

April 1988

MEDICARE CLAIMS

HCFA Proposal to Establish an Administrative Law Judge Unit





United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-230538

April 20, 1988

The Honorable John C. Stennis
Chairman, Committee on Appropriations
United States Senate

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Jamie L. Whitten
Chairman, Committee on Appropriations
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

On March 25, 1988, we briefed certain of your offices on our work relative to the requirement in section 4037 of the Omnibus Budget Reconciliation Act of 1987 to study the Health Care Financing Administration's (HCFA) proposal to establish, at a cost of about \$15 million, its own hearings and appeals unit to handle Medicare cases. A special feature of this proposal was HCFA's projection that administrative law judges (ALJs) located in this unit would handle 50 percent of the appeals over the telephone. HCFA's proposal was presented to the Congress for funding in the fall of 1987; the proposal was not approved primarily because of congressional concerns about conducting the hearings by telephone rather than face-to-face.

We reviewed HCFA's documentation for its proposal and met with Department of Health and Human Services (HHS) officials responsible for developing the proposal and Office of Personnel Management officials responsible for approving and monitoring ALJs in federal agencies. We also discussed the proposal with health service provider associations, national associations representing the elderly, and Medicare claims processing contractors who currently use telephone hearings. (See p. 39.) This briefing report summarizes our work.

Medicare, authorized by title XVIII of the Social Security Act, provides health insurance coverage to most individuals age 65 and older. It is composed of two parts--the Hospital Insurance Program (part A) and the Supplementary Medical Insurance Program (part B). Claimants under parts A and B can appeal decisions made by Medicare concerning claims for reimbursement for services. The Social Security Administration's (SSA) ALJs have historically handled appeals by claimants under Medicare part A. The Omnibus Budget Reconciliation Act of 1986 extended the appeal rights of claimants under part B to include the right to request a hearing before an ALJ in some cases. HCFA estimates 24,000 Medicare cases will receive hearings each year; this includes approximately 7,000 part A and 17,000 part B cases.

Presently, SSA's Office of Hearings and Appeals handles a caseload of about 250,000 cases per year; 3 percent of these cases represent Medicare part A appeals. Cases reviewed by the Office of Hearings and Appeals require about 198 days to complete; no specific data are available on the average time it takes to complete a Medicare case. The average cost for the hearing process, per Medicare case, is about \$900. SSA has 666 ALJs and operates out of 10 regional offices with 134 field offices.

HCFA has proposed to establish its own ALJ unit to handle part A cases and the new part B cases. Under the proposal this unit would use 42 ALJs to hear cases and would operate from one central location. Although a telephone hearing would be at the option of the claimant, HCFA hopes to use the telephone for at least 50 percent of the hearings. Because HCFA believes that the Medicare cases are less difficult to hear than the cases handled by ALJs in other agencies, it is proposing to use GS-14 ALJs; all other federal agencies use ALJs who are GS-15s or higher.

HCFA believes that its proposed ALJ unit will provide faster and less expensive hearings than are currently experienced using the ALJs in SSA. HCFA estimates that it can complete a hearing in 60 days, and that it will cost about \$420 per case. HCFA also believes that its proposed central location concept will lead to improvements in the management of the caseload of the ALJs. For example, central case management will assist in case development, scheduling, and decision preparation. Further, HCFA believes that a centralized location will greatly facilitate ALJ training and will promote consistency in the application of the law and regulations. Also, by

operating from one location, HCFA believes it will be easier to maintain and train the support staff needed by the ALJs.

Assessing the HCFA proposal is difficult because HCFA has not tested its approach and has no empirical evidence to support key assumptions. We found that HCFA has little documentation for its proposal and does not have any experience or assurance that the program will operate as envisioned. For example, HCFA has no basis for its assumption of a 50-percent acceptance rate of telephone hearings, even though the level of acceptance of this type of hearing is central to the projected benefits. If a high enough telephone acceptance rate is not realized, central operations may not be feasible.

RECOMMENDATION TO THE CONGRESS

Given these uncertainties, we recommend that the Congress require HCFA to test and evaluate the proposal before implementation. A test could be done within SSA, or by HCFA in a selected region, or within a Medicare insurance carrier. The issues that should be examined in a test include such factors as the mix of claimants appealing both part A and part B cases; the actual telephone acceptance rate of this proposal; possible variations by type of claimant (e.g., beneficiaries, physicians) in acceptance of the telephone for hearings; the resulting time, caseload, and cost of hearings; and the performance of the hearings in meeting due process requirements. This information should provide HCFA and the appropriate congressional committees with better information on which to base decisions regarding the proposal.

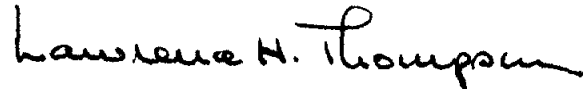
Because of time constraints, we did not obtain agency comments on this briefing report. However, we discussed the information in this report with HCFA officials and incorporated their comments where appropriate. HCFA officials told us that it would be difficult to test the proposal because they believe it would need to be totally implemented to demonstrate the benefits. We disagree. Testing on a small scale is feasible and should, in our opinion, provide needed information to evaluate HCFA's proposal.

B-230538

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Copies of this document are being sent to other interested congressional committees and other parties. If we can be of additional assistance, please call Ms. Janet L. Shikles, Associate Director, at 275-5451.

Sincerely yours,

A handwritten signature in cursive script that reads "Lawrence H. Thompson". The signature is written in dark ink and is positioned above the typed name.

Lawrence H. Thompson
Assistant Comptroller General

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Abbreviations

ALJ	administrative law judge
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OPM	Office of Personnel Management
SSA	Social Security Administration

CONGRESSIONAL BRIEFING

HCFA PROPOSAL
TO ESTABLISH
ALJ UNIT

Objective, Scope, and Methodology

- Review HCFA's proposal for ALJ unit
- Discuss proposal with national associations representing claimants
- Discuss telephone hearing experience with Medicare insurance carriers

OBJECTIVE, SCOPE AND METHODOLOGY

In the fall of 1987, the Health Care Financing Administration (HCFA), a component of the Department of Health and Human Services (HHS), proposed to establish its own hearings and appeals unit to handle Medicare claims. HCFA estimated that this could be done at a cost of about \$15 million. The plan to have an estimated 50 percent of the appeals handled by administrative law judges (ALJs) over the telephone represented a special feature of this proposal. Section 4037 of the Omnibus Budget Reconciliation Act of 1987 included a requirement that GAO review the proposal.

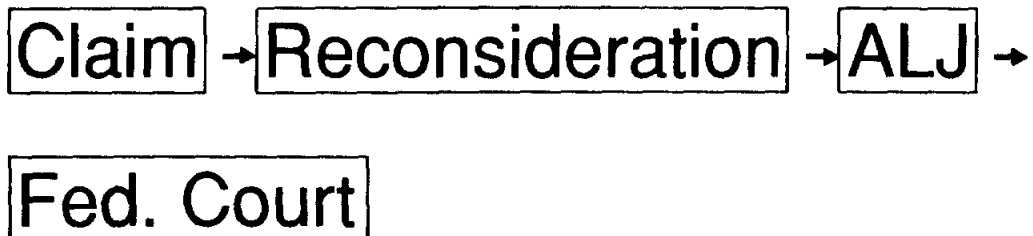
We reviewed HCFA's draft regulations and procedures for its proposed hearings and appeals program and documentation supporting its proposal. We also assessed whether the telephone hearing procedures provided the types of protective measures that due process requires.

We discussed the proposal in general, and the use of telephone hearings in particular, with medical service provider groups and representatives of national associations for the elderly. Because Medicare claims processing contractors use telephone hearings in resolving part B claims problems, we contacted 11 part B carriers and discussed their experiences in using the telephone to handle disagreements over claims with claimants. (See app. I for a list of associations and Medicare insurance carriers we contacted.)

We met with HHS officials responsible for proposing a hearings and appeals process in HCFA as well as Office of Personnel Management (OPM) officials responsible for approving and monitoring the use of ALJs in federal agencies. We also met with representatives of SSA's Office of Hearings and Appeals and the Chief Administrative Law Judges of the Department of Labor and the Department of Agriculture to determine how other federal agencies are organized to hear claims. We did not independently verify the data used by HCFA in its proposal. Except for this limitation, our work, which was done from January through March 1988, was performed in accordance with generally accepted government auditing standards.

Review Process (Pre-87) for Medicare Claims

Part A



Part B



REVIEW PROCESS FOR MEDICARE CLAIMS

Background

Medicare, authorized by title XVIII of the Social Security Act, provides health insurance coverage to most individuals age 65 and older, to certain persons who are entitled to Social Security or railroad retirement benefits because they are disabled, and to certain other individuals. Medicare is composed of two parts: the Hospital Insurance Program--part A; and the Supplementary Medical Insurance Program--part B.

Part A covers inpatient hospital care, posthospital care in a skilled nursing home, home health services, and hospice care for the terminally ill. Part B covers physicians' services and a range of other services, including outpatient hospital services, physical therapy, diagnostic, laboratory, and X-ray services.

Claims

HCFA contracts with various private insurance organizations to process claims for Medicare payments. Organizations handling claims from hospitals, skilled nursing facilities, and home health agencies are called intermediaries; organizations handling claims from doctors and other suppliers of services covered under part B are called carriers.

Reconsideration/Review

Under part A and part B, individuals can obtain a review of coverage determinations and determinations of amounts Medicare will pay on claims for services made by intermediaries or carriers. For decisions concerning part A, an individual can request a review by a Peer Review Organization (PRO)¹ for hospital stays. For all other part A services, an individual can request a reconsideration of the claim by the Medicare intermediary. The individual, if still in disagreement with the intermediary's decision, can request a hearing by an ALJ of the Social Security Administration (SSA), if the amount in question is \$100 or more. Cases involving \$1,000 or more can be appealed to a federal court after a hearing by the ALJ.

Under part B the individual, doctor, or supplier submits the claim for payment. If a disagreement exists on the amount of payment allowed on the claim, a request can be made to the Medicare carrier that handled the payment of the claim for a

¹PROs are groups of practicing doctors who are paid by the federal government to review hospital care of Medicare patients. PROs respond to requests for review of hospital decisions, and they investigate individual patient complaints.

review of that decision. If a disagreement still exists, a hearing by the carrier can be requested by the claimant. After January 1, 1987, an ALJ hearing could also be requested if the claimant was not satisfied with the outcome of the carrier fair hearing and at least \$500 was in controversy. When \$1,000 or more is in controversy, judicial review can be sought after an ALJ hearing.

The following data provided by HCFA show the total claims processed for part A for fiscal years 1986 and 1987, and the number of claims that were (1) reconsidered and (2) heard before an ALJ.

Table 1:
HCFA Data on Part A Claims

	Number	
<u>Part A claims</u>	<u>1986</u>	<u>1987</u>
Claims:	(millions)	
Total processed	64.6	67.4
Denied in whole or in part	2.6	3.1
Reconsiderations:	(thousands)	
Total processed	34,491	72,843
Affirmed ^a	28,692	54,303
Reversed in whole or in part ^b	2,716	6,629
Claims in process	3,083	11,911
Requesting ALJ hearing	5,382	8,199

^aAffirmed means that the claim was reviewed and the intermediary's initial denial decision was upheld.

^bReversed means that the decision of the intermediary on the claim was changed or decided in whole or in part in favor of the claimant.

Part B claims data provided by HCFA show the number of claims processed, reviewed, and for which a carrier fair hearing was held for fiscal years 1986 and 1987.

Table 2:
HCFA Data on Part B Claims

<u>Part B claims</u>	<u>Number</u>	
	<u>1986</u>	<u>1987</u>
Claims:	(millions)	
Total processed	298.9	338.3
Denied in whole or in part	50.7	60.1
Reviews:		
Total processed	4.6	5.5
Affirmed	1.8	2.2
Reversed in whole or in part	2.8	3.3
Carrier fair hearings:	(thousands)	
Hearings held	35,262	48,366
Affirmed	18,581	26,177
Reversed in whole or in part	16,681	22,189

1986 Legislative Change Part B - ALJ Hearings

- Effective 1-1-87, claims under Part B are allowed an ALJ hearing, if requested, and can be appealed to federal court
- April 1987, HCFA requires all Part B claims to have carrier fair hearing before having an ALJ hearing

1986 LEGISLATIVE CHANGE
ALLOWING PART B ALJ HEARINGS

The Omnibus Budget Reconciliation Act of 1986 allowed, effective January 1, 1987, claimants to request ALJ hearings for part B claims where the amount in controversy was at least \$500. Before passage of the act, the last level of appeal for a part B claimant was the carrier fair hearing. Now, part B claimants may request an ALJ hearing, and for cases amounting to \$1,000 or more, these claimants may appeal to a federal court after an ALJ hearing.

In April 1987, HCFA required that claimants requesting an ALJ hearing first complete the carrier fair hearing process. This requirement was intended to encourage the settlement of disagreements between the claimant and Medicare at a lower level and to reduce the number of cases going to an ALJ hearing.

SSA's ALJ Process

- SSA's Office of Hearings and Appeals
 - 666 ALJs in 134 field offices
 - 250,000 cases--3% Medicare
 - 198 days to complete hearing of a case
 - \$900 per case

SSA's ALJ PROCESS

Medicare part A appeals are currently heard by ALJs in SSA's Office of Hearings and Appeals. Until a decision is made concerning the HCFA ALJ unit, SSA's ALJs will also be responsible for hearing Medicare claims appealed under part B. These ALJs operate from SSA's 10 regional offices and 134 field offices. Currently there are 666 ALJs, most of whom are paid at the GS-15 level.

In fiscal year 1987, the Office of Hearings and Appeals handled about 250,000 cases, approximately 3 percent of which were Medicare. The average time to complete a hearing for all cases was about 198 days. SSA does not have specific data on the average number of days required to complete Medicare cases. The average cost for each Medicare case was about \$900. Each SSA ALJ handles about 30 cases per month.

HCFA Proposal to Establish ALJ Unit

- Establish ALJs in HCFA separate from SSA
- Operate from central location, specializing in Medicare claims
- Use telephone for hearings
- Staff with GS-14's

HCFA PROPOSAL TO
ESTABLISH ALJ UNIT

HCFA proposes to establish its own ALJ unit to handle Medicare cases. This unit would be operated from one central location with the ALJs specializing in Medicare claims. HCFA believes that instead of face-to-face hearings, it can use the telephone to handle about 50 percent of these cases. HCFA also believes that Medicare cases are less difficult than Social Security appeals and thus proposes to use GS-14 ALJs to hear these cases rather than GS-15 ALJs.

The proposal that HCFA presented to the Congress in the fall of 1987 requested \$15,348,000 to increase its fiscal year 1988 budget to implement and support its Medicare part A and B hearings and appeals activities. This proposal called for 42 GS-14 ALJs to hear an estimated 24,000 part A and B Medicare cases. It also called for four GS-15 appeals board members who would review ALJ decisions issued under part A and B. In addition, HCFA proposed adding six GS-15 ALJs to handle termination and sanction hearings that deal with the performance of providers of service under Medicare. The support staff for the new unit was estimated at 188 employees.

HCFA Estimated Benefits of the Proposal

- ALJs specializing in Medicare
- More timely hearings
 - Reduced time for hearings from 198 days to 60 days
- Cost savings
 - Reduced average cost of ALJ hearing from \$900 to \$420

HCFA ESTIMATED BENEFITS
OF THE PROPOSAL

HCFA believes that establishing a unit with ALJs who only hear Medicare cases and who also are experts in the Medicare statute and regulations will allow for better decisions for Medicare claimants and the Medicare program. It believes that by having its own hearing process, more timely hearings can be achieved relative to the present SSA system. HCFA estimates it would have hearings completed in 60 days; it also expects to reduce the cost of a hearing from the current SSA cost of about \$900 to about \$420. HCFA has made certain assumptions that we will discuss in detail later in this document. These assumptions, such as the acceptance rate of the telephone for hearings and the operation from one central location, HCFA believes, will allow it to obtain these benefits.

Assumptions Behind the Proposal

- Sufficient caseload for separate hearing office
- Acceptance of telephone for hearings
- Operate out of central location
- Use GS-14's specializing in Medicare

ASSUMPTIONS BEHIND THE PROPOSAL

HCFA believes that by combining the part A and part B Medicare cases, it will have a sufficient number of cases to justify a separate hearings and appeals unit. Also, HCFA believes that use of telephone hearings will be widely accepted by claimants and that operation from one central location will be feasible. HCFA believes that it can use GS-14 ALJs who are knowledgeable of the Medicare program. The following pages discuss the assumptions behind the proposal.

Caseload for Medicare ALJs Part A

- Part A--Estimated 7,000 per year
- Estimate higher than actual FY 86 and lower than FY 87 cases

CASELOAD FOR MEDICARE ALJs,
PART A

HCFA estimates that it will have 7,000 part A claimants requesting an ALJ hearing each year. The basis for HCFA's part A caseload estimate of 7,000 is the actual fiscal year 1986 caseload of 5,382 plus an estimate for future growth. The fiscal year 1987 caseload was 8,199.

Caseload for Medicare ALJs Part B

- Part B-- Estimated 17,000 per year
- No actual experience figures for comparison

CASELOAD FOR MEDICARE ALJs,
PART B

HCFA estimates that 17,000 part B claimants will request an ALJ hearing each year. HCFA estimates that annually 45,000 part B cases would involve a carrier fair hearing. From that figure, 11,250 cases would not be eligible for an ALJ hearing because the dispute would be less than \$500. An estimated 24,000 would be eligible for an ALJ hearing following action by the carrier hearing officer and 70 percent of these claimants, or about 17,000, would request an ALJ hearing each year.

The estimate of 45,000 carrier fair hearings is based on 40,634 hearing requests reported by the carriers for fiscal year 1986, plus an allowance for growth. For fiscal year 1987, there were 51,783 requests for part B carrier fair hearings. According to HCFA, its estimate that 11,250, or 25 percent of the cases, would involve less than \$500 and would therefore be ineligible for appeal to an ALJ was based on estimates provided by several carriers. The estimate of 17,000 cases resolved by the carrier fair hearings process in favor of the claimants was based on an assumed effective reversal rate of 30 percent as a result of the carrier fair hearing.

HCFA has no actual data to support its estimate that 17,000 part B claimants would request an ALJ hearing. As of March 1, 1988, 14 months after the date when part B claimants could request a hearing before an ALJ, HCFA had about 200 claims waiting review by an ALJ. As of April 11, 1988, according to SSA's Chief ALJ, 8 part B cases had been heard. According to HCFA, it can take close to 12 months for an individual to move through the claims and review process before requesting a hearing before an ALJ. Thus, the extent to which part B claimants might request ALJ hearings remains uncertain.

Will Telephone Hearings Be Accepted?

- Assumes 50 percent use
- No data on types of claimants and possible telephone acceptance rate
- Other federal agencies use for fact finding only
- No evaluation of carrier level telephone hearing experience
- Claimants interviewed uncertain of acceptance of telephone hearings

WILL TELEPHONE HEARINGS BE ACCEPTED?

Although telephone hearings will be voluntary for claimants, HCFA assumes that 50 percent of the claimants will request a telephone hearing once the program is in operation. If a telephone hearing is not requested, a HCFA ALJ will travel to the claimant to provide a face-to-face hearing. According to HCFA officials, the use of the telephone will reduce program administrative costs by reducing travel costs to conduct face-to-face hearings. With reduced travel, an ALJ will be able to conduct more hearings--estimated by HCFA at 50 per month. At this rate HCFA believes hearings could be completed in an average of 60 days.

HCFA has no data concerning the likelihood of Medicare claimants choosing a telephone hearing over a face-to-face hearing. Also, HCFA has no data to support how a HCFA ALJ could perform 50 hearings per month. HCFA has no information on the type of claimants it expects to serve. For example, it does not know whether beneficiaries, doctors, or suppliers will be the predominant users of the hearing process, and whether the type of claimant might affect the acceptance rate of telephone hearings.

Currently, no federal agency conducts ALJ telephone hearings. HHS's Grant Appeals Board uses the telephone to perform various pretrial functions, but hearings are not conducted over the telephone.

For the last 4 years, HCFA has allowed part B carriers to provide the option of a telephone hearing in carrying out carrier fair hearings for claimants. We contacted 11 part B carriers concerning the use of the telephone for fair hearings. They reported that actual use varies from very little to about 50 percent of the cases heard. These carriers had a hearing caseload for part B that ranged from 100 to 8,000. All carrier representatives agreed that the biggest advantage to telephone hearings is the reduction in travel costs to perform face-to-face hearings. HCFA has not evaluated the use of the telephone hearings conducted at the carrier level, nor have the carriers that we contacted.

During discussions with representatives of various national associations for the elderly and with health service providers, both parties expressed their concerns about the use of the telephone to conduct ALJ hearings. Their concerns were as follows:

- whether due process (see p. 37) or a fair hearing could be achieved over the telephone,
- whether evidence could be added and witnesses cross-examined over the telephone, and

-- whether a person could be represented by counsel or have other witnesses at the hearing if it was done over the telephone.

Representatives of these organizations also raised the concern that a claimant may feel pressured to use the telephone option because a face-to-face hearing could not be set up in the same time frame as a telephone hearing. The claimant might then choose the telephone hearing because it could be accomplished sooner.

Operation Out of Central Location

- Assumes extensive use of the telephone for nationwide program coverage
- Assumes improved program operation with specialized ALJs for Medicare program

OPERATION OUT OF A CENTRAL LOCATION

HCFA believes that its ALJ unit could operate from one central location and provide complete program coverage. The basis for this assumption is that it can use the telephone for a large number of the required hearings. If a high enough telephone acceptance rate is not realized, central operation may not be efficient.

HCFA also believes that the central location concept will lead to improvements in the management of the caseload of the ALJs. For example, central case management will provide direction and administrative support staff to assist ALJs in case development, scheduling hearings so that all ALJs have a full caseload, and providing assistance to ALJs in decision preparation. Further, HCFA believes that a centralized location will greatly facilitate ALJ training and will promote consistency in the application of the law and regulations. Also, by operating from one location, HCFA expects it will be easier to maintain and train the support staff needed by the ALJs.

Use of GS-14's as ALJs

- Medicare cases less difficult than SSA disability cases
- Other federal agencies use GS-15's or higher for ALJs
- No GS-14's register for ALJs

USE OF GS-14's AS ALJs

According to HCFA, the use of GS-14 ALJs is possible because the Medicare cases would be less complex than those handled by higher graded SSA ALJs. HCFA states that the type of case heard by an ALJ would be the result of a disagreement between a beneficiary, a physician, or a medical supplier and the Medicare program over the amount of reimbursement for a specific type of medical service received. The dispute could also be over coverage of particular medical service. According to HCFA, these cases do not require review of conflicting evidence or generally require ALJs to review expert medical opinions; instead they require a knowledge of the Medicare statute and regulations. However, if the disagreement is over a medical coverage problem, review of medical opinions may be necessary.

According to HCFA, the reason GS-15's are used to hear SSA disability cases is that a higher level of judgment is needed to analyze conflicting medical opinions relative to the physical or mental disabilities of individuals. The result of this analysis of medical testimony determines whether the claimant is eligible to receive payment under title II of the Social Security Act. ALJs used by other federal agencies are also at the GS-15 level or higher.

On August 12, 1987, OPM classified the HCFA ALJ position at the GS-14 level. OPM officials told us that the GS-14 position was approved based on the duties to be performed as described by HCFA for these individuals. According to OPM, there is no GS-14 register of candidates qualified to be ALJs, which means that a HCFA ALJ would be selected from a GS-15 register but paid at a GS-14 level. OPM officials told us that placement on the register is based on the individual's qualifications. The better qualified individuals are ranked higher and normally receive employment first. In order to assess the willingness of these individuals to work at the GS-14 level, HCFA officials contacted candidates on the GS-15 register. Of several hundred candidates on the GS-15 register, HCFA was able to locate 28 from the top 100 who would accept work at the GS-14 level in the HCFA program.

Protections for Claimants

- Due process and the telephone hearings
- HCFA draft regulations and procedures

PROTECTIONS FOR CLAIMANTS

HCFA's proposed telephone hearing procedures provide the types of protective measures that due process requires. They provide that parties must receive adequate notice and copies of all documentary evidence before the hearing and have an opportunity to participate and present oral and/or written evidence, examine or cross-examine witnesses, and be represented by counsel. The ALJ is charged with conducting an impartial hearing and inquiring into all matters at issue. At any time before or during a telephone hearing, the ALJ may require an in-person hearing if he/she determines that the veracity of a party or witness is at issue, that the issues are too complex for telephone hearings, or that the number of witnesses makes the telephone hearing impractical. The ALJ may reopen a hearing, at any time before decision, to receive new material evidence. After decision, a party may petition the proposed HCFA Medicare Review Board for further review if judicial review is not available. The board is to be established to hear appeals by claimants and may review any ALJ decision. Due process protects individuals against arbitrary government action that affects their property interests. Until 1970, loss of government benefits, such as Medicare benefits, was not considered the loss of a property interest protected by due process.

In 1970, the Supreme Court, in the landmark case of Goldberg v. Kelly, 397 U.S. 254 (1970), held that a person's statutory entitlement to welfare benefits is a form of property interest that cannot be terminated without a pretermination hearing that satisfied specific requirements of due process. The Goldberg case and many cases following it have substantially increased the administrative requirements on government agencies as more and more interests have been identified as subject to due process protections.

The cases decided after Goldberg have adopted the concept of "flexible due process," where the procedures are determined for the circumstances of the particular case. The complexity and formality of procedures can vary widely from brief and expeditious to elaborate and comprehensive, depending on the circumstances. For example, in Goldberg, the court determined that a person must be afforded a pretermination hearing that closely approximates a judicial trial with notice, the right to present testimony and evidence, the right to cross-examine and confront adverse witnesses, the right to be represented by counsel, the right to have an impartial decision maker, and the right to a written decision based on the evidence presented at the hearing. In contrast, in Goss v. Lopez, 419 U.S. 565 (1975), which involved a 10-day suspension of a student from high school, the court determined that a person was entitled only to notice, an opportunity to be heard, and a postsuspension hearing.

The required elements of due process vary according to the circumstances of a particular case and may include any, or all, of the following procedural protections:

1. timely and adequate notice,
2. right to disclosure of evidence,
3. right to present evidence and witnesses,
4. right to representation,
5. right to appointed or retained counsel,
6. right to cross-examine adverse witnesses,
7. right to an impartial decision maker, and
8. right to a prompt written decision.

Due process requirements do not mandate that all hearings be oral. Written submissions (a hearing on the record) can be acceptable under some circumstances. However, since the Goldberg v. Kelly decision emphasized the importance of the personal appearance in the welfare setting and expressly disapproved of the use of written submissions, most programs involving government benefits have adopted the oral hearing. The opportunity to be heard must be granted at a meaningful time and in a meaningful manner. Armstrong v. Manzo, 380 U.S. 545 (1965). The degree of formality and procedural requirements can vary widely in compliance with this general standard and must be tailored to the capacities of the parties. An important consideration is to make the hearing work, and to achieve a fair process under the circumstances.

The U.S. Supreme Court has identified three factors that must be considered in determining what procedural protections are necessary to guarantee due process. These are: (1) The private interest that will be affected by official action. (2) The risk of erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards. (3) The government's interest, including the function involved and fiscal administrative burdens that the procedural requirements would involve. Mathews v. Eldridge, 424 U.S. 319 (1976).

Conclusions and Recommendation to the Congress

- Medicare caseload increasing
- SSA process costly and slow
- HCFA expects its process to be less expensive and faster--but untested
- HCFA's proposal should be tested

CONCLUSIONS AND RECOMMENDATION TO THE CONGRESS

In summary, HCFA believes that its proposal to establish its own hearings and appeals unit separate from that of SSA would be an effective and efficient approach to hearing an estimated 17,000 additional Medicare cases each year. These new cases are the result of the 1986 legislative change that provided part B claimants the opportunity to request an ALJ hearing. HCFA's proposal, however, is dependent on an acceptance rate of about 50 percent for claimants using telephone rather than face-to-face hearings. If a high enough telephone acceptance rate is not realized, and it becomes difficult to operate from one central location, the expected timeliness in hearings and cost savings may not be achieved. The difficulty in assessing the HCFA proposal is that HCFA has not tested this approach, and it has no empirical evidence to support key assumptions.

Given these uncertainties, we recommend that the Congress require HCFA to test and evaluate the proposal before implementation. A test could be done within SSA, or by HCFA in a selected region, or within a Medicare insurance carrier. The issues that should be examined in a test include such factors as the mix of claimants appealing both part A and part B cases; the actual telephone acceptance rate of this proposal; possible variations by type of claimant (e.g., beneficiaries, physicians) in acceptance of the telephone for hearings; the resulting time, caseload, and cost of hearings; and the performance of the hearings in meeting due process requirements. The results from testing these factors should provide HCFA and the appropriate congressional committees with better information on which to base decisions regarding the proposal.

HCFA officials told us that it would be difficult to test the proposal because they believe it would need to be totally implemented to demonstrate the benefits. They stated that a test may not produce the projected level of acceptance of telephone hearings since they believe it may take some time before the 50-percent telephone acceptance rate for hearings is achieved. In addition, they believe the innovative case management procedure they propose would be difficult to test in the current SSA hearing process. Further, they stated the Medicare insurance carrier experience may not provide a suitable test for the proposal. We disagree. We believe testing on a small scale is feasible and should, in our opinion, provide needed information to evaluate HCFA's proposal.

LIST OF ASSOCIATIONS AND PART B CARRIERSAssociations

American Association of Retired Persons
Medicare Advocacy Project, Los Angeles, CA
National Senior Citizens Law Center
Center for Medicare Advocacy, South Windham, CT.
Center for Health Care Law
National Council of Senior Citizens
American Health Care Association
National Council on the Aging, Inc.
American Medical Association
National Association of Medical Equipment Suppliers
Health Industry Manufacturers Association
American Federation of Home Health Agencies
National Association for Home Care

Part B Carriers

Equicor
Nationwide Mutual
The Travelers
Prudential Insurance
Blue Cross/Blue Shield of Florida
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