The Audit & Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) Act of 2015

Purpose: Medicare audits and appeals currently pose a large burden for health care providers and for government audit contractors seeking to reduce the amount of improper payments by federal health programs. This bill seeks to increase coordination and oversight of these audit contractors while implementing new strategies to address the growing number of audit determination appeals that delay taxpayer dollars from reaching the correct source. The AFIRM Act would lay the groundwork for creating a more level playing field that would reduce the burden on providers and would give auditors the tools necessary to better protect the Medicare Trust Fund.

Background: The U.S. Department of Health and Human Services (HHS) is required by the Improper Payments Information Act of 2002 to identify programs within HHS that may be susceptible to significant improper payments. To this end, the Centers for Medicare & Medicaid Services (CMS) uses a variety of audit contractors with different scopes and methodologies to root out improper payments, fraud, waste, and abuse. However, as these audit contractor programs have expanded, the oversight capabilities of HHS and CMS have not. Some providers, because of concerns of the accuracy of the audits, have been appealing a large proportion of their denied claims, leading to a backlog at the third level of the appeals process.

Proposed Changes: The AFIRM Act seeks to strengthen the current system in the following ways:

1) Improve oversight capabilities for HHS and CMS that increase the integrity of the Medicare auditors and claims appeals process.
2) Coordinate efforts between auditors and CMS to ensure that all parties receive transparent data regarding audit practices, improved methodologies over time, and new incentives/disincentives to improve auditor accuracy. CMS would create an independent Ombudsman for Medicare Reviews and Appeals to assist in resolving complaints by appellants and those considering appeal. This Ombudsman would further increase the transparency of the appeal process by publishing data regarding the number of determinations appealed, each appeal's outcome, and aggregate appeal statistics for each contractor and provider type.
3) Establish a voluntary alternate dispute resolution process to allow for multiple pending claims with similar issues of law or fact to be settled as a unit, rather than as individual appeals.
4) To ensure timely and high quality reviews, raise the amount in controversy for review by an ALJ to match the amount for review by District Court. For cases with lower costs, a new Medicare Magistrate program would be created to allow senior attorneys with expertise in Medicare law and policies to adjudicate cases in the same way as ALJs. This would allow more complex cases to retain the full focus on the ALJs.

5) Allow for the use of sampling and extrapolation, with the appellant's consent, to expedite the appeals process.