EXHIBIT A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, *et al.*, Plaintiffs, v. SYLVIA MATHEWS BURWELL, in her official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, Defendant.	Civil Action No. 14-cv-00851 (JEB)

DECLARATION OF ELLEN MURRAY

I, Ellen Murray, declare as follows:

1. I am the Assistant Secretary for Financial Resources and Chief Financial Officer of the Department of Health and Human Services (HHS or Department). I have held this position since February 2010. Among my duties, I provide advice and guidance to the Secretary on all aspects of budget, financial management, grants and acquisition management, and provide for the direction and implementation of these activities across the Department. The statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties.

2. Over the last several years, a significant backlog has developed in the number of appeals pending before the Department's Office of Medicare Hearings and Appeals (OMHA). A number of factors have contributed to the growth of this backlog, including the growth in the number of Medicare claims due to an increase in the number of Medicare beneficiaries, and a marked increase in the number of appeals brought by certain providers. Appeals generated from the denial of claims through the Department's statutorily mandated Recovery Audit (RA)

program have also contributed to the growth of the backlog. RA-related appeals, however, are only a portion of the appeals pending before OMHA. As of April 25, 2016, RA-related appeals constituted 31% of the pending appeals at OMHA, and non-RA-related appeals constituted 69% of the pending appeals at OMHA. That percentage is dropping, due at least in part to refinements to the RA program.

3. HHS recognizes that the appeals backlog is a matter of great significance, and it has made it a priority to adopt measures that are designed to reduce that backlog. As described below, HHS has adopted a series of measures, and is in the process of implementing additional measures, that are projected to eliminate the backlog in its entirety by the end of fiscal year (FY) 2021. HHS monitors the appeals backlog continuously and annually projects its size and the impact of the measures the Department has adopted, with quarterly updates. However, given the variance in when providers submit appeals and the time required to implement administrative initiatives and see results, we believe that the Department's progress is more meaningfully measured on a semi-annual and annual basis. Appellants have up to 120 days to submit requests for redetermination, 180 days to request reconsideration of a redetermination decision, and 60 days to request an ALJ hearing on a reconsideration decision. Some large institutional appellants submit appeals daily, while some providers may not submit any appeals in a given month, but wait to submit them in large groups.

4. Attached as Exhibit 1 is a true and correct copy of a table showing data and projections as of March 31, 2016 as to the number of pending OMHA cases from the end of FY 2014 to the end of FY 2020 under different scenarios. As shown in the table, at the end of FY 2014, the number of pending OMHA cases was 767,422. The table illustrates anticipated changes in the number of pending cases based on the projected impact of the current

administrative actions for which data is available and the projected impact of the proposed legislative actions described below. Based on the projected impacts of both types of actions, HHS expects the number of pending OMHA cases to fall to just 50,000 by the end of FY 2020, and the number of pending OMHA cases over 90 days old to be eliminated completely by FY 2021.

Background

5. The Centers for Medicare & Medicaid Services (CMS) processes an estimated 1.2 billion Medicare Fee-For-Service (FFS) claims annually for over 33.9 million beneficiaries whose health care benefits are provided through the Medicare program. Accurate and efficient payment and processing of claims for the services those beneficiaries receive is critical to ensuring the integrity of the Medicare program.

6. When Medicare beneficiaries or providers disagree with coverage or payment decisions made by Medicare, a Medicare health plan, or a Medicare Prescription Drug Plan, they have the right to appeal. In general, there are five levels in the appeals process: (1) redetermination by a Medicare Administrative Contractor (MAC); (2) reconsideration by a Qualified Independent Contractor (QIC) or Independent Review Entity (IRE); (3) hearing by an Administrative Law Judge (ALJ) in OMHA; (4) review by the Medicare Appeals Council (Council) within the Departmental Appeals Board (DAB); and (5) judicial review in federal district court.

7. The Department has statutory responsibilities both to protect the Medicare Trust Funds and to provide for a fair appeals process for Medicare beneficiaries and stakeholders. The Medicare statute charges the Department with the responsibility to ensure that payment from the Trust Funds is made only for valid claims for reimbursement. *See, e.g.*, 42 U.S.C. §§ 1395f(a),

1395g(a), 1395i(h). In fulfillment of this duty, the Department continues to strengthen Medicare program integrity to combat fraud, abuse, and improper payments to help protect the Medicare Trust Funds for current and future generations. The Medicare statute also charges the Department with the responsibility to provide a fair appeals system for its stakeholders. *See, e.g.*, 42 U.S.C. § 1395ff(b). The Department is committed to protecting the rights of Medicare beneficiaries and stakeholders through the Medicare appeals process. Several factors, including the growth in Medicare claims – largely driven by the aging population – and HHS' focus on combatting fraud, abuse, and improper payments have led to more appeals than HHS has the capacity to adjudicate. However, while the volume of appeals has increased dramatically, funding has remained relatively stagnant.

8. As of March 31, 2016, there were 761,318 appeals pending at OMHA and 19,302 appeals pending at the Council. As of March 31, 2016, OMHA was receiving approximately 3,500 new appeals per week, and the Council was receiving approximately 250 new appeals per week. As of March 31, 2016, the average time to obtain a decision for non-beneficiary appeals decided in FY 2016 at OMHA was 819.4 days.

Sources of the Backlog

9. The backlog in appeals pending before OMHA began to grow substantially in FY 2010. The growth in the backlog is due to a number of factors.

10. First, beginning in 2011, Medicare began experiencing a large increase in the number of new beneficiaries as members of the "baby boom" generation began to reach age 65 and become eligible for Medicare. There have also been recent increases in the number of younger disabled individuals enrolling in Medicare. These increases, coupled with the increase in life expectancy of Medicare beneficiaries, have caused increases in the frequency of services

provided, in claims submitted to Medicare, and in the total number of denials of claims and resulting appeals.

11. Second, the Department's continued efforts to strengthen the integrity of the Medicare program have contributed to a growth in appeals. Between FY 2010 and FY 2015, OMHA's traditional workload (non-RA-related, non-State Medicaid Agency appeals) increased by 316%. CMS has contracted with claims review contractors to perform analysis of Medicare fee-for-service claims in order to identify atypical billing patterns and to identify inappropriate payments. CMS has also taken steps to refine and improve coverage policies and documentation requirements to protect against inappropriate payments where data analysis uncovers vulnerabilities to the Medicare Trust Funds. The result of the increased program integrity efforts and additional scrutiny of Medicare claims has been an increase in the number of claims subject to appeal.

12. Third, in recent years there has been a growing sense, among at least some members of the provider community, that it is a good business practice to appeal every denied claim. The absence of filing fees in the administrative appeals process has fostered the notion in the provider community that there is a low risk and potentially high reward associated with pursuing appeals. In addition, the amount in controversy required for an ALJ hearing (currently $150) is substantially lower than the amount in controversy of $1,500 required for judicial review. The amount-in-controversy requirement represents a very low barrier for access to the ALJ hearing process. As a result, a small number of appellants are responsible for a substantial portion of the appeals filed at OMHA in the absence of any disincentive to filing appeals. In FY 2015, of the more than 20,000 appellants that filed appeals with OMHA, including approximately 5,000 individual beneficiaries, three appellants filed nearly 40 percent of the

appeals (over 92,500 appeals). Additionally, since 2012, there has also been a marked increase in companies specializing in the handling of Medicare appeals, fueling increases in appeal filings.

13. Fourth, there has been a significant increase in appeals filed by Medicaid state agencies. Differences in Medicare and Medicaid coverage and payment rules for home health care services has led to an increase in appeals to determine the covered level of care and, in turn, the appropriate primary payer for dually-eligible beneficiaries. These factors have led certain states to seek post-payment review in almost every case where a dual-eligible beneficiary has services billed to Medicaid.

14. Fifth, although adjudication delays at OMHA have affected all categories of appellants, OMHA has recognized that the beneficiary population comprises its most vulnerable stakeholders. Because the issues presented in beneficiary appeals often involve emergent pre-treatment or continuation of care issues, this population is less able to absorb delays in case processing. For this reason, on July 15, 2013, OMHA's Chief ALJ directed the agency to prioritize appeals filed by beneficiaries. This policy has been responsible for the reduction in wait times for beneficiary appeals from a high of 259 days for appeals decided in FY 2013 to the current wait time of 68.4 days for appeals decided in FY 2016 (as of April 30, 2016).

15. Sixth, the number of appeals generated from the denial of claims through the RA program has also contributed to the backlog. However, OMHA's workload has also increased because of an increase in the number of non-RA-related appeals. As of April 25, 2016, RA-related appeals constituted 31% of the pending appeals at OMHA, but that percentage is dropping, due at least in part to the refinements to the RA program that are described below.

Based on trends in receipts at this time, HHS projects that RA-related appeals currently constitute only 20% of incoming appeals, and non-RA-related appeals constitute 80% of incoming appeals.

16. The non-RA-related workload at OMHA is composed of appeals by Medicaid State Agencies for Medicare claim denials for dually enrolled Medicare-Medicaid beneficiaries; appeals by providers, suppliers, and beneficiaries of pre- and post-payment Part A and Part B claim denials by MACs, Zone Program Integrity Contractors (which conduct data analysis to identify patterns of fraud and make appropriate referrals to law enforcement), and the Comprehensive Error Rate Testing Contractor (which measures and reports improper payments in Medicare fee-for-service); appeals by beneficiaries of Part A and Part B Medicare eligibility, entitlement, and premium determinations made by the Social Security Administration; and appeals of Medicare Advantage (Part C) organization determinations made by Medicare Advantage Organizations and Medicare prescription drug coverage determinations made by Part D Plan Sponsors.

Medicare Appeals Process Improvement and Backlog Reduction Plan

17. The Department's Medicare Appeals Process Improvement and Backlog Reduction Plan includes a three-pronged strategy to restore balance to the Medicare appeals process:

a. Take multiple administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process.

b. Request new resources from Congress to invest at all levels of appeal to increase adjudication capacity and to implement new strategies and expand existing activities to alleviate the current backlog.

c. Propose legislative reforms that provide additional funding and new authorities to address the volume of appeals.

18. HHS anticipates that the actions described below will reduce, and eventually eliminate, the backlog in OMHA's processing of appeals and allow OMHA to return to appropriate pending levels and processing times. However, given current workload trends, legislative and regulatory authorities, and funding levels, it is not possible to implement an immediate solution to the backlog at OMHA. HHS anticipates that the time to obtain a decision for non-beneficiary appeals will increase before it improves because the number of appeals that OMHA is receiving currently exceeds OMHA's capacity to decide them. But, as noted, HHS anticipates that the actions described below will succeed in eliminating the backlog and returning OMHA to appropriate pending levels and processing times by the end of FY 2021.

I. Administrative Actions

19. To date, the administrative actions being taken by the Department to reduce the backlog include:

a. CMS Hospital Settlements: In August 2014, CMS offered hospitals an option to administratively resolve appeals of certain inpatient hospital claim denials. The deadline for hospitals to request settlement was October 31, 2014. Under this option, hospitals received timely partial payment of the disputed claims in exchange for withdrawing a pending appeal and/or not further appealing the claim. The settlement provided an opportunity for the government to reduce the pending appeals by resolving a large number of homogeneous claims in a short period. In addition, settling the appeals allowed hospitals to obtain payment for rendered services, rather than waiting an extended time for an ALJ hearing or having to escalate an appeal, and allowed all parties to avoid the risk and expense of continued appeals. All

settlement agreements have been signed by the hospitals and CMS, and all payments have been made. CMS, OMHA, and the Council are currently removing the settled appeals from the system, and expect to complete this action by the end of FY 2016. When complete, the settlements will remove approximately 260,000 appeals that were pending at OMHA and the Council prior to the settlements.

b. Recovery Audit Program Contract Modifications: CMS has made several changes to the RA program to decrease the number of RA contractor-identified claims that are incorrectly denied and enter the Medicare appeals system. First, CMS has modified the RA contracts to require RA contractors, before they refer a claim they have identified as improper for recoupment, to first offer providers the opportunity to discuss the basis of the claim with the RA contractor and to submit additional information to substantiate payment of their claim. Second, CMS has limited the number of reviews the RA contractors may initially conduct under an approved topic, and no additional RA reviews may occur until CMS investigates the RA reviews already conducted and provides approval for additional reviews. Third, when CMS awards new RA contracts (expected in the summer of 2016), CMS will pay RA contractors only after a reconsideration decision by a QIC at the second level of appeal if the RA contractors' decisions are upheld at that level, or after the timeframe to file an appeal at the second level has expired. These contract modifications are expected to improve the accuracy of RA reviews and decrease the number of RA contractor-identified claims that enter the Medicare appeals system. HHS estimates that these actions will reduce the number of appeals that reach OMHA by more than 22,000 appeals by the end of FY 2020.

c. Prior Authorization Initiatives: CMS has initiated a series of demonstration projects, under which CMS requires that providers and suppliers obtain prior

authorization from the MACs for certain items or services in certain jurisdictions before the provider or supplier furnishes the item or service and bills for it. The prior authorization process encourages providers and suppliers to assess Medicare coverage criteria and meet documentation requirements before they furnish the service or item and before submitting a claim. The process also gives providers and suppliers the opportunity to correct errors and omissions because the provider or supplier may resubmit a request for prior authorization an unlimited number of times. It also reduces the number of appeals entering the appeals process by allowing providers to address issues with their documentation before submitting the claim, thereby reducing the number of claim denials. CMS currently has prior authorization demonstrations in nineteen states for power mobility devices, in eight states and the District of Columbia for non-emergent ambulance transport, and in three states for non-emergent hyperbaric oxygen. CMS has also recently finalized a prior authorization regulation for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), 80 Fed. Reg. 81,674 (Dec. 30, 2015). HHS estimates that these initiatives will reduce the number of appeals that would have otherwise reached OMHA by more than 269,000 appeals by the end of FY 2020.

d. QIC Demonstration – DMEPOS Discussions and Reopenings: In January 2016, CMS launched a demonstration with DMEPOS suppliers that submit Medicare FFS claims in two DMEPOS MAC jurisdictions for diabetic testing supplies and oxygen equipment. These MAC jurisdictions cover 37 states and territories. Under this demonstration, suppliers have the opportunity to discuss their claim by telephone with the QIC at the second "reconsideration" level of appeal, submit additional documentation to support their claim, and receive feedback and education on CMS policies and requirements. HHS projects that, as a result of the discussions and educational outreach, new appeals for the DMEPOS items tested under the

demonstration will decrease by 10% due to suppliers submitting accurate Medicare claims to the MAC at the outset, thus reducing the number of claims that denied and then appealed to OMHA.

i. Under the demonstration, the QIC will also reopen certain QIC reconsideration decisions that are pending at OMHA, that could be resolved favorably using the information gained through the formal telephone discussion. Reopening these QIC decisions will reduce the number of appeals currently pending at OMHA.

ii. HHS projects that by the end of FY 2020, the supplier-education aspect of the demonstration will reduce the number of appeals that would have otherwise reached OMHA by more than 13,000 appeals. HHS further projects that the reopening aspect of the demonstration will reduce the number of appeals that reach OMHA by more than 63,000 appeals and resolve more than 202,000 appeals that are currently pending at OMHA. Thus, in total, HHS estimates that this action will reduce the number of appeals either pending at OMHA or that would otherwise reach OMHA by more than 278,000 appeals by the end of FY 2020.

iii. CMS anticipates expanding the scope of this demonstration in the future to include additional types of services, items, and supplies. CMS is not in a position at this time, however, to determine how quickly or to what extent the demonstration should be expanded. These determinations will depend on CMS' empirical experience with the current demonstration as it develops.

e. OMHA Settlement Conference Facilitations: OMHA staff who have been trained in mediation techniques are facilitating settlement conferences between CMS and appellants that currently have at least 20 claims, or $10,000, at issue in appeals pending before OMHA for most Part B appeals; or that currently have at least 50 claims and $20,000 at issue in appeals pending before OMHA for most Part A appeals. These conferences bring those

appellants and CMS together to discuss administratively settling the appeals. As of May 18, 2016, of the 63 requests for facilitation that it has closed, OMHA has facilitated the settlement of 7,924 appeals for 17 appellants through this project – the equivalent of almost eight Administrative Law Judge (ALJ) teams' annual workload. In addition, OMHA is processing expressions of interest from 50 additional appellants for settlement conference facilitation. HHS estimates that, at current funding levels, this action will reduce the number of appeals that are currently pending at OMHA by more than 27,000 appeals by the end of FY 2020.

f. OMHA Voluntary Statistical Sampling: Under this pilot project, appellants with 250 or more claims filed before December 31, 2014 pending at OMHA may choose to have OMHA adjudicate their claims using statistical sampling and extrapolation. This allows the appellants to have large volumes of claims decided based on a statistically valid sample of the appellant's appealed claims, reducing the time and cost to obtain a decision. At this time, OMHA has over 6,000 appeals in this process and plans to open the project in summer 2016 to more claims by removing the date limitation that OMHA adopted while it assessed the pilot and balanced available resources. HHS estimates that this project will allow OMHA to process an additional 25,000 appeals by the end of FY 2020.

g. OMHA On-the-Record Adjudication: Under this program, OMHA senior attorney advisors review cases in which the appellant has waived its right to an oral hearing and requested that OMHA decide the merits of the case on the existing record. An OMHA senior attorney advisor reviews the record to verify that a decision can be issued without a hearing and drafts a recommended decision. An ALJ then reviews the record and the recommended decision, and if he or she concurs, issues the decision. An ALJ may also return the case to the senior attorney advisor with decision instructions. Since the program was initiated in July 2015, in

addition to their other duties, OMHA senior attorneys have been responsible for resolving over 1,000 appeals – the equivalent of one ALJ team's annual workload. The program frees ALJ time to prepare for additional hearings, rather than conducting the initial review and assessment of records for cases in which the appellant has waived the oral hearing, and then issuing case development and/or decision instructions to a decision writer. The program also results in a faster decision because the appeal need not wait in the hearing queue. HHS estimates that, at current funding levels, this program will allow OMHA to process an additional 15,000 appeals by the end of FY 2020.

h. Senior ALJ Program: The Senior ALJ Program is administered by the Office of Personnel Management and allows agencies to reemploy retired ALJs on a temporary and intermittent basis, to work part-time conducting hearings and issuing decisions. The reemployment of retired ALJs allows OMHA to add temporary ALJ adjudication capacity to assist with the processing of delayed appeals. In FY 2016, OMHA will complete the hiring of 11 Senior ALJs through this program. HHS estimates that this action will increase the number of appeals that OMHA can adjudicate by more than 16,000 appeals by the end of FY 2020.

20. HHS estimates that by the end of FY 2020, the administrative actions described above in ¶ 19(a)-(h) will result in an OMHA backlog of nearly 50% fewer appeals than if the Department had not taken these administrative actions.

21. The Department has taken, or is in the process of taking, several additional administrative actions designed to reduce the backlog and increase adjudicative efficiency. The Department believes that these additional actions are contributing and will contribute to a reduction in the backlog and increase adjudicative efficiency at all levels, but it is not currently possible to quantify the extent of their impact. The estimated impact of these administrative

actions will be revisited as the actions are implemented and results from the administrative actions are evaluated. These actions include:

a. Expanding the Medicare Appeals System (MAS): CMS continues to prioritize expanding the utilization of MAS to additional MACs. Currently, over 70 percent of the Part A redetermination workload is processed in MAS. MAS is a web-based system designed to support the management, execution, and administration of first, second and third level appeals. MAS is an integral part of CMS' management and oversight of MAC and QIC appeals. Access to real-time appeals data allows CMS to closely monitor workload trends and contractor performance. Implementing the system at additional MACs will improve accuracy, timeliness, and efficiency in the appeals process and provide electronic appeals case files and consistent processes in appeals activities across MACs and QICs.

b. Accuracy Review Process: CMS uses a comprehensive strategy to promote consistency and accuracy among all Medicare review contractors (including MACs, RA contractors, and others). To this end, CMS has established an Accuracy Review Team to verify that Medicare review contractors make accurate medical review determinations and apply Medicare policies consistently across the program. The Accuracy Review Team conducts monthly reviews of Medicare review contractors' review decisions, looking at varying items and services, including those that are currently part of new medical review initiatives, as well as on an ad hoc basis in response to specific concerns. Additionally, CMS continues to use a validation contractor to assess the accuracy of RA contractor determinations. The validation contractor establishes an annual accuracy score for each RA contractor, which is identified in the annual Recovery Auditing in Medicare Report to Congress. CMS uses the information gained through both of these activities to reexamine and clarify Medicare payment polices, furthering

the effort to improve review consistency while addressing improper payment vulnerabilities. HHS expects that increasing consistency in review decisions and providing policy clarification where needed will result in a decrease in inappropriate denials, and therefore a decrease in appeals.

c. Judicial Education Training for OMHA ALJs and Adjudication Staff: Training sessions provide consistent training to adjudicators on Medicare coverage law and policy and Medicare administrative appeal procedures. The sessions routinely involve collaborative training using policy experts from OMHA, CMS, and the Council. Special sessions have also included participation from the HHS Offices of the Inspector General and General Counsel. This joint training increases decisional consistency between adjudicators at all levels of appeal, which may contribute to lower appeal rates by resolving issues at the lower levels of appeal and affecting appellants' business decisions whether to appeal to higher levels of appeal. After the Department implemented this joint training, the percentage of appeals (including dismissals) in which OMHA ALJs fully or partially reverse claim denials decreased from 63.2% in FY 2010 to the current rate of 28.4% as of March 31, 2016.

d. Field Office Reorganization: OMHA re-engineered its field office staffing structure, which streamlines and centralizes many administrative functions, serves as a template for future offices, and allows OMHA to use more of its funding on direct case-support functions.

e. Field Office of the Future Initiative: This is a collaborative effort between OMHA, the General Services Administration, and the Center for Legal and Courtroom Technology at the College of William & Mary. The initiative concurrently addresses expiring leases in existing agency offices, evaluates expanding business operations, and modernizes the

agency's workspace for transition to an electronic system, while reducing OMHA's overall footprint at significant cost savings, which can be redirected to support case processing.

f. Case Grouping Initiative: This initiative uses data reports to identify appellants with a large number of filings (at least 200 appealed reconsiderations) and group them for assignment to an ALJ as a unit for potential consolidated proceedings and more efficient adjudication.

g. Electronic Case Adjudication Processing Environment (ECAPE): OMHA is in the process of transitioning to an electronic case adjudication processing system that will allow OMHA to process appeals electronically from filing to closure. ECAPE will modernize most aspects of OMHA's business process, especially in the areas of managing and handling documents, exhibiting case records, generating correspondence, scheduling and managing hearings, support the decision process by adding tools such as decision templates to make the decision writing process more efficient, and produce statistics on appeals and appeal trends for evaluation by management. It will also provide a public portal for appellants to file an appeal electronically and to submit evidence and access information about their appeal. ECAPE will also interface with CMS' electronic system, MAS, to retrieve MAC and QIC appeal data and documents and pass OMHA data and documents back to MAS for viewing by other appeal levels. OMHA expects to release phase I of ECAPE, which will allow most appellants to file their requests for hearing online, in summer 2016, and has begun scanning pending requests for an ALJ hearing in anticipation of a full electronic processing of cases in phase II, expected in winter 2017, followed by an expanded public portal in phase III, expected in spring 2017. The goal of ECAPE is to make the case processing and adjudication process more efficient, which will contribute to improving the timeliness of decisions.

h. ALJ Appeal Status Information System (AASIS): AASIS is a website (accessed through OMHA's website) that provides public access to appeal status information, allowing users to obtain appeal data such as the date the request for an ALJ hearing was received, the appeal status, and the assigned field office and ALJ with team contact information. AASIS was introduced on December 30, 2014. This system provides an informational tool for appellants to look up their cases and reduces the number of inquiries that have to be addressed by OMHA staff, freeing that staff to focus on case processing work.

i. Improvement and Formalization of Communications from the Council and OMHA to CMS and its Contractors: Council, OMHA, and CMS staff meet bi-weekly to discuss operational and programmatic concerns and issues. This forum has been a useful tool for sharing information and identifying and resolving issues at all levels of the appeals process. CMS staff relay information they obtain through meetings with CMS contractors to OMHA and the Council. Likewise, OMHA and Council staffs share information from their levels of the appeals process with CMS and each other. These efforts improve case processing times by resolving administrative issues that slow down the adjudication process. For example, staff may identify, discuss, and resolve an operational issue related to the production of a particular group of case files for adjudication on appeal.

j. OMHA Quality Assurance Program: OMHA continues to focus on adjudication quality through an internal peer review program of closed ALJ decisions. The program has been instrumental in identifying areas for training and case processing policy development to enhance decisional quality, and contributed to the increasing consistency in case processing practices, as well as increasing decisional consistency among adjudicators.

k. Expanding Adjudicatory Capacity: By streamlining space requirements and renegotiating leases in its existing offices, and through additional appropriations from Congress, OMHA was able to open a new office in Kansas City, Missouri in summer 2014, increase the size of its office in Arlington, Virginia, and will open a new office in Seattle, Washington, in summer 2016. As these offices open and expand, OMHA has brought on more staff to process appeals.

II. Legislative Proposals for Reforms and Additional Resources

22. Congress is currently considering several legislative proposals included in the FY 2017 President's Budget and in the Audit & Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) Act, S. 2368 – a bill that is under consideration in the Senate -- to address the increasing number of appeals and increase resources to reduce the size of the backlog, including several proposals that would expand administrative actions currently being implemented. These legislative proposals include:

a. Use of Medicare Magistrates and Increase Amount-in-Controversy Required for an ALJ Hearing: Both the FY 2017 President's Budget and the AFIRM Act include proposals that would allow OMHA to use lower cost Medicare Magistrates (senior attorneys), rather than ALJs, to adjudicate cases in which the appealed claims meet the current amount-in-controversy requirement for an ALJ hearing ($150 in 2016), but are below the Federal district court amount in controversy threshold ($1,500 in 2016), and would increase the amount-in-controversy threshold for an ALJ hearing to that required for Federal district court review. Currently, the Social Security Act requires a hearing by an ALJ for a Medicare claim or coverage determination with an amount in controversy of $150 or more. These proposals would reserve ALJs for more complex and higher amount in controversy appeals, and align the amount at issue

with the amount OMHA spends to adjudicate the claim. This action will increase the number of appeals that OMHA can adjudicate because more adjudicators can be hired to decide appeals based on the written record. If the measure becomes law and is fully funded, HHS estimates that 294,000 future appeals will be diverted from the ALJ hearing queue to the new Medicare magistrates by the end of FY 2020.

b. Additional Funding from RA Reimbursement or AFIRM Act: The FY 2017 President's Budget includes a proposal that would allow HHS to use RA program recoveries to supplement the annual appropriations for OMHA and DAB for the workload associated with RA-related appeals. The AFIRM Act also proposes increasing OMHA and DAB appropriations. Either authority would provide OMHA and DAB with an additional $1.3 billion total in funding over 10 years. These additional resources would fund 101 additional ALJ teams who could adjudicate an additional 101,000 appeals per year, as well as additional adjudication capacity at DAB. HHS estimates that this action would increase the number of appeals that OMHA can adjudicate by more than 319,000 appeals by the end of FY 2020.

c. Prior Authorization for Any Non-Emergent Medicare Item or Service: The FY 2017 President's Budget includes a proposal to give the Secretary the authority to require prior authorization for any non-emergency Part A or Part B item or service. HHS estimates that this action would reduce the number of appeals that reach OMHA by more than 90,000 appeals by the end of FY 2020.

d. Refundable Filing Fee: The FY 2017 President's Budget includes a proposal to institute a refundable per-claim filing fee for providers, suppliers, and Medicaid State Agencies, including those acting as a representative of a beneficiary, at each level of appeal. The fee would not apply to appeals filed by beneficiaries (unless the beneficiary was represented by

the provider, supplier, or Medicaid State Agency). Fees would be returned to appellants who receive a fully favorable determination. Under current law, there is no administrative fee paid to the adjudicating entity for filing an appeal; an appellant's cost for utilizing the appeals process is limited to the appellant's costs associated with appeal preparation. Filing fees would partially offset appeals costs and allow HHS to reinvest funds in order to improve responsiveness in the appeals process. In addition, a filing fee would encourage potential appellants to assess the merits of their appeals more carefully before filing. Currently, a small number of appellants file a significant number of appeals in part because their preparation cost is minimal. As noted above, in FY 2015, of the more than 20,000 appellants that filed appeals with OMHA, including approximately 5,000 individual beneficiaries, three appellants filed nearly 40 percent of the appeals (over 92,500 appeals). HHS has not estimated the impact of this action on the backlog. The Department would need to review the program after Congress enacts the legislation before it could reasonably estimate an impact.

e. Sample and Consolidate Similar Claims for Administrative Efficiency: Both the FY 2017 President's Budget and the AFIRM Act include proposals that would allow the Secretary to adjudicate appeals through the use of sampling and extrapolation techniques. Additionally, these proposals would authorize the Secretary to consolidate related appeals into a single administrative appeal at all levels of the appeals process for purposes of administrative efficiency. In addition, parties would be required to file one appeal request to appeal all claims included within an extrapolated overpayment or consolidated previously within the appeals process. Currently, when parties appeal claim determinations that are part of an extrapolated overpayment or a consolidated appeal, they are not required to appeal those determinations together, leading to inefficiencies in appeals processing. HHS has not estimated the impact of

this action on the backlog. The Department would need to review the program after Congress enacts the legislation before it could reasonably estimate an impact.

f. Remand Appeals to the Redetermination Level with the Introduction of New Evidence: Both the FY 2017 President's Budget and the AFIRM Act include proposals that would require an adjudicator to remand an appealed claim to the first level of appeal when a party to the appeal (other than a beneficiary or CMS or its contractors) submits new documentary evidence at the second level of appeal or above. The adjudicator may choose not to remand if the evidence was provided to the lower level adjudicator but erroneously omitted from the record on appeal, or if the adjudicator denies the claim on a new and different basis from earlier determinations. This proposal provides a strong incentive for appellants to produce all evidence early in the appeals process and promotes the goal of having the same record reviewed and considered at the second and subsequent levels of appeal. There continues to be a propensity on the part of providers and suppliers to submit evidence in the administrative appeals process after the reconsideration (second) level. By submitting evidence late, these appellants create situations in which the redetermination and reconsideration levels of appeals correctly uphold claim denials based on the evidence before them, but the ALJ or Council overturns these denials because the appellant has submitted new evidence into the record. This proposal would also deter later submission of evidence, as submissions after the redetermination level would only serve to restart the appeals process and potentially delay payment to the appellant. HHS has not estimated the impact of this action on the backlog. The Department would need to review the program after Congress enacts the legislation before it could reasonably estimate an impact.

g. Expedited Procedure for Claims with No Material Facts in Dispute: Both the FY 2017 President's Budget and the AFIRM Act include proposals allowing OMHA to issue

decisions without holding a hearing if no material facts are in dispute and the ALJ determines that binding authority controls the decision in the matter. These cases include, for example, denials of drug coverage under Medicare Part D because the drug does not qualify as a Part D drug under the statute, or denials of items or services because they do not fall within a Medicare benefit category. Appeals of these "technical denials," as well as appeals that involve only procedural issues, could be resolved without a hearing. This proposal would increase the efficiency of the Medicare appeals system and result in faster adjudications of appeals at the ALJ level. HHS has not estimated the impact of this action on the backlog. The Department would need to review the program after Congress enacts the legislation before it could reasonably estimate an impact.

h. Expanded OMHA Settlement Conference Facilitations: With additional discretionary funding requested in the FY 2017 President's Budget, OMHA could expand the settlement conference facilitation described in paragraph 19(e) above. HHS estimates that this action would reduce the number of appeals that would otherwise be pending at OMHA by 180,000 appeals by the end of FY 2020.

i. Expanded On-the-Record Adjudication: With additional discretionary funding requested in the FY 2017 President's Budget, OMHA could expand the on-the-record adjudication described in paragraph 19(g) above. HHS estimates that this action would increase the number of appeals that OMHA can adjudicate by 69,000 appeals by the end of FY 2020.

Medicare Appeals Council Initiatives

23. Many of the administrative and legislative initiatives discussed above for reducing the backlog at OMHA have the effect of increasing the number of appeals received by the Council. This is because appellants appeal some of the claims OMHA adjudicates (currently

approximately 10%) to the Council. Therefore, additional funding and authorities that increase adjudications by OMHA will also increase the number of cases appealed to the Council. For this reason, one of the Department's main strategies is to address appeals at the lower CMS levels (MAC and QIC) in order to prevent certain appeals from ever entering the system. These initiatives, described in paragraphs 19(a) -19(e), not only decrease the number of appeals received by OMHA, but they also decrease the number of appeals OMHA adjudicates that are then appealed to the Council.

24. The Department has implemented additional initiatives to help reduce the present and anticipated backlog at the Council. Those initiatives include:

a. Case Processing Support: In June 2015, the Council began using contract paralegal support to perform essential case functions including processing incoming mail and docketing incoming appeals. In addition, the contract paralegals draft basic orders, such as CMS Hospital Settlement dismissals and select remand orders, for an AAJ's review, which increases the adjudicative capacity of the Council.

b. Medicare Operations Division (MOD) Process Management Attorney: The Council has identified one of its existing attorney-advisors to act as the MOD Process Management Attorney. The role of the MOD Process Management Attorney is to analyze the backlog, identify beneficiary and other priority cases, such as pre-service cases, and look for potential consolidations to increase case processing efficiencies with the DAB's current resources. The MOD Process Management Attorney will continue to implement process improvements to better accommodate the increased number of new appeals received per week, including reorganization of its pending cases, to increase efficiencies and economize work efforts. Finally, the MOD Process Management Attorney coordinates with other levels of review

to resolve systemic issues that increase case processing times. For example, the MOD Process Management Attorney has established processes with OMHA to quickly address claim file deficiencies, which permits the Council to review cases in a timelier manner.

c. Electronic Case and Record Initiatives: The Council has implemented a series of initiatives that will allow it to process appeals electronically from filing to case closure. The Council began receiving electronic claim files in cases referred by CMS in FY 2014. The use of electronic records improved case processing time by reducing the wait time to correct deficiencies in administrative records and allowing multiple analysts to review records at one time. Beginning in FY 2015, the Council began receiving electronic records in other types of cases and currently receives approximately 35% of its claim files in a digital format. In addition, the Council has developed an electronic filing system that will be tested and deployed in the beginning of FY 2017. The electronic filing system is designed to automate the docketing process, which will further reduce case processing times and allow the Council to identify deficiencies with new appeal requests at an earlier stage. Finally, the Council automated the incoming mail log on April 1, 2016. Automation of the mail log has decreased case intake time and has improved case tracking abilities. In the future, to streamline the review process further, the Council plans to develop a module with interoperability to OMHA's ECAPE case management system.

d. The Department is continuing to explore other initiatives to manage the increase in appeals to the Council that will result from the actions taken to reduce OMHA's backlog.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on May 25, 2016 in Washington, D.C.

Ellen Murray

Exhibit 1: MEDICARE APPEALS BACKLOG - REDUCTION ACTIONS
Data as of 03/31/2016

		FY14	FY15	FY16	FY17	FY18	FY19	FY20
Projections with No Action Taken	Beginning Workload Balance	380,696	767,422	928,901	1,085,984	1,269,930	1,474,558	1,690,789
	New Receipts	474,063	240,360	241,583	275,946	296,628	308,231	317,920
	Disposition	(87,337)	(78,881)	(84,500)	(92,000)	(92,000)	(92,000)	(92,000)
	Cumulative Backlog - No Action Taken	**767,422**	**928,901**	**1,085,984**	**1,269,930**	**1,474,558**	**1,690,789**	**1,916,709**
Projections with Impact of Taking Administrative Actions	CMS Hospital Settlement	-	(42,483)	(215,863)	-	-	-	-
	Recovery Audit Program Contract Modifications	-	-	(974)	(3,894)	(5,355)	(5,841)	(6,085)
	Prior Authorization (Administrative Actions)	-	-	(22,601)	(50,552)	(74,818)	(61,124)	(60,152)
	QIC Demonstration - Provider Education Impact	-	-	(1,396)	(2,871)	(2,951)	(3,034)	(3,122)
	QIC Demonstration - Appeals Resolved before Reaching OMHA	-	-	(7,091)	(14,183)	(14,183)	(14,183)	(14,183)
	OMHA Settlement Conferences	-	(2,401)	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)
	On-the-Record adjudication	-	-	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)
	Senior ALJ Program	-	-	(585)	(3,960)	(3,960)	(3,960)	(3,960)
	Statistical Sampling (Administrative Actions under Current Authorities and Budget)	-	-	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)
	QIC Demonstration - Reopening of Appeals Pending at OMHA		-	(22,500)	(45,000)	(45,000)	(45,000)	(45,000)
	Administrative Actions Impact Total	-	**(44,884)**	**(284,010)**	**(133,460)**	**(159,267)**	**(146,142)**	**(145,502)**
	Cumulative Backlog - With Current Actions Taken	**767,422**	**884,017**	**757,090**	**807,576**	**852,937**	**923,026**	**1,003,444**
Projections with Impacts of Administrative Actions and Congressional Actions (both legislative and budget)	Legislation: Magistrates; Procedural Issues and Revised AIC	-	-	-	(42,000)	(84,000)	(84,000)	(84,000)
	Recovery Audit Reimbursement/Pending Legislation	-	-	-	(16,833)	(101,000)	(101,000)	(101,000)
	OMHA Settlement Conference Facilitations (Additional Capacity - Budget Dependent)	-	-	-	(45,000)	(45,000)	(45,000)	(45,000)
	On-the-Record Adjudication (Additional Capacity - Budget Dependent)	-	-	-	(3,000)	(22,000)	(22,000)	(22,000)
	Prior Authorization for any non-emergent Medicare Item or Service Legislative Proposal	-	-	-	(8,230)	(15,949)	(32,813)	(33,776)
	Legislative/Budget Dependent Actions Impact Total	-	-	-	**(115,063)**	**(267,949)**	**(284,813)**	**(285,776)**
	Cumulative Backlog - Legislative/Budget Dependent Actions Taken	**767,422**	**884,017**	**757,090**	**692,513**	**469,925**	**255,201**	**49,843**