The Medicare Appeals, Regulatory and Contracting Improvements Act of 2001
Sponsored by Senators Kerry, Murkowski, Baucus and Grassley
November 2001

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Section 2. Findings.

- The Secretary of Health and Human Services should place greater emphasis on education of, and outreach to, health care providers in the Medicare program in order to increase understanding and compliance with the regulations and requirements under the program. The Secretary should also ensure that new Medicare program requirements are communicated clearly and consistently throughout the country.

- Beneficiaries and health care providers under the Medicare program currently struggle to navigate through the Medicare appeals process for the purpose of settling billing, payment, and enforcement disputes. These appeals processes suffer from a lack of oversight, inadequate resources, and structural deficiencies. For example, the average adjudication time for a Medicare appeal before an administrative law judge is 382 days. Changes to the Medicare appeals process should result in more timely decisions. Further, Congress should create needed oversight of, and reporting requirements for, such appeals processes in order to provide information for future improvements.

- Administration of the Medicare program is hampered by antiquated restrictions on the contracting authority of the Secretary of Health and Human Services. These restrictions impose burdens and inefficiencies on contractors, taxpayers, providers, and beneficiaries. The Secretary should have more flexibility in Medicare contracting and should have contracting authority consistent with other Federal agencies.

Section 3. Construction.

(a) No Effect on Legal Authority. No existing legal authority for addressing fraud or abuse, including criminal prosecution, civil enforcement, or administrative remedies, will be compromised or affected by any provision of the legislation.

(b) No Effect on Medicare Waste, Fraud, and Abuse Efforts. No provision included in this legislation will in any way prevent the Department of Health and Human Services (HHS) from its ongoing efforts to eliminate waste, fraud, and abuse in the Medicare program.

TITLE I – REGULATORY RELIEF

Section 101. Issuance of Regulations.

(a) Consolidation of Promulgation to Once a Month. Proposed, interim final, and final regulations will be issued on one business day a month, unless the Secretary finds that a regulation must be issued on another day to comply with a statutory requirement or the limitation is contrary to the public interest. In two years, the Secretary will report to Congress as to the feasibility of moving to a quarterly release of new regulations.

(b) Regular Timeline for Publication of Final Regulations. A regular timeline must be established for the progression from proposed regulations to interim final regulations (where appropriate) to final regulations. However, the Secretary has 12 months to issue a final regulation after an interim final regulation has been issued. If a final regulation is not published within 12 months, the interim final regulation may not remain in effect. If the Secretary determines before the 12-month deadline that there is good cause for delaying the deadline, the Secretary must publish a notice with an explanation. The Secretary is then subject to a second and final 12-month deadline for issuing the final regulation. Withing six months of enactment of the Act, the Secretary is required to publish the status of all interim regulations pending on the date of enactment. The notice for each rule will include the status of the rule and the date by which the Secretary plans to issue a final rule, but such rules will not be subject to a 12 month restriction on completion of the final rule as described above.

(c) Limitations on New Matter in Final Regulations. Final regulations must be a logical outgrowth of the relevant notice of proposed rulemaking. If a provision of the final regulation fails to meet this logical outgrowth standard, that portion of the regulation may not be finalized and will not be in effect until an additional comment period is provided.

Section 102. Compliance with Changes in Regulations and Policies.

(a) No Retroactive Application of Substantive Changes. Substantive changes in policy will not be applied retroactively, unless the Secretary finds for good cause that such retroactive application would be necessary to comply with statutory requirements or that failure to apply substantive changes retroactively would be contrary to the public interest.

(b) Timeline for Compliance with Substantive Changes After Notice. Compliance actions for noncompliance with a substantive change are permissible only for items and services furnished on or after the effective date of the substantive change. A substantive change may not take effect until at least 30 days after the Secretary has issued a substantive change. If waiver of the 30-day period is necessary to comply with statutory requirements or if the Secretary finds for good cause that the 30-day period is contrary to the public interest, the Secretary may alter the timeline by including an explanation of such finding in the issuance or publication of the substantive change.

Section 103. Report on Regulatory Burdens.
In two years, and every two years thereafter, the Secretary will report to Congress about areas of confusion, inconsistency, and conflict among Medicare's various statutory and regulatory provisions. This report will also include a description of efforts the Secretary is taking to reduce such areas and recommendations for legislation or administrative action.

TITLE II – APPEALS PROCESS REFORM

Section 201. Transfer of Responsibility for Medicare Appeals.

(a) Designation of Medicare-Only Administrative Law Judges. The Commissioner of Social Security has 60 days following enactment to designate certain administrative law judges (ALJs) as those who will only hear and decide Medicare appeals.

(b) Medicare-Specific Training. The Secretary of HHS has 60 days after the Commissioner of Social Security has designated the Medicare-only ALJs to provide appropriate Medicare training to those judges. This training will be provided to judges at least annually.

(c) Transition Plan. The Secretary of HHS and Commissioner of Social Security will develop and submit to Congress a transition plan to move Medicare ALJ responsibilities from the Social Security Administration to HHS by October 1, 2002. Such plan will include workload data, cost projections, a transition timetable, and recommendations for Medicare appeals regulations, a case tracking system, precedential authority, and access to ALJs.

(d) Transfer of Adjudication Authority. The Secretary of HHS and Commissioner of Social Security will implement the transition plan and transfer responsibility for Medicare appeals from the Social Security Administration to HHS by October 1, 2003. In transferring the authority, the Secretary must assure independence of the judges and provide for an appropriate geographic distribution of such judges. The Secretary will have appropriate financing authority to hire additional judges and enter into office arrangements with the Social Security Administration.

(e) Increased Financial Support. To ensure timely action on appeals, such sums as are necessary are authorized to be appropriated to increase the number of Medicare-only ALJs and support staff, and to improve education and training opportunities.

Section 202. Expedited Access to Judicial Review.
The Secretary will establish an expedited process for providers to obtain judicial review of an appeal of a denied claim or provider agreement determination involving a question of law or regulation. Expedited judicial review will be limited to those cases in which a 3-judge panel from the Departmental Appeals Board determines that the standard appeals process is without authority to decide the question and there are no material issues of fact in dispute. If the review panel fails to make a determination in writing within 60 days of receiving a request, the requester can proceed directly to federal court. Remedies will continue to apply during such an appeal.

Section 203. Expedited Review of Certain Provider Agreement Determinations.

(a) Termination. The Secretary will develop and implement a process to expedite proceedings in which termination of participation has been imposed. Under such process, priority will be given to termination cases.

(b) Increased Financial Support. In addition to any amounts otherwise appropriated, there are authorized to be appropriated such additional sums as necessary to increase the number of administrative law judges (ALJs) and staff at the Departmental Appeals Board for the purpose of reducing the current and projected backlog of provider agreement appeals, and to educate such ALJs and staff on long term care issues. It is expected that average time taken to complete a provider agreement appeal should be reduced by 50 percent.

Section 204. Revisions to Medicare Appeals Process.

(a) Timeframes for the Completion of the Record. The deadline for filing documentation and holding a hearing to complete the record is 90 calendar days after an appeal is requested. A provider or beneficiary may request an extension for good cause. The deadline may be extended by the adjudicator for a time period specified, based upon a finding of good cause. The deadlines established for making a determination (90 calendar days) will not commence until after the timeframe for completion of the record elapses.

(b) Use of Patients' Medical Records. Determinations of claims must be based on, among other information, the medical record of the individual involved.

(c) Notice Requirements for Medicare Appeals. Notifications of determinations must provide the specific reasons for the notification, procedures for obtaining further information, and statements concerning rights of appeal.

(d) Qualified Independent Contractors.

(1) Eligibility Requirements of Qualified Independent Contractors. Peer Review Organizations will be permitted to compete to be qualified independent contractors. Qualified independent contractors must meet certain eligibility requirements including requirements for independence and to prevent conflicts of interest.

(2) Eligibility Requirements for Reviewers. In addition to the independent contractor, individual reviewers, including physician and health professional reviewers, must meet requirements for expertise, independence, and to prevent conflicts of interests.

(e) Implementation of Certain BIPA Reforms. Implementation of sections 521 and 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 will

be delayed by one year to October 1, 2003 and October 1, 2002, respectively. The continuation of service appeal rights that were expanded in BIPA will be excluded from this delay. These rights are triggered when services provided to an individual are about to be discontinued or reduced in the skilled nursing facility, comprehensive rehabilitation facility, and home health settings. Peer Review Organizations will handle these expedited determinations for a period consistent with their contract terms.

Section 205. Hearing Rights Related to Decisions by the Secretary to Deny or Not Review a Medicare Enrollment Agreement.

The Secretary will establish by regulation procedures allowing providers of services, physicians, practitioners, and suppliers to appeal when their enrollment (or re-enrollment) applications are denied. The regulations will establish deadlines for consideration of such appeals and deadlines for actions on enrollment applications. The Secretary will be required to consult with interested parties before revising provider enrollment application forms, such as the CMS 855 enrollment form.

Section 206. Right to Appeal on Behalf of Deceased Beneficiaries.

Where a beneficiary is deceased, and where there is no substitute party available, a Medicare provider of services, physician, practitioner, or supplier may appeal for coverage or payment of services on behalf of such beneficiary.

TITLE III - CONTRACTING REFORM

Section 301. Increased Flexibility in Medicare Administration.

(a) Consolidation and Flexibility in Medicare Administration. The Secretary will have the authority to enter into contracts with any eligible entity to serve as a Medicare administrative contractor with respect to the performance of any or all of the following functions: the determination of payment amounts, making payments, beneficiary education and assistance, provider consultative services, communication with providers, provider education and technical assistance, as well as other functions as necessary. An entity is eligible to enter into a contract if it (1) has demonstrated capability to carry out a given function, (2) complies with conflict of interest standards, (3) has sufficient assets to financially support the performance of a given function, and (4) meets such other requirements as the Secretary may impose.

(b) Contracting Requirements. The Secretary will use competitive procedures for contracting with Medicare administrative contractors. The contracts can be renewed from term to term if the contractor has met or exceeded performance requirements applicable to the contract. However, all contracts must be competed at least once every six years. The Secretary may transfer functions among Medicare administrative contractors as long as the Secretary has ensured that performance quality is considered in such transfers. The Secretary will develop contract performance requirements and standards for measuring the extent to which a contractor has met such requirements. The Secretary may include

satisfaction levels as measured by provider and beneficiary surveys as one of the standards. The Secretary must publish performance requirements and measurement standards in the Federal Register. Medicare administrative contractors must furnish to the Secretary information and reports on a timely basis and maintain such records to assure the correctness of information and reports. Finally, surety bonds may be required of Medicare administrative contractors, and any of their officers or employees certifying payments or disbursing funds.

(c) Terms and Conditions. Contracts with Medicare administrative contractors may contain such terms and conditions as the Secretary finds necessary. The Secretary may provide for the advancement of funds to Medicare administrative contractors for making payments to providers. The Secretary may not require Medicare administrative contractors to match data obtained from other non-Medicare activities for the purposes of Medicare Secondary Payer and other activities.

(d) Limitation on Liability of Medicare Administrative Contractors and Certain Officers. No certifying officer or disbursing officer will be liable to the United States in the absence of gross negligence or intent to defraud the United States. A Medicare administrative contractor can only be held liable to the United States for payments made by its certifying and disbursing officers if the contractor was grossly negligent. Medicare currently makes contractual commitments to indemnify its contractors for liabilities incurred in legal proceedings in connection with the performance of their duties, absent a finding of criminal conduct, fraud, or gross negligence, and the legislation would continue to allow such arrangements.

(e) Effective Date. The Secretary will apply the amendments to contracts that are competitively bid within a year of enactment. The amendments will not apply to contracts until they are let out for competition. Finally, the Secretary must have let by competitive bidding all contracts with Medicare administrative contractors by October 1, 2008.

(f) References. As of the effective date, all references to fiscal intermediaries and carriers will be deemed a reference to an appropriate Medicare administrative contractor.

(g) Secretarial Submission of Legislative Proposal. Within 6 months of enactment, the Secretary will provide to Congress a legislative proposal providing for technical and conforming amendments.

(h) Reports on Implementation. The Secretary will provide an implementation report within a year of enactment and a status report on implementation by October 1, 2006.

TITLE IV - EDUCATION AND OUTREACH IMPROVEMENTS

Section 401. Provider Education and Technical Assistance.

(a) Coordination of Education Funding. Provider education funded through the Medicare Integrity Program and through funds appropriated to the contractors will be coordinated to maximize the effectiveness of federal provider education spending. The Secretary will submit a report to Congress including a description and evaluation of the steps taken to coordinate provider education funding by October 1, 2002.

(b) Incentive to Improve Contractor Performance. By October 1, 2002, the Secretary will develop and implement a methodology to measure the specific claims payment error rates for contractors processing or reviewing claims in order to give contractors an incentive to implement effective provider education and outreach. Before implementation of such methodology, the Comptroller General will review, and make recommendations to the Secretary, regarding the adequacy of such methodology. Before implementation of the methodology, the Secretary will report to Congress on how the error rates will be used when assessing the performance of individual contractors, including whether they will be used as the basis for performance bonuses.

(c) Improved Provider Education and Training. Medicare Integrity Program funding will be increased by $35 million beginning in fiscal year 2003. Such funding will only be used for enhanced provider education and training regarding billing, coding and other appropriate items and to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers. In conducting education and training activities, Medicare contractors will consider the special needs of small providers, defined as institutional providers with fewer than 25 employees and physicians, practitioners, and suppliers with fewer than 10 employees.

(d) Additional Provider Education Provisions. Medicare contractors may not use a provider's attendance, failure to attend, or information gathered during an education program to select or track a provider for the purpose of conducting any type of audit or prepayment review.

Section 402. Access To and Prompt Responses from Medicare Administrative Contractors. The Secretary will develop a process for communications with beneficiaries and providers of services, physicians, practitioners, and suppliers. Medicare administrative contractors will provider general written responses (which may be through electronic transmission) in a clear, concise, and accurate, manner to inquiries submitted from beneficiaries, providers of services, physicians, practitioners, and suppliers within 45 days or receipt of such inquiries. Medicare administrative contractors must also maintain toll-free lines, provider unique identifying information upon request, and track the accuracy, consistency, and timeliness of responses to establish accountability for services. The Secretary will develop standards for contractors for such tracking and publish such standards in the Federal Register. The Secretary may also directly monitor the accuracy, consistency, and timeliness of information provided by the contractors. Results of such monitoring will be factored into evaluations of individual contractor performance.

Section 403. Reliance on Guidance.
Providers who reasonably rely on written guidance or written responses to written inquiries will not be subject to any penalty or interest if the guidance or response was in error, the Secretary determines that the provider has accurately represented the circumstances of the case to the Medicare contractor, and there is ultimately a problem with claims submitted by the provider.

Section 404. Medicare Provider Ombudsman; Medicare Beneficiary Ombudsman.

(a) Medicare Provider Ombudsman. The Secretary will appoint a Medicare Provider Ombudsman to 1) resolve unclear guidance and provider confidential assistance to Medicare providers and suppliers regarding complaints or questions about the Medicare program and 2) recommend changes to improve program administration.

(b) Medicare Beneficiary Ombudsman. The Secretary will also appoint a Medicare Beneficiary Ombudsman from individuals with health care expertise and advocacy experience. The ombudsman will 1) receive complaints, grievance, and requests for information from beneficiaries; 2) provider assistance with respect to those complaints, grievances and requests, including assistance to beneficiaries who appeal claims determinations or those affected by the decisions of Medicare+Choice organizations to leave Medicare; and 3) submit an annual report to Congress and the Secretary describing activities and recommending changes to improve program administration.

(c) Funding. There are authorized to be appropriated necessary sums in fiscal year 2002 and subsequently from the appropriate Medicare Trust Funds for the ombudsman programs.

(d) Use of Central, Toll Free Number (1-800-MEDICARE). The Secretary will establish a toll-free number which will transfer individuals with questions or seeking help to the appropriate entities. The transfer will occur with no charge. The toll-free number will be the general information and assistance number listed on the annual notice provided to beneficiaries.

Section 405. Beneficiary Outreach Demonstration Program.

(a) In General. The Secretary will establish a demonstration program under which Medicare specialists will provide advice and assistance to Medicare beneficiaries at selected local Social Security offices.

(b) Locations. The demonstration program must be conducted in at least six offices or areas, providing preference for offices with a high volume of visits by Medicare beneficiaries. At least two rural areas must be selected to participate in the demonstration program.

(c) Duration. The demonstration program will be conducted over a three-year period.

(d) Evaluation and Report. An evaluation of the demonstration program will include an

analysis of the cost-effectiveness of the program and the utilization of, and beneficiary satisfaction with, the assistance provider under the program. The Secretary will submit to Congress a report on the evaluation, including recommendations on the feasibility of permanently out-stationing Medicare specialists at local Social Security offices.

TITLE V - REVIEW, RECOVERY, AND ENFORCEMENT REFORM

Section 501. Prepayment Review.

The Secretary will change prepayment review policies as follows:

(1) Standardization of Random Prepayment Review. The Secretary will develop a standard protocol for random prepayment audits. Medicare administrative contractors must follow this standard protocol when conducting random prepayment review.

(2) Limitation on Initiation of Non-Random Prepayment Review. A contractor may not initiate a non-random prepayment review of a provider based on the voluntary disclosure by the provider of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

(3) Termination of Non-Random Prepayment Review. The Secretary will issue regulations establishing a concrete endpoint for prepayment review. The endpoint may vary based upon the differences in the circumstances triggering prepayment review.

(4) Construction. Nothing in this section will be construed as preventing the denial of claims for payments actually reviewed under a prepayment review. Further, Medicare administrative contractors are authorized to periodically request supporting documentation for a limited sample of submitted claims to ensure that underlying billing mistakes, which led to the overpayment, are not continuing.

Section 502. Recovery of Overpayments.

The Secretary will modify processes to recover overpayments, inform providers of payments audits and the over-utilization of codes and conduct probe sampling as follows:

(1) Use of Repayment Plans. The Secretary must develop standards for the use of repayment plans. The standards must 1) take into account a provider's reliance on written guidance, and 2) provide for the consideration of the financial hardship imposed on a provider. In developing the financial hardship standard, the Secretary will take into account the amount of the proposed recovery as a proportion of payments made to that provider of services, physician, practitioner, or supplier. If repayment of the overpayment meets these standards, the Secretary must enter into a plan with the provider of services, physician, practitioner, and supplier for offset or repayment of an overpayment for at least one year, but not longer than 3 years. The provider of services, physician, practitioner, and supplier may elect offset or repayment of the overpayment. If a provider fails to make a payment in accordance with a repayment plan, the Secretary may immediately seek to offset or

otherwise recover the total balance outstanding under the plan. Interest will accrue on the balance throughout the duration of the repayment plan. If the Secretary has reason to suspect that the provider may file for bankruptcy or otherwise cease to do business or discontinue participation in the program or if there is an indication of fraud or abuse committed against the program, the Secretary may refuse to extend a repayment plan to the provider.

(2) Limitation on Recoupment Until Reconsideration Exercised. If a provider of services, physician, practitioner, or supplier chooses to appeal, neither the Secretary nor any Medicare contractor may recoup an overpayment until the second level of appeal (to the Qualified Independent Contractor) is exercised. If, at a later level of appeal, the ruling is ultimately reversed, the government must repay the amount recouped with interest (at the same rate required of the provider). If the ruling is against the provider, then the overpayment may be collected with interest.

(3) Payment Audits.

(A) Written Notice of Post-Payment Audits. If a Medicare contractor decides to conduct a post-payment audit of a provider, the contractor will send a written notice (which may be in electronic form) alerting the provider of the audit. This written notice requirement is waived if it will compromise pending law enforcement activity.

(B) Explanation of Findings for All Audits. If a Medicare contractor audits a provider, the contractor will give the provider a full review and explanation of the findings of the audit to make sure the provider understands the findings and develops an appropriate corrective action plan. The contractor must also inform the provider of appeal rights and consent settlement options, and give the provider an opportunity to provide additional information. This requirement does not apply if the findings would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

(4) Notice of Over-Utilization of Codes. The Secretary will establish a process, in consultation with organizations representing classes of providers, to notify classes of providers when a particular code is being over-utilized.

(5) Guidelines for Conducting Probe Samples. The Secretary shall establish a standard methodology for Medicare contractors to use when selecting a probe sample of claims for review in the presence of an aberrant billing pattern.

(6) Consent Settlement Reforms. The decision to offer a consent settlement is within the Secretary's discretion. If, after a preliminary evaluation, there is an indication that there is a potential overpayment, the provider will be informed by the Secretary of the perceived problem and will have 45 days to furnish additional information concerning the medical records for the claims that had been reviewed. The Secretary will take into consideration any additional information and determine if there is an overpayment. If so, the Secretary

will provide notice of the determination to the provider, including an explanation of the reason for such determination. To resolve the overpayment, the Secretary will offer the provider an opportunity for a statistically valid random sample (which does not waive any appeal rights) or an opportunity to enter into a consent settlement.

Section 503. Process for Correction of Incomplete or Missing Data Without Pursuing Appeals Process.
The Secretary will develop a process whereby a provider of services, physician, practitioner, facility, or supplier can correct minor errors or omissions on claims, as defined by the Secretary, without having to initiate an appeal.

Section 504. Authority to Waive a Program Exclusion.
The waiver authority applicable to mandatory program exclusions is expanded, permitting the granting of exclusion waivers in cases where a Federal health care program believes that the subject is a sole community physician or sole source of essential specialized items or services in a community, and that the exclusion would impose a hardship on the program's beneficiaries.

TITLE VI – OTHER PROVISIONS

Section 601. Treatment of Hospitals for Certain Services Under Medicare Secondary Payor (MSP) Provisions.
This provision prohibits the Secretary from asking questions relating to the Medicare Secondary Payer Act in the case of reference laboratory services if the Secretary does not impose such requirements for services furnished by independent laboratories.

Section 602. Clarification of Prudent Layperson Test for Emergency Services Under the Medicare Fee-for-Service Program.
This provision clarifies current-law to require that any emergency care services delivered to a Medicare fee-for-service beneficiary shall be covered by the Medicare program.

Section 603. Review and Report to Congress on Reducing Medicare Reporting Burdens.
This provision requires the Secretary to review the current cost-reporting requirements of hospitals and other providers and suppliers. The Secretary is further required to find ways to reduce the reporting burdens placed on these providers and suppliers. The Secretary is required to conduct this review by October 1, 2003.

Section 604. Authorizing Use of Arrangements with Other Hospice Programs to Provide Core Hospice Services in Certain Circumstances.
The current-law hospice provisions are amended to permit hospices to contract for services with other hospices for extraordinary, exigent, and other non-routine circumstances. These circumstances included unanticipated periods of high patient loads, staffing shortages, or temporary travel of a patient outside a hospice program's service area. The provision shall apply upon enactment of this bill.

Section 605. One Year Delay in Lock In Procedures for Medicare+Choice Plans.
This provision delays the Medicare+Choice lock-in provision by one year. The lock-in provision, enacted under the Balanced Budget Act of 1997, is delayed from CY 2002 to CY 2003.

Section 606. Suspension of the Collection of OASIS Data for Non-Medicare patients.
This provision requires the Secretary to provide Congress with a recommendation for changing the current requirement for home health agencies to collect Outcome and Assessment Information Set (OASIS) data for their patients who are not eligible for Medicare no later than 18 months after the bill's enactment. During the interim period, the current requirement to collect OASIS data is optional for non-Medicare patients until six months after CMS submits its recommendation to Congress. A state may continue to require the collection of this data for non-Medicare patients during this interim delay for home health agencies operating within the state.

Section 607. Coordinated Survey Demonstration Program.
The Secretary is required to conduct a demonstration program to test the effectiveness of permitting a Critical Access Hospital that is under the same governing charter as another health care entity to be subject to one coordinated survey instrument for purposes of determining Medicare and Medicaid eligibility, rather than multiple surveys for each facility. The demonstration shall be conducted in 5 states and for not more than 5 years.