Calendar No. 317

114TH CONGRESS
1ST SESSION

S. 2368

[Report No. 114–177]

To amend title XVIII of the Social Security Act to improve the efficiency of the Medicare appeals process, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 8, 2015

Mr. HATCH, from the Committee on Finance, reported the following original bill; which was read twice and placed on the calendar

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A BILL

To amend title XVIII of the Social Security Act to improve the efficiency of the Medicare appeals process, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015'' or the ''AFIRM Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. INCREASED RESOURCES FOR THE OFFICE OF MEDICARE HEARINGS AND APPEALS AND THE DEPARTMENTAL APPEALS BOARD.

(a) IN GENERAL.—For fiscal year 2016 and for each fiscal year thereafter, for purposes of conducting reviews, hearings, and appeals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of such Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary may determine, of—

(1) $125,000,000 to the Office of Medicare Hearings and Appeals; and

(2) $2,000,000 to the Departmental Appeals Board of the Department of Health and Human Services.

Amounts transferred under the preceding sentence shall be in addition to any other amounts that may be available for such purposes and shall remain available until expended.

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the use of the amount made available to the Office of Medicare Hearings and Appeals under subsection (a) to determine whether the availability of such amounts led to any improvements in the Medicare appeals program, such as an increased number of appeals processed or a decrease in the time required to process an appeal.

(2) REPORT.—Not later than December 31, 2018, the Comptroller General of the United States shall submit a report to Congress on the study required under paragraph (1), together with recommendations for such legislative and administrative actions as the Comptroller General determines appropriate.

SEC. 3. ESTABLISHMENT OF MEDICARE MAGISTRATE REVIEW AND REVISION OF AMOUNT IN CONTROVERSY THRESHOLDS.

(a) ESTABLISHMENT OF MEDICARE MAGISTRATE PROGRAM.—

(1) IN GENERAL.—Section 1869(b) of the Social Security Act (42 U.S.C. 1395ff(b)) is amended by adding at the end the following new paragraph:

''(4) CONDUCT OF REVIEWS BY MEDICARE MAGISTRATES.—

''(A) IN GENERAL.—The Secretary shall establish within the Office of Medicare Hearings and Appeals decision-making officials to be known as Medicare magistrates.

''(B) MEDICARE MAGISTRATE DEFINED.—For purposes of this section, the term 'Medicare magistrate' means an attorney who is licensed by a State, has expertise in this title (including regulations and policies promulgated thereunder), meets such other qualifications as the Secretary shall require, and who performs reviews and renders decisions in appeals described in paragraph (1)(E)(i)(II).

''(C) REQUIREMENTS FOR REVIEWS CONDUCTED BY MAGISTRATES.—The provisions of this subsection and subsection (d) that govern

hearings and decisions by administrative law judges (including provisions related to reviews of decisions by administrative law judges by the Departmental Appeals Board of the Department of Health and Human Services) shall apply to reviews and decisions by Medicare magistrates in the same manner and to the same extent as such provisions apply to hearings and decisions by an administrative law judge. The Secretary may establish by regulation such other requirements and procedures as may be necessary so that reviews by Medicare magistrates are resolved fairly, efficiently, and expeditiously.''.

(2) CONFORMING AMENDMENT.—Section 1869(b)(1)(A) of the Social Security Act (42 U.S.C. 1395ff(b)(1)(A)) is amended by inserting ''and paragraph (4)'' after ''subject to subparagraphs (D) and (E)''.

(b) AMOUNT IN CONTROVERSY THRESHOLDS.—

(1) IN GENERAL.—Section 1869(b)(1)(E) of the Social Security Act (42 U.S.C. 1395ff(b)(1)(E)) is amended—

(A) by striking clause (i) and inserting the following:

"(i) IN GENERAL.—Except as otherwise provided in this section, subject to clause (iii)—

"(I) a review by a Medicare magistrate under paragraph (4), or a hearing by an administrative law judge under this subsection or subsection (d), shall not be available to an individual if the amount in controversy is less than $150;

"(II) a review by a Medicare magistrate under paragraph (4) shall be available to an individual if the amount in controversy is equal to or greater than the amount specified in subclause (I) but less than the amount specified in subclause (III); and

"(III) a hearing by an administrative law judge shall be available to an individual under this subsection or subsection (d) if the amount in controversy is equal to or greater than $1,500.";

(B) in clause (iii)—

(i) by striking ''For requests for hearings'' and inserting ''For requests for Medicare magistrate reviews, hearings,'';

(ii) by striking ''2004'' and inserting ''2017''; and

(iii) by striking ''2003'' and inserting ''2016''; and

(C) by adding at the end the following new clause:

''(iv) JUDICIAL REVIEW.—Judicial review shall not be available to an individual under this section if the amount in controversy is less than the amount specified in clause (i)(III).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1155 of the Social Security Act (42 U.S.C. 1320c–4) is amended—

(i) in the second sentence, by striking ''$200 or more'' and inserting ''equal to or greater than the amount specified in section 1869(b)(1)(E)(i)(III)'';

(ii) in the fourth sentence, by striking ''$2,000 or more'' and inserting ''equal to or greater than the amount specified in section 1869(b)(1)(E)(i)(III)''; and

(iii) by adding at the end the following new sentences: ''Where the amount in controversy is equal to or greater than the amount specified in subclause (I) of section 1869(b)(1)(E)(i) but less than the amount specified in subclause (III) of such section, such beneficiary shall be entitled to a review by a Medicare magistrate in accordance with procedures established by the Secretary pursuant to section 1869. The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to the dollar amounts referred to in this section in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).''.

(B) Section 1852(g)(5) of the Social Security Act (42 U.S.C. 1395w–22(g)(5)) is amended—

(i) in the first sentence, by striking ''$100 or more'' and inserting ''equal to or greater than the amount specified in section 1869(b)(1)(E)(i)(III)'';

(ii) in the second sentence, by striking ''$1,000 or more'' and inserting ''equal to

or greater than the amount specified in section 1869(b)(1)(E)(i)(III)'';

(iii) by inserting after the second sentence the following new sentence: ''If the amount in controversy is equal to or greater than the amount specified in subclause (I) of section 1869(b)(1)(E)(i) but less than the amount specified in subclause (III) of such section, such enrollee shall be entitled to review by a Medicare magistrate in accordance with procedures established by the Secretary pursuant to section 1869.''; and

(iv) in the last sentence, by striking ''the first 2 sentences of''.

(C) Section 1876(c)(5)(B) of the Social Security Act (42 U.S.C. 1395mm(c)(5)(B)) is amended—

(i) in the first sentence, by striking ''$100 or more'' and inserting ''equal to or greater than the amount specified in section 1869(b)(1)(E)(i)(III)'';

(ii) in the second sentence, by striking ''$1,000 or more'' and inserting ''equal to

or greater than the amount specified in section 1869(b)(1)(E)(i)(III)'';

(iii) by inserting after the second sentence the following new sentence: ''If the amount in controversy is equal to or greater than the amount specified in subclause (I) of section 1869(b)(1)(E)(i) but less than the amount specified in subclause (III) of such section, such member shall be entitled to review by a Medicare magistrate in accordance with procedures established by the Secretary pursuant to section 1869.''; and

(iv) in the last sentence, by striking ''the first 2 sentences of''.

(c) CALCULATION OF AMOUNT IN CONTROVERSY FOR THE AGGREGATION OF CLAIMS.—Section 1869(b)(1)(E)(ii) of the Social Security Act (42 U.S.C. 1395ff(b)(1)(E)(ii)) is amended—

(1) by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively, and indenting appropriately;

(2) in the matter preceding item (aa), as so redesignated, by striking ''if the appeals involve'' and inserting the following: ''if—

''(I) the appeals involve—'';

(3) in item (bb), as so redesignated, by striking the period at the end and inserting ''; and''; and

(4) by adding at the end the following new subclause:

''(II) all claims that an individual seeks to aggregate are included in the same request for an aggregated appeal.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2017.

SEC. 4. REMANDING APPEALS TO THE REDETERMINATION LEVEL WITH THE INTRODUCTION OF NEW EVIDENCE.

(a) IN GENERAL.—Section 1869(b)(3) of the Social Security Act (42 U.S.C. 1395ff(b)(3)) is amended by striking ''A provider of services'' and all that follows through the period and inserting the following new subparagraphs:

''(A) REMAND UPON SUBMISSION OF NEW EVIDENCE.—

''(i) IN GENERAL.—Except as provided in subparagraph (B), when a party to an appeal, other than an individual entitled to, or enrolled for, benefits under part

A or enrolled under part B or the Centers for Medicare & Medicaid Services or its contractors, introduces new evidence into the administrative record at a reconsideration conducted by a qualified independent contractor under subsection (c) or at any subsequent, higher level of appeal, the appeal shall be remanded for a de novo redetermination under subsection (a)(3), and any prior decisions (other than the initial determination made by the Secretary pursuant to subsection (a)(1)) on this appeal shall be vacated.

''(ii) REQUIREMENTS.—For purposes of clause (i), except to the extent otherwise provided by the Secretary in regulations, the provisions that apply to redeterminations under subsection (a) and this subsection shall apply to redeterminations of appeals that are remanded.

''(B) EXCEPTIONS.—The provisions of subparagraph (A) shall not apply in instances where an adjudicator determines that introduction of new evidence is justified due to—

''(i) an inadvertent omission or erroneous decision by a lower-level adjudicator to omit the evidence from the administrative record when that evidence was timely submitted to the lower-level adjudicator by a party to the appeal;

''(ii) a decision by a lower-level adjudicator to issue an unfavorable decision based on new or different grounds than were previously adjudicated; or

''(iii) such other circumstances for good cause as the Secretary may establish.

''(C) NO APPEAL.—A decision to remand an appeal under this paragraph shall not be subject to appeal.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2017.

SEC. 5. EXPEDITED ACCESS TO APPEALS.

(a) IN GENERAL.—Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new subparagraph:

''(H) EXPEDITED ACCESS TO APPEALS.—

''(i) DECISION ON THE RECORD.—Not later than January 1, 2017, the Secretary shall establish by regulation and implement

a process authorizing an administrative law judge reviewing a decision pursuant to this subsection or subsection (d) to issue a decision on the record in cases where, based on the evidence of record, there are no material issues of fact in dispute and the administrative law judge determines that there is a binding authority that controls the decision in the matter under review.

''(ii) EXPEDITED ACCESS TO JUDICIAL REVIEW NOT REQUESTED BY APPELLANT.—The Secretary shall by regulation establish a process authorizing an administrative law judge reviewing a decision pursuant to this subsection or subsection (d) to certify the appeal for expedited access to judicial review where—

''(I) the appellant does not request expedited access to judicial review pursuant to paragraph (2);

''(II) there are no material issues of fact in dispute; and

''(III) neither the administrative law judge nor the Departmental Ap-

peals Board has authority to decide the questions of law or regulation relevant to the matters in controversy.

''(iii) APPLICATION OF HEARING RULES TO DECISIONS ON THE RECORD.—The provisions of subsection (d) that govern hearings by administrative law judges shall apply to a decision issued by an administrative law judge without a hearing pursuant to clause (i) in the same manner and to the same extent as such provisions apply to a hearing by an administrative law judge.

''(iv) EFFECT OF CERTIFICATION FOR JUDICIAL REVIEW.—Notwithstanding subsection (d)(2), a decision to certify an appeal pursuant to clause (ii) shall not be subject to further review by the Secretary and shall be deemed a final decision by the Secretary as provided in section 205(g) (as applied to this section) for purposes of determining an individual's entitlement to judicial review.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1155 of the Social Security Act (42 U.S.C. 1320c–4), as amended by section 3(b)(2)(A), is amended—

(A) in the second sentence, by striking ''Where'' and inserting ''Subject to the succeeding sentences of this section, where''; and

(B) by adding at the end the following new sentence: ''The provisions of subparagraph (H) of section 1869(b)(1) shall apply with respect to decisions by an administrative law judge under this section in the same manner as they apply to decisions by an administrative law judge under such subparagraph (H).''.

(2) Section 1852(g)(5) of the Social Security Act (42 U.S.C. 1395w–22(g)(5)), as amended by section 3(b)(2)(B), is amended—

(A) in the first sentence, by striking ''An enrollee'' and inserting ''Subject to the succeeding sentences of this paragraph, an enrollee''; and

(B) by adding at the end the following new sentence: ''The provisions of subparagraph (H) of section 1869(b)(1) shall apply with respect to decisions by an administrative law judge under this paragraph in the same manner as they

apply to decisions by an administrative law judge under such subparagraph (H).''.

(3) Section 1869(b)(1)(A) of the Social Security Act (42 U.S.C. 1395ff(b)(1)(A)), as amended by section 3(a)(2), is amended by striking ''subparagraphs (D) and (E)'' and inserting ''subparagraphs (D), (E), and (H)''.

(4) Section 1876(c)(5)(B) of the Social Security Act (42 U.S.C. 1395mm(c)(5)(B)), as amended by section 3(b)(2)(C), is amended—

(A) in the first sentence, by striking ''A member'' and inserting ''Subject to the succeeding sentences of this subparagraph, a member''; and

(B) by adding at the end the following new sentence: ''The provisions of subparagraph (H) of section 1869(b)(1) shall apply with respect to decisions by an administrative law judge under this subparagraph in the same manner as they apply to decisions by an administrative law judge under such subparagraph (H).''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act and shall apply to cases that are pending as of such date.

SEC. 6. AUTHORITY TO USE SAMPLING AND EXTRAPOLATION METHODOLOGIES AND TO CONSOLIDATE APPEALS FOR ADMINISTRATIVE EFFICIENCY.

(a) IN GENERAL.—Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended by adding at the end the following new subsection:

''(j) AUTHORITIES TO PROMOTE ADMINISTRATIVE EFFICIENCIES.—

''(1) AUTHORITY TO CONSOLIDATE APPEALS.—

''(A) IN GENERAL.—Any individual or entity conducting redeterminations, reconsiderations, reviews, or hearings under subsection (a)(3), (b), (c), or (d) (in this section, referred to as an 'adjudicator') may consolidate pending requests for review into a single action, and may issue a single decision, or separate decisions, with respect to such review requests—

''(i) if such requests involve one or more common questions of fact or law for similar claims submitted by the same individual or entity;

''(ii) if such requests involve claims that were included within a statistical sample during the initial determination or any previous level of appeal;

"(iii) if the appellant requests aggregation of two or more claims under subsection (b)(1)(E)(ii); or

"(iv) in any other case in which the adjudicator determines that consolidation would promote administrative efficiency, consistent with such standards as the Secretary shall establish by regulation.

"(B) DEADLINES.—The Secretary may establish the applicable timeframe for requesting consolidations and for issuing decisions on appeals that have been consolidated.

"(2) REQUIREMENTS FOR CLAIMS THAT WERE INCLUDED IN AN EXTRAPOLATED OVERPAYMENT OR PREVIOUSLY CONSOLIDATED.—An individual or entity requesting a redetermination, reconsideration, review or hearing under subsection (a)(3), (b), (c), or (d) with respect to two or more claims that were included in an extrapolated overpayment, or claims that were consolidated into a single appeal at a lower-level adjudication under this section, must submit a single request for review or hearing with respect to such claims in order to be entitled to a review or hearing.

''(3) AUTHORITY TO USE STATISTICAL SAMPLING AND EXTRAPOLATION METHODOLOGIES IN ADJUDICATIONS.—With the consent of the appellant, an adjudicator may use statistical sampling and extrapolation methodologies in reaching a decision with respect to a claim or claims for benefits for items or services furnished under part A or B. When an appeal involves a decision that was based on a statistical sample at the lower level, the adjudicator's decision shall be based on the same statistical sample.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to requests for review that are pending at any level of appeal as of the date of the enactment of this Act and to those filed after such date.

SEC. 7. IDENTIFICATION AND REFERRAL OF FRAUD.

Not later than January 1, 2017, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services and the Attorney General of the United States, shall establish and implement a process under which the Office of Medicare Hearings and Appeals and the Departmental Appeals Board of the Department of Health and Human Services shall refer cases in which there is a credible suspicion of fraudulent activity to appropriate law en-

forcement agencies and to the Centers for Medicare & Medicaid Services.

SEC. 8. STUDY TO ASSESS HEARING PARTICIPATION.

(a) STUDY.—Not later than January 1, 2017, the Secretary of Health and Human Services shall conduct a study to determine whether it would be feasible to increase the participation, with respect to hearings conducted by the Office of Medicare Hearings and Appeals, of—

(1) the Centers for Medicare & Medicaid Services;

(2) entities serving as qualified independent contractors under section 1869(c) of the Social Security Act (42 U.S.C. 1395ff(c));

(3) entities serving as medicare administrative contractors under section 1874A of such Act (42 U.S.C. 1395kk–1);

(4) entities services as recovery audit contractors under section 1893(h) of such Act (42 U.S.C. 1395ddd(h)); and

(5) other Medicare claims review entities determined appropriate by the Secretary.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish a report containing the results of the study required under subsection (a) on the

Internet website of the Department of Health and Human Services.

SEC. 9. IMPROVEMENTS TO THE OFFICE OF MEDICARE HEARINGS AND APPEALS.

(a) TRAINING FOR ALJS AND MEDICARE MAGISTRATES.—Section 1869(e)(3) of the Social Security Act (42 U.S.C. 1395ff(e)(3)) is amended—

(1) in the paragraph heading, by striking ''AND ADMINISTRATIVE LAW JUDGES'' and inserting '', ADMINISTRATIVE LAW JUDGES, AND MEDICARE MAGISTRATES; ANNUAL TRAINING FOR ADMINISTRATIVE LAW JUDGES AND MEDICARE MAGISTRATES'';

(2) by striking ''The Secretary'' and inserting the following:

''(A) CONTINUING EDUCATION REQUIREMENT.—The Secretary'';

(3) by inserting ''and, beginning in 2017, to Medicare magistrates'' after ''administrative law judges'' the first place it appears;

(4) by striking ''and administrative law judges'' and inserting '', administrative law judges, and Medicare magistrates''; and

(5) by adding at the end the following new subparagraph:

"(B) ANNUAL TRAINING.—Beginning with 2017, each year the Secretary shall provide to each administrative law judge and Medicare magistrate within the Office of Medicare Hearings and Appeals training on Medicare policies, including any policies that were changed or instituted in the previous year.".

(b) TREATMENT OF QIC DECISIONS.—Section 1869(d)(4) of the Social Security Act (42 U.S.C. 1395ff(d)(4)) is amended—

(1) in subparagraph (B), by striking "and" at the end;

(2) in subparagraph (C), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(D) in the case of a review conducted on or after January 1, 2017, of a decision by a qualified independent contractor in which the administrative law judge reaches a different decision than the qualified independent contractor, the reasons why the decision of the administrative law judge differs from the decision of the qualified independent contractor.".

(c) PUBLICATION OF APPEALS INFORMATION.—Section 1869(e) of the Social Security Act (42 U.S.C. 1395ff(e)) is amended by adding at the end the following new paragraph:

"(5) PUBLICATION OF APPEALS INFORMATION.—Not later than January 1, 2017, and annually thereafter, the Secretary of Health and Human Services shall publish and maintain on the Internet website of the Department of Health and Human Services the following information, which may be effectuated through the use of statistical sampling, regarding appeals heard by the Office of Medicare Hearings and Appeals for each fiscal year:

"(A) The percentage of appeals that received fully favorable, partially favorable, and unfavorable decisions.

"(B) For each administrative law judge, the percentage of appeals that received fully favorable, partially favorable, and unfavorable decisions.

"(C) For each type of service, the percentage of appeals that received fully favorable, partially favorable, and unfavorable decisions.

''(D) The average length of time elapsed between the initial request for review and a final decision.

''(E) Such other information as the Secretary determines necessary to ensure greater transparency for the Office of Medicare Hearings and Appeals.''.

(d) GAO REVIEW OF CONSISTENCY OF OMHA DECISIONS.—

(1) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study of decisions rendered by the Office of Medicare Hearings and Appeals to determine the frequency with which decisions by administrative law judges or Medicare magistrates—

(i) diverge from the interpretation of Medicare policy and program instruction of the Centers for Medicare & Medicaid Services;

(ii) demonstrate significant variation in the interpretation of similar Medicare policies or instructions; and

(iii) fail to apply applicable Medicare law, regulation, policy, or instruction.

(B) METHODOLOGY.—In conducting the study required under this paragraph, the Comptroller General of the United States shall focus on decisions rendered by the Office of Medicare Hearings and Appeals not less than 1 year after the date of the enactment of this Act and, if the Comptroller so chooses, may use sampling to identify decisions to evaluate.

(2) REPORT.—Not later than January 1, 2018, the Comptroller General of the United States shall submit a report to Congress on the study required under paragraph (1), together with recommendations for such legislative and administrative actions as the Comptroller General determines appropriate.

(e) IDENTIFICATION OF INCONSISTENT INTERPRETATIONS OF POLICIES ACROSS REVIEW ENTITIES.—Not later than January 1, 2017, the Secretary of Health and Human Services shall establish and implement a process for identifying policies or coverage determinations relating to title XVIII of the Social Security Act that are most frequently interpreted and applied differently by review entities, Medicare magistrates, administrative law judges, or the Department Appeals Board of the Department of Health and Human Services. As a part of such process, the Secretary shall, where appropriate, issue guidance or

take other administrative action to clarify how a policy or coverage decision should be interpreted in order to prevent future conflicting interpretations.

(f) STUDY AND REPORT ON ADMINISTRATIVE LAW JUDGE SPECIALIZATION.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine if the specialization of administrative law judges within the Office of Medicare Hearings and Appeals by type of appeal would lead to more consistent decisions by administrative law judges determining cases with similar facts.

(2) REPORT.—Not later than January 1, 2018, the Secretary of Health and Human services shall submit to Congress a report containing the results of the study required under paragraph (1), together with recommendations for such legislative and administrative action as the Secretary determines appropriate.

(g) ALTERNATIVE DISPUTE RESOLUTION.—

(1) IN GENERAL.—Section 1869(b) of the Social Security Act (42 U.S.C. 1395ff(b)), as amended by section 3(a), is amended by adding at the end the following new paragraph:

''(5) ALTERNATIVE DISPUTE RESOLUTION.—

''(A) IN GENERAL.—

''(i) REDETERMINATION AND RECONSIDERATION ADR PROCESS.—The Secretary shall establish one or more alternative dispute resolution processes whereby, at the Secretary's discretion, an individual or entity entitled to a redetermination under subsection (a)(3) by a medicare administrative contractor or a reconsideration under subsection (c) by a qualified independent contractor may have the option to enter into alternative dispute resolution with the Centers for Medicare & Medicaid Services, consistent with the following:

''(I) During the alternative dispute resolution process, the request for review with respect to the claims covered by the alternative dispute resolution shall be suspended.

''(II) In the event that an alternative dispute resolution does not result in a settlement, the request for review with respect to the claims covered by the alternative dispute resolu-

tion shall resume under subsection (a)(3) or subsection (c), as applicable.

''(ii) HEARING AND REVIEW MEDIATION.—The Secretary shall establish an alternative dispute resolution process whereby, at the Secretary's discretion, an individual or entity entitled to a review or hearing on a decision of a qualified independent contractor by a Medicare magistrate or an administrative law judge may have the option to enter into an alternative dispute resolution process mediated by staff members of the Office of Medicare Hearings and Appeals selected for the purpose of mediating alternative dispute resolutions under this paragraph.

''(B) EFFECT OF ALTERNATIVE DISPUTE RESOLUTION.—

''(i) IN GENERAL.—As part of any alternative dispute resolution settlement under this paragraph, an appellant shall be required to—

''(I) forego the right to such redetermination, reconsideration, review, or hearing, as applicable; and

"(II) withdraw all requests for review with respect to the claims covered by the settlement.

"(ii) NO JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the alternative dispute resolution settlement and the claims covered by the settlement.

"(C) COORDINATION WITH LAW ENFORCEMENT AND CMS.—The Secretary shall establish a process under which the officers responsible for conducting an alternative dispute resolution process shall coordinate with appropriate law enforcement agencies and the Centers for Medicare & Medicaid Services to avoid the inadvertent settlement of cases that involve fraud or other criminal activity.

"(D) NO ENTITLEMENT TO ALTERNATIVE DISPUTE RESOLUTION.—Nothing in this paragraph shall be construed as creating an entitlement to alternative dispute resolution.".

(2) CONFORMING AMENDMENTS.—

(A) Section 1869(a)(3)(A) of the Social Security Act (42 U.S.C. 1395ff(a)(3)(A)) is

amended by inserting ", subject to subsection (b)(5)," after "regulations shall".

(B) Section 1869(b)(1)(A) of the Social Security Act (42 U.S.C. 1395ff(b)(1)(A)), as amended by section 3(a)(2), is amended—

(i) by inserting "and paragraph (5)" after "Subject to subparagraph (D)"; and

(ii) by striking "and paragraph (4)" and inserting "and paragraphs (4) and (5)".

SEC. 10. REVIEW PROGRAM IMPROVEMENTS.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

"(7) The review program improvements described in subsection (j).";

(2) by redesignating subsection (i) as subsection (j); and

(3) by inserting after subsection (h) the following new subsection:

"(i) REVIEW PROGRAM IMPROVEMENTS.—

"(1) IN GENERAL.—".

"(A) GUIDELINES.—

''(i) IN GENERAL.—To ensure uniformity and consistency in initial determinations and appeals decisions relating to the appropriateness of payment with respect to items or services furnished under this title, the Secretary shall ensure that claim review guidelines are established for reviewing claims for payment submitted by providers of services and suppliers.

''(ii) REQUIREMENTS.—Prior to the implementation of the claim review guidelines described in subparagraph (A)(i), the Secretary shall—

''(I) approve the claim review guidelines;

''(II) make the claim review guidelines publicly available as described in subparagraph (B);

''(III) ensure that review contractors apply the claim review guidelines consistently, as appropriate; and

''(IV) ensure that Medicare magistrates, administrative law judges, and the Departmental Appeals Board

are trained in the application of the claim review guidelines.

''(iii) TRANSITION PERIOD.—The Secretary may provide for or establish one or more transition periods, during which the use of existing claim review guidelines for reviewing claims submitted by providers of services and suppliers shall be permitted to continue until such time as the Secretary is able to review and approve the claim review guidelines established under this subparagraph.

''(B) TRANSPARENCY.—

''(i) IN GENERAL.—The Secretary shall ensure that the information described in clause (iii)—

''(I) is published on the Internet website of the Department of Health and Human Services for not less than 30 days prior to its implementation;

''(II) remains available on such Internet website after such publication; and

''(III) is updated at least annually.

''(ii) EXPEDITED PROCESS.—The Secretary of Health and Human Services may expedite the process described in clause (i) for claims review guidelines that are expected to impact the improper payment rate, frequency of denials of payment, or costs to the Medicare program.

''(iii) INFORMATION DESCRIBED.—The information described in this clause is the following:

''(I) Subject to clause (ii) and subparagraph (A), any new claim review guideline approved for use under this paragraph.

''(II) Any updates or revisions to existing claim review guidelines.

''(C) LIMITATION.—Nothing in this section is intended to—

''(i) delineate sample size or how claims are to be selected for review;

''(ii) require the publication of algorithms or methodologies used for claim selection; or

''(iii) require the publication of information that could promote fraud or potential gaming.

''(D) REVIEW CONTRACTOR DEFINED.—In this subsection, the term 'review contractor' means—

''(i) a medicare administrative contractor (as defined in section 1874A(a)(3)(A)) with a contract to conduct prepayment or post-payment reviews of claims for payment by providers of services or suppliers;

''(ii) a recovery audit contractor with a contract under subsection (h); or

''(iii) any other contractor the Secretary determines appropriate.

''(2) PROGRAM INTEGRITY INITIATIVES.—To improve existing and future Medicare program integrity initiatives, and to limit unnecessary burdens on providers of services and suppliers, the Secretary shall designate a point of contact to oversee and undertake the following:

''(A) Develop a comprehensive strategy for claim review determinations made on a prepay-

ment, post-payment, or prior-authorization basis that—

"(i) focuses on identifying and reducing those claim errors that have the largest impact on the improper payment rate, pose the greatest risk to the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), or are likely to negatively affect quality of care;

"(ii) reduces unnecessary burden on providers of services and suppliers and minimizes any negative effects on Medicare beneficiaries; and

"(iii) utilizes data and other sources, including claims data, improper payment rate data, and reports from the Office of the Inspector General of the Department of Health and Human Services, the General Accountability Office, the Medicare Payment Advisory Commission, and the media.

"(B) Develop methods to ensure, using all available data, that review contractors do not unnecessarily conduct duplicate reviews of specific individual claims.

"(C) To the extent possible given the specific mission of each entity that has contracted with the Secretary, work with all review contractors to develop a uniform, consistent, and transparent review process to reduce the burden on providers of services and suppliers to the greatest extent possible, including a uniform approach for such entities to notify parties of pending reviews and to request medical documentation, improved communication with providers of services and suppliers, better refinement of audits to target claims that are at the highest risk for improper payments or other errors, and any other areas in which the Secretary determines that the burden on providers of services and suppliers may be decreased.

"(D) Identify local coverage determinations, national coverage determinations, regulations, and program instructions issued by the Centers for Medicare & Medicaid Services for the Medicare program that need updating or

that inappropriately conflict with other Medicare policies and make modifications where appropriate, and, if necessary, establish new policies or claim review guidelines with input from stakeholders as appropriate.

''(E) Publish on the Internet website of the Department of Health and Human Services the volume and type of prepayment and post-payment claim reviews performed by medicare administrative contractors under section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) and recovery audit contractors under section 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

''(F) Coordinate with the Office of Medicare Hearings and Appeals and the Departmental Appeals Board of the Department of Health and Human Services to ensure that the improved claim review guidelines and evidentiary standards established by the provisions of, and the amendments made by, this Act, such as the decision to remand an appeal, are properly implemented.

''(G) Ensure that providers of services and suppliers subject to post-payment review by a medicare administrative contractor are granted

a discussion period with the contractor of at least 30 days from the letter from the contractor regarding the result of the review.

''(H) Develop qualification standards for review contractors that require prepayment and post-payment reviews of claims for payment submitted by providers of services or suppliers to be conducted or approved by medical doctors with knowledge of relevant Medicare laws, regulations, and program instruction, as appropriate.

''(I) Verify, through the use of sampling if the Secretary so chooses, that decisions by review contractors are consistent with Medicare laws, regulations, and program instruction (taking into account geographical variations that are a result of local coverage determinations).

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

''(3) MEDICARE PROVIDER CLAIM AUDIT INTERNET PORTAL.—

''(A) IN GENERAL.—The Secretary shall establish a secure, Internet-based system (which may be based on the existing database system of claims under review used by review contractors or a similar existing system) through which a provider of services, a supplier, or other appropriate entity may track the status of any claim for payment submitted by such provider or supplier that is being audited or processed as an appeal by—

''(i) a medicare administrative contractor under section 1874A; or

''(ii) a qualified independent contractor, Medicare magistrate, administrative law judge, or the Departmental Appeals Board of the Department of Health and Human Services under section 1869.

''(B) FRAUD PREVENTION.—The Secretary shall ensure that the system established under paragraph (1) does not impede any ongoing investigations of potential fraud.

''(C) PROGRESS REPORT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit a report to Con-

gress describing the plan to establish and operate the system described in paragraph (1).''.

(b) ANNUAL RAC REPORT.—Section 1893(h)(8) is amended by inserting '', and, with respect to reports submitted after the date of the enactment of the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015, the number of claims corrected in the discussion period, the percentage of appeals of determinations by recovery audit contractors that were ultimately successful, a careful description of the denominator of total audits and appeals (given the likelihood that many appeals in a given year will not have a decision in that year), and separate reports on complex Medicare part A, complex Medicare part B, semiautomated, and automated reviews'' before the period at the end.

(c) INDEPENDENCE OF ADJUDICATORS.—Nothing in this section or the amendments made thereby shall be construed as authorizing the Secretary to limit the authority or decisional independence of Medicare magistrates, administrative law judges, or the Departmental Appeals Board of the Department of Health and Human Services.

SEC. 11. CREATION OF MEDICARE PROVIDER AND SUPPLIER OMBUDSMAN FOR REVIEWS AND APPEALS.

Section 1808 of the Social Security Act (42 U.S.C. 1395b–9) is amended by adding at the end the following new subsection:

''(d) MEDICARE REVIEWS AND APPEALS OMBUDSMAN.—

''(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, the Secretary shall appoint within the Centers for Medicare & Medicaid Services a Medicare Reviews and Appeals Ombudsman.

''(2) DUTIES.—The Medicare Reviews and Appeals Ombudsman shall—

''(A) identify, investigate, and assist in the resolution of complaints and inquiries related to the Medicare audits and appeals process from providers of services or suppliers with respect to benefits under part A or B;

''(B) identify trends in complaints and inquiries regarding the current Medicare review and appeals systems to provide recommendations for improvements to the Secretary that would improve the efficacy and efficiency of claim review and appeals systems, as well as

communication to beneficiaries, providers of services, and suppliers;

"(C) design a system by which to objectively measure and evaluate reviewer responsiveness to addressing inquiries from providers of services and suppliers and inquiries from the Ombudsman;

"(D) provide administrative and technical assistance to appellants and those considering an appeal;

"(E) publish data regarding the number of review determinations appealed, each appeal's outcome, and aggregate appeal statistics—

"(i) for each medicare administrative contractor conducting redeterminations under section 1869(a)(3);

"(ii) for each qualified independent contractor conducting reconsiderations under section 1869(c);

"(iii) for each recovery audit contractor conducting reviews under section 1893(h);

"(iv) by type of provider of services; and

"(v) by type of supplier;

''(F) assist in education and training efforts for providers of services, suppliers, and review contractors (as defined in section 1893(i)(1)(D));

''(G) communicate with the Medicare Beneficiary Ombudsman to assist with the identification, investigation, and resolution of beneficiary-related complaints, including those that overlap with requests for review and appeals submitted by providers of services or suppliers; and

''(H) perform such other duties as determined appropriate by the Secretary.''.

SEC. 12. LIMITING THE AUDIT AND RECOVERY PERIOD FOR PATIENT STATUS REVIEWS.

(a) IN GENERAL.—Section 1893(h)(4) of the Social Security Act (42 U.S.C. 1395ddd(h)(4) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and moving such clauses 2 ems to the right;

(2) by striking ''Each such'' and inserting the following:

''(A) IN GENERAL.—Except as provided in subparagraph (B), each such''; and

(3) by adding at the end the following new subparagraph:

"(B) LIMITATION.—

"(i) IN GENERAL.—With respect to the classification of an individual entitled to, or enrolled for, benefits under part A or enrolled under part B, or both, as an inpatient or an outpatient for purposes of hospital claims for payment for items or services furnished to such individual under this title, such contracts shall provide that a recovery audit contractor shall only send additional documentation requests related to the appropriateness of such classification in the first 6 months after the date on which such items or services were furnished.

"(ii) EXCEPTION.—The limitation described in clause (i) shall not apply where a claim for payment is submitted more than 3 months after the date on which such items or services were furnished.".

(b) STUDY ON SHORTENING THE AUDIT AND RECOVERY PERIOD FOR OTHER REVIEWS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to assess—

(A) the potential burden on providers of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) and suppliers (as defined in subsection (d) of such section 1861) under the Medicare program of the audit and recovery period applicable to audit and recovery activities conducted by recovery audit contractors under section 1893(h)(4) of such Act (42 U.S.C. 1395ddd(h)(4)); and

(B) the impact of shortening such period with respect to different types of reviews.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish a report containing the results of the study required under paragraph (1) on the Internet website of the Department of Health and Human Services.

(c) AUTHORITY TO IMPLEMENT SHORTER AUDIT AND RECOVERY PERIOD.—Section 1893(h)(4) of the Social Security Act (42 U.S.C. 1395ddd(h)(4)), as amended by subsection (a), is further amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(2) by adding at the end the following new subparagraph:

''(C) AUTHORITY TO IMPLEMENT SHORTER AUDIT AND RECOVERY PERIOD.—Notwithstanding subparagraph (A)(ii), with respect to payments made under this title for specific categories of services, the Secretary may enter into contracts under paragraph (1) that provide for a retrospective period during which audit and recovery activities may be conducted of not more than 3 years.''.

(d) REPORT ON RAC PAYMENT STRUCTURE.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on ways to change, in a budget neutral manner, the payment structure for recovery audit contractors under section 1893(h)(1) of the Social Security Act (42 U.S.C. 1395ddd(h)(1)) from an incentive-based model to a non-incentive based approach that does not impose additional financial burdens on providers.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2017, and shall apply to contracts between the Secretary and recovery audit contractors entered into on or after such date.

SEC. 13. INCENTIVES AND DISINCENTIVES FOR MEDICARE CONTRACTORS, PROVIDERS, AND SUPPLIERS.

Section 1893 of the Social Security Act (42 U.S.C. 1395ddd), as amended by section 10, is further amended—

(1) by redesignating subsection (j) as subsection (k); and

(2) by inserting after subsection (i) the following new subsection:

''(j) COMPLIANCE INCENTIVE PROGRAM.—

''(1) IN GENERAL.—Not later than January 1, 2017, the Secretary shall establish a compliance incentive program, consisting of the components described in paragraphs (2) and (3), to encourage—

''(A) providers of services and suppliers to submit accurate claims that comply with this title and the policies, regulations, and program instructions promulgated thereunder, as well as any applicable national or local coverage determinations; and

''(B) entities that have entered into contracts with the Secretary under subsection (h) or section 1874A (referred to in this subsection as 'review contractors') to conduct reviews under this section or section 1874A, as applicable, in a manner that is consistent with the provisions of this title and the claim review guidelines, regulations, and program instructions promulgated thereunder, as well as any applicable national or local coverage determinations.

''(2) COMPLIANCE WITH CLAIM PROCEDURES BY PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—Not later than January 1, 2017, the Secretary shall establish a system through which a provider of services or supplier that has achieved a low rate of denials of claims for payment subject to additional documentation requests over a 2 year period, as determined by the Secretary, shall be exempt for a period of 1 year from any post-payment review of claims for payment conducted by review contractors.

''(B) LIMITATION.—The Secretary shall not exempt or shall rescind an exemption granted to a provider of services or supplier under

subparagraph (A) if the Secretary determines that there is evidence of systematic gaming, fraud, abuse, or delay in the provision of services or items by such provider or services or supplier.

''(3) COMPLIANCE WITH REVIEW PROCEDURES BY MEDICARE CONTRACTORS.—

''(A) IN GENERAL.—Not later than January 1, 2017, the Secretary shall establish a process, which may include the use of sampling, for determining the frequency with which the decisions made by a review contractor with respect to reviews conducted under this section or section 1874A are consistent with the provisions of this title and the policies, regulations, and program instructions promulgated thereunder, as well as any applicable national or local coverage determinations. The results of this process shall be made available to the public on the Internet website of the Department of Health and Human Services.

''(B) ACCESS TO MEDICAL RECORDS BY REVIEW CONTRACTORS.—

''(i) ACCESS TO RECORDS BASED ON PERFORMANCE REVIEW.—Not later than

January 1, 2017, the Secretary shall establish a system under which, for any incentive period—

"(I) the number of medical records that a review contractor that was a high-performing review contractor in the performance review period associated with such incentive period may request from a provider of services or supplier in carrying out activities under this section or section 1874, as applicable, may be increased (on a sliding scale); and

"(II) the number of medical records that a review contractor that was a low-performing review contractor in the performance review period associated with such incentive period may request from a provider of services or supplier in carrying out activities under this section or section 1874A, as applicable, may be decreased (on a sliding scale).

"(ii) DEFINITIONS.—In this subparagraph:

"(I) HIGH-PERFORMING REVIEW CONTRACTOR.—The term 'high-performing review contractor' means a review contractor that, for a given performance review period, makes decisions with respect to reviews conducted under this section or section 1874A, as applicable, of the activities of providers of services and suppliers that are consistent with the provisions of this title and the policies, regulations, and program instructions promulgated thereunder, as well as any applicable national or local coverage determinations, at a rate that is equal to or greater than 95 percent.

"(II) INCENTIVE PERIOD.—The term 'incentive period' means, with respect to a performance review period, a period of time (to be determined by the Secretary) following such performance review period during which the number of medical records that a review contractor may request from a provider of services or supplier may be

increased or decreased based on such contractor's status as a high-performing review contractor or a low-performing review contractor for such performance review period.

''(III) LOW-PERFORMING REVIEW CONTRACTOR.—The term 'low-performing review contractor' means a review contractor that, for a given performance review period, is not described in subclause (I).

''(IV) PERFORMANCE REVIEW PERIOD.—The term 'performance review period' means a period of time (to be determined by the Secretary) during which a review contractor's decisions with respect to reviews conducted under this section or section 1874A, as applicable, are evaluated to determine if such review contractor is a high-performing contractor or a low-performing contractor for such period.''.

Calendar No. 317

114TH CONGRESS
1ST SESSION

S. 2368

[Report No. 114–177]

A BILL

To amend title XVIII of the Social Security Act to improve the efficiency of the Medicare appeals process, and for other purposes.

DECEMBER 8, 2015

Read twice and placed on the calendar