Creating a More Efficient and Level Playing Field:

Audit and Appeals Issues in Medicare

Testimony

Prepared for

United State Senate
Senate Finance Committee

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Introduction

I would like to thank Committee Chairman Senator Hatch, Ranking Member Senator Wyden, and honorable members of the Committee for providing MAXIMUS Federal Services the opportunity to discuss the Medicare appeal program and areas for potential efficiencies and enhancements to the program.

Since 1989 MAXIMUS Federal Services, Inc. (MAXIMUS Federal) and our affiliates have served as a Qualified Independent Contractor (QIC) for the Centers for Medicare and Medicaid Services (CMS). In this role we have completed more than two million Medicare appeals across all Parts of Medicare addressing all forms of Medicare benefit and payment disputes.

Throughout our partnership with CMS we served as the Part A East QIC (since 2005), the Part A West (from 2008 to 2015), the Part B South QIC (from 2005 to 2014), the Part C QIC (since 1989), the Part D QIC (since 2006) and the Administrative QIC (since 2004).

Our QIC work is the hallmark of our largest market segment - Independent Benefit Appeals and Independent Medical Review. We are the largest provider of these services in the United States and currently serve more than 50 Federal and state clients.

MAXIMUS Federal Services is a wholly owned subsidiary of MAXIMUS, Inc. MAXIMUS, Inc. is a global government services organization, based in Reston, Virginia that provides services to Federal, State, and Local government entities. We have no contracts with any commercial entity including any health care payer or provider. We take pride in the fact that MAXIMUS has no direct or material in-direct conflict of interest in helping government serve the people. This independence is part of our mission and is also a statutory requirement for our QIC contracts and Medicaid contracts we administer throughout the United States.

The Qualified Independent Contractor Program

Pursuant to 1869(a)(1) of the Social Security Act a qualified independent contractor (QIC) is defined as "an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations". The organizations encompassed within the meaning of section 1869(a)(1) include, but are not limited to, Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs), Recovery Audit Contractors (RACs), and/or Quality Improvement Organizations (QIOs).

The primary goals of the QIC program include:

- Timely adjudication of reconsiderations and expedited reconsiderations of initial determinations using established protocols
- Case management and documentation into the Medicare Appeals System (MAS) (including document imaging)
- Collection and transmission of information regarding the receipt and disposition of reconsiderations and expedited reconsiderations via the MAS
- Integrated document imaging to produce a complete second level electronic case file

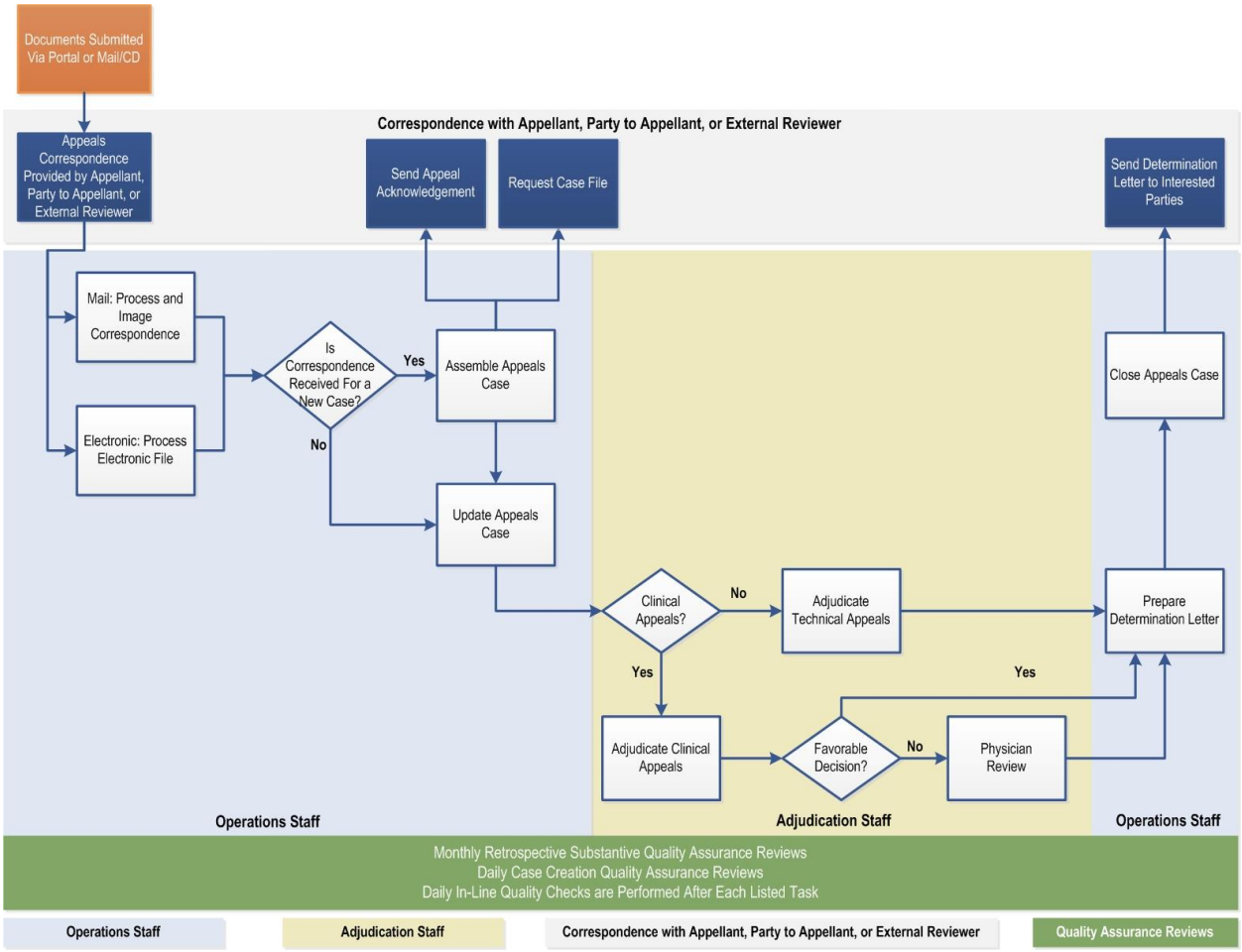
- Participation and coordination with other entities in the Medicare appeals chain including CMS, the Administrative QIC (AdQIC), ACs, the ALJ Hearing Offices, and the Departmental Appeals Board (DAB)

CMS awards task orders to perform QIC work under an Indefinite Delivery/Indefinite Quantity (IDIQ) contract for QIC work based on established jurisdictions and/or claim type as follows:

- Two QIC jurisdiction-based task orders (East and West) for Part A appeals
- Two QIC jurisdiction-based task orders (North and South) for Part B appeals,
- One QIC jurisdiction-based task order for DME appeals
- One QIC task order for Part C appeals
- One QIC task order for Part D appeals

In addition to these seven task orders, CMS awards one task order to perform administrative and data analysis tasks for Parts A, B, and DME of the QIC program, otherwise referred to as the Administrative QIC (AdQIC) task order.

At a very high level the process of an appeal is illustrated below.



There is a five-level appeals process[1] that affords providers, suppliers, beneficiaries, and other parties an opportunity to dispute initial payment decisions on Medicare claims. While some differences exist in processing and terminology based on the type of claim being appealed (Part A/B/durable medical equipment (DME), Part C, or Part D), the levels themselves are relatively consistent as described in the table below.

Appeal Level	Medicare Fee-For-Service (FFS) Claim Appeals	Medicare Part C Appeals	Medicare Part D Appeals
Level One	Redetermination by a Medicare Administrative Contractor: An independent review of an initial determination of a Medicare fee-for-service (FFS) claim.	Reconsideration by Health Plan	Redetermination by Part D Plan sponsor

[1] 42 CFR Subpart I, § 405

Appeal Level	Medicare Fee-For-Service (FFS) Claim Appeals	Medicare Part C Appeals	Medicare Part D Appeals
Level Two	Reconsideration by a QIC: An independent, on-the-record, review of an initial determination, including the redetermination and all issues related to payment of the claim.	Reconsideration by an Independent Review Entity (IRE)[2]: An independent review of a health plan's adverse reconsideration or an independent review when the health plan fails to meet the adjudicatory timeframes for an organization determination or reconsideration request.	Reconsideration by an IRE[3]: An independent review of a sponsor's adverse redetermination or an independent review when the plan fails to meet the adjudicatory timeframes of an initial coverage determination or redetermination request.
Level Three	Hearings before an Administrative Law Judge (ALJ) within the Office of Medicare Hearings and Appeals within the Department of Health and Human Services: Under FFS provisions, if a party is dissatisfied with a QIC's reconsideration or if the adjudication period for the QIC to complete the reconsiderations has elapsed, a party may request an ALJ hearing. Under Part C provisions, if any party to the reconsideration (except the Health Plan) is dissatisfied with the IRE's reconsideration determination, the party may request an ALJ hearing. Under Part D provisions, if the enrollee or enrollee's representative is dissatisfied with IRE's reconsideration, the enrollee may request an ALJ hearing. The amount in controversy (AIC) to appeal at the ALJ level for 2015 is $1504.		
Level Four	Review by the Medicare Appeals Council within the Departmental Appeals Board in the Department of Health and Human Services: An on-the-record review of an ALJ's decision.		
Level Five	Judicial review in Federal District Court: A review of the decision by Federal District Court. The AIC to appeal at the Federal District Court for 2015 is $1,460.		

Part A Qualified Independent Contractors (QIC)

MAXIMUS Federal Services has been the Part A East contractor since 2005. Part A East reviews disputed claims from Part A providers, including disputes involving claims processed by MACs, RACs, QIOs, ZPICs, and PSCs.

Medicare Part A covers some of the costs of providing medically necessary inpatient hospital care, skilled nursing facility care following a hospital stay, home health care, and hospice care. Individuals entitled to Social Security or Railroad Retirement benefits are automatically entitled to Part A hospital insurance beginning with the first day of the month in which the individual attains the age of 65. Those younger than age 65 who receives Social Security disability benefits and those with end-stage renal disease (ESRD) are also entitled to Part A. Individuals who worked in certain Medicare-qualified federal, state, or local government employment may also qualify for coverage provided certain conditions are met.

Part A also provides CMS support in ALJ hearings through party and non-party participation in a select number of hearings and through adhoc reporting.

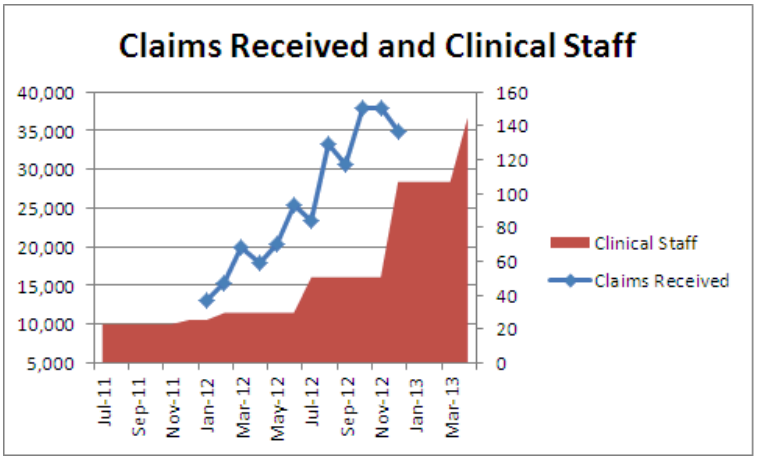
[2] The Part C IRE work is currently competed as a task order under the QIC Indefinite Delivery/Indefinite Quantity (IDIQ) contract.

[3] The Part C IRE work is currently competed as a task order under the QIC Indefinite Delivery/Indefinite Quantity (IDIQ) contract.

4 The AIC requirement for all ALJ hearings and Federal District Court reviews is adjusted annually in accordance with the medial care component of the Consumer Price Index. The table above reflects the calendar year 2015 AIC amounts.

Volume Challenges

MAXIMUS faced several issues that are directly related to the rapid, unprecedented volume that inundated us with appeals in spring and summer of 2013. As detailed in ***Error! Reference source not found.***, we were faced with drastic increases in the appeal volumes that were not anticipated in the initial contract. These increases were so dramatic that they effectively constituted requirements far beyond any foreseeable expectation of performance under this contract. To provide some context, in February 2010, we received a total of 4,953 appeals. In February 2012, we received a total of 12,865 appeals, an increase of 159%. In February 2013, one year later, we received 45,520 appeals, which is an increase of 253% over 2012 and 815% in the prior two year period.



In order to respond to the increasingly high volumes of appeals, we established an approach to increase our staff and our contracted physician medical reviewer panel and by adding subcontractors. We built and implemented Expert Gateway (EG) to allow remote users to connect to our Virtual Desktop Infrastructure (VDI) server. The driving force behind using the VDI solution was data security. The VDI is a secure environment that is controlled by MAXIMUS. Users cannot save data locally or copy, paste, or print data. All data is processed, saved, and archived on our VDI server.

In addition to adding staff and improving technology to address the increased volume we evolved our work processes. Such process changes included developing specialized teams to address specific case types allowing them to become Subject Matter Experts in their case types. This approach allowed us to be more agile with our responsiveness to volume fluctuations as we are able to rapidly increase the number of available clinicians. Using increased staff, new technology and improved processes, MAXIMUS Federal Services was able to resolve the backlog that began in Spring of 2013 as of September 2013.

Part B South Qualified Independent Contractors (QIC)

MAXIMUS Federal Services, through its wholly owned subsidiary Q2 Administrators, has been the Part B South contractor since 2006. Part B South reviews disputed claims from Part B providers, including disputes involving claims processed by MACs, RACs, ZPICs, and PSCs.

Medicare Part B covers some of the costs of receiving medically necessary services from physicians and other health care providers. Part B also covers some of the costs of medically necessary outpatient care, durable medical equipment, transportation, home health care, and some preventive services.

Part B also provides CMS support in ALJ hearings through party and non-party participation in a select number of hearings and through adhoc reporting.

Part C Qualified Independent Contractor (QIC)

MAXIMUS has been the sole Part C contractor since 1989 (the contract was originally held by a firm which MAXIMUS acquired). We address expedited pre-service cases (72-hour turnaround), standard pre-service cases (30-day turnaround) and standard retrospective claim payment cases (60-day turnaround) from various types of Medicare Advantage plans.

We review appeals for denials related to all services covered by Medicare Parts A and B: inpatient hospital, skilled nursing facility, hospice, and home health care and services; services from doctors and other health care providers, outpatient care, durable medical equipment; and some preventive services. In addition, most plans also include extra ("supplemental") benefits and services such as routine dental care, eyewear, or fitness programs. In addition to medical necessity issues, we also review cost-sharing, "lock-in," and health plan dismissals. Most appeals are submitted by Medicare beneficiaries and non-contract providers, both physicians and facilities.

Part D Qualified Independent Contractors (QIC)

The Part D QIC provides independent reconsideration of denials affecting Medicare beneficiaries. We have adjusted our staff and resources as necessary over the years to accommodate the fluctuations in both drug and Late Enrollment Penalty (LEP) appeals. MAXIMUS has been the only contractor in Part D since the inception of the program. . We review prescription drug denials from MAPDs and PDPs. We process both Redeterminations and Reopenings for issues in dispute which include formulary and tiering exceptions, prior authorization and other utilization management issues, medical necessity, off-label usage, and cost sharing. We review Late Enrollment (LEP) appeals as well.

The Administrative QIC (ADQIC)

MAXIMUS, through our wholly owned subsidiary Q2Administrators, has been the AdQIC since 2004. Under the AdQIC task, we provide administrative processes associated with Fee-for-Service (FFS) QICs. We develop, deliver, and update standard work protocols and training curriculums; produce Joint Operating Agreement (JOA) templates between the QICs and outside contractors; analyze data to identify appeals trends and spot improvement opportunities; analyze ALJ decisions for possible Departmental Appeals Board (DAB) review; manage document imaging; retain and store case files; and prepare draft CMS reports to Congress about the appeals processes. We support appeal statistics and programmatic support, the Office of General Council, and DOJ with case files for pending litigation.

Five Year QIC Volumes

QIC Part A East								
Year Received	Dismissed	Escalated	Favorable	Misrouted	Partially Favorable	Unfavorable	% Overturned	% Overturned-All
2010	2,758		3,965	150	2,316	55,099	10.2%	9.8%
2011	3,641		6,942	162	3,069	58,813	14.5%	13.8%
2012	4,624	620	23,572	108	2,900	183,247	12.6%	12.3%
2013	8,190	990	43,965	357	6,999	306,687	14.2%	13.9%
2014	2,985	13	36,999	278	3,524	187,570	17.8%	17.5%
QIC Part A West								

Year Received	Dismissed	Escalated	Favorable	Misrouted	Partially Favorable	Unfavorable	% Overturned	% Overturned-All
2010	1,251		1,763	243	1,671	15,082	18.5%	17.2%
2011	1,401		3,298	115	908	24,610	14.6%	13.9%
2012	2,224	525	16,258	75	1,134	79,532	17.9%	17.5%
2013	4,328	584	37,377	177	846	149,923	20.3%	19.8%
2014	1,657	12	26,595	206	2,318	85,074	25.4%	25.0%
QIC Part B South								
Year Received	Dismissed	Favorable	Misrouted	Partially Favorable	Unfavorable		% Overturned	% Overturned-All
2010	14,227	37,912	436	22,617	68,455		46.9%	42.1%
2011	12,185	34,679	414	27,032	68,986		47.2%	43.1%
2012	29,801	55,397	492	32,291	101,589		46.3%	39.9%
2013	20,016	45,670	548	31,779	81,658		48.7%	43.1%
2014	14,356	38,268	397	28,162	76,978		46.3%	42.0%
QIC Part C								
Year Received	Dismiss Appeal	Overturn MCO Denial	Partly Overturn MCO Denial	Uphold MCO Denial	Withdraw Appeal		% Overturned	% Overturned-All
2010	27,623	5,996	962	25,737	2,218		21.3%	11.1%
2011	36,117	4,677	675	24,671	2,458		17.8%	7.8%
2012	73,848	4,829	730	27,725	2,592		16.7%	5.1%
2013	82,936	3,956	338	28,029	4,084		13.3%	3.6%
2014	10,605	3,412	306	30,048	2,411		11.0%	7.9%
QIC Part D - Drug								
Year Received	Dismiss Appeal	Fully Reverse Plan	Partially Reverse Plan	Remand to Plan	Uphold Plan	Withdraw Appeal	% Overturned	% Overturned-All
2010	6,438	5,654	219	1	6,572	75	47.2%	31.0%
2011	5,036	3,372	200	7	5,107	30	41.2%	26.0%
2012	5,836	2,105	119	8	6,018	46	27.0%	15.7%
2013	5,127	4,091	210	144	14,108	36	23.4%	18.1%
2014	5,923	3,731	291	60	12,666	21	24.1%	17.7%
QIC Part D - LEP								
Year Received	Dismiss	Fully Reverse	Partially Reverse	Uphold	Withdraw		% Overturned	% Overturned-All
2010	8,137	17,152	1,713	7,931	320		70.4%	53.5%
2011	9,158	15,134	1,813	9,638	53		63.7%	47.3%
2012	7,025	17,469	2,190	10,521	51		65.1%	52.8%
2013	7,926	17,228	2,142	11,186	55		63.4%	50.3%
2014	9,368	20,688	2,565	13,558	49		63.2%	50.3%

* % Overturned excludes Dismissed, Withdrawn, Escalated, Misrouted, Remanded Dispositions in the denominator

** % Overturned-All includes all Dispositions in the denominator

Quality Assurance in our QIC Work

Our QA Department regularly and continuously selects a random sample of appeals in progress for each staff member. We recognize the importance of monitoring the quality of all aspects of an appeal, from the accuracy of the decision itself to the rationale used to arrive at the decision to the data recorded in the MAS. We draw a statistically valid sample of appeals from the previous month that exceeds the USOW minimum requirement of 50 decisions per month. This sample includes at least one decision per adjudicator per month. Sampling at this level allows for the evaluation of each staff member as well as the overall project performance. We review the validity of the decision, parties to the appeal, handling of requests for information, quality of the medical review, rationale supporting the decision, quality of the decision letter, and accuracy of the Medicare Appeal System (MAS) data. The results of the quality reviews and in-line structured audits are recorded and measured to identify trends or weaknesses in the process.

In addition to our internal QA processes each of our QIC programs is evaluated annually by CMS's outside independent Evaluation and Oversight contractor, Optimal Solutions.

Based upon our most recently reported audit by Optimal Solutions on our Part A East project, CMS rated MAXIMUS very good for quality of product. Under this audit CMS conducted a review of the quality of the QIC activities and overall compliance with the Statement of Work (SOW) requirements under this contract including review of more than 70 appeal case files. Through this quality review, CMS found that 95% (57 of the 60) of the standard and expedited reconsiderations reviewed were accurate, and 90% (70 of the 78) of the total cases reviewed met all of the remaining contractual requirements for overall timeliness of activities, quality of decision letters and/or case file organization in accordance with the SOW. Similarly for our Part A West project CMS rated us very good for quality of product finding 98.0% (59/60) of the standard and expedited reconsiderations reviewed were accurate and 92.0% (59/64) of the total cases reviewed met all of the remaining contractual requirements for overall timeliness of activities, quality of decision letters and/or case file organization in accordance with the SOW.

For our Part B South project CMS rated MAXIMUS very good for quality of product. CMS found that 97% (58 out of 60) of the reconsiderations reviewed were accurate and 90% (63 out of 70) of the total cases reviewed met all of the remaining contractual requirements for quality decision letters and/or case file organization in accordance with the SOW.

For our Part C project CMS found MAXIMUS exceptional for quality of product indicating. agreement with 98% of the reviewed decisions. For the AdQIC project CMS rated MAXIMUS exceptional for quality of product finding 98% (112/114) of the cases sampled without error. The results or our most recent Part D audit have yet to be released.

Efficiencies and Enhancements

CMS continually works diligently with all stakeholders in the audit and appeals process to improve the efficiency and effectiveness of the programs. Examples of recent CMS enhancements to the program include:

- Support of electronic records. Medicare Administrative Contractors are permitted to send case file records via secure electronic delivery system which ensures faster, cheaper and more efficient transfer of information. CMS is providing organization support to MFS creation of portal to receive appeal requests/information from appellants and Level 1 entities.

- MACs use of the Medicare Appeal System (MAS). This permits first level reviewers to utilize MAS to record pertinent case file information and allow QIC access to case file used by MAC.
- Adjusting Appointment of Representation (AOR) requirements for treating providers in Part C appeals permitting greater access to appeal process for enrollees.

In addition to the above we believe the following efficiencies and enhancements could assist overall program performance and satisfaction.

- Institute auto-escalation of Part D appeals. In Medicare Managed Care (Part C), beneficiary appeals are automatically escalated to the QIC after a Level 1 denial. However, with the exception of when a Part D plan misses its processing time frame, the beneficiary, or the prescriber on behalf of the beneficiary, is required complete an appeal request for Level 2 (IRE) Part D appeals. We believe this is a significant barrier for beneficiaries and is one of the likely reasons for the lower volume of Part D appeals. Allowing auto-escalation of Part D appeals to the IRE when the plan issues a redetermination denial would eliminate the burden on beneficiaries and their prescribers to take affirmative action, under tight deadlines, to continue the appeals process.
- Initiate coordination with Part D plans, enrollees and past employers to assist in addressing Part D Late Enrollment Penalties (LEPs). A reason for the high volume of LEP appeals is that at the time of joining a Part D plan, it is not 100% established whether a new member to the plan has had prior creditable coverage. This often leads to an LEP being assessed. Through the appropriate facilitation of communication between the new member, the entity proving prior coverage, if any, and the Part D plan, we believe an accurate creditable coverage determination can be made immediately upon enrollment, resulting in many fewer LEP appeals.
- Administratively establish a RAC/Audit Contractor only QIC in conjunction with administrative RAC (AdRAC) responsibilities. Along with processing RAC/Audit Contractor appeals the RAC QIC would provide support services to providers as well as a system to allow providers information on case status and other case related information including a customer services center and portal to provide stakeholders access to case status and other case processing information. Similar to the specialized teams we created to address the increase in volume we believe a RAC/Audit Contractor only QIC would ensure the most consistency for the program as well as a centralized resource to assist with program oversight and provider education.
- Create a RAC/Audit Contractor only ALJ unit while providing ALJs appropriate subject matter support such as nurses, physicians, certified coding specialists to assist ALJs in making determinations. We believe this will assist in ensuring consistent decisions and provide resources to significantly reduce existing backlog in a timely manner.
- In lieu of providing ALJ SME support, allow QICs to participate in a greater percentage of hearings. QIC hearing participation generally results in a significantly lower overturn rate at the ALJ level and provides appropriate subject matter expertise at the hearing.
- Have ALJ cases wherein a provider appellant submits new evidence remanded to the QIC for re-review. This will ensure the complete record is reviewed and will assist in reducing ALJ volumes.
- Change Audit Contractor pricing to a per case review as opposed to contingency pricing.
- Continue transition to fully electronic communication and access to case files between all appeal levels. Fully electronic communication and access to a case will provide the program significant time and cost efficiencies while ensuring access to the complete case file. Currently, QICs are required to

provide ALJs with paper case files, even though the QICs most likely received the case as electronic records. This means we are receiving electronic records and printing; organizing; packaging; shipping the files. Then ALJ must unpackage, organize, store, and retrieve paper files as opposed to placing electronic files in an electronic folder.

- Enhance the Scope of Work of the AdQIC making it responsible for the consistent and uniform application of all Medicare policies that relate to reviewing provider and supplier claims for medical necessity.