Congress of the United States
Washington, DC 20515

May 9, 2005

The Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: File Code CMS-4064-IFC

Dear Secretary Leavitt:

As the Ranking Members on the Committee on Ways and Means and the Committee on Energy and Commerce, and as four of the original authors of the provision to transfer Medicare appeals out of the Social Security Administration's system, we respectfully submit the following comments on the Medicare Program: Changes to the Medicare Appeal Procedures, Interim Final Rule, issued in the March 8, 2005, Federal Register.

While we have long been advocates of streamlining the Medicare appeals process and alleviating the historic backlog of cases, the current regulations fail to adequately protect beneficiaries' right to appeal. Specific proposed regulations seriously undermine beneficiary access to in-person appeals and the ability to receive timely decisions at all stages of the process.

We have chosen to focus our comments on three fundamental changes in the regulations. Other provisions have points of concern as well, but would not damage the appeals process as dramatically as do the areas outlined in this letter.

Administrative Law Judge (ALJ) Independence

One of the major legislative challenges regarding the fundamental shift of Medicare appeals from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS) was ensuring the continued independence of ALJs in deciding appeals. Creating an independent appeals office in HHS, organizationally separate from CMS and similar in stature and treatment to the Office of the Inspector General, appears to attain this goal. However, §405.1062 requires ALJs to give "substantial deference" to multiple types of CMS guidance. This section further requires ALJs to explain any decisions that deviate from these policies.

Medicare appeals must be conducted by independent ALJs who review the facts of each case based on the record created by the lower-level reviews. The substantial deference requirement severely limits ALJ independence and may cause them to rubber stamp lower-level decisions. It was not the intent of Congress to turn ALJ hearings into a venue for denying benefits because decisionmakers must give substantial deference to

guidance. This section clearly tilts the process in favor of HHS. We urge you to eliminate the "substantial deference" language.

Beneficiary Access to Timely, In-Person ALJ Hearings

The presumption that all hearings be conducted by videoteleconferencing (VTC) where available, as stated in §405.1020(b), effectively denies beneficiaries their statutory and due process rights to timely, in-person hearings. Although the regulations permit a beneficiary to request an in-person hearing instead of the VTC, the threshold showing of "good cause" that the beneficiary must make as required under §405.1020(h)(5) is vague and potentially difficult to meet. Additionally, the fact that requesting an in-person ALJ hearing constitutes a waiver of the statutorily defined 90-day time frame makes it possible, if not likely, that any person requesting an in-person hearing will go months or even years before receiving a hearing.

The intent of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), as amended by the Medicare Modernization Act (MMA), was to give everyone access to an ALJ hearing, regardless of venue, within the statutorily defined 90-day time frame. In creating only four appeals offices (Cleveland, OH, Miami, FL, Irvine, CA, Arlington, VA), access to in-person hearings is effectively denied. There is no indication in the regulations that ALJs will travel to hear cases, and there is no provision to provide travel allowances for appellants. An appellant may need to travel hours to reach a place where VTC or in-person hearing is possible and the lack of reimbursement for these costs is a de facto denial of a hearing for those who cannot afford to reach the hearing site. Because of these deficiencies in the regulations, there is no guarantee that beneficiaries will have access to timely in-person hearings. This is a serious erosion of current rights that runs contrary to the intention of the statutory language.

Furthermore, we are also very concerned that HHS may not have secured adequate facilities to accommodate the volume of VTC hearings that will be required because of the presumption in §405.1020. The current infrastructure to conduct VTC hearings is wholly inadequate to handle all Medicare appeals. In many cases beneficiaries and providers may be forced to travel hundreds of miles to get to a VTC hearing site. Although providers may be able to handle this, beneficiaries are mostly over age 65, are often ill or disabled, and may not be able to travel long distances.

Timeliness of Lower Level Reviews

Statutory deadlines for reconsiderations, which were clearly defined in BIPA as amended by MMA, are undermined by extensions in the regulations. The unlimited and automatic extensions of up to 14 days upon submission of new evidence, as required by §405.966(b) and §405.970, are unlawful under 42 USC 1395ff(c)(3)(C)(iv), which states that a reviewer may be granted additional time as the individual requesting such reconsideration specifies, not to exceed 14 days.

Additionally, similar unlimited and automatic extensions of up to 14 days upon submission of new evidence, as required by §405.946(b) and §405.950, clearly

undermine the 60-day statutory time frame enacted by Congress within which redeterminations are to be adjudicated.

Although we recognize the need for time to review new evidence, the potential for abuse created under these regulations is unacceptable and deters beneficiaries from continuing to assert their appeal rights. To the extent that such unlawful extensions are implemented, they will be struck down.

Conclusion

The Interim Final Rule thwarts the intent of Congress to provide Medicare beneficiaries with access to timely, independent, in-person appeals. The geographic distribution of ALJs combined with the presumption of VTC hearings will gravely limit the due process rights of beneficiaries. ALJ hearings have historically been independent, and this process has often resulted in beneficiaries receiving coverage for claims that were initially denied. The substantial deference requirement undermines ALJ independence and limits an ALJ's ability to overturn reconsiderations. Finally, Congress created strict time frames for lower-level reviews to expedite the appeals process and avoid the huge backlogs that have plagued the system. Potentially unlimited 14-day extensions are inconsistent with statutory language and should not be implemented as part of the redetermination and reconsideration processes.

Sincerely,

John D. Dingell
Ranking Member
Committee on Energy and Commerce

Charles B. Rangel
Ranking Member
Committee on Ways and Means

Sherrod Brown
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce

Pete Stark
Ranking Member
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