September 2003

MEDICARE APPEALS

Disparity between Requirements and Responsible Agencies' Capabilities

GAO Accountability • Integrity • Reliability

Highlights

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.

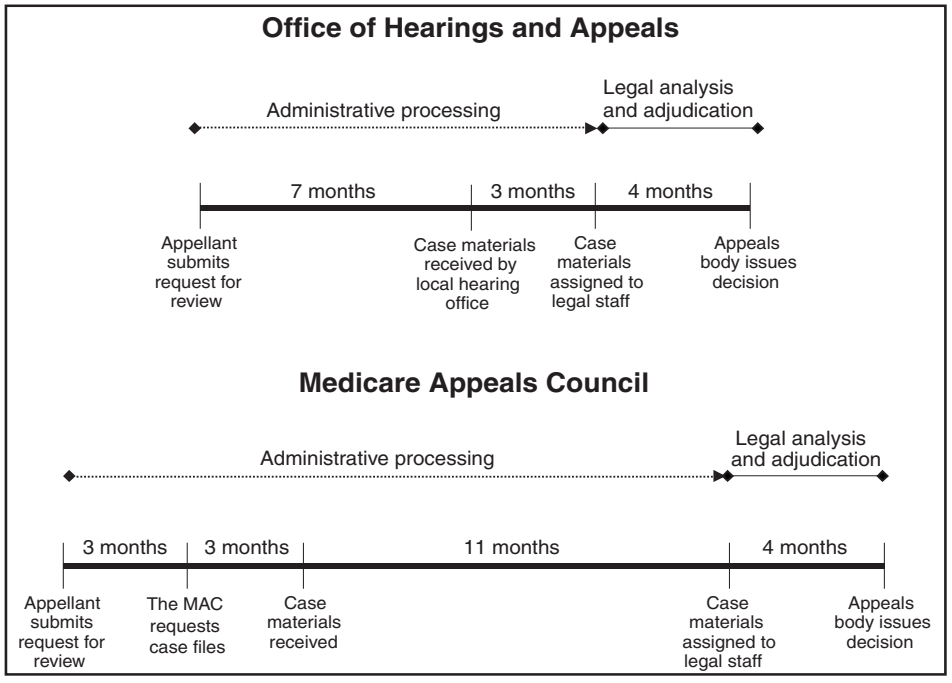
www.gao.gov/cgi-bin/getrpt?GAO-03-841.

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.

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.