# Description of the Chairman's Mark

# Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015

Scheduled for Markup
By the Senate Committee on Finance
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**SECTION 1 – INCREASED RESOURCES FOR THE OFFICE OF MEDICARE HEARINGS AND APPEALS AND THE DEPARTMENTAL APPEALS BOARD**

**Current Law**

Section 1869 of the Social Security Act (Act)[1] and accompanying regulations establish a process for making determinations with respect to benefits under Parts A and B of Medicare and appealing these determinations when a claim for benefits is denied in whole or in part. In accordance with regulations, the Secretary of HHS (the Secretary) is required to make an initial determination concerning, for example, the amount of benefits available to the individual, or whether payment may not (or may no longer be) made for an item or service. The appeals process created under section 1869 offers up to five levels of review under which individuals (i.e., beneficiaries, providers, suppliers, and State Medicaid Agencies) may challenge an adverse initial determination. First, pursuant to this section and accompanying regulations, an individual may request a Medicare Administrative Contractor (MAC) to make a redetermination with respect to the claim. Redeterminations generally must be concluded no later than 60 days after the day the contractor receives the request.

Second, section 1869 of the Act permits any individual dissatisfied with the initial determination and the redetermination to file a request for reconsideration. Pursuant to section 1869(c), reconsiderations are conducted by Qualified Independent Contractors (QICs) that must meet certain specified requirements, and the Secretary is required to enter into contracts with no less than 4 of these entities. Reconsiderations must be processed within 60 days, subject to exception. Section 1869(b) of the Act also provides that an individual may request, and the Secretary must provide, an expedited determination or expedited reconsideration of an individual determination if an individual receives a notice that a provider of services plans to (1) terminate all services to an individual (and a physician certifies that failure to continue the provision of services likely places the individual's health at significant risk), or (2) discharge the individual from the provider.

In accordance with section 1869 and implementing regulations, if an individual is dissatisfied with a QIC's reconsideration, or if the adjudication period for the QIC to conclude its reconsideration has passed, the party may request a hearing before an Administrative Law Judge (ALJ). Section 1869(d) specifies that an ALJ must render a decision on such hearing no later than the end of the 90–day period following the date of when the request for the hearing was timely filed, subject to exception. Further, the Secretary must provide continuing education to these ALJs (as well as QICs) with respect to coverage of items or services under Medicare and certain policies of the Secretary, in order for such contractors and judges to make informed decisions on appeals.

In order to be entitled to a hearing before an ALJ, certain amount in controversy requirements must be met. Section 1869(b) of the Act establishes amount in controversy threshold amounts for ALJ hearing

[1] Section 1155 also results in appeals under Medicare A/B, from a Quality Improvement Organization initial determination, and reconsideration, to an ALJ and the Council. A different amount in controversy currently applies ($200) and the rules are in part 478 of 42 CFR. In addition, sections 1852(g)(5), 1876(c)(5)(B), and 1860D-4(h) have appeal provisions for the Medicare managed care and prescription drug programs.

requests for Medicare Part A and Part B appeals[2] that are subject to an annual adjustment. As indicated in a notice published in the Federal Register, for calendar year 2015, if the amount in controversy is less than $150, an ALJ hearing is not available to an individual under this section. In determining the amount in controversy, the Secretary, pursuant to regulations, must permit two or more appeals to be aggregated[3] if the appeals involve the similar or related services provided to the same individual by one or more providers or suppliers or common issues of law and fact arising from services provided to multiple individuals by one or more providers or suppliers.

After an ALJ hearing decision or dismissal has been issued, or if the ALJ has failed to render a decision within the specified timeframe, parties may request review by the Departmental Appeals Board of the Department of Health and Human Services (HHS), the final level of administrative appeal. Under section 1869(d) of the Act, in general, the Departmental Appeals Board must conduct and conclude its review and make a decision or remand the case to the ALJ for further consideration no later than 90 days following the date of a request for review. If a party wishes to appeal the decision of the Board, or the Board's time frame for issuing a ruling has elapsed, judicial review may be requested. Claims are filed in U.S. district court, and are subject to an amount in controversy ($1,460 for calendar year 2015) and other requirements. Additionally, section 1869(b) directs the Secretary to establish a process under which beneficiaries, providers, and suppliers can obtain expedited access to judicial review. This access may be granted if a review entity (comprised of at least three ALJs or members of the Departmental Appeals Board) determines that the Board does not have authority to decide questions of law or regulation relevant to matters in controversy, and there is no material issue of fact in dispute. A party may also bring an action in district court if the review entity generally fails to make a determination within 60 days.

According to HHS, FY2016 Justification of Estimates for Appropriations Committees, the Office of Medicare Hearings and Appeals (OMHA) was appropriated discretionary funding of $82.4 million in FY2014 and $87.4 million in FY2015. HHS requested $270 million in the President's FY2016 budget proposal which included $140 million in discretionary budget authority and $130 million in program funding from proposed legislation. The $130 million in proposed FY2016 program funding from legislation includes indefinite mandatory authority to access a $125 million appropriation from Medicare Recovery Audit Contractor (RA) overpayment recoveries.

**Chairman's Mark**

The Chairman's Mark would require $127 million per year to be appropriated from the Medicare Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) Trust Funds (in amounts to be determined at the Secretary HHS's discretion) beginning in FY2016, providing $125 million to OMHA and $2 million to the Departmental Appeals Board of HHS for purposes of conducting reviews, hearings, and appeals. The funds appropriated would be available until spent and would be in addition to any other funds that may be available to OMHA and the Departmental Appeals Board for the same purposes.

The Chairman's Mark would require the Government Accountability Office (GAO) to conduct a review of the use of the additional funds provided to determine if OMHA increased the number of appeals

[2] Except those appeals for an ALJ hearing brought under Section 1155 of the Act.

[3] The amount in controversy (AIC) applies to the amount of the claim, and aggregation allows multiple claims that do not meet the AIC to be brought together to get a hearing – slight distinction, but an important one, as a single appeal may involve multiple claims.

processed, decreased the time required to process an appeal, and achieved other program improvements. GAO would be required to report such information to Congress no later than December 31, 2018.

## SECTION 2 – ESTABLISHMENT OF MEDICARE MAGISTRATE REVIEWS AND REVISIONS TO THE AMOUNT IN CONTROVERSY

### Current Law

Section 1869 of the Act and accompanying regulations establish a process for making determinations with respect to benefits under Parts A and B of Medicare and appealing these determinations when a claim for benefits is denied in whole or in part. In accordance with regulations, the Secretary of HHS is required to make an initial determination concerning, for example, the amount of benefits available to the individual, or whether payment may not (or may no longer be) made for an item or service. The appeals process created under section 1869 offers up to five levels of review under which individuals (i.e., beneficiaries, providers, suppliers, and State Medicaid Agencies) may challenge an adverse initial determination. First, pursuant to this section and accompanying regulations, an individual may request a MAC to make a redetermination with respect to the claim. Redeterminations generally must be concluded no later than 60 days after the day the contractor receives the request.

Second, section 1869 of the Act permits any individual dissatisfied with the initial determination and the redetermination to file a request for reconsideration. Pursuant to section 1869(c), reconsiderations are conducted by QICs that must meet certain specified requirements, and the Secretary is required to enter into contracts with no less than 4 of these entities. Reconsiderations must be processed within 60 days, subject to exception. Section 1869(b) of the Act also provides that an individual may request, and the Secretary must provide, an expedited determination or expedited reconsideration of an initial determination if an individual receives a notice that a provider of services plans to (1) terminate all services to an individual (and a physician certifies that failure to continue the provision of services likely places the individual's health at significant risk), or (2) discharge the individual from the provider.

In accordance with section 1869 and implementing regulations, if an individual is dissatisfied with a QIC's reconsideration, or if the adjudication period for the QIC to conclude its reconsideration has passed, the party may request a hearing before an ALJ. Section 1869(d) specifies that an ALJ must render a decision on such hearing no later than the end of the 90–day period following the date of when the request for the hearing was timely filed, subject to exception. Further, the Secretary must provide continuing education to these ALJs (as well as QICs) with respect to coverage of items or services under Medicare and certain policies of the Secretary, in order for such contractors and judges to make informed decisions on appeals.

In order to be entitled to a hearing before an ALJ, certain amount in controversy requirements must be met. Section 1869(b) of the Act establishes amount in controversy threshold amounts for ALJ hearing requests for Medicare Part A and Part B appeals that are subject to an annual adjustment. As indicated in a notice published in the Federal Register, for calendar year 2015, if the amount in controversy is less than $150, an ALJ hearing is not available to an individual under this section. In determining the amount in controversy, the Secretary, pursuant to regulations, must permit two or more appeals to be aggregated if the appeals involve the similar or related services provided to the same individual by one or more providers or suppliers or common issues of law and fact arising from services provided to multiple individuals by one or more providers or suppliers.

After an ALJ hearing decision or dismissal has been issued, or if the ALJ has failed to render a decision within the specified timeframe, parties may request review by the Departmental Appeals Board of HHS, the final level of administrative appeal. Under section 1869(d) of the Act, in general, the Departmental Appeals Board must conduct and conclude its review and make a decision or remand the case to the ALJ for further consideration no later than 90 days following the date of a request for review. If a party wishes to appeal the decision of the Board, or the Board's time frame for issuing a ruling has elapsed, judicial review may be requested. Claims are filed in U.S. district court, and are subject to an amount in controversy ($1,460 for calendar year 2015) and other requirements. Additionally, section 1869(b) directs the Secretary to establish a process under which beneficiaries, providers, and suppliers can obtain expedited access to judicial review. This access may be granted if a review entity (comprised of at least three ALJs or members of the Departmental Appeals Board) determines that the Board does not have authority to decide questions of law or regulation relevant to matters in controversy, and there is no material issue of fact in dispute. A party may also bring an action in district court if the review entity generally fails to make a determination within 60 days.

According to HHS, FY2016 Justification of Estimates for Appropriations Committees, OMHA was appropriated discretionary funding of $82.4 million in FY2014 and $87.4 million in FY2015. HHS requested $270 million in the President's FY2016 budget proposal which included $140 million in discretionary budget authority and $130 million in program funding from proposed legislation. The $130 million in proposed FY2016 program funding from legislation includes indefinite mandatory authority to access a $125 million appropriation from RA overpayment recoveries.

**Chairman's Mark**

The Chairman's Mark would establish within OMHA decision-making officials known as Medicare Magistrates. Beginning on January 1, 2017, Medicare Magistrates would perform reviews and render decisions in certain appeals described below. Medicare Magistrates would be licensed attorneys with expertise in the Medicare statute, policies, and procedures, who would be appointed by the Secretary of HHS, and meet other qualifications as determined by the Secretary of HHS.

Medicare Magistrates would perform reviews and render decisions that are appealed to OMHA when the amount in controversy of an appealed claim is less than the new amount in controversy as established by this section (described below) for an ALJ hearing through OMHA but equal to or greater than the amount in controversy under current law for an ALJ hearing through OMHA (for example for FY2015 an appealed claim with an amount in controversy that falls in between $150 and $1,460). The current rules and guidelines that govern appeals adjudicated by ALJs would apply to Medicare Magistrates and the independent reviews conducted by Medicare Magistrates. Decisions made by Medicare Magistrates could be appealed to the Departmental Appeals Board but could not be appealed to the federal court level because the amount in controversy would be below the threshold required by the federal court level.

The Chairman's Mark would increase the current amount in controversy threshold for Medicare appealed claims heard by an ALJ through the OMHA from the current amount of $150 set for FY2015 to a dollar threshold equal to the amount in controversy as required for Medicare appealed claims to be heard at the federal court level. The new threshold is effective in calendar year 2017 and would be indexed for inflation and updated annually as it is in current law.

## SECTION 3 – REMAND APPEALS TO THE REDETERMINATION LEVEL WITH THE INTRODUCTION OF NEW EVIDENCE

### Current Law

Section 1869 of the Act and accompanying regulations establish a process for making determinations with respect to benefits under Parts A and B of Medicare and appealing these determinations when a claim for benefits is denied in whole or in part. In accordance with regulations, the Secretary of HHS is required to make an initial determination concerning, for example, the amount of benefits available to the individual, or whether payment may not (or may no longer be) made for an item or service. The appeals process created under section 1869 offers up to five levels of review under which individuals (i.e., beneficiaries, providers, suppliers, and State Medicaid Agencies) may challenge an adverse initial determination. First, pursuant to this section and accompanying regulations, an individual may request a MAC to make a redetermination with respect to the claim. Redeterminations generally must be concluded no later than 60 days after the day the contractor receives the request.

Second, section 1869 of the Act permits any individual dissatisfied with the initial determination and the redetermination to file a request for reconsideration. Pursuant to section 1869(c), reconsiderations are conducted by QICs that must meet certain specified requirements, and the Secretary is required to enter into contracts with no less than 4 of these entities. Reconsiderations must be processed within 60 days, subject to exception. Section 1869(b) of the Act also provides that an individual may request, and the Secretary must provide, an expedited review of an initial determination or expedited reconsideration of an initial determination if an individual receives a notice that a provider of services plans to (1) terminate all services to an individual (and a physician certifies that failure to continue the provision of services likely places the individual's health at significant risk), or (2) discharge the individual from the provider.

In accordance with section 1869 and implementing regulations, if an individual is dissatisfied with a QIC's reconsideration, or if the adjudication period for the QIC to conclude its reconsideration has passed, the party may request a hearing before an ALJ. Section 1869(d) specifies that an ALJ must render a decision on such hearing no later than the end of the 90–day period following the date of when the request for the hearing was timely filed, subject to exception. Further, the Secretary must provide continuing education to these ALJs (as well as QICs) with respect to coverage of items or services under Medicare and certain policies of the Secretary, in order for such contractors and judges to make informed decisions on appeals.

In order to be entitled to a hearing before an ALJ, certain amount in controversy requirements must be met. Section 1869(b) of the Act establishes amount in controversy threshold amounts for ALJ hearing requests for Medicare Part A and Part B appeals that are subject to an annual adjustment. As indicated in a notice published in the Federal Register, for calendar year 2015, if the amount in controversy is less than $150, an ALJ hearing is not available to an individual under this section. In determining the amount in controversy, the Secretary, pursuant to regulations, must permit two or more appeals to be aggregated if the appeals involve the similar or related services provided to the same individual by one or more providers or suppliers or common issues of law and fact arising from services provided to multiple individuals by one or more providers or suppliers.

After an ALJ hearing decision or dismissal has been issued, or if the ALJ has failed to render a decision within the specified timeframe, parties may request review by the Departmental Appeals Board of HHS, the final level of administrative appeal. Under section 1869(d) of the Act, in general, the Departmental

Appeals Board must conduct and conclude its review and make a decision or remand the case to the ALJ for further consideration no later than 90 days following the date of a request for review. If a party wishes to appeal the decision of the Board, or the Board's time frame for issuing a ruling has elapsed, judicial review may be requested. Claims are filed in U.S. district court, and are subject to an amount in controversy ($1,460 for calendar year 2015) and other requirements. Additionally, section 1869(b) directs the Secretary to establish a process under which beneficiaries, providers, and suppliers can obtain expedited access to judicial review. This access may be granted if a review entity (comprised of at least three ALJs or members of the Departmental Appeals Board) determines that the Board does not have authority to decide questions of law or regulation relevant to matters in controversy, and there is no material issue of fact in dispute. A party may also bring an action in district court if the review entity generally fails to make a determination within 60 days.

According to the HHS, FY2016 Justification of Estimates for Appropriations Committees, the OMHA was appropriated discretionary funding of $82.4 million in FY2014 and $87.4 million in FY2015. HHS requested $270 million in the President's FY2016 budget proposal which included $140 million in discretionary budget authority and $130 million in program funding from proposed legislation. The $130 million in proposed FY2016 program funding from legislation includes indefinite mandatory authority to access a $125 million appropriation from RA overpayment recoveries.

**Chairman's Mark**

Beginning on January 1, 2017, the Chairman's Mark would require a QIC; a Medicare Magistrate, as established in section 2; an ALJ, or the Departmental Appeals Board to remand an appeal to the MAC for a redetermination when the appellant introduces new evidence into the administrative record at a subsequent level of appeal.

The Chairman's Mark would provide an exception to the remand process described above when the introduction of new evidence is made by an individual entitled to, or enrolled for, benefits under part A or enrolled under part B, or the Centers for Medicare & Medicaid Services (CMS) or its contractors, or justified due to 1) an inadvertent omission or erroneous decision by a lower level adjudicator to omit the evidence from the administrative record despite its timely submission by the appellant, 2) an instance where a decision by a lower-level adjudicator was made on new or different grounds than the initial decision, or 3) other circumstances as determined by the Secretary of HHS.

## SECTION 4 – EXPEDITE PROCEDURES FOR CLAIMS WITH NO MATERIAL FACT IN DISPUTE

**Current Law**

Section 1869 of the Act and accompanying regulations establish a process for making determinations with respect to benefits under Parts A and B of Medicare and appealing these determinations when a claim for benefits is denied in whole or in part. In accordance with regulations, the Secretary of HHS is required to make an initial determination concerning, for example, the amount of benefits available to the individual, or whether payment may not (or may no longer be) made for an item or service. The appeals process created under section 1869 offers up to five levels of review under which individuals (*i.e.*, beneficiaries, providers, suppliers, and State Medicaid Agencies) may challenge an adverse initial determination. First, pursuant to this section and accompanying regulations, an individual may request a MAC to make a

redetermination with respect to the claim. Redeterminations generally must be concluded no later than 60 days after the day the contractor receives the request.

Second, section 1869 of the Act permits any individual dissatisfied with the initial determination and the redetermination to file a request for reconsideration. Pursuant to section 1869(c), reconsiderations are conducted by QIC that must meet certain specified requirements, and the Secretary is required to enter into contracts with no less than 4 of these entities. Reconsiderations must be processed within 60 days, subject to exception. Section 1869(b) of the Act also provides that an individual may request, and the Secretary must provide, an expedited review of an initial determination or expedited reconsideration of an initial determination if an individual receives a notice that a provider of services plans to (1) terminate all services to an individual (and a physician certifies that failure to continue the provision of services likely places the individual's health at significant risk), or (2) discharge the individual from the provider.

In accordance with section 1869 and implementing regulations, if an individual is dissatisfied with a QIC's reconsideration, or if the adjudication period for the QIC to conclude its reconsideration has passed, the party may request a hearing before an ALJ. Section 1869(d) specifies that an ALJ must render a decision on such hearing no later than the end of the 90–day period following the date of when the request for the hearing was timely filed, subject to exception. Further, the Secretary must provide continuing education to these ALJs (as well as QICs) with respect to coverage of items or services under Medicare and certain policies of the Secretary, in order for such contractors and judges to make informed decisions on appeals.

In order to be entitled to a hearing before an ALJ, certain amount in controversy requirements must be met. Section 1869(b) of the Act establishes amount in controversy threshold amounts for ALJ hearing requests for Medicare Part A and Part B appeals that are subject to an annual adjustment. As indicated in a notice published in the Federal Register, for calendar year 2015, if the amount in controversy is less than $150, an ALJ hearing is not available to an individual under this section. In determining the amount in controversy, the Secretary, pursuant to regulations, must permit two or more appeals to be aggregated if the appeals involve the similar or related services provided to the same individual by one or more providers or suppliers or common issues of law and fact arising from services provided to multiple individuals by one or more providers or suppliers.

Section 1869(b)(3) of the Act currently states the following: "A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the QIC under subsection (c) of this section, unless there is good cause which precluded the introduction of such evidence at or before that reconsideration."

After an ALJ hearing decision or dismissal has been issued, or if the ALJ has failed to render a decision within the specified timeframe, parties may request review by the Departmental Appeals Board of HHS, the final level of administrative appeal. Under section 1869(d) of the Act, in general, the Departmental Appeals Board must conduct and conclude its review and make a decision or remand the case to the ALJ for further consideration no later than 90 days following the date of a request for review. If a party wishes to appeal the decision of the Board, or the Board's time frame for issuing a ruling has elapsed, judicial review may be requested. Claims are filed in U.S. district court, and are subject to an amount in controversy ($1,460 for calendar year 2015) and other requirements. Additionally, section 1869(b) directs the Secretary to establish a process under which beneficiaries, providers, and suppliers can obtain expedited access to judicial review. This access may be granted if a review entity (comprised of at least three ALJs or members of the Departmental Appeals Board) determines that the Board does not have

authority to decide questions of law or regulation relevant to matters in controversy, and there is no material issue of fact in dispute. A party may also bring an action in district court if the review entity generally fails to make a determination within 60 days.

According to HHS, FY2016 Justification of Estimates for Appropriations Committees, the OMHA was appropriated discretionary funding of $82.4 million in FY2014 and $87.4 million in FY2015. HHS requested $270 million in the President's FY2016 budget proposal which included $140 million in discretionary budget authority and $130 million in program funding from proposed legislation. The $130 million in proposed FY2016 program funding from legislation includes indefinite mandatory authority to access a $125 million appropriation from RA overpayment recoveries.

**Chairman's Mark**

No later than January 1, 2017, the Chairman's Mark would require the Secretary of HHS to establish and implement a process whereby ALJs and Medicare Magistrates, as established in section 2, could issue decisions, based on the evidence of record, without holding a hearing when there are no material issues of fact in dispute and the ALJ or the Medicare Magistrate determines that there is a binding authority that controls the decision in the matter under review. The new process described above would apply to requests for review that are pending on or filed after the date of the enactment of this bill.

The Chairman's Mark would require the Secretary of HHS to establish a process by which an appeal before an ALJ can be certified for expedited access to judicial review when 1) the appellant has not requested expedited access to judicial review, 2) there is no material fact in dispute, and 3) neither the ALJ nor the Departmental Appeals Board has the authority to decide the questions of law or regulation relevant to the matters in controversy. Such a determination would exhaust the administrative appeals process, rendering the appeal eligible for judicial review.

## SECTION 5 – AUTHORITY TO USE SAMPLING AND EXTRAPOLATION METHODOLOGIES AND TO CONSOLIDATE APPEALS FOR ADMINISTRATIVE EFFICIENCY

**Current Law**

Section 1869 of the Act and accompanying regulations establish a process for making determinations with respect to benefits under Parts A and B of Medicare and appealing these determinations when a claim for benefits is denied in whole or in part. In accordance with regulations, the Secretary of HHS is required to make an initial determination concerning, for example, the amount of benefits available to the individual, or whether payment may not (or may no longer be) made for an item or service. The appeals process created under section 1869 offers up to five levels of review under which individuals (i.e., beneficiaries, providers, suppliers, and State Medicaid Agencies () may challenge an adverse initial determination. First, pursuant to this section and accompanying regulations, an individual may request a MAC to make a redetermination with respect to the claim. Redeterminations generally must be concluded no later than 60 days after the day the contractor receives the request.

Second, section 1869 of the Act permits any individual dissatisfied with the initial determination and the redetermination to file a request for reconsideration. Pursuant to section 1869(c), reconsiderations are conducted by QIC that must meet certain specified requirements, and the Secretary is required to enter into contracts with no less than 4 of these entities. Reconsiderations must be processed within 60 days,

subject to exception. Section 1869(b) of the Act also provides that an individual may request, and the Secretary must provide, an expedited review of an initial determination or expedited reconsideration of an initial determination if an individual receives a notice that a provider of services plans to (1) terminate all services to an individual (and a physician certifies that failure to continue the provision of services likely places the individual's health at significant risk), or (2) discharge the individual from the provider.

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**Chairman's Mark**

As of the date of enactment, the Chairman's Mark would allow for a review entity (*e.g.*, a MAC or a QIC); a Medicare Magistrate, as established in section 2; an ALJ, or the Departmental Appeals Board to consolidate more than one pending request for review or appeal into a single action or appeal if 1) the individual requests involve one or more common question of fact or law for similar claims submitted by the same individual or entity, 2) the party requests aggregation of claims, 3) the requests for review or appeal were included within a statistical sample during initial review or previous level of appeal, or 4) other circumstances that are identified by the Secretary of HHS prior to the use of consolidation that would promote administrative efficiency.

The Chairman's Mark would require a request for review or appeal that had been previously consolidated at a lower level of appeal or involving claims that were included as part of an extrapolation to be submitted as a single request for review or appeal in order to be entitled to a review or hearing. When an appeal involves a decision that was based on a statistical sample at a lower level, the adjudicator's decision of such appeal must be based on the same statistical sample. The Chairman's Mark would allow an adjudicator to use statistical sampling and extrapolation methodologies for any requests for review or appeals that are pending on or filed after the date of the enactment of this bill, with the consent of the appellant.

## SECTION 6 – IDENTIFICATION AND REFERRAL OF FRAUD

**Current Law**

No provision.

**Chairman's Mark**

No later than January 1, 2017, the Chairman's Mark would require the Secretary of HHS, in consultation with HHS Inspector General and the Attorney General, to establish and implement a process by which OMHA and the Departmental Appeals Board would refer credible suspicion of fraudulent activity to appropriate law enforcement entities and CMS.

## SECTION 7 – STUDY TO ASSESS HEARING PARTICIPATION

**Current Law**

Section 1869 of the Act and accompanying regulations establish a process for making determinations with respect to benefits under Parts A and B of Medicare and appealing these determinations when a claim for benefits is denied in whole or in part. In accordance with regulations, the Secretary of HHS is required to make an initial determination concerning, for example, the amount of benefits available to the individual, or whether payment may not (or may no longer be) made for an item or service. The appeals process created under section 1869 offers up to five levels of review under which individuals (i.e., beneficiaries, providers, suppliers, and State Medicaid Agencies) may challenge an adverse initial determination. First, pursuant to this section and accompanying regulations, an individual may request a MAC to make a redetermination with respect to the claim. Redeterminations generally must be concluded no later than 60 days after the day the contractor receives the request.

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In accordance with section 1869 and implementing regulations, if an individual is dissatisfied with a QIC's reconsideration, or if the adjudication period for the QIC to conclude its reconsideration has passed, the party may request a hearing before an ALJ. Section 1869(d) specifies that an ALJ must render a decision on such hearing no later than the end of the 90–day period following the date of when the request for the hearing was timely filed, subject to exception. Further, the Secretary must provide continuing education to these ALJs (as well as QICs) with respect to coverage of items or services under Medicare and certain policies of the Secretary, in order for such contractors and judges to make informed decisions on appeals.

In order to be entitled to a hearing before an ALJ, certain amount in controversy requirements must be met. Section 1869(b) of the Act establishes amount in controversy threshold amounts for ALJ hearing requests for Medicare Part A and Part B appeals that are subject to an annual adjustment. As indicated in a notice published in the Federal Register, for calendar year 2015, if the amount in controversy is less than $150, an ALJ hearing is not available to an individual under this section. In determining the amount in controversy, the Secretary, pursuant to regulations, must permit two or more appeals to be aggregated if the appeals involve the similar or related services provided to the same individual by one or more providers or suppliers or common issues of law and fact arising from services provided to multiple individuals by one or more providers or suppliers.

After an ALJ hearing decision or dismissal has been issued, or if the ALJ has failed to render a decision within the specified timeframe, parties may request review by the Departmental Appeals Board of HHS, the final level of administrative appeal. Under section 1869(d) of the Act, in general, the Departmental Appeals Board must conduct and conclude its review and make a decision or remand the case to the ALJ for further consideration no later than 90 days following the date of a request for review. If a party wishes to appeal the decision of the Board, or the Board's time frame for issuing a ruling has elapsed, judicial review may be requested. Claims are filed in U.S. district court, and are subject to an amount in controversy ($1,460 for calendar year 2015) and other requirements. Additionally, section 1869(b) directs the Secretary to establish a process under which beneficiaries, providers, and suppliers can obtain expedited access to judicial review. This access may be granted if a review entity (comprised of at least three ALJs or members of the Departmental Appeals Board) determines that the Board does not have authority to decide questions of law or regulation relevant to matters in controversy, and there is no material issue of fact in dispute. A party may also bring an action in district court if the review entity generally fails to make a determination within 60 days.

According to HHS, FY2016 Justification of Estimates for Appropriations Committees, the OMHA was appropriated discretionary funding of $82.4 million in FY2014 and $87.4 million in FY2015. HHS requested $270 million in the President's FY2016 budget proposal which included $140 million in discretionary budget authority and $130 million in program funding from proposed legislation. The $130

million in proposed FY2016 program funding from legislation includes indefinite mandatory authority to access a $125 million appropriation from RA overpayment recoveries.

**Chairman's Mark**

No later than January 1, 2017, the Chairman's Mark would require the Secretary of HHS to conduct a review to determine whether it would be feasible to increase the participation of the CMS or the review entity contractors (*e.g.*, program integrity contractors, RAs, MACs, QICs) in appeal hearings conducted by OMHA, including a process to provide notice of a hearing to all relevant contractors.

## SECTION 8 – IMPROVEMENTS TO THE OFFICE OF MEDICARE HEARINGS AND APPEALS

**Current Law**

No provision.

**Chairman's Mark**

Beginning in calendar year 2017, the Chairman's Mark would require OMHA to conduct annual training for all ALJs and Medicare Magistrates on Medicare policies, including changes made to such policies in a given year.

Beginning on January 1, 2017, the Chairman's Mark would require the Secretary of HHS to publish annually on a publically accessible website the following: 1) the percentage of appeals that receive fully favorable, partially favorable and unfavorable decisions; 2) such information (described in 1) for each individual ALJ and by type of service (*e.g.*, Part A hospital, Part B, durable medical equipment); 3) the length of time elapsed between request for review and final decisions; 4) the instances in which the Departmental Appeals Board reversed or remanded the decisions of individual ALJs on the grounds that they diverted from Medicare policies and coverage; 5) the instances in which individual ALJs reached a decision that differed from the opinion of a physician employed by the QIC; and 6) other information as determined by the Secretary of HHS that would provide greater transparency of OMHA.

The Chairman's Mark would require the GAO to conduct a review of decisions rendered at OMHA to identify the frequency in which (i) ALJ or Medicare Magistrate decisions diverted from CMS interpretation of Medicare policies and program instruction, (ii) ALJ or Medicare Magistrate decisions demonstrate significant variation in the interpretation of similar Medicare policies or instruction, and (iii) ALJ or Medicare Magistrate decisions failed to apply the applicable Medicare law, regulation, policy or instruction. Nothing in this section shall be construed as questioning the independence of the ALJs, but is to be used to provide empirical information regarding how ALJ decisions are reached. Data related to the frequency in which ALJ decisions diverted from Medicare law, regulation, policy, or coverage decisions shall focus on decisions adjudicated no less than one year after the enactment of this bill and may be evaluated through the use of sampling. This shall be reported to Congress no later than January 1, 2018.

No later than July 1, 2018, the Chairman's Mark would require the Secretary of HHS to establish and implement a process to identify Medicare policies or coverage decisions that, when surrounded by similar facts or circumstances are most frequently interpreted differently by Medicare review entity contractors, Medicare Magistrates, ALJs, or the Departmental Appeals Board. Such a process should determine

whether further clarification or adjustment to such policies is needed to prevent future varied interpretations.

The Chairman's Mark would require the Secretary of HHS to determine if the specialization of ALJs by type of appeal (*i.e.*, the type of Medicare service or provider) and/or the mandatory use of clinical experts alongside ALJs would lead to more consistent decisions made by ALJs for cases with similar facts. The Secretary of HHS shall conduct a study to investigate such issues and report to Congress no later than July 1, 2018.

Beginning in calendar year 2017, the Chairman's Mark would require the Secretary to establish alternative dispute resolution processes, including mediation, in which providers, suppliers, beneficiaries, or State Medicaid Agencies could voluntarily resolve large volumes of pending appeals involving similar issues of law or fact. As part of any settlement agreement, the appellant would be required to withdraw all requests for hearing or review for the claims covered by the settlement. The Secretary would have discretion to establish the program in a cost-effective manner, including consideration of thresholds and available resources. The Secretary of HHS would establish a process to coordinate with appropriate law enforcement officials and/or CMS to avoid inadvertent settlement or resolution of cases or appeals with suspected fraud or abuse, systematic gaming, or delays in the provision of care by a provider of services or other criminal activity.

## SECTION 9 – REVIEW PROGRAM IMPROVEMENTS

### Current Law

Current Medicare law does not specifically require the Secretary of HHS to establish guidelines and methodologies for reviewing reimbursement claims submitted by providers and suppliers.

The Secretary is required to administer Medicare Parts A (Act, section 1816) and B (Act, section 1842) by contracting with MACs as identified at section 1874A of the Act. In addition, current law (Act, section 1893) established the Medicare Integrity Program (MIP), which requires the Secretary to contract with eligible entities to conduct program integrity activities. Under MIP, the Secretary is required to contract with Medicare RAs to identify Medicare overpayments and underpayments (Act, section 1893(h)). RAs are required to be paid only from funds that were recouped as a result of their reviews in the form of contingency fees which consist of a percentage of the overpayment and underpayment amounts they identify. The Secretary also was authorized to use a portion of RA recoveries to administer the RA program. All other RA overpayment funds recovered from providers are returned to the Medicare Trust Funds. Recently, § 505(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) authorized the Secretary to use up to 15% of RA recoveries for additional purposes.

In implementing MIP requirements, the Secretary also established contracts with other entities that include Zone Program Integrity Contractors (ZPIC), a Supplemental Medical Review Contractor (SMRC), and a Medicare-Medicaid Data Match Contractor (MMDMC).

The Centers for Medicare & Medicaid Services uses Medicare contractors to review claims submitted by providers and suppliers both before and after claims are paid. MACs, in addition to initial and routine scanning for completeness and consistency, also conduct certain claim review activities prior to paying claims (prepayment review), as well as after paying claims (post-payment review). Other contractors such as RAs, ZPICs and SMRCs, also review Medicare claims after payment was made. Most post-

payment claim reviews involve medical review, which CMS describes as "the collection of information and clinical review of medical records by Medicare contractor staff to ensure that payment was made only for services that met all Medicare coverage, coding, and medical necessity requirements.[4]" Medical review processes and decisions generally are guided by policies that may be provided in CMS manuals or required by CMS, but developed and implemented by contractor staff. Medical review processes and policies can vary depending on the contractor type – MAC, RA, ZPIC, QIC, SMRC, or MMDMC – conducting the review, the individual contractors, and the type of service under review. Current Medicare law gives Medicare contractors discretion to develop and tailor coverage decisions to local medical conventions and preferences; as a result there is some variation in interpreting and enforcing medical review policies.

CMS, through contractor oversight and contractor performance requirements, facilitates most coordination among MACs. CMS also has administrative policies and procedures to help minimize medical review duplication or inconsistency with Medicare law, regulations, and program instructions, but is not required to do so under current law. The Secretary also is required to assure that the duties of MACs do not overlap with other contractors, including RAs, although overlap with durable medical equipment (DME) suppliers is permitted (Act, section 1874A(a)(5)(A)).

**Chairman's Mark**

The Chairman's Mark would require the Secretary of HHS to promote transparency and consistency in Medicare payment and coverage policy, as appropriate, and ensure that review entity contractors, Medicare Magistrates, ALJs, and the Departmental Appeals Board uniformly and consistently apply these policies.

The Chairman's Mark would require the Secretary of HHS to approve review guidelines and methodologies prior to their use in the review of any claims paid by Medicare. The Chairman's Mark would allow the Secretary of HHS to provide or establish a transition period by which existing reviews would be permitted to continue until such time as the Secretary of HHS is able to review and approve the review guidelines or methodologies. Review topics or guidelines that have been approved for use by the Secretary shall be made publically available on the CMS website, no less frequently than annually. The Secretary of HHS may prioritize the guideline and methodology approval process according to error rate, frequency of denials, and cost to the Medicare Trust Fund.

The Chairman's Mark would require the Secretary of HHS to designate a point of contact to coordinate, oversee, and perform the following tasks, in order to improve upon the existing and future program integrity initiatives and to limit unnecessary provider or supplier burden.

1. Develop a comprehensive strategy for claims review determinations made on either a prepayment, post-payment, or prior-authorization basis. The strategy shall focus on identifying and reducing those claim errors that have the largest impact on the error rate, pose the greatest risk to the Medicare Trust Fund, or are likely to negatively affect quality of care. In developing such strategy, the Secretary shall consider ways to minimize unnecessary burden on providers and suppliers. Such strategy should utilize data and other sources

[4] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html

including: claims data, Office of Inspector General reports, GAO reports, news reports, Medicare Payment Advisory Commission reports, and Comprehensive Error Rate Testing (CERT) reports;

2. Develop methods to ensure that there is not unnecessary duplication of review of specific individual claims among the review entity contractors used by the Department to conduct claims review, including the use of all available data;

3. Work with all review entity contractors to develop a uniform, consistent, and transparent review process to reduce provider burden to the greatest extent possible. Such efforts could include a uniform approach for review entity contractors to notify parties of pending reviews and requests for medical documentation; improved communication with providers; methods for providing review results; or better refinement of reviews to target claims that are at the highest risk for improper payments or other errors;

4. Identify CMS local coverage determinations (LCDs), national coverage determinations (NCDs), regulations, and program instructions that need updating or inappropriately conflict with other Medicare policies and make the appropriate modifications. In the event that the Secretary of HHS identifies a lack of necessary Medicare policies and review guidelines related to a particular issue, the Secretary of HHS shall establish such instructions, with input from stakeholders, as appropriate;

5. Post on a publicly accessible website the volume and type of prepayment and post-payment claim reviews performed by the Medicare review contractors;

6. Coordinate with OMHA and the Departmental Appeals Board to ensure that the improved methodologies and evidentiary standards established within this bill, such as the decision to remand an appeal, are properly implemented;

7. Ensure that providers subject to post-payment review are granted a discussion period with the contractor of at least 30 days from the letter from the review entity contractor regarding the result of the review;

8. Develop qualification standards for review entity contractors to have audits conducted or approved by medical doctors with knowledge of relevant Medicare laws, policies, and program instruction, as appropriate.

9. Determine whether additional punitive actions against review entity contractors could be taken and what, if any, financial incentives or disincentives could be used to promote the accuracy of a review entity's reviews.

**SECTION 10 – CREATION OF MEDICARE PROVIDER AND SUPPLIER OMBUDSMAN FOR REVIEWS AND APPEALS**

**Current Law**

Under current Medicare law, the Secretary is not required to offer Medicare providers or suppliers access to an Ombudsman. According to CMS's annual beneficiary publication, *Medicare & You*,[5] an ombudsman is someone who reviews complaints and helps to resolve those complaints.

Medicare law requires the Secretary to conduct a satisfaction survey at least every five years of beneficiaries as well as providers and suppliers who submitted appeals (Act, section 1869(e)) and to submit a report to Congress on the results of the survey. In addition, section 1808(c) of the Act requires the Secretary to appoint a Medicare Beneficiary Ombudsman. The Office of Medicare Ombudsman (OMO) was created to identify and address systemic issues that affect Medicare beneficiaries, but OMO does not assist providers, suppliers, or Medicare contractors in resolving complaints and other issues.

**Chairman's Mark**

The Chairman's Mark would require the Secretary of HHS to establish a CMS OMBUDSMAN FOR MEDICARE REVIEWS AND APPEALS. The Medicare Provider & Supplier Ombudsman's duties would include:

1. Identifying, investigating, and assisting in the resolution of complaints (including referring to the appropriate entity) involving Medicare review or appeals processes from appellants or those considering appeals.

2. Identifying trends in complaints regarding the current Medicare review and appeals systems to provide recommendations for improvements to the Secretary of HHS. Such recommendations would improve the efficacy and efficiency of the claims review and appeals system as well as communication to beneficiaries, providers, and suppliers regarding the claims review and appeals system.

3. Designing a system by which to objectively measure and evaluate reviewer responsiveness to addressing provider issues and Ombudsman inquiries.

4. Providing administrative and technical assistance to appellants and those considering appeals.

5. Publish data regarding the number of review determinations appealed, each appeal's outcome, and aggregate appeal statistics for each contractor and provider type. Such data shall be displayed in a uniform, consistent, and easily understood format.

6. Assisting in education and training efforts for providers, suppliers, and review entity contractors.

[5] http://www.medicare.gov/Pubs/pdf/10050.pdf

## SECTION 11 – ABILITY TO REBILL INPATIENT STATUS DENIALS

### Current Law

Current law also requires RA contracts to permit RAs to review claims in the current fiscal year and retrospectively for up to four additional fiscal years, for a total of five fiscal years (SSA § 1893(h)(4)(A) and (B)). According to the RA Statement of Work currently in effect, the look-back period is measured from the date of the initial determination to the date of the RA issues the medical records request letter for complex reviews, the overpayment notification letter for semi-automated reviews, or the demand letter for automated reviews. Currently, CMS has limited the RA look-back period to three fiscal years.

Section 6404 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) amended the SSA to limit the maximum period for provider and supplier submission of Medicare claims to one calendar year from the date of service (SSA § 1814(a), § 1842(b)(3), and § 1835(a)). Under the new RA contracts, CMS indicated that it would limit the RA look-back period to six months from the date of service for patient status reviews, where hospitals submitted claims within three months of the date of service.

To comply with timely filing rules, as stated above, hospitals must submit a claim within one year from the date of service, but the RAs have a three year look-back period. When a RA issues a decision denying an inpatient status claim that is more than one year from the date of service, the hospital is unable to re-bill as an outpatient service because the time period for filing a claim has expired.

For most acute care hospitals, Medicare uses two distinct payment systems for inpatient and outpatient services. Hospitals can sometimes receive substantially higher payments for the same services if patients were admitted to the hospital as inpatients rather than treated as outpatients.

A number of hospital claims reviewed by RAs since FY2010 were identified as inappropriate payments because RAs determined that the care should have been delivered in outpatient settings rather than the inpatient setting where hospitals delivered the services, so the claims were not reasonable and necessary for payment under Medicare Part A. When these (Part A) inpatient claims were denied, under the prior CMS policy, hospitals were prohibited from resubmitting the claims as (Part B) outpatient claims, except for a limited number of services. Hospitals appealed many of these claims. Some claims were overturned at third and fourth appeal levels (ALJ and Medicare Appeals Council levels); other claims are pending in the appeal process.

On March 13, 2013, CMS issued a Ruling that established a process for handling these claims that were being appealed, which allowed rebilling of inpatient services under Part B when an inpatient claim was denied. CMS also published a rule finalizing the policy on rebilling these claims under Part B, on how claims should be re-submitted, and on how the resolution of claims already appealed could be expedited. The rule also clarified when it would generally be appropriate for an inpatient admission to be paid under Medicare Part A, referred to as the Two-Midnight Rule, which stipulated that in cases where a doctor expects a patient would require a hospital stay for at least two midnights, it would be considered a medically necessary inpatient stay. CMS believed that the Ruling and the Rule on Medicare Part B inpatient billing would help to clarify appropriate billing procedures and reduce overpayments and appeals.

Even under the Part B inpatient billing policy, hospitals may be unable to resubmit denied Part A inpatient claims under Part B because providers and suppliers must submit claims within one calendar year of the date of service to comply with timely filing rules, whereas RAs can look back three previous fiscal years

when reviewing claims. If RAs review Part A inpatient claims from three fiscal years ago prior and deny claims, under timely filing rules, it is too late for the hospital to resubmit the claim under Part B for payment.

The Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) required the Secretary to prohibit RAs from reviewing inpatient claims for patient status (whether a patient is an inpatient or an outpatient) with admission dates between October 1, 2013 and March 31, 2015 (PAMA, § 111 – Extension of Two-Midnight Rule). PAMA also specifically permitted the Secretary to review inpatient claims if there was evidence of systemic gaming, fraud, abuse, or delays in the provision of care. Under PAMA, other Medicare contractors, such as MACs, are permitted to review a sample of inpatient claims to assess compliance and educate providers on Medicare's Two-Midnight rule under a Probe and Educate process.

MACRA extended the PAMA provisions at § 111 that prohibited RA reviews of patient status on inpatient claims from April 1, 2015 through September 30, 2015 (MACRA, § 521 – Extension of Two-Midnight PAMA Rules on Certain Medical Review Activities). MACRA also stipulated that the Secretary was permitted to pursue fraud and abuse activities under RA authority or otherwise.

**Chairman's Mark**

The Chairman's Mark would prohibit RAs from conducting patient status reviews (*i.e.*, inpatient versus outpatient status) more than 6 months after the date of service if the claim was submitted within 3 months of the date of service.

The Chairman's Mark would require the Secretary to study the impact of shortening the look-back period for other RA audits, including audits for physicians and other health care providers and suppliers, and would provide the Secretary with discretion to implement a look-back period to a period of less than three years.

## SECTION 12 – INCENTIVES AND DISINCENTIVES FOR MEDICARE CONTRACTORS, PROVIDERS, AND SUPPLIERS

**Current Law**

Medicare law requires participating providers and suppliers to comply with Medicare requirements stipulated in the Act as well as CMS regulations. Medicare law also requires the Secretary to provide incentives for MACs to provide quality service and to promote efficiency (Act, section 1874A(b)(1)(D)). In addition, the Secretary is required to develop contract performance requirements for MAC duties and standards for measuring MAC's performance in meeting those requirements (Act, section 1874A(b)(3)). Moreover, in developing standards for measuring MAC performance, the Secretary is required to consult with stakeholders and to make the performance standards publically available.

MACRA required MACs to have an improper payment outreach and education program that would provide outreach, education, training, and technical assistance to providers and suppliers within each contractor's geographic service area (Act, section 1874A(a)(4)).

CMS also requires all Medicare contractors to provide outreach and education to providers and suppliers and provides guidance to Medicare contractors on communications and interactions with providers and suppliers in the Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6 –

Provider Customer Service Program (Rev. 31, 02-13-2015). This manual identifies a number of Medicare contractor requirements to provide education, outreach, and overall support through the Provider Customer Service Program (PCSP). CMS makes data available on the results of the PCSP on its Contractor-Provider Customer Service Program website including contractor performance data.

In July 2014, CMS announced the establishment of a Provider Relations Coordinator. CMS indicated that the Provider Relations Coordinator was intended to improve communications between providers and CMS and to help increase program transparency while offering more efficient resolutions to providers affected by the review process. Providers were instructed to raise broader concerns with the Provider Relations Coordinator, but to continue to interact with MACs and RAs on individual claim questions.

**Chairman's Mark**

The Chairman's Mark would require the Secretary to establish and implement, no later January 1, 2017, a system that takes into account the denial rate as a percentage of claims audited and final determination of appeals by type of issue (for example, patient classification or medical necessity for specific procedures) by which providers or suppliers with a low error rate for claims subject to additional document requests over a two-year period are exempt from audits by RAs and MACs on a post-payment basis for one year unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services.

The Secretary of HHS shall assess the frequency in which decisions being made by the review entity contractors are consistent with Medicare payment and coverage law, regulations and program instruction (but taking into account geographical variation that are a result of local coverage determinations). The Secretary of HHS may use sampling to fulfill this requirement. The results of the validation shall be posted to the CMS website.

The Chairman's Mark would require the Secretary to adjust the number of medical records a review entity can request from a provider or supplier for the purposes of review based on the assessment described above. This adjustment would be directly related to the accuracy of the review entity's reviews. Contractors with an accuracy rate of 95% or more may be eligible to request additional medical records. Contractors with an accuracy rate of less than 95% may be limited in their ability to request medical records, according to a sliding scale established by the Secretary.