DEPARTMENT of HEALTH and HUMAN SERVICES

OFFICE OF MEDICARE HEARINGS AND APPEALS

FY 2012 Online Performance Appendix

Introduction

The FY 2012 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 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Summary of Performance and Financial Information (SPFI). These documents are available at http://www.hhs.gov/budget/.

The FY 2012 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2010 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS SPFI 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 2012 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 2012 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 2012 Online Performance Appendix reflects progress that OMHA has made during its fifth full year of operations by exceeding four of seven performance objectives for FY 2010. 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. In FY 2012, OMHA looks forward to making additional progress in the areas of staffing and moving towards an electronic record environment.

Nancy J. Griswold
Chief Administrative Law Judge

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Summary of Performance Targets and Results

Office of Medicare Hearing and Appeals (OMHA)

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	6	6	100%	2	33%
2008	7	7	100%	7	100%
2009	7	7	100%	6	86%
2010	7	7	100%	4	57%
2011	7	N/A	N/A	N/A	N/A
2012	6	N/A	N/A	N/A	N/A

Performance Detail (by Activity)

OMHA's mission is to efficiently and effectively adjudicate Level III Medicare appeals within the statutory 90-day timeframe. In FY 2010, OMHA met or exceeded four out of the seven agency performance goals as follows:

- *Increase the number of BIPA cases closed within 90 days* - In FY 2010, OMHA processed 95% of the BIPA cases within the statutory timeframe. OMHA exceeded its performance target of 88% for FY 2010 by 7% primarily due to the continued nationwide implementation of best practices identified in OMHA field offices, increased efficiencies and standardization, and the implementation of a workload measurement system for balancing national caseloads across offices through case transfers.

- *Increase the number of non-BIPA cases closed within 90 days* - 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. In FY 2010, OMHA processed 72% of the non-BIPA cases within 90 days, thereby exceeding its performance target of 55% for FY 2010 by 17% primarily due to the continued nationwide implementation of best practices identified in OMHA field offices and other process improvements and efficiencies that support reduced case processing timeframes.

- *For cases that go to hearing, increase the percentage of decisions rendered in 30 days* - OMHA's primary mission is to adjudicate cases within required timelines (i.e., 90 days). During OMHA's first year of operation, rendering decisions within 30 days of when a hearing is held was expected to be a leading indicator of the likelihood of meeting the 90-day timeframe. The percentage represents the cases where a decision was rendered within 30 days of completing the ALJ hearing. In FY 2010, OMHA issued 73% of its decisions for cases that went to hearing within 30 days. This fell short of the performance target of 84%. After five years of operations, however, the data has confirmed this is not an accurate indicator of meeting the 90-day adjudicatory timeframe or any other performance goal. There is little correlation between the time when a hearing is held and when the decision is rendered, and the likelihood of meeting the 90 day timeframe. OMHA believes this measure should serve more as a management tool instead of an external performance measure. As a result OMHA will retire this performance measure at the end of FY 2011.

- *Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council* - The legal accuracy of OMHA decisions remains of paramount importance to the agency. OMHA 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. The performance target for FY 2010 was 1% which OMHA exceeded by having only 0.2% of its decisions reversed or

remanded on appeals to the MAC.

- *Increase the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level* - OMHA is evaluating its customer service through an independent evaluation that captures the scope of the Level III appeal experience by randomly surveying selected appellants and appellant representatives. The survey measures the overall appellant experience, the quality of OMHA materials, hearing scheduling and format, and interactions with OMHA staff. The measure aims to assure that appellants and related parties are satisfied with their Medicare appeals experience with OMHA. On a scale of 1 – 5, 1 represents the lowest score (very dissatisfied) and 5 represents the best score (very satisfied). In FY 2010, OMHA achieved a 4.30 level of appellant satisfaction nationwide, exceeding the FY 2010 target of 3.20 by 1.10. This result indicates the vast majority of appellants were either somewhat or very satisfied with OMHA services, from initiation of cases through closure, as well as with hearing formats used to adjudicate their cases.

- *Decrease the cost per claim adjudicated* - OMHA seeks to gain efficiencies and cost savings through reduced case processing timeframes despite rising costs for staffing, rent, contracts and other services needed to support the appeals process. In FY 2010, OMHA fell short of this performance target. The average cost per claim in FY 2010 was $388 compared to $300 in FY 2009. The average cost per claim is driven by claim receipts. The projected number of claims processed per ALJ was based on the full implementation of the CMS RAC program during FY 2010. The RAC program was delayed several months, resulting in fewer claim receipts per ALJ. OMHA expects the cost per claim adjudicated to decrease in FY 2012.

- *Increase the number of claims processed per ALJ team* – ALJ teams (comprised of an ALJ, attorney, paralegal and hearing clerk) strive to meet statutory timeframes and increasing workloads while also maintaining the quality and accuracy of OMHA decisions. The FY 2010 performance target was to increase the number of claims processed by each ALJ team by 1%. OMHA fell short of this performance target. The average number of claims processed per ALJ in FY 2010 was 2,789 compared to 3,336 in FY 2009. The projected number of claims processed per ALJ was based on the full implementation of CMS RAC program during FY 2010. However, the RAC program was delayed by several months, resulting in fewer claim receipt per ALJ. OMHA expects the average number of claims adjudicated per ALJ team to increase in FY 2012.

OMHA is improving its methodology for calculating the number of cases closed with 90 days (Measure 1.1 and Measure 1.2) by counting all appeals closed during a fiscal year, regardless of when the appeals were received. Previously, OMHA counted only appeals received and closed in a fiscal year. This more stringent methodology will increase the accuracy and transparency of these measures. These changes resulted in a new FY 2010 baseline. The FY 2011 targets are based on this new baseline.

OMHA Online Performance Appendix Performance Measure Table

Program: BIPA and non-BIPA cases

Agency Long-Term Objective**:** Consistently process BIPA and non-BIPA cases within 90-day timeframe.

Measure	FY	Target	Result
*1.1.1: Increase the number of BIPA cases closed within 90 days. (Output)	2012	89%	N/A
	2011	88%***	N/A
	2010	88%	95% (Target Exceeded)
	2009	87%	94% (Target Exceeded)
	2008	86%	95% (Target Exceeded)
	2007	85%	84% (Target Not Met but Improved)
*1.1.2: Increase the number of non-BIPA cases closed within 90 days. (Output)	2012	57%	N/A
	2011	55%***	N/A
	2010	55%	72% (Target Exceeded)
	2009	53%	69% (Target Exceeded)
	2008	51%	72% (Target Exceeded)
	2007	49%	43% (Target Not Met)
**1.1.3: For cases that go to hearing, increase the percentage of decisions rendered in 30 days. (Output)	2012	Discontinued	N/A
	2011	84%***	N/A
	2010	84%	73% (Target Not Met)
	2009	83%	81% (Target Not Met)
	2008	82%	84% (Target Exceeded)
	2007	81%	80% (Target Not Met)
1.1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council. (Output)	2012	1%	N/A
	2011	1%***	N/A
	2010	1%	0.2% (Target Exceeded)
	2009	1%	0.8% (Target Exceeded)
	2008	1%	0.8%

Measure	FY	Target	Result
			(Target Exceeded)
	2007	4%	1% (Target Exceeded)
1.1.5: Increase the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level (Output)	2012	3.6	N/A
	2011	3.4***	N/A
	2010	3.2	4.3 (Target Exceeded)
	2009	3.2	4.3 (Target Exceeded)
	2008	3.1	4.36 (Target Exceeded)
1.1.6: Decrease the cost per claim adjudicated (Efficiency)	2012	-3%	N/A
	2011	-3%***	N/A
	2010	-3%	29% (Target Not Met)
	2009	-5%	-18% (Target Exceeded)
	2008	-10%	-26% (Target Exceeded)
	2007	-15%	-20% (Target Exceeded)
1.1.7: Increase number of claims processed per ALJ Team (Efficiency)	2012	2%	N/A
	2011	1%***	N/A
	2010	1%	-16% (Target Not Met)
	2009	2%	23% (Target Exceeded)
	2008	3%	49% (Target Exceeded)
	2007	4%	-2% (Target Not Met)

* Starting in FY 2011, the methodology for Measure 1.1.1 and Measure 1.1.2 will include counting appeals closed during a fiscal year, regardless of when the appeals were received. Previously, OMHA counted only appeals received and closed in a fiscal year.

** Measure 1.1.3 will be retired at the end of FY 2011.

*** FY 2011 targets are based on new FY 2010 baseline reflecting improved methodology.

OMHA Data Source and Validation Table

Agency Program: BIPA and non-BIPA cases

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	Appellant Climate Survey	The most recent version of the survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed within fiscal year 2010. 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).
1.1.6	Medicare Appeals System and Unified Financial Management System	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 2010, 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 2009, OMHA met six of seven performance targets. In FY 2010, OMHA met four of seven performance targets as described on the following pages.

Measure	FY	Target	Result
1.1.1: Increase the number of BIPA cases closed within 90 days (Output)	2010	88%	95% (Target Exceeded)
	2009	87%	94% (Target Exceeded)
	2008	86%	95% (Target Exceeded)
	2007	85%	84% (Target Not Met but Improved)

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 Medicare, Medicaid, and 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 Social Security Administration (SSA) to OMHA, the Government Accountability Office (GAO) reported that between October 2004 and March 2005 SSA averaged 295 days to resolve an appeal. OMHA's five year goal is to achieve 90% of BIPA cases processed in 90 days. Output measures are used for OMHA since its functions are primarily to ensure 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 measurement data to identify potential challenges and/or emerging trends that may require adjusting resources to process incoming cases.

Results:

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, exceeding the performance target by 9%. In FY 2009, OMHA processed 94% of the BIPA cases by the statutory timeline, exceeding the performance target of 87% by 7%. In FY 2010, OMHA processed 95% of the BIPA cases by the statutory timeline. OMHA exceeded its FY 2010 performance target of 88% by 7% due to the continued nationwide implementation of best practices identified in OMHA field offices, case transfers to balance national caseload across offices, and other process improvements that support reduced case processing timeframes.

In FY 2008, OMHA 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 Medicare Modernization Act (MMA). MAS contributes to the timely and efficient processing of appeals. In FY 2010, OMHA continued to work 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)	2010	55%	72% (Target Exceeded)
	2009	53%	69% (Target Exceeded)
	2008	51%	72% (Target Exceeded)
	2007	49%	43% (Target Not Met)

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 adjudication of Medicare appeals. Each week, OMHA reviews performance and workload measure data for all 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 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 it received within 90 days, exceeding the performance target by 21%. In FY 2009, OMHA processed 69% of the non-BIPA cases it received within 90 days, exceeding the performance target by 16%. In FY 2010, OMHA processed 72% of the non-BIPA cases within 90 days, thereby exceeding its performance target of 55% for FY 2010 by 17% primarily due to the continued 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)	2010	84%	73% (Target Not Met)
	2009	83%	81% (Target Not Met)
	2008	82%	84% (Target Exceeded)
	2007	81%	80% (Target Not Met)

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 was expected to be 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 was originally expected to assist OMHA in meeting or exceeding mandated case processing timelines in the Medicare appeals process. Case data is entered into the Medicare Appeals System which is a controlled-access database, with case-specific information. Data used for this performance measure is 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 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, exceeding the performance target of 82% by 2%. In FY 2009, OMHA issued 81% of its decisions for cases that went to hearing within 30 days, thereby missing the 83% target by 2%. In FY 2010, OMHA issued 73% of its decisions for cases that went to hearing within 30 days of the hearing, thereby not meeting the 84% target by 9%. After five years of operations, however, the data has confirmed this is not an accurate indicator of meeting the 90-day adjudicatory timeframe or any other performance goal. There is little correlation between the time when a hearing is held and when the decision is rendered, and the likelihood of meeting the 90 day timeframe. OMHA believes this measure should serve more as a management tool instead of an external performance measure. As a result OMHA will retire this performance measure at the end of FY 2011.

Measure	FY	Target	Result
1.1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council (Output)	2010	1%	0.2% (Target Exceeded)
	2009	1%	0.8% (Target Exceeded)
	2008	1%	0.8% (Target Exceeded)
	2007	4%	1% (Target Exceeded)

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 is 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 2007, 1% of OMHA decisions were reversed or remanded which exceeded the performance target of 4% by 3%. In FY 2008, 0.8% of OMHA's decisions were reversed or remanded which exceeded the performance target of 1% by 0.2%. In FY 2009, 0.8% of OMHA's decisions were reversed or remanded which exceeded the performance target of 1% by 0.2%. The performance target for FY 2010 was 1% which OMHA exceeded by having only 0.2% of its decisions reversed or remanded on appeals to the Medicare Appeals Council.

Measure	FY	Target	Result
1.1.5: Improve the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level (Output)	2010	3.2	4.3 (Target Exceeded)
	2009	3.2	4.3 (Target Exceeded)
	2008	3.1	4.36 (Target Exceeded)
	2007	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 customer service 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 (very dissatisfied) and 5 (very satisfied) 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 FY 2008, OMHA achieved a 4.36 level of appellant satisfaction nationwide, exceeding the 3.10 performance target level. In FY 2009, OMHA achieved a 4.30 level of appellant satisfaction nationwide, exceeding the 3.20 performance target level. In FY 2010, OMHA achieved a 4.3 level of appellant satisfaction nationwide, exceeding the 3.20 performance target level. These results indicate 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	FY	Target	Result
1.1.6: Decrease the cost per claim adjudicated (Efficiency)	2010	-3%	29% (Target Not Met)
	2009	-5%	-18% (Target Exceeded)
	2008	-10%	-26% (Target Exceeded)
	2007	-15%	-20% (Target Exceeded)

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:

For FY 2007, the performance target was to reduce the cost per claim adjudicated by 15% from the prior year's cost (to $524 per claim). OMHA exceeded this performance target by reducing the cost per claim adjudicated by 20% (to $494 per claim). For FY 2008, the performance target was to reduce the cost per claim adjudicated by 10% from the prior year's cost (to $445 per claim). OMHA exceeded this performance target by reducing the cost per claim adjudicated by 26% (to $364 per claim). For FY 2009, the performance target was to reduce the cost per claim adjudicated by 5% from the prior year's cost (to $346 per claim). OMHA exceeded this performance target by reducing the cost per claim adjudicated by 18% (to $300 per claim). In FY 2010, the performance target was to reduce the cost per claim adjudicated by 3% from the prior year's cost (to $291 per claim). The average cost per claim is driven by claim receipts. In FY 2010, the projected number of claims processed per ALJ was based on the full implementation of the CMS RAC program. The RAC program was delayed several months, resulting in fewer claim receipts per ALJ. The cost per claim adjudicated rose 29% (to $388 per claim), therefore, OMHA did not meet this performance target.

Measure	FY	Target	Result
1.1.7: Increase number of claims processed per ALJ Team (Efficiency)	2010	1%	-16% (Target Not Met)
	2009	2%	23% (Target Exceeded)
	2008	3%	49% (Target Exceeded)
	2007	4%	-2% (Target Not Met)

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 (comprised of an ALJ, attorney, paralegal and hearing clerk). 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. Data is entered into the Medicare Appeals System which is a controlled-access database, with case-specific information. Data used for this performance measure is 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 2007, each ALJ team processed 1,814 claims (or 2% less than FY 2006), missing the FY 2007 performance target of 4% additional claims by 6%. The FY 2008 performance target was to increase the number of claims per ALJ team by 3% to 1,868. In FY 2008, OMHA increased the number of claims per ALJ team to 2,710 (or a 49% increase). The FY 2009 performance target was to increase the number of claims per ALJ team by 2% to 2,764. In FY 2009, OMHA increased the number of claims per ALJ team to 3,336 (or a 23% increase).

The FY 2010 performance target was to increase the number of claims by 1% to 3,369 for each ALJ team. The projected number of claims processed per ALJ was based on the full implementation of CMS RAC program during FY 2010. However, the RAC program was delayed by several months, resulting in fewer claim receipt per ALJ. In FY 2010, the number of claims processed per ALJ team decreased to 2,789 (a 16% decrease).

OMHA Linkages to HHS Strategic Plan

OMHA's core mission and performance budget support HHS Strategic Goal 1B: Transform Health Care: Improve health care quality and patient safety and Strategic Goal 4A: Increase Efficiency, Transparency and Accountability of HHS Programs: Ensure program integrity and responsible stewardship of resources. By providing an independent forum for the timely and legally sufficient adjudication of Level III Medicare appeals, OMHA helps to transform health care access by ensuring that Medicare beneficiaries receive the services to which they are entitled. In addition, OMHA's role helps to improve patient safety by ensuring that Medicare providers render a standard of care that is both reasonable and necessary.

OMHA's Strategic Plan has two Strategic Goals: (1) To assure the highest quality in all aspects of the Medicare Level III appeals process; and (2) To assure efficient operations in all aspects of the Medicare Level III appeals process. Under these two goals, OMHA has implemented numerous strategic objectives that guide OMHA's activities to revolve around quality and efficiency. Taken together, OMHA's two overarching goals, quality and efficiency, support the President's priorities of improving the quality of and access to health care.

The table below shows the alignment of OMHA's strategic goals with HHS Strategic Plan 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: T**o assure efficient operations in all aspects of the Level III appeals process.
1 Transform Health Care		
1. A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured.		
1.B: Improve health care quality and patient safety	X	X
1.C: Emphasizes primary and preventive care linked with community prevention services		
1.D: Reduce the growth of health care costs while promoting high-value, effective care		
1.E: Ensure access to quality, culturally competent care for vulnerable populations		
1.F: Promote the adoption of health information technology		
2. Advance Scientific Knowledge and Innovation		
2.A: Accelerate the process of scientific discovery to improve patient care		
2.B: Foster innovation at HHS to create shared solutions		
2.C: Invest in the regulatory sciences to improve food and medical product safety		
2.D: Increase our understanding of what works in public health and human service practice		

	OMHA Goal 1: To assure the highest quality in all aspects of the Administrative Law Judge (Level III) Medicare appeals process.	**OMHA Goal 2: T**o assure efficient operations in all aspects of the Level III appeals process.
3 Advance the Health, Safety and Well-Being of Our People		
3.A: Ensure the safety, well-being, and healthy development of children and youth		
3.B: Promote economic and social well-being for individuals, families, and communities		
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults		
3.D: Promote prevention and wellness		
3.E: Reduce the occurrence of infectious diseases		
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies		
4 Increase Efficiency, Transparency and Accountability of HHS Programs		
4.A: Ensure program integrity and responsible stewardship of resources	X	X
4.B: Fight fraud and work to eliminate improper payments		
4.C: Use HHS data to improve the health and well-being of the American people		
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability		
5 Strengthen the Nation's Health and Human Services Infrastructure and Workforce		
5.A: Invest in the HHS Workforce to help meet America's health and human service needs today and tomorrow		
5.B: Ensure that the Nation's health care workforce can meet increased demands		
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad		
5.D: Strengthen the Nation's human services workforce		
5.E: Improve national, state, and local, and tribal surveillance and epidemiology capacity		

Summary of Full Cost

(Budgetary Resources in Millions)

HHS Strategic Goals and Objectives	FY 2010	FY 2011	FY 2012
1 Transform Health Care			
1.A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured			
1.B: Improve health care quality and patient safety	**47.43**	**47.43**	**54.01**
1. C: Emphasize primary and preventive care linked with community prevention services			
1.D: Reduce the growth of health care costs while promoting high-value, effective care			
1.E: Ensure access to quality, culturally competent care for vulnerable populations			
1:F: Promote the adoption of health information technology			
2 Advance Scientific Knowledge and Innovation			
2.A: Accelerate the process of scientific discovery to improve patient care			
2.B: Foster innovation at HHS to create shared solutions			
2.C: Invest in the regulatory sciences to improve food and medical product safety			
2.D: Increase our understanding of what works in public health and human service practice			
3 Advance the Health, Safety, and Well-Being of the American People			
3.A: Ensure the safety, well-being, and healthy development of children and youth			
3.B: Promote economic and social well-being for individuals, families, and communities			
3.C: Improve the access ability and quality of supportive services for people with disabilities and older adults			
3.D: Promote prevention and wellness			
3.E: Reduce the occurrence of infectious diseases			
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4 Increase Efficiency, Transparency, and Accountability of HHS Programs			
4.A: Ensure program integrity and responsible stewardship of resources	**23.71**	**23.71**	**27.01**
4.B: Fight fraud and work to eliminate improper payments			
4.C: Use HHS data to improve the health and well-being of the American people			
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability			
5 Strengthen the Nation's Health and Human Service Infrastructure and Workforce			
5.A: Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow			
5.B: Ensure that the Nation's health care workforce can meet increased demands			
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad			
5.D: Strengthen the Nation's human service workforce			
5.E: Improve national, state, local, and tribal surveillance and epidemiology capacity			
Total	**71.14**	**71.14**	**81.02**

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

The preparation of the 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 2012 Online Performance Appendix.