

September 2003

MEDICARE APPEALS

Disparity between Requirements and Responsible Agencies' Capabilities





Highlights of [GAO-03-841](#), a report to the Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Appellants and others have been concerned about the length of time it takes for a decision on the appeal of a denied Medicare claim. In December 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required, among other things, shorter decision time frames. BIPA's provisions related to Medicare appeals were to be applied to claims denied after October 1, 2002, but many of the changes have not yet been implemented. GAO was asked to evaluate whether the current Medicare appeals process is operating consistent with BIPA's requirements and to identify any barriers to meeting the law's requirements.

What GAO Recommends

GAO recommends that the Secretary of HHS and the Commissioner of SSA more closely coordinate their efforts to improve administrative processing, develop strategies for reducing the backlog of pending cases, and establish data requirements to facilitate the successful implementation of BIPA's mandated changes. HHS and SSA agreed that inefficiencies in the appeals process require attention and that the process would benefit from better coordination.

www.gao.gov/cgi-bin/getrpt?GAO-03-841.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600.

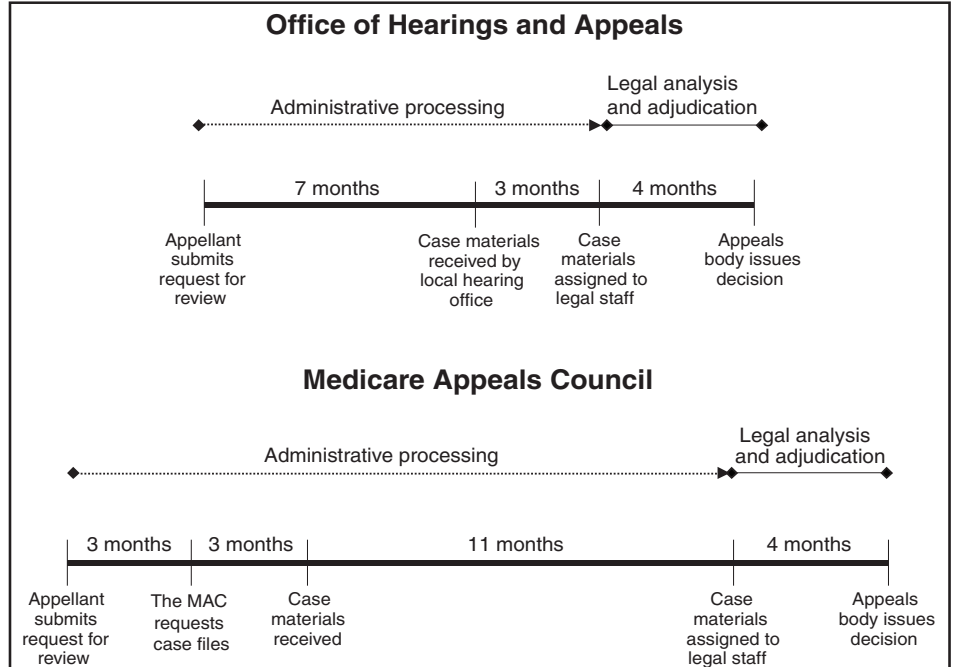
MEDICARE APPEALS

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What GAO Found

BIPA demands a level of performance, especially regarding timeliness, that the appeals bodies—the contract insurance carriers responsible for the first two levels of appeals, the Social Security Administration's (SSA) Office of Hearings and Appeals (OHA), and the Department of Health and Human Services (HHS) Medicare Appeals Council (MAC)—have not demonstrated they can meet. While the carriers have generally met their pre-BIPA time requirements, in fiscal year 2001, they completed only 43 percent of first level appeals within BIPA's 30-day time frame. In addition to average processing times more than four times longer than that required by BIPA, OHA and the MAC—the two highest levels of appeal—have accumulated sizable backlogs of unresolved cases. Delays in administrative processing due to inefficiencies and incompatibility of their data systems constitute 70 percent of the time spent processing appeals at the OHA and MAC levels.

Average Time Spent in Each Stage of Processing for Cases Adjudicated by OHA and the MAC in Fiscal Year 2001



Sources: OHA and the MAC.

The appeals bodies are housed in two different agencies—HHS and SSA. The lack of a single entity to set priorities and address operational problems—such as incompatible data and administrative systems—at all four levels of the process has precluded successful management of the appeals system as a whole. Uncertainty about funding and a possible transfer of OHA's Medicare appeals workload from OHA to HHS has also complicated the appeals bodies' ability to adequately plan for the future.

Contents

Letter		1
	Results in Brief	2
	Background	3
	Appeals Process Operations Inconsistent with BIPA's Requirements	9
	Appeals Bodies' Lack of Coordination and Resources Is a Barrier to BIPA Implementation	14
	Conclusions	20
	Recommendations for Executive Action	21
	Agency Comments and Our Evaluation	21
Appendix I	Scope and Methodology	25
Appendix II	The Scope of Part B Claims Rejections, Denials, and Appeals	28
Appendix III	Changes Mandated by Section 521 of BIPA	31
Appendix IV	Comments from the Department of Health and Human Services	33
Appendix V	Comments from the Social Security Administration	40
Appendix VI	GAO Contact and Staff Acknowledgments	45
	GAO Contact	45
	Acknowledgments	45

Tables

Table 1: Reason for Denials of Initial Medicare Part B Claims in Fiscal Year 2001	29
Table 2: Growth in Part B Appeals Cases Submitted by Appeal Level from Fiscal Year 1996 through Fiscal Year 2001	30

Figures

Figure 1: Levels and Time Frames for the Pre-BIPA and BIPA-Mandated Appeals Process	6
Figure 2: Average Time Spent in Each Stage of Processing for Cases Adjudicated by OHA and the MAC in Fiscal Year 2001	12

Abbreviations

ALJ	administrative law judge
BIPA	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
CROWD	Contractor Reporting of Operational and Workload Data
DAB	Departmental Appeals Board
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
LCD	local coverage determination
LMRP	local medical review policy
MAC	Medicare Appeals Council
MOU	memorandum of understanding
NCD	national coverage determination
OHA	Office of Hearings and Appeals
QIC	qualified independent contractor
SOW	statement of work
SSA	Social Security Administration

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G A O

Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

September 29, 2003

The Honorable W.J. “Billy” Tauzin
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

In fiscal year 2002, Medicare—the nation’s largest health insurer—paid over \$200 billion to provide medical care to 40 million elderly and disabled beneficiaries. The Centers for Medicare & Medicaid Services (CMS),¹ an agency within the Department of Health and Human Services (HHS), administers the Medicare program with the help of about 50 claims administration contractors. Among other things, CMS is charged with protecting the program by identifying and denying health care claims that are invalid, incomplete, or otherwise appear to be improper. Beneficiaries and providers² may pursue the payment of denied claims through a multilevel administrative appeals process. The entities—or appeals bodies—that constitute the process include the Social Security Administration (SSA) and HHS’s Departmental Appeals Board (DAB), in addition to CMS. In fiscal year 2001, 3.7 million Part B³ appeals were submitted to the first level in the process.

In recent years, there has been widespread concern about the length of time it takes the appeals bodies to render decisions. In December 2000, the Congress enacted the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 521 of BIPA amended section 1869 of the Social Security Act by mandating shorter

¹On June 14, 2001, the Secretary of Health and Human Services announced that the name of the Health Care Financing Administration (HCFA) had been changed to the Centers for Medicare & Medicaid Services. In this report, we will refer to HCFA where our findings apply to operations that took place under that organizational structure and name.

²For the purposes of this report, the term “provider” refers to any nonbeneficiary appellant, including physicians and other suppliers.

³Medicare 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.

time frames and expedited procedures for processing Medicare appeals.⁴ It also added the requirement that the Secretary of HHS report on the number of appealed claims and consistency of appeals decisions. The provisions were to be applied to claims denied on or after October 1, 2002.

Concerned about the appeals bodies' ability to implement BIPA's provisions, you asked that we conduct an assessment of the Medicare appeals process. Specifically, we examined whether (1) the current appeals process is operating consistent with BIPA's requirements and (2) there are any barriers in meeting the law's requirements.

Because the majority of appeals are related to the denial of Part B claims, we limited our work to assessing the appeals process for these claims. We reviewed statutes, regulations, policies, and other documentation related to the four levels of the administrative appeals process, including Part B carriers,⁵ which conduct the first two levels of appeal; the Office of Hearings and Appeals (OHA) within SSA, which hears the third level of appeals; and the Medicare Appeals Council (MAC) within HHS's DAB, which reviews OHA's decisions. To assess the conditions present at the time BIPA was passed, we analyzed fiscal year 2001 appeals processing data. We subsequently reviewed more current data and confirmed that the conditions were relatively unchanged. We interviewed officials from CMS, OHA, and the MAC to discuss the management of the appeals process and the implementation of BIPA requirements. We conducted our work from November 2001 through September 2003, in accordance with generally accepted government auditing standards. (See app. I for more information on our scope and methodology.)

Results in Brief

The appeals bodies are not currently performing at the level that would enable them to meet BIPA's more rigorous timeliness requirements. Their performance is far from meeting BIPA requirements with the two higher levels of appeal taking, on average, more than four times the amount of time BIPA requires to complete an appeal. In addition, both OHA and the MAC face large backlogs of pending appeals because they have been unable to routinely resolve all of the appeals that they receive. Long-

⁴Pub. L. No. 106-554, app. F, 114 Stat. 2763, 2763A-534 (codified at 42 U.S.C. § 1395ff (2000)).

⁵Medicare contractors that process Part A claims are called fiscal intermediaries, while those that process Part B claims are called carriers.

standing administrative problems among the appeals bodies, such as time-consuming transfers of paper appeals files and delays caused by outdated technology, which account for about 70 percent of the time spent in processing appeals at OHA and the MAC, have not been corrected. BIPA's provision allowing appellants the right to bypass appeals bodies that do not resolve their appeals within prescribed time frames by elevating them to the next level may only shift processing delays to the higher appeals bodies. The combined effect of these factors has prevented the appeals bodies from attaining the level of performance BIPA demands.

The appeals bodies face several barriers to the successful implementation of BIPA. Because appeals bodies are housed in different agencies, the coordination among them is inherently difficult. Each agency has its own priorities and, although officials from the appeals bodies worked together to develop a proposed rule for the implementation of BIPA, they have not coordinated their BIPA implementation strategy. The lack of adequate data to pinpoint weaknesses in the appeals process and enable informed decision-making has further hindered BIPA's implementation. And, although some of the appeals bodies are planning to obtain or have implemented new data management systems, they have not coordinated with their counterparts to ensure compatibility of the systems across agencies. Uncertainty about funding and a possible transfer of the OHA's Medicare appeals workload from OHA to HHS has also complicated the appeals bodies' ability to adequately plan for the future.

We are recommending that the Secretary of HHS and the Commissioner of SSA more closely coordinate their efforts to improve administrative processing, develop strategies for reducing the backlog of pending cases, and establish data requirements to facilitate the successful implementation of BIPA's mandated changes. HHS and SSA agreed that inefficiencies in the appeals process require attention and that the process would benefit from better coordination.

Background

Providers and beneficiaries may appeal any denied claim. Claims are denied for a variety of reasons. In fiscal year 2001, the most common reason for denying claims was that the services provided were determined not to have been medically necessary for the beneficiaries. Other reasons for denials include that Medicare did not cover the services, or that the beneficiary was not eligible for services. Claims that do not meet the

requirements outlined in Medicare statutes and federal regulations may be denied.⁶ In addition, denials may be issued for claims that are inconsistent with CMS's national coverage determinations (NCD) and carrier-based policies, including local medical review policies (LMRP), local coverage determinations (LCD), and other carrier instructions.⁷ Relatively few denied claims are ever appealed, and only a small fraction is appealed to the highest level. (App. II contains more information regarding the denial of claims, including common reasons for denials.)

The Medicare Part B appeals process consists of four levels of administrative appeals performed by three appeals bodies. Medicare carriers are responsible for the first two levels of appeal—the carrier review⁸ and the carrier hearing. Through a memorandum of understanding (MOU) implemented in March 1995—when SSA was separated from HHS and became an independent agency—OHA's administrative law judges (ALJ) within SSA continue to hear the third level of appeal. OHA's continued role in Medicare appeals is uncertain, as SSA officials have indicated that they plan to discontinue adjudicating Medicare appeals and expect to transfer the workload to HHS. However, until an agreement between SSA and HHS is reached, OHA will continue to adjudicate Medicare appeals. The MAC adjudicates appeals at the fourth level of the administrative appeals process. In addition, appellants who have had their appeals denied at all four levels of the administrative appeals process have the option of filing their appeals in federal court.

Section 521 of BIPA requires numerous administrative and structural changes to the appeals process, including moving the second level of appeals—the carrier hearing—from the Medicare carriers to a group of

⁶The Medicare program is governed by title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq. (2000), and related regulations, 42 C.F.R. pts. 400-425 (2002).

⁷NCDs are developed by CMS to describe the circumstances for Medicare coverage for a specific medical service, procedure, or device. All Medicare carriers must observe NCDs in determining if a claim is payable; appeals bodies at all levels must apply NCDs when adjudicating appeals. LMRPs and LCDs, developed by contractors, specify the clinical circumstances under which a service is covered to enhance or clarify national Medicare guidance. Due to carrier-based policies, services covered by Medicare in one area may not be covered in another area served by a different carrier. For more information on Medicare coverage policy, see U.S. General Accounting Office, *Medicare: Divided Authority for Policies on Coverage of Procedures and Devices Results in Inequities*, [GAO-03-175](#) (Washington, D.C.: Apr. 11, 2003).

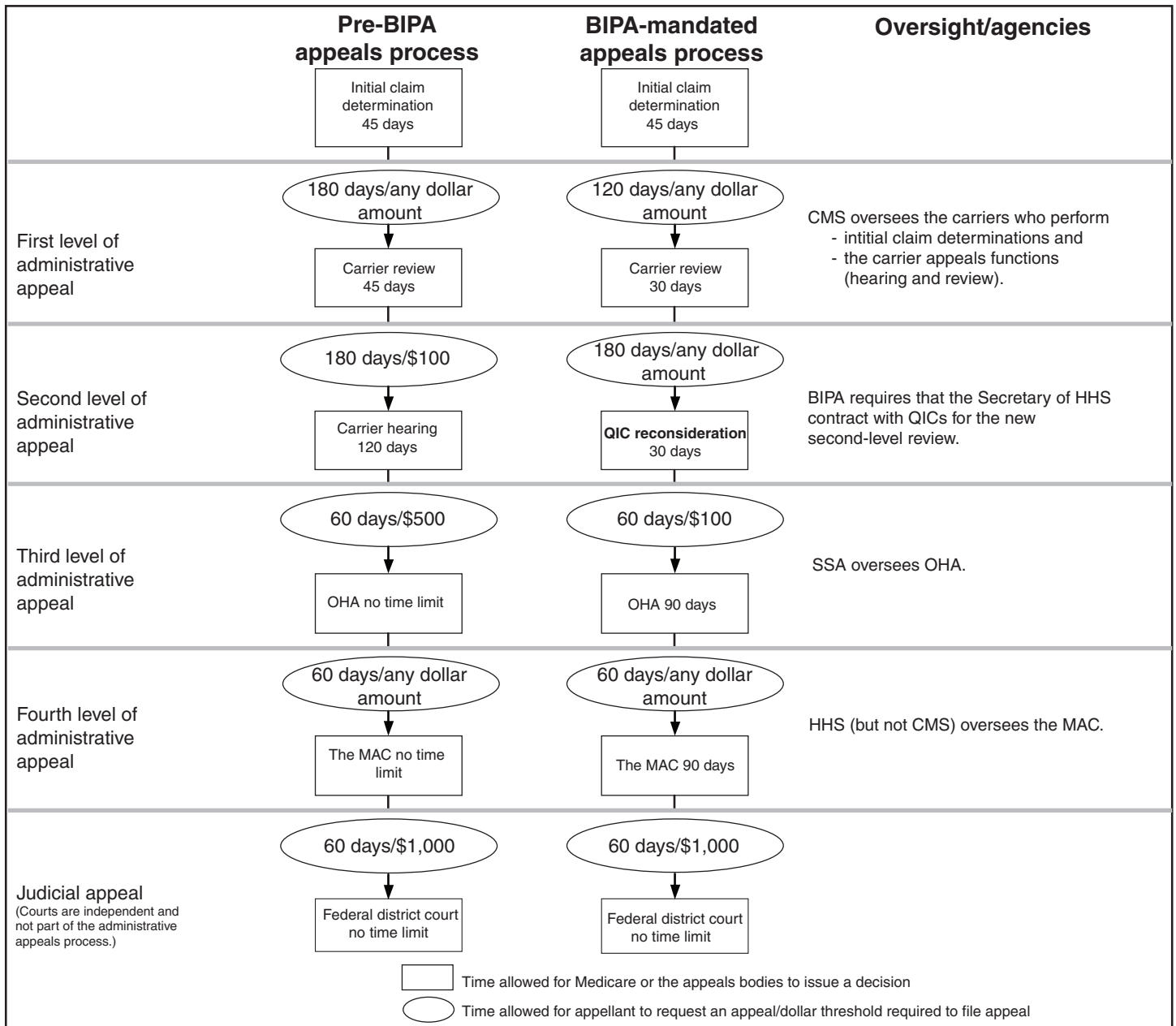
⁸BIPA refers to the carrier review level as the “redetermination.”

yet-to-be-established contractors, known as qualified independent contractors (QIC). Figure 1 outlines the steps of the existing appeals process and the process BIPA requires. BIPA's changes to the appeals process were to apply with respect to initial determinations—that is, claims denials—made on or after October 1, 2002. Although CMS published a rule⁹ on October 7, 2002, the ruling implemented only two of BIPA's provisions—revising the deadline for filing an appeal to the carrier review level and reducing the dollar threshold for filing an appeal at the OHA level. The October 7th rule outlines the criteria used to select the changes that would be immediately implemented; among the criteria is that the provision can be implemented using existing CMS resources. CMS published a proposed rule for complete implementation of BIPA-mandated changes on November 15, 2002,¹⁰ but the final rule has not been issued. As of June 2003, the appeals process is generally operating in accordance with regulations established prior to BIPA's passage. (See app. III for a comprehensive list of BIPA's changes.)

⁹67 *Fed. Reg.* 62,478.

¹⁰67 *Fed. Reg.* 69,312.

Figure 1: Levels and Time Frames for the Pre-BIPA and BIPA-Mandated Appeals Process



Sources: CMS, BIPA, and 20 CFR 422.210 § (2002).

Beneficiaries and providers have the right to appeal denied claims if appeals are filed within the deadline. CMS's October 2002 ruling implemented the BIPA-mandated deadline for filing an appeal at the

carrier review level, shortening it from 180 to 120 days—one of two BIPA provisions implemented thus far. Appeals at the carrier hearing level must be submitted within 180 days of the denial or unfavorable determination. Appellants who are dissatisfied with decisions reached at the carrier hearing level may appeal to OHA and then to the MAC, and their appeals must be filed within 60 days of receiving an unfavorable determination at the previous level.

There is no dollar minimum required to file an appeal at the carrier review level. However, an appeal at the carrier hearing and OHA levels must meet specific dollar thresholds of \$100 and \$500, respectively. To meet the thresholds, multiple denied claims may be aggregated into a single appeals “case.” The MAC does not have a dollar threshold for considering appeals. Finally, appellants who receive unfavorable determinations from the MAC may appeal the decisions in federal court if the amount in dispute is at least \$1,000. BIPA provisions change the threshold amounts at the second level of appeal and OHA. When QICs replace carrier hearings as the second level of appeal, the dollar threshold for submitting an appeal at that level will be eliminated. Further, CMS’s October 2002 ruling implemented BIPA’s reduced dollar threshold for filing an appeal at OHA—the second of two BIPA provisions to be implemented thus far—by dropping the threshold from \$500 to \$100.

BIPA also shortened the time frames the appeals bodies have for adjudicating appeals at the first two levels and established time frames for the first time at the higher levels. BIPA’s provisions that revise the timelines for processing appeals have not been implemented, and the appeals bodies are following previously issued performance standards specifying that 95 percent of carrier reviews be completed within 45 days and 90 percent of carrier hearings be completed within 120 days. BIPA required that carrier reviews be completed in 30 days and that the QICs issue their decisions in 30 days. While OHA and the MAC have not previously been bound by time limits, BIPA required that they issue decisions within 90 days of the date an appeal was filed.¹¹ BIPA also gave appellants the right to escalate their appeals to the next level in the process for adjudication when a decision is not issued within the specified time frame. Escalation is available from any level of appeal except the first—carrier review. However, CMS’s November 2002 proposed rule regarding BIPA’s implementation provides that appellants who escalate

¹¹OHA and MAC time limits may be waived at the appellant’s request.

their appeals to the next level will, in essence, be waiving their right to a decision within the statutory time frame governing that level. For example, an appeal that is escalated from the OHA to the MAC would not be subject to the 90-day limit that applies to appeals received by the MAC that have not been escalated.

The first three levels of appeal share a protocol for adjudication, called *de novo* review, which permits adjudicators to consider results from earlier decisions but requires them to independently evaluate evidence and issue original decisions. The appeals bodies reexamine the initial claim to determine if it should be paid and consider any new documentation or information supporting the claim that the appellant submitted. The fourth level of review, the MAC, does not share this protocol. Rather than performing *de novo* review of evidence, it evaluates the appropriateness of OHA decisions and considers whether new evidence submitted will alter the decision. BIPA changes require that the MAC performs *de novo* review in all cases.

The appeals bodies reach decisions through either a review of the file for the initial claim or through hearings. At the first level of appeal, a carrier review officer who was not involved in the initial denial reexamines the initial claim and any new supporting documentation provided by the appellant but does not conduct a hearing. The second level of appeal—the carrier hearing—provides the appellant with an opportunity to participate in a hearing at the carrier’s facility or by telephone. OHA conducts hearings at the third level of review. OHA’s hearings are held at its central office in Falls Church, Virginia, or at one of its 140 local hearing offices nationwide. The MAC’s adjudication is based on a review of OHA’s decisions, and it does not conduct hearings.

Appeals bodies have several options when deciding a case. The case may be decided fully or partially in favor of the appellant and payment awarded for all or part of the claim or claims in dispute. Alternatively, the decision may be unfavorable to the appellant and the initial denial of payment upheld. The MAC has an additional option of remanding the appeal—returning it to the OHA judge who issued the original decision—for a variety of reasons. For example, the MAC may determine that more evidence is needed, additional action by OHA is warranted, or that OHA should issue a modified decision based on the MAC’s instructions. Finally, the MAC may deny an appellant’s request for review if it finds that OHA’s decision is factually and legally adequate.

In making a determination regarding whether the claim is payable or will continue to be denied, the first two levels of appeal are bound by the same guidance used in the initial denial determination—Medicare statutes, federal regulations, CMS’s NCDs, the carrier’s own LMRPs and LCDs, and, pursuant to carrier’s contracts with CMS, CMS’s general instructions, such as manuals and program memoranda. The statutes, regulations, and NCDs also bind OHA and the MAC—and the QICs, when they are established. But QICs, OHA, and the MAC only need to consider—rather than definitively follow—the carrier-based LMRPs and LCDs in rendering their decisions.

Management of the Medicare appeals process is currently divided among CMS, SSA, and the MAC. CMS is charged with establishing procedures for carriers to follow in considering appeals—including developing guidelines for timeliness and quality of communications with the appellant—and is also responsible for ensuring that the carrier review and carrier hearing processes comply with statutory and regulatory requirements. SSA establishes its own requirements and procedures, with input from CMS, for OHA’s review of third-level appeals. CMS reimburses OHA for its appeals work. The MAC independently establishes its own procedures and guidelines for completing Medicare appeals.

Appeals Process Operations Inconsistent with BIPA’s Requirements

Carriers generally meet CMS’s existing time frames for processing appeals, but all appeals bodies—the carriers, OHA, and the MAC—fall far short of meeting BIPA’s time frames. The large backlog of pending cases at OHA and the MAC, combined with BIPA’s escalation provision and the requirement for *de novo* review at the MAC, will demand a level of performance that the appeals bodies have not demonstrated they can meet. Administrative delays, caused by inefficiencies such as difficulties in transferring and locating files and outdated technology, constitute a large portion of time spent in the appeals process—especially at OHA and the MAC. QICs have not yet been implemented and there is insufficient information to predict their ability to meet BIPA’s performance measures.

Appeals Bodies’ Current Performance Is Far from Meeting BIPA’s Timeliness Standards

There is a substantial gap between carriers’ current performance and that required by BIPA’s standards. For example, at the first level of appeals—the carrier review—while carriers completed about 91 percent of their reviews within CMS’s current 45-day time frame, this is insufficient by BIPA’s standards. Only about 43 percent of the carrier reviews completed in fiscal year 2001 met BIPA’s mandated 30-day deadline. At the carrier hearing level—eventually to be replaced by the appeals to the QICs—the

ability to meet BIPA's time frames remains largely unanswered because the QICs have not yet been established. Although the carriers exceeded CMS's performance standards in fiscal year 2001 by completing more than 90 percent of the carrier hearings within 120 days, this standard is much less stringent than the one imposed by BIPA, which requires the QICs to complete all appeals within 30 days.

Similarly, OHA and the MAC fall far short of BIPA's required 90-day time frame for completing 100 percent of their cases. For example, in fiscal year 2001, OHA took an average of 14 months from the date an appeal was filed to complete adjudication. The MAC took even longer to process appeals during the same year, with cases taking an average of 21 months to adjudicate. As of September 2003, OHA and the MAC had not implemented BIPA-mandated time frames and continued to operate without time frames for rendering decisions. Although officials at both appeals bodies told us that they are concerned with meeting BIPA time frames, neither body has developed strategies for doing so. Instead, the officials stated that they would take action once regulations implementing BIPA are finalized and they are more certain how the new regulations will affect them.

Existing backlogs of unprocessed cases may also interfere with the appeals bodies' compliance with BIPA's mandated time frames for appeals of claims denied after October 2002. While backlogs at the carrier review and carrier hearing levels are relatively small,¹² OHA and the MAC have been unable to meet workload demands. For example, OHA's backlog at the end of fiscal year 2001 included nearly 35,000 Part B cases—equal to about the average number of cases processed in 7 months. At the end of that same year, the MAC had a backlog of 15,000 cases—twice the number of cases it adjudicated in 2001. The MAC has been making strides to improve its efficiency and, near the end of fiscal year 2003, reported reducing its backlog to 10,100 cases. According to OHA and MAC representatives, BIPA-governed cases—appeals of claims denied after October 1, 2002—will have higher priority than cases filed earlier, virtually ensuring that pre-BIPA cases experience even longer delays. However, as of July 2003, none of the appeals bodies had determined how they would prioritize the processing of BIPA appeals while completing their pre-BIPA workloads.

¹²At the end of fiscal year 2001, the backlog of cases past their pre-BIPA deadline at both the carrier review and carrier hearing levels was about the average number carriers process in a single month.

At OHA, protocols for assigning appeals to ALJs may contribute to delays. Although OHA plays a critical role in resolving Medicare appeals, its primary focus is disability appeals for SSA, which constitute 85 percent of its total caseload. While they are a smaller workload, Medicare appeals are often more complex than disability appeals. Some local OHA hearing offices take advantage of their ALJs' Medicare expertise by assigning all Medicare cases to a single judge. However, other offices assign cases randomly, requiring judges to refamiliarize themselves with basic Medicare statutes each time they hear a Medicare case—potentially prolonging the process.

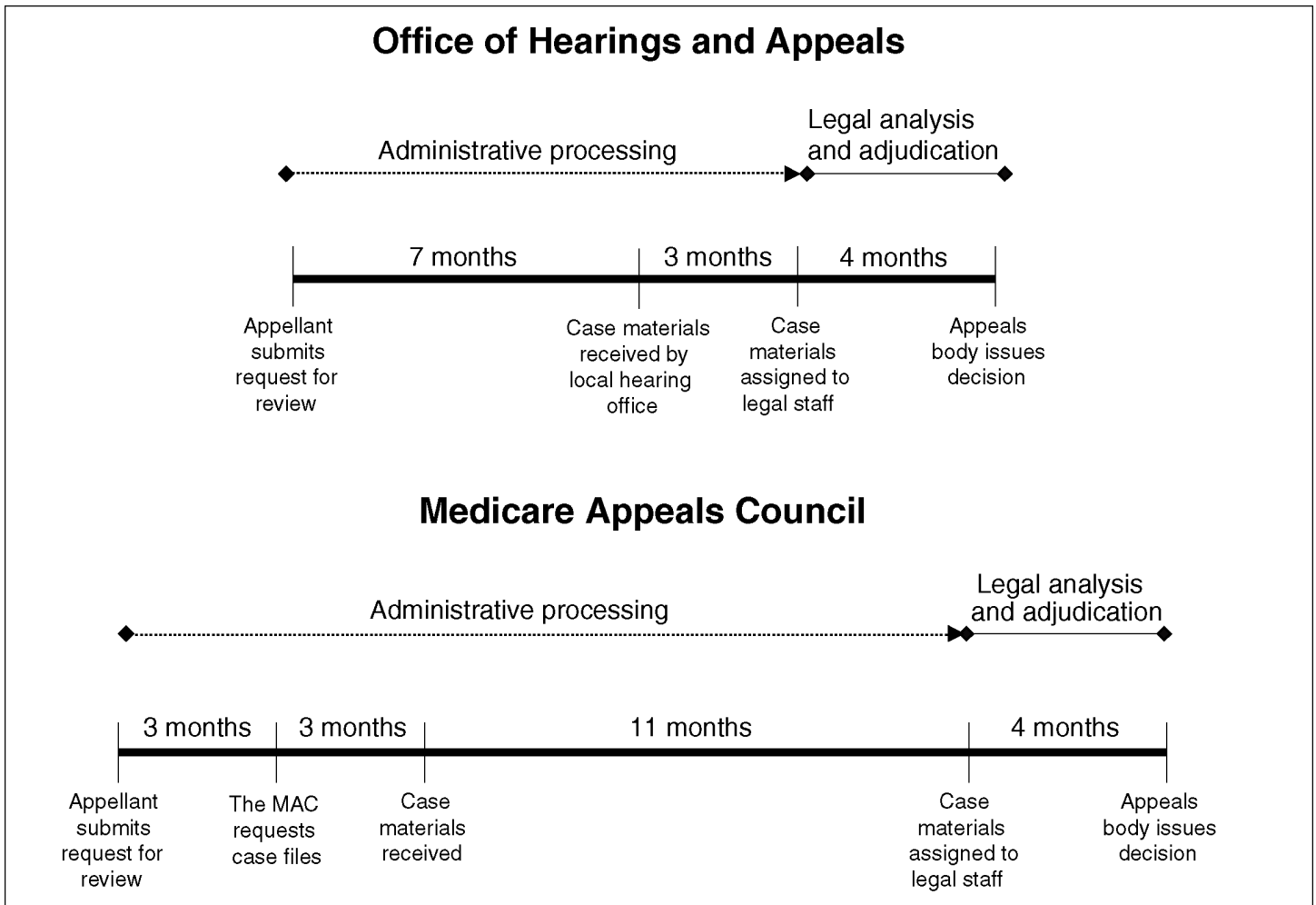
While all of the appeals bodies are subject to BIPA's processing time frames, the MAC is uniquely challenged in meeting these deadlines because the requirement for *de novo* review expands the scope of the MAC's work. MAC officials pointed out that shifting from ensuring that OHA interprets policy correctly to becoming a fact-finding body requires a substantial amount of additional resources and more time to gather and evaluate evidence. MAC officials report that they do not have a strategy to address the expansion in the scope of their work and the contraction in time to render decisions.

Delays in Administrative Processing at OHA and the MAC Further Suggest BIPA's Time Frames Will Not Be Met

The bulk of time at OHA and the MAC is spent on assembling files and completing other administrative tasks rather than in performing legal analyses of appeals and adjudicating cases. Each agency takes more than a year, on average, to complete an appeal. For example, OHA spent 14 months, on average, to complete a case in fiscal year 2001¹³ and an average of 10 months of that was consumed obtaining case files from the lower level appeals bodies and performing related processing tasks. In that same year, the MAC adjudicated nearly 7,100 Part B cases and spent about 17 months, on average, performing administrative tasks. As shown in figure 2, on average, over 70 percent of the time to resolve OHA and MAC cases was spent on administrative activities, rather than on substantive legal analysis of the appeals.

¹³OHA completed more than 56,300 Part B cases in fiscal year 2001.

Figure 2: Average Time Spent in Each Stage of Processing for Cases Adjudicated by OHA and the MAC in Fiscal Year 2001



Sources: OHA and the MAC.

Officials from both OHA and the MAC report that it may take months to receive appellants' case files from the previous level of review or the appropriate storage facility. Case files—which are all paper documents—are a critical component of the adjudication process as they contain all evidence submitted by the appellant in previous appeals. The MAC, in particular, requires OHA's case files to assess the evidence, the hearing tapes, and the letter of decision so that it may determine whether OHA's decision was appropriate.

OHA and the MAC are dependent on the Medicare carriers to forward the appropriate files to their hearing offices for review. CMS allows carriers 21 to 45 days to forward case files to OHA, depending on the number of appellants and dollar value of the case. However, locating files is further complicated by the fact that appellants are required to include little information in their appeal requests. Therefore, OHA and the MAC may receive appeals that do not identify the carrier that originally denied the claim. Locating files can also be hindered if the appeal has been in process for several years and the carrier that initially denied the claim is no longer a Medicare contractor. Although the defunct carrier should have transferred all of its files, including its appeals records, to the replacement carrier, such transitions are not always smooth. Instead, files are often difficult to locate, causing delays in forwarding specific requested cases.

The MAC faces an additional challenge in locating case files. OHA-completed cases are routed to a special clearinghouse contractor for temporary storage. If OHA determines that the appellant is due a full or partial payment, the clearinghouse returns the files to the carrier that initially denied the claim so that payment may be processed. If OHA continues to deny payment, the clearinghouse holds the accompanying file for 120 days to expedite the MAC's retrieval should the appellant continue to appeal. However, the MAC may not know whether to approach the clearinghouse contractor or the relevant carrier to request needed files. And, like the carriers, the clearinghouse does not always provide files in a timely manner. In fiscal year 2001, the MAC waited an average of nearly 3 months—the entire time allowed for the MAC to adjudicate appeals under the BIPA amendments—to receive case files. The MAC, which is empowered to remand, or return, cases to OHA when there is insufficient information in the existing record to issue a decision, in fiscal year 2001 remanded 1,708 cases—nearly a quarter of the cases it adjudicated that year—to OHA because needed files were either missing or incomplete. Although CMS has not performed a comprehensive evaluation of the clearinghouse's accuracy in routing appeals files, it recently determined that the clearinghouse had a 10 percent error rate in routing case files to particular carriers for payment.

Inadequate technology and the need for manual processing also indicate that the appeals bodies are not prepared to address BIPA's requirements. For example, providers often aggregate groups of claims for different beneficiaries to meet the dollar threshold for filing an OHA appeal. To maintain beneficiary confidentiality, a separate electronic file—containing the same provider information—is created for each beneficiary. While widely available technology allows the creation of multiple data files by

entering the information one time and then quickly duplicating it, OHA's system requires administrative staff to separately enter repetitive information pertaining to each denied claim that constitutes the appeal. For example, if a provider is appealing a similar group of claims in a single appeal, OHA must nonetheless create a separate case file and data record for each beneficiary.

BIPA provides that appellants may escalate their appeals from the QIC or OHA to the next level in the administrative appeals process when it is not resolved within the time frames mandated. MAC cases not meeting the time frame may be escalated to the federal district court. More than 95 percent of OHA appeals and about 85 percent of MAC appeals did not meet BIPA time frames in fiscal year 2001, suggesting that a number of cases would be eligible for escalation.¹⁴ However, escalation may not ensure that appellants secure timely adjudication. Escalated cases will lack comprehensive records because the prior level of appeal did not complete the cases and may not have the full collection of case documentation. OHA and MAC officials report that cases without complete records from earlier levels of appeal will require the next level to perform time-consuming research. The MAC may remand cases with incomplete files, causing additional time to be spent locating and transferring files between the appeals bodies.

Appeals Bodies' Lack of Coordination and Resources Is a Barrier to BIPA Implementation

While appellants may view the consideration and resolution of their appeals as a single process, several separate and uncoordinated bodies are responsible for administering the various appeals levels. The appeals bodies have traditionally worked independently; however, close coordination is critical to successful planning for BIPA changes. Further, appeals bodies lack the management data to track cases and analyze case characteristics, preventing them from identifying barriers to efficiency—a first step in streamlining the process. Planning for BIPA implementation has also been hampered by (1) proposed regulations that have not been finalized, (2) the uncertainty of funding amounts for implementation, and (3) unresolved details regarding the possible transfer of OHA's appeals workload to HHS.

¹⁴Since QICs have not yet been implemented, there are no data to assess whether any of their cases will be eligible for escalation.

Appeals Bodies Need Stronger Coordination to Successfully Implement BIPA's Requirements

CMS, OHA, and the MAC—located within two federal agencies—are each responsible for administering a portion of the appeals process. However, neither the agencies nor the appeals bodies have the authority to manage the entire process. The appeals bodies focus primarily on their individual priorities, which may differ and complicate planning for making improvements to the process as a whole. Attempts to modernize the appeals process have been undermined when individual appeals bodies have identified opportunities for improvement, but have failed to sufficiently take into account the impact of their plans on the other bodies. For example, CMS issued a draft statement of work (SOW) outlining the expectations for QICs—the BIPA-mandated replacement for the workload of Medicare carriers at the second level of review, the carrier hearing. The draft SOW asks potential QIC applicants whether they have the capacity to convert paper case files into an electronic format, with the expectation that this would ease the transfer of needed files to the higher levels of appeals. However, CMS officials told us that they did not consult with OHA to ensure that it would have the capacity to use and store electronic files. OHA officials agree that electronic files offer an important opportunity to reduce lost files, speed transfers, and permit case tracking. However, OHA has focused its own plans to implement a system of electronic folders—scheduled for January 2004—exclusively on its SSA disability cases.

Recent planning for BIPA implementation intensified the need for appeals bodies to work together because the demanding time requirements alone call for a more efficient appeals process. While officials from CMS, OHA, and the MAC worked together to develop the proposed rule for implementing the majority of BIPA's requirements, the agencies have not taken the opportunity to coordinate strategies to meet the time frames mandated by the act.

Lack of Management Data Inhibits Appeals Bodies' Ability to Understand Barriers to Efficiency

We found that the appeals bodies are not sufficiently coordinated to track an appealed claim, or group of claims, through all four levels of the process. This is attributable, in part, to the use of different numbering systems for case identification at each appeals body and the fact that the individual claims making up a “case” can change at every level. For example, appeals bodies often reconfigure cases to group claims with similar issues. Appellants also change the configuration of their cases by aggregating their claims to meet minimum dollar thresholds necessary to file an appeal at a given level. Case numbering is further complicated when a partially favorable decision is made. In these situations, some of the claims within the appeal are paid, while the remaining denied claims are

eligible for further appeal by beneficiaries and providers and subject to further reconfiguration with new case numbers. Accordingly, assigning a variety of numbers to any particular claim or group of claims at each level of the process makes it virtually impossible to track an individual claim from one level to the next.

Some problems with data quality are also a product of a lack of coordination between appeals bodies. CMS, OHA, and the MAC are making individual efforts to improve their data systems to better manage their caseloads, but their systems remain incompatible. For example, although CMS is gradually shifting its carriers to one common claims processing data system—also used to track appeals at the carrier level—it is not compatible with OHA’s or the MAC’s data systems. OHA has also initiated data system improvements, but did not consult with CMS in setting the parameters for new system requirements or provide CMS’s appeals group with a copy of its planning document. The MAC does not know if the improvements it is instituting—such as its transition to more powerful data management software used to organize its caseload—will be compatible with OHA’s, CMS’s, or the carriers’ systems. Compatible data systems would facilitate the transfer of case information between appeals levels and analyses of the process as a whole.

Not only do appeals bodies have incompatible data systems, but data gathered individually by CMS from carriers and by OHA from local hearing offices are aggregated and not used to pinpoint problems and develop solutions to improve the appeals process. For example, CMS only collects workload data from its carriers in the form of monthly productivity totals. OHA collects aggregate data from each of its 140 hearing offices, despite the fact that the local offices are tracking individual cases. The aggregate numbers allow OHA and CMS to develop basic workload statistics, such as the number of cases they resolve and the average time frames for adjudication. However, the data do not allow CMS and OHA to perform more detailed analyses, such as isolating process steps that create a bottleneck or identifying specific cases that linger at an appeals level for unusually lengthy periods.

The lack of specific data on case characteristics also limits the appeals bodies’ understanding of the nature and types of appeals that they must resolve. For example, only the MAC collects data on the reason for the appeal, the type of denial being appealed, and the amount in controversy; however, the MAC is not consistent in ensuring that the information is routinely entered in the database. Furthermore, carriers do not collect data that allow CMS to distinguish if the appellant is a beneficiary or a

provider, and none of the appeals bodies collects information on the rates of appeal among provider specialty groups. Analyses of case characteristic data could be valuable in identifying confusing or complex policies or requirements that lead to denied claims and the submission of appeals. The data would also be useful to the agencies in understanding the nature of denied claims that are appealed at each level and guiding more appropriate initial reviews of claims and educating providers about proper claim submission.

BIPA mandated the use of QICs to replace the second appeals level and required them to develop management information through a data system that would identify (1) the types of claims that give rise to appeals, (2) issues that could benefit from provider education, and (3) situations that suggest the need for changes in national or local coverage policy. QICs must report their information to the Secretary of HHS and, among other things, must monitor appeals decisions to ensure consistency between similar appeals. However, the requirements do not affect data collection at the other appeals bodies. As a result, without corresponding changes at the other appeals bodies, it will remain difficult to evaluate the performance of the appeals process as a whole and make informed decisions affecting more than one appeals level. CMS stated that it plans to expand the QICs' data system to the third level of appeal—the ALJ-adjudicated level—and, eventually, to all levels of appeal. Until the compatible data systems are in place at all appeals bodies—which CMS plans for 2005—the appeals bodies will not be able to perform the most fundamental types of analyses to improve the management of the process.

Uncertainties in Regulations, Funding, and the Role of OHA Hinder BIPA Implementation Planning

While BIPA mandated several changes to the current appeals process, CMS, OHA and the MAC are charged with developing regulations for implementing BIPA's mandates in accordance with the Administrative Procedures Act.¹⁵ As of September 2003, guidance regarding two provisions—adjusted deadlines for appellants filing first-level appeals and reduced dollar thresholds required for filing appeals at OHA—have been issued. CMS officials stated that they expect that the proposed regulations¹⁶ implementing the remaining provisions of BIPA section 521

¹⁵With limited exceptions, the Administrative Procedures Act requires agencies to publish proposed rules and provide an opportunity for the public to comment on them before they become effective. 5 U.S.C. § 553(b) (2000).

¹⁶67 *Fed. Reg.* 69,182 (Nov. 15, 2002).

will be finalized by early 2004. The regulations, once finalized, will provide directions specifying how each body will operate. Without final regulations, officials from carriers, OHA, and the MAC said that they have had difficulty estimating what the actual effect on their workloads will be and, accordingly, have not made specific plans to comply with BIPA's mandates.

Even after the regulations are finalized, several important issues will not have been resolved. For example, when it published its ruling on October 7, 2002, CMS acknowledged that transition issues from the current appeals process to the new process would require additional policy guidance prior to implementation. Specifically, questions will remain regarding the necessity of operating two separate appeals processes concurrently, dependent on the date of the initial claim determination. Appeals of claims denied before the effective date of the BIPA amendments are not governed by them, barring specific guidance to the contrary, and are subject to pre-BIPA guidelines and processes.

No additional funding was provided to the appeals bodies in fiscal year 2003 to implement BIPA's changes. Moreover, uncertainties exist about the funds available in fiscal year 2004. The first uncertainty concerns funding for HHS. The President's proposed budget for fiscal year 2004 includes \$126 million in funding for CMS to complete BIPA's changes—including establishing the QICs, developing the QIC data systems, and implementing the shortened time frames at the first and second appeals levels—as well as assuming the workload currently performed by OHA. However, this funding level was premised on the assumption that BIPA would be amended to reduce the number of QICs, increase the time frames for completing appeals at all levels, and require that providers pay a \$50 user fee for filing appeals at QICs. However, as of September 2003, BIPA had not been amended. Moreover, the proposed budget contained no additional funding for the MAC to implement BIPA. The second budgetary uncertainty concerns funding for the third level of the appeals process, currently performed by OHA. While SSA's fiscal year 2003 budget included a \$90 million "direct draw" from the Medicare Trust Fund for Medicare appeals, the proposed 2004 budget eliminates the direct draw and does not include a new source for Medicare appeals funding, reflecting SSA's plan to transfer OHA's Medicare appeals workload to HHS.

Although BIPA required CMS to establish QICs in time for them to begin adjudicating appeals of claims denied as of October 1, 2002, CMS estimated, in its fiscal year 2004 budget request, that QICs would become operational, at the earliest, February 2005. Agency officials detailed that

the implementation of QICs would require approximately 10 months of drafting and finalizing the related regulations and conducting the bidding process, and 6 months for hiring staff, renting space, and performing other tasks associated with making QICs operational, including developing the QICs' data systems. In commenting on a draft of this report, HHS stated that CMS now plans for QICs to begin operation in fiscal year 2004. However, we were not provided with CMS's implementation plan or sufficient details to evaluate its feasibility.

Finally, one of the critical issues related to BIPA's implementation involves the possible transfer of the Medicare caseload currently adjudicated by SSA's OHA to HHS. Several issues remain unresolved. In 1995, when SSA separated from HHS and became an independent agency, SSA entered into an MOU with the Health Care Financing Administration to continue to perform the Medicare appeals work it had been conducting. Recently, SSA has taken the position, which is reflected in its budget request for fiscal year 2004, that it intends for OHA to discontinue adjudicating Medicare appeals and has proposed a revised MOU outlining the transfer of OHA work to HHS. However, as of September 2003, HHS had not signed the revised MOU and the transfer of the workload to HHS had not been finalized. In addition, legislation has been introduced that would expressly provide for the transfer of Medicare appeals to HHS.¹⁷ However, provider and beneficiary groups have protested because they believe shifting responsibility to HHS will compromise the ALJs' independence.

OHA's departure from the appeals process would create a new challenge for HHS. OHA's process for adjudicating administrative appeals includes 140 local hearing offices and over 1,000 ALJs. Because SSA disability appeals constitute about 85 percent of OHA's work, OHA would continue to require the use of its hearing offices and judges regardless of whether it continues to hear Medicare appeals. BIPA language specifies that the third level of appeal be adjudicated by ALJs, but because HHS has far less capacity than OHA to hear ALJ cases,¹⁸ HHS would have to compensate for

¹⁷H.R. 810, 108th Cong. (2003); S. 1127, 108th Cong. (2003); H.R. 1, 108th Cong. (2003); and H.R. 2473, 108th Cong. tit. IV (2003).

¹⁸HHS has nine additional ALJs—one at the Food and Drug Administration and eight who hear enforcement cases including those on Medicare fraud and provider penalties. The latter have a backlog of 700 unresolved cases. HHS's DAB, which houses both the MAC and the Medicare fraud ALJs, is located in Washington, D.C. It has five satellite locations but no hearing rooms—its ALJs use the hearing rooms of local courts or other agencies.

OHA's departure by developing plans that would enable it to adjudicate the current workload demands within BIPA's time frames and to address the backlog of cases accumulated before the transfer to HHS. As of June 2003, CMS was evaluating OHA's Medicare operations, workload, and facilities and developing and assessing the feasibility of various options. A CMS official stated that assuming OHA's workload would be a notable challenge for the agency.

Conclusions

BIPA demands a level of performance—especially regarding timeliness—that the appeals bodies have not demonstrated they can meet. In addition to lengthy processing times, OHA and the MAC have developed sizable backlogs of unprocessed cases. The backlogs raise a question about how BIPA-governed cases, with their mandated time frames, will be prioritized relative to unresolved cases filed before BIPA's mandated implementation date. Administrative and systemic inefficiencies, which span all levels of appeals, strongly indicate the need for improvement. Without significant improvements, the appeals bodies will be unable to meet BIPA's more rigorous performance requirements. Uncertainties regarding BIPA regulations and funding further complicate the challenge the appeals bodies face in implementing BIPA and meeting its requirements. Moreover, the transfer of OHA's Medicare appeals work from SSA to HHS involves major challenges, and until all of the stakeholders resolve workload and timeliness issues, the full impact of such a transfer will not be known.

CMS, its carriers, OHA, and the MAC have traditionally not coordinated their management of the appeals process. Instead, each has operated as though the process consisted of discrete and independent segments. Greater coordination could enable them to resolve the barriers that currently preclude successful management of the appeals process as a whole. Inefficiencies in file transfer and case file tracking, developing comprehensive and meaningful data, and planning for BIPA implementation require a joint effort including each appeals body and its agency. The lack of a single entity that sets priorities and addresses operational problems at all four levels of the process makes it imperative that all bodies work closely together. If OHA's Medicare appeals workload is to be transferred to HHS, it is critical that all of the current appeals bodies work together to develop a carefully planned transition and build efficiencies to help HHS assume the workload. We believe that the creation of a Medicare appeals process that can consistently address BIPA's requirements will require a commitment for close coordination from all appeals bodies.

Recommendation for Executive Action

We recommend that the Secretary of HHS and the Commissioner of SSA create an interagency steering committee with representatives from CMS, the carriers, OHA, and the MAC to serve as an advisory body to the Secretary of HHS and the Commissioner of SSA with the following responsibilities:

- make administrative processes, such as file tracking and transfer, compatible across all appeals bodies;
- negotiate responsibilities and strategies for reducing the backlog of pending cases, especially at OHA and the MAC, and establish the priority for adjudicating pre-BIPA cases relative to BIPA-governed cases; and
- establish requirements for reporting specific and comparable program and performance data to CMS, SSA, and HHS so that management can identify opportunities for improvement, and determine the resource requirements necessary to ensure that all appeals bodies will be able to meet BIPA's requirements.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS and SSA and received written comments from both agencies. In its comments, HHS emphasized its commitment to implementing the appeals provisions in BIPA and highlighted the steps it has taken to do so. Similarly, SSA emphasized its efforts to provide quality service to Medicare appellants. We have reprinted HHS's and SSA's letters in appendixes IV and V, respectively.

HHS agreed with our conclusion that a more coordinated approach to the appeals process is needed. HHS said, however, that we understated its progress in this area and described a variety of efforts it has engaged in to facilitate improved coordination between the appeals bodies. As we noted in the draft report, HHS has made strides in enhancing coordination, but we believe that greater progress can be made by creating an interagency steering committee to develop a consolidated and strategic approach to implementing BIPA.

SSA's comments also emphasized the benefits of enhanced coordination between the appeals bodies. It largely attributed the inefficiencies that exist in the current appeals process to the lack of a single entity with ownership of, and accountability for, Medicare appeals. SSA indicated that it believes that HHS is the sole entity with the authority to unify the policies and procedures for the Medicare appeals process.

HHS stated that it would consider the appropriateness of an interagency steering committee but did not specifically agree or disagree with our recommendation to create such a body. However, it stated that the transfer of the work performed by SSA's OHA to HHS is critical to achieving the level of coordination needed to address the inefficiencies outlined in our report. SSA indicated that it generally agreed with the specific responsibilities of the steering committee. It also stated that it believes that HHS has ultimate responsibility for Medicare appeals and that HHS should carry out the functions of the steering committee through CMS. SSA stated that its budget anticipates the transfer of OHA's appeals workload to HHS, and SSA has submitted a new MOU to HHS to facilitate a smooth transition. While SSA emphasized its commitment to serving Medicare appellants during the expected transition, it also pointed out that Medicare appeals make up a small portion of its work. Therefore, SSA cautioned that while it will participate in efforts to improve the Medicare appeals process, it must consider the demands of its total workload in allocating its resources.

While HHS did not specifically comment on our recommendation to make administrative processes, such as file tracking and transfer, compatible across all levels of appeal, SSA agreed that an interagency steering committee could be beneficial in ensuring such compatibility among appeals bodies. SSA also noted that the steering committee would be helpful in defining the roles of the appeals bodies both in their current operating status and during the anticipated transfer of the OHA workload to HHS.

Regarding our recommendation to negotiate responsibilities for reducing the backlog of pending cases, HHS agreed that a strategy for setting clear requirements to prioritize pre-BIPA and BIPA cases and reduce the backlog of cases at all levels is needed. HHS also reported that the MAC has already reduced its backlog and we revised the report to reflect the reduction. HHS also said that prioritizing cases and other transition matters would be addressed in the forthcoming final regulations. SSA agreed that strategies for reducing both the backlog of pending cases and the lengthy processing times for Medicare appeals are needed and expressed a willingness to help resolve the backlogs and delays.

HHS agreed with our recommendation to establish comparable program and performance data across appeals levels and indicated that improved appeals data capabilities are needed. To that end, HHS noted that it has issued a request for proposals to develop the data system required by BIPA. SSA acknowledged that fragmentation of the appeals process has

precluded the development of comparable data. However, SSA pointed out that preparations to transfer OHA's work to HHS have created a need for greater data sharing. SSA also pledged to work to capture comparable data to facilitate the transfer of the OHA's work.

In addition, in response to HHS's specific comments, we have

- revised the use of the word "rule" to "ruling;"
- clarified that the scope of our work excluded managed care, Medicare entitlement, and overpayment cases, as well as Part B claims processed by durable medical equipment contractors and fiscal intermediaries;
- defined the term "provider," as used in this report, to include any nonbeneficiary appellant, including physicians and other suppliers;
- distinguished between claims that are rejected because they are duplicate or missing information and those that are denied for substantive reasons, in appendix II;
- revised the legend of figure 1;
- modified our description of BIPA's escalation provision to recognize that CMS has developed specific requirements for escalation in its notice of proposed rulemaking;
- revised our explanation of the MAC's procedures regarding the parameters for accepting evidence in its current decision-making process and the MAC's criteria for denying an appellant's request for review; and
- added that CMS policy is a binding element in carrier review.

However, we did not revise the draft report in response to HHS's specific comment regarding our use of the word "review." While BIPA refers to the first level of appeal as "redetermination," we have used the term "carrier review" because the adjudication process at the review level is unchanged by BIPA. Nor did we make revisions in response to HHS's specific comment that both OHA and the MAC use their own systems for processing appeals and conduct their own hiring. As we noted in the draft report OHA and the MAC independently establish their own procedures and guidelines. Finally, we did not revise the draft in response to HHS's specific comment that we imply that the MAC has done no planning related to BIPA requirements. As we noted in the draft report, the MAC has made some improvements, but as MAC officials told us, and as HHS indicated in its comments, a detailed action plan to meet BIPA requirements has not been developed. In its comments, HHS noted that a detailed plan is premature because the MAC will not receive BIPA cases for some time—until after they have passed through the other levels of appeal—however, BIPA requirements apply to claims denied on or after October 1, 2002, and such cases have already been submitted.

HHS also provided us with technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to the Secretary of HHS, the Commissioner of SSA, interested congressional committees, and other interested parties. We will then make copies available to others upon request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff who made contributions to this report are listed in appendix VI.



Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Appendix I: Scope and Methodology

Our analyses were limited to the appeals process for denied Part B claims—rather than managed care, Medicare entitlement, and overpayment cases—because Part B cases constitute the majority of appeals. We also excluded Part B claims processed by durable medical equipment contractors and fiscal intermediaries to focus on the work performed by carriers. We reviewed the four levels of the administrative appeals process; our scope did not extend to the federal district court level.

To gain a better understanding of the process for Part B appeals at the time the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) was passed and the changes it mandated, we reviewed agency procedures for completing Part B appeals regulations and agreements guiding Medicare appeals and other laws. We also analyzed appeals workload data and interviewed officials at the Centers for Medicare & Medicaid Services (CMS) and at all levels of the administrative appeals process—the carriers, the Office of Hearing and Appeals (OHA), and the Medicare Appeals Council (MAC).

We reviewed regulations and procedures pertaining to the initial denials of claims and the submission of appeals by providers and beneficiaries. We also examined the processes for data management and guidelines and regulations for adjudicating cases at all levels. We reviewed the memorandum of understanding between the Health Care Financing Administration and the Social Security Administration, which outlines the responsibilities of both agencies in the adjudication of Medicare appeals. In addition, we reviewed the October 2002 ruling implementing selected BIPA amendments and the proposed rule for the implementation of the balance of the BIPA amendments to the appeals process.

We also analyzed appeals data from CMS, four selected carriers, OHA, and the MAC to understand the scope and efficiency of the Medicare appeals process and the characteristics of appeals. All data examined were for cases adjudicated from fiscal years 1996 through 2001, with a primary focus on fiscal year 2001, which represents the conditions that existed at the time BIPA was passed. In reviewing later data and in conversations with the appeals bodies, we confirmed that the conditions reflected in the data are relatively unchanged. Limitations in collected and reported data at each level precluded comprehensive and consistent analyses in some cases. CMS and the MAC alerted us to some limitations in their data, including inconsistency in data entry, changes in data systems that caused the loss of data, and poorly defined variables. At some levels, only aggregated data were available, which did not permit detailed analysis.

We studied carrier performance by selecting four carriers located in different regions of the country and obtaining processing data on appeals submitted to those carriers at the first two levels of appeals. We also reviewed the results of CMS's contractor performance evaluations of carriers' appeals activities in fiscal years 1999, 2000, and 2001.

We visited three OHA local hearing offices located in proximity to three of the four selected carriers' appeals operation centers to learn more about their role in the appeals process and to assess the impact of carrier performance on their operations. We also examined the processes and procedures used at the OHA local hearing offices. To understand the efficiency of the appeals process, we examined the average total time to process appeals at each level, and the average time spent in each step of the adjudication process at OHA and the MAC. We also examined MAC data to determine the number of cases remanded to OHA because of lost files in fiscal year 2001.

Appeals bodies performed analyses of their appeals data at our request. CMS performed analyses of the Contractor Reporting of Operational and Workload Data (CROWD), including the reason for initial claims denials, the time each carrier took to process carrier reviews and carrier hearings, and the number of cases at the first three levels of appeal. CMS analyses of CROWD, OHA analyses of its data, and our analyses of the MAC's data also provided information on the average time spent in adjudicating appeals and the number of pending cases. OHA's central facility analyzed its Part B data based on our request, and we analyzed data provided by the MAC to determine the time elapsed between processing milestones at OHA and the MAC. In the analysis of the time spent in the various phases of case processing at the MAC, cases with missing date information or cases with negative dates were omitted. All results of, and methodologies for, our analyses of MAC data were examined and confirmed by the MAC.

To gain a better understanding of the concerns of appellants regarding the current appeals process and the potential effects of BIPA, we interviewed representatives from three Medicare beneficiary advocacy organizations that assist beneficiaries with Medicare appeals—the Center for Medicare Advocacy, the Center for Medicare Rights, and the Medicare Advocacy Project of Massachusetts. We conducted a focus group with representatives from billing companies through an association for billers and coders—the Health Care Billing and Management Association. In addition, we interviewed representatives from nine medical professional associations:

- American Academy of Ophthalmology
- American College of Physicians-American Society of Internal Medicine
- American Hospital Association
- American Orthopedic Association
- American Medical Association
- American Podiatric Medical Association
- American Urological Association
- California Medical Association
- Medical Group Management Association

Appendix II: The Scope of Part B Claims Rejections, Denials, and Appeals

In fiscal year 2001, carriers processed about 773 million Medicare Part B claims and rejected or denied, in full or in part, about 161 million—or 21 percent—of the claims processed. Many claims are rejected because they are missing information or are duplicates of claims previously processed and paid or denied.¹ In fiscal year 2001, carriers rejected over 19.5 million claims that were missing information and more than 40 million claims that they considered duplicate. Duplicate claims may be submitted for several reasons. For example, inconsistent regulations may confuse providers causing them to resubmit denied Part B claims—even though Medicare rules do not allow this—because Medicare allows denied Part A claims to be resubmitted for payment. Also, turnover in administrative and billing personnel at providers’ offices may result in confusion about whether a claim was previously submitted, and under what circumstances a claim can be resubmitted for payment. According to officials from the Centers for Medicare & Medicaid Services’ (CMS), carrier error also contributes to the rate of duplicate submissions because some carriers have system limitations that do not always recognize appropriate claims. For example, if a claim is submitted that appropriately includes the performance of the same service to two separate limbs, the two distinct services may be construed as duplicate claims by some carrier systems.

Claims are denied if they do not meet the requirements in Medicare statutes, federal regulations, or CMS’s national coverage determinations. Carriers may also deny claims based on their own local medical review policies and local coverage determinations, which may enhance or clarify national Medicare policy.

CMS compiles data submitted by carriers categorizing the reason for denying claims. Table 1 shows the reasons for denials of Part B claims in fiscal year 2001, excluding rejections. Although CMS has established the categories for data submission shown in table 1, it has not provided strict definitions of these categories for carriers to follow. Instead, each carrier has developed its own unique set of definitions for each category. As a result, these data do not provide a precise or reliable explanation of the reasons for denial. For example, the category “other,” which comprised more than 17 percent of reported Part B denials in fiscal year 2001, may

¹In its comments on a draft of this report, HHS pointed out that unprocessable claims—duplicate claims and claims missing information—are rejected, rather than denied. According to HHS, such claims can be resubmitted but not appealed.

**Appendix II: The Scope of Part B Claims
Rejections, Denials, and Appeals**

include denials at one carrier that another carrier would have included in another category.

Table 1: Reason for Denials of Initial Medicare Part B Claims in Fiscal Year 2001

Reason for denial	Number of denials	Percentage of total
Medically unnecessary ^a	32,480,000	29.4
Services not covered	26,536,000	24.1
Other	19,795,000	17.9
Claim part of a global fee for a procedure ^b	14,351,000	13.0
Medicare is secondary payer for claim ^c	7,697,000	7.0
Claimant ineligible	7,324,000	6.6
Filing limitation exceeded ^d	2,150,000	1.9
Total denials	110,333,000	100^e

Source: CMS.

^aMedicare law requires that for services to be covered, they must be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” 42 U.S.C. § 1395y (a) (A) (1) (2000).

^bGlobal fee is a total charge for a bundled set of services, such as a single surgery that encompasses presurgical and postsurgical care or a diagnostic service that represents physician and equipment charges. Individual services included in the global fee cannot be paid separately.

^cMedicare is the secondary payer when a beneficiary has an insurance policy or health plan, other than Medicare, that has primary responsibility for covering the cost of the beneficiary’s care. 42 U.S.C. § 1395ff (2000).

^dTo be eligible for payment, claims must be filed no later than the end of the calendar year following the year the service was provided.

^ePercentage does not total to 100 due to rounding.

Relatively few cases are appealed when compared to the number of denials, and only a small fraction is appealed to the highest level. CMS, the Office of Hearings and Appeals (OHA), and the Medicare Appeals Council (MAC) do not track the number of denied claims that are appealed, although CMS collects the number of claims that are adjudicated in the appeals process for the carrier review, carrier hearing, and OHA levels. In fiscal year 2001, about 7.1 million claims—less than 7 percent of denied Part B claims—were adjudicated at the carrier review level.² In that year

²Postpayment denials—denials of claims that have been paid but selected for medical review at a later date—are not included in the denial rates shown. Postpayment denials generate some appeals; however, CMS does not collect data on the proportion of appeals resulting from post-payment denials.

Appendix II: The Scope of Part B Claims Rejections, Denials, and Appeals

about 554,000 Part B appeals were adjudicated at the carrier hearing level and over 201,000 at OHA. The MAC received about 8,800 Part B appeals cases in fiscal year 2001; however, the MAC does not track the number of claims comprising cases.

Appeals requests at the higher levels have grown rapidly in recent years, as shown in table 2. For example, requests for Medicare appeals at OHA—the third level of appeals—increased a total of 200 percent from fiscal year 1996 to fiscal year 2001, and the MAC’s workload grew by nearly 500 percent from fiscal year 1997 to fiscal year 2001.

Table 2: Growth in Part B Appeals Cases Submitted by Appeal Level from Fiscal Year 1996 through Fiscal Year 2001

Fiscal year	Carrier review	Carrier hearing	OHA hearing	MAC adjudication
1996	4,100,000	69,000	21,000	^a
1997	3,900,000	87,000	35,000	1,500
1998	3,500,000	95,000	35,000	2,700
1999	3,500,000	93,000	61,000	6,300
2000	3,300,000	101,000	62,000	7,600
2001	3,700,000	102,000	63,000	8,800
Total growth over the period (percent)	-400,000 (-10)	32,000 (47)	42,000 (200)	7,300 (487)

Sources: CMS, OHA, and the MAC.

Note: Appeals cases may contain several claims.

^aMAC data for fiscal year 1996 were not available.

Appendix III: Changes Mandated by Section 521 of BIPA

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) mandates administrative, structural, and management changes in the appeals process. It includes the following:

- Revises the filing deadline for appellants at the first level of appeal: reduced from 180 days to 120 days
- Reduces the minimum thresholds for filing appeals:
 - To second level, from \$100 to no minimum
 - To third level, from \$500 to \$100
- Changes adjudication time frames at all levels of appeal:
 - At first level, from completing 95 percent in 45 days to completing 100 percent in 30 days
 - At second level, from completing 90 percent in 120 days to completing 100 percent in 30 days
 - At third level, time frames of 90 days where none previously existed
 - At fourth level, time frames of 90 days where none previously existed
- Allows appellants to escalate the appeal to the next level, including federal district court, when adjudication time frames have not been met at the second, third, or fourth levels of appeal
- Replaces the second level of appeal, currently known as a carrier hearing, with a redetermination by qualified independent contractors (QIC)
 - The Department of Health and Human Services (HHS) must establish 3-year contracts with at least 12 QICs
 - QICs, like the Office of Hearings and Appeals (OHA) and the Medicare Appeals Council (MAC), are not bound by, but shall consider, local coverage determinations
- Establishes that the MAC adjudicate cases *de novo*¹ instead of evaluating OHA's decisions, as had been done
- Requires that QICs have a comprehensive data system to collect and share information
 - QICs must maintain accurate records of each decision that enable it to identify specific types of claims that give rise to appeals, situations suggesting the need for provider education, situations suggesting changes in national or local coverage policy, and situations suggesting changes in local medical review policy
 - QICs must monitor their decisions to ensure consistency in outcomes between similar appeals
 - QICs must make all decisions available to carriers
 - QICs must report annually to the Secretary of HHS

¹*De novo* review allows for new evidence and an in-depth and independent review.

- Requires that, at least every 5 years, the Secretary of HHS survey a sample of appellants regarding their satisfaction with education on the appeals process and with the process itself; and that the Secretary must report the results and any recommendations to the Congress
- Requires that the Secretary of HHS annually report the following to the Congress:
 - The number of appeals
 - Issues that require administrative or legislative action and recommendations with respect to actions
 - Analysis of consistency of decisions at QICs, including any reasons for inconsistency

Appendix IV: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 2 2003

Ms. Leslie G. Aronovitz
Director, Health Care – Program
Administration and Integrity Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on your draft report entitled, "Medicare Appeals: Disparity Between Requirements and Responsible Agencies' Capabilities." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided several technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

A handwritten signature in cursive script, appearing to read "Dara Corrigan".

Dara Corrigan
Acting Principal Deputy Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services on the General Accounting Office's Draft Report, "Medicare Appeals: Disparity Between Requirements and Responsible Agencies' Capabilities" (GAO-03-841)

The Department of Health and Human Services (Department / HHS) appreciates the opportunity to review and comment on the above-referenced draft report. The General Accounting Office (GAO) draft report focuses on improvements that are needed in the Medicare claims appeal procedures in order to meet the Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP) Benefits Improvement and Protection Act of 2000 (BIPA), and the barriers to implementing these changes.

The Centers for Medicare & Medicaid Services (CMS) and the HHS Departmental Appeals Board's Medicare Appeals Council (MAC) and its supporting division, the Medicare Operations Division (MOD), continue to take aggressive steps to implement the BIPA requirements and improve the structural problems that are identified in the GAO's report. These efforts include:

- Redesigning MAC's adjudication process and increasing productivity dramatically from around 1000 dispositions per-year in the mid-1990s to a current rate of more than 10,000 per year.
- Reducing the MAC/MOD's total pending caseload for all claim types to 10,100 – far below the 2001 pending caseload reported by GAO for Part B. MAC/MOD uses strategic planning to prioritize cases by setting quarterly disposition goals, screening cases for those that can be disposed of quickly, and systematically focusing on the older, more complex cases.
- Issuing a CMS ruling in October 2002, outlining procedures for Medicare contractors, Administrative Law Judges (ALJs), and the HHS Departmental Appeals Board to use for handling initial determinations and appeals as of October 1, 2002. This interim guidance addressed short-term implementation issues and implemented several BIPA 521 provisions, including establishing a new 120-day deadline for filing requests for redeterminations of claims denials and setting \$100 as the threshold for the amount in controversy for ALJ hearings.
- Publishing a Request for Information (RFI) to solicit industry comments in connection with a BIPA 521 requirement that CMS contract with at least 12 Qualified Independent Contractors (QICs) to conduct reconsiderations, the second level of appeals. We also obtained comments on a draft statement of work for prospective bidders and other interested members of the industry. CMS intends to issue the formal Request for Proposal (RFP) to solicit bids for the QIC work in September 2003. In keeping with the President's fiscal year (FY) 2004 budget request, this solicitation will permit QIC implementation beginning in FY 2004.

- Publishing a comprehensive proposed rule on November 15, 2002, covering all necessary regulatory changes related to BIPA 521, as well as other long-needed changes aimed at volume control, fairness and efficiency, and the creation of Medicare-specific ALJ and MAC regulations. We are now considering the comments on the proposed rule and are in the process of developing the final rule for publication in early 2004, consistent with our QIC implementation strategy.
- Issuing a request for proposals (RFP) in June 2003, to develop the data system needed to implement the BIPA 521 changes. The RFP specifies that the new Medicare Appeals System (MAS) database will be available by April 2004 to accept case-specific data at both the QIC and ALJ level. The implementation of the MAS will represent a critical step toward providing the management data needed both to track an appeal across different levels of the system and to identify, and resolve, systematic problems.
- Working with the Social Security Administration (SSA) to bring about the transfer of the ALJ hearing function from SSA to a new organization with a dedicated focus on Medicare ALJ hearings. Although the precise timing of this transfer may be influenced by legislation, we believe that this change is critical to achieving the needed coordination among appeals levels that your report identifies as the single most important factor in improving the Medicare administrative appeals system.

We believe that these actions illustrate our commitment to full implementation of the BIPA statute and the progress we continue to make toward this goal.

General Comments

- 1) We agree with the report's primary conclusions concerning the need for close coordination among all appeals bodies and for improved appeals data capabilities. However, we believe the report significantly understates the extent to which CMS has already taken strides to address these issues. As noted above, CMS is committed to contracting to build a data system that will, for the first time, make available uniform program and performance data at all levels of the appeals process. In addition, MAC/MOD has already migrated its case-tracking database to the HHS standard (Oracle); the new database contains some of the data noted by GAO, but because it is primarily an internal workflow and assignment system, it is not intended to analyze and track the type of information discussed by GAO. In the process of designing the required specifications for the Medicare Appeals System (MAS), it is important to note that HHS is continuing to work with representatives of the Social Security Administration's (SSA) Office of Hearings and Appeals to ensure that the data needs of all levels of the appeals system will be met by the new system.
- 2) Although the Secretary has delegated authority to CMS to develop the new regulations that are needed to implement the BIPA appeals provisions and other changes to the appeals procedures, CMS consulted with MAC and with Administrative Law Judges (ALJs) from SSA in drafting the proposed rule. Most recently, in an effort to continue to

improve this coordination CMS has established the Office of Medicare Adjudication (OMA). This new office will strengthen CMS's ability to provide executive leadership and direction for all Medicare hearings-related matters, including the critical role of ensuring systematic coordination among the different organizations responsible for the various levels of appeal. CMS is currently seeking additional information from SSA to achieve a better understanding of the characteristics of the OHA hearing workload. Thus, we will certainly consider the appropriateness of a formal interagency steering committee, particularly in view of the likely transfer of the Medicare ALJ function from SSA to HHS. CMS and MAC will also be coordinating on intra-agency operational issues related to the appeals processes.

- 3) We agree with the need for a clear strategy for reducing the backlog of pending cases at all levels of the process, and for establishing clear requirements with respect to the adjudication of pre-BIPA cases, some of which have been addressed by MAC/MOD's efforts to prioritize cases. We intend to address this issue as well as other transition issues in the forthcoming final regulation on the BIPA changes and other appeals process improvements. Appeals backlogs are primarily a concern at the ALJ and MAC level, however, as the reports explains, CMS annually issues instructions to its contractors addressing how the appeals workload should be prioritized, including the elimination of any backlogs. In addition, CMS is establishing a financial incentive (in FY 2004) for reducing appeals backlogs for several contractors that are participating in an ongoing pilot program.
- 4) The BIPA provisions include measures that are likely to increase numbers of appeals to the ALJs and MAC (such as lowering amount in controversy), as well as others that may decrease appeals (such as QIC provisions), so predicting post-BIPA numbers is extremely difficult. Additionally, the final version of the implementing regulations will affect the MAC workload.

Specific Comments

- 1) Throughout the draft report, the term "rule" is used to refer to the October 7, 2002, CMS Ruling, and the term "draft ruling" is incorrectly used to refer to CMS's November 15, 2002, notice of proposed rule making.
- 2) The report indicates that its scope includes Part B claim appeals, although our understanding is that GAO did not review appeals procedures for Part B claims processed by fiscal intermediaries or by durable medical equipment carriers. We believe that the scope of the study should be clarified. On a related note, the report routinely uses the term "providers" to describe all non-beneficiary appellants. For Medicare purposes, the term "provider" technically refers only to institutional entities such as hospitals, skilled nursing facilities, and home health agencies, and their claims generally fall under Part A of Medicare. Further, provider appeals rights are more constrained than those of beneficiaries, in contrast to the statement on page 3, 3rd paragraph. We recommend that the report clarify that the term "providers" is used to refer to any non-beneficiary appellants and thus includes physicians and other suppliers, and that the statements in the

3rd paragraph of page 3 and the 1st paragraph of page 5 be modified, for example, by adding “generally” or “in certain circumstances.”

- 3) Further, the report should acknowledge that caseloads that were not analyzed included Part A, Part C and other managed care cases, Medicare entitlement, and overpayments. These caseloads present other procedural and process problems and add to the administrative challenges of running an appeals process.
- 4) Pages 3 and 25 of the GAO draft report provide that in fiscal year 2001, the most common reason for denying claims was the resubmission of duplicate claims previously processed. The report also provides that “other common reasons for denials include ... that information critical to the claims was missing.” Technically, when a claim is not paid because it is a duplicate or because information critical to processing the claim is missing, CMS does not consider the non-payment a “denial.” Rather, because the party may submit the claim a second time, the nonpayment is considered a rejection. Denials are subject to appeal rights, while rejections are not. Thus, it is somewhat misleading for the GAO to include claims denied on the basis of missing information or duplication in its report on appeals, since such claims could not be appealed. We would recommend that the GAO include a footnote in the third paragraph on page 3 of the report that explains CMS’s distinction between rejections and denials. We suggest that the footnote read as follows:

Note: CMS distinguishes between claims that are rejected because they are unprocessable and claims that are denied for substantive reasons. Submissions that are unprocessable because they are missing information may not even be considered claims if there is not, for example, enough information to identify the enrollee. Because these claims are not being denied for substantive reasons, the rejections are not subject to appeal under §§ 3000 and 3005 of the Medicare Carriers Manual. In addition, claims rejected because they are duplicates are not considered appealable unless the party is appealing whether the claim submitted is in fact a duplicate.

- 5) In the chart on page 5 of the draft report, the key is reversed. The information provided in the rectangles of the chart represent the time allowed for Medicare or the appeals bodies to issue a decision and the information presented in the ovals represents the time allowed for the appellant to request an appeal, as well as the dollar threshold required to file appeal.
- 6) In several places, the report reflects GAO’s apparently broader interpretation of the “escalation” requirement of BIPA than that adopted by CMS. For example, on page 6, in the 2nd paragraph, the GAO states: “BIPA also gave appellants the right to escalate their appeals to the next level in the process for adjudication when a decision is not issued within the specified timeframe. Escalation is available from any level of appeal except the first – carrier review.” We believe that the statute imposes a deadline and subsequent escalation only in cases where there has already been a decision issued at the lower level of appeal. Thus, as explained in the November 2002 proposed rule (67 FR 69329):

Appellants who escalate their appeals will, in essence, be waiving their right to obtain a decision within the statutory deadline at the next level. For example, section 1869(d)(1)(A) provides that unless the appellant waives the statutory adjudication deadline, the ALJ “shall conduct and conclude a hearing on a decision of a [QIC] and issue a decision by the 90th day from the date a request for hearing is timely filed” We interpret this as requiring an ALJ to decide a case within 90 days when the QIC has issued a final action in a case, but not when the appellant has escalated the case to the ALJ level before the QIC issues a decision. A similar distinction is found in the provisions governing MAC review, which provide that the MAC must complete its “review of a decision” within 90 days. Therefore, when an appellant escalates an appeal from the QIC to the ALJ level or from the ALJ level to the MAC, the proceedings before the ALJ or MAC are not subject to the 90-day limit.

Although CMS may administratively decide to allow escalation more than once, this would be an administrative decision, and would not be required by statute.

- 7) Page 6, 2nd paragraph: The Part B decision-making timeframes are statutory, rather than regulatory. Also, in the last paragraph, the term carrier “review” should be “redetermination.”
- 8) Also on page 6, the report describes the standards of review employed at the various steps of the Part B appeals process as follows:

The first three levels of appeal share a protocol for adjudication called *de novo* review, which permits adjudicators to review results from earlier decisions, but requires them to independently evaluate evidence and issue original decisions. The appeals bodies reexamine the initial claim to determine if it should be paid and consider any new documentation or information supporting the claim submitted by the appellant. The fourth level of review, the MAC, does not share this protocol. Rather than performing *de novo* review, it evaluates the appropriateness of OHA decisions and *does not consider the submission of new evidence or documentation*. BIPA changes will require that the MAC also perform *de novo* review in all cases.

We agree that BIPA will alter the MAC’s review procedures in several significant ways. However, the report does not accurately describe the MAC’s current standard of review, which is governed by 20 C.F.R. § 404. 970, and is a *de novo* review in certain respects. Under 20 C.F.R. § 404. 970(b), the MAC may consider new and material evidence, “where it relates to the period on or before the date of the administrative law judge hearing decision.” Therefore, we would recommend replacing the last two sentences in this paragraph with the following language:

Rather than performing *de novo* review of evidence, it evaluates the appropriateness of OHA decisions and considers whether new

evidence will alter the decision. BIPA changes will require that the MAC perform *de novo* review in all cases.

9) On page 7, the report states:

Finally MAC may deny an appellant's request if it find no error of law in the OHA decision.

Since the applicable regulations at 20 CFR provide for a number of reasons for MAC review other than error of law, the above-cited language is too narrow. We suggest instead:

Finally MAC may deny an appellant's request for review if it finds that the OHA decision is factually and legally adequate.

- 10) Pages 7 and 16: The report states that SSA establishes its own procedures for appeals and that CMS, OHA, and MAC are all charged with developing procedural regulations to implement BIPA. We note that the Secretary of HHS has delegated authority to CMS to develop these procedural regulations. Such procedural regulations bind not just CMS contractors, but also OHA, SSA ALJs, and the MAC. However, you may wish to note that both OHA and MAC use their own systems for processing appeals and conduct their own hiring.
- 11) Page 7, 3rd paragraph: The report describes the types of law that bind the first two levels of appeal. We believe that the list should also include CMS's policy guidance, such as manuals and program memoranda, since Medicare contractors are bound by such guidance. Therefore, we recommend rewriting the first sentence as follows: "In making a determination . . . the first two levels of appeal are bound by the same substantive legal standards used in the initial denial determination – Medicare statutes, Federal regulations, CMS's NCDs, the carrier's own LMRPs and LCDs, and, pursuant to carriers' contracts with CMS, CMS's general instructions (such as manuals and program memoranda)."
- 12) The draft erroneously suggests that MAC has done no planning related to BIPA requirements. The MAC/MOD redesign and its continuing strategic planning for adjudicating the pending caseload are part of our overall efforts to improve quality and to process cases on a current basis.
- 13) Although some BIPA requirements are subject to interpretation and cannot be planned for or implemented until final regulations are issued, the report fails to recognize that MAC will not start receiving cases subject to BIPA until they work their way up through the other levels or are escalated up. Accordingly, a detailed action plan could not be developed without more concrete information about what factors would need to be addressed, such as the rate of cases expected, the experience of the other review levels under BIPA and MAC's caseload and resources at the time when BIPA cases are actually expected to be filed.

Appendix V: Comments from the Social Security Administration



SOCIAL SECURITY

The Commissioner

August 22, 2003

Ms. Leslie G. Aronovitz
Director, Health Care – Program
Administration and Integrity Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Aronovitz:

Thank you for the opportunity to review and comment on the draft report "Medicare Appeals: Process Disparity Between Requirements and Responsible Agencies' Capabilities" (GAO-03-841). Our comments on the report are enclosed.

If you have any questions, please have your staff contact Laura Bell at (410) 965-2636.

Sincerely,


Jo Anne B. Barnhart

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

COMMENTS ON THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT "MEDICARE APPEALS PROCESS: DISPARITY BETWEEN REQUIREMENTS AND RESPONSIBLE AGENCIES' CAPABILITIES" (GAO-03-841)

Thank you for the opportunity to review and comment on the draft report. We acknowledge that efficiency and compatibility issues exist within the Medicare appeals process and we, like GAO, believe that many of the issues are the result of the lack of a single entity's ownership of and/or accountability for the process. While the President's Fiscal Year (FY) 2004 Budget Request anticipates the transfer of the Medicare hearings function from the Social Security Administration (SSA) to the Department of Health and Human Services (DHHS), SSA is committed to providing high quality service to all SSA claimants and appellants.

Therefore, On July 2, 2003 we sent to HHS a proposed memorandum of understanding (MOU) to address all matters related to the transfer of the Medicare hearings function from SSA to HHS. We have agreed to assist HHS by retaining responsibility for all Medicare Part B hearings cases received on or before May 31, 2004. However, as the President's FY 2004 budget did not request funds for SSA to process these hearings, part VI of the MOU addresses reimbursement to SSA from HHS at a prescribed cost per hearing disposition. We will continue our efforts to provide the best service possible to Medicare appellants until HHS assumes responsibility for handling Medicare appeals.

The Medicare appeals process is unique as it weaves in and out of private contractors, SSA and HHS. Despite the inherent difficulties of managing such a fragmented process, the following are some measures SSA has taken to improve the service it provides to Medicare appellants.

- The Office of Hearings and Appeals (OHA) established a cadre of Medicare specialist administrative law judges (ALJ) who hear the most complex and voluminous cases. Attorneys and staff from Office of the Chief Administrative Law Judge's (OCALJ) Division of Medicare assist the ALJs. The Division provides legal analysis, hearing support, and decision-writing assistance to the hearing offices in Medicare "big box" cases (\$40,000 or more in controversy and multiple beneficiaries), and pre-screens Part C cases for hearing offices.
- OHA developed an intranet Medicare Online website to assist the field in processing Medicare cases.
- The Hearing Office Tracking System (HOTS) has been enhanced recently to collect separate data about Medicare cases and to generate management information essential to improving the efficiency of the process.

These measures and other workload management improvements have resulted in increased productivity in Medicare cases at SSA.

In an effort to further improve our management of the Medicare appeals workload and to mitigate the problems resulting from fragmentation, in January 2002, we created the Executive Counselor for Interagency Adjudication (ECIA). The ECIA is an executive level position that serves as our liaison to the Center for Medicare and Medicaid Services (CMS) within HHS. The primary role of the ECIA is to enhance the coordination and cooperation between SSA and HHS on Medicare issues, improve service delivery for both Medicare and disability appeals, plan and coordinate the administrative transfer of the Medicare appeals function to HHS, and to work with CMS on other service delivery issues, including implementation of the Benefits Improvement and Protection Act (BIPA).

Highlights of our efforts to date include providing comments on the CMS's Notices of Proposed Rulemaking to implement Sections 521 and 522 of BIPA, interagency discussion by key SSA and CMS staff resulting in increased understanding of the entire appeals process and the problems each agency faces, joint development of detailed process maps, exchanges of caseload reports and systems information, and development of a proposed Memorandum of Understanding for the transfer of the Medicare hearing function to HHS on October 1, 2004. As demonstrated above, the level of communication and coordination for improved service to Medicare appellants has increased and continues to be a priority for us.

While we recognize that decisions regarding the transfer of the Medicare hearings function are pending, our comments on the recommendations encompass both the current and anticipated structure of the Medicare appeals process.

Recommendation 1

GAO recommends that the Secretary of HHS and the Commissioner of SSA create an interagency steering committee with representatives from CMS, the carriers, OHA and MAC, to serve as an advisory body to the Secretary of HHS and the Commissioner of SSA.

Response

The Social Security Act places ultimate responsibility for administration of the Medicare program, including its due process appeals, with HHS, and it is the single entity with the authority to "unify" the Medicare appeals process in terms of both policies and procedures. We continue to support the transfer of full operational responsibility for the Medicare appeals process to HHS and have been working with HHS to accomplish that goal. On July 2, 2003 we sent to HHS a proposed memorandum of understanding (MOU) to address all matters related to the transfer of the Medicare hearings function from SSA to HHS. We would agree, in the proposed MOU, to assist HHS by retaining responsibility for all Medicare Part B hearings cases received on or before May 31, 2004. However, as the President's FY 2004 budget did not request funds for SSA to process

these hearings, part VI of the MOU addresses reimbursement to SSA from HHS at a prescribed cost per hearing disposition.

We understand that HHS recently established an Office of Medicare Adjudication within CMS, which we believe should carry out the functions of the proposed interagency steering committee, since, as noted, HHS has ultimate responsibility for all Medicare appeals. Since Medicare appeals are only a small part of SSA's appeals workload, it should be noted that SSA can only take such actions with respect to Medicare that are consistent with meeting the demands of our total service obligations. SSA will participate and assist HHS/CMS in their effort to carry out their appeals process responsibilities.

Regarding the specific responsibilities of an interagency steering committee, we offer the following:

Make administrative processes, such as file tracking and transfer, compatible across all appeal bodies.

The proposed steering committee may be helpful in further supporting the recommendation for compatible administrative processes by helping define roles across CMS, SSA and HHS during its current operation and during the transfer of the hearing function to HHS. Pending development of a comprehensive integrated data system by CMS, we will continue to use our HOTS to track Medicare cases on a reimbursable basis since there is no funding for Medicare appeals in our FY 2004 President's Budget Request.

Negotiate responsibilities and strategies for reducing the backlog of pending cases, especially at OHA and the Medicare Appeals Council, and establish the priority for adjudicating pre-BIPA cases relative to BIPA-governed cases.

We agree with the need for consistent and comprehensive strategies for reducing the backlog of pending cases and reducing the overall processing time for Medicare appeals. To the extent that BIPA cases are adjudicated under the current interagency appeals process, coordination for handling BIPA cases will be required, and SSA will participate in this effort to address these activities.

Establish requirements for reporting specific and comparable program and performance data to CMS, SSA and HHS so that management can identify opportunities for improvement, and determine the resource requirements necessary to ensure that all appeals bodies will be able to meet BIPA's requirements.

As stated above, we believe that the current process fragmentation prevented the development of a comprehensive data collection and analysis process to identify efficiency issues and the development of design improvements. However, in anticipation of the transfer of Medicare hearings, we have worked to increase the

4

understanding of the entire appeals process by bringing together key SSA and CMS staff. In addition to previously mentioned activities, SSA has provided CMS specifications for HOTS, which could be used as an interim system by CMS until a more comprehensive data system is developed. We have also demonstrated and shared information about the new Case Processing and Management System (CPMS) that SSA is developing so CMS can evaluate it for its own future needs. As stated, SSA has already made enhancements to HOTS to permit improved case tracking and workload management and to collect separate data on Medicare case processing. During the period that SSA continues to handle Medicare hearings, we will work with CMS and HHS to capture comparable data through HOTS.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Geraldine Redican-Bigott, (312) 220-7678

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Ankit Mahadevia, Margaret J. Weber, Anne Welch, and Craig Winslow made major contributions to this report.

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