THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 22, 2011

The Honorable John A. Boehner
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

I am respectfully submitting the enclosed report to Congress entitled, "Status on Medicare Contracting Reform Implementation" as required by section 911(g) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173. As specified by the MMA, the report outlines the progress made by the Centers for Medicare & Medicaid Services in implementing the statutory requirements to contract with new Medicare Administrative Contractors.

I am sending an identical copy of this report to the President of the Senate.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 22, 2011

The Honorable Joseph R. Biden, Jr.
President of the Senate
Washington, DC 20510

Dear Mr. President:

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I am also sending a copy of this report to the Speaker of the House of Representatives.

Sincerely,

Kathleen Sebelius

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Enclosure

Report to Congress
Status on Medicare Contracting Reform Implementation

Kathleen Sebelius
Secretary of Health and Human Services
2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS for MEDICARE & MEDICAID SERVICES

Report to Congress

Status on Medicare Contracting Reform Implementation

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Executive Summary

Effective October 1, 2005, Congress directed the Secretary of Health and Human Services to contract with new Medicare Administrative Contractors (MACs) as specified under section 1874A of the Social Security Act, added by section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173. The MACs replace the legacy fiscal intermediaries (FIs) and carriers that had historically processed Medicare fee-for-service (FFS) claims under sections 1816 and 1842 of the Social Security Act. The MMA requires that the Centers for Medicare & Medicaid Services (CMS) compete all MAC contracts by October 2011.

This report outlines the progress made by CMS in implementing the statutory requirements for Medicare contracting reform. The CMS made initial awards on 19 MAC contracts, which includes four Durable Medical Equipment (DME) MAC contracts for all of the four DME jurisdictions and 15 Part A and Part B (A/B) MAC contracts for all of the 15 A/B jurisdictions. The CMS has implemented 13 of the MAC contracts (9 A/B and 4 DME) and anticipates implementing the remainder by the end of fiscal year (FY) 2011.

Chapter I: Introduction

In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act, or the MMA (Public Law 108-173) was enacted. Section 911 of the MMA required that the Secretary of Health and Human Services (the Secretary) replace the contracting authority under title XVIII of the Social Security Act (the Act) with the new Medicare Administrative Contractor (MAC) authority. This provision (referred to as Medicare contracting reform) was intended to improve Medicare's administrative services to beneficiaries and health care providers through the use of competitive contract procedures and performance incentives. The MMA required that the Centers for Medicare & Medicaid Services (CMS) compete all MAC contracts by October 2011.

THE VISION FOR FEE-FOR-SERVICE MEDICARE

In 2005, the Secretary submitted to Congress a plan for implementing these new MAC contracts. The vision was for a premier health plan that allowed for comprehensive, quality care and world-class beneficiary and provider service. Medicare would establish a single point-of-contact for beneficiaries through 1-800-MEDICARE, and providers would use the MACs as their primary point-of-contact for conducting all claims-related business and obtaining information for their patients. The CMS also envisioned the delivery of comprehensive care to beneficiaries and providers through the integration of Medicare Parts A and B under the MAC contracts and a modernized administrative IT platform.

MAC Implementation Strategy

Prior to the enactment of the section 911 reforms, CMS contracted with 25 fiscal intermediaries (FIs) to process fee-for-service (FFS) claims for hospitals and skilled nursing facilities and 18 carriers to process FFS claims for physician, laboratory, and other services. In addition, four carriers served as durable medical equipment regional carriers (DMERCs) for claims related to durable medical equipment (DME), prosthetics, orthotics, and supplies. Similarly, four fiscal intermediaries served as regional home health intermediaries (RHHIs) for home health and hospice (HH+H) claims.

Chapter III of the 2005 Report to Congress outlined CMS' plan for moving from the FI and carrier contracting authority, or legacy contract environment, to the new MAC authority. The CMS planned to consolidate from 51 contractors to 23 MACs by awarding 15 Part A and Part B (A/B) MACs to service the majority of provider types, 4 specialty MACs to service DME suppliers, and 4 specialty MACs to service HH+H providers.

The 15 A/B MAC contracts would operate in 15 distinct, non-overlapping geographic jurisdictions. The eight specialty MACs (DME and HH+H) would perform claims administrative services in geographical jurisdictions that reflected a realignment of the existing jurisdictions for RHHIs and DMERCs that fit the boundaries of the A/B MAC jurisdictions. The CMS designed these jurisdictions based on the concept of integrated Part A and B claims processing, with one MAC processing the claims and services related to a single beneficiary.

The CMS planned to compete the new MAC contracts through three cycles of acquisitions (activities from solicitation to award) and transitions. The first cycle would compete four DME MAC contracts and one A/B MAC contract. The remaining MAC contracts would be competed in two separate cycles.

PROGRESS TO DATE: MEDICARE CONTRACTING REFORM

The CMS has complied with the Secretary's plan (as described above) to implement Medicare contracting reform. To date, CMS has awarded 100 percent of the new MAC contracts and transitioned 65 percent of the FFS workload to the new MACs that are operational. However, certain factors, primarily bid protests, have extended the time required for contract awards and implementation activities on several MAC contracts[1]. In addition, CMS decided to change its HH+H contracting strategy to maximize administrative savings while ensuring that a small number of MACs focus on the unique policies for HH+H providers[2].

In addition to the changes to the MAC implementation strategy, CMS redesigned its contract administration structure for overseeing the MAC contracts. The CMS established a MAC Program Management Office (PMO) comprised of three divisions that are geographically aligned with the MAC jurisdictions. This PMO works closely with a centralized Contract Office to ensure timely communications with MACs and high quality contract performance. Business processes have been created or reengineered to support this contract administration structure, which include CMS' change management process and performance monitoring through quality control plans. Also new to this process are quality assurance surveillance plans (QASPs) and award fee plans[3].

Medicare contracting reform, in its initial stage of implementation, is generating considerable savings to the government, as well as administrative efficiencies. Throughout the process, CMS has identified a considerable number of best practices that it is applying, through an ongoing process of operational and administrative re-engineering, to reshape its administration of these new contracting entities. As a result, CMS is establishing a streamlined, re-invigorated, and modernized system of managing the Medicare FFS Program. Most recently, CMS has proposed further opportunities for efficiencies by consolidating the 15 A/B MAC jurisdictions to a lesser number.

[1] Chapter V discusses the factors affecting changes to CMS' MAC implementation timeline.
[2] Chapter II discusses CMS' change to the HH+H strategy.
[3] Chapter III discusses changes to CMS' administrative structure.

CONTENT OF THE REPORT

This report, which describes CMS' progress on implementing the Medicare contracting reform provisions contained in section 911 of the MMA, is organized as follows:

Chapter I	Introduction: Describes the initial plan identified in the 2005 Report to Congress for implementing the Medicare contracting reform provisions and provides a brief overview of CMS' progress.
Chapter II	Status on MAC Implementation: Describes significant work accomplishments related to Medicare contracting reform implementation.
Chapter III	Administration, Oversight, and Management: Describes the changes made to CMS' FFS administrative structure to more effectively manage the contract and oversee Program operations.
Chapter IV	FFS Projects and MAC Integration: Describes the status on other FFS initiatives discussed in the 2005 Report to Congress and describes CMS' approach for integrating and managing these activities.
Chapter V	Ongoing Risk Management: Describes the overall risk management and mitigation strategies to support the successful completion of Medicare contracting reform.

In addition, this report contains three appendices, organized as follows:

Appendix A	Current Contractor Lists: Identifies the MAC or legacy contractor currently providing claims administration services for each MAC jurisdiction.
Appendix B	MAC Jurisdictions: Identifies the geographic service area for each MAC contract.
Appendix C	Definitions: Provides definitions of terms used in this Report.

Chapter II: Status on MAC Implementation

Since FY 2005, CMS awarded four DME MAC contracts for all of the four DME jurisdictions and 15 A/B MAC contracts for all of the 15 A/B jurisdictions. CMS also either began or completed many of the implementation activities for these awarded MACs. To date, CMS has completed the implementation activities for four DME MACs and nine A/B MACs. Table 1 describes CMS' key accomplishments for FYs 2005-2009 and activities that will need to occur in the near future.[4]

Table 1: Key Accomplishments and Next Steps

Fiscal Year 2005	• Issued MAC Implementation Plan (Report to Congress). • Initiated procurements for five MAC contracts (four DME MACs and one A/B MAC).
Fiscal Year 2006	• Awarded and implemented three DME MAC contracts (Jurisdictions A, B, D), which represents 58.4% of the national FFS DME workload. • Awarded and began implementation activities for the first A/B MAC contract (Jurisdiction 3), which represents 2.7% of the national FI/carrier workload. • Initiated seven A/B MAC procurements (Jurisdictions 1, 2, 4, 5, 7, 12, and 13). • Launched first computer-based training module on Medicare contracting reform.
Fiscal Year 2007	• Published policy (under 42 CFR 421) for assigning providers to MACs. • Developed integrated project schedule for Medicare FFS initiatives. • Awarded and implemented one DME MAC contract (Jurisdiction C), which represents 41.6% of the national FFS DME workload. • Completed the implementation for the first A/B MAC contract (Jurisdiction 3). • Awarded and began implementation activities for two A/B MAC contracts (Jurisdictions 4 and 5), which represent 13.5% of the national FI/carrier workload. • Established a contract performance assessment program that emphasizes a centralized approach with primary reliance on structured surveillance. • Initiated remaining seven MAC procurements (Jurisdictions 6, 8, 9, 10, 11, 14, and 15).
Fiscal Year 2008	• Awarded five A/B MAC contracts (Jurisdictions 1, 2, 7, 12, and 13), representing 31.9% of the national FI/carrier workload. • Began implementations activities for three A/B MAC contracts (Jurisdictions 1, 12, and 13). • Completed implementations for two A/B MAC contracts (Jurisdictions 4 and 5).

[4] Although CMS awarded all 19 MAC contracts, protests on many awards have delayed some of the MAC implementation activities. Chapter V provides additional information on award protests.

Fiscal Year 2009	• Awarded seven A/B MAC contracts (Jurisdictions 6, 8, 9, 10, 11, 14, and 15), representing 45.5% of the national FI/carrier workload and 100% of the HH+H workload. • Completed implementation activities for six A/B MAC contracts (Jurisdictions 1, 9, 10, 12, 13, and 14).
Next Steps	• Complete corrective actions for two Cycle Two A/B MAC contracts (Jurisdictions 6 and 8). • Complete implementations for four Cycle Two A/B MAC contracts (Jurisdictions 6, 8, 11, and 15). • Develop strategy to re-compete all MAC contracts. • Re-compete three DME MAC contracts (Jurisdictions A, B, and D).

CHALLENGES TO CONTRACT AWARDS

Protests on award decisions and subsequent corrective actions have created delays in the implementation of MAC contracts. These protests, each filed in time to trigger a stay of the implementation of the MAC workload, demonstrate an active desire from various entities to become or continue to be CMS' partner in the delivery of health care services. In the Cycle Two competitions (Jurisdictions 6, 8, 9, 10, 11, 14, and 15) alone, CMS received protests on its contract awards in five of the seven jurisdictions. All protests have been filed with the U.S. Government Accountability Office (GAO), which by law has up to 100 days in which to render its decision. In some cases, the GAO decisions have been to dismiss the protest and uphold CMS' award decision, which allowed for implementation efforts to commence on the contract. However, in other instances, either GAO has sustained a protest and required CMS to perform corrective action or CMS has notified GAO prior to a decision that the agency would voluntarily take corrective action. Corrective action has taken between one month to over a year, depending on the recommendations from the GAO and/or the Department's Office of General Counsel and the level of work necessary to carry out the corrective action. Chapter V provides additional information on MAC protests.

UPDATES TO THE MEDICARE CONTRACTING REFORM STRATEGY

As discussed in Chapter I, CMS planned to award contracts for 15 A/B MACs, four DME MACs, and four HH+H MACs. Each MAC contract would contain a grouping of states, referred to as jurisdictions. For the DME and HH+H MAC contracts, CMS planned to create four identical jurisdictions that would geographically align with the 15 A/B MAC jurisdictions.

The CMS has moved forward with the establishment of the 15 A/B MAC and four DME MAC contracts. However, after careful analysis on procuring, implementing, and administering MAC contracts, CMS determined that two changes to the initial plan were necessary to efficiently procure and implement the HH+H work.

1. The CMS incorporated the HH+H workloads into four of the A/B MAC contracts.

2. The CMS realigned the geographical boundaries for its HH+H jurisdictions to align with the existing boundaries of its legacy RHHIs.

These changes allowed for both administrative and programmatic savings to FFS operations, which are described below.

- The total number of MAC contracts would be reduced from the 23 envisioned in the 2005 Report to Congress to 19, thereby decreasing overhead requirements in competing and managing the contracts.

- This strategy, in which a small number of MACs administer HH+H claims, is consistent with the current environment. This specialization, which is strongly preferred by the industries served, has been demonstrated to effectively focus attention on their unique issues.

- Medicare processes HH+H claims using the same claims processing systems used for A/B claims, so bringing the two workloads together in the same organization should not be difficult. In fact, this approach allows for the incorporation of management overhead for this relatively small workload into the larger A/B MAC contracts, which should reduce administrative costs.

- The realignment of the jurisdictional boundaries allowed for several implementation and operational advantages concerning CMS' Healthcare Integrated General Ledger Accounting System (HIGLAS) and several other Medicare FFS ongoing projects. The realignment decreases the number of workload splits (data division) that the HIGLAS project would need to perform. This allows the HIGLAS resources to focus on the more immediate A/B MAC workload splits that need to be completed for MAC implementations.

Table 2 describes the HH+H jurisdictional groupings and how CMS assigned the four HH+H workloads to the A/B MAC contracts. In addition, Appendix B outlines the jurisdictions for the A/B and DME MACs.

Table 2: Home Health and Hospice Jurisdictional Groupings

HH+H Jurisdiction	HH+H States	A/B MAC Assignee	A/B MAC Jurisdiction States (Non-HH+H)
A	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	J14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
B	Delaware, District of Columbia, Colorado, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming	J15	Kentucky and Ohio
C	Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas	J11	North Carolina, South Carolina, Virginia, and West Virginia
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Puerto Rico, Oregon, U.S. Virgin Islands, Washington, and Wisconsin	J6	Illinois, Minnesota, and Wisconsin

Chapter III: Administration, Oversight, and Management

Because CMS contracts out the administrative functions for FFS benefits, it is critical that CMS have an effective management strategy in place for overseeing the performance of these Medicare claims contractors. These contractors not only play a critical role in the administration of the Medicare benefit, but also in the Nation's health care economy. In FY 2009, Medicare FFS contractors processed over one billion claims and made benefit payments of more than $400 billion to approximately 1.5 million health care providers and suppliers.

The CMS has implemented a series of structural and procedural reforms for contract administration in order to achieve the goals listed in figure 1.

Figure 1: CMS' Contract Administration Goals

- Establish clear accountability for Medicare Contract Administration
- Improve CMS' contractor performance evaluation processes
- Ensure objectivity in contractor evaluation
- Link planning/management for contractor systems and operations
- Improve consistency in contractors' business operations

In order to streamline its communications with the FIs and carriers, and to prepare for Medicare contracting reform implementation, CMS began to consolidate its contract administration activities. First, CMS integrated the performance oversight and monitoring activities within one functional area – the Medicare Contractor Management Group (MCMG). After this change, CMS aligned the structure within MCMG to better focus its oversight and reporting activities for Medicare contractors.

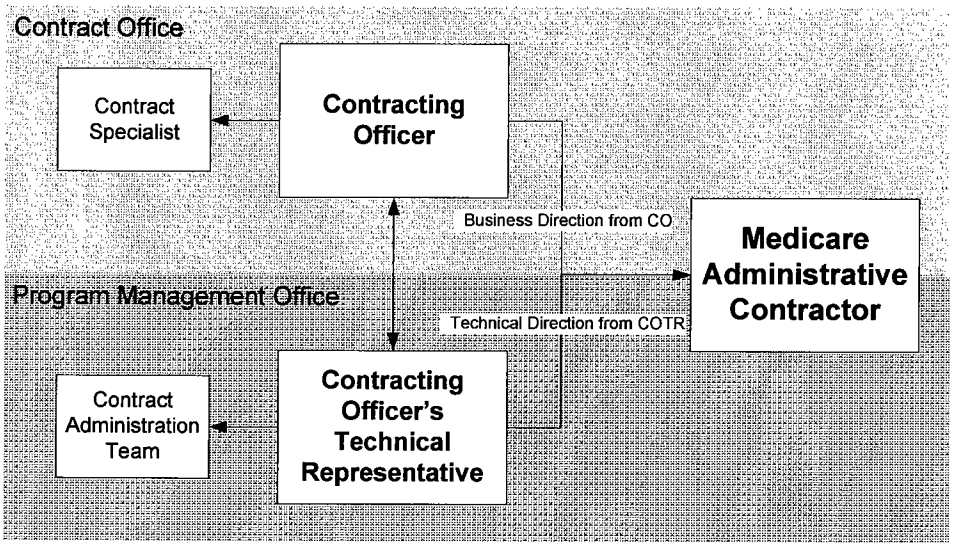
In addition to changing its internal management structure, CMS also began making changes to its internal management systems and processes for managing FIs and carriers. For example, CMS redesigned its change management process (discussed in further detail in the sections below) by establishing an internet-based system for the review and comment of proposed changes to FFS program requirements. This change streamlined what had been a tedious process based on individual e-mails across various CMS staff and Medicare contractors.

Although these changes brought significant improvements to CMS' oversight of its claims contractors, implementation of Medicare contracting reform required CMS to further change its internal structure and processes for overseeing contractor performance in order to support a Federal Acquisition Regulation (FAR)-based contracting environment. These changes have further streamlined management activities, resulting in more consistent communications between CMS and the MACs and greater efficiencies in CMS contractor monitoring processes. The sections below discuss the management structures and processes in place for overseeing MAC performance.

MAC ADMINISTRATIVE STRUCTURE

Even before the implementation of Medicare contracting reform, CMS began to streamline and consolidate its contractor management activities under a single operational unit. For the MACs, CMS further streamlined its activities through a new administrative, oversight, and management structure to provide consistent direction to the MACs and to provide transparent processes to providers and beneficiaries. This structure consists of two distinct offices, a Contract Office and a Program Management Office (PMO), that collaborate to monitor contractor performance and ensure compliance with contract requirements. Figure 2 describes this MAC administrative structure.

Figure 2: MAC Administrative Structure



While the Contract Office is centralized, CMS established its PMO within three geographic divisions to align with the MAC jurisdictions and ensure effective contract oversight and management. Table 3 displays the MAC contracts managed by these MAC PMO Divisions.

Table 3: MAC Program Management Office

Eastern Division:	• DME Jurisdictions A,B,C, and D • A/B Jurisdictions 8, 12, 13, and 15
Southern Division:	• A/B Jurisdictions 4, 7, 9, 10, and 14
Western Division:	• A/B Jurisdictions 1, 2, 3, 5, 6, and 11

These Divisions are also responsible for administering the remaining legacy FIs and carriers, within their geographical area, for as long as they remain in the Medicare FFS Program.

MAC Contract Office

The MAC Contracting Officer (CO) has the administrative responsibility for the MAC contract and is the only person authorized to enter into and bind the government by contract. The CO negotiates and prepares the MAC contract document, modifies any terms or conditions of the contract, accepts

delivered services, and approves vouchers for payment. The CO works closely with the MAC Contracting Officer's Technical Representative (COTR) in order to administer the contract, evaluate performance, and provide payment.

The MAC Contract Specialist supports the CO in performing all contract administration functions for the MACs. This individual is responsible for coordinating and controlling contract related efforts, including assisting with the development and documentation of contract documents and participating in the negotiation process.

MAC Program Management Office

The MAC Contracting Officer's Technical Representative (COTR) (also referred to as the Project Officer) serves as the first point of contact for the MACs. The COTR is responsible for the exchange of information and the receipt of programmatic approvals on deliverables and other work under the MAC contract. The COTR is the technical representative of the MAC CO and provides technical direction to the MAC as necessary for all of the business functions contained in the MAC statement of work (SOW). The MACs will only follow those instructions that are conveyed to them by their COTR or CO.

The Contract Administration Team (CAT) is comprised of regional and central office staff that support the COTRs in carrying out contract oversight, reviewing vouchers, reviewing programmatic changes for incorporation into the MAC SOW, and providing data and analytical support in assessing the MAC's performance of key contract metrics.

MANAGING FFS PROGRAM CHANGES

Changes to the Medicare program—which serves about 46 million beneficiaries and processes over one billion FFS claims a year—are frequent and complex. The Medicare FFS change management process includes developing standards, policies, procedures, and instructions, providing training, and ensuring compliance across CMS components in order to appropriately deal with such changes.

The CMS has streamlined its change management process by creating an internet-based system (e-Chimp, the Electronic Change & Information Management Portal) to manage changes to program requirements. With the implementation of the MACs, CMS is looking to find additional efficiencies in how these changes are made by adding additional features to e-Chimp to allow for additional communications to occur through this workflow exchange process.

Changes to program requirements and/or direction occur through two media. The CMS communicates with the MACs through a Change Request (CR) or a Technical Direction Letter (TDL). This allows for COTRs and COs to have an increased level of control over the work a MAC performs and the cost incurred by that work. The sections below describe these two communications media in further detail.

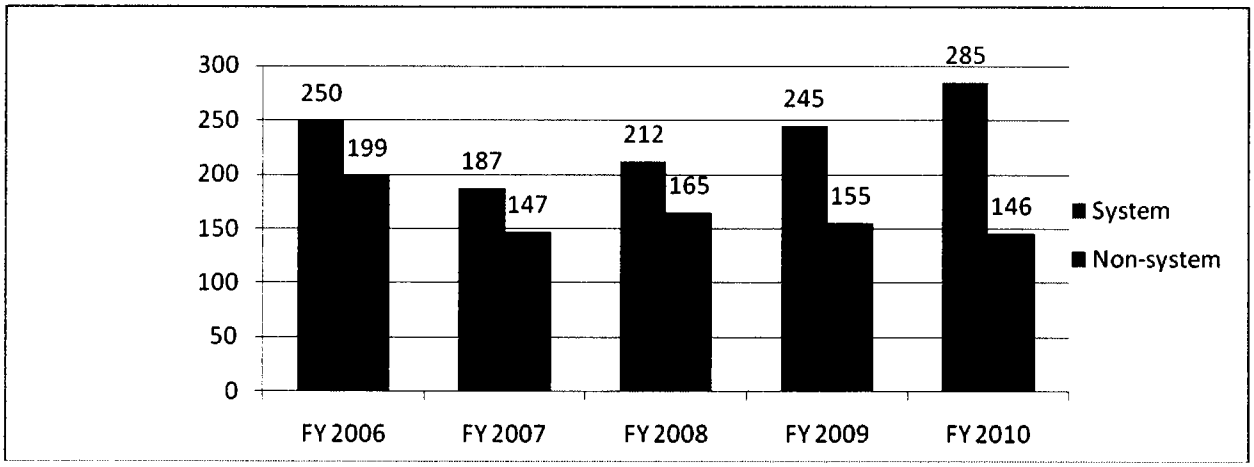
Change Requests

CRs are formal, written instructions to Medicare contractors to alter existing business processes or system functions. Several different events can create the need for CMS to issue a CR, including:

- New legislation issued by Congress;
- A change in regulations;
- Court orders in response to a legal action;
- Business or technical developments that offer improvements to the Medicare business and/or technical processes; and
- New policies and innovations sometimes developed with input from the MACs, which offer improvements, warrant a change in the current operating procedures, or upgrade IT systems.

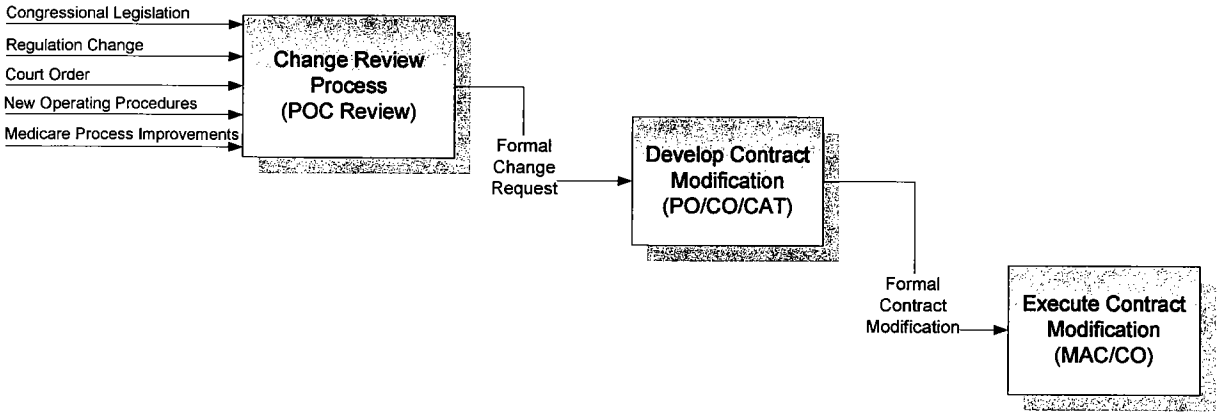
On average, CMS issues around 400 CRs each year that must be reviewed and approved by the MAC PMO. Table 4 details CRs issued for FYs 2006-2010.

Table 4: Change Requests Issued by Type



As part of the change management process, during the Point of Contact (POC) Review the MAC COTR analyzes draft CRs to see if the proposal falls within the existing scope and budget of any given MAC contract/SOW. If a draft CR is within the scope and budget of the MAC contracts (as most CRs are), then the CR will be implemented without a contract modification. If, however, a CR has proposed changes that are either outside the statement of work or the current budget does not provide for these changes, then a contract modification is required. At this point, the CO may follow-up with a formal Request for Quote or Cost Proposal to the MAC. This action could result in initiating changes to the SOW through a formal contract modification (see figure 3), or modifying or canceling the CR.

Figure 3: MAC Change Management Process (Outside Current Scope or Budget)



Further, POC Review gives MACs an opportunity to raise questions or comments before CMS finalizes CRs. The CMS responds to these comments and revises the CR as appropriate. The MACS are required to indicate if they believe the CR is in scope of the SOW, in scope of the SOW, but insufficiently funded, or out of scope. The COTRs review these responses and follow up with the MACs as needed.

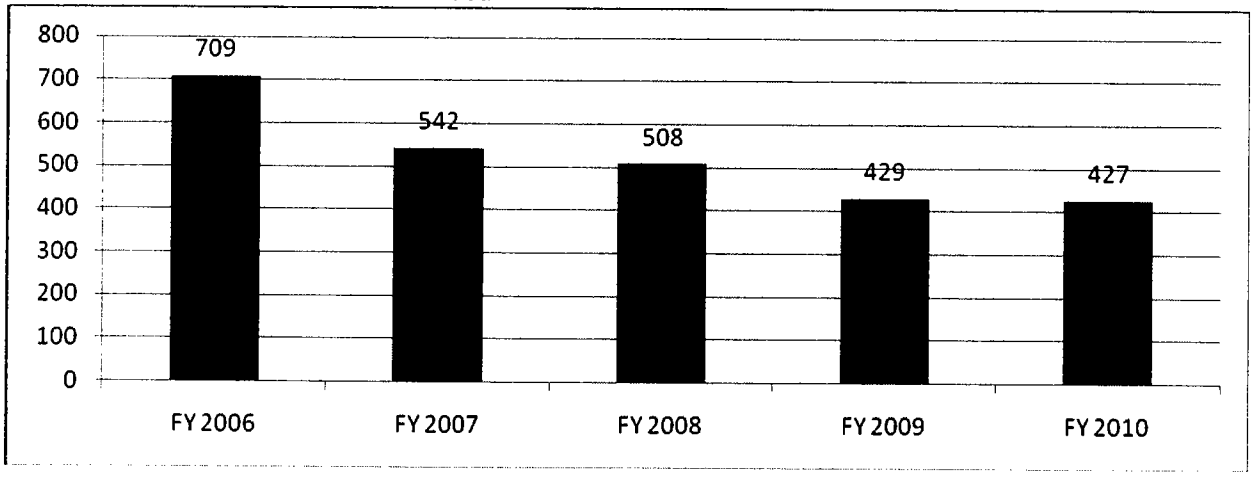
Technical Direction Letters

During the course of business operations, it may be necessary to provide technical direction (via a TDL) to MACs to:

- Clarify existing instructions;
- Make an administrative announcement and/or communicate an emergency alert;
- Make a one-time request for information that will not require shared system changes; or
- Provide clarification about an aspect of the SOW or contract.

Due to the complexity of the Medicare program, the initial request for technical direction may come from many areas of CMS, but it is the COTR who is responsible for reviewing the TDL to determine if it is within the scope of work of the SOW or if costs are affected. If the SOW is affected or costs are associated, the COTR will work directly with specialized staff within CMS to resolve any issues and to determine if a modification to the SOW or an increase in funding is necessary. If it is determined that the TDL is within the scope of the SOW and if costs are not affected, the MAC COTR approves the TDL for issuance. On average, CMS issues over 500 TDLs each year. The TDLs were created to meet the formal contracting requirements required for the MAC contracts. Prior to the MAC contracts, equivalent guidance was provided to the legacy FIs and carriers via joint signature memoranda. Table 5 details TDLs issued for FYs 2006-2010.

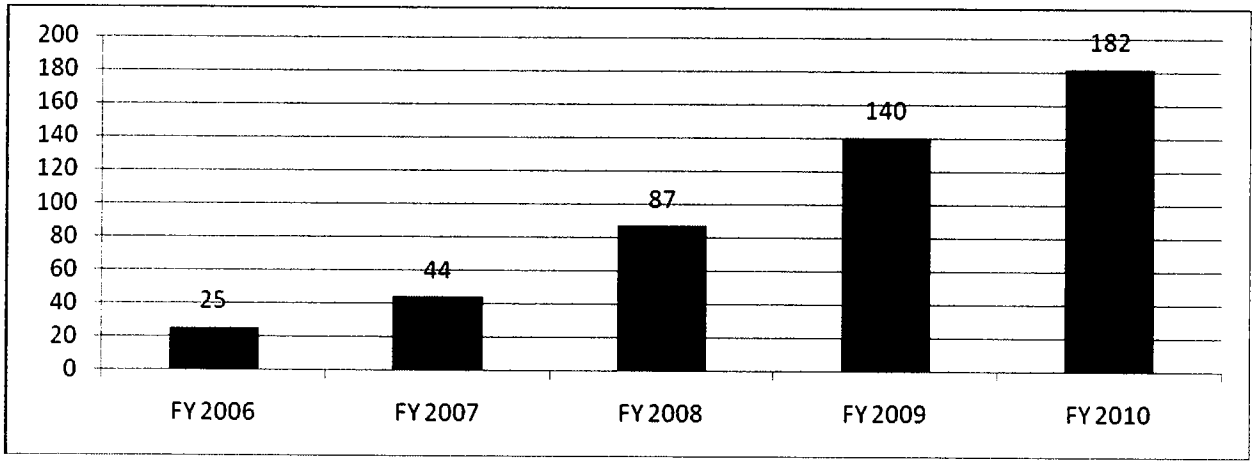
Table 5: Technical Direction Letters Issued



Contract Modifications

In addition to the numerous policies, procedures, and instructions that are communicated to the MACs via CRs and TDLs, the MACs must at all times perform their work in accordance with their contract with CMS. Those contracts are subject to contract modifications whenever the terms or conditions of the contract require a modification. Contract modifications may either be unilateral (usually to either issue change orders or to make administrative changes that do not affect the substantive rights of the MAC or CMS) or bilateral (for example, to make negotiated equitable adjustments resulting from the issuance of a change order). The first MAC contract was awarded in FY 2006 (January 2006), and contract modifications were required soon thereafter. Table 6 details the contract modifications issued for FYs 2006-2010.

Table 6: Contract Modifications Issued



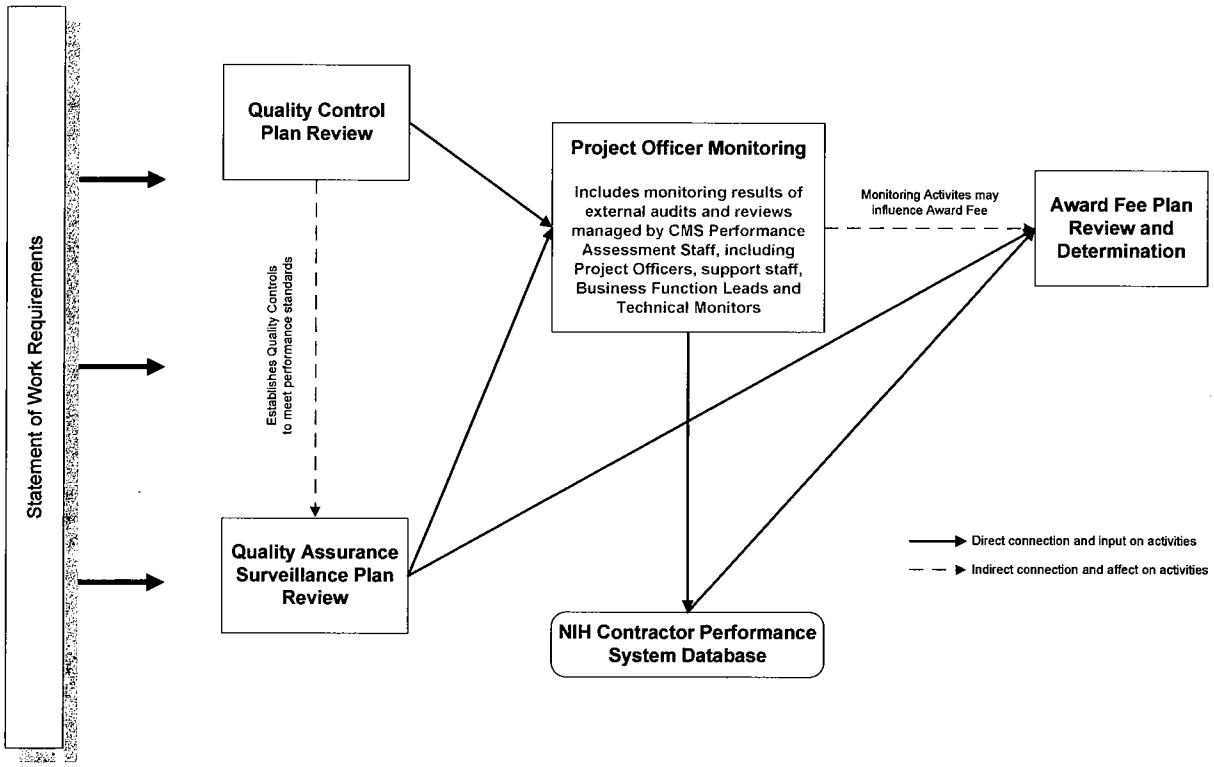
PERFORMANCE ASSESSMENT

A goal of Medicare contracting reform is to ensure high-quality services through the establishment of best-in-class contractors. MACs may be awarded monetary incentives for exceeding SOW requirements, and contract awards will be made, in part, on an assessment of a contractor's ability to deliver quality

services to CMS and providers. The award fee process is designed to motivate and reward Contractor excellence in the performance of contract requirements important to program success, while the Contractor meets at least minimum acceptable performance levels in all other areas.

The CMS has a performance assessment program in place to ensure proper incentive payments are made and to support procurement efforts. The COTRs on the MAC contracts, with support from designated agency staff, are responsible for overseeing contractor performance and for reporting on that performance in a publicly accessible database at the end of each contract year. The COTRs and other staff use a variety of data sources to evaluate and monitor contractor performance, which include various audit findings, compliance reviews, error rates, review of the MAC's monthly reporting, and QASP results. The MAC key performance standards are developed at the beginning of each contract year. The key performance metrics are then incorporated into the QASPs. As figure 4 shows, CMS uses a variety of data, such as the Quality Control Plan (QCP) Review and the QASP results, when developing their annual contract evaluation, which is documented in a Department of Health and Human Services repository of contractor performance (the NIH Contractor Performance System Database). The contractor evaluation and the QASP results then feed into the CMS award fee determination process. The sections below discuss the quality control plans, the QASP reviews, and award fee plans.

Figure 4: MAC Performance Assessment



Quality Control Plans

Each MAC is responsible for implementing quality control actions necessary to meet the requirements and standards set forth by the contract. The document that establishes the MAC's plan is called the QCP.

The QCP is a contract deliverable prepared by the MAC that describes how the contractor will manage its quality management system to assure its ability to meet contract requirements. QCP elements include, but are not limited to:

- Documenting procedures and processes for services to ensure that the contractor meets the contract performance requirements outlined in its SOW;
- Documenting the change management program to ensure that correct procedures and processes are followed;
- Providing and maintaining an inspection and audit system to ensure that services meet contract performance requirements;
- Providing a method of identifying nonconformance or deficiency in the quality of services performed;
- Providing a formal system to implement corrective action;
- Providing a file of all quality records relating to inspections and audits conducted by the MAC and the corrective action implemented; and
- Providing for Government inspections and audits while work is in process or complete.

The CMS conducts a QCP Review for each MAC to ensure that the MAC's operations comply with the quality control actions outlined in its plan.

Quality Assurance Surveillance Plans

The QASP is prepared in conjunction with the preparation of the SOW. The QASP reviews—conducted at MAC contractor sites or in CMS offices (via desk reviews) by CMS subject matter experts—measure MAC contractor performance against the SOW requirements. The reviews are to document if the MAC contractors meet the minimum requirements and include such business functions as:

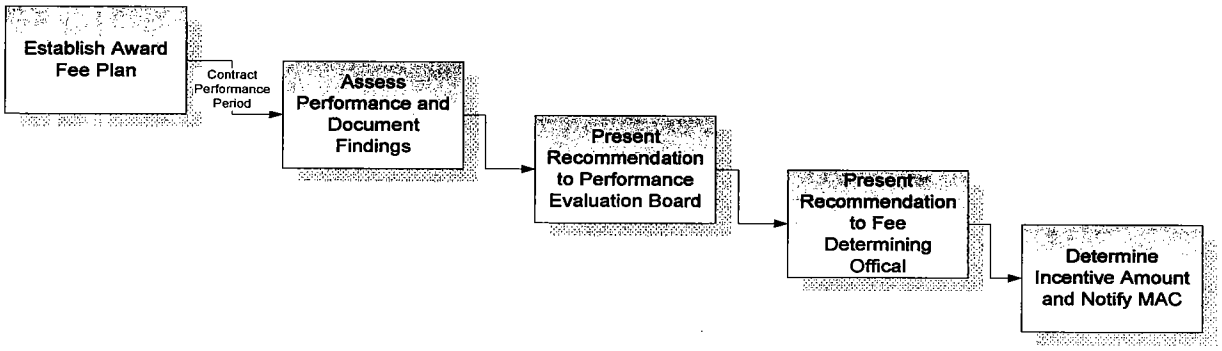
- Appeals
- Claims Processing
- Collecting Overpayments
- Medical Review
- Medicare Cost Report and Reimbursement
- Medicare Secondary Payments
- Provider Enrollment

When a MAC is found to have not met a SOW requirement as a result of a QASP review, CMS requires that an Action Plan be submitted to provide a detailed, defined process for improving the performance.

Award Fee Plans and Their Impact on MAC Work

The MAC contracts contain performance incentives, allowing contractors to earn incentive fees when they are more efficient, innovative, cost-effective, and deliver high-quality administrative services to beneficiaries and providers that exceed contract requirements. The CMS has contracted with MACs using a cost-plus-award-fee (CPAF) contract, which is a cost-reimbursement contract that provides a special fee incentive to the contractor. (The CMS is also continuing its efforts to explore firm-fixed-price and cost-plus-incentive-fee contracting vehicles). The contractor is reimbursed for all allowable costs incurred during contract performance. Additionally, the contractor is paid a fee, consisting of the minimum base amount fixed at award of the contract and an earned amount based on evaluated performance that exceeds the SOW requirements. At the beginning of each performance period (approximately every 12 months), CMS provides the MAC with an Award Fee Plan that establishes standards for an award fee determination. In general, the standards in the Award Fee Plan represent levels of performance that exceed the performance standards outlined in the MAC SOWs. Thus, while the QASP standards are used to ensure compliance with SOW requirements (that is, the minimum requirements under the contract), the standards in the Award Fee Plan are used to identify and award contract performance that exceeds SOW requirements. Figure 5 outlines our process for determining the amount of award fee that will be awarded to a MAC.

Figure 5: Award Fee Process



Chapter IV: FFS Projects and MAC Integration

This chapter provides an update on functional contractors that will work with the MACs in the management and delivery of services to beneficiaries and providers. It also describes the status of planned IT improvements to support the Medicare FFS environment.

STATUS OF FUNCTIONAL FFS CONTRACTORS

As planned, the MACs interact with a number of contractors that perform adjunct functions, some of which were previously carried out by legacy FIs and carriers. These contractors are:

- ***Beneficiary Contact Center (BCC).*** The BCC has assumed the beneficiary communication activities traditionally performed by FIs and carriers. To date, CMS has awarded one task order to perform contact center operations and serve as the single Medicare point-of-contact to beneficiaries.

- ***Coordination of Benefits Contractor (COBC).*** The CMS established a COBC who operates in conjunction with the MAC to support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. This information is used to coordinate the payment process to ensure the proper order of payment.

- ***Medicare Secondary Payer Recovery Contractor (MSPRC).*** The MSPRC is responsible for recovering mistaken primary payments made when a Group Health Plan is the primary payer. The MSPRC also recovers conditional payments associated with situations where liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan is the primary payer. (Medicare pays conditionally when a beneficiary's liability insurance, no-fault insurance, or workers' compensation claim is in dispute in order to ensure continuity of care for beneficiaries.) The MAC continues to accept unsolicited Medicare Secondary Payer (MSP) refunds from providers, physicians, and other suppliers and to recover provider, physician, or other supplier duplicate primary payments. The CMS consolidated all of the other functions and workloads related to MSP post-payment recoveries into one MSP recovery contract.

- ***Qualified Independent Contractors (QICs).*** The QICs are responsible for conducting the second level of appeals (reconsiderations of initial determinations and re-determinations of Medicare claims). The MAC is responsible for handling the first level of appeals. The CMS has reduced the number of QICs from 12 to four through the award of task orders under an Indefinite Delivery/Indefinite Quantity (IDIQ) contract.

- ***Recovery Audit Contractors (RACs).*** RACs are responsible for identifying improper Medicare payments (overpayments and underpayments) that may have been made to healthcare providers and that were not detected through existing program integrity efforts. To date, CMS has established four RACs to oversee four regions. The RACs are responsible for identifying improper payments for Medicare FFS claims. The RAC national program began in February 2009 and was implemented nationwide in October 2009.

- ***Zone Program Integrity Contractors (ZPICs).*** ZPICs, formerly referred to as Program Safeguard Contractors (PSCs), will only be responsible for benefit integrity work. This means that for some segment transitions, the MAC will be required to assume medical review functions that currently are being performed by a PSC. The CMS aligned the ZPIC jurisdictions to geographically match the MAC jurisdictions. The CMS is also consolidating the number of contractors performing benefit integrity from 15 to 7.

STATUS OF IT IMPROVEMENTS

The CMS continues to move towards its goal to integrate functions and processes to improve its services and to enhance the data that CMS uses to administer FFS Medicare. The status of these IT initiatives is discussed in the bullets below.

- ***CMS Analysis, Reporting, and Tracking System (CMS-ART).*** The CMS has adapted the web-enabled CMS-ART to allow the MACs to submit their final estimated cost proposals (business proposals) and monthly cost reports electronically to CMS. The CMS-ART supports CMS' efforts to monitor, review, and analyze actual costs incurred (monthly cost reports) versus projected costs and hours agreed to upon contract award (business proposal). The CMS plans to enhance the reporting capabilities of CMS-ART to allow MACs to submit their contract deliverables.

- ***Enterprise Data Centers (EDCs).*** To improve the IT platform supporting Medicare, CMS has consolidated the number of data centers. The CMS has awarded task orders and completed the data center transitions under the IDIQ contract to Hewlett Packard (formerly Electronic Data Services (EDS)) and Companion Data Services (CDS).

- ***Healthcare Integrated General Ledger Accounting System (HIGLAS).*** The HIGLAS is currently in the development and transition phase to consolidate the accounting systems maintained by CMS and Medicare FFS contractors. The CMS has completed transitions for 20 FFS contractors and has reached 86 percent compliance with the Federal Financial Management Improvement Act of 1996 (FFMIA)[5]. All HIGLAS transitions are scheduled to be completed during the fourth quarter of FY 2012.

- ***Medicare Claims Processing Front End Redesign.*** The CMS has consolidated the four separate front end claims processing systems for DME claims into one DME MAC Common Electronic Data Interchange (CEDI) System. The CEDI standardizes the front-end edits for DME claims transactions. Future endeavors explore the benefits of a common front end Electronic Data Interchange system for Part A and Part B claims processing.

[5] The FFMIA requires that Federal agencies implement and maintain financial management systems that comply with Federal management systems requirements.

MAC INTEGRATION WITH EDC AND HIGLAS

The CMS has identified a need to coordinate tasks with three key Medicare FFS initiatives to meet the implementation timeline for Medicare contracting reform: EDCs, MACs, and HIGLAS. The focus of these initiatives is to consolidate and standardize FFS operations to improve the quality of services provided to beneficiaries and providers and improve the overall management of Medicare contractors. In order to maximize Medicare Program efficiencies from these consolidation efforts, CMS has identified an optimal sequence for implementing EDCs, MACs, and HIGLAS. This sequence of events is shown in figure 6. Since EDCs are now government furnished property to the MACs, EDCs must be in place prior to a MAC implementation. Further, to support timely MAC implementations, HIGLAS workload transitions that have not already started will wait until that workload is transitioned to both the EDC and the MAC.

Figure 6: Sequence of FFS Workload Implementation

1. Move data processing workloads to EDCs from legacy Medicare contractors.
2. Completely implement the MAC jurisdictions.
3. Merge workloads into EDC processing regions.
4. Convert financial data and accounting reporting in HIGLAS.

Chapter V: Ongoing Risk Management

The CMS has successfully managed the procurement process and initially awarded all MAC contracts by January 2009, well ahead of the Secretary's schedule as required by section 911 of the MMA. The CMS procured the MAC contracts using three rounds of full and open competitions. The first round, or Start-up Cycle, procured four DME MAC contracts and one A/B MAC contract. The next two rounds of procurement each procured seven A/B MAC contracts. This phased-in approach required that CMS simultaneously evaluate proposals on multiple MAC jurisdictions (up to seven MAC jurisdictions in the same period of time).

In addition to the complexity of evaluating and awarding the MAC contracts, CMS faced a number of challenges that increased the risk of meeting its objectives. However, by using risk management techniques, such as project and schedule management, CMS mitigated many of the issues that had the potential for jeopardizing the progression of Medicare contracting reform. Common risk factors and how CMS dealt with them are discussed below in both the procurement phase and the implementation phase.

PROCUREMENT PHASE

Schedule Coordination

The program and contracting offices worked together in preparing an overall acquisition strategy and procurement schedule. The acquisition strategy contained details for awarding contracts and addressed key elements such as contract type, performance measures, and technical evaluation criteria. The procurement schedule contained the tasks, milestones, dates, and assignments for implementing the acquisition strategy. The offices met on a regular basis to discuss status, progression to the milestones, issues, and action items to keep the MAC procurements on schedule.

Protests

Protests are an inherent risk in any procurement. Due to the significant size of the MAC contracts, and despite all of the Agency's best efforts, protests were inevitable given the economic importance of the large MAC contracts to the Medicare contractors. Table 7 summarizes important dates relevant to the MAC protests and subsequent corrective actions.

Table 7: MAC Protests

DME Region C	• CMS received award protest on January 24, 2006. • GAO sustained protest. • CMS completed corrective action on September 29, 2006. • CMS received second award protest on October 6, 2006. • GAO dismissed protest. • CMS implemented MAC contract in FY 2007.

DME Region D	• CMS received award protest on January 24, 2006. • GAO dismissed protest. • CMS implemented MAC contract in FY 2006.
Jurisdiction 1	• CMS received award protest on November 14, 2007. • GAO dismissed protest. • CMS implemented MAC contract in FY 2008.
Jurisdiction 2	• CMS received award protest on May 27, 2008. • CMS initiated voluntary corrective action prior to GAO's decision. • CMS canceled procurement as part of A/B jurisdictional consolidation.
Jurisdiction 6	• CMS received award protests on January 26, 2009. • CMS initiated voluntary corrective action prior to GAO's decision. • CMS is performing corrective action.
Jurisdiction 7	• CMS received award protest on July 2, 2008. • GAO sustained protest. • CMS completed corrective action on July 10, 2009. • CMS received second award protest on July 20, 2009. • CMS initiated voluntary corrective action prior to GAO's decision. • CMS canceled procurement as part of A/B jurisdictional consolidation.
Jurisdiction 8	• CMS received award protest on January 26, 2009. • GAO sustained protest. • CMS is performing corrective action.
Jurisdiction 10	• CMS received competitive range protest on August 21, 2008. • GAO dismissed protest. • CMS implemented MAC contract in FY 2009.
Jurisdiction 11	• CMS received award protest on February 2, 2009. • CMS initiated voluntary corrective action prior to GAO's decision. • CMS completed corrective action on May 21, 2010. • CMS received second award protest on June 1, 2010. • GAO denied protest.
Jurisdiction 12	• CMS received award protest on November 5, 2007. • CMS initiated voluntary corrective action prior to GAO's decision. • CMS completed corrective action on March 5, 2008. • CMS implemented MAC contract in FY 2009.

Jurisdiction 15	• CMS received award protest on January 27, 2009. • GAO sustained protest. • CMS completed corrective action on July 8, 2010. • CMS received second award protest on July 23, 2010. • GAO denied protest.

IMPLEMENTATION PHASE

Schedule Delays

While a protest does delay the finalization of a contract award, its most significant impact is a resultant delay of the MAC implementation. Protests can also have a cascading effect on CMS' ability to implement other MAC jurisdictions as well as other initiatives (including the EDC and HIGLAS schedules). Further delays to MAC implementations occur in the event that the GAO sustains the protest or in the event that CMS takes voluntary corrective action.

The MMA chartered the implementation of many Medicare contracting reform projects, which were also mandated to be in place by the same year, 2011, as the MACs. This simultaneous procurement and implementation of these projects increased the risk level and complexity of the MAC implementation schedule for several reasons:

- The project schedules were highly complex and interdependent.
- The project schedules relied on the same resources for implementation at the same time.
- The project schedules included critical tasks that were assigned to multiple CMS components.
- If one schedule was delayed then there was a high probability that this would cause a delay in one or more other schedules.

The overall risk management approach was to form a fully-sponsored team, comprised of the FFS project leads and/or business owners from each of the projects and sub-workgroups. The purpose is to establish a structured communication forum. The Project Integration Team produced initial integration snapshots that continue to support planning and decision making surrounding MAC implementation. However, all of these projects are expected to progress and change at different rates, and integration work must be continuous through the life cycle of the group of projects.

The Team provides regular status briefings to management covering project overlaps, risks associated with overlaps, and steps to be taken to mitigate those risks.

Appendix A: Current Contractor Lists

Table 8A: Start-Up Cycle Contractors (DME MACs)

Jurisdiction	States	Percent of National DME Workload	MAC	Award Date	Total Contract Value (5 Years)
DME JA	ME, NH, VT, MA, RI, CT, NY, PA, NJ, MD, DE, DC	17.9	National Heritage Insurance Company (NHIC)	1/6/2006	$59 million
DME JB	OH, KY, MI, IN, IL, WI, MN	20.6	National Government Services, Inc. (NGS)	1/6/2006	$90 million
DME JC	WV, VA, NC, SC, GA, FL, PR, TN, AL, MS, AR, LA, OK, TX, CO, NM	41.6	Cigna Government Services, LLC (CGS)	9/30/2006	$144 million
DME JD	IA, MO, ND, SD, NE, KS, MT, WY, ID, UT, AZ, WA, AK, OR, CA, NV, HI	19.9	Noridian Administrative Services, LLC (NAS)	1/6/2006	$249 million

Table 8B: Start-Up Cycle Contractors (A/B MACs)

Jurisdiction	States	Percent of National A/B Workload	MAC	Award Date	Total Contract Value (5 Years)
A/B J3	AZ, MT, ND, SD, UT, WY	3.0	NAS	7/31/2006	$150 million

Table 9: Cycle One Contractors (A/B MACs)

Jurisdiction	States	Percent of National A/B Workload	MAC	Award Date	Total Contract Value (5 Years)
A/B J1	CA, HI, NV	8.8	Palmetto GBA	10/25/2007	$358 million
A/B J4	CO, NM, OK, TX	9.7	TrailBlazer Health Enterprises, LLC	8/6/2007	$377 million

			(TrailBlazer)		
A/B J5	IA, KS, MO, NE	4.5	Wisconsin Physicians Service Insurance Corporation (WPS)	9/10/2007	$225 million
A/B J12	DC, DE, MD, NJ, PA	10.8	Highmark Medicare Services, Inc. (HMS)	10/24/2007	$466 million
A/B J13	CT, NY	8.2	NGS	3/18/2008	$323 million

Table 10: Cycle One Contractors (Legacy FIs and Carriers)

Jurisdiction	States	Percent of National A/B Workload	Current Contractors	Projected Award Date
A/B J2	AK, ID, OR, WA	3.0	• CGS • WPS • NAS	August 2011
A/B J7	AR, LA, MS	3.4	• Cahaba Government Benefit Administrators, LLC (Cahaba) • Pinnacle Business Solutions, Inc. • WPS	July 2011

Table 11: Cycle Two Contractors (A/B MACs)

Jurisdiction	States	Percent of National A/B Workload	MAC	Award Date	Total Contract Value (5 Years)
A/B J9	FL, PR, VI	8.2	First Coast Service Options, Inc. (FCSO)	9/12/2008	$368 million
A/B J10	AL, GA, TN	7.2	Cahaba	1/7/2009	$335 million
A/B J11	NC, SC, VA, WV *RHHI States:* AL, AR, FL, GA, IL, IN, KY, LA, MS, NC, NM, OH, OK, SC, TN, TX	9.8	Palmetto GBA	5/21/2010	$304 million
A/B J14	MA, ME, NH, RI, VT *RHHI States:* CT, MA, ME, NH, RI, VT	4.1	NHIC	11/19/2008	$176 million
A/B J15	KY, OH *RHHI States:* CO, DE, DC, IA, KS, MD, MO, MT, ND, NE, PA, SD, UT, VA, WV, WY	5.6	CGS	7/8/2010	$243 million

Table 12: Cycle Two Contractors (Legacy FIs and Carriers)

Jurisdiction	States	Percent of National A/B Workload	Current Contractors	Projected Award Date
A/B J6	IL, MN, WI *RHHI States:* AK, AZ, CA, GU, HI, ID, MI, MN, MP, NV, NJ, NY, OR, PR, VI, WA, WI	7.9	• NGS • NAS • WPS	May 2011
A/B J8	IN, MI	5.8	• NGS • WPS	May 2011

Appendix B: MAC Jurisdictions

Figure 7: A/B MAC Jurisdictions

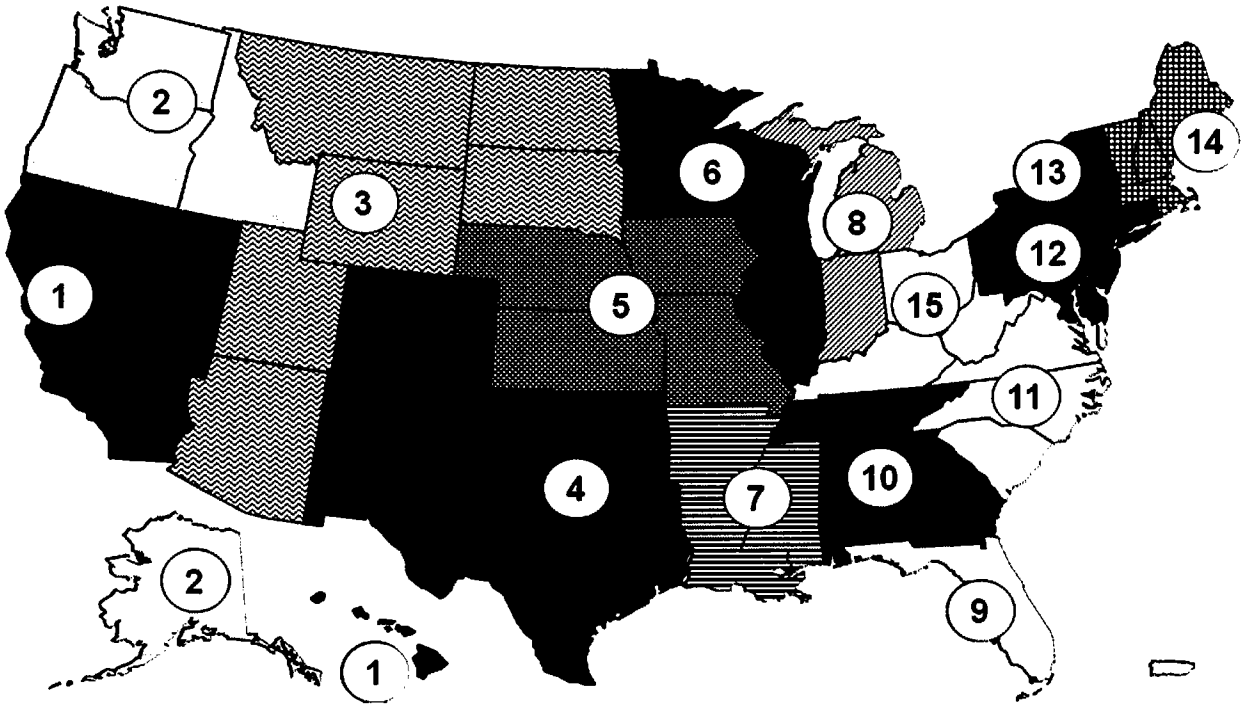
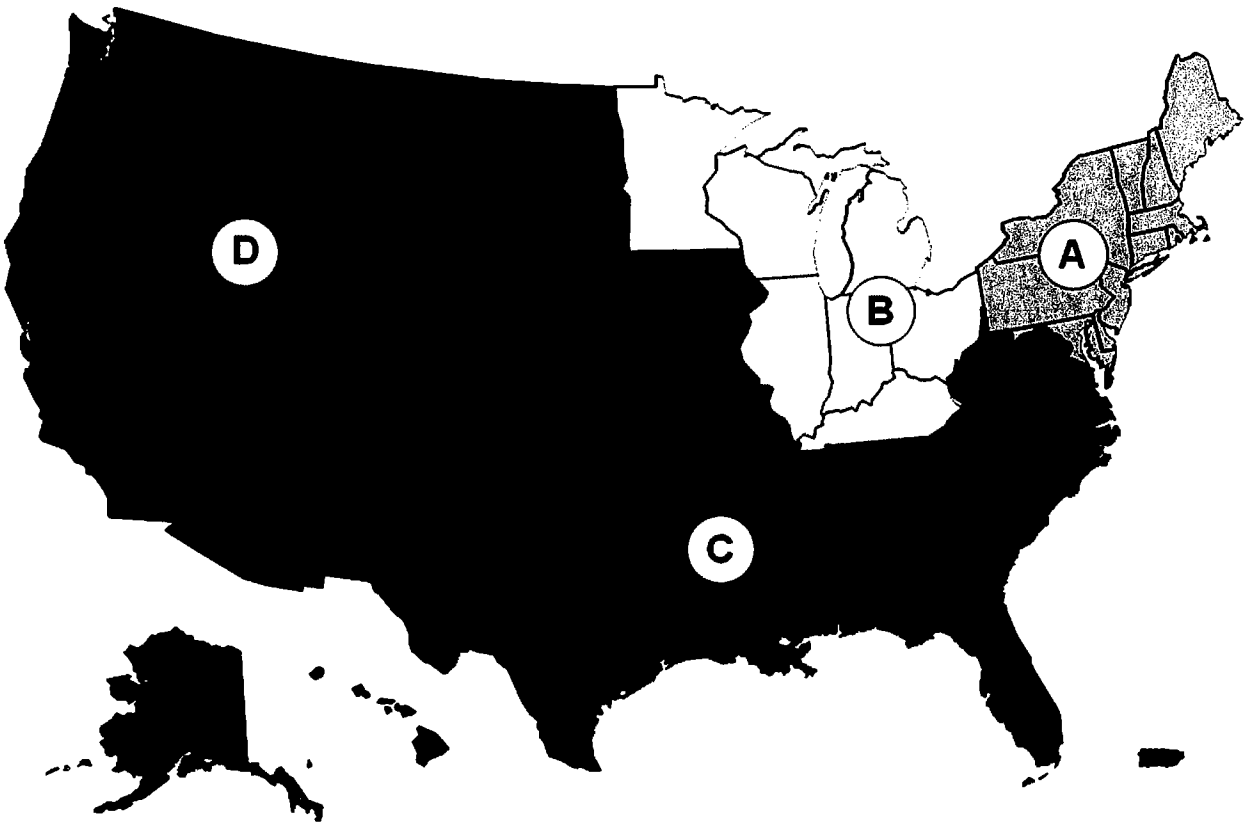


Figure 8: DME MAC Jurisdictions



Appendix C: Definitions

Beneficiary	A person who has health insurance through the Medicare program.
Beneficiary Contact Center (BCC)	A customer service center handling telephone and written inquiries from Medicare beneficiaries and their authorized representatives.
Blue Cross and Blue Shield Association (BCBSA)	An association that represents the common interests of the independent, locally operated Blue Cross and Blue Shield plans.
Carrier	A private company that has a contract with CMS to pay Medicare Part B claims.
Centers for Medicare & Medicaid Services (CMS)	The HHS agency responsible for administering the Medicare and Medicaid programs.
Common Working File (CWF)	A data file used by fiscal intermediaries, carriers, and MACs to check beneficiary eligibility.
Compliance Program	Internal program designed to ensure adherence to laws, regulations, and business policies.
Consolidation	The realignment of workloads to increase the size and responsibility of administrative contracts and reduce the number of entities CMS must oversee.
Contracting Officer	A person with the authority to enter into, administer, and/or terminate contracts and make related determinations and findings.
Contracting Officer's Technical Representative	A person who serves as the technical representative of the MAC CO and provides technical direction to the MAC as necessary for all of the business functions contained in the MAC SOW. Also called a Project Officer.
Contracting Reform	1. Section 911 of the MMA. 2. The initiative pursued by CMS to revise Medicare contracting strategy to improve claims administrative and benefit management services for the Medicare FFS program.
Coordination of Benefits Contractor (COBC)	A private company that contracts with CMS to determine the proper order of payment (that is, whether some other plan or insurance policy will pay first, before Medicare) and to perform other coordination of benefit activities such as facilitating secondary payments by other insurers, where appropriate.
Durable Medical Equipment (DME)	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home. DME is paid for under Medicare Part B.
Federal Acquisition Regulation (FAR)	Government standards by which federal procurement and contracting actions must be performed.
Fiscal Intermediary (FI) (also referred to as an **Intermediary**)	A private company that has a contract with CMS to pay Part A bills and some Part B claims.

Fiscal Year (FY)	The period that runs from October 1st through September 30th of the following year. The government follows a budget that is planned for a fiscal year.
Healthcare Integrated General Ledger Accounting System (HIGLAS)	Financial management system that tracks payment of Medicare claims.
Home Health & Hospice (HH+H)	Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.
Incentives	Opportunity under a contract to earn additional money by meeting particular requirements or exceeding performance requirements.
Medicare Administrative Contractor (MAC)	A private entity that Medicare will contract with under Section 1874A of the Social Security Act, as added by the MMA, for Medicare claims processing and related services under the MMA.
Medicare Contractor	A Medicare Part A FI, a Medicare Part B Carrier, a Regional Home Health Intermediary (RHHI), a Medicare Durable Medical Equipment Regional Carrier (DMERC), an A/B MAC, or a DME MAC.
Medicare Fee-For-Service (FFS) – (also known as the **Original Medicare Plan**)	A pay-per-visit health plan that pays for services provided to beneficiaries by any doctor, hospital, or other health care provider who accepts Medicare payment. Medicare FFS has two parts: Part A (hospital insurance) and Part B (medical insurance).
Medicare Integrity Program (MIP)	The program established by Congress through the Health Insurance Portability and Accountability Act of 1996 to fight fraud and abuse in the Medicare program.
Non-Shared-System Change Request	Any change request that does NOT affect any of the Shared-system Maintainers (for more information about Shared-systems, see Shared-system Change Requests).
Part A – (also referred to as **Medicare Hospital Insurance**, or **HI**)	The hospital insurance portion of Medicare. It was established by Section 1816 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health care services, and hospice care.
Part B– (also referred to as **Medicare Supplementary Medical Insurance**, or **SMI**)	The supplementary or "physicians" insurance portion of Medicare. It was established by Section 1842 of the Title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.
Physician	An individual licensed under state law to practice medicine or osteopathy.

Provider	1. Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare. 2. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.
Regional Home Health Intermediary (RHHI)	A private company that contracts with Medicare to pay home health and hospice bills and check on the quality of home health care.
Secretary	The Secretary of the Department of Health and Human Services.
Shared-System Change Requests	CMS classifies a change request (CR) as a shared-system CR if its instructions affect one or more of the shared-system maintainers: • FISS: Fiscal Intermediary Shared System • MCS: Multi-Carrier System • VMS: ViPS Medicare System • CWF: Common Working File By contract, CMS must give the shared-system maintainers five months to implement any instructions included in a CR. During each fiscal quarter, CMS collects the shared-system CRs into a quarterly release; CMS then issues all CRs included in the release five months prior to the start of the fiscal quarter.
Supplier	Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.
Transition	An activity whereby CMS moves work from one administrative contractor to another and the incoming contractor officially takes over work functions.
Workload	The total work performed by a Medicare claims processing contractor, usually expressed as the number of claims processed on a yearly basis.
Zone Program Integrity Contractors (ZPICs)	An entity that CMS contracts with to perform program integrity functions for Medicare Parts A-D, DME, home health, hospice and the coordination of Medicare-Medicaid data matches (Medi-Medi program).