# *Medicare Regulatory and Contracting Reform*

The Medicare regulatory and contracting reform provisions take 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**

- Prohibits the introduction of new material in final rules without an opportunity for public comment.
- Prohibits retroactive application of new regulations and policies.
- Requires a waiting period of 30 days after the announcement of a substantive change before it can become effective.
- Prohibits sanctions if a provider follows written, erroneous guidance from the government and its agents.

**Contracting Reform**

- Creates a competitive process for contracting for Medicare administrative functions such as processing and paying of claims. In addition, expands the potential pool of expertise by allowing companies besides insurance companies to compete for contracts.
- Provides for information security for administrative contractors.

**Education and Outreach**

- Creates incentives for contractors to improve education and outreach.
- Requires prompt responses from contractors to provider and beneficiary questions, including written responses within 45 days and responses to toll free lines. Requires monitoring of contractor responses for accuracy.
- Enhances 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 technical assistance demonstration program for small provider.
- Requires CMS to use a central, toll-free number to allow beneficiaries to get answers to Medicare questions.
- Establishes an Ombudsman for Medicare beneficiaries.
- Provides for notification of beneficiaries about skilled nursing benefits and information on Medicare-certified skilled nursing facilities in hospital discharge plans.

**Appeals**

- Requires the transfer of Medicare Administrative Law Judges from the Social Security Administration to the Department of Health and Human Services, and ensures their independence.
- Expedites access to judicial review for legal issues that cannot be resolved administratively, and requires expedited review of certain provider agreement determinations.
- Establishes standards for notices sent to beneficiaries about their use of Medicare services.
- Establishes standards for random prepayment reviews; establishes limits on the use of non-random prepayment review; and requires notification at the end of a prepayment review.

- Allows providers up to three years to repay overpayments in cases of hardship (five years if extreme hardship).
- Prohibits recovery of overpayments during an appeal until after an evaluation by an independent party (the new qualified independent contractor level).
- Prevents extrapolating overpayments, based on a small sample of claims, to a larger number of claims unless a sustained or high level of payment error has been identified, or unless documented educational intervention has failed to correct the problem.
- 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.
- Ensures that underlying billing mistakes can be corrected by permitting providers to submit supporting documentation.
- Notifies a provider when it may be overusing a particular code.
- Requires that providers are notified in writing of post-payment audits, and that a full review and explanation of all audits be made available to providers, except where fraud is suspected.
- Instructs the Secretary to create a standard method for probe sampling.
- Requires the Secretary to establish a process for provider enrollment, and establishes hearing rights for disenrolled providers.
- Requires the Secretary to develop a process to allow providers to correct minor errors or omissions in submitted claims without having to initiate an appeal.
- [Establishes a process for beneficiaries and their doctors to find out in advance whether certain items and services are covered by Medicare.]

**Other Regulatory Issues**

- Suspends data collection from privately-insured home health patients until CMS reports on the use of the information and releases a final regulation.
- Requires pilot testing of new evaluation and management guidelines used for physician visits prior to their implementation, and studies of simpler systems of documentation for physician claims.
- Establishes a task force on regulations for the delivery of emergency services, clarifies that Medicare will pay for mandated services, and requires notification of providers when an investigation on the delivery of emergency services is closed.
- Prohibits group health plans from requiring dental providers to file claims for excluded services.
- Allows hospices to use the staff of other hospice programs in certain emergency circumstances.
- Requires Medicare Secondary Payor data collection criteria to be the same for hospitals and independent labs performing reference (no patient contact) lab tests.
- Establishes a council for technology and innovation, requires studies on the use of external data and local coverage determinations, and requires establishment by regulation of payments for new lab tests.
- Guarantees that hospitals will be furnished information they need to compute the disproportionate share hospital formula.
- Allows staffing companies to bill for physicians under contract.
- Ensures coverage of air ambulance services.
- [Extends OSHA blood borne pathogens standard to certain public hospitals.]