DEPARTMENT of HEALTH and HUMAN SERVICES

OFFICE OF MEDICARE HEARINGS AND APPEALS

FY 2008 Annual Performance Report

Introduction

The FY2008 Annual Performance Report provides information on Office of Medicare Hearings and Appeals performance and progress in achieving the goals established in the FY2008 Annual Performance Plan which was published in February 2007 as part of OMHA's Online Performance Appendix (http://www.hhs.gov/budget/09budget/omhafy09opa.pdf).

The goals and objectives contained within this document support the Department of Health and Human Services' Strategic Plan (available at http://aspe.hhs.gov/hhsplan/2007/).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals
Office of the Chief Administrative Law Judge

I am pleased to present the Office of Medicare Hearings and Appeals' (OMHA) Fiscal Year 2008 Annual Performance Report. This performance report reflects OMHA's commitment to providing an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties. To the best of my knowledge, the performance data reported in OMHA's Fiscal Year 2008 Annual Performance Report is accurate, complete, and reliable, and there are no material inadequacies in the data provided in this report.

OMHA's mission is carried out by a cadre of knowledgeable ALJs exercising decisional independence with the support of a professional legal and administrative staff. In fulfilling this mission, OMHA strives for the equitable treatment of all who appear before it, and recognizes its responsibility to be both efficient and effective. Consistent with these goals, OMHA's performance objectives align with HHS's objectives for improving the safety, quality, affordability and accessibility of health care; including increasing health care service availability and accessibility, improving health care quality, safety and cost/value, and recruiting, developing and retaining a competent health care workforce.

Most importantly, OMHA's Fiscal Year 2008 Annual Performance Report reflects the significant progress that OMHA has made during its third full year of operations by exceeding six of its seven performance objectives for the year. These seven objectives are discussed in greater detail in the report but the underlying message is clear. Since opening its doors in July 2005, OMHA has been committed to continuous improvement in timely adjudicating Medicare appeals decisions despite increasing caseloads. This commitment has yielded positive results for OMHA appellants nationwide and continues to drive OMHA's mission, accountability, and progress.

Perry Rhew
Chief Administrative Law Judge

TABLE OF CONTENTS

Office of Medicare Hearings and Appeals

OMHA provides an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties.

The Medicare Prescription Improvement and Modernization Act of 2003 (MMA) required the Social Security Administration to transfer responsibility for Medicare Administrative Law Judge (ALJ) hearings to the Department of Health and Humans Services (HHS). Consequently, HHS established the Office of Medicare Hearings and Appeals (OMHA) to conduct ALJ hearings that constitute the third level of Medicare appeals. OMHA began operations in July 2005.

Before OMHA, the SSA hearings were held primarily in person at the 141 Social Security offices throughout the country. Under SSA, there was no timeliness requirement for appeal decisions. In contrast, OMHA opened four field offices to conduct ALJ hearings for appeals involving Medicare Parts A, B, C, and D as well as entitlements and eligibility determinations. OMHA provides appellants with hearings that are timely and have a broad array of access points. In addition, OMHA faced a new statutory requirement that certain (i.e., primarily Medicare Part A and Part B) cases be decided within 90 days. This requirement was established by the Medicare Benefits Improvement and Protection Act of 2000 (BIPA) and the applicable cases are referred to as BIPA appeals.

Approximately 44 million Americans currently receive Medicare benefits. On average, 1.2 billion claims are submitted for payment to the Medicare program annually. Since opening its doors in 2005, OMHA has been committed to conducting impartial and timely hearings for the third level of Medicare appeals.

OMHA'S workload continues to increase relative to the country's aging demographics. In FY 2006, OMHA received 106,000 claims. In FY 2007, OMHA received more than 137,000 claims and this number increased to more than 187,000 claims (or 36%) in FY 2008. Based on this historical workload, OMHA projects a similar increase in claims in FY 2009.

Strategic Plan Includes Long Term and Efficiency Measures

OMHA developed and started implementing its Strategic Plan for FYs 2007 -2011. The Strategic Plan identifies the organization's strategic goals and efficiency measures. OMHA also integrated its Strategic Plan into the agency's program management system. As part of its Strategic Plan formulation process, OMHA also completed the development of long-term and annual performance measures and submitted baseline and performance target information to OMB. Currently, OMHA's long term measures and established targets include: (1) Increase the percentage of BIPA cases closed within 90 days to 90% by 2012; (2) Increase the percentage of non-BIPA cases closed within 90 days to 59% by 2012; and (3) Achieve average survey results of 3.3 or above from appellants reporting good customer service on a scale of 1 -5 at the ALJ Medicare Appeals level by 2012. This third long term measure was added in 2008 to ensure customer satisfaction as claims continue to be processed in less time. While this target has been set, the FY08 baseline for this third long term measure is not expected until March 2009.

Combined, these long-term output measures balance the need to ensure appellants have access to timely hearings with the need to demonstrate effective stewardship to the American taxpayers. Output measures are appropriate for OMHA because its functions are primarily to ensure a timely adjudication of Medicare appeals and compliance with the Social Security Act.

In addition to the three long term measures, OMHA has two additional annual performance measures that include: (1) For cases that go to hearings, increase the percentage of decisions rendered within 30 days of the hearing; and (2) Reduce the percentage of appealed decisions reversed or remanded by the Medicare Appeals Council (as a percentage of all ALJ decisions issued).

OMHA also established two efficiency measures that include: (1) Decrease the cost per claim adjudicated from the previous year by target percentage; and (2) Increase number of claims processed per ALJ team by target percentage. These two measures enable OMHA to gauge program efficiency and timeliness related to the cost of processing claims.

Summary of Annual Performance Targets and Results

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2004					
2005					
2006	6	6	100%	5	83%
2007	6	6	100%	2	33%
2008	7	6	86%	6	86%
2009	7				

In FY 2006, its first full year of operations, OMHA met five of its six (or 83%) performance targets. In FY 2007, OMHA met two of it six (or 33%) annual performance targets. During these formative years, OMHA continued to build upon its operational experience and expanding legal expertise. OMHA undertook a nationwide best practices review and developed guidance and standardized procedures to foster greater efficiencies. Despite a higher caseload in FY 2008, OMHA met or exceeded six of its seven (or 86%) of its performance targets established for the fiscal year. OMHA expects survey results regarding the one unmet performance target (involving Medicare appeals customer satisfaction) by March 2009. Additional information regarding these seven performance targets is discussed in greater detail below.

Summary of OMHA Outcomes and Outputs

The following outcomes and outputs refer to Long Term Objective 1: Consistently process BIPA and non-BIPA cases within 90-day timeframe.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
1.1	Increase the number of BIPA cases closed within 90 days	N/A	74%	85%	84%	86%	94.7%	87%
1.2	Increase the number of non-BIPA cases closed within 90 days	N/A	47%	49%	43%	51%	72.3%	53%
1.3	For cases that go to hearing, increase the percentage of decisions rendered in 30 days	N/A	80%	81%	80.1%	82%	84.4%	83%
1.4	Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council (as a percentage of all ALJ decisions issued)	N/A	1%	4%	1.4%	1%	0.8%	1%
1.5	Average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level	N/A	N/A	N/A	N/A	3.1	Results available 3/09	3.2
1.6	Decrease the cost per claim adjudicated	N/A	$617	-15%	-20%	-10%	-26%	-5%
1.7	Increase number of claims processed per ALJ Team	N/A	1,851	+4%	-2%	+3%	+49%	+2%

Performance Narrative

For FY 2008, OMHA had seven established performance targets to support OMHA's Long Term Objective 1 -- To consistently process BIPA and non-BIPA cases within 90-day timeframe. In FY 2007, OMHA met two of these seven performance targets (or 33%) as it built upon its operational experience and expanding legal expertise, implemented a nationwide best practices review, and developed guidance and standardized procedures. In FY 2008, OMHA was able to meet six of these seven performance targets as highlighted below.

1.1 Increase the number of BIPA cases closed within 90 days.

Rationale:

One of OMHA's long-term goals is to consistently adjudicate BIPA cases within the 90 day statutory timeframe. The SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) mandates that the Administrative Law Judge Medicare cases be processed within 90 days. Prior to this function being transferred from the SSA to OMHA, GAO reported that between October 2004 and March 2005 SSA averaged 295 days to resolve an appeal. The five year goal is to achieve 90% of BIPA case processed in 90-days. Output measures are used for OMHA since its functions are primarily to ensure a timely adjudication of Medicare appeals and compliance with the BIPA. This statutory requirement is critical to OMHA's mission and influences its core processes and management decisions. OMHA regularly reviews performance and workload measure data to identify potential challenges and/or emerging trends that may require adjusting resources to process incoming cases.

Results:

In FY 2006, OMHA processed 74% of the BIPA cases within 90 days. In FY 2007, OMHA processed 84% of the BIPA cases it received within 90 days, thereby missing the 85% target by 1%. In FY 2008, OMHA processed 94.7% of the BIPA cases within the statutory timeframe. OMHA exceeded its performance target for FY 2008 of 86% by 8.7% primarily due to the nationwide implementation of best practices identified in OMHA field offices and other process improvements that support reduced case processing timeframes.

OMHA also established a revised memorandum of understanding (MOU) with the Centers for Medicare and Medicaid (CMS) and its affiliated Qualified Independent Contractors (QICs) outlining the roles and responsibilities for case file transfers between Levels II and III in the Medicare appeals process. Since CMS is the custodian of the administrative case files, OMHA is unable to adjudicate cases prior to receiving the administrative case files from CMS although the 90 day processing time begins when OMHA receives the request for hearing. The revised MOU facilitated improved efficiencies.

The Medicare Appeals System (MAS) is the primary automated computer system that supports the Medicare appeals process. As co-business owners, CMS and OMHA established a formal process for the governance, management, funding and provision of IT services in support of the Medicare appeals activities. Both are equally committed to providing timely and accurate disposition of Medicare appeals while maintaining functional independence as required by Section 931 of the MMA. MAS contributes to the timely and efficient processing of appeals. In FY 2008, OMHA also worked with CMS to improve the accuracy and completeness of MAS data to further facilitate the timely resolution of claims.

1.2 Increase the number of non-BIPA cases closed within 90 days.

Rationale:

Although there is no statutory requirement to decide non-BIPA cases within 90 days, OMHA identified the timely closure of non-BIPA cases as an important long-term goal. OMHA makes a concerted effort to adjudicate non-BIPA cases expeditiously and adopted many of the same process improvements for non-BIPA cases. This measure assures OMHA meets or exceeds all mandated case processing timelines throughout the Medicare appeals process. OMHA expects the number of non-BIPA cases to decrease in the out years. Output measures are used in place of outcome measures for OMHA since its functions are primarily to ensure a timely monthly adjudication of Medicare appeals. Each week, OMHA reviews performance and workload measure data for non-BIPA cases to identify potential challenges and/or emerging trends.

Results:

OMHA's efforts described above to improve the processing times for BIPA cases also apply to non-BIPA cases. In FY 2006, OMHA processed 47% of the non-BIPA cases within 90 days. In FY 2007, OMHA processed 43% of the non-BIPA cases it received within 90 days, thereby not meeting the 49% target by 6%. In FY 2008, OMHA processed 72.3% of the non-BIPA cases within 90 days, thereby exceeding its performance target of 51% for FY 2008 by 21.3% primarily due to the nationwide implementation of best practices identified in OMHA field offices and other process improvements that support reduced case processing timeframes.

1.3 For cases that go to hearing, increase the percentage of decisions rendered in 30 days.

Rationale:

OMHA's primary mission is to adjudicate cases within required timelines (e.g., 90 days). Rendering decisions within 30 days of when a hearing is held is a leading indicator of the likelihood of meeting a 90 day timeframe. The percentage represents the cases where a decision was rendered within 30 days of completing the ALJ hearing. This measure supports OMHA in meeting or exceeding mandated case processing timelines in the Medicare appeals process. Case data are entered into the Medicare Appeals System which is a controlled-access database, with case-specific information. Data used for this performance measure are validated by generating regular reports from the database. At the end of the fiscal year, the report totals are cross-checked with the annual figures.

Results:

In FY 2006, OMHA issued 80% of its decisions for cases that went to hearing within 30 days after the hearing. In FY 2007, OMHA issued 80.1% of its decisions for cases that went to hearing within 30 days of the hearing, thereby not meeting the 81% target by 0.9%. In FY 2008, OMHA issued 84.4% of its decisions for cases that went to hearing within 30 days. This exceeded the performance target of 82% by 2.2%. In part, this success is attributable to operational experience.

1.4 Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council.

Rationale:

Measuring reversals or remands from the next appellate level in the Medicare appeals process is used to ensure decisional quality and accuracy at the Administrative Law Judge (ALJ) Level. Data used for this performance measure are validated by generating regular reports from the database. At the end of the fiscal year, the report totals are cross-checked with the annual figures.

The legal accuracy of OMHA decisions remains of paramount importance to OMHA. The agency is committed to providing accurate decisions that are not reversed or remanded on appeals to the Medicare Appeals Council (MAC), which provides the fourth level of Medicare appeals. This goal focuses on maintaining the overall quality and accuracy of OMHA decisions.

Results:

In FY 2006, 1% of OMHA's decision were reversed or remanded on appeals to the Medicare Appeals Council. In FY 2007, 1.4% of OMHA decisions were reversed or remanded which exceeded the performance target of 4% by 2.6%. The performance target for FY 2008 was 1% which OMHA exceeded by having only 0.8% of its decisions reversed or remanded on appeals to the Medicare Appeals Council.

1.5 Average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level

Rationale:

In accordance with the FY 2008 PART Improvement Plan, OMHA is evaluating its efficiency and effectiveness through an independent evaluation that captures the scope of the Level III appeal experience. This measure will assure appellants and related parties are satisfied with their Level III appeals experience based on beneficiary survey results. Survey results will be reviewed on an annual basis. On a scale of 1 – 5, 1 will represent the lowest score and 5 will represent the best score.

OMHA contracted with an independent firm to develop and administer a Medicare appeals customer satisfaction survey to randomly selected appellants and appellant representatives. The survey received OMB clearance and will measure the overall appellant experience, the quality of OMHA paper and electronic materials, hearing scheduling and format, and interactions with OMHA staff.

Results:

The preliminary baseline results for the last quarter of FY 2008 are expected by March 2009.

1.6 Decrease the cost per claim adjudicated

Rationale:

One of OMHA's primary efficiency measures is the cost per claim adjudicated. OMHA seeks to gain efficiencies and cost savings through its reduced case processing timeframes despite rising costs for staffing, rent, contracts and other services needed to support the appeals process. This measure assures efficient operations of the Medicare appeals. Information from the Medicare Appeals System and the Unified Financial Management System will be used to calculate the cost per claim for each fiscal year.

Results:

In FY 2006, OMHA's baseline cost per claim adjudicated was $617. For FY 2007, the performance target was to reduce this cost by 15% (to $524 per claim). OMHA exceeded this performance target by reducing the cost per claim adjudicated by 20% (to $494 per claim). In FY 2008, OMHA exceeded the performance target of a 10% reduction (to $445 per claim) when it actually decreased cost per claim by 26% (to $364 per claim). This increased efficiency is due to several factors, including "start up" costs for the first two year of operations as well as increased efficiencies gained from OMHA's operational and adjudicatory experience.

1.7 Increase number of claims processed per ALJ team.

Rationale:

One of OMHA's other primary efficiency measures is the number of claims processed per ALJ team. This has proved to be a critical component of handling the increased caseload while maintaining the quality and accuracy of OMHA decisions and reducing processing times. This measure assures efficient operations in all aspects of the Medicare Level III appeals process. Case data are entered into the Medicare Appeals System which is a controlled-access database, with case-specific information. Data used for this performance measure are validated by generating regular reports from the database. At the end of the fiscal year, the report totals are cross-checked with the annual figures.

Results:

In FY 2006, each ALJ team processed an average 1,851 claims. In FY 2007, each ALJ team processed 1,814 claims (or 2% less). This missed the FY 2007 performance target of 4% additional claims by 6%. The FY 2008 performance target was to increase the number of cases by 3% to 1,868 claims for each ALJ team. In FY 2008, OMHA actually increased the number of ALJ cases to 2,710 claims (or 49%). This was one of the most dramatic areas of demonstrated improvement for OMHA. As noted earlier, OMHA's caseload increased by 36% in FY 2008 from FY 2007 while the number of ALJ teams (comprised of an ALJ, attorney, paralegal and hearing clerk) remained fairly constant with 66 ALJ teams nationwide at the end of FY 2008.

HHS Strategic Goals and Objectives

Two of OMHA strategic goals support the greater Departmental goal "To improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long term care":

1. To assure the highest quality in all aspects of the Administrative Law Judge Medicare appeals process; and
2. To assure efficient operations of the Level III appeals process. This alignment is highlighted below.

HHS Strategic Goals	**OMHA Strategic Goal #1:** To assure the highest quality in all aspects of the Administrative Law Judge (Level III) Medicare appeals process	**OMHA Strategic Goal #2:** To assure efficient operations in all aspects of the Level III appeals process
1: Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.		
1.1 Broaden health insurance and long-term care coverage.		
1.2 Increase health care service availability and accessibility.	*Supports HHS Goal*	*Supports HHS Goal*
1.3 Improve health care quality, safety and cost/value.	*Supports HHS Goal*	*Supports HHS Goal*
1.4 Recruit, develop, and retain a competent health care workforce.	*Supports HHS Goal*	*Supports HHS Goal*
2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats		
2.1 Prevent the spread of infectious diseases.		
2.2 Protect the public against injuries and environmental threats.		
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.		
2.4 Prepare for and respond to natural and man-made disasters.		
3: Human Services Promote the economic and social well-being of individuals, families and communities.		
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.		
3.2 Protect the safety and foster the well being of children and youth.		
3.3 Encourage the development of strong, healthy and supportive communities.		
3.4 Address the needs, strengths and abilities of vulnerable populations.		
4: Scientific Research and Development Advance scientific and biomedical research and development related to health and human services.		
4.1 Strengthen the pool of qualified health and behavioral science researchers.		
4.2 Increase basic scientific knowledge to improve human health and human development.		
4.3 Conduct and oversee applied research to improve health and well-being.		
4.4 Communicate and transfer research results into clinical, public health and human service practice.		

Other Performance Information - Program Assessment Rating Tool (PART) Findings

In FY 2008, OMHA's performance was assessed using the PARTI and improved the PART rating to Moderately Effective. During the PART reassessment, OMHA demonstrated significant progress in establishing meaningful performance measures and meeting its underlying program objectives. The recent PART reassessment cited program purpose and design, strategic planning and program management as strong attributes of OMHA's program.

OMHA has focused on three improvement actions that comprise its FY 2008 PART Improvement Plan. First, OMHA plans to undertake preliminary review of marginal cost analysis to link program accomplishment of performance goals and resource needs for future planning and budget submissions.

Second, OMHA is conducting an independent evaluation through an appellant survey that captures customer satisfaction on the appeal experience. OMHA contracted with an independent contractor to develop and administer a Medicare appeals customer satisfaction survey to randomly selected appellants and appellant representatives. The survey received OMB clearance and will measure the overall appellant experience. The preliminary results for the last quarter of FY08 are expected by March 2009. The survey will be re-administered quarterly with summary annual reporting. The evaluation will provide baseline data to address OMHA's performance measure on customer satisfaction.

Third, OMHA has improved internal processes to support the 90-day statutory timeline for processing cases. For example, OMHA implemented data standardization procedures to streamline data entry and emphasize essential data elements required for case adjudication.

Data Source and Validation

OMHA receives its data from the MAS Appeals System (MAS) which is a database shared with the Centers for Medicare & Medicaid (CMS).

Outcome Identifier	Data Source	Data Validation
1.1	Medicare Appeals System	Weekly and monthly reports from MAS are cross-checked with annual figures
1.2	Medicare Appeals System	Weekly and monthly reports from MAS are cross-checked with annual figures
1.3	Medicare Appeals System	Weekly and monthly reports from MAS are cross-checked with annual figures
1.4	Medicare Appeals System	Weekly and monthly reports from MAS are cross-checked with annual figures
1.5	Beneficiary survey results	Survey results will be reviewed on a bi-annual basis
1.6	Medicare Appeals System	Information form the Medicare Appeals System and the Unified Financial Management System will be used
1.7	Medicare Appeals System	Weekly and monthly reports from MAS are cross-checked with annual figures

Disclosure of Assistance by Non-Federal Parties

Preparation of Annual Performance Reports and Annual Performance Plans is an inherently governmental function that is only to be performed by Federal employees. OMHA has not received any material assistance from any non-Federal parties in the preparation of this FY 2008 Annual Performance Report.