DEPARTMENT of HEALTH and HUMAN SERVICES

OFFICE OF MEDICARE HEARINGS AND APPEALS

FY 2010 Online Performance Appendix

Introduction

The FY 2010 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2010 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/asrt/ob/docbudget/index.html.

The FY 2010 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2008 Annual Performance Report and FY 2010 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

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 2010 Online Performance Appendix. This performance appendix 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 2010 Online Performance Appendix 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 Administrative Law Judges (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 2010 Online Performance Appendix reflects the significant progress that OMHA has made during its third full year of operations by exceeding all seven performance objectives for FY 2008. 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

Summary of 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
2005	0	0	0%	0	0%
2006	6	4	67%	2	50%
2007	6	6	100%	2	33%
2008	7	7	100%	7	100%
2009	7	0	0%	0	0%
2010	7	0	0%	0	0%

Performance Measures Table

Measure	FY	Target	Result
1.1.1: Increase the number of BIPA cases closed within 90 days *(Output)*	*2009*	87%	N/A
	2008	86%	95% (Target Exceeded)
	2007	85%	84% (Target Not Met but Improved)
	2006	85%	74% (Target Not Met)
	2005	N/A	N/A
1.1.2: Increase the number of non-BIPA cases closed within 90 days *(Output)*	*2009*	53%	N/A
	2008	51%	72% (Target Exceeded)
	2007	49%	43% (Target Not Met)
	2006	46%	47% (Target Exceeded)
	2005	N/A	N/A
1.1.3: For cases that go to hearing, increase the percentage of decisions rendered in 30 days *(Output)*	*2009*	83%	N/A
	2008	82%	84% (Target Exceeded)
	2007	81%	80% (Target Not Met but Maintained)
	2006	80%	80% (Target Met)
	2005	N/A	N/A
1.1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council *(Output)*	*2009*	1%	N/A
	2008	1%	0.8% (Target Exceeded)
	2007	4%	1% (Target Exceeded)
	2006	4%	1% (Target Exceeded)
	2005	N/A	N/A
1.1.5: Average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level *(Output)*	*2009*	3.2	N/A
	2008	3.1	4.36 (Target Exceeded)
	2007	N/A	N/A
	2006	N/A	N/A
	2005	N/A	N/A

Measure	FY	Target	Result
1.1.6: Decrease the cost per claim adjudicated *(Efficiency)*	*2009*	5%	N/A
	2008	10%	26% (Target Exceeded)
	2007	15%	20% (Target Exceeded)
	2006	Baseline	$617/ per claim
	2005	N/A	N/A
1.1.7: Increase number of claims processed per ALJ Team *(Efficiency)*	*2009*	2%	N/A
	2008	3%	49% (Target Exceeded)
	2007	4%	-2% (Target Not Met)
	2006	Baseline	1851 Claims
	2005	N/A	N/A

Data Validation Table

Measure	Data Source	Data Validation
1.1.1 1.1.2 1.1.3 1.1.4 1.1.7	Medicare Appeals System	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included direction for development of a plan transitioning work from SSA to HHS. An element specifically included was "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."[§931(a)(2)(E)] The Medicare Appeals System (MAS) was developed in response to this and implemented with the opening of the new Office of Medicare Hearings and Appeals on July 1, 2005. MAS is the sole appeals tracking and reporting system supporting Medicare Parts A, B, C, and D, Entitlement, and Income Related Monthly Adjustment Amount (IRMAA) appeals across Levels 2 and 3 of the appeals process. MAS allows users to track the processing of appeals electronically and facilitates the transfer of appeal data records throughout the various levels. MAS is able to import scanned documents, produce reports for analysis, reporting, and workflow management, and ensure consistency of information across the levels of Medicare Appeal. Throughout the adjudication process, MAS provides workflow management through team-specific task sharing – allowing all adjudicatory team members access to information on tasks that have been completed and those yet to be accomplished. The entire adjudicatory process, from the initial request for hearing to the decision, is tracked in MAS. The system's data collection includes appeal request information, case file location, claims information, parties to the appeal, and appeal dispositions. Processing appeals using MAS improves timeliness, assists in meeting required processing deadlines, and minimizes paper utilization. In addition to supporting case processing and workload balancing, data derived from MAS has been used for replies to Congressional queries, the OIG audit of the OMHA program, appellant satisfaction surveys, and tracking performance measures.
1.1.5	Beneficiary survey results	The survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed from March through August 2008. The survey was designed to collect appellant: demographic information, overall satisfaction, satisfaction with hearing format, satisfaction with other aspects (e.g., scheduling, clarity of case processing documents, interaction with the ALJ team after the scheduling and prior to the hearing, and use of the OMHA website) and possible predictors of satisfaction (e.g., case fully heard and considered, ALJ behavior, etc). The survey required OMB clearance, which was received on September 5, 2008. The survey tool consists of nine sections with a total of 64 questions.
1.1.6	Medicare Appeals System and UFMS	Information from the Medicare Appeals System (see above). The Unified Financial Management System is used as an HHS-wide financial management and reporting tool. This tool provides integrated information for HHS-level financial statements and reports.

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 all seven performance targets as highlighted below.

Measure	FY	Target	Result
1.1.1: Increase the number of BIPA cases closed within 90 days *(Output)*	*2009*	87%	N/A
	2008	86%	95% (Target Exceeded)
	2007	85%	84% (Target Not Met but Improved)
	2006	85%	74% (Target Not Met)
	2005	N/A	N/A

1.1.1 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 certain 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, thereby missing the 85% target by 11%. 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 95% of the BIPA cases within the statutory timeframe. OMHA exceeded its performance target for FY 2008 of 86% by 9% 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.

Measure	FY	Target	Result
1.1.2: Increase the number of non-BIPA cases closed within 90 days *(Output)*	*2009*	53%	N/A
	2008	51%	72% (Target Exceeded)
	2007	49%	43% (Target Not Met)
	2006	46%	47% (Target Exceeded)
	2005	N/A	N/A

1.1.2 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, which exceeded the 46% target by 1%. 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% of the non-BIPA cases within 90 days, thereby exceeding its performance target of 51% for FY 2008 by 21% primarily due to the nationwide implementation of best practices identified in OMHA field offices and other process improvements that support reduced case processing timeframes.

Measure	FY	Target	Result
1.1.3: For cases that go to hearing, increase the percentage of decisions rendered in 30 days *(Output)*	*2009*	83%	N/A
	2008	82%	84% (Target Exceeded)
	2007	81%	80% (Target Not Met but Maintained)
	2006	80%	80% (Target Met)
	2005	N/A	N/A

1.1.3 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, meeting the initial target of 80%. In FY 2007, OMHA issued 80% of its decisions for cases that went to hearing within 30 days of the hearing, thereby not meeting the 81% target by 1%. In FY 2008, OMHA issued 84% of its decisions for cases that went to hearing within 30 days. This exceeded the performance target of 82% by 2%. In part, this success is attributable to operational experience.

Measure			
1.1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council *(Output)*	*2009*	1%	N/A
	2008	1%	0.8% (Target Exceeded)
	2007	4%	1.4% (Target Exceeded)
	2006	4%	1% (Target Exceeded)
	2005	N/A	N/A

1.1.4 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 which exceeded the performance target of 4% by 3%. In FY 2007, 1% of OMHA decisions were reversed or remanded which exceeded the performance target of 4% by 3%. 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.

Measure	FY	Target	Result
1.1.5: Average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level *(Output)*	*2009*	3.2	N/A
	2008	3.1	4.36 (Target Exceeded)
	2007	N/A	N/A
	2006	N/A	N/A
	2005	N/A	N/A

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

Rationale:

As part of its program assessment, 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 began measuring the overall appellant experience, the quality of OMHA paper and electronic materials, hearing scheduling and format, and interactions with OMHA staff on a quarterly basis.

Results:

In the initial administration of this survey, OMHA achieved a 4.36 level of appellant satisfaction nationwide. This result indicates that the vast majority of appellants were either somewhat or very satisfied with OMHA services, from initiation through closure, as well as with the hearing formats used to adjudicate their cases.

Measure			
1.1.6: Decrease the cost per claim adjudicated *(Efficiency)*	*2009*	5%	N/A
	2008	10%	26% (Target Exceeded)
	2007	15%	20% (Target Exceeded)
	2006	Baseline	$617 per claim
	2005	N/A	N/A

1.1.6 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, which established the baseline target for future out years. 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.

Measure	FY	Target	Result
1.1.7: Increase number of claims processed per ALJ Team *(Efficiency)*	*2009*	2%	N/A
	2008	3%	49% (Target Exceeded)
	2007	4%	-2% (Target Not Met)
	2006	Baseline	1851 claims
	2005	N/A	N/A

1.1.7 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, which established the baseline target for future out years. 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.

OMHA Linkages to HHS Strategic Plan

The table below shows the alignment of OMHA's strategic goals with HHS Strategic Plan goals.

HHS Strategic Goals	**OMHA Goal 1:** To assure the highest quality in all aspects of the Administrative Law Judge (Level III) Medicare appeals process.	**OMHA 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.	✓	✓
1.3 Improve health care quality, safety and cost/value.	✓	✓
1.4 Recruit, develop, and retain a competent health care workforce.	✓	✓
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, healthier and supportive communities.		

HHS Strategic Goals	**OMHA Goal 1:** To assure the highest quality in all aspects of the Administrative Law Judge (Level III) Medicare appeals process.	**OMHA Goal 2:** To assure efficient operations in all aspects of the Level III appeals process.
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.		

Summary of Full Cost for OMHA

(Budgetary Resources in Millions)

HHS Strategic Goals and Objectives	FY 2008	FY 2009	FY 2010
1 Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care. (Total)	$63.8	$64.6	$71.1
1.1 Broaden health insurance and long-term care coverage.	$0	$0	$0
1.2 Increase health care service availability and accessibility.	$31.1	$31.4	$34.6
1.3 Improve health care quality, safety and cost/value.	$31.1	$31.5	$34.7
1.4 Recruit, develop, and retain a competent health care workforce.	$1.6	$1.7	$1.8
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. (Total)	$0	$0	$0
2.1 Prevent the spread of infectious diseases.	$0	$0	$0
2.2 Protect the public against injuries and environmental threats.	$0	$0	$0
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	$0	$0	$0
2.4 Prepare for and respond to natural and man-made disasters.	$0	$0	$0
3 Human Services Promote the economic and social well-being of individuals, families, and communities. (Total)	$0	$0	$0
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.	$0	$0	$0
3.2 Protect the safety and foster the well being of children and youth.	$0	$0	$0
3.3 Encourage the development of strong, healthier and supportive communities.	$0	$0	$0
3.4 Address the needs, strengths and abilities of vulnerable populations.	$0	$0	$0
4 Scientific Research and Development Advance scientific and biomedical research and development related to health and human services. (Total)	$0	$0	$0
4.1 Strengthen the pool of qualified health and behavioral science researchers.	$0	$0	$0
4.2 Increase basic scientific knowledge to improve human health and human development.	$0	$0	$0
4.3 Conduct and oversee applied research to improve health and well-being.	$0	$0	$0
4.4 Communicate and transfer research results into clinical, public health and human service practice.	$0	$0	$0
Agency Total	$63.8	$64.6	$71.1

Summary of Findings and Recommendations

On January 26th, 2009, the Department of Health and Human Services Office of Inspector General issued a report Memorandum Report titled "Administrative Law Judge Hearings: Update, 2007-2008". This report compared the performance of OMHA during its first year of operation to its performance during its third year of operation and citied numerous areas of demonstrated improvement by OMHA, specifically in Administrative Law Judge decisions and data quality. Based on these findings, the OIG report included no recommendations.

Disclosure of Assistance by Non-Federal Parties

Preparation of the Online Performance Appendix 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 2010 Online Performance Appendix.