

# **REPORT TO CONGRESS**

**March 2004**

## **PLAN FOR THE TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS**

**Developed under section 931 of the Medicare Prescription  
Drug, Improvement and Modernization Act of 2003 (MMA),  
Pub. L. No. 108-173, 117 Stat. 2066 (2003)**

**Submitted by:  
The Secretary of Health and Human Services  
and  
The Commissioner of Social Security**

## **Introduction**

This plan was developed in response to section 931 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, 117 Stat. 2066 (2003) (Appendix A) and includes information as compiled and agreed upon by the Social Security Administration (SSA) and the Department of Health and Human Services (HHS). The plan is designed to describe the process through which HHS and SSA will accomplish the transfer of responsibility for the functions of administrative law judges (ALJs) responsible for hearing Medicare appeals under title XVIII of the Social Security Act (the Act). The Secretary of HHS and Commissioner of SSA are committed to working together to ensure a successful transition and the availability of an efficient and effective appeals process both during the transition process and after the transfer of responsibility over these appeals to HHS is complete.<sup>1</sup>

## **Background**

SSA was originally a part of HHS. Historically, ALJs in the SSA Office of Hearings and Appeals (OHA) provided hearings on behalf of the Secretary of HHS on some but not all types of Medicare appeals, and the SSA Appeals Council provided the final level of review. In the 1980s and early 1990s, the Secretary transferred some types of Medicare cases from OHA to ALJs at the Departmental Appeals Board (DAB) and provided that the DAB would issue the final decision on behalf of the Secretary in those cases.<sup>2</sup>

In 1994, the Social Security Independence and Program Improvements Act (Independence Act), Pub. L. No. 103-296, 108 Stat. 1464 (1994), established SSA as an independent agency. Section 105(a)(2)(A)(i) of the Independence Act stipulated a shared responsibility for the Medicare appeals process in which SSA would continue to perform the hearings function for those Medicare appeals that SSA was hearing in 1994. Section 105(a)(2)(B) provided that SSA "shall perform" this function in accordance with the same financial and other terms in effect on the date of the Act, except to the extent the Commissioner of SSA and the Secretary of HHS "agree to alter such terms pertaining to any such function or to terminate the performance by the Social Security Administration of any such function." Pursuant to these provisions, SSA continues to hear certain Medicare appeals on behalf of HHS. Specifically, these cases include:

- Determinations made by SSA under section 1869(b) of the Social Security Act (the Act) concerning whether an individual is entitled to benefits under Part A or Part B of title XVIII (Medicare) of the Act. See 42 C.F.R. Parts 405.701(a)(1), 406 and 407.
- Determinations under section 1869(b) of the Act by Medicare intermediaries or carriers concerning claims for benefits under Part A or Part B of title XVIII. See 42 C.F.R. Part 405,

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<sup>1</sup> In developing this plan, HHS and SSA considered the information and recommendations contained in the report prepared by the General Accounting Office (GAO), dated September 2003 (GAO-03-841), *Medicare Appeals, Disparity between Requirements and Responsible Agencies' Capabilities*.

<sup>2</sup> Specifically, transferred cases included: 1) program exclusions and civil money penalty cases brought by the HHS Office of the Inspector General or Centers for Medicare & Medicaid Services (CMS) [then the Health Care Financing Administration] under various fraud and abuse authorities; and 2) CMS provider and supplier certification and enforcement actions. See 42 C.F.R. Parts 1005 and 498.

## Subparts G and H.

- Determinations under section 1852(g) of the Act by a Medicare+Choice organization under Part C of title XVIII with respect to specified payment or coverage issues. See 42 C.F.R. Part 422, Subpart M.
- Determinations under section 1876 of the Act by a health maintenance organization (HMO) or competitive medical plan (CMP) regarding benefits. See 42 C.F.R. Part 417, Subpart Q.
- Determinations made by Quality Improvement Organizations (QIOs)<sup>3</sup>, under section 1154 of the Act and the procedures in section 1155 of the Act, that services furnished or proposed to be furnished are not reasonable, necessary, or delivered in the most appropriate setting. See 42 C.F.R. Part 478, Subpart B.

In this plan, the terms “Medicare hearing” and “Medicare appeals” refer only to these categories described above.<sup>4</sup>

To facilitate the continued performance of the Medicare hearings function by SSA after it became an independent agency, SSA and the Health Care Financing Administration (HCFA) [now the Centers for Medicare & Medicaid Services (CMS)] entered into a Memorandum of Understanding (the Umbrella MOU), effective March 31, 1995 (Appendix B). The Umbrella MOU was designed to ensure that both parties continued working cooperatively to maximize program efficiency, effectiveness and service to the public. In addition, Article V, Section 9, of the Umbrella MOU detailed the parties’ commitment to “further discussions regarding the potential transfer of” the Medicare hearings function and related resources to HHS. The parties also agreed that the ultimate transfer of the ALJ hearings function was in the best interest of the public inasmuch as HHS has administrative responsibility for the Medicare program.

On October 20, 1995, HHS and SSA signed a second agreement (Supplemental Agreement—Appendix C), which transferred to HHS the Medicare appellate review functions performed by the SSA Appeals Council. This body, now called the Medicare Appeals Council (MAC), is housed within the DAB and reviews ALJ decisions in the types of cases detailed above.<sup>5</sup>

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) Pub. L. No. 106-554, 114 Stat. 2763 (2000) amended section 1869 of the Social Security Act by creating new appeal rights and requiring major revisions to the Medicare appeals process. In anticipation of the implementation of BIPA, HHS and SSA then began negotiating the potential transfer of the Medicare hearings function. As a result of these negotiations, it was tentatively agreed that, pending budget approval, responsibility for Medicare hearings would be transferred

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<sup>3</sup> The Act refers to Peer Review Organizations (PROs) as opposed to QIOs. All references to PROs have been changed to QIOs pursuant to Federal Register notice, 67 FR 36539.

<sup>4</sup> The transferred cases also do not include any matters currently heard by either the Provider Reimbursement Review Board or the Medicare Geographic Classification Review Board. These cases concern matters such as appeals of payments to hospitals, based on a review of hospital cost reports, and hospital wage index appeals.

<sup>5</sup> The Supplemental Agreement covers the “. . . appellate review of all pending and future cases, including hearings where appropriate, in disputes involving: 1) Medicare entitlement/entitlement-related issues, and 2) Medicare coverage, claims reimbursement, and denial of service issues.”

beginning October 1, 2003. Accordingly, SSA did not request the resources needed to process the Medicare workload in its fiscal year (FY) 2004 budget. In the meantime, Congress was considering Medicare reform legislation that would significantly impact the processing of Medicare appeals. Specifically, the legislation would delay the transfer of the appeals function to not earlier than July 1, 2005, and not later than October 1, 2005, and it would require that the ALJs hearing Medicare appeals be organizationally and functionally separate from CMS. To ensure continuation of the Medicare hearings function pending the transfer, HHS and SSA entered into a Reimbursable Agreement in December 2003 under which SSA would be reimbursed by HHS for continuing to perform the Medicare hearings function in FY 2004 (Reimbursable Agreement—Appendix D). Pursuant to the Reimbursable Agreement, it is anticipated that SSA will complete up to 50,000 "units of service" at a cost not to exceed \$50 million during FY 2004.<sup>6</sup> The Reimbursable Agreement may be renewed by mutual consent of the agencies.

The MMA was enacted on December 8, 2003. As anticipated, section 931 of the MMA requires the transfer of responsibility for the Medicare appeals function to HHS and provides that the ALJs performing this function be organizationally and functionally separate from CMS and report to, and be under the general supervision of, the Secretary. Accordingly, HHS assumed overall responsibility for negotiations with SSA. Section 931 also requires the Commissioner and the Secretary to develop and transmit to Congress and the Comptroller General of the United States a plan to transfer responsibility for the functions of ALJs hearing cases under title XVIII of the Social Security Act (and related provisions of title XI of such Act). This plan must be submitted to Congress not later than April 1, 2004. As specified in section 931(b)(1) of the MMA, "Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary."

This plan is organized to address the subject matter areas outlined in section 931(a)(2) of the MMA.

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<sup>6</sup> In accordance with the Reimbursable Agreement, a "unit of service" is the adjudication of request(s) for hearing on one or more claims involving one or more beneficiaries that are properly disposed of by a single decision or dismissal. Request(s) for hearing may involve multiple units of service and be assigned multiple docket numbers only when a beneficiary's claim or claims require unique findings of fact and/or application of law to fact, e.g., individual medical necessity determinations.

## I. WORKLOAD

### Medicare Claims

Approximately 41.6 million Americans receive Medicare benefits. On an annual basis, carriers and intermediaries process approximately 1 billion claims, with carriers processing Medicare Part B claims and intermediaries generally processing Medicare Part A claims.<sup>7</sup> Of this amount, carriers and intermediaries (Parts A and B) approve payment for approximately 900 million claims, with denials accounting for approximately 10 percent of total claims.

Claims submitted for Medicare items and services are denied for a variety of reasons. The most common reason for denying a claim is that the services provided were determined not to have been medically necessary for the beneficiary. Other reasons for denials include that Medicare did not cover the services or that the beneficiary was not eligible for services. Generally, beneficiaries, providers and suppliers have the right to appeal denied claims if appeals are filed within the required timeframes and satisfy the amount in controversy requirements. This appeal, called a redetermination, is heard by the appropriate carrier or intermediary. A beneficiary's appeal right may be assigned to the provider or supplier that furnishes the item or service in question. As a result, the current appeals process is dominated by provider or supplier appellants with a smaller subset of beneficiaries bringing appeals on their own behalf. Therefore, the actual number of individual beneficiaries involved in a specific appeal varies since a specific provider or supplier may group appeals or beneficiary appellants may aggregate their claims to meet dollar thresholds.

A majority of all denials are for Medicare Part B claims processed by the Medicare carriers. Approximately 14 percent of all Medicare Part B claims are denied at the initial level. Of these, less than 1 percent is forwarded to the ALJ hearing level. Medicare Part A claims account for 16 percent of the total claims processed. Approximately 8 percent of all Medicare Part A claims are denied at the initial level. Of these, less than .06 percent make it to the ALJ hearing level.

Under BIPA, if the carrier or intermediary renders a decision upholding the denial of payment, the provider, supplier or beneficiary may then request a second level appeal. The second level appeal, called a reconsideration, will be conducted by the qualified independent contractors (QICs).<sup>8</sup> Should the denial again be upheld at the second level, the provider, supplier or beneficiary may then submit an appeal at the third level of the appeals process, the ALJ level. In FY 2003, approximately 122,500 claims<sup>9</sup> were appealed to the ALJ level.

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<sup>7</sup> Medicare fee-for-service consists of two parts—A and B. Part A claims cover inpatient hospital, skilled nursing facility, hospice, and certain home health services. Part B claims cover physician services, diagnostic tests, and related services and supplies.

<sup>8</sup>The process described here is that required under section 521 of BIPA. Prior to BIPA, the second level of appeal was heard by the carrier for Part B cases only. There was no second level of appeal for claims arising under Part A. Once the BIPA section 521 regulations are implemented, these reconsiderations will be heard for both Part A and Part B cases by the QICs.

<sup>9</sup> Numerous claims can be associated with one case or one hearing.

## SSA Experience

OHA has approximately 950 available ALJs and 5,200 support staff located nationwide (10 regional offices, 139 field offices and 4 satellite offices). The ALJ workload is dispersed throughout OHA's hearing offices with many ALJs spending some portion of their time on Medicare appeals. In FY 2003, an average of 46.18 ALJs were used to adjudicate Medicare appeals each month. While SSA does not have a dedicated ALJ corps or support staff for Medicare appeals, a cadre of 34 ALJs with Medicare hearings experience and expertise conducts hearings for "big box"<sup>10</sup> cases that result in a substantial portion of Medicare dispositions. Demographic patterns, location of large providers and suppliers, and variations in the practices of state governments and CMS contractors account primarily for the distribution of the SSA appeals workload. Workload distribution has been affected in a few instances by assignment of cases to the office where a cadre ALJ is located. The following data were taken from SSA's Hearing Office Tracking System (HOTS) regarding the Medicare appeals workloads:

	Open Pending	Annual Receipts	Annual Cases Closed
FY 2001	35,904	77,276	69,663
FY 2002	43,517	71,576	77,388
FY 2003*	37,705	75,493	78,005

\*Includes 75% Medicare Part B, 24 % Medicare Part A, and 1% Medicare+Choice/Medicare Advantage (managed care)  
Source: OHA Hearing Office Tracking System.

The above data addressing ALJ appeals filed show a 5 percent increase of appeals receipts between FY 2002 and FY 2003. It is still too early in FY 2004 to determine appeals receipts for the entire fiscal year, and first quarter receipts are traditionally lower than those throughout the remainder of the year. However, the opening pending workload for FY 2004 was 35,193 appeals. Pursuant to the Reimbursable Agreement entered into in December 2003, it is anticipated that SSA will complete up to 50,000 "units of service" during FY 2004 at a cost not to exceed \$50 million dollars. The Reimbursable Agreement may be renewed by mutual consent to include Medicare hearings performed by SSA in future years. The agencies have agreed on a definition of a "unit of service" in the Reimbursable Agreement. The definition of "unit of service" (See footnote 6) is for reimbursement purposes only and does not indicate any changes in functions performed by staff in processing Medicare cases. The data above do not reflect the definition of "unit of service" in the Reimbursable Agreement.

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<sup>10</sup> A big box case is defined as consolidated cases containing 30 beneficiaries or more and \$40,000 or more in controversy, as well as appeals where sampling is used by the contractors to calculate an overpayment.

## **Statutory Changes**

Section 521 of BIPA included major revisions to appeals procedures at the ALJ level for the original Medicare plan beneficiaries. It imposed a 90-day time limit for conducting ALJ appeals, lowered the amount in controversy, and allowed appellants to escalate an appeal from the QIC to the ALJ level if the QIC did not meet its 30-day timeframe for issuing a determination.

The MMA included reforms to the Medicare appeals process regarding presentation of evidence, notice requirements and requirements for QICs. Additionally, the new law reduces the minimum number of QICs from 12 to 4. The MMA also extends the timeframes for carriers and fiscal intermediaries to issue redeterminations and for the QICs to complete their reconsiderations from 30 days to 60 days. The new law also requires the dollar amounts in controversy to be adjusted annually by the percentage increase in the medical care component of the consumer price index for all urban consumers.

The MMA also establishes a prescription drug benefit for Medicare beneficiaries under title I that allows exceptions and appeals for enrollees in Prescription Drug Plans (PDPs) to be able to obtain (1) formulary drugs at a lower tiered cost sharing amount than originally established under the plan and (2) plan coverage for non-formulary drugs. Determinations made under these exceptions would be subject to appeal procedures similar to those under the Medicare + Choice/Medicare Advantage program, which includes appeal to an independent review entity and subsequently to an ALJ. Depending upon the policies announced in the final rule, these appeals may have some impact on the volume of claims submitted. Given that the final policies have not been announced and that the prescription drug benefit is a totally new benefit affecting 41.6 million eligible beneficiaries, the exact impact in terms of numbers of appeals to ALJs is unknown at this time.

## **HHS Projected Future Staffing Requirements:**

The FY 2005 President's Budget projects that the claims volume will increase by 4 percent. While this is likely to impact the ALJ appeals volume, an increase in claims volume brought about by legislative and regulatory changes may further increase the number of Medicare appeals. Taking into account the SSA experience and the Medicare claims information coupled with new legislative requirements in BIPA and MMA, including the prescription drug program, HHS has developed the following plan for the staffing of Medicare appeals:

- Although SSA currently uses an average of 46.18 ALJs to adjudicate Medicare appeals each month, it is anticipated the workload burden will increase as a result of the imposition of the 90-day time limit for conducting ALJ appeals, a reduced amount in controversy, and the new right of appellants to escalate a case from the QIC to the ALJ level if the QIC does not meet the 60 day decision making timeframe. HHS estimates that a minimum of 50 ALJs will be needed to process this workload. ALJs will be dispersed throughout a number of HHS regional offices and will be functionally and organizationally separate from CMS. HHS will initially hire about 50 ALJs, and increase

that number based on appropriated budget and workload increases. HHS anticipates greater ALJ efficiencies in processing cases through workload specialization.

- HHS estimates a 4:1 ratio of support staff per ALJ hired. This ratio is somewhat lower than SSA's current 4.5:1 ratio, which is based on the entire SSA hearings workload, composed primarily of disability appeals. The staff may include an attorney advisor, paralegal and support staff. Included in support staff is central administrative support for the new hearings office. This support will include, but not be limited to, personnel services, training, information technology (IT), video conferencing (VTC) services, and the overall management of the Medicare hearings workload.

## **II. COST PROJECTIONS AND FINANCING**

From the beginning of the Medicare program, SSA has been responsible for most ALJ hearings arising from Medicare. SSA's annual appropriation included funds to carry out this activity. Through cost allocation, the cost of conducting ALJ hearings was charged to the Medicare Trust Funds. The administrative costs for Social Security are appropriated as a "limitation account" which sets the total amount SSA can obligate for the programs it administers. The mix of actual work processed in a particular fiscal year determines the amount charged to each funding source; i.e., the various trust funds or the general fund for Supplemental Security Income (SSI) work. SSA's cost allocation methodology determined the cost of conducting Medicare hearings that were charged to the Medicare Trust Funds.

Since the President's Budget for FY 2004 assumed the transfer of responsibility for providing Medicare administrative hearings and related functions from SSA to HHS, SSA's budget request for FY 2004 did not include the resources to process the Medicare workload. Instead, Congress provided funding for processing ALJ level appeals in CMS' discretionary Program Management account. HHS and SSA agreed that SSA would continue to process the Medicare workload under the Reimbursable Agreement previously described, which provides that HHS will reimburse SSA \$1,000 per unit of service up to \$50 million in FY 2004. The definition of a "unit of service" agreed to by HHS and SSA in the Reimbursable Agreement is for reimbursement purposes only in FY 2004 and in any subsequent reimbursable agreements. Therefore, historical data do not provide a comparable basis for projecting future resource needs. Consequently, in order to determine the resources HHS will need for the ALJ hearings function, SSA will provide HHS with quarterly reports of the number of units of service completed throughout FY 2004. These data will enable HHS to make the best projection of the hearings workload it will have to process and to re-assess its future resource needs.

Both the FY 2004 and FY 2005 President's Budgets requested \$129 million in the CMS discretionary budget for appeals reform, which includes funds for HHS start up costs, funds to reimburse SSA for continuing to process Medicare cases in FY 2004 and FY 2005, and funds for CMS to implement other BIPA reforms, as amended by the MMA. The FY 2005 request assumes that HHS will enter into another Reimbursable Agreement or similar arrangement with SSA to continue to handle Medicare appeals through the end of that year.



Start up costs included in the FY 2005 request allows HHS to begin hiring ALJs, attorneys, paralegals, and clerical support staff. As noted earlier, HHS will need to hire additional ALJs and support staff to process the Medicare appeals workload when the responsibility for the ALJ function is fully transitioned to HHS. Due to the advent of the new prescription drug benefit established by Medicare Part D during calendar year (CY) 2006, as well as an expected shift of Medicare beneficiaries into managed care from fee-for-service, it is difficult to predict the number of ALJ level appeals HHS can expect in the future. HHS will include projections for workloads resulting from the new prescription drug benefit and other MMA changes in its estimates of resources needed to perform the ALJ hearings function.

HHS will request funding in the FY 2006 budget to perform the complete ALJ Medicare hearings function. Before Congress receives the FY 2006 President's Budget request, HHS will work with SSA, the Office of Budget and Management (OMB), and other entities involved in the process to develop a comprehensive estimate of future funding needs and a budget strategy. This estimate depends on many factors, including: when and how many ALJs and support staff HHS hires, geographic dispersion, and the new and pending workload estimates. Among other things, HHS will use the data reported in SSA's FY 2004 quarterly reports to formulate future funding requests and a comprehensive budget strategy.

### **III. TRANSITION TIMETABLE**

SSA and HHS have agreed on a plan for the phased transfer of the Medicare hearings function. The intent of the plan is for SSA to complete its performance of the Medicare hearings function on October 1, 2005, and for HHS to begin to perform the Medicare hearings function without a pending workload transferred from SSA. The plan provides for CMS' contractors, beginning July 1, 2005, to send to HHS all Medicare appeals that would otherwise have been sent to SSA. SSA will complete processing its pending Medicare workload (appeals received by SSA prior to July 1, 2005) by September 30, 2005. HHS will begin handling the workload of cases sent to it after June 30, 2005, without an SSA pending workload. The agencies are developing a joint strategy to enable SSA to complete processing its pending workload by September 30, 2005. The strategy requires a set of complementary initiatives to be undertaken by each agency to increase the units of service SSA can provide and the commitment of sufficient additional resources to reimburse SSA, and revising the FY 2004 Reimbursable Agreement, if necessary, to ensure all pending cases are completed.

In order to process all cases, SSA and HHS will implement initiatives to increase the efficiency of Medicare appeals processing. These include:

- Uniform file organization and improved case preparation by Medicare contractors.
- Full screening of Medicare receipts by a centralized unit of SSA and HHS Medicare expert staff for potential dismissals and on the record decisions.
- Increased specialization of ALJs and support staff handling Medicare cases.
- Maximum use of VTC hearings and expert testimony by phone.

The following is the plan for the phase in of new Medicare appeals to HHS:

1. HHS will begin to exercise adjudicative authority for Medicare Part A and Part B ALJ appeals received by it on or after July 1, 2005. This will permit SSA to concentrate on reducing the pending workload on hand as of July 1, 2005 and will permit HHS to process the appeals in preparation for beginning to conduct ALJ hearings. All Part A and Part B appeals for which HHS will exercise adjudicative authority after June 30, 2005, will be sent to HHS by contractors beginning July 1, 2005.
2. HHS will begin to exercise adjudicative authority for Medicare Part C ALJ appeals received on or after September 1, 2005. All Part C appeals will be sent to HHS by the independent review entity beginning September 1, 2005.
3. HHS will begin to exercise adjudicative authority for initial Medicare entitlement-only appeals as of July 1, 2005. All such appeals filed with SSA on or after July 1, 2005 will be sent to HHS.
4. SSA will retain adjudicative authority to process all Medicare Part A and Part B appeals received by it on or before June 30, 2005 and all Part C cases received prior to September 1, 2005.

With HHS beginning to exercise adjudicative authority over Medicare ALJ appeals on July 1, 2005, it estimates the following with respect to hiring and training ALJs and support staff:

- Last quarter of CY 2004--HHS will begin to solicit applications for ALJ positions, request an ALJ register from OPM, and post for attorneys and other support staff. Further, HHS will perform and complete an analysis of allocation to regional sites of positions and resources, including staff, IT systems, video teleconference equipment, etc.
- Second quarter of CY 2005—HHS will begin hiring ALJs and support staff.
- Second quarter of CY 2005—HHS will begin training ALJs and support staff.

In addition, HHS will begin to receive and track all Medicare Part A and Part B appeals received on or after July 1, 2005, and Medicare Part C appeals received on or after September 1, 2005. SSA will continue to provide information regarding the status of Medicare appeals being adjudicated by SSA until all Medicare appeals retained by SSA are completed.

#### **IV. REGULATIONS**

Section 521 of BIPA made comprehensive changes in the Medicare claims appeal process. In compliance with the MMA as well as the statutory mandates of BIPA, HHS envisions implementing the following regulations.

As an initial step after the passage of BIPA, CMS issued a Ruling on October 1, 2002, that established *interim* administrative procedures for CMS contractors, ALJs, and the DAB to follow in processing Medicare claims appeals. This Ruling and related instructions will be followed until CMS finalizes comprehensive regulations implementing BIPA section 521.

CMS published proposed regulations on November 15, 2002, (CMS-4004-P) "Changes to the Medicare Claims Appeal Procedures," that comprehensively addressed the overall changes to the Medicare claims appeal process required by BIPA section 521. 67 Fed. Reg 69312. The proposed regulations reflect the BIPA requirements by proposing to establish a uniform process for handling both Medicare Part A and Part B appeals; revise the timeframe for filing appeals; reduce the time limits for decision-making at all levels of the Medicare administrative appeals process; allow appellants to escalate appeals if the pertinent appeals body does not meet mandatory deadlines; implement the new appeals entities known as QICs; and establish the right to an expedited determination regarding a decision to discharge or terminate services to an individual.

The proposed regulations also included provisions related to the processing of BIPA section 521 Medicare appeals by ALJs. The existing ALJ regulations are quite voluminous and are intended primarily to apply to appeals of SSA disability cases, rather than to Medicare appeals. The need for the Medicare program to establish its own regulations for these upper level appeals has been widely recognized, including most recently by the Office of the Inspector General in its January 2002 report: "Medicare Administrative Appeals—The Potential Impact of BIPA," (OEI-04-01-00290). Moreover, the statutory timeframe for ALJ and DAB decisions and the opportunity for escalation of appeals apply only to Medicare appeals, and not to SSA disability appeals. Accordingly, HHS believes that these differences in the appeals procedures present another compelling argument in support of codifying the ALJ and DAB requirements for Medicare administrative appeals within the Medicare regulations at Title 42 of the Code of Federal Regulations. Thus, the regulation will codify the key rules governing all aspects of Medicare claims appeals, beginning with the statutory requirements that apply to initial determinations and proceeding through all four levels of the administrative appeals process.

As noted in the Workload section of this report, the MMA sets forth further changes to address evidence requirements for providers and suppliers, notice requirements at all levels of the appeals process, timeframes for redeterminations and reconsiderations, and a number of requirements related to QICs. HHS intends to carry out the necessary rulemaking to implement these changes concurrently with the other changes required by section 521 of BIPA. Additionally, regulations regarding the prescription drug plan, electronic filing of appeals and the use of VTC for Medicare appeals will be issued at a later time.

## **V. CASE TRACKING**

### **Background**

When discussions first began regarding the transfer of the appeals workload, each agency's technical teams immediately began communicating regarding the data requirements and

functional needs of the system in order to develop a solution that supported a smooth transition of the workload.

A two-pronged approach was chosen. First, an interim solution would be developed to meet short-term needs. This interim system, called the Medicare Case Tracking System (MCATS), was expected to be operational by the original October 2003 proposed transfer date. Its design focused on tracking the receipt of appeals and the minimum data necessary to track appeals throughout their life cycle, that is, through the issuance of the ALJ decisions. In order to meet the original timeframe, CMS staff modified the HOTS, which is the system SSA currently uses in support of its processing of the Medicare appeals workload. The MCATS became available in December 2003.

### **Medicare Appeals System**

In order to achieve a more robust and enduring technical solution to all the appeals processing needs, the Medicare Appeals System (MAS) was awarded to a contractor in September 2003. The MAS design is intended to support a unified case tracking system that will facilitate maintenance and transfer of case specific data with regard to fee-for-service and managed care appeals (Medicare + Choice/Medicare Advantage) throughout the four levels of the appeals process, i.e., level 1 appeals: affiliated contractors, level 2 appeals: QICs, level 3 appeals: ALJs, and level 4 appeals: the DAB. In developing the MAS, HHS and SSA will work together to capitalize on SSA's knowledge and experience in developing the case processing management system (CPMS) and avoid unnecessary duplication.

In addition to basic case tracking across all levels of Medicare appeals in a unified system, the MAS also will provide the capability to report on appeals data, enable more accurate and expedient responses to Congressional questions, and provide more precise data for assessment and policy-setting. MAS will fulfill these business needs by focusing on data collection, data analysis, and workflow management. The MAS will be capable of docketing/calendaring hearings, scheduling expert witnesses for testimony, and providing information on the Medicare appeals workload as it relates to the number of ALJs and support staff required to process appeals. Moreover, the MAS envisions a future environment in which all of the management of the appeal files will be handled electronically. Specifically, the ALJ would have electronic access to all necessary documents, prior decisions, and other relevant information.

Implementation of the MAS is set to occur incrementally. The strategy of incremental development and deployment supports the flexibility necessary in accommodating the requirements for all levels of Medicare appeal processing based upon the priority of the stakeholders while also limiting associated risks. The incremental approach also will ensure that the MAS is aligned with critical business drivers. For example, the MAS is designed in a manner that will enable it to accommodate new legislative developments, such as the new appeals workload associated with the new drug benefit. The specific tasks associated with each increment of the MAS deployment are as follows:

- MAS Increment A  
This increment will provide support for the level 2 QIC/Administrative QIC Medicare fee-for-service appeals processing workload. The MAS will supply robust reporting functionality - both standard reports and 'ad hoc.' In addition, electronic interface to the Medicare Beneficiary Database and to 1-800-MEDICARE will also be implemented for the purpose of initiating appeals status reporting. Increment A of the MAS is scheduled for deployment in the summer of 2004.
  
- MAS Increment B  
The proposed functional content of this increment will support the level 2 Independent Review Entity responsible for the Medicare managed care (Medicare + Choice/Medicare Advantage) appeals processing workload. In addition, electronic interface to the Medicare affiliated contractors and to the Qualified Independent Organization for expedited appeals will be established. It also will deploy the prototype for the level 3 ALJ Medicare appeals processing workload, with eventual refinement of those requirements. MAS Increment B is scheduled for deployment in the second quarter of 2005.
  
- MAS Increment C  
The proposed functional content of this increment will support pilot electronic data management and interface with the level 4 DAB. Increment C is scheduled for deployment in the fourth quarter of 2005.

### **Transfer of Data**

Prior to enactment of the MMA, CMS and SSA technical staff worked together to develop a process to transfer all data from HOTS to CMS. The transfer capability designed will accomplish the transfer of all data regarding the level 3 appeals from SSA to HHS – i.e., all data regardless of whether the appeal has been completely adjudicated or is in process.

## **VI. FEASIBILITY OF PRECEDENTIAL AUTHORITY**

Currently, final agency decisions issued by the MAC of the DAB do not generally constitute binding authority, which decision-makers (ALJs and contractors) at lower levels of the Medicare appeals process must follow in rendering decisions. After a thorough consideration of the Medicare administrative appeals process, HHS has determined that it is neither feasible nor appropriate at this time to confer binding, precedential authority upon decisions of the MAC.

A decision of the MAC arises from an adjudication of the rights of a single appellant or group of appellants with respect to a particular claim or group of claims, and the adjudicatory process is open only to the parties to the appeal. Although in its proposed rule implementing section 521 of BIPA, CMS has proposed to authorize the agency to participate as a party in some appeals, at the present time the agency cannot participate directly in administrative appeals. See 67 Fed. Reg. 69312, 69332 (Nov. 15, 2002). As a result, it is often difficult for the agency to ensure that all relevant issues and authorities are presented to the MAC for consideration before it makes a final

determination in a particular case. Moreover, the agency is not able to appeal adverse or erroneous rulings by the MAC. Affording precedential authority to decisions where a particular legal argument has not been raised or thoroughly considered may result in an inaccurate or incomplete interpretation of an agency regulation or ruling, and may ultimately result in greater problems and uncertainty in subsequent cases when the issue is raised more clearly or in different factual circumstances.

Although the HHS Office of the Inspector General Report, entitled “Medicare Administrative Appeals – ALJ Hearing Process” (OEI-04-97-00160) (Sept. 1999) noted that the lack of precedent may contribute to “inconsistencies and other problems in the appeals process,” HHS believes there are steps that can be taken, short of granting binding, precedential authority to decisions of the MAC, to improve the consistency of administrative decisions. For example, the internet has greatly enhanced the MAC’s ability to circulate its decisions, and electronic search tools are now available, which make it easier to locate decisions on particular issues. The MAC also posts some key decisions on its website in order to provide guidance to ALJs on complex issues and in areas in which ALJs commonly make procedural errors. In addition, other changes mandated by BIPA and MMA are expected to help improve the uniformity and consistency of decision-making at the lower levels of the administrative appeals process. Accordingly, HHS has determined that, at this time, any problems that may arise from the possibility of inconsistent ALJ rulings are outweighed by the difficulties that could result from conferring binding, precedential authority upon decisions of the MAC.

HHS will, however, undertake to reevaluate the merits of granting binding, precedential authority to some or all decisions of the MAC within a reasonable time after the full implementation of the changes to the Medicare administrative appeals process mandated by both BIPA and MMA.

## **VII. ACCESS TO ADMINISTRATIVE LAW JUDGES**

### **Filing Appeals with ALJs Electronically**

CMS has begun work on a beneficiary portal to allow the Medicare beneficiary population to access their own personal Medicare data using the internet. While internet access to personal data is becoming commonplace in our society, as stewards of the data, the federal government must develop appropriate security to protect data covered by the Privacy Act of 1974, Pub. L. No. 93-579, 88 Stat. 1897 (1974) and the Health Insurance Portability and Accountability Act of 1996, (HIPAA) Pub. L. No. 104-191, 110 Stat. 1936 (1996). The CMS beneficiary portal is currently in a pilot implementation for a limited community. Based upon the assessment of that pilot, decisions will be made to expand functionality to allow beneficiaries to perform internet-based transactions. Through this web-based system, CMS anticipates developing a mechanism for beneficiaries to file appeals electronically, and CMS will then develop the necessary regulations. Results of the assessment are not available at this time.

## **Conducting Hearings Using Tele- or Video-Conference Technologies**

The availability of video-teleconferencing (VTC) and telephone hearings as service delivery options creates the opportunity to conduct hearings more efficiently. Unlike SSA disability hearings, where in-person hearings may be needed in order to evaluate credibility, Medicare hearings are less dependent on the physical presence of the appellant and other witnesses and accordingly, are more suited to video hearings. Consequently, HHS plans to adopt wider use of VTC. This will still allow for face-to-face hearings but would significantly reduce the time and expense involved in travel by both appellants and ALJs.

➤ **Tele-Conference**

HHS believes phone hearings are a feasible option. A small number of Medicare appeals are currently heard by phone with the concurrence of the appellants. However, a more frequent use of the tele-conference is to obtain the testimony of expert witnesses for whom the travel time and lost earnings due to in-person hearings are factors which limit their availability. Time and travel cost savings, as well as increased availability of experts, make this a desirable option. HHS plans to expand the use of tele-conferences, where appropriate.

➤ **Video-Teleconference (VTC)**

VTC can provide an excellent alternative to in-person hearings. HHS plans to develop a strategy that will permit ALJs to utilize a number of VTC facilities, including use of SSA VTC sites, private contractor sites and other government agency facilities. This will accomplish the primary goal of making hearings more accessible to claimants while minimizing lengthy trips by the ALJs. SSA has expressed a willingness to permit HHS to share its hearings network (refer to Section XII, Shared Resources). This approach will enable HHS to delay establishing its own networks until a more thorough need assessment can be completed. It is anticipated that VTC use will increase over time as appellants and their representatives become more familiar with the new process and technology. Private Network vendors also are available. A number of teleconferencing firms have put together “virtual private network” contracting with major telecommunications providers for large amounts of network bandwidth and sell off pieces of it to smaller users. This approach provides users with a private network without building and maintaining their own infrastructure. Many facilities offer VTC rooms that can be rented at a reasonable rate. These rooms are available through office supply stores, hotels, conferencing facilities and educational institutions. SSA has coordinated with some Federal and State agencies to use their VTC sites when available. As noted earlier, HHS plans to issue regulations around the use of VTC for Medicare hearings.

## **VIII INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES**

SSA has a long history of maintaining independence of ALJs and the Secretary will consult with the Commissioner in order to adopt procedures and policies to maintain such independence upon the transfer of the Medicare hearings function. Consistent with MMA and the Administrative Procedure Act (APA), the Secretary will establish a new organizational entity within HHS to

ensure the judicial independence of ALJs. This organizational structure will place ALJs in an administrative office that is organizationally and functionally separate from CMS. The ALJs will report to, and be under the general supervision of, the Secretary. ALJs will not report to, or be subject to supervision by, another officer of the HHS.

## **IX. GEOGRAPHIC DISTRIBUTION**

A central hearing support office will be located in the Baltimore/Washington area and will be responsible for strategic direction, liaison, budget support and human resource management of the Medicare hearings function nationally. HHS also anticipates a regional presence by creating a regionally located field structure. The size and location of this field structure will be determined after an analysis of allocation to regional sites of positions and resources, including staff, IT systems, VTC equipment, etc.

HHS intends to develop a process to determine the size and location of the field structure based on, among other considerations, its hearings workloads and origination, Medicare contractor jurisdictions, costs, and other factors that will maximize its services to its beneficiaries and providers. By the end of CY 2004, utilizing this process, a final decision will be made.

## **X. HIRING**

### **Background**

When hiring newly appointed ALJs, the law requires agencies to use the Office of Personnel Management's (OPM) ALJ register. OPM has the non-delegable statutory authority to administer the ALJ exam and establish an ALJ hiring register. In the process of preparing this plan, OPM has advised HHS and SSA of the following information regarding the status of the ALJ register. The current ALJ exam opened on a continuous basis in 1993. New ALJ applications were accepted and added to the ALJ register from September 1993 through April 1999, when the ALJ examination was suspended due to the class action litigation filed with the Merit Systems Protection Board (MSPB). The suspension was lifted briefly in early 2001, during which time OPM provided SSA with a certificate of eligibles to fill more than 120 positions, but the MSPB imposed a new stay in April 2001. That stay prevented OPM from issuing any new certificates and prevented SSA from using its certificate. OPM convinced the MSPB to briefly lift the stay in the fall of 2001 to allow SSA to use the certificate issued in March. In February 2003, the U.S. Court of Appeals for the Federal Circuit issued a decision in favor of OPM's use of the 1996 scoring formula.<sup>11</sup> As a result, the stay ceased to be operative in July 2003, and OPM reactivated the ALJ register and updated scores based on the 1996 scoring formula in August 2003. Since that time, OPM resumed processing applications that were pending during the stay (OPM is not accepting new applications except from 10-point preference eligibles), which has resulted in adding another 84 individuals to the register. In addition,

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<sup>11</sup> *Azdell v. OPM*, 87 M.S.P.R. 133 (2000), adhered to on recons., 89 M.S.P.R. 88 (2001), rev'd, *Meeker v. MSPB*, 319 F.3d 1368 (Fed. Cir. 2003), reh'g en banc denied (July 3, 2003), cert. denied, *Azdell v. Meeker*, \_\_\_ S. Ct. \_\_\_, 72 U.S.L.W. 3310, 2004 WL 368117 (U.S. Mar. 1, 2004).



eligibles already on the register were permitted to submit updated resumes for use by agencies. As of now, there are a total of 1,620 eligible candidates on the register. Another 50 plus applicants have nearly completed the process and will be added to the register. In December 2003, OPM provided SSA with a certificate of eligibles that was drawn from the existing register. SSA is currently planning to hire an additional 50 ALJs. Besides the certificate issued to SSA in December 2003, OPM has issued five other certificates to requesting agencies.

OPM is currently working on the development of a new ALJ examination. At this point, the completion date of that process is unknown. When the new ALJ examination is completed and announced, the current register will be terminated. Any individual on the existing register who wishes to remain an ALJ candidate will have to re-apply and participate in all parts of the new examination. OPM will, however, continue to use the existing ALJ register until an ALJ register based on the new exam is developed.

### **ALJ Support**

HHS plans to explore all hiring options for ALJs. Options include hiring from the existing OPM register, hiring reemployed annuitants and making selections from the existing ALJ corps. HHS will consider those judges with Medicare experience in making selections.

At the present time, OPM has committed to working closely with HHS to enable it in FY 2005 to hire an outstanding corps of ALJs from the register as well as from the alternative programs listed below.

- Hiring From Existing OPM Register  
HHS will request a hiring certificate from OPM.
- Re-employed Annuitants - "Senior ALJ Program"  
Currently there are 110 retired ALJs on the Senior ALJ Master List who are available for temporary reemployment. ALJs may be appointed part time/full time or on an intermittent basis. Because the senior ALJs would be hired under a temporary Federal appointment, then the annuitant is considered a "re-employed annuitant". While reemployed, the retired ALJs' annuities will continue, and their Federal Salaries will be offset by the annuities. (The cost to the hiring agency is the full amount of the salary.)
- Other ALJ Selections  
Sitting judges or former judges are eligible to apply. HHS must create a position description and a vacancy announcement. Job announcements will be posted for at least 30 days.

### **Support Staff**

HHS expects to carry out support staffing functions at a slightly lower level of support staff to ALJ staff, in part, because the staff will be handling only the Medicare appeals, rather than both the disability and the Medicare appeals. HHS estimates a 4:1 ratio of support staff per ALJ hired. This may include an attorney advisor, paralegal and support staff. Included in support

staff is central administrative support for the new hearing offices. This support will include, but not be limited to, personnel services, training, IT, VTC services, and the overall management of the Medicare hearings workload.

HHS plans to explore and consider all hiring options with respect to acquiring ALJ support staff, e.g. current or new full-time and part-time federal employees as well as contract employees.

## **XI. PERFORMANCE STANDARDS**

In considering the appropriateness of establishing performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII, a significant amount of research was conducted regarding the current state of the law under the APA. Based on this research, both SSA and HHS believe that under the APA an agency has the right and the duty to ensure that ALJs issue decisions in a timely manner. The issuance of timely decisions is an important agency objective and is essential to the delivery of "first class" service. The agency may establish reasonable administrative practices and programming policies that ALJs must follow, as long as the agency takes no actions which abridge, directly or indirectly, the duty of impartiality an ALJ owes the claimant when hearing and deciding cases.

Currently, ALJs are excluded from the definition of "employee," set forth in 5 U.S.C. section 4301, and this exclusion prohibits an agency from establishing performance appraisal systems for the periodic appraisal of an ALJ's job performance and using the results of performance appraisals as a basis for training, rewarding, reassigning, promoting, reducing in grade, retaining, and removing ALJs. 5 U.S.C. section 4302. The exclusion of the ALJs from the coverage of chapter 43 further supports the insulation of ALJs from agency involvement in pay, classification, and tenure decisions. However, this does not preclude an agency from considering performance deficiencies under 5 U.S.C. section 7521, and a blanket exemption of ALJs from all performance-based actions could easily erode public confidence in the appeals process. HHS v. Goodman, 19 M.S.P.R. 321 (1984).

Under 5 U.S.C. section 7521, an agency may take disciplinary action against an ALJ for "good cause." The courts and the MSPB have interpreted this "good cause" standard to include "appropriate administrative supervision . . . required in the course of general office management," so long as such supervision does not interfere with the ALJ's performance of a "quasi judicial function." Brennan v. HHS, 787 F.2d 1559, 1562 (Fed. Cir. 1986). "Good cause" may be based on performance, or unacceptably low productivity, and it is not unreasonable to expect that ALJs will perform at a minimally acceptable level of efficiency. Nash v. Bowen, 869 F.2d 675, 681 (1989).

The tribunals have consistently held that agencies have broad authority to establish and enforce substantive and procedural standards for its ALJs, so long as the agency takes no actions to compromise an ALJ's ability to act as an impartial arbiter in a particular case or class of cases. Sannier, 931 F.2d 856, 858-859 (Fed. Cir. 1991); Goodman v. Svahn, 614 F.Supp. 726, 730 (1985); HHS v. Manion, 19 M.S.P.R. 298, 303 (1984).

In light of the established timeframe for processing appeals mandated by BIPA and MMA, it is important that ALJs adhere to the new timeframe when processing appeals. Medicare beneficiaries have a right to expect that their disputes will be adjudicated accurately, fairly, reliably and timely. It is also important that all levels of the appeals process operate in an efficient manner to meet the needs of Medicare beneficiaries. HHS will continue to work with the appropriate bodies to ensure any steps we take facilitate adherence to BIPA timeframe and do not interfere with the impartiality of ALJs.

## **XII. SHARED RESOURCES**

The agencies agree to consider opportunities for sharing resources consistent with the efficient and effective accomplishment of each agency's mission. One such resource sharing opportunity involves the use of VTC. HHS recognizes the potential benefits of using VTC in its delivery of service to Medicare appellants. In order to provide increased access to appellants and their representatives, HHS intends to use VTC hearings to the greatest extent possible. SSA is aggressively expanding its network of VTC equipment to improve the efficiency of its hearings process and to meet increased demands for future service. SSA has offered the use of its VTC network, which is being expanded to over 278 sites through FY 2006. If HHS uses this service, SSA will charge HHS on a per hearing actual cost basis, including the cost of contract hearing monitors, digital recording equipment and joint scheduling software. SSA will have priority for use of VTC facilities, but will accommodate HHS requests based on availability. If HHS uses the VTC facilities, HHS and SSA will enter into a reimbursable agreement setting forth the terms for shared use.

SSA and HHS will also work to develop a joint case tracking capability to facilitate the orderly transition of workload, movement of case files, and provision of accurate information to appellants about their cases. If additional shared resource opportunities are identified and agreed upon by the parties, SSA and HHS will enter into reimbursable agreements setting forth the terms for shared use and the amount of any reimbursement.

## **XIII. TRAINING**

HHS recognizes that a structured and well-defined training plan is essential to the successful administration of its programs. In order to fully and successfully implement the transition of the ALJ function from SSA, HHS must design and develop a comprehensive training plan that is structured to meet the unique needs of ALJs and their appeals support staffs.

Initial and ongoing training will be structured and delivered in a manner that will facilitate learning and promote a greater understanding of the practices and principles of the Medicare program and the adjudicative process. To address Medicare coverage, operational and process issues, HHS is developing short and long-term strategies to provide training, improve decisional accuracy, and accountability at every step in the process. HHS' short-term ALJ training strategy consists of four major elements. The elements are:

- ALJ Hearings Adjudication Procedures – will provide a comprehensive review of the HHS appeals process, applicable statutory and regulatory authorities, and the process and procedures associated with conducting an administrative hearing, including procedural considerations such as due process, the rules of evidence and their applicability to the proceeding, the admission and treatment of evidence, and the writing/drafting of administrative decisions.
- ALJ Claim Review – will focus on technical Medicare billing issues, including reading billing documentation, medical records, coding procedures, bundling, sampling, and waiver of liability.
- Medicare Program and Coverage Issues – will focus on Medicare payment and coverage issues. Specifically, this training will focus on fee-for-service payment and coverage issues for each Medicare provider type, Medicare Advantage payment and coverage policies.
- Workload Management and Administrative Procedures – will provide ALJs with information regarding workflow management, research, decision writing, privacy issues, including HIPAA, and other operational and procedural matters.

While HHS is concentrating on developing and implementing the short-term training strategy in FY 2005, it also recognizes the need for ongoing and focused ALJ training once the transition occurs.

#### **XIV. ADDITIONAL INFORMATION**

At this time, neither the Secretary nor the Commissioner anticipates a need for changes to, or modifications of, current statutory requirements associated with the Medicare hearings process.

#### **XV. CONCLUSION**

This report describes the commitment of SSA and HHS to work together to ensure a smooth transition and an efficient and effective appeals process. The actions described in this plan will serve well the present and future Medicare beneficiaries and the public.

The Secretary and the Commissioner look forward to receiving comments from the Congress and GAO on this plan and pledge to work cooperatively to achieve the goals established by the Congress in the MMA.

#### **XVI. APPENDICES**

Appendix A—Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, 117 Stat. 2066 (2003), Section 931.

Appendix B— Memorandum of Understanding entered into between the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) and the Social Security Administration, effective March 31, 1995.

Appendix C—Supplemental Memorandum of Understanding entered into between the Department of Health and Human Services and the Social Security Administration, effective October 20, 1995.

Appendix D—Reimbursable Agreement entered into on December 3, 2003, between the Department of Health and Human Services and the Social Security Administration.

# **APPENDIX A**

## Subtitle D--Appeals and Recovery

### SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

#### (a) TRANSITION PLAN-

(1) IN GENERAL- Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS- The plan shall include information on the following:

(A) WORKLOAD- The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING- Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan.

(C) TRANSITION TIMETABLE- A timetable for the transition.

(D) REGULATIONS- The establishment of specific regulations to govern the appeals process.

(E) 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.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY- The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES- The feasibility of--

- (i) filing appeals with administrative law judges electronically; and
- (ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES- The steps that should be taken to ensure the independence of administrative law judges consistent with the requirements of subsection (b)(2).

(I) GEOGRAPHIC DISTRIBUTION- The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to carry out subsection (b)(3).

(J) HIRING- The steps that should be taken to hire administrative law judges (and support staff) to carry out subsection (b)(4).

(K) PERFORMANCE STANDARDS- The appropriateness of establishing performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act taking into account requirements under subsection (b)(2) for the independence of such judges and consistent with the applicable provisions of title 5, United States Code relating to impartiality.

(L) SHARED RESOURCES- The steps that should be taken to carry out subsection (b)(6) (relating to the arrangements with the Commissioner of Social Security to share office space, support staff, and other resources, with appropriate reimbursement).

(M) TRAINING- The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION- The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act).

(4) GAO EVALUATION- The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY-

(1) IN GENERAL- Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES- The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another officer of the Department of Health and Human Services.

(3) GEOGRAPHIC DISTRIBUTION- The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY- Subject to the amounts provided in advance in appropriations Acts, the Secretary shall have authority to hire administrative law judges to hear such cases, taking into consideration those judges with expertise in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.



(5) FINANCING- Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES- The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT- In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to--

- (1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);
- (2) improve education and training opportunities for administrative law judges (and their staffs); and
- (3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT- Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking 'of the Social Security Administration'.

# **APPENDIX B**

**MEMORANDUM OF UNDERSTANDING**  
**BETWEEN**  
**THE SOCIAL SECURITY ADMINISTRATION**  
**AND**  
**THE HEALTH CARE FINANCING ADMINISTRATION**  
**FOR**  
**PROGRAM COORDINATION AND COOPERATION**

**MEMORANDUM OF UNDERSTANDING  
BETWEEN  
THE SOCIAL SECURITY ADMINISTRATION  
AND  
THE HEALTH CARE FINANCING ADMINISTRATION**

**Article I**

**Introduction and Purpose**

The Social Security Administration (SSA) and Health Care Financing Administration (HCFA) are responsible for administration of national programs authorized by the Social Security Act to provide a comprehensive package of health, retirement, disability, assistance and death benefits to the nation's elderly and disabled citizens, their entitled dependents and survivors. HCFA's responsibilities include the Medicaid Program and the Medicare Program -- the latter consisting of both Hospital Insurance and Supplementary Medical Insurance protection (HI/SMI). SSA's responsibilities include the Supplemental Security Income Program and the Social Security Program -- the latter consisting of both Old-Age and Survivors Insurance and Disability Insurance protection (OASI/DI).

Because of the close programmatic linkages between the OASI/DI and HI/SMI programs and the SSI and Medicaid programs, SSA and HCFA have historically coordinated program administration to maximize efficiency and effectiveness. Many individual agreements document interagency cooperation and relations. With the enactment of Public Law 103-296 making SSA an independent agency effective March 31, 1995 and HCFA's relocation to a new facility away from the jointly shared Woodlawn complex, both Agencies agreed to reexamine their roles, responsibilities and relationship for the future.

This memorandum of understanding (MOU) documents the results of that examination and serves as an umbrella agreement between SSA and HCFA that will guide employees of both Agencies in working cooperatively in the future to maximize program efficiency, effectiveness and service to the public. It demonstrates a mutual commitment to deliver quality services to the beneficiaries of all programs administered by the two Agencies. This MOU also satisfies the quality of service requirements specified in Section 704 (e)(2) of the Social Security Act, enacted by Section 104 of Public Law 103-296, "The Social Security Independent Agency and Program Improvements Act of 1994."

All prior agreements between HCFA and SSA are hereby superseded unless incorporated by reference.

## Article II

### Definitions

- A. "HCFA" is the Health Care Financing Administration; an Operating Division in the Department of Health and Human Services (DHHS).
- B. "Medicaid" is the Federal-State medical assistance program for needs-based recipients established by title XIX of the Social Security Act and funded from General Fund appropriations to HCFA.
- C. "Medicare" is the Federally administered health care program for insured individuals established by title XVIII of the Social Security Act and funded from the Hospital Insurance and Supplementary Medical Insurance Trust Funds.
- D. "OASI/DI" refers to the Old Age and Survivors Insurance and Disability Insurance programs (also referred to as the "Social Security" programs) established by title II of the Social Security Act and funded from the OASI/DI Trust Funds.
- E. "SSA" is the Social Security Administration; formerly an Operating Division in DHHS but established as an independent agency effective March 31, 1995 by Public Law 103-296.
- F. "SSI" is the Supplemental Security Income program for needs-based recipients established by title XVI of the Social Security Act and funded from General Fund appropriations to SSA.

### Article III

#### Primary Agency Responsibilities

- A. SSA's primary mission is to pay monthly cash benefits directly to about 50 million individuals entitled to or eligible for OASI/DI and SSI entitlements. To accomplish its primary mission, SSA assigns social security numbers (SSNs) to the public, provides them a SSN card and Personalized Earnings and Benefit Estimates Statements, maintains their lifetime earnings records to determine eligibility and trust fund revenues, processes claims for benefits, holds hearings and appeals on award or denial decisions and maintains beneficiary rolls to, among other reasons, verify continuing eligibility and initiate recurring monthly benefit payments. In executing its basic responsibilities, SSA also performs functions in support of the Medicare and Medicaid programs and HCFA itself. These responsibilities are described in this MOU under each subject matter area.
- B. HCFA's primary mission is to assure health care security for 70 million beneficiaries through the administration of the Medicare program and the Federal aspects of the Medicaid program. HCFA's nationwide staff establishes policies to govern these programs and coordinates program activities with partners and stakeholders outside the Agency to enhance its ability to meet the needs of its customers. In the Medicare program, HCFA enters into contracts and agreements with Medicare fiscal intermediaries and carriers, State survey agencies, Peer Review Organizations, and the direct premium billing contractors. In the Medicaid program, HCFA approves the Medicaid State plans, oversees their implementation by the Medicaid State Agencies, and matches State expenditures for program administration and medical assistance to low income recipients. Hospital, physicians, and other providers and suppliers of covered services submit claims on behalf of beneficiaries and recipients to the Medicare fiscal intermediaries and carriers, and to the Medicaid State agencies or their fiscal agents. These entities process and pay claims with funds supplied by HCFA, (in the case of Medicaid, on a matching basis).

## Article IV

### Coordination of Strategic Planning, Legislation, Regulations and Instructions

#### Purpose

This article outlines the approach for SSA and HCFA to coordinate their strategic planning and legislative programs including responses to legislative proposals initiated by third parties. It also outlines the development of regulations, manuals and other instructional materials used by both Agencies in support of their programs.

#### Strategic Planning

Strategic plans outline the role of each Agency's programs in the future and the vision for delivering service to the public in that environment. SSA and HCFA agree to share their strategic plans, updates thereto and supporting planning documents as may be appropriate. SSA's Executive contact point for this purpose in the Office of the Commissioner is the Director, Office of Strategic Management. HCFA's Executive contact point is the Associate Administrator for Operations and Resource Management. SSA and HCFA agree to satisfy Quality of Service Report requirements of section 704 (e)(2) of the Social Security Act. Service delivery objectives shall be jointly developed and consider the views of HCFA's customers and stakeholders and the cost implications of identifying actual performance. Both Agencies must agree on the service delivery objectives and the precise formulae to be used to compute performance. Appendix B describes the Quality of Service reporting process. SSA's Executive contact point for customer service delivery objectives is the Chief Policy Officer.

#### Assessments of Proposed Legislation

Because legislative proposals for one Agency's programs can have a material, sometimes unforeseen impact on the other Agency's programs, both HCFA and SSA, agree that close coordination and cooperation is necessary. This shall be accomplished as follows:

- o SSA's Office of Legislation and Congressional Affairs (OLCA) and HCFA's Office of Legislative and Inter-governmental Affairs (OLIGA) will serve as the focal points for legislative proposals. To ensure early collaboration and communication in the legislative process, each respective office agrees to routinely keep the other office informed of potential legislative proposals which may be of interest to the other Agency.
- o SSA's OLCA will function as the SSA focal point to provide HCFA with SSA's assessments of legislative proposals. The Director of OLIGA will serve as the HCFA focal point and provide any and all HCFA requests for SSA assessments of proposed legislation to SSA's Deputy Commissioner for Legislation and Congressional Affairs. Any SSA requests for HCFA assessments of proposed legislation will flow through the same SSA and HCFA officials.

- o SSA's OLCA will obtain any and all input from SSA components when responding to HCFA requests and provide OLIGA the requested assessment(s). When making requests for HCFA assessments of proposed legislation, SSA's OLCA will make every effort to:
  - (1) provide HCFA with sufficient lead time to conduct a complete assessment; and
  - (2) provide as much specific information as possible to facilitate HCFA's legislative assessment.
- o OLIGA will serve as the HCFA focal point for all HCFA requests for SSA assessments of proposed legislation. In making such requests, HCFA will make every effort to:
  - (1) provide SSA with sufficient lead time to conduct a complete assessment; and
  - (2) provide as much specific information as possible to facilitate SSA's assessment. When responding to SSA requests for HCFA assessments of proposed legislation, HCFA's Director of Legislative and Inter-Governmental Affairs will obtain any and all input from the appropriate HCFA components and provide SSA's OLCA with the requested assessment(s).
- o Such SSA/HCFA requests for legislative assessments will include proposals developed for the annual legislative program submission to OMB, requests from Congressional Committees and other ad hoc requests. Where necessary, appropriate and feasible, such SSA and HCFA assessments will include Actuarial estimates (e.g., program cost and caseload) and administrative cost estimates.
- o Both parties recognize that the timeframes imposed by Congress for such assessments can sometimes be minimal and the information limited. Notwithstanding the foregoing, both parties agree to put forth a good faith effort to provide whatever assessments are feasible within the parameters of a given request.

#### Implementation of Enacted Legislation and Regulations

Successful implementation of enacted legislation which impacts both SSA and HCFA programs requires close coordination and cooperation. This shall be accomplished as follows:

- o SSA's Office of Program Policy Evaluation and Communications (OPPEC) will function as the SSA focal point to coordinate SSA implementation of enacted Medicare and Medicaid legislation affecting SSA's delivery of Medicare and Medicaid services to beneficiaries. Such implementation will include the development of appropriate implementing regulations. HCFA's Executive Secretariat (EXEC SEC) will serve as the HCFA focal point and provide any and all HCFA requests for development of implementation plans for enacted Medicare and Medicaid legislation to the Deputy Commissioner for Program Policy, Evaluation and Communications (DCPPEC).
- o SSA's DCPPEC will work with all SSA components and coordinate the development and execution of implementation plans for such legislation. Such implementation plans will include but not be limited to:
  - development, clearance and publishing of implementing regulations;
  - development of systems and procedure changes;



- preparation of operating instructions and forms;
- any other changes in SSA's business processes to achieve implementation; and
- development, clearance and scheduling of notice language.

DCPPEC will ensure that HCFA input is provided to appropriate SSA components to facilitate the implementation process and ensure quality service to Medicare and Medicaid beneficiaries. DCPPEC will take necessary measures to facilitate HCFA participation in the implementation process by sharing appropriate implementation plans, inviting HCFA staff to meetings and calling ad hoc meetings with appropriate SSA components and HCFA to discuss HCFA and SSA concerns. SSA's DCPPEC and HCFA's Office of Regulations are the Agencies' focal points for regulatory activity. Each of these offices will coordinate any proposed regulation with its counterpart organization whenever such regulation presents a potential impact on the opposite Agency's operations and policies.

o HCFA's Exec Sec will provide timely, accurate input to SSA's DCPPEC on such legislation in order to facilitate development of implementation plans that result in quality service to Medicare and Medicaid beneficiaries. The Exec Sec will:

- Manage the development of input from all HCFA components, contractors and relevant State Agencies and serve as the single HCFA contact point with SSA on these matters.
- Ensure that appropriate HCFA components, contractors, and relevant State Agencies are involved in: (1) review of SSA implementation plans; and (2) attendance at general and ad hoc meeting to discuss implementation.
- Ensure that HCFA components provide appropriate responses to questions and requests for information from SSA. All such requests should flow through the SSA and HCFA officials designated in this subarticle.

Both parties agree that the implementation of enacted legislation is an important function. Both parties agree to be responsive to the other within the framework of the process described in this subarticle. Both parties recognize that SSA must balance the quality of service delivery for all programs it delivers to its beneficiaries within the resources available to SSA. Within these parameters, the parties agree to work cooperatively to implement legislative changes in a manner that ensures delivery of quality service to beneficiaries of programs in both Agencies.

#### Development and Implementation of Instructions

SSA publishes a comprehensive set of instructions for its central, regional and field operations staff known as the Program Operations Manual System (POMS). Most Parts of the POMS contain instructions that SSA staff needs to know about Medicare. Medicare sections of the POMS are written or cleared by HCFA and constitute SSA's written instructions on the operations of the Medicare program in SSA. There are also instructions affecting Medicare program operations in the Modernized Systems Operations Manual (MSOM), the Teleservice Center Operating Guide (TSOG), and the Hearings, Appeals and Litigation Law Manual

(HALLEX) and other issuances on appeals related matters. The SSI income, disability and resources chapters of the POMS contain information which is important to the administration of the Medicaid program. HCFA Regional Offices and Medicaid State Agencies rely on these sections of the POMS. They rely upon ongoing timely receipt of POMS transmittals and policy changes involving these sections. SSA will provide POMS to all HCFA Regional Offices and HCFA Central Office as needed.

HCFA will update and maintain those sections of the POMS for which it is responsible and request SSA clearance of any SSA notices in those POMS sections. SSA will continue to involve HCFA in any revisions to Medicare sections of the POMS, MSOM, HALLEX or TSCOG. If SSA restructures its manuals, it will involve HCFA in any manual issuances which affect the Medicare or Medicaid programs. HCFA will be responsive and provide timely input and clearance. HCFA will inform SSA timely about Medicare policy and procedural changes that may affect SSA. HCFA will provide SSA clear, concise, and up-to-date policy and procedural instructions (POMS) and notice language about the Medicare Program for use by SSA employees. HCFA will provide timely interim policy and procedural instructions on legislative changes pending the release of POMS instructions. These instructions will be incorporated into the POMS on a timely basis. An SSA/HCFA workgroup will coordinate the update of the Health Insurance chapter of POMS which is prepared by HCFA.

SSA will continue to develop, publish and issue systems procedures for SSA systems that support the Medicare and Medicaid programs (initial claims and post-entitlement processes) for the SSA field components. Specifically, this relates to the processes developed by and maintained by SSA such as Post Entitlement Premium Payment and Enrollment (PEPPER), Third Party Annotation Operation (TPAO), etc... HCFA will provide timely review and comment relative to all systems procedures and instructions and provide supportive input as necessary.

In addition, SSA and HCFA ROs jointly develop and issue program circulars (PCs) and regional supplements to POMS on various Medicare and Medicaid topics. These can be informational and instructional material or clarification of a Medicare policy issue. As appropriate, SSA and HCFA may continue to develop regional circulars or POMS on various Medicare and Medicaid topics. SSA will clear PCs, POMS and any other Medicare-related documents through the HCFA RO and, where appropriate, HCFA central office.

When SSA becomes independent on 03/31/95, both Agencies will continue the current arrangement of cooperation and coordination of POMS and other operating instructions. This close interagency coordination will continue and be unaffected by HCFA's move to its new site. SSA will continue to provide this service at no charge if volumes required by HCFA remain relatively unchanged or decrease.

#### Development of Notices

SSA and HCFA issue a variety of notices to beneficiaries, and their responsibilities for these notices are interrelated. SSA notices have an SSA letterhead; HCFA notices have a HCFA

letterhead, but are often produced and mailed by SSA computer systems or operational components. In addition, some SSA notices include language that requires HCFA policy decisions and/or input, or require joint HCFA/SSA development.

SSA has a strategic plan for notice improvements called Access 6.1, Accelerate Notice Improvements. This plan is separate from the USA Automated Data Processing (ADP) plan. The Access 6.1 schedule includes many projects that involve major changes to SSA computer systems, including those that produce some HCFA notices. As these systems are modernized, the notice language must be revised and improved. This work is scheduled by the Access 6.1 Steering Committee (SC). In addition, all other notice language that is developed or revised must also be scheduled by the SC. SSA and HCFA will both fully participate in SC scheduling and decision-making process.

SSA notices must meet the SSA Notice Standards—certain format and readability criteria—and are subject to the SSA approval process. All language to be included in SSA notices will continue to be subject to the Standards and the approval process. Although HCFA notices are not subject to these same requirements, HCFA will obtain SSA input on all HCFA notices to be sent to SSA beneficiaries.

## Article V

### Medicare Program

#### Purpose

This article of the MOU sets forth the specific activities and responsibilities of both SSA and HCFA with respect to the Medicare program. It outlines existing services each Agency performs for the other and replaces all previously negotiated MOUs and reimbursable agreements executed by SSA and HCFA for the Medicare program except as listed in appendix A. The latter are subordinate to this umbrella MOU. Where there is conflicting language between this MOU and any previous agreement, this MOU will take precedence. All reimbursable agreements listed in appendix A must be renewed annually for purposes of establishing funding levels and recording obligations for the new fiscal year.

#### Specific Medicare Program Functions Performed by SSA

Currently, approximately 1,300 SSA field offices (FOs), teleservice centers and processing centers are the first point of contact for current and future Medicare beneficiaries. SSA personnel will continue to perform eligibility determinations for Medicare and assist with post eligibility functions closely allied with SSA's OASI/DI operations. As described in article IV, Development and Implementation of Instructions, detailed policy and operating procedures shall be incorporated in the POMS. Until POMS have been brought up to date, and thereafter, SSA will not change current operating procedures on Medicare issues without consulting HCFA. Both Agencies agree to collaborate to maximize program integration and the efficiency of program operations. Any functional transfers between the two Agencies shall be accompanied by resource transfers.

HCFA will continue to have periodic meetings with SSA operational liaisons, however, the SSA Executive contact point for negotiating changes in operating policies and procedures with respect to SSA's role in the Medicare program is the Associate Commissioner for ORSISSIP. That executive also will provide to HCFA updated policy information on changes in OASI/DI entitlement and eligibility factors.

1. Enrollment Functions -- SSA will continue to perform the full range of activities related to the initial enrollment of Medicare beneficiaries during appropriate enrollment periods (initial, general or special). These activities include:
  - o Automatic enrollments -- Enrollment of OASI beneficiaries who are 64 and 8 months or in the 21st month of disability cash benefits and are currently entitled to OASI aged or disability benefits based upon OASI/DI claims previously filed and adjudicated by SSA.

- o State Buy-in-Enrollments of SMI for eligible title XVI recipients who reside in States with section 1634 agreements with SSA.
- o Initial filing cases -- Enrollment of aged, disabled or end stage renal disease (ESRD) beneficiaries who have never established any entitlement to Medicare or OASI/DI benefits or are filing a new claim after prior entitlement using certain processes and requirements common to all programs.
- o Notification of eligibility -- Monthly identification and notification of potential entitlement to Medicare for Puerto Rican, foreign and working disabled beneficiaries. Performing activities that will enable these beneficiaries to enroll in Medicare.
- o Medicare enrollment cards and notices -- SSA presently prints and mails enrollment card packages, notices and other Medicare-related beneficiary mailings. There currently are about 11 such beneficiary directed mailings. SSA and HCFA both agree to work together to convert this printing and mailing operation to a contract printing and mailing with HCFA serving as the project officer, effective October 1, 1996, or earlier if both Agencies agree. In the event that the Government Printing Office delegates contracting officer responsibilities, then HCFA would assume this role as well.

SSA will transfer budgetary resources coincident with the transfer of functions. Adjustments will be made as necessary to HCFA and SSA appropriation requests to accomplish this functional and resource transfer. SSA also agrees to provide HCFA with the appropriate level of technical assistance needed to enable HCFA to assume the project officer responsibility. SSA systems will continue to produce the data needed by the contractor to prepare the printing and mailings and to resolve any issues arising with the data provided to the contract printer.

2. Post-entitlement Functions -- SSA will continue to provide post eligibility support in order to provide updated Medicare information and continuing eligibility information. Post eligibility support includes but is not limited to the following:
  - o Maintaining entitlement and eligibility information and passing the information to HCFA to keep Medicare records updated and current.
  - o Processing voluntary requests for termination of medical (and/or premium hospital) insurance coverage.
  - o Taking, developing and processing requests (after initial filing) for enrollment during the initial, general or special enrollment periods.
  - o Replacing lost or stolen Medicare cards as provided in paragraph 1 above.

- o Developing and resolving date of death discrepancies involving SSA records.
- o Withholding Medicare reimbursement overpayments from OASI/DI benefits.
- o Maintaining folders or electronic equivalent for Medicare beneficiaries.
- o Resolving certain ESRD discrepancies
- o Notifying States through the State data exchange when title XVI eligibility is lost so that States may determine if a redetermination of State buy-in is appropriate.

SSA and HCFA will continue to review post entitlement workloads to determine the best methods for processing these workloads in the future.

3. Ethnicity/Race Data -- SSA presently performs extract operations to gather ethnicity/race data from Numident and to periodically provide such information to HCFA. This is done pursuant to an agreement with HHS as a result of a court settlement. SSA will continue the data extraction and periodic operations that have been already agreed to and will continue to provide HCFA with ethnicity and racial information that is already resident in the SSA records.
4. Premium Billing Functions -- SSA will continue to perform appropriate support activities associated with the collection of Medicare premiums including coordinating the premium deduction activity with HCFA's direct premium billing operation.
5. Medicare Inquiries and Referrals -- SSA will continue to answer questions on appropriate aspects of the Medicare program and will handle appropriate Medicare referrals. SSA and HCFA will work together to determine how to best route to HCFA, Medicare inquiries that are HCFA's jurisdiction.
6. Entitlement Issues -- SSA will recognize potential entitlement issues resulting from bill denials and will refer them to the appropriate location for correction. Actual resolution of entitlement issues involving correction to the Enrollment Database or correction to the Common Working File will be completed by HCFA. Resolution of entitlement issues which result from incorrect data on the MBR or other SSA controlled data bases will be completed by SSA.
7. Managed Care Activities -- SSA will handle appropriate requests for HMO disenrollments, inform beneficiaries about their two choices (to choose Medicare fee-for-service or a Medicare approved HMO), make appropriate referrals, respond to general inquiries, and maintain lists of approved Medicare HMOs provided by HCFA.

8. Continuing Disability Reviews -- SSA will perform continuing disability reviews for Medicare qualified beneficiaries who have been terminated from disability insurance benefits for substance abuse and for Medicare Qualified Government Employees, widow(er)s over age 60 entitled to Medicare, working disabled beneficiaries entitled to premium-Hospital Insurance, and initial disability determinations where a disability beneficiary reentitled 5 years after cessation is attempting to have the 24-month waiting period waived.
9. Medicare Hearings and Appeals -- SSA will continue to process Medicare entitlement/entitlement-related issues at all levels (initial, reconsideration, hearing, etc.). SSA will also continue to process requests for hearing by an Administrative Law Judge (ALJ) on Medicare entitlement/entitlement-related issues and Medicare coverage, claims reimbursement, and denial of service issues. These requests for an ALJ hearing may be filed with HCFA (including its Medicare contractors), SSA, or (in the case of qualified railroad retirement beneficiaries) with the Railroad Retirement Board (RRB). SSA will perform all functions necessary to process these hearings requests, including (but not limited to) developing the record, holding hearings and issuing ALJ decisions/dismissals. SSA and HCFA are committed to further discussions regarding the potential transfer of this Medicare ALJ function to HHS. Discussions will continue on the timing of the potential transfer of the Medicare hearings function and related resources.

SSA will, for the immediate future, continue to perform all functions necessary to process requests for Appeals Council review of ALJ decisions/dismissals, Agency protests of ALJ decisions/dismissals, new court cases and court remands relating to Medicare entitlement/entitlement-related issues and Medicare coverage, claims reimbursement and denial of service issues. Activities necessary to the transfer of the Medicare Appeals Council and litigation support functions to HHS are in process. Transfer of the Appeals Council and litigation support functions and related resources will occur as soon as possible. Separate memoranda of understanding will be drawn up to address the specifics of this transfer.

SSA and HCFA will develop a procedure for HCFA input and clearance on Medicare policy issues; the necessary procedures will be developed within 6 months of the date this MOU is signed. SSA OHA will retain final clearance authority for internal adjudicative procedures related to Medicare appeals.

SSA's Office of Hearings and Appeals (OHA) will meet periodically with HCFA's Bureau of Policy Development (BPD) and Bureau of Program Operations (BPO) to ensure on-going SSA and HCFA communication and involvement in the Medicare Appeals Process.

10. Systems Support -- SSA will provide systems support services to HCFA to facilitate Medicare program administration as outlined in article VIII of this MOU.

11. Workload Data -- SSA will provide workload data on SSA's Medicare workloads to assist HCFA in monitoring and planning work. The SSA and HCFA points of contact for Medicare issues will agree to a list of data to be reported by September 1 of each year for the following fiscal year. This information will be limited to data which is already collected by SSA's internal workload reporting and measurement systems. HCFA will provide projected workload data for SSA's use in planning and monitoring work.

#### Specific Medicare Program Functions To Be Performed by HCFA

The HCFA Executive contact point for coordination of the following HCFA Medicare-related responsibilities with SSA is the Director, Bureau of Program Operations.

1. Premium Billing Functions -- There is a need for improved SSA/HCFA/OPM coordination for deducting part B premiums from Civil Service Annuities. HCFA and SSA will continue to work with OPM to improve its process and timeframes for initiating OPM premium deductions.
2. Reports on Voluntary Withdrawal of Medicare Claims -- HCFA will provide Part A and Part B payment information to SSA as required to process voluntary withdrawals of Medicare claims.
3. HCFA Surveys -- HCFA will notify SSA at least 30 days in advance of any upcoming survey questionnaires to enable SSA to handle any inquiries it subsequently receives about the survey and its authenticity.
4. Medicare Handbook -- HCFA will issue the annual updated English and Spanish versions of the Medicare Handbook and provide them to SSA by January 1 of each year or as soon thereafter as possible.
5. Judicial Orders -- Defining exact needs to meet requirements of judicial orders, conveying those requirements timely to appropriate SSA staff, and monitoring the timeliness of SSA assistance in meeting those requirements. HCFA will be responsible for providing, on a timely basis, SSA OHA with the Secretary's position on the implementation of any judicial orders or agreements resulting from Medicare-related litigation.

#### Regional Office and Field Office Working Relationships

1. SSA/HCFA Regional Relationships -- The SSA and HCFA Regional Offices (ROs) have a good working relationship which is expected to continue after the transition. SSA ROs handle critical Medicare-related inquiries from FOs and the public on entitlement,



premium billing and collection and HMO disenrollments issues, and take appropriate action. They serve as liaisons between the HCFA ROs and SSA and HCFA central offices for issues that cannot be resolved within SSA or at the regional level.

SSA and HCFA ROs will continue to coordinate activities at the regional level in areas of mutual concern. These staffs will continue to work together to resolve issues at the regional level. Issues that cannot be handled within the region will be referred to central office for necessary action.

2. **Medicare Contractors** -- HCFA will ensure that Medicare contractors are responsive to beneficiary inquiries in a timely and accurate fashion. HCFA and its contractors are responsible for responding to claims specific inquiries including those related to denial of claims and coverage issues.

HCFA ROs monitor the performance of Medicare contractors. When SSA ROs or FOs receive complaints from the public about a Medicare contractor, they will refer the complaint to the HCFA RO for necessary action. HCFA will develop and with SSA concurrence publish procedures for SSA to refer complaints about Medicare contractors.

HCFA currently provides Medicare contractors updated information to process Medicare claims through the common working file. The common working file does not contain address information so HCFA will ensure that this feature is added to the future Medicare Transaction System.

After notice of a pending request for ALJ hearing, appropriate Medicare contractors will prepare a case file. The Medicare contractors or HCFA ROs will assist ALJs in developing additional evidence controlled by HCFA or its contractors.

Medicare contractors will continue to handle Medicare Secondary Payer inquiries and problems. SSA will refer beneficiaries to the appropriate Medicare contractor if they receive an inquiry in this area.

3. **Problem Referral and Resolution** -- HCFA will promptly handle and correct problems related to:
  - Medicare Enrollment Database (except those for which SSA is responsible under article V, item 1, "Enrollment Functions.")
  - Common Working File
  - State buy-in
  - Congressional or public inquiries that SSA cannot or should not address (e.g., Medicare policy or legislation)
  - HMOs
  - MSP problems

SSA ROs and FOs will refer problems to the HCFA ROs. HCFA ROs will refer cases to SSA ROs for correction as appropriate. SSA and HCFA will explore developing an electronic means of referring problem cases between the Agencies to ensure accurate and timely responses to beneficiaries. HCFA will provide timely responses on issues referred by SSA and beneficiaries.

4. **Public Information** -- SSA will continue to stock, display and distribute HCFA public information materials and publications, such as the Medicare Handbook. HCFA will ensure that the publications are current.

SSA publishes for HCFA and SSA use, a number of Medicare specific letters and pamphlets, and monthly public information material used in local SSA offices in public information outreach. Most offices include Medicare information in their public information activities--speeches, pre-retirement seminars, media releases, etc. HCFA ROs and local SSA offices will continue to assist each other in outreach activities. SSA will ensure that the information it publishes is cleared by appropriate HCFA personnel.

HCFA will provide SSA with appropriate public information material such as videotapes, slide presentations, and questions and answers. Depending on resources and the local managers' discretion, SSA will continue to assist HCFA in public information activities. Because of heavy SSA workloads and staffing shortages, SSA staff may not always be available for Medicare public information activities.

HCFA will use available resources to address public information and outreach needs (e.g., speakers from HCFA-funded counseling services and Medicare contractor representatives).

5. **Training** -- HCFA is committed to the training of SSA service representatives on the Medicare program and will develop appropriate materials. HCFA regional office staff will participate in such training and provide necessary support to the extent possible.

## Article X

### Financial Arrangements

#### Purpose

This article describes the procedures for funding costs when one Agency provides services in support of the other Agency or its programs.

#### General Funding Policy

Incurred costs will be charged to the benefitting programs or Agency. Except where specifically authorized by law and by mutual consent, this shall be accomplished by SSA and HCFA reimbursing the other for services rendered. For joint ventures such as shuttle service, each Agency will fund its appropriate share of the venture's costs.

#### Medicaid Program Funding Policy

HCFA shall seek direct appropriations to fund the Federal share of all Medicaid program costs including administrative expenses. For all Medicaid-related work performed by SSA, HCFA shall directly reimburse SSA for all costs incurred. To the extent appropriate and necessary, HCFA shall recover the States' share of SSA's Medicaid-related costs by offsetting grant awards to States. Specific terms and conditions shall be documented in reimbursable agreements executed annually.

#### Medicare Program Funding Policy

HCFA shall seek direct appropriations to fund Medicare-related administrative costs including ad hoc services requested of SSA, costs of functions transferred from SSA by mutual consent and costs of new Medicare-related work required by statute or mutual consent.

SSA shall seek direct appropriations to fund all of its basic business functions including Medicare-related functions SSA previously agreed to perform on a continuing basis. The principles for SSA funding of Medicare-related work follow:

- o If SSA already is budgeting, performing and funding a function from its appropriation, that practice will continue until HCFA and SSA mutually agree to revise the approach.
- o If HCFA identifies new or expanded functions which SSA agrees to perform, HCFA will directly reimburse SSA for the new or expanded work activity.

- o If a new Medicare function is explicitly assigned to SSA in law, HCFA will directly reimburse SSA for the new or expanded work activity, unless Congress provides appropriations directly to SSA for these purposes.

The Social Security and Medicare programs have been deliberately designed to be highly integrated for maximum administrative flexibility. This integration eliminates the need for costly, duplicative administrative organizations and activities and also reduces the burden on beneficiaries of these programs. For example, SSA issues new and replacement Social Security numbers which are a common identifier for OASI/DI and HI/SMI purposes. SSA processes annual wage reports and maintains individuals' lifetime earnings records used for revenue and entitlement determinations in both Agency's programs. SSA's claims process determines both eligibility for OASI/DI benefits and supports Medicare enrollment. In other cases, SSA does work solely for Medicare such as take Medicare-only applications, make disability determinations for retired Federal employees entitled only to Medicare and answer Medicare inquiries. Article V describes SSA's support role in greater detail.

In recognition of this integrated approach to program delivery, section 201(g) of the Social Security Act permits SSA to obtain a single trust fund appropriation to fund the costs to administer the OASI/DI, SSI and HI/SMI functions. It also requires a cost analysis system to determine the portion of costs actually incurred each year by SSA that should be borne by the general fund for SSI and each trust fund for OASI, DI, HI and SMI. SSA's charges to each program are made accordingly.

SSA and HCFA agree to perform a joint examination of the most appropriate methodology which could be used to determine the costs to be borne by the Medicare trust funds for Medicare-related functions performed by SSA. The results of the joint review shall be reported to the Senate Finance Committee and House Ways and Means Committee by August 15, 1997. In the event that HCFA and SSA cannot agree on cost allocation methodology, any issue(s) shall be submitted to the Federal Accounting Standards Advisory Board or the Office of Federal Financial Management, OMB for decision.

The SSA Executive contact point to negotiate changes in financial arrangements is the Deputy Commissioner of the Office of Finance, Assessment and Management. The HCFA Executive contact point is the Director of the Office of Financial and Human Resources.

## Article VI

### Medicaid Program

#### Purpose

This article of the MOU sets forth the specific activities and responsibilities of both SSA and HCFA with respect to the Medicaid program. Appendix A lists all previously negotiated agreements between HCFA and SSA which shall remain in effect but be subordinate to this umbrella MOU. If there is conflicting language between this MOU and any previous agreement, this MOU will take precedence. All reimbursable agreements listed in part III of appendix A must be renewed annually for purposes of establishing funding levels and recording obligations for the new fiscal year (FY).

#### Specific Medicaid Program Functions Performed by SSA

SSA has agreements with individual States to determine Medicaid eligibility for SSI recipients and participants in the work incentives under section 1619 of the Social Security Act in those States. These are called "1634 Agreements" and as of January 1, 1995, SSA had 1634 Agreements in effect with 32 States and the District of Columbia. Because of the 1634 Agreements, SSA gathers additional data related only to Medicaid eligibility in those 33 jurisdictions which the jurisdictions use to fulfill their requirements under title XIX of the Act. SSA is reimbursed for these activities as explained below and in items A and B of part III of appendix A. SSA also informs all States about potential Medicaid eligibility for individuals participating in the work incentives under section 1619 of the Act through routine postings to a data exchange, and provides Medicaid referrals for beneficiaries in all States.

The SSA executive contact point for negotiating changes in operating policies and procedures dealing with SSA's role in the Medicaid program is the Associate Commissioner, Office of Retirement and Survivors Insurance and Supplemental Security Income Policy. SSA's Medicaid-related responsibilities include:

- o Providing services to the States (including the District of Columbia and the Commonwealth of the Northern Mariana Islands) used in the administration of their Medicaid programs. These services include, but are not limited to:
  - Third party query system;
  - "Pickle Amendment" and Lynch tapes and listings;
  - State data exchange;
  - Beneficiary data exchange;

- o Maintaining current Agreements with the States under section 1634(a) of the Act for Medicaid eligibility determinations and to determine unpaid medical expenses where applicable. These Agreements will be updated to reflect the Commissioner's, rather than the Secretary's, responsibility for Medicaid eligibility determinations in those States.
- o By FY 1997, submitting bills to the Director, Office of Financial and Human Resources, HCFA, for the costs of gathering data concerning unpaid medical expenses in the 3 months before SSI application in those States which have included this task in their Agreements with SSA under section 1634(a) of the Act.
- o Maintaining current Agreements with the Medicaid Bureau of HCFA listed under items A and B in part III of appendix A which reimburse SSA for activities, related to Medicaid-only eligibility criteria by SSA field offices (FOs) and teleservice centers (TSCs) as an addition to the supplemental security income (SSI) eligibility determination and redetermination processes. Such activities which supply information to States include querying SSI claimants and beneficiaries to identify (1) any transfer of assets to third parties for less than fair market value and (2) any possible third party liability for medical costs and, where appropriate, have SSI recipients assign to States their right to reimbursement from such third parties.
- o Maintaining the current Interagency Agreement on Data Sharing with HCFA listed under item C in part III of appendix A for SSA reimbursement to HCFA for Medicaid facility admission/billing data, used to maintain the integrity of SSI benefit payments.
- o From data developed for SSI purposes, developing what appears to be Medicaid trusts and similar legal devices and convey information and available data concerning the suspected existence of potential Medicaid trusts or other similar legal devices to States with Agreements with the Commissioner under section 1634(a) of the Act.
- o Maintaining interagency cooperation at central office and regional levels, including the informal sharing of data and provision of terminal access to individual HCFA staff as needed to determine the eligibility status of specific clients.
- o Assisting HCFA when appropriate to meet the requirements of judicial orders.
- o Assisting HCFA when appropriate to meet deadlines for implementing enacted legislation.
- o Working with HCFA to establish a process before FY 1996 and ongoing thereafter for nursing homes to report the admission of SSI recipients to SSA.
- o Evaluating HCFA recommendations for improvements in program administration.

### Specific Medicaid Program Functions to be Performed by HCFA

The HCFA executive contact point for coordination of the following Medicaid-related functions with SSA is the Director of the Medicaid Bureau. HCFA's SSA-related Medicaid responsibilities include:

- o Periodically monitoring timeliness and adequacy of data provided by SSA to the States on an as needed basis. Provide results of monitoring to SSA with recommendations for improvements in program administration.
- o Providing assistance and coordination of approvals of State Medicaid plan amendments by States which wish to complete an Agreement with the Commissioner under §1634(a) of the Act. Advise States and assist them to determine whether it is in the State's best interest to amend its Agreement under §1634(a) of the Act for SSA to determine unpaid medical expenses.
- o Effective FY 1997 and continuing, requesting sufficient appropriations from the General Funds of the Treasury to directly reimburse SSA for the full cost of SSA asking Medicaid-only questions about unpaid medical expenses in the 3 months before SSI application when requested by a State. HCFA shall recover the States' share of SSA's costs by offsetting the Federal share of costs under title XIX to those States.
- o Billing SSA for Medicaid facility admission/billing match data listed in item C of part III of appendix A.
- o Notifying SSA when a State Medicaid plan amendment proposed by a State could affect SSA's continuing to make Medicaid eligibility determinations under an Agreement under §1634(a) of the Act.
- o Reimbursing SSA as specified in the agreements listed under items A and B in part III of appendix A and requesting updated cost figures from SSA as appropriate.
- o Providing review and clearance of SSA instructions and memorandums prepared by SSA as part of SSA's role in the Medicaid eligibility determination process.
- o Defining exact needs to meet requirements of judicial orders, conveying those requirements timely to appropriate SSA staff and monitor the timeliness of SSA assistance in meeting those requirements.
- o Defining exact needs to meet requirements of enacted legislation, conveying those requirements timely to appropriate SSA staff and monitor the timeliness of SSA assistance in meeting those requirements.

- o Working with SSA to establish a process before FY 1996 and ongoing thereafter for nursing homes to report the admission of SSI recipients to SSA.



## Article VII

### Data Exchanges

#### Purpose

This article of the MOU discusses the cooperative relationship between SSA and HCFA in arranging data and information exchanges to enhance the effectiveness and efficiency of program administration.

#### Responsibilities of SSA and HCFA

SSA and HCFA agree to negotiate a separate MOU that will provide the framework for administering data and information exchanges between the two Agencies. Such MOU shall be subordinate to this umbrella MOU and serve to satisfy the data and information requirements of the two Agencies and Section 104 of Public Law 103-296, "The Social Security Independent Agency and Program Improvements Act of 1994."

The SSA Executive contact point for data and information exchanges is the Director, Office of Disclosure Policy. The HCFA contact point is the Director, The Bureau of Data Management and Strategy.

## Article VIII

### Systems Support

#### Purpose

This article highlights the systems support that SSA and HCFA will provide each other, including the current ongoing operations and data exchanges, and the approach to be used to cooperate with systems changes due to continuous improvement initiatives.

#### Existing Agreements

Details of SSA's systems support services to HCFA are contained in a subordinate agreement entitled "SSA Support of HCFA Automated Data Processing and Telecommunication Requirements - Extension of Interagency Agreement for Fiscal Year 1995" dated January 6, 1995. All codicils of this agreement shall continue to be in force until specifically amended. This agreement shall continue to be reviewed and renewed annually as the basic agreement between the Agencies surrounding ongoing ADP support services.

Appendix A, part V lists existing additional agreements between SSA and HCFA which directly or indirectly may impact systems support. Such agreements will continue to be binding on both parties but shall be subordinate to this umbrella MOU.

#### Administrative Procedures

No less than annually, the specific arrangements cited in this umbrella MOU and in the above referenced subordinate agreement will be reviewed for continued applicability. The primary points of contact regarding these matters will be the Associate Commissioner for Systems Requirements in SSA and the Director, Division of Beneficiary Systems in HCFA. Specific agreements involving the conduct of operations in the National Computer Center at SSA will be coordinated with the Associate Commissioner for Systems Operations in SSA.

Final system agreements in SSA will be approved at the Deputy Commissioner for Systems level; in HCFA, they will be approved at the Director, Bureau of Data Management and Strategy level.

Changes to these agreements may be initiated by either Agency during the life of the agreement through negotiation at the aforementioned levels. Any changes or new agreements will be subject to the full range of ratification requirements.

### Specific Systems Support Services

Following are delineated the specific system support services provided for in the agreement.

-o **Ongoing daily and periodic operations**

SSA will continue to provide daily and cyclical operational support to HCFA as defined in the existing interagency agreement referred to above. Service support as defined in that agreement shall continue to be used as the way of measuring SSA service.

SSA will continue to provide requirements analysis, software development, testing, and validation support to maintain the Medicare related processes carried out by SSA and to make minor modifications and enhancements to those processes consistent with overall systems priorities. SSA will also make periodic ad hoc extractions and data requests in support of HCFA processes on an as requested basis. Scheduling and priority will be subject to individual request by request negotiation.

HCFA will continue to provide SSA with regular problem resolution support for those Medicare related processes involving SSA systems, operational, and field resources. Appropriate contact points will be defined for direct communication by the SSA program service center and regional offices. SSA and HCFA will continue to jointly address problems which arise in the Medicare processes conducted by SSA systems.

SSA will continue to provide batch data transmission support services to HCFA using the Network Data Mover system for communications between the HCFA data center and the SSA data center. SSA will also continue to provide NDM support for transmission of buy-in data to the SSA Program Service centers, the HCFA regional offices, the State Agencies, the Railroad Retirement Board, and the Office of Personnel Management. New applications and workloads will be evaluated on a case by case basis. Any new information exchanges must meet the criteria set forth in Article VII - Data Exchanges and in the "Master Memorandum of Agreement for Information Exchange Between the Social Security Administration and the Health Care Financing Administration".

SSA will also continue to conduct regular periodic extractions of HCFA records to the Master Earnings File to identify cases where Medicare recipients are continuing to work and may have employer provided medical coverage which should be the primary payer rather than Medicare.

SSA will periodically, but not less than annually, screen the Master Earnings File to identify full part A premium amount collected enrollees who have acquired 30 quarters of coverage and post such quarters to the Master Beneficiary Record. This screening will

allow HCFA to accurately bill for part A premiums. SSA will also conduct other extractions periodically from the Master Earnings File to identify beneficiaries who have earned between 30 and 40 quarters of coverage and may be entitled to reduced part A premiums.

o **Online Access to Claims and Medicare Data**

HCFA will continue to provide SSA with direct online access to Medicare enrollment and premium billing and collection information as currently covered in the interagency agreement entitled "Agreement between the Health Care Financing Administration and the Social Security Administration for Access to HCFA's Enrollment Data Bases." (See appendix A, part V.B.)

New or significantly expanded accesses will be evaluated pursuant to appropriate justification and security clearances and agreements. Such access will be allowed from SSA Central Office, regional office, and field facilities. This access is currently included in the list in part V of this agreement and is specifically defined in the separate interagency agreement on access to the HCFA enrollment data bases.

SSA will continue to provide HCFA with online access to SSA master record data such as master beneficiary record, NUMIDENT, supplemental security income record, and Payment History Update System for use in the administration of the Medicare and Medicaid programs. Access is available to HCFA central office and regional office sites.

o **Redesign and Modernization Support**

Both SSA and HCFA are currently engaged in system modernization/redesign efforts on their major systems to upgrade those systems and service levels and to allow them to continue effective processing into the next millennium. The Agencies recognize the interactivity that exists between the systems and the need to provide mutual support to one another. Additionally, they recognize the need to closely coordinate those changes necessary for the year 2000 and to provide mutual assistance in modifying and validating those changes. SSA plans to have all Year 2000 changes validated by December 1998 and will need HCFA interface software available at that time.

SSA will continue to provide analytic, procedural, and systems development support to the HCFA redesign effort to modify those systems which interface with or feed data to the modernized HCFA systems. SSA will also assist HCFA in validating those systems by providing transactions, interface records, etc., and in reviewing appropriate output documents. SSA will also provide technical support and assistance to HCFA regarding year 2000 activities based on SSA experience to date and will share all future experience gained with them.

SSA will continue to keep HCFA advised on the status of title II modernization and will directly involve them in any activity that touches on Medicare or Medicaid issues or systems.

HCFA will provide any needed support for the SSA modernization effort as it impacts on HCFA systems and Medicare related processes.

There will be regular redesign status meetings, briefings, and information sharing sessions between Agency technical personnel to ensure that close coordination and liaison exists.

o **Systems Change Process**

SSA has a formal systems change process through which requested systems changes are submitted, reviewed, evaluated, and appropriately approved or rejected. SSA will provide for the inclusion of HCFA in that process so that modifications that they wish in SSA supported systems may be fully considered.

HCFA will be represented as a component member of the User Planning Team, the group through which normal systems change requests are considered. This will allow HCFA to submit, justify, prioritize, and support HCFA generated proposals. It will also enable them to have input into the changes that SSA will undertake and to better understand the various issues that are involved. Such participation will also provide opportunities where HCFA proposals can be combined with other SSA development activities, thereby saving resources and resulting in more effective project development.

Should HCFA projects of importance not be approved at the User Planning Team level, HCFA will have the same right of reconsideration and appeal as SSA internal components. That is, they may raise the issue to the Associate Commissioner level or the Deputy Commissioner for Systems level as appropriate to ensure that proper consideration is directed to their concerns.

HCFA will also be included in broad SSA systems planning since we service the same population and changes that either SSA or HCFA initiates may have a direct effect on the other Agency. This mandates close coordination and planning.

Smaller scale system change requests requiring minimal expenditure of SSA resources or essential maintenance activities can continue to be made at Associate Commissioner and Division levels. If requests prove to be larger in scope than anticipated, they will be addressed at the ADP Planning group level.

o **Systems Liaison**

**Primary systems liaison points between HCFA and SSA systems will be the Associate Commissioner for Systems Requirements and the Associate Commissioner for Systems Operations in SSA and the Bureau of Data Management and Strategy, Director, Division of Beneficiary Systems in HCFA. Regular meetings will be held between these individuals to address problems of mutual concern and to ensure that adequate service and support is being provided. These meetings will be no less frequently than quarterly.**

**Ongoing staff dialogue and contact will continue to be at Division and lower levels with regard to day to day activities, established projects, maintenance, etc.**

o **Financial Arrangements**

**Systems support services shall be governed by the financial arrangements outlined in article X.**

## Article IX

### Administrative Support Services

#### Purpose

This article sets forth the administrative support service interrelationships between SSA and HCFA. It documents existing support services that each Agency performs for the other and where appropriate, provides the terms and conditions of reimbursement. This article replaces all previously negotiated MOUs and reimbursable agreements for administrative services except as listed in appendix A, part VI.

#### Administrative Services and Responsibilities

HCFA's relocation to its new single site location will generate changes in its SSA-provided service level requirements in many administrative service functional areas. HCFA's move will be accomplished in phases from May-September 1995, with turnaround space availability requirements in SSA's Woodlawn Complex continuing through December 1995. To document the change in service requirements, this article includes "duration of service" language.

1. Executive Secretariat Coordination on Correspondence and Audits -- SSA and HCFA will exchange information and resolve differences on correspondence-related matters through their respective Executive Secretariat organizations.

Duration -- The existing level of coordination will remain the same.

Reimbursement Mechanism -- There are no charges or reimbursements by either Agency related to these services.

2. Baltimore/Washington Shuttle -- HCFA and SSA operate separate shuttle service between Baltimore and Washington, D.C. The Agencies' shuttle services currently provide mutual support in that each Agency permits employees of the other Agency to utilize its shuttles on a space-available basis, based upon employee shuttle reservations.

Duration -- Both Agencies will continue to provide this service. The SSA bus loop will continue to be the pickup and dropoff point for SSA employees using the HCFA shuttle. The East High Rise shuttle stop (or Lot C, HCFA Bus Stop, after HCFA relocates to single site) will be the pickup and dropoff point for HCFA employees using the SSA shuttle.

SSA and HCFA have coordinated a new schedule to include stops at the Universal South Building, Cohen Building and HCFA single site. The Agencies agree to review shuttle utilization after 60 days and make any necessary adjustments.

Reimbursement Mechanism -- There are no charges or reimbursements by either Agency related to these services.

3. Building Maintenance Services for the East High Rise (EHR) and East Low Rise (ELR) Buildings -- SSA currently provides building maintenance services to the EHR and ELR buildings under a delegation of building management authority from the General Services Administration (GSA). HCFA makes rent payments on these buildings direct to GSA. All "above-standard-level services" charges for these buildings are paid by SSA as the building manager and SSA is reimbursed by HCFA for such services through an IOTV.

Duration -- SSA will continue to provide all standard level building maintenance services while HCFA continues to pay rent for space occupied in these buildings. HCFA will notify GSA and SSA as complete blocks of floor space in the East Buildings are vacated in order to request a rent reduction. Once GSA agrees with the request, HCFA will no longer require building operation services for these areas. A phase out of building operation services and payments will occur as HCFA moves out of its old space and into its new location. At this time, HCFA believes all space in the EHR and ELR Buildings will be relinquished by January 1, 1996.

Reimbursement Mechanism -- When SSA becomes Independent on 3/31/95, all open IOTV balances will be converted to SF 1151 transfers. The SSA/HCFA building manager/tenant relationship will cease when HCFA completely vacates the Woodlawn East Buildings. At this time, HCFA will no longer reimburse SSA for "above-standard-level" services and all financial obligations under the contracts for "above-standard-level" services are satisfied.

4. Shared Conference Facilities -- Because of limited conference space in the East Buildings, on occasion HCFA uses SSA conference facilities for large groups (e.g., Altmeyer Auditorium and Multi-Purpose room, 171 Altmeyer, etc.). HCFA is accorded the same priority as any SSA component when requesting conference space. During major ceremonies, HCFA utilizes a portion of the cafeteria space and purchases refreshments directly from the cafeteria. Permits are cleared through SSA's Buildings Operations.

Duration -- SSA will continue to honor HCFA requests to reserve such space, on an emergency basis through the time HCFA continues to occupy East Building space. HCFA anticipates that these services will no longer be needed after September 1, 1995. At this juncture, both Agencies agree to consider sharing conference space on an emergency, as needed, basis.

Reimbursement Mechanism -- There are no charges or reimbursements by either Agency related to these services.



5. Contract Security Guard Services -- Under its delegation of building management authority from GSA, SSA performs certain contract guard oversight and monitoring functions for guards patrolling the EHR and ELR buildings. These functions include conducting background investigations of guard company employers, maintaining records of contractor performance, work hours, deductions for non-performance and other contractual provisions.

Duration -- When SSA becomes independent on 3/31/95, it will continue to perform these contract guard oversight functions. A phase-out of contract guard services and payments for such services will occur as HCFA moves out of its old space and moves into its new location. Toward this end, SSA and HCFA will work together closely throughout the term of HCFA's phased move out of the Woodlawn complex. HCFA will provide SSA with a move schedule identifying hours of coverage and communicate any changes in the schedule. SSA will communicate HCFA's requirements to the contractor. Once HCFA's move is completed, there will be a final settlement to determine HCFA's contractual obligations. This settlement will include appropriate adjustments in HCFA's billing.

SSA will not be involved in security guard services at HCFA's new site which will be managed by GSA.

Reimbursement Mechanism -- SSA receives funding from GSA for space delegations activities. SSA's charges to HCFA are limited to "above standard level" services which are paid via IOTV. When SSA becomes Independent on 3/31/95, any open IOTV balances must be converted to SF-1151 transfers. HCFA will no longer reimburse SSA for above-standard-level services when it occupies its new building and all contractual financial obligations are satisfied.

6. Telecommunications/Telephones -- HCFA's local phone lines and service are provided as part of SSA's Headquarters Switching Center. Maintenance is provided to SSA under contract with Nortel Federal Systems. HCFA has its own discrete lines and equipment and is billed by SSA for their portion of the contractor-provided phone services and equipment. HCFA recently contracted for independent telephone service at its new site and will not require SSA's contractor-provided telephone support services.

Duration -- SSA will continue to provide local phone lines and service when it becomes independent on March 31, 1995. HCFA plans a graduated phase out of phone services and charges paralleling its phased move. As space is vacated, services to that area will be terminated; however, SSA will provide an intercept treatment for all service that is disconnected for a period of 60 days. SSA will also continue to allow HCFA to use the public address system until the move is complete.

**Reimbursement Mechanism** -- Reimbursement is effectuated via OPAC transfers. Reimbursements will cease when all contractual obligations are satisfied.

7. **Recyclable Materials** -- SSA currently accepts and handles HCFA materials for delivery to a recycling center. Some recycling collection containers are also provided by SSA. SSA will not be involved in HCFA's recycling services at HCFA's new site, which will be managed by GSA.

**Duration** -- SSA will continue the current arrangement when it becomes independent on 03/31/95. HCFA will receive the current level of recycling services until December 31, 1995 for the East Buildings.

**Reimbursement Mechanism** -- SSA does not receive reimbursement for this service which is performed under the GSA delegation of building management authority.

8. **SSA Self Service Store** -- HCFA currently utilizes SSA's self service store to purchase supplies (desk top supplies, materials and forms). This arrangement is documented in a 1988 amendment to the 1981 Memorandum of Agreement (MOA) between SSA and HCFA. The current FY 1995 agreement is for \$125,000.

**Duration** -- SSA will continue the current arrangement when it becomes independent on 03/31/95. The level of need for the self-service store will begin to decline as HCFA begins using the GSA "Customer Supply System". With the completion of HCFA's relocation in September 1995, HCFA will continue to use the SSA supply store on an emergency basis only.

**Reimbursement Mechanism** -- HCFA pays SSA for the supplies purchased at the SSA store. Reimbursement is effectuated via quarterly OPAC transfers with HCFA's charges identified based on unique store cards issued to HCFA. Purchases and reimbursements will decrease significantly as HCFA implements use of the GSA system. The same mechanisms will be used in the future and HCFA expects to issue a very limited number of store cards to contain utilization.

9. **Compilation of Social Security Laws and Legislative History** -- SSA issues the "Compilation of Social Security Laws" which consists of three volumes. Volume I is published in bound and loose leaf editions and contains the Social Security Act, certain provisions of the Internal Revenue Code and an index. Volume II is a bound edition containing provisions from the public laws and other material which affects one of the programs under the Social Security Act. Volume III contains superseded provisions of the Social Security Act and is currently updated by transmittals issued as necessary.

When legislation is enacted, SSA issues replacement pages for seven titles: II, IV, VII, XI, XVI, XVIII and XIX. SSA works with GPO and the House Ways and Means Committee on the printing of the compilations. Every 2 years, SSA also issues a **Legislative History Titles I-XX of the Social Security Act** which includes changes from every enactment of the Congress which amends the Social Security Act, relevant material from accompanying House and Senate reports and a Finder's Aid for each Public Law. GPO publishes a "ride the run" announcement inviting other Federal Agencies to place orders and receive copies directly from GPO.

SSA's Technical Documents staff coordinates with HCFA printing staff to make sure HCFA is aware of the print. Each Agency pays GPO directly for copies of the prints it receives. SSA sometimes receives "trailing requests" from HCFA for additional copies of the prints. SSA Technical Documents staff meet these requests by providing any extra copies that may be on hand. There are no charges or payments for these "small volume" requests.

Duration -- When SSA becomes independent on 03/31/95 it will continue this coordination and service. When HCFA moves to its new facility it will still require these services and the above arrangements will continue. HCFA will communicate "ride the run" announcements to all affected components to minimize "trailer requests" for additional copies of already printed documents.

Reimbursement Mechanism -- Each agency pays GPO directly for its prints when "ride the run" procedures are followed. SSA will continue to fill orders for small volume trailer requests at no charge.

10. Printing HI and SMI Trustee Reports -- SSA prints the annual Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) Trustees Reports. These reports are printed on or about late March of each year and are printed at the same time as the SSA Trustees reports (OASI/DI). The reports are printed in two waves. The first print is done in SSA's in-house print shop and SSA prints and distributes about 2200-2300 copies of the HI and SMI Reports on HCFA's behalf. The second wave is printed by GPO using the "ride the run" procedures discussed above in subsection 9.

Duration -- SSA will continue to provide the existing service unchanged when it becomes independent on 03/31/95. This service will be unaffected by HCFA's move to its new site in September 1995.

Reimbursement Mechanism -- SSA does not charge HCFA for its in-house printing and distribution of the HI and SMI reports. HCFA pays GPO directly for the prints it receives when the "ride the run" procedures are used. These arrangements will continue unchanged.

11. SSA Library -- The SSA Library has an excellent collection of Medicare and Medicaid books going back to their 1965 enactment, which is still being maintained. HCFA will still require access to the SSA Library because it will still be the only source of the older reference material on the Medicare and Medicaid programs.

Duration -- SSA will still provide this service when it becomes independent on 03/31/95. HCFA's new site will contain an upgraded library which will include law-related computer data bases.

Reimbursement Mechanism -- None.

12. Misdirected Mail -- Currently SSA and HCFA exchange misdirected mail which is facilitated by their collocation in the Woodlawn complex.

Duration -- SSA and HCFA will still provide each other this service when SSA becomes independent on 03/31/95. When HCFA relocates to its new site in September 1995, HCFA and SSA will develop a mutually acceptable operating procedure to handle internal misdirected mail including a schedule for pick up and drop off of the misdirected mail and ways and means to transport misdirected mail to the other Agency's location.

Reimbursement Mechanism -- None.

13. Child Care Center -- SSA currently operates a child care center. HCFA employees participate in the center under terms spelled out in a formal reimbursable agreement.

Duration -- SSA and HCFA will continue to operate under the terms of the existing 1995 agreement when SSA becomes independent on 03/31/95. HCFA is establishing its own child care center at its new site which it plans to open in the summer of 1995.

Those HCFA employees who wish to continue use of the SSA Child Care Center beyond the opening of HCFA's Center may do so at no added expense.

Reimbursement Mechanism -- Under terms of the agreement, HCFA pays a pro rata share of center expenses based on the number of child care slots allocated to HCFA. Reimbursements are collected quarterly through OPAC. Reimbursements will cease after the FY 1995 agreement is executed and all financial obligations of the agreement are satisfied.

14. Parking Spaces -- Currently, under terms of the 1988 amendment to the 1981 SSA/HCFA MOA, HCFA utilizes parking lots A, EA and 102 spaces on lot B at the Woodlawn complex.

Duration -- Current arrangements will continue unchanged when SSA becomes independent on 03/31/95. Arrangements will change when HCFA moves to its new site. HCFA employees will still have occasion to visit SSA's Woodlawn complex and SSA employees will have occasion to visit HCFA's new site. SSA will honor HCFA employee parking at area U of its Woodlawn complex with the exception of area U/DK (across from Annex Cafeteria). HCFA will honor SSA employee parking in the unreserved area of HCFA's parking spaces at HCFA's new site. If in the future either Agency redesigns its parking area layout, it will notify the other Agency of the new area it has designated for that Agency's employees to park in. The Agency making such a change will also provide parking maps in sufficient numbers for the other Agency to distribute to its employees.

Reimbursement Mechanism -- HCFA pays rent directly to GSA for its parking spaces at the Woodlawn complex. When HCFA relocates to its new site and HCFA and SSA honor the other Agency's employees parking in their respective designated unreserved area, there will be no charges or reimbursements for the arrangement.

15. Employee Identification Badges -- Currently HCFA I.D. badges are recognized by Security personnel at SSA's Woodlawn buildings and HCFA employees have limited access to SSA buildings. Likewise, SSA badges are recognized by Security personnel in HCFA occupied buildings and limited access to HCFA buildings is provided to SSA personnel.

Duration -- When SSA becomes independent on 03/31/95, and when HCFA relocates to its new site in September 1995 the current level of cooperation will continue. Each Agency will honor the badges of the other's employees. SSA and HCFA will continue to provide each other's security services a list of those employees who were terminated. The parties agree to reexamine this arrangement at the close of calendar year 1996.

Reimbursement Mechanism -- None.

#### Mechanism for Future Changes

The SSA Executive contact point to negotiate changes in administrative services provided HCFA is the Deputy Commissioner of the Office of Finance, Assessment and Management. The HCFA contact point is the Director or Deputy Director of the Office of Financial and Human Resources. Modifications to article IX may be incorporated as a byproduct of the joint biannual review by SSA and HCFA (see paragraph A of article XI).

Article XI

Effective Date, Responsible Officials and Approvals

A. Effective Date

This agreement shall be effective March 31, 1995 and continue in effect until modified or terminated. Both Agencies shall conduct a joint review of the provisions of this umbrella agreement at least bi-annually or more frequently by mutual consent.

B. Officials Responsible for Umbrella Agreement


Agency officials responsible for Executive oversight of this agreement and coordinating approvals of any modifications made as a consequence of the joint bi-annual review are:

SSA: Deputy Commissioner for Programs, Policy  
Evaluation and Communication

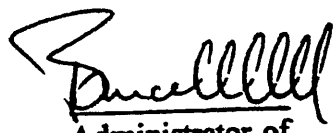
HCFA: (Deputy Associate Administrator  
for Operations and Resource Management)

C. Approvals

We, the undersigned, do hereby agree to the foregoing provisions of this agreement, which supersedes all earlier agreements and subsequent modifications except those which are incorporated by reference in appendix A.

  
Commissioner of  
Social Security

4-11-95  
Date

  
Administrator of  
Health Care Financing  
Administration

4/7/95  
Date

## APPENDIX A

### LISTING OF SUBSIDIARY AGREEMENTS AND MEMORANDA OF UNDERSTANDING

#### Part I. Agreements Concerning Primary Agency Responsibilities

- A. Memorandum of Agreement (MOA) on functions and positions to be transferred from SSA to HCFA.
- o Agreement is presumed to be the final product of an SSA/HCFA workgroup which was established to determine the details of SSA resource transfers in conjunction with the Reorganization Order of March 8, 1977 which established HCFA.
  - o References in a subsequent agreement refer to the signing of this agreement during the week of October 15, 1980. Those references indicate that the agreement was signed by the Director of HCFA's Office of Management and Budget and by the Acting Associate Commissioner (AAC) of SSA's Office of Management, Budget and Personnel (OMB). (However, no copy of the actual agreement has been located in either SSA or HCFA.)
- B. MOA Between HCFA and SSA on Functions and Related Resources of HCFA and SSA Relative to the Administrative Management and General Support of the Medicare Program
- o Agreement documents conditions for transfer of funds for selected administrative management and general support functions.
  - o The agreement was signed by the AAC of SSA's OMB on August 7, 1981.
- C. Amendment to August 1981 MOA
- o This amendment to the previous agreement listed in item I. B. above provided for certain additional fund transfers between the two Agencies and details concerning the responsibilities of each Agency.
  - o The agreement was signed for SSA by Commissioner Hardy on March 11, 1988.

## **Part II. Agreements Concerning the Medicare Program**

### **A. Medicare Secondary Payer Match**

- o Agreement is part of a three-agency reimbursable arrangement which also involves the Internal Revenue Service.
- o Agreement signed by Commissioner Chater on March 7, 1994.

### **B. Intra-Agency Agreement (IA) to Amend the March 24, 1987 MOU Between SSA and HCFA**

- o Agreement intended to ensure that SSA offices receive copies of updated Medicare handbooks before their distribution to beneficiaries.
- o Agreement signed by SSA's Deputy Commissioner for Finance, Assessment and Management on May 4, 1994.

### **C. IA Between HCFA and SSA for the Shipment of Medicare Tapes via Express Mail**

- o Agreement provides for SSA to ship tapes covering third party Medicare buy-ins and premium collections to the States.
- o Agreement signed by the Director of SSA's Division of Administrative Budget (DAB) on January 10, 1994.

### **D. Agreement for Reimbursable Services (RA) Provided to HCFA by SSA for the Keying of Medical Insurance Application Data**

- o This agreement provides for SSA to select and key to magnetic tape selected data from the Medicare application. The tapes are then transmitted to HCFA.
- o Agreement signed by Director of SSA's DAB on 1/7/94.



### **Part III. Agreements Concerning the Medicaid Program**

- A. Transfer of Resources (TOR), Medicaid Qualifying Trusts (MQTs)**
  - o IA on TOR and MQTs signed by Commissioner Chater on August 22, 1994.
  - o RA Number HCFA-TOR-1-95, beginning October 1, 1994, ending September 30, 1995, signed by Commissioner Chater on August 22, 1994.
- B. Assignment of Rights (AOR) and Third Party Liability (TPL)**
  - o IA on AOR and TPL signed by Commissioner Chater on August 30, 1994.
  - o RA Number HCFA95-TPL/AOR, beginning October 1, 1994, ending September 30, 1995, signed by Commissioner Chater on August 22, 1994.
- C. Electronic Matching of Medicaid Facility Admission/Billing Data**
  - o Agreement signed by Commissioner King on July 30, 1992. Most recent modification signed by Commissioner Chater on December 15, 1994.
  - o Interagency Agreement (IAA) on Data Sharing Number HCFA-95-01, beginning October 1, 1994, ending September 30, 1995; reimbursement authorized by Commissioner Chater's signature of modification on December 15, 1994.
- D. Medicaid Eligibility Determinations**
  - o SSA currently has agreements with 32 States and the District of Columbia which provide for SSI eligibility determinations to also serve as Medicaid eligibility determinations. [While these agreements are between SSA and the States, rather than SSA and HCFA, they are noted here for clarity.]
- E. Agreement Between SSA and HCFA for Disclosure of Medicaid Facility Admission Data**
  - o The purpose of this agreement is to provide for the provision to SSA by HCFA of Medicaid facility admission and billing data in order to enable SSA to compare this information with its SSI beneficiary records in order to identify and reduce incorrect SSI payments.
  - o The agreement was signed by Commissioner Chater on June 23, 1994.

**Part IV. Agreements Concerning Data Exchange**

[An umbrella data exchange agreement between SSA and HCFA is being drafted and reviewed simultaneously with the development of this agreement. See article VII.]

**Part V. Agreements Concerning Systems Support**  
**Agreements Concerning Systems Support**

**A. MOU Between SSA and HCFA for SSA Support of HCFA's Automated Data Processing (ADP) and Telecommunications (TC)**

- o The agreement documents the ADP and TC support which SSA will provide to HCFA. The agreement is updated at least annually.
- o The most recent update to the agreement was signed by Commissioner Chater on or about January 6, 1995.

**B. IA Between HCFA and SSA for Access to HCFA's Enrollment Database**

- o The agreement provides guidelines and procedures for SSA read only access to HCFA's enrollment database.
- o The agreement was signed by SSA's Commissioner on January 6, 1995.

**Part VI. Agreements Concerning Administrative Support Services**

**A. Transfer of Funds VIA Inter-Office Transfer Voucher (IOTV) from HCFA to SSA to Provide for Above-Standard Level Services**

- o SSA provides services as building manager under a delegation of authority from the General Services Administration.
- o IOTV funding arrangement will be replaced by transfer via SF-1151 upon SSA independence.

**B. IAA Between SSA and HCFA for HCFA's Use of SSA's Child Care Center**

- o Agreement provides for the use of SSA's Child Care Center by the children of HCFA employees and for HCFA reimbursement to SSA of a pro rata share of the rent and utility costs for that center.
- o Agreement signed by Commissioner Chater on January 11, 1994.

**C. IAA Between HCFA and SSA for SSA's Use of HCFA's Fitness Center**

- o Agreement provides for the use by SSA employees of HCFA's San Francisco fitness center.**
- o Agreement signed by SSA's Commissioner in or about June 1994.**

## **APPENDIX B**

### **QUALITY OF SERVICES REPORT**

#### **I. BACKGROUND**

Section 104 of the Social Security Independence and Program Improvement Act of 1994 (P.L. 103-296) requires the Commissioner of Social Security to enter into an agreement with the Secretary under which the Commissioner provides data to the Secretary concerning the quality of:

- o Services and information provided to Medicare and Medicaid beneficiaries; and
- o The administrative services provided by SSA in support of the Medicare and Medicaid programs.

This agreement shall stipulate the type of data to be provided and the terms and conditions under which the data are to be provided. The content and frequency of such reporting, as well as the agreed upon methodology to be used by SSA and HCFA to evaluate and improve customer-focused services follows:

#### **II. PRINCIPLES OF REPORTING**

##### **1. Philosophy**

SSA's independence from HHS is viewed as an opportunity to revitalize SSA's and HCFA's cooperative and collaborative relationship. With this philosophy, the Quality of Services Report becomes one mechanism available to strengthen that relationship into a true partnership that focuses on the best interest of both HCFA and SSA customers.

The purpose of the Quality of Service Report is to provide a vehicle for both Agencies to measure and continuously improve the quality of services being provided to their mutual customers -- the Medicare and Medicaid beneficiaries. Although this report requires specific objectives to be measured in evaluating performance expectations, it does not create a burdensome reporting process for either Agency. The Quality of Services Report will:

- o Capture and confirm SSA and HCFA's effectiveness in providing high quality services to Medicare and Medicaid beneficiaries; and

- o Support the renewed partnership and collaborative efforts of both Agencies to meet customer service requirements.

To accomplish these goals, the report will identify areas of needed improvement in SSA's performance, and highlight areas where HCFA must improve its ability to provide SSA with the information and support necessary to fulfill both Agencies' obligations.

## 2. Accountability for Results

Both SSA and HCFA, in support of the Executive Order 12862, "Setting Customer Service Standards" have made a commitment to providing the highest quality of service possible to the American public. Each Agency has defined customer standards that meet their customers' needs and are putting customers first in all Agency planning. To maintain and continuously improve the quality of services SSA provides to HCFA and its beneficiaries, inconsistencies or deficiencies identified as a result of this evaluation will be addressed by SSA and HCFA through a continuous improvement process. Quality service objectives that result in less than acceptable performance must be resolved by SSA and HCFA through a mutually agreed upon plan of correction within an agreed upon length of time. SSA's Executive contact point for customer service delivery objectives is the Chief Policy Officer.

## III. METHODOLOGY

The Quality of Services Report consists of a two-part process that is designed to measure the most critical on-going functions SSA provides, while facilitating creative solutions to more long-range Continuous Quality Improvement issues. The first part includes specific Customer Service Delivery Objectives that act as quality indicators, while the second part focuses on long-range continuous improvement by identifying two new areas of improvement each year.

### 1. Customer Service Delivery Objectives

Specific quality of service objectives have been jointly identified by SSA and HCFA and have been included in this agreement. The service delivery objectives listed are considered critical to HCFA's ability to service beneficiaries, but are not exhaustive. Other services and functions, not listed as critical service delivery objectives but detailed in SSA and HCFA Memorandums of Understanding (MOUs), are vital to the Medicare and Medicaid programs and should be reviewed by both HCFA and SSA during the evaluation process.

The Service Delivery Objectives and related performance measures follow. SSA's reporting will include a brief discussion and analysis of performance and an assessment of the prospects for improvement.

**SERVICE DELIVERY OBJECTIVE****PERFORMANCE MEASURE**

1. SSA will, in its initial claims process, make correct Medicare award and disallowance determinations.	- Percentage of Medicare award and disallowance determinations made correctly.
2. SSA will, in its initial claims process, make correct Medicare premium amount determinations.	- Percentage of Medicare premium amount determinations made correctly.
3. SSA will, in its post entitlement process, make correct repayments of excess Medicare premium collections.	- Percentage of excess Medicare premiums correctly repaid to beneficiary.
4. SSA will, in its post entitlement process, correctly withhold deficient Medicare premiums.	- Percentage of deficient Medicare premiums correctly withheld.
5. SSA will, in its post entitlement process, correctly process SMI enrollment changes.	- Percentage of SMI enrollment changes correctly processed.
6. SSA will, when providing toll-free telephone service, provide accurate Medicare information to the public.	- Percentage of callers who received accurate Medicare information from SSA's tele-service center employees.
7. SSA and HCFA will make systems and procedural changes timely to ensure new legislation is implemented in accordance with effective dates in statutes.	- Percentage of legislation jointly impacting SSA and HCFA implemented by effective dates specified in statutes.

## 2. Continuous Quality Improvement Focus

In addition to the Service Delivery Objectives listed above, each year HCFA and SSA will jointly establish two areas of improvement for the upcoming reporting period. These areas of focus may address any variety of process improvements, customer service, quality, communications or partnership issues.

The actual structure for addressing these issues will depend on the areas of focus and the scope of the work that has been identified. SSA and HCFA may choose to form adhoc partnerships or workgroups that use a team approach to tackle larger issues. Other operational areas of focus may only require additional attention on either the part of SSA, HCFA or both.

For the reporting period beginning April 1, 1995, and ending March 31, 1996, SSA and HCFA agree to focus on the following two areas:

- o Improve the ability of SSA's Service Representatives to better meet the needs of both Agencies and their customers through improved instructions and training.
- o Monitor and refine the new working relationship between HCFA, SSA and the Departmental Appeals Board for the Medicare hearings and appeals functions in the areas of policy guidance; operational concerns (e.g. systems interface and case routing); and communications structure.

## IV. HCFA RESPONSE

The Quality of Services Report will allow an opportunity for HCFA to respond to the findings of the report. The purpose of such a response is to address issues, problems, accomplishments or recommendations cited by the report and provide feedback and direction for future Continuous Quality Improvement efforts.

## V. TIMEFRAMES

Each year, the Quality of Services Report will cover the period April 1 through March 31. SSA will deliver the report to the Secretary by August 1 of each year. Thus, the first Quality of Services Report will cover the period April 1, 1995 through March 31, 1996, and the first Report will be due August 1, 1996. HCFA should respond to the findings of the report 60 days following submission to the Secretary.

## **VI. PROCESS FOR CHANGE**

The list of Service Delivery Objectives may be expanded or contracted in the future by mutual consent as provided in article IV, Strategic Planning. Quality improvement initiatives to close the gap between actual and desired service delivery objectives or for other purposes will be pursued through changes to this MOU. The two issues identified as the focus of quality improvement initiatives for the upcoming April 1 through March 31 reporting period shall be agreed to in advance and incorporated into this MOU via an amendment executed at the onset of the new reporting period. Adjustments to the list of service delivery objectives shall be made at that time assuming they had received appropriate analysis as discussed in article IV, Strategic Planning.

SSA will continue to report on the Quality of Services provided to HCFA in the manner outlined in this agreement, unless and until such time as SSA and HCFA agree on any changes to the elements or to the transfer of responsibilities which impact those elements.

The primary points of contact regarding these matters will be the Director, Office of Strategic Management assisted by the Associate Commissioner for ORSISSIP in SSA and the Immediate Office of the Associate Administrator for Operations and Resource Management in HCFA.



# **APPENDIX C**

**MEMORANDUM OF AGREEMENT (MOA)  
BETWEEN THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)  
AND THE  
SOCIAL SECURITY ADMINISTRATION (SSA)**

**I. PURPOSE**

This is an agreement between the Department of Health and Human Services (HHS) and the Social Security Administration (SSA) concerning the Office of Hearings and Appeals (OHA) of SSA and the Departmental Appeals Board (DAB) of HHS. Under the agreement, DAB will assume from the OHA the functions currently provided by the Health Insurance Branch of OHA. This includes appellate review of all pending and future cases, including hearings where appropriate, in disputes involving:

- 1) Medicare entitlement/entitlement-related issues,
- 2) Medicare coverage, claims reimbursement, and denial of service issues, and
- 3) Medicare or Medicaid related sanction actions.

These cases involve Medicare or Medicaid related matters under titles XI, XVIII, and XIX of the Social Security Act.

This is the second MOA signed by the parties regarding the transfer of function of these cases from OHA to DAB. This MOA supplements, but does not replace, the agreement signed by the parties on March 30 and 31, 1995.

**II. BACKGROUND**

The cases which are the subject of this agreement involve matters which, as of September 30, 1995, were reviewed by OHA through its Health Insurance (HI) Branch. These cases involve, among other matters, disputes regarding:

- 1) Medicare entitlement/entitlement-related issues,
- 2) Medicare coverage, claims reimbursement, and denial of service issues, and
- 3) Medicare or Medicaid related sanction actions.

These cases involve Medicare or Medicaid related matters under titles XI, XVIII, and XIX of the Social Security Act. This transfer of function does not include the matters currently reviewed by the Provider Reimbursement Review Board (PRRB) of the Health Care Financing Administration (HCFA).

Since SSA separated from HHS effective March 31, 1995, the overwhelming majority of OHA's current caseload involves social security eligibility determinations, and

the DAB has extensive experience working with other types of disputes arising under federal medical programs (including title XVIII), all parties have agreed that it is in the best interest of all concerned to transfer these cases, and associated resources, to the DAB.

### III. DELEGATIONS OF AUTHORITY

By virtue of this agreement, all delegations of authority to the SSA regarding the cases which are currently handled by the OHA HI Branch and which are the subject of this transfer of function will be redelegated to the DAB, unless withdrawn or modified by HHS. HHS will publish appropriate delegations of authorities and notices (including those required by the Privacy Act) in the Federal Register regarding the functions to be transferred to the DAB. These delegations of authorities will be published in the Federal Register.

### IV. PERSONNEL

SSA hereby agrees to transfer to the DAB a total of 23 full-time equivalents (FTEs) to carry out this transfer of function.

This includes 19 FTE positions which are currently filled by existing OHA personnel, consisting of 16 current HI Branch staff as well as three other OHA personnel, who will transfer to work on this function. These 19 positions are as follows:

- O Appeals Council Member
- O Appeals Officer
- O Appeals Assistant
- O HI Branch Chief
- O HI Technical Assistant
- O Hearings and Appeals Assistant
- O Legal Assistant
- O 12 Hearings and Appeals Analysts

The parties agree that each of the OHA personnel will be transferred at the same grade and step level as he or she has attained as of the date of the transfer, and that the transfer shall not result in a demotion or in a reduction of the basic pay rate of any employee. Should any person assigned to the above-designated positions not be transferred with the position because of resignation, transfer to another position, or otherwise, the DAB will get one FTE for each such person who does not transfer with the job.

The remaining four FTEs will be filled by the DAB, at its discretion and as the need arises. While three of the remaining four FTEs to be transferred are designed to account for the administrative overhead resources used currently to support the OHA personnel performing Medicare appeals work, the parties agree that it is within the DAB's discretion as to how to designate these positions, given that some of the overhead functions may be absorbed by current HHS personnel after the transfer.

The parties agree that there are no reductions-in-force (RIFs) which are either foreseen or expected. Should such RIFs occur at DAB in the future, the employees transferred with this function, along with other personnel of the DAB, will be treated equitably and in accordance with government-wide RIF policies and procedures. For purposes of any future RIFs at the DAB, the transferred employees will retain the seniority which they would have attained had their positions not been transferred from the OHA to the DAB, and the positions which the transferred employees occupy at the time of the transfer will not be considered terminated at OHA and recreated at the DAB for purposes of RIF policies and procedures.

#### V. LOCATION OF EMPLOYEES

The parties understand that the DAB intends to move the 19 existing OHA personnel (as well as any personnel hired prior to the move to fill any of the four vacant FTEs) to offices outside of their current location in Suite 1400, One Skyline Tower (5107 Leesburg Pike, Falls Church, VA, 22041) as soon as acceptable space is available, but no later than September 30, 1996. The parties further agree that the OHA personnel to be transferred may remain at their current location in suite 1400 of One Skyline Tower until such move is feasible.

To the extent that such move occurs after October 1, 1995, HHS will reimburse SSA for the space used by the OHA personnel to be transferred the lesser of:

- (1) the same rate per square foot that OHA pays for comparable space utilized by OHA personnel in the One Skyline Tower building; OR
- (2) the rate per square foot that OHA will have paid for space used by the transferring employees.

Such payments shall be made on a quarterly basis and shall be pro-rated for any partial quarter that the OHA personnel to be transferred occupy the space.

It is agreed that DAB will make the necessary arrangements and coordinate the move of the furniture, equipment and other resources of the employees designated to relocate from SSA-leased space to the DAB worksite.

No other obligations will be incurred on behalf of the transferred employees without the approval of the Chair, DAB.

#### VI. EQUIPMENT AND OTHER RESOURCES

The parties agree that the furniture of the existing 19 OHA transferring personnel will remain with the employees and become the property of HHS. As for the remaining four FTEs to be transferred, SSA agrees to provide furniture of comparable quality to, and of certainly no lesser quality than, that transferred with existing personnel.

The parties further agree that other property and resources currently used predominantly by the 19 transferring personnel (and other personnel hired prior to the transfer of function to fill any of the four vacant FTEs) will also become the property of HHS. This includes, but is not limited to:

- specialized audio recording equipment currently assigned to the existing 19 employees to be transferred and/or used by the HI Branch;
- legal and other resource materials, currently maintained by the HI Technical Assistant and used predominantly by the 19 employees to be transferred.

#### VII. METHOD OF FUNDING

HHS and SSA agree that SSA will transfer the funds to HHS associated with the functions transferred by this and the

March 30/31, 1995 MOAs during FY 1996 by making a one-time resource transfer in the amount of \$1,982,760 effective October 1, 1995. This amount includes compensation and benefits for the 23 FTEs and \$18,000 per FTE for other object class costs (OC 21/31).

HHS will budget for these resources for FY 1997 and subsequent fiscal years.

VIII. DATA PROCESSING EQUIPMENT AND ACCESS

The parties agree that all data processing equipment currently used predominantly by the transferring employees will become the property of HHS. This includes, but is not limited to:

- o personal computers and related equipment assigned to the transferring personnel; and
- o laserjet printers and other computer equipment currently used predominantly by the transferring personnel.

The above equipment shall be transferred on October 1, 1995 with the transferring personnel. The parties agree that outdated, inferior, or otherwise unacceptable data processing equipment shall not be substituted for the equipment currently used by the transferring employees prior to or at the time of the transfer of function.

SSA agrees that the transferring personnel will continue to have access to the Novelle LAN system until such time as they are moved from their current location at One Skyline Tower. Until such time as they are moved, SSA will continue to allow the transferring personnel to access SSA's data files through the presently established electronic systems.

The parties agree that the HI Branch will be converted from the current WANG system to OHA's Appeals Council Automated Processing System (ACAPS) prior to the transfer of function. After the HI Branch is moved, SSA will permit continued access to SSA's data files through its ACAPS system. At that time, SSA will provide a copy of ACAPS and any user manuals and instructional manuals. At the time SSA furnishes a copy of this software, it will train three individuals in the use, maintenance and support of this software. Further, SSA agrees to furnish the DAB with any updates or changes to this software and to furnish any instructions, memoranda, or other material relevant to the use of this software at the time of issuance. The DAB and SSA will each designate an individual who will function as a liaison.

The parties agree that HCFA and SSA will work with the DAB to allow access to current and future computer

systems which are necessary or expedient for this transfer of function.

**IX. INTERAGENCY LIAISONS AND GENERAL COORDINATION BETWEEN PARTIES**

SSA agrees to appoint one or more persons from the remaining OHA to serve as liaisons to the DAB. Likewise, HHS agrees to appoint one or more persons from HCFA to serve as liaisons to the DAB. HHS will appoint one or more persons from the DAB to serve as contact points for SSA and HCFA.

SSA through OHA agrees to retain responsibility for certifying records related to decisions it issues prior to October 1, 1995, for court proceedings. Thus, OHA will maintain and keep in its possession files of cases it decides or dismisses prior to October 1, 1995. SSA agrees to transfer all files of cases which have not yet been decided or dismissed by October 1, 1995 to the DAB on such date.

DAB agrees to be responsible for and make whatever arrangements are necessary to both collect and deliver mail relating to claims handled under this transfer of function to the DAB until such time as OHA ceases to receive such mail. This includes providing its own messenger service between DAB and Suite 1400, One Skyline Tower. SSA agrees to set aside all mail it receives with regard to claims which are transferred to the DAB (or mail which should otherwise be turned over to the DAB) for pick-up by the DAB. The DAB agrees to make a good faith effort to notify the public, through reasonable means, at least 30 days in advance of any address changes for filing mail relating to the current HI Branch functions.

**X. MODIFICATION TO THE AGREEMENT**

This Memorandum of Agreement may be modified at any time by mutual written agreement of the parties.

**XI. AUTHORITY**

Specifically, the authority to transfer functions from SSA to HHS relating to issuing final decisions of the Secretary relating to title XVIII (Medicare) claims derives from section 105(a)(2)(B) of The Social Security Independence and Program Improvements Act of 1994, Public Law 103-296.

The authority to transfer functions within the government derives generally from 5 C.F.R. Part 351, Subpart C. See also 52 Fed. Reg. 10,023 (March 30, 1987).

See also 31 U.S.C. § 1535.


**XII. EFFECTIVE DATE**

Unless otherwise specified, the provisions of this agreement are effective October 1, 1995.

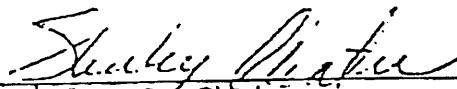
**XIII. CONTACTS**

- o M. Terry Johnson, Board Member, DAB
- o William C. Taylor, Executive Director, Office of Appellate Operations, OHA

Oct 20 1995  
(date)

  
\_\_\_\_\_  
Donna E. Shalala  
Secretary of Health and Human Services

DEC 5 1995  
(date)

  
\_\_\_\_\_  
Shirley S. Chater  
Commissioner of Social Security

#1,982,760.00 dc 11/6/95  
SUBJECT TO  
AVAILABILITY OF FUNDS

~~#1,982,760.00 dc 10/31/95~~  
~~FUNDS AVAILABLE  
DCAD OCP~~  
11/6/95



# **APPENDIX D**



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

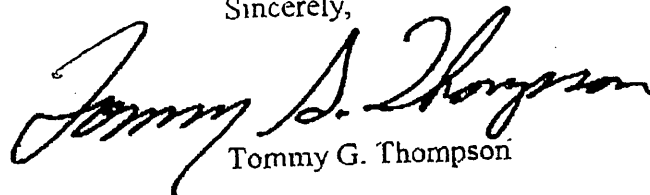
December 3, 2003

Jo Anne B. Barnhart  
Commissioner of Social Security  
Washington, D.C. 20254

Dear Commissioner Barnhart:

Enclosed please find a copy of the Memorandum of Understanding (MOU) for processing Medicare hearings in FY 2004. Thank you for initiating the process of preparing this MOU. We look forward to working with SSA in executing this MOU. I have been advised that once we receive an appropriation from the Congress for FY 2004, minor revisions to the agreement may be necessary.

Sincerely,

  
Tommy G. Thompson

Enclosure

**REIMBURSABLE AGREEMENT**  
**BETWEEN THE**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)**  
**AND THE**  
**SOCIAL SECURITY ADMINISTRATION (SSA)**  
**FOR MEDICARE HEARINGS**

**REIMBURSABLE AGREEMENT  
BETWEEN THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)  
AND THE  
SOCIAL SECURITY ADMINISTRATION (SSA)  
FOR MEDICARE HEARINGS**

**I. PURPOSE**

The President's fiscal year (FY) 2004 budget assumes the transfer of responsibility for providing administrative hearings and performing related functions for the Medicare hearings workload from SSA to DHHS. Consequently, SSA's budget request for FY 2004 does not include the resources needed to process the Medicare workload. The parties agree that SSA will continue to process the Medicare workload as provided in Section III below. The purpose of this Agreement is to establish the details and the process for reimbursement to SSA for processing the Medicare workload.

**II. AUTHORITY**

The authority to transfer functions from SSA to DHHS relating to issuing final decisions of the Secretary on Title XVIII (Medicare) claims derives from section 105(a)(2)(B) of the Social Security Independence and Program Improvements Act of 1994, P.L. 103-296. The Economy Act provides the authority for SSA to provide this reimbursable work during FY 2004.

**III. SCOPE OF WORK AND RESPONSIBILITIES**

**A. Responsibilities**

SSA will be responsible for all Medicare Parts A, B, and C administrative hearings and related functions, up through and including the issuance of final dispositions, during the time period October 1, 2003 through September 30, 2004.

**B. Management Oversight**

SSA will exercise increased management control and oversight over the issuance of docket numbers and proper processing of related claims in Medicare appeals in accordance with the procedures set forth in Appendix A of this Agreement.

**C. Progress Reports**

On a quarterly basis, SSA will report the total number of units of service during FY 2004. At a minimum, the reports will detail the total number of units of service, the date on which each unit of service was completed, and the type of claim (Part A, B, or C) involved. SSA will also report the number of pending Medicare appeals on a quarterly basis. DHHS reserves the right to review the units of service and the status of the pending Medicare workload for compliance with the terms of this Agreement.

#### IV. DURATION OF AGREEMENT

This Agreement applies to the Medicare workload processed according to the terms of this Agreement for the period October 1, 2003 through September 30, 2004. The parties acknowledge the possibility that they may be required to enter into additional agreements for successive periods so that SSA may be reimbursed for work accepted in FY 2004 but completed in those successive periods.

#### V. FUNDS

##### A. Service Provided

CMS agrees to reimburse SSA \$1,000 for each unit of service. The parties consider the following a unit of service:

A "unit of service" is the adjudication of request(s) for hearing on one or more claims involving one or more beneficiaries that are properly disposed of by a single decision or dismissal. Request(s) for hearing may involve multiple units of service and be assigned multiple docket numbers only when a beneficiary's claim or claims require unique findings of fact and/or application of law to fact, e.g., individual medical necessity determinations. See Appendix B for examples of the application of the definition of a unit of service.

##### B. Work Planning Assumption

The parties anticipate SSA will complete approximately 50,000 units of service, at a cost not to exceed \$50 million, during the time period October 1, 2003 through September 30, 2004. In the event SSA's actual production will exceed this 50,000 level, SSA shall notify the CMS Project Liaison as soon as this becomes apparent.

##### C. Transfer of Funds

The continued performance of the hearings function for Medicare appeals by SSA is contingent on the receipt of sufficient appropriated funds in FY 2004 by DHHS or SSA. If Congress appropriates funds in FY 2004 directly to SSA rather than DHHS, this agreement will be void.

Should appropriations for the Medicare hearings function be made to DHHS, reimbursement to SSA will be made quarterly using Treasury's IPAC system based on the quarterly reports provided by SSA as detailed in Section III above. Funds will be transferred from the Centers for Medicare & Medicaid Services (CMS) to SSA using the following information:

#### CMS

Agency Symbol: 75050080  
Appropriation: 20 X 8005.3  
EIN: 52-0883104

Finance Contact:  
Jean Katzen

#### SSA

Agency Symbol: 28-04-001  
Appropriation: 28-4-8704  
EIN: 52-600-4813

Finance Contact:  
Chris Molander

Financial Management Specialist  
Division of Accounting Operations  
Telephone: (410) 786 - 5423

Director  
Division of Central Accounting  
(410) 965 - 0003

## VI. DUPLICATION

This Agreement supplements and replaces during FY 2004 those provisions related to the reimbursement of SSA for the processing of the Medicare hearings workload contained in Article X of the 1995 MOU, effective March 31, 1995 (Tab A). This Agreement is consistent with those provisions of the Supplemental Agreement effective October 1, 1995 (Tab B). Other than those provisions listed above, full implementation of this Agreement will not duplicate any existing agreements.

## VII. PRIVACY

The Parties agree that for any data that may be exchanged which falls under the Privacy Act of 1974, as amended, 5 U.S.C. 552a; the Freedom of Information Act, 5 U.S.C. 552; section 1106(a) of the Social Security Act, 42 U.S.C. 1306; or the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, the specific data exchanged and impact on any systems of records will be detailed in the Transfer of Function Plan and/or applicable Interagency Agreement(s).

## VIII. PROJECT LIAISONS

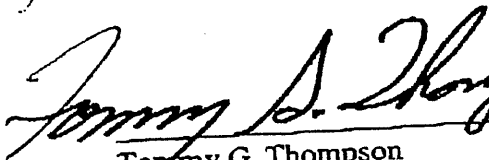
**DHHS:**  
Carmen M. Keller  
Director  
Office of Medicare Adjudication  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Mailstop: C5-24-04  
Telephone Number: (410) 786-3031  
Facsimile Number: (410) 786-7585

**SSA:**  
Rita S. Geier  
Executive Counselor to the  
Commissioner  
Social Security Administration  
400 Virginia Avenue, SW  
Suite 700  
Washington, DC 20024  
Telephone Number: (202) 358-6502  
Facsimile Number: (202) 358-6506

## IX. SIGNATURES

WHEREFORE, the Department of Health and Human Services and the Social Security Administration, do hereby enter into this Agreement as evidenced by the signatures below and agree that this Agreement is consistent with all applicable law and regulation:

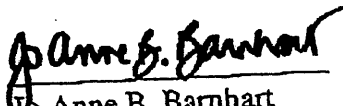
For the Department of Health  
and Human Services:

  
\_\_\_\_\_  
Tommy G. Thompson  
Secretary of  
Health and Human Services

DEC 3 2003

Date

For the Social Security Administration:

  
\_\_\_\_\_  
Anne B. Barnhart  
Commissioner of  
Social Security

NOV 21 2003

Date





## APPENDIX A

SSA will publish and disseminate to all SSA employees involved in the processing of Medicare appeals a statement of mandatory agency procedures regarding assignment of docket numbers and proper processing of related claims in Medicare appeals.

### Procedures:

1. In Medicare Part B appeals, assignment of docket numbers will continue to be centralized in the Division of Medicare in Falls Church, Virginia by personnel under the direct supervision of the Administrative Law Judge in Charge of the Division of Medicare and documentation of the reason for assignment of multiple docket numbers will be maintained. Requests for assignment of additional docket numbers after appeals have been assigned to ALJs shall be made in writing stating the justification for additional docket numbers. The requests will be reviewed by the Administrative Law Judge in Charge to determine if the additional numbers are appropriate under the published procedures. If the request is granted, documentation of the request and the reason for assigning additional docket numbers shall be maintained.
2. In Medicare Part A appeals, upon receipt, the Hearing Office docket clerk shall run the beneficiary's name through the Hearing Office Tracking System (HOTS) to determine if the hearing office has other appeals pending for that beneficiary with which the new appeal can be associated and a single decision issued. Requests to process related claims by the same beneficiary separately shall be made in writing stating the justification for processing separately. The requests will be reviewed by the Hearing Office Chief Administrative Law Judge who shall determine if separate processing is appropriate under the published procedures. Documentation of the request and justification for separate processing shall be maintained.
3. The above measures will be applied within ten days after the effective date of this Agreement. If DHHS/CMS requests the justification for assignment of additional docket numbers or separate processing of related claims in any pending appeal subject to this Agreement, SSA will review the justification for its processing of these appeals and, if necessary, will make appropriate adjustments.

## **APPENDIX B**

Below are some examples of a single unit of service that shall not be assigned multiple docket numbers or be entered as individual adjudications that include but are not limited to the following. The list is not exhaustive and is included for illustrative purposes only. Additional facts or circumstances that arise in an actual Medicare appeal might well affect the proper processing of that appeal, including the assignment of docket numbers. See Appendix A for mandatory SSA procedures.

- An instance where an appellant or multiple appellants challenge(s) only the sampling methodology used to determine an overpayment amount calculated by extrapolation from a statistical sample, regardless of the number of Medicare claims involved. For example, assume an overpayment case that involves a statistical sample of 100 claims for which an actual overpayment was calculated and then extrapolated to a universe of 1,000 claims. If the appellant is challenging only the validity of the statistical sampling methodology, there would be only one issue to adjudicate. Therefore, only one decision or dismissal would be required to adjudicate this case. Exception: When the appeal includes a challenge of the denied claims that underlie the overpayment.
- An instance where an appellant or multiple appellants challenge(s) only the reimbursable rate for a Medicare service, and the appeal does not include a challenge to whether all of the coverage criteria for the service were satisfied. For example, assume an overpayment case involving a coding issue such as whether a modifier may correctly be applied to a particular procedure code. If the appellant is only challenging the denial of payment for the service as billed with the modifier, there would be only one issue to adjudicate. Therefore, only one decision or dismissal would be required to adjudicate this case.
- An instance where an appellant or multiple appellants challenge(s) the denial(s) of one or more Medicare claims from the same provider of services in one appeal, regardless of whether the denial(s) covers a weekly, monthly, or yearly period of service. For example, assume a single request for hearing that consists of ten claims for monthly physical therapy services provided to one beneficiary by a home health agency. If the appellant is challenging the denial of coverage of such services, there would be only one issue to adjudicate. Therefore, only one decision or dismissal would be required to adjudicate this case.
- An instance where an appellant or multiple appellants challenge(s) a medical necessity determination for an individual beneficiary regardless of the number of Medicare claims for the item or service involved. For example, assume an appeal in which a beneficiary received enteral nutrition multiple times a day, every day, for one month. If the appellant is challenging the denial for lack of medical necessity of some or all of the enteral nutrition and related supplies, there would be only one issue to adjudicate. Therefore, only one decision or dismissal would be required to adjudicate this case.