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Comments on Regulatory and Contractor Reform Legislation

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INTRODUCTION

The House of Representatives passed the "Medicare Regulatory and Contracting Reform Act of 2001" (H.R. 3391) in December 2001. The legislation culminated a year-long effort by members of the U.S. House of Representatives Committee on Energy & Commerce (Subcommittee on Health) and Committee on Ways & Means (Subcommittee on Health), and by officials in the Centers for Medicare and Medicaid Services (CMS). Their goals were to simplify regulations, streamline procedures used to pay health care providers, and realize efficiencies in contracting with fiscal intermediaries. The intent of this *Brief* is to inform policy and report back to the "field" regarding the rural issues of, and suggested modifications to, contractor reform.

The findings in this *Brief* are based on interviews with 20 respondents from California, Georgia, Iowa, Michigan, Minnesota, Missouri, Montana, Nebraska, and Texas. Respondents included: state hospital associations, rural hospital administrators and staff, physicians, accounting firms, lawyers, consultants, rural health clinics, and physician clinics. While some respondents provided information based solely on their personal experience, a majority of respondents represented several hospitals, clinics, and/or physicians; had a large client base to draw from; or spoke from a state-wide experience. Apart from the interviews, this topic was also discussed in a meeting format with hospital administrators and accountants.

Many of the issues surrounding contractor reform are pertinent to both rural and urban providers/hospitals. However, the dynamics of provider-contractor relationships could be affected by some characteristics common to many rural providers: the small size of the provider organization (e.g., physician clinic, hospital); a modest resource base (low reserves, small operating margins, small number of employees performing multiple tasks); and the struggle to maintain an appropriate mix of services.

SALIENT RURAL ISSUES REPORTED BY RESPONDENTS

1. Communications can be problematic, both in timeliness and in reliability. There are reported problems in getting return calls from contractors. There are also problems in getting different answers from different representatives within the same contractor, and different answers to the same question from different contractors. The latter can be a problem for rural providers serving beneficiaries in multiple states.

2. Fiscal intermediaries may not be conversant in current rules concerning Critical Access Hospitals and Rural Health Clinics.

3. Providers are uncertain of any recourse if the answer from the first contact with a contractor seems to be in error.

4. CMS and the contractors are not always prepared to implement policy change in a timely manner. Examples include:

    - not getting necessary data (provider statistical and reimbursement report) from the intermediary for implementing changes in outpatient and home health payment;
    - CMS not providing software or interpretations to the contractor in a timely manner when a change occurs;
    - not giving guidance on how to compute the 50/50 payment for Medicare dependent hospitals when it comes to transfer cases;
    - applying the skilled nursing facility consolidated billing process to Rural Health Clinic services;
    - retroactively applying budget neutrality factors when rebasing sole community hospital rates using 1996 data;
    - proposed rule not allowing overlapping Medicare Geographic Classification Review Board applications; and
    - arbitrarily reducing outpatient prospective payment system hold harmless/transitional corridor payments to 85%.

5. Regionalization of the fiscal intermediary service could significantly increase travel costs.

6. If contractors are selected based on a process of competitive bidding, it is possible that a contractor in New Jersey could service Nebraska. This is relevant not only because of the geographical distance, but also because of the lack of knowledge about the region as well as a lack of understanding of the issues specific to or directly impacting rural providers/hospitals. Furthermore, this decreases the likelihood of a "personal knowing" between the contractor and the provider/hospital.

7. Inconsistency in and timeliness of payment from the contractor to the provider/hospital can be especially problematic for rural providers because of their limited financial reserves.

RESPONDENT SUGGESTIONS FOR DEVELOPING A POLICY OF COMPETITIVE BIDDING

Although some respondents support competitive bidding, an overwhelming majority were cautious about proceeding, were unsure of exactly how to proceed in the least harmful and most efficient manner, and anticipated shortcomings with a competitive bidding process.

1. The bidding process should be an open process whereby requests for bids are widely circulated and qualifying entities are allowed to submit a bid.

2. A fiscal intermediary with a record of responsiveness and performance should not be lost because of the bidding process.

3. The competitive bidding process should not be driven by the lowest bidder. Instead, criteria for assessing bids should include:

    - evidence of being able to serve the region covered in the bid (experience in the region is preferable);
    - commitment to training providers in local regions; and
    - analysis of the effects of any regulatory change affecting payment on the liability of beneficiaries.

4. Bids should be allowed to cover multiple years, thus seeking to provide stability and continuity. This may help maintain or improve communication between the contractor and the provider and contribute to "relationship building" between the two entities. There will need to be provision for termination of the contract for lack of performance.

5. The performance assessment of contractors should include:

    - polling rural hospitals (customer satisfaction);
    - providing proof of staying current on all regulations affecting rural providers;
    - providing timely and full payment to providers, <u>not</u> reducing payment; and
    - providing evidence of timely and accurate response to providers' inquiries.

OTHER RESPONDENT SUGGESTIONS

1. Include rural examples (impact statements) in all new regulations.

2. Support the requirement that regulations be published on a certain date monthly.

3. Consolidate, standardize, and properly maintain claims systems. However, contractors could become too big to handle the volume of claims. Furthermore, rural providers may receive reduced service from the contractor and decreased communication and "personal" service.

4. Do not separate functions among contractors, as this could lead to unproductive turf battles. Furthermore, there is concern that there would be a "passing of the buck" (i.e., between payment and audit) if contractors performed separate functions. From a rural provider/hospital perspective, many do not have the resources or staff to deal with multiple functions.

5. Establish a single point of contact within CMS to archive information that is responsive to rural questions and provides clear, final answers.

6. Provide a mechanism to appeal to a regional or national CMS office when competing answers are given to the same question.

7. Conduct small/rural impact analyses with each new rule.

8. Implement the reform in a one-state area first, before implementing across the country.

OTHER RESPONDENT REMARKS

1. The way CMS compensates contractors seems inherently flawed, with no economic incentive to accomplish objectives. The system of contracting needs a complete overhaul to reward the performance objectives.

2. CMS requests that additional work be done within the current financial levels–this system discourages performance.

3. There should be less emphasis on budgeting and more on risk incentives built into intermediary contracts.

4. There should be an opportunity to appeal an initial CMS determination and have timely resolution of the appeal.