FACT SHEET: HHS Issues Final Rule to Improve the Medicare Appeals Process

Overview

Today, the U.S. Department of Health and Human Services (HHS) announced it is issuing the *Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures* final rule. This final rule streamlines administrative appeal processes, increases consistency in decision making across appeal levels, and improves efficiency for both appellants and adjudicators, and in particular benefits Medicare beneficiaries by clarifying processes and adding provisions for increased assistance when they are unrepresented.

Background

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

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

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

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

While the administrative actions announced today are a first step in addressing the pending appeals, these actions alone will not eliminate the backlog. Therefore, the FY 2017 President's Budget requested additional funding to bring disposition capacity in line with current appeal volume at both OMHA and the DAB. The budget request also includes a comprehensive

legislative package aimed at both helping HHS process a greater number of appeals and encouraging resolution of appeals earlier in the process before they reach the OMHA and the DAB. With the administrative authorities set forth in the final rule and the FY 2017 proposed funding increases and legislative actions outlined in the President's Budget, we estimate that that the backlog of appeals could be eliminated by FY 2020.

Changes to the Medicare Appeals Process

The changes in the final rule are primarily focused on the third level of appeal and will:

- Permit designation of Medicare Appeals Council decisions (final decisions of the Secretary) as precedential to provide more consistency in decisions at all levels of appeal, reducing the resources required to render decisions, and possibly reducing appeal rates by providing clarity to appellants and adjudicators.
- Expand OMHA's available adjudicator pool by allowing attorney adjudicators to decide appeals for which a decision can be issued without a hearing, review dismissals issued by a Qualified Independent Contractor (QIC) or Independent Review Entity (IRE), issue remands to Centers for Medicare & Medicaid Services (CMS) contractors, and dismiss requests for hearing when an appellant withdraws the request. This change will allow ALJs to focus their efforts on conducting hearings and adjudicating the merits of more complex cases.
- Simplify proceedings when CMS or CMS contractors are involved by limiting the number of entities (CMS or contractors) that can be a participant or party at the hearing (although additional entities may submit position papers and/or written testimony or serve as witnesses).
- Clarify areas of the regulations that currently causes confusion and may result in unnecessary appeals to the Medicare Appeals Council.
- Create process efficiencies by eliminating unnecessary steps (e.g., by allowing ALJs to vacate their own dismissals rather than requiring appellants to appeal a dismissal to the Medicare Appeals Council); streamlining certain procedures (e.g., by using telephone hearings for appellants who are not unrepresented beneficiaries, unless the ALJ finds good cause for an appearance by other means); and requiring appellants to provide more information on what they are appealing and who will be attending a hearing.
- Address areas for improvement previously identified by stakeholders to increase the quality of the process and responsiveness to customers, such as establishing an adjudication time frame for cases remanded from the Medicare Appeals Council, revising remand rules to help ensure cases keep moving forward in the process, simplifying the escalation process, and providing more specific rules on what constitutes good cause for new evidence to be admitted at the OMHA level of appeal.

Additional Information

For more information, please visit:
https://www.federalregister.gov/documents/2017/01/17/2016-32058/medicare-program-

changes-to-the-medicare-claims-and-entitlement-medicare-advantage-organization. The final rule will be effective 60 days after the Federal Register publication date.