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Medicare Sidesteps Congress With Changes on Coverage Decisions

By Shira Stein

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- Medicare agency makes changes similar to bill passed in House
- Changes include open meetings for coverage determinations

Changes to the way the Medicare program will approve coverage of services and medical devices will partially preempt a bill passed by the House last month.

The Centers for Medicare & Medicaid Services announced Oct. 3 it will make changes to the process for achieving coverage of services and medical devices on a local level.

These are the first revisions made to the Medicare Program Integrity Manual since August 2015, and feedback from requests for information informed the changes, according to the agency.

“The redesigned local coverage determination process will pave the way to expanded access to new medical technologies,” CMS Administrator Seema Verma said in a statement.

“Coverage decisions will be made more transparently with an explanation of the clinical evidence that supports them, and with input from beneficiaries who are affected,” Verma said.

Services and medical devices are either approved on a national level by the CMS or on a regional basis by Medicare administrative contractors, the private insurers that process claims.

A bill (H.R. 3635) that would codify the same process passed the House Sept. 12. That bill would also require a written public comment period, holding open public meetings, a written rationale for the determination, and offering a reconsideration process for denied coverage.

A companion bill (S. 794) was introduced in the Senate in March 2017, but no action has been taken since.

The CMS proposed changes to the local coverage determination process in the calendar year 2015 physician fee schedule.

Changes

The agency’s changes include making contractor advisory committee meetings open to the public and allowing them to be held virtually.

Contractor advisory committees review draft local coverage determinations, although they don't make the final decision on coverage. CACs also communicate with local physicians and involve them in the local coverage determination process.

The process for obtaining a local coverage determination will need to be clearly written out, and the reconsideration process will have to be consistent with the national reconsideration process.

Health-care professionals, such as nurses and social workers, will now be able to serve on CACs. Those committees will be required to include a beneficiary representative.

To contact the reporter on this story: Shira Stein in Washington at sstein@bloomberglaw.com

To contact the editor responsible for this story: Brian Broderick at bbroderick@bloomberglaw.com

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