

FACT SHEET: HHS Proposes Improvements to the Medicare Appeals Process

Overview

The U.S. Department of Health and Human Services (HHS) announced June 28, 2016 it is proposing changes to the Medicare appeals process that would streamline administrative appeal processes, increase consistency in decision making across appeal levels, and improve efficiency for both appellants and adjudicators.

Background

The Medicare appeals process is experiencing a sustained increase in the number of appeals. This increase, coupled with only modest increases in funding, has created a significant backlog of appeals at the third and fourth levels of appeal, which are administered by the Office of Medicare Hearings and Appeals (OMHA), which conducts Administrative Law Judge (ALJ) hearings, and the Departmental Appeals Board (DAB), which houses the Medicare Appeals Council. (For additional information on the backlog, see the HHS Primer: The Medicare Appeals Process, available on OMHA's website at <http://www.hhs.gov/omha/files/medicare-appeals-backlog.pdf>.)

HHS has developed a three-pronged strategy to address the backlog:

- 1) Invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog.
- 2) Take administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process.
- 3) Propose legislative reforms that provide additional funding and new authorities to address the appeals volume.

The proposed regulatory changes in the Notice of Proposed Rulemaking (NPRM) are the latest in a series of administrative actions designed to reduce the number of pending appeals and encourage resolution of cases earlier in the Medicare appeals process. The NPRM demonstrates HHS's continuing commitment to addressing the Medicare appeals workload challenges, and is one part of HHS's comprehensive effort to address the appeals workload through every available administrative means under current statutory and budgetary authorities.

In addition to these administrative actions, the FY 2017 President's Budget requests additional funding to bring disposition capacity in line with current appeal volume at both the OMHA and the DAB. The budget request also includes a comprehensive legislative package aimed at both helping HHS process a greater number of appeals and encouraging resolution of appeals earlier in the process before they reach the Office of Medicare Hearing and Appeals (OMHA) and the Departmental Appeals Board (DAB). If the Administration could implement the administrative authorities set forth in this NPRM in conjunction with the proposed funding increases and legislative actions outlined in the FY 2017 President's Budget, we estimate that that the backlog of appeals could be eliminated by FY 2021.

Proposed Changes to the Medicare Appeals Process

The proposals in the NPRM are primarily focused on the third level of appeal and would:

- **Designate select Medicare Appeals Council decisions (final decisions of the Secretary) as precedential** to provide more consistency in decisions at all levels of appeal, reducing the resources required to render decisions, and possibly reducing appeal rates by providing clarity to appellants and adjudicators.
- **Expand OMHA's available adjudicator pool** by allowing attorney adjudicators to decide appeals for which a decision can be issued without a hearing, review Qualified Independent Contractor (QIC) dismissals, issue remands to Centers for Medicare & Medicaid Services (CMS) contractors, and dismiss requests for hearing when an appellant withdraws the request. This change would allow ALJs to focus their efforts on conducting hearings and adjudicating the merits of more complex cases.
- **Revise the amount in controversy (AIC) calculation** for certain claim appeals to generally use the Medicare allowable amount (rather than the billed amount) for most Part B claims. This change would more closely align the AIC, which is the threshold amount required for an ALJ hearing, with the actual amount in dispute in an appeal.
- **Simplify proceedings when CMS or CMS contractors are involved** by limiting the number of entities (CMS or contractors) that can be a participant or party at the hearing (although additional entities may continue to submit position papers and/or written testimony).
- **Clarify areas of the regulations** that currently confuse appellants or OMHA staff and may result in unnecessary appeals to the Medicare Appeals Council.
- **Create process efficiencies** by eliminating unnecessary steps (e.g., by allowing ALJs to vacate their own dismissals rather than requiring appellants to appeal a dismissal to the Medicare Appeals Council); streamlining certain procedures (e.g., by using telephone hearings for appellants who are not unrepresented beneficiaries, unless the ALJ finds good cause for an appearance by other means); and requiring appellants to provide more information on what they are appealing and who will be attending a hearing.
- **Address areas for improvement previously identified by stakeholders** to increase the quality of the process and responsiveness to customers, such as establishing an adjudication time frame for cases remanded from the Medicare Appeals Council,

revising remand rules to better ensure cases keep moving forward in the process, simplifying the escalation process, and providing more specific rules on what constitutes good cause for new evidence to be admitted at the ALJ level of appeal.