

Committee on Ways and Means

Subcommittee on Health

JOHNSON-STARK MEDICARE REGULATORY AND CONTRACTING REFORM ACT OF 2001

This legislation addresses legitimate concerns raised by providers and suppliers regarding regulatory issues in the Medicare program. It takes sensible steps to educate providers and clarify processes and provider rights, while protecting the Federal False Claims Act and efforts to eliminate waste, fraud, and abuse in Medicare.

Issuance of Regulations and Compliance with Changed Policies

- ? Creates specific time frames for release of new regulations and progression to final rules
- ? Requires additional comment period for portions of final regulations that do not represent a logical outgrowth from the proposed rule
- ? Establishes implementation/compliance period for policy changes
- ? Prohibits retroactive application of new guidance
- ? Prohibits sanctions/recovery of overpayments if provider follows written, erroneous guidance

Contracting Reform

- ? Reforms the contracting system by permitting the Secretary to contract with separate contractors for discrete duties; allowing greater flexibility in selecting contractors, assigning contractor functions, permitting competitive contracting; and eliminating provider nomination of national or state organizations for contracting purposes
- ? Expands the kind of entities eligible to serve as contractors and establishes new evaluation criteria
- ? Requires that the reimbursement and termination of contracts is consistent with the Federal Acquisition Regulation (FAR), which allows for incentive cost plus or other arrangements
- ? Consolidates fiscal intermediary and carrier responsibilities under a common contracting framework

Provider Education and Technical Assistance

- ? Coordinates and increases provider education funds
- ? Creates process to assess performance of individual contractors
- ? Requires contractors to monitor toll-free lines, and to educate and train providers on issues regarding billing, coding, and other appropriate items
- ? Establishes special outreach to small providers
- ? Makes FAQs and HCFA's answers publicly available over the Internet
- ? Creates a new Medicare provider ombudsman and a new beneficiary ombudsman
- ? Prevents HCFA from using attendance at education programs to trigger audits
- ? Notifies providers when a particular code is being over-utilized

- ? Requires contractors to provide clear answers to specific billing and cost reporting questions - including the responder's unique identifying information

Small Provider Technical Assistance Demonstration Program

- ? Establishes two-year voluntary small provider demonstration in which the Secretary will contract with qualified organizations to offer technical experts to perform compliance evaluations and suggest options to better fulfill program obligations
- ? Participating small providers will pay 25% of the costs of the technical assistance
- ? Protects participants from recovery for overpayments identified through the demonstration, if the problem is corrected to the satisfaction of the Secretary
- ? Requires GAO study to test whether the demonstration reduces small providers' claims errors

Provider Appeals

- ? Increases resources for Medicare education for ALJs who handle Medicare cases
- ? Requires the Secretary and the Social Security Commissioner to develop and implement a plan to transfer responsibility for Medicare administrative law judges to HHS by 2003
- ? Expedites access to judicial review for issues that cannot be resolved administratively
- ? Requires providers to present full evidence at the qualified independent contractor level of appeal

Recovery of Overpayments and Prepayment Review

- ? In cases of hardship, provides up to three years to repay overpayments (5 years in extreme hardship)
- ? Prohibits recovery of overpayments until the administrative law judge level of appeal is exercised and awards interest if underpayment made in error
- ? Standardizes methods for random prepayment audits
- ? 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
- ? Establishes a concrete endpoint to prepayment review
- ? Requires that providers be notified of post-payment audits, and that a full review and explanation of all non-law enforcement audits be made available to providers
- ? Requires the Secretary to establish a process for enrollment of providers in the Medicare program, and establishes an appeals process 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

Beneficiary Assistance Demonstration

- ? Establishes three-year demonstration program to restore Medicare specialists in selected Social Security offices to answer beneficiary questions on Medicare issues
- ? Conducts evaluation prior to the end of the demonstration to determine whether it has been effective and should be expanded

Evaluation and Management Guidelines

- ? Requires pilot testing of new evaluation and management guidelines prior to implementation
- ? Requires a report to Congress on alternative systems of documentation for physicians' claims

Improvement in Oversight of Technology and Coverage

- ? Requires the Secretary to coordinate reviews of coverage decisions for Medicare with pre-market approval of FDA.
- ? Establishes a Council for Technology and Innovation to coordinate the activities of coverage, coding and payment under Medicare with regard to new technologies, procedures and drugs.
- ? Requires the GAO to study improvements in external data collection for use in inpatient payment system.
- ? Requires hospitals not otherwise subject to the Occupational Safety and Health Act to comply with the blood borne pathogens standard, but would not subject a hospital that fails to comply to termination.
- ? Requires the Institute of Medicine to study the capabilities and information available for local coverage determinations.
- ? Prohibits the Secretary from requiring more than 3 months of marketing experience as a condition for the assignment of a technology specific code except where the Secretary deems the new technology to be insignificant.

Miscellaneous

- ? The Secretary may not require hospitals to ask questions regarding secondary payor requirements for reference labs that are not required for independent labs.
- ? Clarifies the prudent layperson test for fee-for-service Medicare.