HHS on October 1, 2005. According to them, it is not a given that SSA will have the capability, or even the legal authority as of that date, to adjudicate Medicare appeals under any arrangement with HHS. In our view, this is the type of issue a contingency plan could address. In agency comments, both SSA and HHS reported that they have identified a mechanism for HHS to continue to use SSA ALJs to adjudicate Medicare appeals after the date of the transfer, if necessary. However, neither agency provided details concerning this mechanism in their comments. As a result, we are unable to evaluate it.

Category B: The Plan's Assumptions to Predict the Scope of Work Are Not Credible

Understanding the size of the appeals workload is a critical first step in planning for the transfer because other decisions, such as the number of ALJs needed to complete the adjudications, are predicated on it. We found that the transfer plan does not present a thorough analysis of the expected workload and the costs to transfer the function and adjudicate appeals. Further, the plan is based on unreliable staff and cost data, which undermine the validity of the plan's projections. MMA mandated that certain external factors be incorporated into the plan's analyses, such as changes in the number of appeals and the effect of statutory changes. However, the plan did not contain a detailed discussion of the implications of these factors on workload and costs.

Element 2: Workload

HHS's plan to initially hire 50 ALJs is based on information from OHA that it uses an average of 46 ALJs to adjudicate Medicare appeals each month.

However, SSA does not have a dedicated corps of ALJs who are exclusively devoted to hearing Medicare appeals, and based its estimate on the average amount of time ALJs spend doing Medicare work. OHA has no formal timekeeping system for its ALJs, and instead, the chief of each local hearing office estimates the amount of time ALJs spend each month adjudicating Medicare appeals. Individual ALJs do not provide their own time estimates, and the information supplied by each local office is not otherwise verified. The transfer team did not independently determine the accuracy of this information, despite the plan's heavy reliance on it.

Despite the fact that MMA requires the plan to address the number of ALJs and support staff required to hear Medicare appeals now and in the future, the plan limits itself to the present. It does not specifically address how the implementation of recent statutory changes to Medicare may affect the appeals workload and increase the need for personnel. For example, the plan does not address the potential impact of additional appeals resulting from MMA's new prescription drug benefit.[9] Further, the largest impact may result from the implementation of BIPA's changes, which will not become effective until the QICs are fully established—now slated for October 2005. BIPA's changes to the appeals process were to apply to appeals of claims denied on or after October 1, 2002. However, CMS issued a ruling on October 7, 2002,[10] that held that the majority of BIPA's provisions apply only to appeals adjudicated by QICs. Because QICs are not yet operational, the appeals process is currently operating in accordance with regulations established prior to BIPA's passage.[11] The establishment of the QICs and new regulations implementing BIPA's provisions are now expected to occur simultaneously with the plan to transfer the OHA workload. As a result, it will be HHS's ALJs who will be expected to comply with BIPA's shorter time frames for processing appeals. While their OHA colleagues, who faced no deadlines, took an average of 327 days to complete a Medicare appeal in fiscal year 2003, HHS ALJs will be expected to render decisions much more quickly—within 90 days. The plan is silent as to how HHS's new corps of ALJs will meet

[9]MMA created a new, voluntary prescription drug benefit for Medicare beneficiaries, to start in 2006.

[10]67 *Fed. Reg*. 62,478.

[11]There are two exceptions that resulted from the October 7, 2002 ruling, implementing BIPA's changes—revising the deadline for filing an appeal for the first level of review and reducing the dollar threshold for filing an appeal at the OHA level.

BIPA's time frames by completing the same workload in less than one-third the time taken by OHA.

In addition, the plan states that efficiencies will be gained from hiring ALJs and staff who are specialized in Medicare, increasing reliance on teleconferences and videoconferences to minimize travel, and improving the management of appeals cases. While efficiencies may be gained in the long term, we found that the plan did not provide a sound quantitative basis to support HHS's claim that efficiencies would mitigate demand for more resources in the first year of operation. Further, the plan does not contain a contingency provision to address the possibility that greater efficiencies may not be achieved. In our view, this is significant as, in the short term, HHS may experience a period of diminished efficiency while new staff—both ALJs and support personnel—take time to attend training, develop expertise with Medicare issues, and gain familiarity with their new organization and infrastructure.

Element 3: Cost Projections and Financing

The plan notes that $129 million was requested for fiscal year 2005 for Medicare appeals reforms, which includes start-up funds for HHS's ALJ unit; funds to reimburse SSA for continuing to process Medicare appeals; and funds to implement other BIPA reforms, as amended by MMA. In fiscal year 2004, $50 million was intended for processing appeals submitted to ALJs. HHS officials told us that they anticipate requiring the same amount for fiscal year 2005. The $50 million for processing appeals is based upon SSA's agreement to adjudicate approximately 50,000 cases,[12] at a cost of $1,000 each, in fiscal year 2004. We learned that HHS expects to use $8 million in fiscal year 2005 to meet start-up costs for the transfer of ALJ functions. Although the plan notes that start-up funds will allow HHS to begin hiring attorneys and other staff, it makes no mention of office space, equipment, and other infrastructure development costs. Most of the remaining balance is expected to be used for establishing QICs. We also noted that the plan does not provide cost projections for years subsequent to 2005, as required by MMA.

[12]An appellant may aggregate multiple denied claims into a single appeal or "case" to meet OHA's minimum dollar threshold for filing an appeal. In addition, the appeals bodies may reconfigure a "case" to group denied claims related to similar issues.

Office of Management and Budget officials, who are responsible for approving HHS's requests, and HHS officials could not provide specific budgetary details related to the plan. Moreover, HHS's estimate of the costs of adjudicating Medicare appeals in fiscal year 2005 is based on its assumption that those costs will mirror what it is paying SSA to resolve appeals this fiscal year under its reimbursable agreement. However, OHA reported that the actual costs of adjudicating these appeals exceeded the amount it was being paid. After adjusting for inflation and overhead, OHA officials estimated that their actual cost in fiscal year 2003—the most current data available—was closer to $1,300 per case. MMA allows for increased financial support to ensure that the HHS ALJ unit meets its workload demands. However, should additional funds be needed, the plan does not include a contingency provision that defines criteria and other relevant measures to justify future requests for increased financial support.

Category C: Completion of Adjudication Guidance for ALJs Not Fully Addressed

The timely issuance of regulations governing the appeals process will have a significant effect on the implementation of the transfer plan. Without regulations implementing the provisions of BIPA, and more recently MMA, the appeals process will lack guidance critical for its operation. Nonetheless, the plan does not address time frames for establishing these regulations nor does it discuss what actions will be taken should the regulations not be finalized by the time of the transfer. It appears, however, that no regulations will be needed regarding the use of MAC decisions as binding precedents on lower levels of the appeals process, including ALJs, at least in the near future. The plan has addressed this matter by retaining current policy, which allows ALJs and the other appeals bodies to consider these decisions as guidance, but does not require them to be viewed as binding precedents. However, the plan suggests that this decision may only be for the short term.

Element 4: Regulations

To implement MMA's provisions to transfer SSA's workload to HHS, regulations will need to be drafted and finalized by October 1, 2005—the date that the transfer is required to be complete. As required by MMA, the plan acknowledges the need for specific regulations and mentions that regulations will be developed in several areas, such as providing appellants the opportunity to file appeals electronically and a reliance on videoconferences in lieu of in-person hearings. However, the plan is silent on the anticipated time frames for issuing these regulations and does not include interim dates to ensure they are finalized on time. In the absence

of regulations, it is not clear how appellants will be assured of having sufficient access to ALJs. For example, without regulations it is uncertain what forum will be used to provide information to beneficiaries and providers, how access to this information will be provided, and what will be used as the basis for this information. The plan also does not address whether there will be a need to issue additional regulations on other aspects of the transfer, such as procedures for hiring ALJs, initiating a training program, developing ALJ performance standards, and identifying opportunities for HHS and SSA to share resources. Given the ambiguity in the plan, it is unclear how the required transfer of the appeals function to HHS could proceed on a timely basis.

Moreover, although the plan recognizes that regulations implementing most of BIPA's provisions have not been finalized, it does not address the impact of this situation. This is particularly troubling because, according to CMS, the implementation of QICs will be delayed if final regulations are not issued by November 2004. As a result, HHS may be compelled to develop and operate two separate processing systems—one that follows current rules, and another that complies with BIPA's mandated deadlines and other requirements.

Element 5: Feasibility of Precedential Authority

In response to an MMA requirement to address precedential authority, the plan makes clear that MAC decisions will not be binding on lower levels of the appeals process, including ALJs. The plan acknowledges that precedential authority may contribute to more consistent decisions by ALJs. However, it concludes that the risk of an inaccurate or incomplete interpretation of an agency ruling could result in greater problems when the same issue is raised more clearly or in different circumstances. The plan therefore concludes that the risks inherent in giving the MAC precedential authority outweigh the benefits. The plan also suggests that high-level decisions could serve as guidance to the lower levels in the process, without having the full force of precedent. Although the plan indicates that HHS will reevaluate its stand on the merits of granting binding precedential authority to MAC decisions, it does not specify what might contribute to a change in its current position on the issue.

Category D: Operational Matters Need Greater Specificity

Absent or insufficient details and vague descriptions regarding critical operational aspects of the transfer prevented us from fully evaluating these components and, in our view, put the successful implementation of the transfer at risk. The lack of a geographic distribution plan for HHS

ALJs alone threatens to undermine efforts to accomplish the transfer in a timely manner. Beyond this, the lack of specific plans to ensure access to ALJs nationwide and to share resources with SSA to enhance appellant access may well compromise service to appellants. Finally, although the plan outlines important details concerning the establishment of a new case tracking system, its implementation is linked to the establishment of the QICs in July 2005, making a current evaluation impractical.

Element 6: Geographic Distribution

While the plan addresses the topic of the future geographic distribution of ALJs, it does not include the steps to be taken to ensure that appellants across the country will have timely access to such judges, as MMA requires. Rather than detailing a specific geographic distribution strategy, the transfer plan indicates that a central hearing support office will be located in the Baltimore, Maryland and Washington, D.C., metropolitan area and that a field structure will be established. Because many issues relating to the successful implementation of the transfer, such as hiring staff, hinge on the strategy for distributing ALJs throughout the country, its absence from the plan is a serious shortcoming.

The plan notes that HHS will develop a process for determining the size and location of the field structure and will reach a final decision about the geographic distribution of ALJs by the end of calendar year 2004. However, the plan does not include key information that would enable us to analyze this critical component of the plan, such as the anticipated number of field office locations or the size and resources required for each office. The plan also does not supply information about the number of judges to be housed in each location or details concerning whether certain case processing activities—such as case receipt, research, and preparation for hearings—will be centralized or regionally based.

Element 7: Access to ALJs

MMA required the plan to address the feasibility of electronically filing appeals to the ALJ level. CMS is developing a beneficiary Web site, which, in its pilot at one contractor, allows beneficiaries Internet access to claims information. The plan anticipates that HHS will use this Web site to allow electronic appeals submissions. Although the plan does not discuss when this feature will be available, a CMS official estimated it would not be ready for testing for at least 2 years. HHS is also exploring the possible development of another Internet-based filing system that does not depend on CMS's beneficiary Web site.

MMA also required that the plan address the feasibility of using video- and teleconferencing to provide access to ALJs. Although the plan identifies a variety of sources for providing ALJs and appellants with videoconference access—including SSA, private contractors, and other government agencies—no analysis has been conducted to determine where videoconference sites are needed, where such sites are actually available, and the costs of such services. Moreover, SSA does not expect appellants to travel more than 75 miles to attend hearings, but the plan does not address HHS's expectations in this regard. Appellants in remote areas of the country may be unlikely to find access to videoconference facilities within such a radius. In regard to teleconferences, the plan notes that a small number of appeals are currently conducted in this manner, but more commonly, teleconferences are used to obtain the testimony of expert witnesses. The plan refers to HHS's willingness to expand its use of teleconferences, where appropriate, but does not define the conditions that would constitute "appropriate" use.

Moreover, no analysis has been done to determine what proportion of appellants would actually be interested in having their appeals heard using videoconferences or teleconferences. Several ALJs told us that beneficiaries are often uncomfortable using videoconference facilities and prefer to have their cases heard face-to-face. While appellants have the right to request in-person hearings, the plan does not include an assessment of HHS's capacity to conduct such hearings. There is no contingency provision to facilitate in-person hearings, should this be appellants' preference. Further, as a result of changes to the appeals process due to BIPA, hearings by ALJs will provide an appellant's sole opportunity to be heard in person, making access to them all the more important. Although OHA has been able to accommodate appellants through its network of 10 regional offices and an additional 143 field offices with hearing rooms throughout the United States and Puerto Rico, HHS currently has no available capacity to hear Medicare claims appeals.[13]

[13]Although HHS employs nine ALJs, they focus on other departmental matters. One of these ALJs adjudicates appeals at the Food and Drug Administration. The remaining eight work at DAB and hear enforcement appeals, including those related to Medicare fraud and provider penalties. The latter have a backlog of almost 500 pending cases. However, these ALJs have no hearing rooms and, instead, use the hearing rooms of local courts or other agencies.

Element 8: Shared Resources

The plan does not address MMA's mandate that it include steps for SSA and HHS to share office space, support staff, and other resources. Moreover, it does not include a contingency element should HHS be unable to use SSA resources to complete the Medicare workload. Instead, the plan focuses exclusively on sharing videoconference facilities, but the arrangements for sharing this resource are ambiguous. For example, while the plan notes that SSA is willing to share its videoconference sites, it also makes clear that SSA will have priority over the use of the equipment and does not include a protocol for ensuring that HHS will have sufficient and timely access. One SSA official told us the agency anticipates that it will have excess videoconference capacity once it expands its videoconference system. Currently, SSA has 148 videoconference units available but plans to increase this number to 351 units at 302 different sites by 2006. However, the agency has not yet performed an analysis to establish where and when excess capacity is anticipated. Because SSA ALJs schedule their hearings well in advance, HHS ALJs may have difficulty scheduling videoconferences in their localities to meet their 90-day BIPA-mandated deadline. Moreover, even with access to 302 facilities, depending on the location of available equipment, HHS ALJs may have to travel to videoconferences, which could be as time-consuming as traveling to in-person hearings.

Element 9: Case Tracking

The plan addresses the mandate's directive to develop a unified case tracking system for all appeals levels, and outlines a new tool designed to fulfill the mandate's requirements—the Medicare Appeals System (MAS). We found that the design and approach to implementing MAS appear reasonable. However, the plan was drafted with the expectation that MAS would be first used by QICs in the summer of 2004. The delay in implementing QICs, which are now not expected to become fully operational until October 2005, has reduced the time available for live testing of the system to determine if it will perform as expected. Currently, HHS is unable to conduct such testing. This delay may leave insufficient time to fully test MAS and make necessary adjustments to the system, but the plan leaves no margin for such an occurrence. However, should MAS be unavailable at the time of the transfer, CMS has an alternate case tracking system that could be temporarily deployed until the new system becomes operational.

Category E: Strategy for Staffing HHS's ALJ Unit Is Undeveloped

The plan lacks a detailed staffing strategy to ensure that HHS can attract both ALJs and support staff by the time of the transfer. MMA required the plan to include steps to hire ALJs, taking into account their expertise in Medicare, and to address training in Medicare laws and regulations.

Element 10: Hiring

As required by MMA, the plan addresses steps that should be taken to hire ALJs and support staff. It outlines HHS's intention to hire ALJs from various sources, including OPM's register of qualified ALJs, the list of retired ALJs who have expressed interest in returning to work and are available for temporary reappointment, and ALJs currently employed and adjudicating administrative appeals at other agencies.[14] However, it does not discuss how HHS will be able to ensure that it can attract the 50 ALJs it plans to hire. Moreover, we expect that it may be difficult for HHS to identify and hire 50 ALJs with Medicare knowledge. For example, OPM's register, the largest source of new ALJs with 1,300 potential candidates, does not include information indicating whether candidates have Medicare expertise. Similarly, HHS cannot tell which of the 110 retired ALJs on the register of those interested in returning to work have Medicare expertise. And, although ALJs already employed at other agencies may be interested in seeking employment at HHS, few of them are likely to have knowledge of Medicare rules. Given that the majority of ALJs currently employed by SSA focus primarily on disability appeals, few of them are likely to have significant Medicare expertise.

HHS's plan to hire ALJs and other professional and administrative staff in a manner that ensures an appropriate geographic distribution is a major staffing consideration. However, the plan does not address how HHS will incorporate this feature into its hiring plans. Given the lack of such a geographic distribution plan, there is no way for ALJ candidates to know where new positions will be located—which may have a great bearing on their interest. As a result, even the OHA ALJs with Medicare expertise may

[14]OPM administers the ALJ examination and maintains a hiring register. Federal agencies that intend to hire ALJs must specify the number and locations of the judgeships they would like to fill and submit their requests for candidates to OPM. OPM supplies three to five of the highest ranked candidates for each slot. Those not hired are returned to the register. Agencies may also hire temporary ALJs from a roster of retired judges who have made themselves available for reemployment. This roster is also maintained by OPM. In addition, federal agencies may hire ALJs who are already employed in that capacity at other agencies by posting vacancy announcements and evaluating applicants.

not be interested in transferring to HHS, if this would require them to relocate.

The plan lacks other details concerning HHS's hiring plans. For example, it is not explicit about whether HHS will hire the 50 ALJs and 200 support staff all at once, or if it intends to conduct several rounds of hiring and training. The plan does not outline who is to be involved in the hiring process and, as of July 2004, HHS had not decided whether a chief judge might be hired first to participate in the hiring of the ALJs and support staff. Finally, the plan does not acknowledge the possibility that HHS may be unable to hire all needed staff by the time of the transfer. By not recognizing this possibility, the plan misses the opportunity to develop critical contingency arrangements.

Element 11: Training

As required by the mandate, the plan describes HHS's plans to develop a training strategy but, nonetheless, leaves key questions unanswered. Although the plan establishes four broad categories for short-term training, it does not include substantive information on the training's content. It also lacks other critical information, such as a detailed description of its plans to provide initial training for HHS's ALJs. While OHA's ALJ training of new hires lasts 5 weeks, the plan does not describe the duration of HHS's planned training or the depth of material to be covered. It also does not specify who will be responsible for developing the training curriculum and course materials or presenting the training to new ALJs. The plan mentions that HHS is also developing a long-term training strategy, but there are no details for providing ongoing training and refresher classes to ALJs in future years. Even OHA ALJs with Medicare knowledge may need additional training, as some indicated to us that their understanding of the program's rules is not current.

In addition to our concerns regarding the content of this plan element, the lack of a detailed schedule for developing and presenting the new training program raises concerns about HHS's ability to have an adequately prepared staff to adhere to its plans to begin processing appeals by July 1, 2005. The only date included in HHS's training schedule indicates that both hiring and training will begin in the second quarter of calendar year 2005—at most, 3 months before the plan anticipates HHS ALJs will begin hearing appeals. This poses a challenging time frame for HHS, especially if its training will mirror OHA's 5-week program. Given the plan's timeline, there is little opportunity to pursue alternate training arrangements, should delays occur.

Category F: Issues of Oversight Remain Unresolved

Although the plan recognizes the importance of ALJ decisional independence—an element critical to the integrity of the appeals process—it does not specify, organizationally, where ALJs will be housed within HHS nor does it discuss the safeguards that will be put in place to ensure ALJs are insulated from undue influence from HHS. The plan outlines the circumstances under which performance standards can be applied to ALJs without threatening their independence. However, other than meeting time frames prescribed by law, the plan proposes no standards nor does it describe the process that might be used to develop such standards.

Element 12: Independence of ALJs

Despite the fact that the independence of ALJs is critical to ensuring due process to appellants, the plan is silent on what steps will be taken to shield ALJs from real or perceived external pressures, including pressure from elsewhere in HHS, which is tasked with overseeing the Medicare program. ALJs throughout the federal government may have to issue rulings against the agencies that employ them.[15] However, since SSA became an independent agency in 1994, OHA ALJs hearing Medicare appeals, as SSA employees, have not been in this position.

The plan notes that SSA has a long history of maintaining independence of ALJs. MMA required that the plan provide information on steps to be taken to ensure the independence of ALJs hearing Medicare appeals once this function has been transferred to HHS. However, the plan merely repeats MMA's requirement—that the HHS ALJ unit will report solely to the Secretary of HHS and that it will be separate from CMS. The plan provides no information about the proposed, new organizational structure, nor does it specify who, in terms of title and duties, will direct and manage the HHS ALJ unit. Furthermore, the plan does not define the relationship of ALJs to other HHS offices, such as CMS and the MAC—with which the ALJ unit will have to communicate and coordinate—or where, organizationally, the ALJ unit will be housed. The plan also does not include standards that either HHS, or the new ALJ unit, could use to evaluate whether the independence of the ALJ unit is being achieved. Similarly, the plan makes no reference to the steps that will be taken to ensure the objectivity of ALJ

[15]To ensure that ALJs feel free to exercise their independent judgment, federal law provides them with several protections. For example, ALJs are excluded from the definition of "employee," for the purposes of performance appraisal systems applicable to other federal employees. 5 U.S.C. § 4301(2)(D) (2000).

training. Finally, the plan does not recognize the possibility that the independence of the ALJ unit could be questioned nor does it specify a contingency plan to ensure—and if necessary, restore—the continued independence of ALJs.

Element 13: Performance Standards

The plan addresses the appropriateness of establishing performance standards for ALJs, as required by MMA. Although the plan acknowledges that it is important that ALJs adhere to the new time frames for processing appeals as established by BIPA, it is unclear whether any other performance standards for ALJs will be established. The plan notes that the law allows the imposition of "administrative practices and programming policies that ALJs must follow," including timeliness of decisions, so long as the agency does not use the guidelines to influence the ALJs' decisions. In addition, the plan holds that it is not unreasonable to expect a minimum level of efficiency and that ALJs can be disciplined for "good cause," which may be based on performance or unacceptably low productivity. However, the plan does not discuss whether such guidelines will be imposed, by what means the agency would evaluate a minimum level of efficiency, who would evaluate the judges, and what actions might be taken based on unsatisfactory findings. Similarly, the plan does not include specific steps the agency would take to ensure that any guidelines and performance standards that are imposed would not interfere with ALJ independence. Finally, the plan does not address how ALJs would be evaluated should any new standards be challenged.

Conclusion

SSA and HHS have stressed their commitment to ensuring a successful transfer of the ALJ level of the Medicare appeals process from SSA to HHS. Addressing the 13 elements specified in MMA and developing and implementing contingency provisions are key to ensuring that the transition is smooth and that services to appellants are not disrupted. Although both agencies have stressed that they are continuing to further develop details of the plan, based on the information they have developed thus far, we believe that the plan does not comprehensively address the 13 elements and, thus, seriously jeopardizes a successful and timely transition. For example, the absence of specific milestones, the use of unreliable data, and the lack of an acknowledgement that HHS may ultimately need to develop two separate processing systems to adhere to current practices and those required by BIPA are serious shortcomings. Moreover, the absence of details related to providing appellants access to ALJs, hiring and training staff with expertise in Medicare, and preserving

ALJ independence further undermine the plan's credibility. The plan's lack of specific details jeopardizes HHS's ability to begin adjudicating appeals as scheduled. Unless SSA and HHS act quickly to effectively address the 13 elements required by MMA and finalize the transition plan for transferring responsibility for adjudicating Medicare appeals from SSA to HHS, the appeals process could be compromised.

Recommendations for Executive Action

To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, we recommend that the Secretary of HHS and the Commissioner of SSA take steps to complete a substantive and detailed transfer plan. Specifically, we recommend that the Secretary and Commissioner take the following six actions:

- Prepare a detailed project plan to include interim and final milestones, individuals or groups responsible for completing key elements essential to the transfer, and contingency plans.
- Validate data and perform analyses to support decisions regarding key elements, such as workload, staffing needs, and costs.
- Outline a strategy that addresses the possible need for two separate processing systems at HHS—one for appeals that follows the current processing practices and one that complies with BIPA's time frames and other requirements—in the event that the BIPA provisions establishing the QICs are not implemented as scheduled.
- Identify where staff and hearing facilities—including videoconference equipment—are needed as well as opportunities to share staff and office space.
- Develop an approach to ensure that ALJs and support staff with Medicare expertise can be hired, and that all staff are adequately trained to process and adjudicate Medicare appeals.
- Define the relationship of HHS's ALJ unit to the other organizations within the department, and identify safeguards that will be established to ensure decisional independence.

Agency Comments and Our Evaluation

We provided a draft of this report to both SSA and HHS for their review. In its written comments, HHS agreed with all but one of our recommendations. HHS said that contingency plans for several plan elements—regulations, feasibility of precedential authority, independence of ALJs, and performance standards—were unnecessary. Because of the critical nature of these provisions and the inter-dependence of the plan's components, we continue to believe that the establishment of such plans

for each congressionally mandated element would best ensure a smooth and timely transition.

Further, HHS emphasized that it attempted to ensure that it provided us with the most current information available regarding decisions associated with the transition. However, we do not believe that HHS has kept us fully apprised of all of its efforts. For example, in its comments, HHS described the establishment of the Office of Medicare Hearings and Appeals Transition and the activities of this new office related to the transfer. Although HHS indicated that this office was established in July 2004, before our work was complete, this information was not shared with us. In addition, although HHS noted several other efforts to enhance the transition process—such as its analysis of internal data to make caseload projections for fiscal years 2005 and 2006—this information also was not provided to us during the course of our work. Although this, and other efforts HHS cited to facilitate the transfer of Medicare appeals might have promise, we had no opportunity to evaluate them.

We are also concerned with HHS's characterization of our findings and its own progress in implementing the transfer. For example, HHS interprets figure 2 in our report as indicating that we believe that the plan meets substantially all MMA requirements. However, figure 2 clearly shows that 5 of the 13 plan elements do not completely address these requirements. Moreover, figure 2 shows that the plan lacks detailed information and contingency plans for the vast majority of the elements. Such significant deficiencies suggest that a smooth and timely transfer may be in jeopardy. HHS also stated that the public comments it received concerning the plan were positive. Our information does not support this assertion. Our evaluation of these comments showed that they mirrored the concerns addressed in our report and raised serious questions about the ability of SSA and HHS to effect the transfer in a manner that would preserve the independence of ALJs and ensure the quality of service to appellants.

In its written comments, SSA agreed with our recommendations by either expressing its concurrence or by citing steps it has taken to aid with their implementation. SSA also noted that it shared our concern that adequate planning needs to take place and agreed that detailed contingency planning is important. Although SSA's comments focused on its continuing contribution to enhance HHS's understanding of the current Medicare appeals process, it also emphasized that some elements of the plan are the sole responsibility of HHS. While we agree that HHS must ultimately assume full and complete responsibility for the appeals process, until the transition is complete, we believe that both agencies are accountable for

ensuring that appeals are adjudicated promptly and competently, and for coordinating their efforts so that the transfer occurs on a smooth and timely basis.

Finally, both SSA and HHS expressed concern with the title of our report. HHS said that the title might raise unnecessary fears among the advocate and beneficiary communities. Further HHS stated that it is on track for an efficient and effective transfer of the ALJ function at the earliest possible time allowed by the MMA. Although HHS indicated that much progress has been made in key areas, such as development of regulations and the assurance of ALJ independence, it provided no new information in support of these efforts. In addition, many other significant questions raised in our report, such as the geographic distribution of ALJs, were not addressed in its comments. Therefore, we continue to have significant concerns about the agencies' abilities to effectuate the transfer on a timely basis. Both agencies also reported that they had identified a mechanism for HHS to continue to use SSA ALJs to adjudicate Medicare appeals after the statutory date of the transfer, if necessary. However, neither SSA nor HHS described this mechanism and we therefore were unable to evaluate it. Consequently, we continue to believe that our evaluation of the evidence supports the report title. SSA's and HHS's comments are reprinted in appendixes II and III, respectively.

We are sending copies of this report to the Secretary of HHS, the Commissioner of SSA, and other interested parties. In addition, this report will be available at no charge on GAO's Web site at http://www.gao.gov. We will also make copies available to others upon request.

If you or your staffs have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff members who prepared this report are listed in appendix IV.

Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Appendix I: Analysis of the Medicare Appeals Transfer Plan

Based on our review of the plan and additional materials provided by the transfer team, we found that the plan to transfer the Medicare appeals function from the Social Security Administration to the Department of Health and Human Services is insufficient to ensure a smooth and timely transition. Although the plan generally addresses each of the 13 elements mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as indicated in figure 2, it omits important details on how each element will be implemented. Furthermore, the plan overlooks the need for contingency provisions, which could prove to be essential, should critical tasks not be completed in a timely manner.

Figure 2: Completeness of Medicare Appeals Transfer Plan

Plan elements mandated by MMA	Characteristics of the transfer plan: Addresses MMA requirements	Contains detailed information	Includes contingency plan
1. Transition timetable	●	○	○
2. Workload	◒	○	○
3. Cost projections and financing	◒	◒	○
4. Regulations	●	○	○
5. Feasibility of precedential authority	●	●	○
6. Geographic distribution	◒	○	○
7. Access to ALJs	●	○	○
8. Shared resources	◒	○	○
9. Case tracking	●	●	●
10. Hiring	●	○	○
11. Training	●	○	○
12. Independence of ALJs	◒	○	○
13. Performance standards	●	○	○

● This aspect of the plan is complete
◒ This aspect of the plan is partially complete
○ This aspect of the plan is incomplete

Source: GAO analysis of Medicare appeals transfer plan and supporting information.

Appendix II: Comments from the Social Security Administration

SOCIAL SECURITY
The Commissioner
September 24, 2004

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

Dear Ms. Aronovitz:

Thank you for the opportunity to review and comment on the draft Government Accountability Office (GAO) report "Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants (GAO-04-1055).

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

We wish to assure GAO, Congress, and the public that we are confident that the two agencies, working together, can ensure that case processing is not interrupted. For this reason, we recommend that GAO revise the title of the report. We believe that the title "Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants" may raise unnecessary fears among the advocate and beneficiary communities. We suggest "Prompt Action Needed to Complete Planning for Transfer of the Appeals Workload from SSA to HHS."

In the draft report, GAO expressed concern about a successful transfer of the Administrative Law Judge (ALJ) level of the Medicare appeals process from SSA to HHS. Generally, GAO's concerns relate to the level of detail in the Report to Congress.

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

We share GAO's concern that adequate planning takes place to address the full range of issues and contingencies. We also agree that detailed contingency planning is important in order to ensure that appeals continue to be processed, even if the transfer is not completed by the statutory deadline.

Enclosed are detailed comments and suggestions we have on the draft report. In addition, I have enclosed a summary of SSA's role in each of the 13 required elements from the MMA addressed in the draft report. If you have any questions, please have your staff contact Candace Skurnik at (410) 965-4636.

Sincerely,

Jo Anne B. Barnhart

Jo Anne B. Barnhart

Enclosures

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION (SSA) ON THE GOVERNMENT ACCOUNTABLITY OFFICE (GAO) DRAFT "MEDICARE: INCOMPLETE PLAN TO TRANSFER APPEALS WORKLOAD FROM SSA TO HHS THREATENS SERVICE TO APPELLANTS" (GAO-04-1055)

We appreciate the opportunity to review the subject report. We are taking this opportunity to provide comments and supplemental information to clarify and more fully describe major actions SSA has taken in preparation for the transfer of the Medicare appeals function.

Decisions on the structure and procedures for the Department of Health and Human Services (HHS) appeals process are within the purview of HHS, and SSA defers to that agency on these points. Thus, as the draft report makes clear, SSA's role in the transfer has two major elements:

- Assisting HHS in developing its system for handling these appeals, and
- Ensuring a smooth handoff of the Medicare appeals workload from SSA to HHS.

SSA takes these responsibilities seriously and has worked with HHS to ensure that our sister agency is provided with the tools it needs to develop their new process. In order to facilitate the exchange of information and ideas, SSA established a work group led by the Executive Counselor to the Commissioner to coordinate the agency's participation in the joint SSA-HHS Medicare Workgroup.

SSA assumed its joint responsibility with HHS for the development and implementation of the transfer plan by providing open access and complete information about the Medicare hearing process. In addition to providing a vast array of information to HHS to assist in making decisions and developing plans for how it will carry out the hearing function, SSA has given particular attention to coordination and development of those aspects of the transfer which directly affect SSA's ability to provide service. These areas include the implementation of initiatives to process SSA's pending Medicare workload, effective interface of databases and sharing of information necessary to let appellants know the status and location of their cases, and coordinated planning to meet each agency's needs for Administrative Law Judges (ALJ) and other staff.

Information Sharing

SSA has shared with HHS information on areas such as:

- The current and historic Medicare Appeals workload as well as its geographical distribution;
- Startup costs of hearing offices, including the space and equipment requirements per staff position and the timeline for acquiring space through the General Services Administration; and
- The timeline and process for hiring ALJs, staff learning curves, and the timeline for staff to achieve full productivity, along with basic training materials.

SSA Preparation for Medicare Appeals Transfer to HHS

To expedite handling of its current Medicare appeals workload, the Office of Hearings and Appeals (OHA) has developed and implemented, with the contribution of HHS resources, a centralized Medicare Screening Unit. The Screening Unit is designed to identify appeals that can be resolved at the earliest stage possible in the appeal process. The Screening Unit was staffed beginning in June 2004, and immediately began the screening process for all Parts B and C appeals. Beginning in July 2004, all Part A appeals were forwarded directly to the Screening Unit from the Centers for Medicare and Medicaid Services (CMS) contractors. We have an established cadre of ALJs to handle Medicare cases, and have streamlined assignment of cases to these ALJs. We also are identifying ways to direct cases not handled by the Medicare cadre ALJs to ALJs with experience handling Medicare cases. To further facilitate the processing of Medicare appeals, we have developed plans to hold video hearings scheduled from the Screening Unit beginning in October 2004.

Database Continuity

During the transition period when both SSA and HHS will be processing Medicare hearings, it is critical that both agencies have the ability to advise appellants and their representatives as to whether their cases are located at SSA or HHS. SSA and HHS are exploring the most efficient way to provide current Medicare hearings data to both agencies. SSA will continue to monitor and track the status and location of cases within its jurisdiction in the Hearing Office Tracking System (HOTS). Systems experts from HHS and SSA have met to discuss the technical issues, including the possible exchange of Medicare hearings data between SSA and HHS, as well as resources needed to provide the necessary information. We expect to resolve these issues well before implementation.

Our responses to the specific recommendations are provided below:

Recommendation 1

Prepare a detailed project plan to include interim and final milestones, individuals or groups responsible for completing key elements essential to the transfer, and contingency plans.

SSA Response

We agree. SSA will expand upon our plans, described above, to process the Medicare appeals workload prior to transfer. As noted above, we are working with HHS to develop a contingency plan to ensure uninterrupted handling of appeals if a complete transfer does not take place before the statutory deadline.

Recommendation 2

Validate data and perform analyses to support decisions regarding key elements, such as workload, staffing needs, and costs.

SSA Response

As indicated in our response to recommendation 1, SSA has provided HHS with extensive information and analysis regarding the Medicare appeals workload, staffing, and costs. As we operate under our expedited procedures for handling Medicare appeals, we will provide additional information and analysis to HHS.

Recommendation 3

Outline a strategy that addresses the possible need for two separate processing systems at HHS—one for appeals that follows the current processing practices and one that complies with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protect Act of 2000 (BIPA)'s timeframes and other requirements, in the event that the BIPA provisions establishing the qualified independent contractors (QICs) are not implemented as scheduled.

SSA Response

Because SSA has not been involved with the QICs, our contribution in this area of planning is limited.

Recommendation 4

Identify where staff and hearing facilities—including videoconference equipment—are needed as well as opportunities to share staff and office space.

SSA Response

SSA/HHS jointly studied opportunities for sharing resources, and determined that, generally, it is feasible to do so only for videoconference equipment and space. SSA is in the process of a major expansion of its videoconference facilities. In planning the need for and location of these new facilities, we have taken into account projected use for Medicare video hearings.

Recommendation 5

Develop an approach to ensure that ALJs and support staff with Medicare expertise can be hired, and that all staff are adequately trained to process and adjudicate Medicare appeals.

SSA Response

As noted above, SSA has provided HHS with information about hiring and training ALJs and support staffing needs, as well as with basic training materials.

Recommendation 6

Define the relationship of HHS's ALJ unit to the other organizations within the department, and identify safeguards that will be established to ensure decisional independence.

SSA Response

This task is one that uniquely lies with HHS. We will, of course, continue to provide any information that would assist HHS in making these determinations but will defer to HHS on how its ALJ unit should be structured.

Social Security Administration Role
MMA Transfer Plan Elements from Draft GAO Report
(Terminology Taken from Tables in the Draft Report)

1. *Transition Timetable:*	Provide HHS with information on processes and startup times and with a suggested timetable.
2. *Workload:*	Provide current and historical information on Medicare appeals case load and anticipated case volume.
3. *Cost Projections/Financing:*	Provide salary information and startup costs for hearing offices.
4. *Regulations:*	Task specific to HHS.
5. *Precedential Authority:*	Task specific to HHS.
6. *Geographic Distribution:*	Provide HHS with a breakdown on the Medicare caseload by geographic area.
7. *Access to ALJs:*	Consider Medicare appeals load in selecting sites for new SSA video hearing facilities. Share electronic disability appeals processing technology if requested.
8. *Shared Resources:*	Provide HHS access to video hearing facilities.
9. *Case Tracking:*	Maintain the Hearing Office Tracking System through the transition. Share development work on the Case Processing Management System if requested.
10. *Hiring:*	Share full information on workloads, ALJ productivity and support staff needs.
11. *Training:*	Provide HHS with basic ALJ training materials. Share experience on helping new ALJs reach full productivity.
12. *Independence of ALJs:*	Task specific to HHS.
13. *Performance standards:*	Share information on SSA/OPM standards.

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 24 2004

Ms. Lelsie G. Aronovitz, Director
Health Care—Program Administration
and Integrity Issues
United States Government Accountability Office
Washington, D.C. 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on your draft report entitled, "Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants" (GAO-04-1055). The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Acting Inspector General

Enclosure

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

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT "MEDICARE—INCOMPLETE PLAN TO TRANSFER APPEALS WORKLOAD FROM SSA TO HHS THREATENS SERVICE TO APPELLANTS" (GAO-04-1055)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) Draft Report No. GAO-04-1055, which was prepared in accordance with section 931 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) Pub. L. No. 108-173. Consistent with section 931, HHS and the Social Security Administration (SSA) reported to the Congress in March 2004 on their plan to accomplish the transfer of responsibility for the functions of administrative law judges (ALJs) responsible for hearing Medicare appeals under title XVIII of the Social Security Act (the Act) to HHS from SSA. GAO's report will fulfill its obligation under section 931(a)(4) to report to the Congress on its evaluation of that plan. In the interim, the Secretary of HHS and the Commissioner of SSA have continued working together to ensure a successful transition and the availability of an efficient and effective appeals process both during the transition and after the transfer of responsibility for the appeals function to HHS is complete.

Since the enactment of the MMA on December 8, 2003, HHS has taken a series of steps toward the statutory goal of assuming responsibility for the appeals workload no later than October 1, 2005. HHS has completed the essential groundwork needed for successful effectuation of the transfer of the ALJ function. HHS notes that GAO, in Table 2 of the draft report "Evaluation of Medicare Appeals Transfer Plan's Implementation Readiness," concludes that HHS meets substantially all MMA requirements.

As GAO recognized on page 4 of the draft report, "Transferring the Medicare appeals workload from SSA to HHS poses a complex challenge that requires careful preparation and the precise implementation of many inter-related tasks." Given the complexity of the transfer of the ALJ function, HHS is using the time remaining to complete the transition (approximately 1 year) to take a prudent and responsible course by evaluating input from all stakeholders and implementing the transition plan in a deliberative manner while aggressively seeking to take responsibility for the appeals function at the earliest time the statute will allow. Moreover, it should be noted that although the GAO report calls for more specificity in certain areas, the plan did address all of the elements required by the statute.

It is important to note that the March 2004 report to the Congress was completed in just over 3 months after enactment of the MMA. Thus, the report inevitably could not supply the degree of detail that the GAO's evaluation suggests would have been desirable. HHS has taken a deliberative approach to establishing the new ALJ appeals entity that is aimed at ensuring both a timely transition and the long-range success of the appeals process.

Throughout this ongoing process, HHS has attempted to ensure that GAO and the Congress have the most current information available regarding decisions associated with the transition and the development of the new ALJ appeals entity. On May 12, 2004, HHS briefed GAO about the President's fiscal year (FY) 2004 budget, the Centers for Medicare & Medicaid Services (CMS) FY 2004 operating plan, and the President's FY 2005 budget request for needs associated with the new appeals workload. Moreover, HHS staff has had ongoing communication, including a meeting and conference calls with Senate and House staff of the committees of jurisdiction, to receive input and address issues and concerns. As HHS moves forward with this transition, conference calls will continue as necessary to ensure that the Congress is kept up-to-date on transition progress.

GAO Recommendations

HHS generally agrees with the recommendations in the draft report. However, we believe that the title "Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants" may raise unnecessary fears among the advocate and beneficiary communities. We suggest "Prompt Action Needed to Complete Transfer of Appeals Workload from SSA to HHS." Below are GAO's recommendations, and HHS' responses, as well as additional information regarding steps HHS has taken since the transfer plan was submitted to the Congress on March 25, 2004.

GAO Recommendation

Prepare a detailed project plan to include interim and final milestones, individuals or groups responsible for completing key elements essential to the transfer, and contingency plans.

HHS Response

HHS agrees that project planning is an important and integral element of a successful transition. To that end, HHS created the Hearing and Appeals Restructuring Team (HAR), which includes senior leadership from across the Department, to provide overall direction and guidance. In addition, on July 25, 2004, HHS established the Office of Medicare Hearings and Appeals Transition (OMHAT) within the Office of the Secretary/Assistant Secretary for Administration and Management.

Since it was established, OMHAT has reviewed and evaluated materials provided by SSA concerning, among other things, workload, training, and processes. Building on this information, OMHAT has completed several actions that further the timely and efficient transfer of the hearings function from SSA. First, OMHAT issued three task orders: one to assess how best to employ videoconferencing and audio-conferencing technologies in the hearings process; one to assess HHS staffing needs for the ALJ hearings function and to develop a weighted workload system; and another to create a simulation of the anticipated case workflow for the Medicare hearings function. Second, OMHAT contracted with "HHS University" (an intra-Department educational network that offers HHS employees training opportunities) for a project manager to oversee the development of all training materials and the scheduling and coordination of training

for all new staff associated with the hearings function, and for a complete analysis of HHS' future training needs for staff in the new ALJ appeals entity.

In addition, HHS staff are actively working with a contractor to develop the documentation and workflow analysis for the ALJ portion of the data system.

The basics of project management involve taking actions to effect a positive outcome, as well as thinking through possible roadblocks, how to prevent them, and what arrangements would be needed if they arise. The Department is assuring that the project management process considers contingencies as one of the many inherent steps in approaching each area of this initiative.

The HHS/SSA transition plan anticipates addressing necessary contingencies. For example, the plan states that HHS will adjust the hiring of ALJs and other staff depending on actual workload volume, and will consider any possible expansion or re-alignment of the initial location of appeals offices depending on experience. Although the GAO report recommends contingencies for all of the MMA transfer plan requirements, several items in the plan, however, do not require specific contingency planning, e.g., regulations, feasibility of precedential authority, independence of ALJs, and performance standards.

GAO Recommendation

Validate data and perform analyses to support decisions regarding key elements, such workload, staffing needs, and costs.

HHS Response

HHS agrees with the recommendation to perform further data analysis and is taking steps to accomplish this independent of reliance on any prior data. Given the short time period in which the transition plan had to be developed, HHS, of necessity, relied on SSA staff and cost data. Presently, HHS is analyzing its internal data to make FY 2005 and FY 2006 caseload projections for all Part A, B, and C appeals, as well as the new Part D appeals. In addition, HHS is reviewing the SSA Medicare ALJ caseload by conducting a real-time activity-based review of the appeals function, including examining actual appeal case files. The knowledge garnered through this review will be used to develop workload, staffing, and budget forecasts. The actual caseload projections have not been finalized and the review is ongoing.

In the short term, efforts have focused on coordinating with SSA to finalize caseload data to assist in the transition. HHS will closely evaluate the data using the Medicare Case Tracking System (MCATS) to develop information regarding caseload projections and future funding requirements. As the new ALJ appeals entity begins hearing cases, MCATS data will be supplemented and eventually superceded by data collected in the new Medicare Appeals System (MAS), the long-range data system currently being developed by HHS. As the GAO report notes, the MAS will, for the first time, provide appeals-specific information on each claim that reaches the Qualified Independent Contractors (QIC) reconsideration, ALJ, or Departmental Appeals Board (DAB) level. HHS is working closely with all involved parties to produce a

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shared data system that will provide the data needed by each component for claim and case tracking purposes.

GAO Recommendation

Outline a strategy that addresses the possible need for two separate processing systems at HHS—one for appeals that follows the current processing practices and one that complies with BIPA's timeframes and other requirements, in the event that the BIPA provisions establishing the QICs are not implemented as scheduled.

HHS Response

HHS anticipated the need for two processes. Work is on track to finalize the relevant regulations and implement the QICs in order to facilitate and complement the transfer of the appeals function. Because the two processes will be quite similar and will parallel one another in most respects, the system will accommodate both types of appeals.

GAO Recommendation

Identify where staff and hearing facilities—including videoconference equipment—are needed as well as opportunities to share staff and office space.

HHS Response

HHS agrees with this recommendation and has evaluated issues associated with the geographic distribution and organizational structure of the ALJ appeals entity. Final decisions are expected soon and will be shared with the Congress.

HHS has made decisions regarding the internal organization of the ALJ appeals entity. The director's office for the new ALJ appeals entity will be located in the Office of the Secretary and report directly to the Secretary—a structure that is nearly identical to the organizational structure of the DAB. The structure meets statutory MMA requirements that the new ALJ appeals entity be independent of and physically separate from CMS.

GAO Recommendation

Develop an approach to ensure that ALJs and support staff with Medicare expertise can be hired, and that all staff is adequately trained to process and adjudicate Medicare appeals.

HHS Response

HHS agrees with this recommendation and is working with OPM to address hiring and staffing needs, including consideration of Medicare expertise, classification of the ALJ position, and the need for an expedited hiring process. HHS is also evaluating training needs and is developing a comprehensive training strategy.

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GAO Recommendation

Define the relationship of HHS's ALJ unit to the other organizations within the Department, and identify safeguards that will be established to ensure decisional independence.

HHS Response

HHS agrees that decisional independence is of paramount importance and will take steps to ensure that this occurs. The organizational structure of the new ALJ appeals entity will also reflect this independence.

Other Matters

In addition to the areas highlighted by the draft report, HHS has taken significant steps in other areas since the transition plan was submitted to the Congress to ensure the successful and timely transition of the appeals function. These steps include the following:

Public Input

To ensure that stakeholder expectations are taken into consideration in establishing the new ALJ appeals entity, HHS published a Federal Register notice on June 28, 2004 soliciting input from stakeholders on the issues related to the process of transferring the responsibility for the Medicare appeals from SSA to HHS, with comments due July 28, 2004. Overall, the comments received were positive and provided significant input into aspects HHS should consider in designing the new ALJ appeals entity. Many of the comments centered around issues regarding the organizational structure, the geographic distribution of hearing offices, and ALJ decisional independence from CMS. Responders raised many of the same questions HHS has been meticulously addressing over the last nine months, such as the manner in which the backlog of cases will be handled and the process for hiring and training ALJs. Again, HHS has spent considerable time and energy over the last 5 months collecting information pertinent to the questions raised by responders, and is evaluating and considering the information as part of the decision-making process.

Budget Formulation

Much effort has focused on the numerous budget issues associated with the transfer of the appeals responsibility and the establishment of the new ALJ appeals entity. This includes evaluating both FY 2004 budget issues for SSA and HHS, as well as the HHS funding issues for subsequent years. For example, HHS is working with SSA to develop the Memorandum of Understanding (MOU) for FY 2005, which ensures that, consistent with the Medicare appeals transition plan submitted to the Congress in March 2004, SSA completes the processing of all Medicare appeals received by it prior to July 1, 2005. In addition, HHS and SSA have identified a mechanism for HHS to continue to use SSA ALJs to adjudicate Medicare appeals after the date of the transfer, if necessary.

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Policy Development

HHS has been working on the development and clearance of the final regulations needed to implement the BIPA and MMA changes to the Medicare claims appeals process, including the BIPA section 521 changes to the appeals procedures. Work is on track to finalize the regulations and implement the QICs in order to facilitate and complement the transfer of the appeals function.

A significant amount of work also has been conducted to identify the numerous procedures that must be in place to ensure that operations run smoothly once the new ALJ appeals entity assumes responsibility. For example, HHS has identified and begun evaluating policies associated with the manner in which cases will be identified that involve multiple claimants with common issues, and the practicality of the electronic filing of appeals.

Operational Policy Coordination

HHS also is working to make sure that a coordinated operational approach is in place among all the key components in the appeals process that need to play a role in bringing about a successful ALJ hearing function. HHS is continuing to examine methods to address ALJ performance standards. HHS has also worked to ensure smooth communication at the pre-ALJ and post-ALJ levels of the appeals process, including seeking input from the DAB to assure that appeals data and case files will be transferred timely between the new ALJ appeals entity and the DAB once HHS assumes responsibility for the hearings function.

Conclusion

HHS appreciates GAO's thoughtful consideration of the Medicare appeals transition plan delivered to the Congress in March 2004 and welcomes the opportunity to review and comment on the GAO draft report evaluating the plan. As the report noted, this is a complex undertaking that requires careful preparation and the precise implementation of many interrelated items. The careful, deliberative work necessary to successfully manage the transfer of responsibility is ongoing and steady progress is being made in every area. By its responsible actions now, HHS is on track for an efficient and effective transfer of the ALJ function at the earliest possible time allowed by the MMA.

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Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Acknowledgments

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