GRASSLEY-WARNER AMENDMENT #1

Grassley-Warner Amendment #1 to the Chairman's Mark.

Short Title: Medicare Orthotics and Prosthetics Improvement Act of 2015

Description of Amendment: The amendment includes the text of S.829, the Medicare Orthotics and Prosthetics Improvement Act of 2015. The bill amends the Social Security Act to apply accreditation and licensure requirements to providers and suppliers for Medicare payment purposes, to modify the designation of accreditation organizations for orthotics and prosthetics, to recognize orthotics and prosthetics suppliers as independent professional providers of medical care for Medicare beneficiaries, and other purposes.

Thune Amendment #1 to the Chairman's Mark

Short Title: An amendment to expedite appeals for critical access hospitals (CAHs).

Description of Amendment: Under this amendment to section 4 of the Chairman's Mark, the Secretary must create a system in which ALJs or Medicare Magistrates prioritize appeals by CAHs that are not processed or concluded within 120 days.

Thune Amendment #2 to the Chairman's Mark

Short Title: To ensure that the federal workforce is not permanently expanded.

Description: The current mark establishes within the Office of Medicare Hearings and Appeals (OMHA) decision-making officials known as Medicare Magistrates. The amendment would specify that these licensed attorneys, appointed by the Secretary, would serve as contractors rather than permanent employees of the Department of Health and Human Services.

Burr Amendment #1 to ensure that providers and suppliers are consulted in the Secretary of HHS' impact study of shortening the look-back period for RA audits and such study is made publicly available.

Short Title: Look-Back Study

Description of Amendment: This amendment would ensure that the Secretary of HHS consults with providers and suppliers regarding the burdens of the look-back period for RA audits and such study is made publicly available.

Burr Amendment #2 to clarify the Secretary's work with review entity contractors to develop a uniform, consistent, and transparent review process to reduce provider and supplier burden to the greatest extent possible.

Short Title: Work with Review Entity Contractors

Description of Amendment: This amendment would clarify that the Secretary's work with all review entity contractors to develop and uniform, consistent, and transparent review process to reduce provider and supplier burden to the greatest extent possible includes a uniform approach for review entity contractors to notify parties of pending reviews and request for medical documentation; improved communication with providers and suppliers; methods for providing review results; and better refinement of reviews to target claims that are at the highest risk for improper payments or other errors.

Heller Amendment #1 to adjust the number of medical records a review entity can request from a provider or supplier based on the performance accuracy of the review entity_____-

Short Title: _ Availability of medical records based on accuracy_____
_____

Description of Amendment: This amendment 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 performance accuracy of the review entity contractor. This adjustment would be directly related to the accuracy of the review entity contractor's reviews based on calculations by an independent verification contractor. Review entity contractors with a high accuracy rate may be eligible to request additional medical records for a period of three months. Review entity contractors with a lower accuracy rate shall be limited in their ability to request medical records, according to a sliding scale established by the Secretary.

Stabenow Amendment #1 to Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act

Short Title: Strike Contractor Document Collection Language

Description of Amendment: Strike language in Section 12 of the Chairman's Mark that would permit contractors to request additional records from providers beyond current statutory limits.

Offset: N/A (no cost)

Stabenow Amendment #2 to Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act

Short Title: Recovery Auditor Payment Structure

Description of Amendment: Direct the Secretary of Health and Human Services to recommend to Congress budget-neutral ways to change the recovery audit payment structure from an incentive-based model to a non-incentive based approach without additional financial burdens on providers.

Offset: N/A (no cost)

AMENDMENT TO

"AUDIT & APPEAL FAIRNESS, INTEGRITY, AND REFORMS IN MEDICARE ACT OF 2015

Senator Carper Amendment #1 to "Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015"

Short Title: Providing Improved Transparency Through a Medicare Provider Claim Audit Web Portal

Description of Amendment:

Currently, there is no single web-based or other centralized electronic procedure for Medicare providers to obtain basic information about their individual claims that are under audit. At times, providers face challenges on simply determining which Medicare audit contractor is handling the claim, or even what step in the audit process the claim resides. Claims under review at the level of Adjudicated Law Judges do have a single web-pasted system for providers to determine claim status. However, at other levels in the audit process, each contractor maintains a separate system. Therefore, there is no centralized way for a provider to determine the status of a claim under audit, or even which audit contractor is reviewing the claim.

To provide improved transparency over the status of a claim within the Medicare audit and appeals process, the Secretary should create an internet based system for use by provider, and other entities involved with a claim, in order to determine status of claims under review. Since the Centers for Medicare and Medicaid Services already has an established, operational electronic system for tracking claims under audit, creating a modified system for providers and others to access would not prove difficult.

Amendment Text:

The Secretary shall establish a single, secure internet based system for access by providers, and other appropriate entities, in order to determine status of claims under review by any Medicare audit or oversight contractor, or that is under review through an Administrative Law Judge. This system could be based on the existing database system of claims under review used by audit contractors, or a similar existing system. The Secretary shall report to Congress within 180 days of passage of the Act on a plan to establish and operate such a portal.

Cardin Amendment #1 to the Chairman's Mark
(Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015)

Short Title: Improving Accuracy and Transparency of Federal Reporting of Recovery Auditor (RA) Auditing and Appeals.

Description of the Amendment: To increase accuracy and transparency, this amendment would require that all future federal reports of RA auditing and appeals (1) include cases overturned in the discussion period; (2) count each appealed claim only once, based upon the decision made at the highest appeal level; (3) carefully describe 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 (4) consistently report complex Part A, complex Part B, semiautomated, and automated reviews separately. It would also require the Secretary of HHS to take those factors into account when assessing "the frequency in which decisions being made by review entities are consistent with Medicare payment and coverage laws, regulations, and program instruction," as required by Section 12 of the Chairman's Mark.

Background: CMS's recent reports of Recovery Audit (RA, previously known as Recovery Audit Contractor or RAC) auditing and appeals activity differ significantly from hospital accounts of RA auditing and appeals activity for several identifiable reasons.

First, in its most recent report of RA auditing and appeals activity,[1] CMS did not account for denials overturned in the discussion period because it is not considered part of the formal appeals process.

A study was recently published in the *Journal of Hospital Medicine* regarding RAC audits and appeals of complex Medicare Part A cases at three academic medical centers (University of Wisconsin Hospital, University of Utah Health Care, and Johns Hopkins University Hospital).[2] Sheehy *et al.* found that:

- RAC overpayment determinations increased nearly three-fold during the last two calendar years of the study (from 680 in 2010-2011 to 1,856 in 2012-2013), while the hospitals won, either in discussion or appeal, a combined greater percentage of contested overpayments each year (from 36.0% in 2010, to 38.5% in 2011, to 46.1% in 2012, to 68.0% in 2013).
- One-third (33.3%, 645/1935) of all resolved cases were decided in favor of the hospital during the discussion period, with these discussion cases accounting for two-thirds (66.8%) of all favorable resolved cases for the hospital.

[1] Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf

[2] Sheehy AM, Locke C, Engel JZ, Weissburg DJ, Mackowiak S, Caponi B, Gangireddy S, Deutschendorf A, Recovery audit contractor audits and appeals at three academic medical centers, J Hosp Med. 2015 Apr;10(4):212-9.

Although the majority of successfully contested cases in the study occurred in the discussion period, those cases were not included in CMS reports of RA activity because, as noted above, the discussion period is not considered part of the formal appeals process. This suggests that RA auditing accuracy may been have overestimated in those reports. Second, according to CMS's most recent report, "[a]ppealed claims may be counted multiple times if the claim has multiple appeal decisions rendered during FY 2013. For example, if a claim was appealed to the first level and received a decision in FY 2013, then appealed to the second level and received a decision in FY 2013, both decisions would be counted."[3] This means that a single claim that was denied at the first and second levels and then overturned at the third level would result in a 33% overturn rate – instead of 100%.
Third, in its FY 2013 report, CMS used overpayment determinations from FY 2013, but counted all appeal decisions that occurred in FY 2013, even though it acknowledged that some of these decisions may have been for overpayment determinations prior to FY 2013.[4]

Addressing these issues would increase the transparency of federal reporting and provide policymakers and stakeholders with a more complete and accurate picture of RA auditing and appeals activity.

Offset: N/A; this amendment is budget neutral.

[3] Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf
[4] Centers for Medicare & Medicaid Services. Recovery Auditing in Medicare for Fiscal Year 2013. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf

Brown Amendment # 1 (to the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015).

Short Title: Ensuring the continued independence of Medicare Magistrates, ALJs, and the Departmental Appeals Board

Description: On page 14, replacing the second full paragraph (beginning with "The Chairman's Mark would require the Secretary of HHS to promote transparency") with the following text:

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 uniformly and consistently apply these policies and that Medicare Magistrates, ALJs, and the Departmental Appeals Board are aware of and trained in these policies. Nothing in this section should be construed as questioning the independence of Medicare Magistrates, ALJs, or the Departmental Appeals Board, but is to help ensure that consistent guidelines and methodologies exist and are available to those entities reviewing reimbursement claims submitted by providers and suppliers.

And on page 14, replacing the first numbered paragraph (beginning with "1. Develop a comprehensive strategy for") with the following text:

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 reduce unnecessary burden on providers and suppliers and minimize any unintended effects of these policies on beneficiaries. Such strategy should utilize data and other sources including: claims data, Office of Inspector General reports, GAO reports, news reports, Medicare Payment Advisory Commission reports, and Comprehensive Error Rate Testing (CERT) reports;*

Summary: These changes will help clarify that the creation of new Medicare policies designed to apply to Contractor practices 1) do not compromise the effect of existing statutes and regulations when they differ from Medicare policies and guidelines and 2) protect the continued independence of Medicare Magistrates and ALJs by ensuring they are not bound to the same policies and practices as Contractors.

Brown Amendment # 2 (to the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015).

Short Title: Clarifying that Existing Laws & Regulations Preempt CMS Policies and Regulations

Description: On page 15, replacing the fourth numbered paragraph (beginning with "4. Identify CMS local coverage determinations") with the following text:

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. Nothing in this section shall be construed as undermining the independent authority of Medicare Magistrates, ALJs, or the Departmental Appeals Board; rather, these policies should be modified and updated in a manner consistent with all existing statute and regulations. 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;*

Summary: This change will help clarify that the creation of new Medicare policies designed to apply to Contractor practices 1) do not compromise the effect of existing statutes and regulations when they differ from Medicare policies and guidelines and 2) protect the continued independence of Medicare Magistrates and ALJs by ensuring they are not bound to the same policies and practices as Contractors.

Brown Amendment # 3 (to the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015).

Short Title: Ensuring Beneficiary Access to the Provider and Supplier Ombudsman for the Purposes of Appeals and Guaranteeing Communication Between the Beneficiary Ombudsman and the Provider and Supplier Ombudsman for Purposes of the Appeals Process

Description: On page 16, replacing the third full paragraph (beginning with "The Chairman's Mark would require the Secretary of HHS to establish a CMS OMBUDSMAN") with the following text:

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

And on page 16, adding a seventh numbered paragraph (following paragraph six, "Assisting in education and training efforts…"):

7. *Communicating with the Medicare Beneficiary Ombudsman to assist with the identifying, investigating, and resolution of beneficiary-related complaints, including those that overlap with reviews and appeals submitted by a provider.*

Summary: These changes will help ensure that the CMS Ombudsman for Medicare Reviews and Appeals – an entity who serves as a resource and an expert in the Medicare appeals process – is also a resource for and responsive to beneficiaries who are navigating the appeals process.