

Committee on Ways and Means

Summary of H.R. 810

Medicare Regulatory and Contracting Reform Act of 2003

The Medicare Regulatory and Contracting Reform Act takes sensible steps to educate providers, clarify provider rights, improve the contracting process and help educate beneficiaries. Many of these provisions will help providers better understand Medicare's program rules and regulations. Equally important are provisions that will help beneficiaries receive information on their benefits and coverage.

Regulatory Reform

- Requires additional comment period for portions of interim final and final regulations that do not represent a logical outgrowth from the proposed rule.
- Prohibits retroactive application of substantive changes.
- Establishes that a substantive change will not become effective until 30 days after the change is announced.
- Prohibits sanctions/recovery of overpayments if a provider follows written, erroneous guidance.

Contracting Reform

- Creates a competitive process for contracting for Medicare administrative functions such as the payment and processing of claims. In addition, companies other than insurance companies would be eligible to compete in the process.
- Provides for information security for administrative contractors.

Education and Outreach

- Creates incentives to improve contractor performance related to education and outreach.
- Requires access to and prompt responses from contractors, including general written responses to inquiries within 45 days and responses to toll free lines. Contractor responses will be monitored for accuracy.
- Authorizes enhanced resources for provider education, and establishes special outreach for small providers.
- Makes frequently asked questions and answers publicly available over the Internet.
- Prevents contractors from using attendance at education programs to trigger audits.
- Creates a small provider technical assistance demonstration program.
- Establishes a Medicare Provider Ombudsman.
- Requires CMS to use a central, toll free number to allow beneficiaries to get answers to Medicare questions and establishes a Medicare Beneficiary Ombudsman.
- Provides for notification of beneficiaries about skilled nursing benefits and information on Medicare-certified skilled nursing facilities in hospital discharge plans.

Appeals

- Requires that physician claims will be reviewed by a physician.
- Expedites access to judicial review for issues that cannot be resolved administratively, and

requires expedited review of certain provider agreement determinations.

- Establishes notice requirements for determinations and redeterminations.
- Sets forth standards for the conduct of random prepayment reviews; establishes limitations on the use of non-random prepayment review; and sets a concrete endpoint to prepayment review.
- In cases of hardship, provides between 6 months and three years to repay overpayments (five years in extreme hardship).
- Prohibits recovery of overpayments until the new qualified independent contractor level of appeal is exercised.
- Prevents extrapolation unless a sustained or high level of payment error has been identified, or unless documented educational intervention has failed to correct the problem.
- Ensures that underlying billing mistakes are corrected by permitting contractors to request supporting documentation for a limited sample of claims.
- Allows providers to submit additional information in the consent settlement process.
- Requires Medicare contractors, within the context of a consent settlement, to notify a health care provider of the nature of problems identified and what steps the provider should take to address the problems before an overpayment projection may be made from a probe sample of claims.
- Notifies providers when a particular code is being over-utilized.
- Requires that providers be notified in writing of post-payment audits, and that a full review and explanation of all non-law enforcement audits be made available to providers
- Instructs the Secretary to create a standard methodology for probe sampling.
- Requires the Secretary to establish a process for enrollment of providers in the Medicare program, and establishes hearing rights for disenrolled providers.
- Requires the Secretary to develop a process to allow correction of minor errors or omissions in submitted claims without having to initiate an appeal.
- Establishes a process for seniors and their doctors to find out in advance whether certain items and services are covered by Medicare.

Other Regulatory Issues

- Requires pilot testing of new evaluation and management guidelines prior to implementation and studies of simpler systems of documentation for physician claims.
- Establishes EMTALA task force and makes other EMTALA modifications regarding payment for services provided in the emergency room under EMTALA; mandatory PRO review; and notification to the provider when an investigation was closed.
- Instructs GAO to report on the appropriateness of the current physician payment system.
- Prohibits group health plans from requiring dental providers to file claims for excluded services.
- Authorizes use of arrangements with other hospice programs to provide hospice services in certain emergency circumstances.
- Applies OSHA bloodborne pathogens standard to selected public hospitals.
- Requires Medicare Secondary Payor data collection criteria to be the same for hospitals performing reference lab tests and independent labs.
- Improves oversight of technology and coverage by establishing a council for technology and innovation and studies on the use of external data and local coverage determinations. Requires establishment by regulation payments for new lab tests.
- Guarantees that hospitals will be furnished information they need to compute the disproportionate share hospital formula.
- Requires reports on home health conditions of participation and notices relating to use of hospital lifetime reserve days.