PROCESSING OF FEE-FOR-SERVICE CLAIMS FOR PART A AND PART B

CONCEPT OF OPERATIONS

AUGUST 2007

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Introduction

From Medicare's start, the federal government has used private insurance companies to process claims and perform related administrative services for the program's beneficiaries and health care providers. Today, the Centers for Medicare and Medicaid Services (CMS) relies on a network of contractors to process nearly 1 billion Medicare claims each year from more than 1 million health care providers. In addition to processing claims, the contractors, in conjunction with other entities, enroll health care providers in the Medicare program and educate them on Medicare billing requirements, handle claims appeals, answer beneficiary and provider inquiries, and detect and prevent fraud and abuse.

In July 2006, CMS began implementing its plan to modernize fee-for-service (FFS) claims processing. The vision that drives FFS modernization is one of creating a premier health plan that includes comprehensive quality care and first-class service. To realize that vision, CMS plans to establish 15 Medicare administrative contractor (MAC) jurisdictions and to award a contract to a single contractor in each jurisdiction to take responsibility for processing both Part A and Part B claims. CMS plans also include the establishment of 4 MACs to process claims for durable medical equipment and 4 MACs to process home health and hospice (HH) claims. As of August 2007, CMS has awarded 2 contracts for Part A/B claims processing in Jurisdictions 3 and 4 and the 4 DME MAC contracts. Appendix A describes the jurisdictions and the transition schedule, and Appendix B defines key terms related to FFS claims processing.

This Concept of Operations (ConOps) provides a high-level description of the business functions in the new FFS environment and of the agency's plans for performing them.

MODERNIZING MEDICARE ADMINISTRATION

Until July 2006, CMS contractors included 25 fiscal intermediaries (FIs) to process FFS claims for institutional providers under Parts A and B of the Medicare program, including hospitals and skilled nursing facilities, and 18 carriers to process FFS claims for professional providers under Part B of the Medicare program, in particular, physician, laboratory, and other services. Another 4 FIs served as regional home health intermediaries (RHHIs), concentrating exclusively on HH claims, and 4 carriers served as durable medical equipment regional carriers (DMERCs), focusing exclusively on claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

As successful as Medicare has been, the program's use of contractors to pay FFS claims—the backbone of its current administrative structure—has not kept pace with decades of dramatic improvements in health care. Medicare's business processes and, in some cases, technologies have not kept pace with the country's evolving health care delivery system and are currently not fully prepared to handle the greater challenges that lie ahead, such as the oncoming retirement of the "baby boom" generation.

Taking advantage of the opportunity to create a Medicare administrative structure that is capable of meeting current and future health care delivery challenges, Congress passed a major reform of Medicare's contracting provisions in 2003.[1] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is designed to achieve better medical management and more efficient processing by improving Medicare's administrative services to beneficiaries and health care providers. Both Congress and CMS have established goals that should be met as a result of the MMA's implementation.

Legislative Direction

With the passage of the MMA, Congress directed CMS to expand competition beyond traditional health insurers for Medicare's claims-payment business for the first time in the program's 39-year history. Many of Congress's goals for the extensive overhaul of Medicare's administrative structure, which are contained in Sections 911 and 912 of the MMA, do the following:

- Permit CMS to contract for Medicare functions in a more open marketplace using the Federal Acquisition Regulation (FAR) rather than provisions of Title XVIII
- Remove all constraints, except those that apply to all agencies, on CMS's ability to negotiate incentives for Medicare FFS contractor functions
- Ensure that FFS contractors can be held accountable for inappropriate fiduciary conduct
- Eliminate the process that allows providers to choose their FI
- Ensure that contractors implement an information security program with the same requirements as other federal agencies.

CMS refers to this part of the MMA, and its implementation, as Medicare contracting reform. Many of the needed FFS contracting reform elements build on existing operational trends and policy positions, while other elements represent a

[1] The major reform of Medicare contracting provisions is contained in Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), signed into law by President George W. Bush in December 2003.

significant departure from past practice. The transition of claims processing operations to the MACs must be completed by October 2011.

CMS Goals

CMS's Medicare Contractor Management Group (MCMG) is responsible for both the management of the current FFS contractors and the acquisition, implementation, and management of the MACs. MCMG is furthering CMS goals for modernizing Medicare's administrative structure by ensuring that the MAC contracts focus on three critical areas:

- *Customer service.* MACs serve as the providers' primary contact with Medicare, and CMS holds MACs accountable for overall provider satisfaction with their services and for improving the providers' ability to submit correct claims.

- *Financial management.* MACs promote the fiscal integrity of Medicare and are accountable stewards of public funds. They pay claims in a timely, accurate, and reliable manner while promoting cost efficiency and the delivery of maximum value to the customer.

- *Operational excellence.* MACs maintain a level of operational excellence, effectively manage the use of employees and information systems, and accomplish program goals. In addition, CMS encourages MACs to foster efficiencies in the administration of Medicare to provide the best value to the government.

Although the ultimate customer of Medicare is the beneficiary, the prime customer for the MAC is the provider. By improving their services to providers, MACs improve efficiency, improve customer satisfaction, and improve the provider's interactions with original FFS Medicare.

KEY ASSUMPTIONS

Given the legislative mandates and the CMS goals, the agency has made the following major assumptions about the implementation and operation of the MACs:

- *Competition.* CMS will fully and openly compete contracts for services related to claims payment.

- *Beneficiary-centered contracting.* Contracting services for Parts A and B will be consolidated to provide beneficiaries and providers with unified Medicare points of contact; create a modernized administrative information technology (IT) platform that will result in more unified, higher-quality care for beneficiaries; and improve beneficiary and provider access to information through consolidated, standardized administrative services.

- *Contract performance incentives.* Contracts will pay performance incentives, allowing contractors to earn profits when they are more efficient, innovative, and cost-effective and to deliver better administrative services to beneficiaries and providers.

- *Improved contractor management.* Using Medicare's new contracting authority, CMS will compete contracts among a broader range of private-sector organizations, allowing for increased competition and cost efficiencies and strengthening its ability to manage contractors based on performance.

PURPOSE OF CONOPS

The ConOps includes both the business functions to be performed by the MACs and those performed by other contractors. Because the MACs perform the bulk of the FFS work, the ConOps often refers to them specifically in the text. The context of the discussion makes it clear which contractor is being referred to. The ConOps also serves as the organizing description for the more detailed enterprise architecture (EA) view of the FFS business.[2]

The ConOps focuses on the Medicare Parts A and B environment after the MAC contracts are awarded; it is not intended to represent the current environment of the FIs and carriers. The purpose of this document is to provide potential MACs some key information necessary for developing proposals that effectively address CMS requirements. The ConOps is organized as follows:

- Chapter 2 describes the functional or business view of the FFS environment without regard to how functions are performed.

- Chapter 3 identifies the entities performing the business functions and their key roles in the FFS environment. It also discusses some of the interactions among those entities.

- Chapter 4 describes the major computer applications and technology supporting the FFS processes, in addition to several future technology initiatives.

- Chapter 5 address the management of the FFS process.

The appendixes provide additional detail.

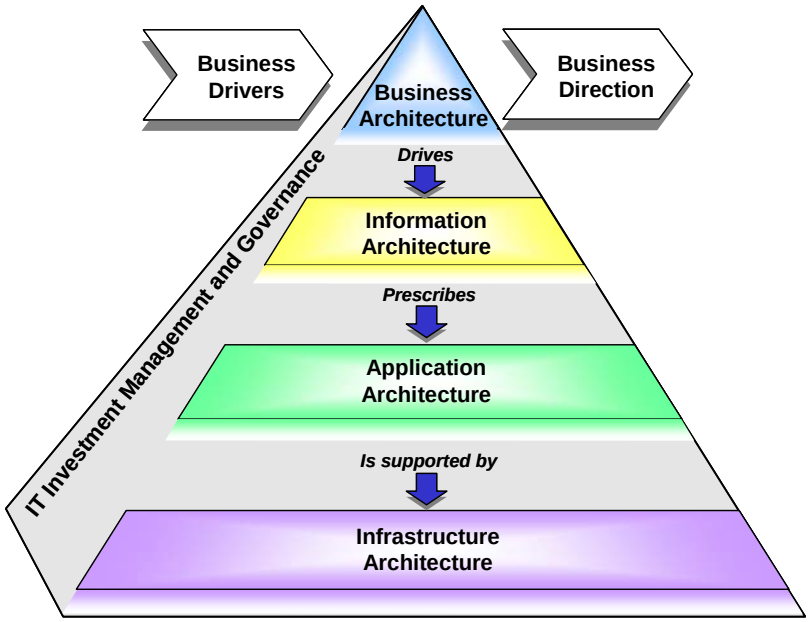
[2] CMS, *Processing Claims for Part A and B: Enterprise Architecture*, September 2005.

The companion EA document focuses on the current functional and technical environment for processing FFS claims. The EA consists of four domains, which are referenced in the ConOps:

- The *business architecture* represents the functions and processes that support the business, the organizations that perform the business, and the locations where the business is performed.
- The *information architecture* identifies the major types of information needed to support the business functions. It identifies and defines the information model, data sets, and metadata repositories, and their relationships to the business functions and the application systems.
- The *application architecture* identifies and describes applications and modules, as well as their relationships to business processes and other applications systems and modules.
- The *infrastructure architecture* identifies and describes the hardware, software, and communications network technologies required to manage business applications in the MAC environment.

The business architecture represents the claims processing functions—the functional environment. The information, application, and infrastructure architectures represent the technical environment in which the processing occurs. Figure 1-1 depicts the domains and their interrelationships.

Figure 1-1. Interrelationship of Architecture Domains in the MAC Environment



The conceptual framework has various components that fit into the interrelated architectural layers, and security is integrated throughout the conceptual framework.[3]

[3] Security has many owners and many facets, ranging from the contents of personnel policies and hiring practices to internal controls of functions such as the approval process, to data access and update rights, to firewalls and encryption.

Chapter 2
Major Business Functions

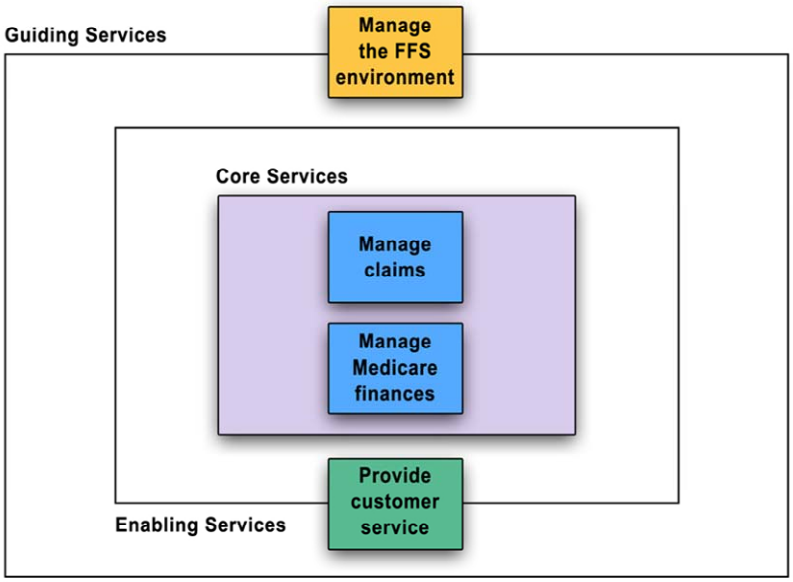
FFS claims processing is a complex business, fulfilling a variety of laws and regulations and serving the needs of providers, beneficiaries, and all stakeholders that have an interest in Medicare. In addition to management of standard Medicare claims, the FFS environment includes demonstration projects and specialty activities, Medicare Advantage, and integration of Part A and Part B functions. This chapter reviews these major business aspects of the FFS environment.

FFS CLAIMS MANAGEMENT

Medicare business functions can be defined and grouped in many different ways. Our approach is to divide the work into four major categories (see Figure 2-1):

- Manage claims
- Manage Medicare finances, including payments
- Provide customer service to providers (and beneficiaries), which enables the processes to meet customer expectations
- Manage the FFS environment, which guides the way the processes are carried out.

Figure 2-1. High-Level View of FFS Processing



As the figure shows, the first two categories are the two core services for FFS processing. In this alignment, the first and last categories—"manage claims" and "manage the FFS environment"—address the CMS goal for Medicare FFS administration of operational excellence. The "manage Medicare finances" category fulfills the financial management goal, and the "provide customer service" category supports the CMS goal of customer service.

The following sections discuss the business functions in the first three areas. Because the fourth area, managing the environment, is highly dependent on the network of contractors used in FFS processing and on the technology employed, the discussion of that area of work is contained in the final chapter of the ConOps.

Manage Claims

The "manage claims" business function consists of the environmental business processes and business rules that are needed to complete an individual claim; the receipt, edit, and adjudication of claims; and the analysis and reporting associated with claims files created during these processes.

CLAIMS ENVIRONMENT

Managing the submission and adjudication of claims requires a foundation to define the business rules and work procedures for the processing, followed by the ongoing processing of the individual claims. Figure 2-2 illustrates the major components.

Figure 2-2. Functional Processes for "Manage Claims"

The business rules in the foundation include a wide range of items, including the following:

- Defining the edits to be used to validate claims
- Establishing the workflow that is best-suited to a MAC's environment
- Determining local medical policies
- Establishing prepay processing rules
- Integrating the definitions and restrictions associated with demonstration projects or specialty claims processing.

Many of the business rules are established by CMS on a national basis and are expressed in shared claims processing systems to be used by each of the MACs. Other rules are established by the MACs to adapt to local needs of providers, to make the Medicare processing more consistent with other corporate processes, or to add business efficiencies that are related to the MAC's specific environment, such as those that take advantage of the MAC's technical capabilities.

CLAIMS PROCESSING

The heart of the MACs work is the processing of claims. Although much of the work is automated in the shared systems or MAC systems, the MACs have wide latitude outside the systems in how they plan, staff, equip, and carry out the business functions. The high-level steps that lead to a fully adjudicated claim are as follows:

- *Receive and accept electronic and paper claims*. Providers are responsible under Medicare for submitting claims on behalf of beneficiaries. The claims are to be in standard Health Insurance Portability and Accountability Act (HIPAA) formats if they are submitted electronically from providers or from clearinghouses. Part A providers can currently enter their claims directly into the shared systems, which does not involve the HIPAA processing formats. CMS would like to introduce the use of portal technology for claims submission and for communications back to providers. In the receipt of claims business process, preliminary edits are performed and the claims are either returned to the provider or accepted into the system.
- *Perform internal claims edits*. In the next phase of processing, the claim is validated for the proper coding of fields or for missing claims information that is needed for processing.

- *Perform claims validation edits*. In this phase, the claim is checked against historical data or external files for valid information. The edits include areas such as utilization, eligibility, or detection of duplicate claims.

- *Complete claims development and adjudication.* MACs process suspended claims or seek missing claim information.

- *Issue final approval.* The formal determination of whether to pay the claim is determined by the Common Working File (CWF) application.

Completion of the adjudicated claims ends the claims processing business function in our model. Payment and other financial processing steps are described in the "Manage Medicare Finances" section below.

Reporting and Analysis

Claims data are stored at various points throughout the claims process and can be used by the MACs and other functional contractors for error analysis, reporting, management activities, and specialized processes. Claim files can show data as they existed when they entered the system, after adjudication is complete, or as part of historical financial files. CMS mandates certain reports, while others are used by the MACs to improve the efficiency of the business processes or to provide information to external stakeholders. Finally, standard reports help ensure that MACs provide desired outcomes required under performance-based contracting.

Manage Medicare Finances

The "manage Medicare finances" business function includes the payment and management of the expenditures for claims, benefit integrity functions, and, Medicare secondary payer (MSP) processing.

Claims Expenditures

The MACs create, maintain, and track payments for the services provided under Medicare, which today is more than 1.2 billion clams each year. (CMS is deploying a new system for financial management, the Healthcare Integrated General Ledger Accounting System, or HIGLAS, to be used by the contractors; HIGLAS is discussed in Chapter 4.) The MACs also collect payments owed to CMS, maintain information on providers and other payees, and manage all financial transactions associated with claims. Managing the expenditures is usually divided into managing payables, managing receivables, and financial reconciliation.

Health care providers (and beneficiaries) submit claims to the MACs, which then conduct claims review and disburse appropriate payments for valid claims, as defined by Medicare rules and regulations. The MACs have business processes in place to account for and manage these payments and to provide the appropriate

control over the payments that they make. The payables management function has four business processes: maintain payees, establish payables, generate payments, and process period end.

The receivables process is established to collect payments owed to the Medicare program. The payments include delinquent debt interest assessment, offsets, adjustments, and write-offs. In many instances, when the providers find an error, they remit payment to the contractor on their own accord. In other instances, the contractor must use offsets to new payments or direct recovery of funds from the provider. The MACs have processes and systems in place to account for and manage both instances of accounts receivable. Receivables management has five processes: maintain customers, establish receivables, process collections, manage receivables, and process the associated general ledger activity.

The MAC must also reconcile benefit payments. This function comprises reconciling the bank-cleared check payments, the bank-settled electronic funds transfer (EFT) payments, and zero-dollar payments (checks and EFTs) as well as creating and reconciling miscellaneous transactions.

PROGRAM INTEGRITY

Program integrity functions protect the public from potential fraud, waste, and abuse by providers or beneficiaries, and they assure CMS, through various audits and oversight, that finances are handled appropriately, according to all of the laws and regulations that govern Medicare disbursements. Potential fraud, waste, and abuse is detected through data analysis, medical review, cost report audits, and a variety of other leads and sources.

The MAC performs both internal and external activities in support of program integrity. The MAC monitors the integrity of monetary transactions inside the shared system and HIGLAS. The MAC also monitors or audits errors that occur during batch and online processing of transactions, reviewing and validating the audit trails that are produced by the systems. In general, the MAC must ensure that its processes, procedures, and results can be certified as accurate by its Chief Financial Officer (CFO).

The MAC also performs external audits, such as those for provider cost reports, as part of the support of program integrity and financial management. These audits encompass both desk and field audits of providers. The MAC also cooperates with the audits of its own performance that are described in Chapter 5, Managing the New Environment.

MEDICARE SECONDARY PAYER

“Medicare secondary payer” is the term that CMS uses to describe the situation in which Medicare is not responsible for paying first on a claim. The term “coordi-

nation of benefits" is also used to describe this situation, in which two or more payers are responsible for a percentage of a claim.

Eligibility flags are set in a beneficiary's records to indicate that MSP applies. Claims are then routed and processed, with partial payment issued by the MAC and the remainder by the beneficiary's insurance. MACs often pay conditionally in this type of situation and then have to recover the overpayment.

Provide Customer Service

Customer service, a key goal of CMS for the MAC implementation, is a business function that applies to providers, beneficiaries, and other stakeholders. Because service plays a key role in customer satisfaction with CMS and the MACs, the appeals process is also considered a part of customer service.

By viewing customer service as a single business function, CMS and the MACs can better organize and manage services to the providers, particularly for education and outreach services. Regardless of improvements in the efficiency and effectiveness of FFS business processes, improvements in the providers' ability to submit correct claims is at the core of the benefits that CMS will achieve with the MAC consolidation.

Management and Enrollment of Providers

The major business functions associated with providers are enrolling and updating provider information, offering education to providers in general on Medicare program issues, providing education to individual providers on specific issues, and handling provider inquiries.

The provider enrollment function is not limited to establishing the provider as an approved offeror of Medicare services, but includes connecting to front-end processing systems, connecting the claims payment to the right financial institutions, and identifying the appropriate specialties for which the provider is eligible to submit claims. In addition, with the implementation of the new CMS PECOSWEB, providers will be able to submit enrollment information through the web, expediting enrollment. MACs rely on states and CMS to determine the eligibility of institutional providers.

The MACs are also responsible for ensuring that Medicare rules and processing requirements are known and understood by the range of providers for whom they process claims. This provider education can include outreach beyond enrolled providers to state medical societies, specialty groups, or institutions. Another responsibility is to provide individual assistance to providers who submit claims in error or who need specific assistance. Contractors identify these situations through analysis of errors in the submission and processing of claims.

When demonstration projects or new specialty processing is initiated, the MAC needs to ensure that the providers are properly identified, if necessary, for that type of claim and that they understand all the processes and procedures that are needed to comply with Medicare requirements of those processes.

Finally, the MAC must handle a large volume of written and phone inquiries from providers. The subjects of the inquiries include such disparate activities as the status of claims or the interpretation of Medicare rules.

Management of Beneficiaries

Medicare beneficiaries need services that are similar to the ones providers receive. The Social Security Administration, rather than CMS, establishes the beneficiary's eligibility and then this information is updated in the CMS systems.

Medicare offers brochures, websites, and contact centers to ensure that beneficiaries get the information that they need to properly obtain services and reimbursement and to handle claims or general Medicare inquiries.

Management of Other Stakeholders

Medicare has numerous stakeholders and participants beyond those that give and receive health care. Commercial services such as banks and billing agencies are key players in financial functions. Law enforcement agencies, ranging from local ones to the FBI, are involved in fraud and abuse cases. Employers and their health plans play a key role in determining who is paying for particular services.

Each of the stakeholders have business dealings with the FFS contractors and should keep current on laws, regulations, and processes that affect them.

Appeals

The right to appeal Medicare decisions by providers and beneficiaries has been a part of the Medicare legislation since its inception. Medicare has six levels of appeal that range from the simple reconsideration of the initial decisions to the federal courts.

Recent legislation has revised some of the levels of appeal, along with the time frames for filing cases at different levels. The next chapter contains a summary of the current participants in the appeals process.

Demonstration Projects and Specialty Activities

Beyond standard FFS claims processing, CMS funds demonstration projects that generally explore new methods of payment. The agency also has defined specialty functions that require somewhat different processing rules. If a MAC is involved

in a demonstration project, it exercises varying responsibilities depending on the project's scope. The MAC's responsibilities may include the following:

- Assist with developing the edits, prices, or other information associated with establishing the claims environment
- Enroll (or identify) the providers that are eligible to provide the services covered
- Educate—either in general or on specific topics—providers on how to successfully file the demonstration and specialty claims
- Provide any specialized review that may be needed.

Appendix C lists the current demonstration projects and types of specialty contractors.

MEDICARE ADVANTAGE

The FFS processing environment requires interactions with other Medicare benefit programs, such as Medicare Advantage. CMS is trying to more effectively control Medicare costs without cutting benefits; one result is new contractors and more competition being introduced into FFS processing. New interactions also arise from activities associated with processing claims for initiatives that serve particular provider populations. As the programs created from MMA develop, more programs (and interaction) are likely to arise.

INTEGRATION OF PART A AND PART B FUNCTIONS

Since Medicare's inception, Parts A and B, though started on the same day, have grown to be distinctly different programs:

- Part A dealt with institutional providers, while Part B dealt with physicians and suppliers.
- Reimbursement under Part A was largely based on reasonable costs, while payment under Part B was based on a reasonable "charge" or a fee schedule.
- The services covered under Part A were in terms of days or "length of stay"; under Part B, specific procedures were the items billed.

With the above in mind, it is easy to understand why two very different processing systems arose. Although we do not emphasize these differences in the ConOps and enterprise architecture, we note where they affect high-level business processes.

The CMS vision for the future Medicare FFS environment is one of more efficient and effective services to Medicare beneficiaries and health care partners in an evolving heath care delivery system under Medicare contracting reform. The single MAC entity provides the most immediate benefit in program and administrative savings through combining what has historically been processed separately by the FIs and carriers. In the new FFS environment, we expect that MACs can take advantage of this situation and save both administrative and benefit dollars.

MACs should find ways to combine functions to provide a unified Medicare point of contact for providers and should increase efficiency in operations. Areas such as customer service and outreach, combined use of Part A and B claims processing systems and data exchange mechanisms (e.g., skilled nursing facility and home health consolidated billing), and combined Part A and B Medicare Summary Notices (MSNs) are examples of activities that promote these objectives.

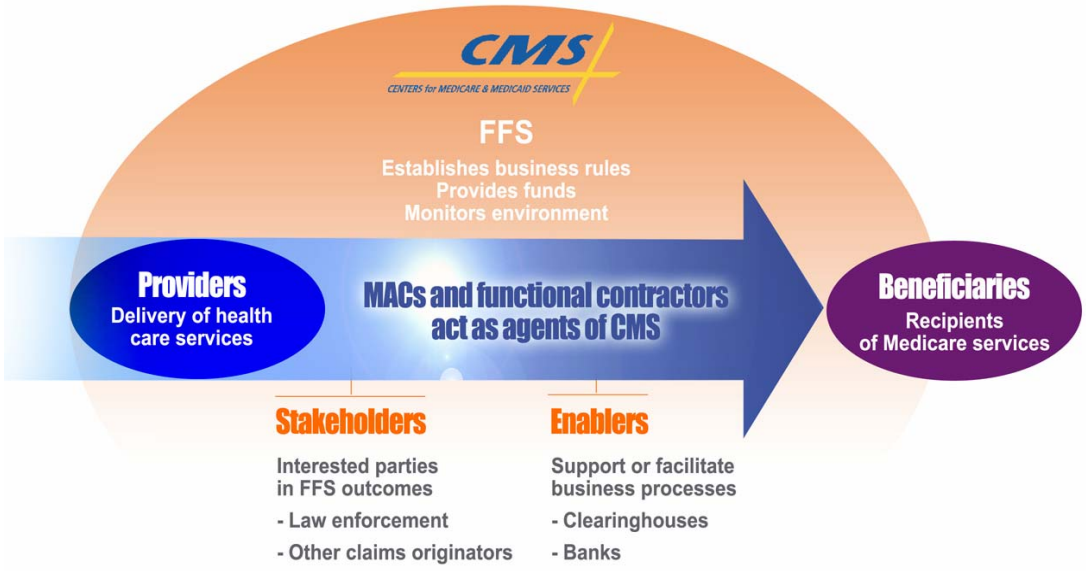
The CMS vision of the future FFS environment also includes programs such as the Medicare Health Support program, which could serve as a model for the future FFS environment. This program utilizes a variety of organizations to ensure that individual plans of care for beneficiaries are developed and followed. Improved patient compliance can enhance the overall quality of care for the beneficiary by incorporating standardized clinical practices used in both the Part A and the Part B program.

Chapter 3
Entities Performing the Business Functions

The Medicare FFS program's complex business functions are carried out by numerous entities: CMS, the MACs, and a network of specialized contractors, including functional contractors and other contractors designated with specific tasks to optimize the FFS environment for cost and operational effectiveness. Numerous stakeholders and enablers also support the FFS environment.

This chapter identifies the entities performing the business functions and their key roles. It also discusses some of the interactions among those entities. Figure 3-1 is an overview of the major business roles that interact within the FFS environment.

Figure 3-1. Major FFS Business Roles



CMS

As the government agency in charge of Medicare FFS processing, CMS is ultimately responsible to the public for its successful operations. CMS determines policy, establishes rules, allocates business functions to a variety of contractors, oversees the contractor's activities, and provides the funds both for administering the FFS environment and for paying providers for health care delivery.

MEDICARE ADMINISTRATIVE CONTRACTORS

MACs are to assume the claims payment work that is now performed by FIs and carriers. The contracts consist of 15 primary MACs servicing the majority of provider types, 4 specialty MACs servicing the majority of HH providers, and 4 specialty MACs servicing DME suppliers. The primary MACs will operate in 15 distinct, nonoverlapping geographic jurisdictions, which form the basis of the Medicare FFS claims processing operation. (Appendix A contains more detail on the jurisdictions and the transition schedule.)

The MACs serve as the providers' primary point of contact for the receipt, processing, and payment of claims. They perform all core claims processing operations for both Part A and Part B.

FUNCTIONAL CONTRACTORS

The term "functional contractor" is used to describe a company that performs a specific business function, as described in the FFS functional hierarchy. In the FFS environment, MACs maintain relationships with a number of functional contractors: Beneficiary Contact Centers (BCCs), a Coordination of Benefits Contractor (COBC), Program Safeguard Contractors (PSCs), and Qualified Independent Contractors (QICs). (As part of its comprehensive management of the Medicare FFS environment, CMS continually evaluates additional areas in which functional contractors can bring advantages to beneficiaries and providers while providing administrative benefits to the program.) Table 3-1 lists the major business functions and the contractors to whom they are currently designated.

Table 3-1. Major Business Functions Performed by MACs and Functional Contractors

Business function	MAC	BCC	COBC	PSC	QIC
Manage claims					
Establish and maintain claims environment	●		●		
Process claims	●				
Support claims analysis and reporting	●				
Manage Medicare finances					
Manage claims expenditures	●				
Perform program integrity functions	●		●	●	
Perform provider audit and reimbursements	●				
Perform MSP processing	●		●		
Provide customer service					
Manage providers	●				
Manage beneficiaries		●	●		
Manage other stakeholders	●		●	●	●
Manage appeals	●				●

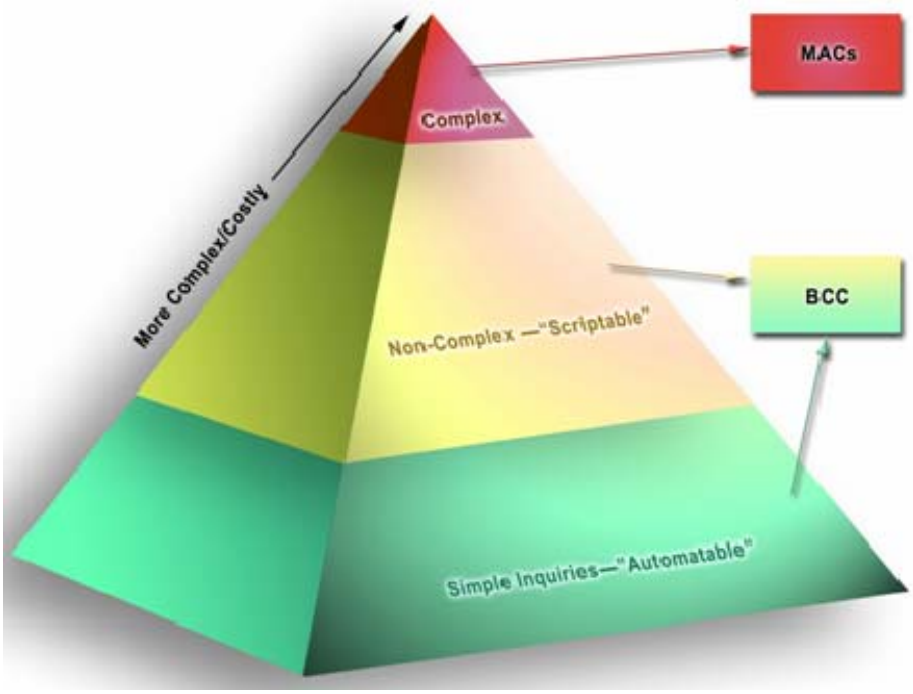
The following subsections describe the roles of the functional contractors.

Beneficiary Contact Centers

In the FFS environment, beneficiaries have a single Medicare point of contact. BCCs connect them to a seamless network of customer service entities that can answer questions and resolve problems. The BCC is designed so that a single source can handle all types of inquiries. CMS also uses interactive voice response (IVR) technology to answer basic inquiries.

Although they do not have a primary role in beneficiary customer service, MACs support the BCCs as a research center/responder by accepting and responding to complex inquiries that require their expertise to resolve. For example, a BCC may refer an inquiry it cannot resolve to the MAC that originally processed the claim. The MAC then takes ownership of the inquiry and responds directly back to the beneficiary. Figure 3-2 depicts the process for responding to beneficiary inquiries in the FFS environment.

Figure 3-2. Medicare Inquiries



Coordination of Benefits Contractor

The COBC is responsible for identifying the health benefits available to a Medicare beneficiary and ensuring that other payers are properly identified.

The COBC process incorporates the need to identify other payers that have primary or supplemental payment responsibilities into the Part A/B MAC claims

processing operation. The COBC uses a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. MSP claims investigations are initiated from and researched at the COBC. The COBC provides a centralized, one-stop customer service approach, handling inquiries from any source, including beneficiaries, attorneys and beneficiary representatives, employers, insurers, providers, and suppliers. The COBC's primary function is to gather information; it does not process any claims.

The Part A/B MAC interfaces with the COBC on MSP issues and on crossover claims. A crossover claim is a record of a Medicare paid claim that is sent to a supplementary insurer generally for payment of the deductible and coinsurance. The COBC is responsible for developing MSP information and for forwarding processed claims data to other health insurers that pay after Medicare.

Program Safeguard Contractors

CMS created PSCs under the authority of the Medicare Integrity Program (MIP) to give greater focus to Program Safeguard activities. In the Part A/B MAC environment, PSCs perform activities related to program integrity (fraud and abuse), coordinating closely with the Part A/B MACs. Each PSC and its related Part A/B MAC enter into a Joint Operating Agreement (JOA) to delineate roles and responsibilities and establish clear lines of communication for information exchange.

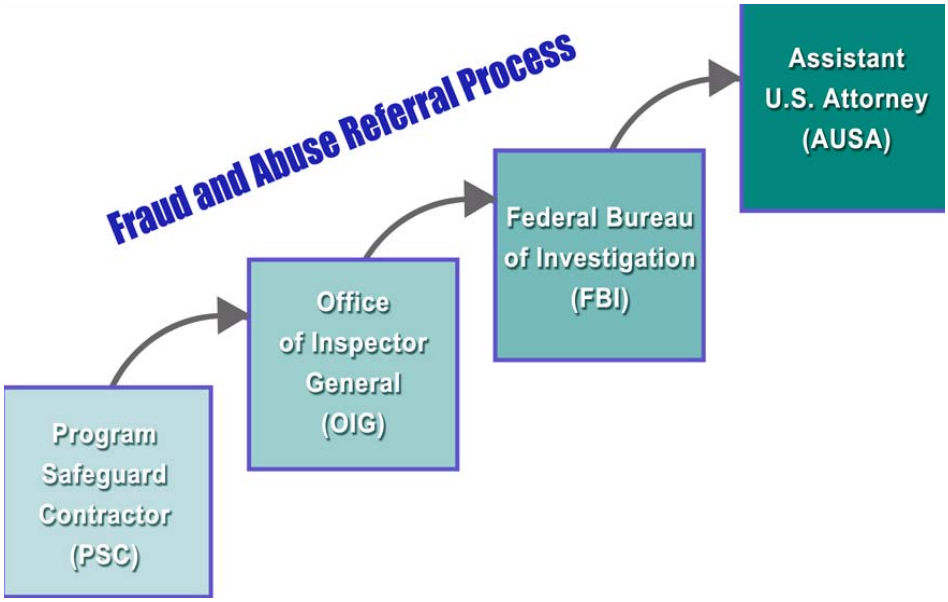
CMS is considering establishing seven jurisdiction zones, aligned with MAC jurisdictions, for which the PSCs will handle fraud and abuse issues. The following are among the PSC functions:

- Develop potential fraud cases
- Investigate entities that may be involved in fraudulent activities such as enrollment, eligibility determination, and benefit distribution
- Identify program vulnerabilities
- Identify overpayments
- Take administrative actions as appropriate
- Coordinate and provide support to law enforcement agencies, state agencies, and other government agencies as appropriate for identification and investigation of potential fraud and abuse
- Analyze data, including matching of claims data, to identify potential fraud and abuse.

Because of the wide impact of PSC work areas, the PSCs interact with many organizations that perform FFS functions, as well as other activities related to Medicare organizations. As depicted in Figure 3-3, the MACs are a primary

source of information and may be asked to participate at any or all levels of the escalation of fraud and abuse cases.

Figure 3-3. Fraud and Abuse Referral Process



Qualified Independent Contractors

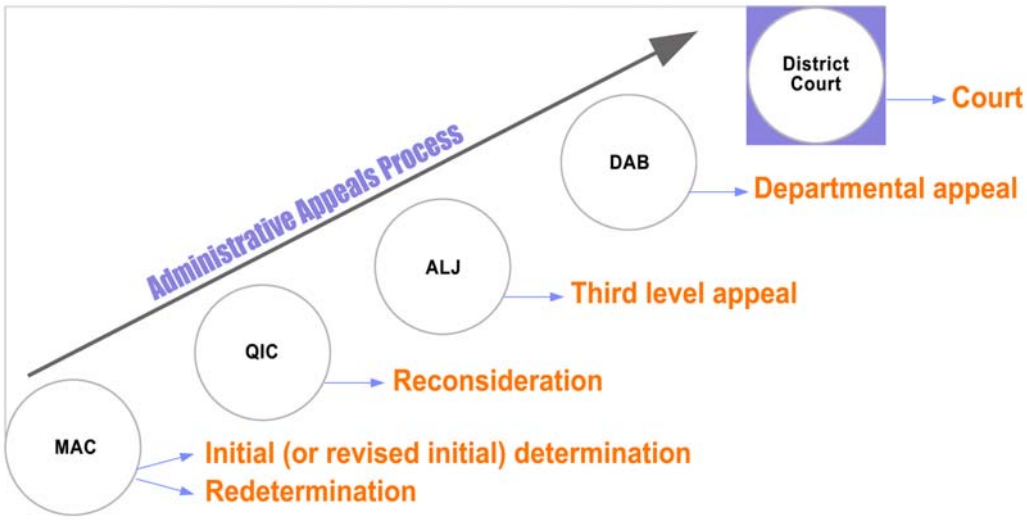
CMS established QICs in compliance with the Benefits Improvement and Protection Act of 2000 (BIPA). BIPA revised section 1869 of the Social Security Act in several significant ways. Among other things, it standardized procedures and timelines for Part A and B appeals and required that all second-level appeals be conducted by QICs.

In September 2004, CMS procured QIC services through FAR contracts that permit the agency to build in meaningful cost containment incentives and an evaluation and performance improvement process. QICs and MACs share information on specific beneficiary and provider appeals.

The FFS operating environment has two Part A and two Part B QICs. These QICs conduct all second-level appeals for the Part A/B MAC reconsiderations of initial determinations and redeterminations of Medicare claims; that is, what was a “fair hearing” under the old appeals process became the responsibility of the QICs. In addition, QICs control all appeals beyond the fair hearing, which includes Department of Health and Human Services (DHHS) Administrative Law Judges (ALJs), the Departmental Appeals Board (DAB), and then, finally, the federal court system. Of course, effectuation of payment decisions remains the responsibility of the Part A/B MACs.

Figure 3-4 shows the appeals process with the QICs and all the other parties to appeals.

Figure 3-4. Claims Appeals



OTHER KEY CONTRACTORS

In addition to the functional contractors, a number of other entities provide specific FFS business functions, notably, the following:

- Quality Improvement Organizations (QIOs) (formerly known as Peer Review Organizations)
- National Plan and Provider Enumeration System (NPPES) contractor
- Clearinghouses and billing consolidators
- Comprehensive Error Rate Testing (CERT) contractor.

The following subsections discuss the roles of these entities. The MACs also maintain relationships with various technical or support contractors that provide claims processing functions in the current Medicare Data Centers or the new Enterprise Data Centers (EDCs), discussed in Chapter 4.

Quality Improvement Organizations

A QIO is a group of practicing doctors and other health care experts that is paid by the federal government to review and improve the care given to Medicare patients. QIOs make initial determinations and reconsiderations with respect to certain hospital discharges, and they review complaints about the quality of health care services given to Medicare beneficiaries and certain appeals determinations regarding services in acute care hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and home health agencies. QIOs also review cases from acute care hospitals and long-term care hospitals to make sure

the care was medically necessary, was provided in the appropriate setting, and was coded correctly. In addition, QIOs assist hospitals, nursing homes, physician offices, and home health agencies with measuring and improving quality.

NPPES Contractor

The NPPES contractor issues National Provider Identifiers (NPIs). CMS is currently implementing the NPI program as a part of a national initiative to improve electronic transactions in health care business processing. In May 2005, CMS announced the availability of the new identifier for use in standard electronic health care transactions. The NPI will be the single provider identifier, replacing the different numbers used by each health plan. The new NPI number, mandated by HIPAA, is to be used by most health plans, health care clearinghouses, and health care providers that use standard electronic transactions. NPI is scheduled to replace the Unique Provider Identification Number (UPIN) and the Online Survey, Certification and Reporting (OSCAR) system by late 2007.

Clearinghouses and Billing Consolidators

Although they do not have a direct relationship with CMS, clearinghouses and billing consolidators (utilized throughout the health care community) offer services for the submission of claims and the exchange of data with the MACs. The clearinghouses provide services such as HIPAA translation and message retrieval services. Billing consolidators submit claims to the MAC as part of their contractual arrangements with providers.

CERT Contractor

CMS uses the CERT program to assess and measure the accuracy of Medicare FFS payments. The CERT program produces national, contractor-specific, and provider compliance paid claims error rates and other information that enables CMS to identify where problems exist and to target areas for improvement. In the MAC environment, the CERT error rates are used as part of the overall contractor performance evaluation process.

The CERT program includes review of a random sample of Medicare claims to ensure that payment is made appropriately, that is, for medically necessary services covered by Medicare for eligible individuals. The CERT contractor reviews claims that have been paid or denied to ensure that the payment decision was appropriate. The outcome of the review is a provider compliance error rate and a paid claims error rate. The paid claims error rate information is used by CMS to clarify policies and develop strategies aimed at reducing improper payments. The information is used by MACs to develop error rate reduction plans, including provider education efforts and claims review activities, in an effort to reduce their error rates, as well as the overall Medicare FFS paid claims error rate.

STAKEHOLDERS AND ENABLERS

Table 3-2 lists some of the major stakeholders in and enablers of the new FFS environment.

Table 3-2. Stakeholders and Enablers

Type	Entity
Other government entities	State survey and certification programs
	State licensing authorities
	Medicaid state agencies, Medicaid fiscal agents, and Medicaid fraud control units
	Government Accountability Office
	Social Security Administration
Other claims originators	Indian Health Service
	Medicare Advantage and Medicare+Choice
Law enforcement entities in coordination with the PSCs	Department of Justice
	FBI
	Office of Inspector General
	Law enforcement health care task forces
CMS contractors	Other MACs
	Other functional or specialized contractors: PSCs, QIOs, etc.
	Technical support contractors, e.g., shared system maintainers
Private parties	Professional societies
	Peer review organizations
	Managed care organizations
	Private health insurers
	Payers (including private/commercial side of MACs)

INTERACTIONS

Whenever a business function involves more than one entity, an interaction occurs that requires some degree of formal definition. As the number of contractors and other participants increases, more formalized attention to roles and responsibilities ensures that both sides are aware of and carry out their appropriate functions.

The most common approach for defining interactions—and the most formal—is the use of JOAs. For example, a JOA delineates the major interfaces between the contractor managing appeals (the QIC) and its related Part A/B MAC. Apart from the Part A/B MACs' needing to take adjustment actions based on decisions, mechanisms are needed to transfer claims data, medical review policy information, and other information either party may need to fulfill its program responsi-

bilities. In addition, ongoing liaison between the organizations is required to ensure that the process runs smoothly.

Trading partner agreements are another form of formal interface used to establish the protocols and mechanisms for transferring claims data between a clearinghouse or consolidated billing service and the MACs.

Memorandums of understanding (MOUs) are also used to ensure that roles and responsibilities are properly defined between two entities. These are often used between government agencies, such as CMS and the Social Security Administration. Some relationships, such as the one between the MAC and its bank, are defined by a contract.

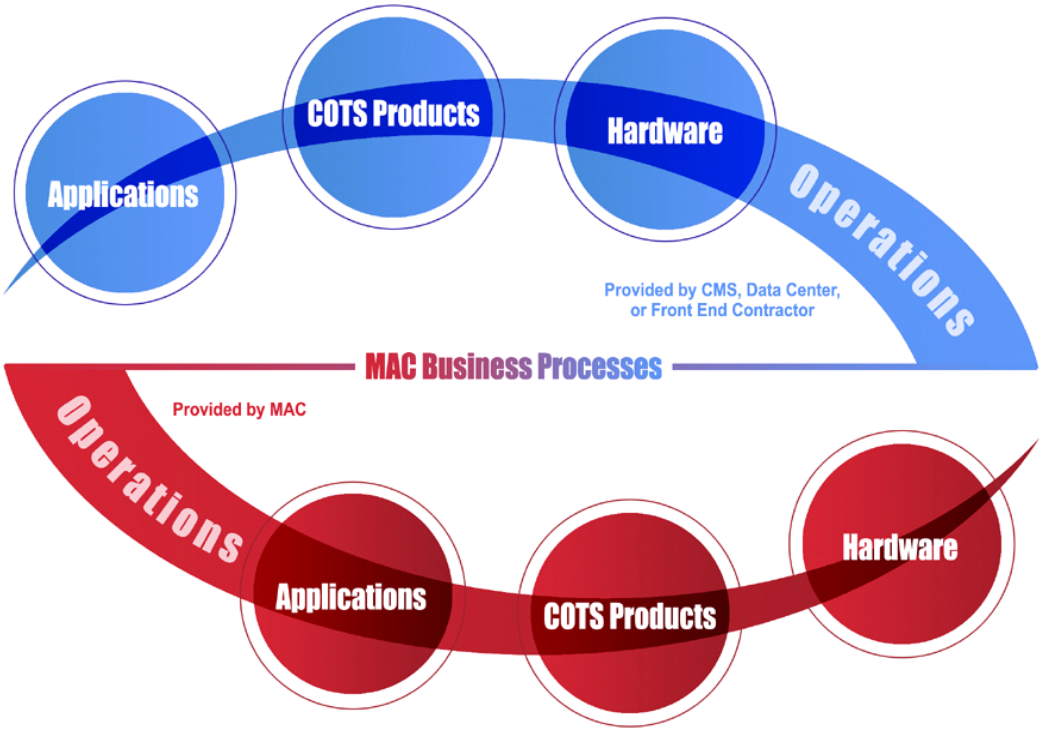
Finally, interactions of FFS participants with law enforcement agencies are ad hoc, so a formal agreement may not be utilized. MACs must provide data, files, and analyses and must fully cooperate in investigations of fraud and abuse.

Chapter 4
Major Supporting Technology

One goal of contracting reform is to integrate functions and processes to improve service to beneficiaries and providers and to enhance the data used by CMS to administer the FFS Medicare program. Currently, CMS does not have sufficient timely and accurate data nor are business platforms suitable to allow CMS to fully capitalize on innovations in the business and science of health care. Moreover, the agency's IT platform is not sufficiently secured to allow CMS to move forward as it should to optimize use of the Internet.

Figure 4-1 depicts the new FFS environment in which CMS, the MACs, and other contractors provide the applications and technology required to perform the business functions (operations).

Figure 4-1. MAC Operating Environment



This chapter describes the major computer applications and infrastructure supporting the FFS processes, and it addresses government-furnished equipment (GFE) vs. MAC-supplied equipment and interfaces. In addition, this chapter discusses several future technology initiatives.

APPLICATIONS

FFS operations are supported by a network of critical IT systems provided by CMS and the contractors. Part A/B MACs use the shared systems and CWF to process claims, the HIGLAS and Recovery Management and Accounting System (ReMAS) financial systems, and a variety of other key applications.

Shared Systems and Common Working File

The FFS claims processing system is composed of two separate shared systems—Fiscal Intermediary Standard System (FISS) and Multi-Carrier System (MCS)—for processing benefit claims for Part A and Part B and the CWF for validation and approval.[1] (HIGLAS, although mainly an accounting system, is also "integrated" into the claims processes.)

FISCAL INTERMEDIARY STANDARD SYSTEM

FISS is the shared system that currently supports Part A and some Part B claims processing. The system has 3.2 million lines of code, based on IBM's Customer Information Control System (CICS) online and on COBOL, COBOL II, and Assembler Language Code (ALC) batch programs.

FISS contains the following subsystems:

- Report
- Financial
- Automated correspondence
- Recovery tracking
- Purge and retrieval
- Casework
- MedATran
- SuperOps, for local control.

HIGLAS (discussed below) will remove the need for much of the financial processing currently performed by FISS.

[1] A third shared system is used to process DMEPOS claims. It is described in *Processing of Claims for Durable Medical Equipment: Concept of Operations and Enterprise Architecture*, April 2005.

MULTI-CARRIER SYSTEM

MCS is the system that supports Medicare Part B claims processing, including data collection and validation, claims control, pricing, adjudication, correspondence, online inquiry, file maintenance, reports, reimbursement, and financial processing. Excluding programs generated by the MCS System Control Facility (SCF), MCS is made up of 3,126 programs: 1,637 programs are written in COBOL containing 1.7 million lines of code, and 1,489 programs are in ALC with approximately 1.3 million lines of code.

MCS functions in an IBM Multiple Virtual Storage environment with CICS and uses direct and indexed file structures. CICS screens are written in Basic Mapping Support and use ALC to assemble the maps. Some applications have been developed in PowerBuilder.

The following MCS applications control processing:

- File maintenance
- File inquiries
- Provider enrollment
- Electronic media claims (EMCs)
- Editing, pricing, suspense
- Medical policy, CWF
- Financial
- Cash
- Correspondence.

As with FISS, HIGLAS will remove the need for much of the financial processing currently performed by MCS.

COMMON WORKING FILE

The CWF is a system that uses localized databases, which are maintained by host contractors, to validate and approve prepayment of Medicare claims and to coordinate Medicare Part A and B benefits. The system also provides contractors with beneficiary entitlement and utilization information.

Healthcare Integrated General Ledger Accounting System

CMS is replacing its fragmented and overlapping accounting systems, maintained by both CMS and Medicare contractors, with HIGLAS—a single, unified general ledger accounting system that complies with the Federal Managers Financial Integrity Act. CMS expects to have HIGLAS fully in place some time in 2011. HIGLAS will support all CMS financial accounting and administration, including the financial functions performed by the MACs. It will establish standard financial processes and data classifications. It will also promote consistent and standard accounting processes for both CMS and Medicare contractors. Finally, it will produce automated standardized financial statements and reports.

The MAC's responsibility for financial management remains the same as that of the existing FIs and carriers, but HIGLAS will provide a more consistent comprehensive tool for accomplishing the work. Also, HIGLAS will not replace all of the standard reporting systems that the MAC uses, such as the Provider Statistical and Reimbursement System (PS&R), but will feed financial information to these systems either directly or through the interface with the shared systems.

Once a Medicare claim has been processed, HIGLAS, not the accounting systems currently used by Medicare contractors, will perform the payment calculation, formatting, and accounting. HIGLAS will replace the benefit accounting processes used by the Medicare contractors, enabling CMS to better record, track, and collect accounts receivable and enhancing CMS payment decision making.

HIGLAS is being implemented nationally as contractors migrate to the new consolidated jurisdictions. Some MAC transitions will occur prior to the implementation of HIGLAS, and some will occur following the HIGLAS implementation.

Recovery Management and Accounting System

ReMAS identifies and tracks instances of mistaken Medicare primary payments—cases in which Medicare should have been the secondary payer—so that CMS can initiate recovery of funds from the party that should have paid first. It has two main features:

- Timely identification of provider and beneficiary debt
- Management and control of recovery cases in a centralized database.

ReMAS covers the following group health plan (GHP) cases:

- Insurer/employer
- Third-party administrator/employer.

For non-GHP cases, the ReMAS scope includes Liability, No Fault, and Workers Compensation.

ReMAS is used to track MSP receivables. Once ReMAS has identified and verified an overpayment case, it forwards the case to HIGLAS. In non-GHP situations, the case is sent to HIGLAS when there has been a settlement. HIGLAS then produces the demand letter and establishes the accounts receivable; The case is tracked in HIGLAS from that point forward.

ReMAS is a VisualBasic application running on a user's desktop. It accesses the data housed at the CMS Data Center. ReMAS is being implemented in conjunction with HIGLAS.

Other Key Applications

The following are other key applications used to support the FFS environment:

- *Contractor Administrative Budget and Financial Management System (CAFM I)*—system for tracking benefit Medicare program payments and CFO data.

- *Contractor Reporting of Operational and Workload Data System (CROWD)*—system that collects and reports on operational and contractor workload data and types of claims processed for all Medicare contractors. Data include types of claims, overall number of claims, and processing cost per claim. CROWD reporting system will migrated to a new platform that will be need to be developed.

- *Provider Statistical and Reimbursement System (PS&R)*—system that transforms claims processing system's data to a form that is suitable for cost report systems. The PS&R system is a critical part of the cost settlement process.

- National Plan and Provider Enumeration System *(NPPES)*—system used to assign an NPI, which is a numeric 10-digit identifier adopted by DHHS as the standard identifier for health care providers.

- *Unique Physician Identification Number System (UPIN)*—database of physician UPINs and associated practice settings (offices). A UPIN uniquely identifies a physician across all practice settings. UPIN will no longer be used after 2007.

- *Provider Enrollment, Chain and Ownership System (PECOS)*—system used by contractors that captures Medicare enrollment information. The PECOS database retains enrollment information and transmits enrollment status and information to contractors.

- *Comprehensive Error Rate Testing Database (CERT)*—system used to determine contractor error rates and causes.

Contractor Extensions and Applications

Although the shared systems provide a broad range of functionality to the MACs, the contractors have historically developed their own extensions and applications, often referred to as "non-base systems." Locally developed interface applications are used to connect specific pieces of hardware or communications equipment that are not part of the shared systems. Ancillary support systems, such as case tracking applications, data warehouse initiatives, imaging hardware and software, workflow management, and even additional editing routines also extend the business functionality of the shared systems or interface to corporate processes. Another purpose of these systems is to enhance customer service.

These non-base functions and applications are being integrated into the EDC environment, as FIs and carriers migrate to the EDCs. The EDC contractor will allow the services and software currently deployed as part of the EDC FFS claims processing task orders to be used by the mainframe non-base applications. Any hardware or software required by the non-base applications that is not currently deployed in that EDC will be provided as GFE or by contract modification to the EDC or will be provided by the non-base maintainer to the EDC.

INFRASTRUCTURE

The infrastructure architecture identifies and describes the hardware, software, and communications network technologies required to manage business applications throughout the CMS enterprise. Influences include communications networks, equipment capacities, operational procedures, and technology capabilities. The purpose of documenting the infrastructure architecture is to identify the technologies used to carry out key activities, such as data security, preparation, storage, and retrieval, across functional, organizational, and geographic boundaries. The infrastructure architecture is documented using the conceptual representation of common services and interfaces found in the Technical Reference Model (TRM).[2] The MACs work through the CMS EDC Program Management Office (PMO) to ensure adequate capacity and connectivity. The following are some of the major infrastructure components supplied by the MACs:

- Communications controller to interface with the CMS Medicare Data Communications Network (MDCN)
- Communications network for Part A/B MAC staff
- 3270 emulation software on PCs

[2] *HCFA IT Architecture, Version 2.0*, Volume 5, Section 5.5, November 1999.

- Security hardware, such as penetration monitoring
- ICR/OCR software
- Communications hardware and software for linking with providers
- Software used to connect to MDCN
- Commercial translation software
- Third-party letter generator software
- Bulk mailing support tool.

Networks

CMS and the MACs use a variety of networks for communications. The following are currently in use:

- MDCN—network, built on the AT&T Global Network Service, that provides connectivity between CMS locations and the various entities that access Medicare data or support system operations, including claims processing contractors and fraud detection organizations The MACs are responsible for establishing telecommunications to the MDCN
- CMSnet—CMS private intranet
- Extranet—CMS extranet
- Internet—public internet
- QualityNet—peer review organization distributed network.

CMS anticipates growth in the use of the Internet to provide services to Medicare customers, subject to appropriate security measures to safeguard personal and medical information.

Medicare Data Centers

The CMS Data Center in Baltimore, MD, supports the administrative and decision support system needs of CMS as well as the deployment of newer MMA applications, including some, such as PECOS, that are used by the MACs.

Traditional Medicare FFS claims have been processed at 15 Medicare Data Centers (MDCs) located throughout the country. The MDCs are owned and operated by FIs, carriers, or other contractors involved in the claims process. The MDCs provide all of the hardware and software needed to operate the shared systems and contractor-specific applications.

CMS is replacing the MDCs with two EDCs. CMS plans to migrate claims processing workloads, Part A and Part B, prior to MAC implementations.

Enterprise Data Centers

In February 2006, CMS awarded contracts to establish three EDCs to house software systems for Medicare claims. The EDC contractor will provide the necessary hardware, commercial off-the-shelf software, labor, supervision, tools, materials (including manuals and schematics), documentation, parts, equipment, transportation, and supplies necessary to process Medicare claims using the base shared systems.

These EDCs consolidate the large number of data centers currently supporting Medicare FFS contractors. The EDC concept is a critical component of the modernization initiative. The MMA has accelerated the need to successfully modernize the CMS IT environment. In many ways, the successful implementation of MMA depends on the ability of CMS to develop and maintain a robust, stable, and enterprise-wide IT environment.

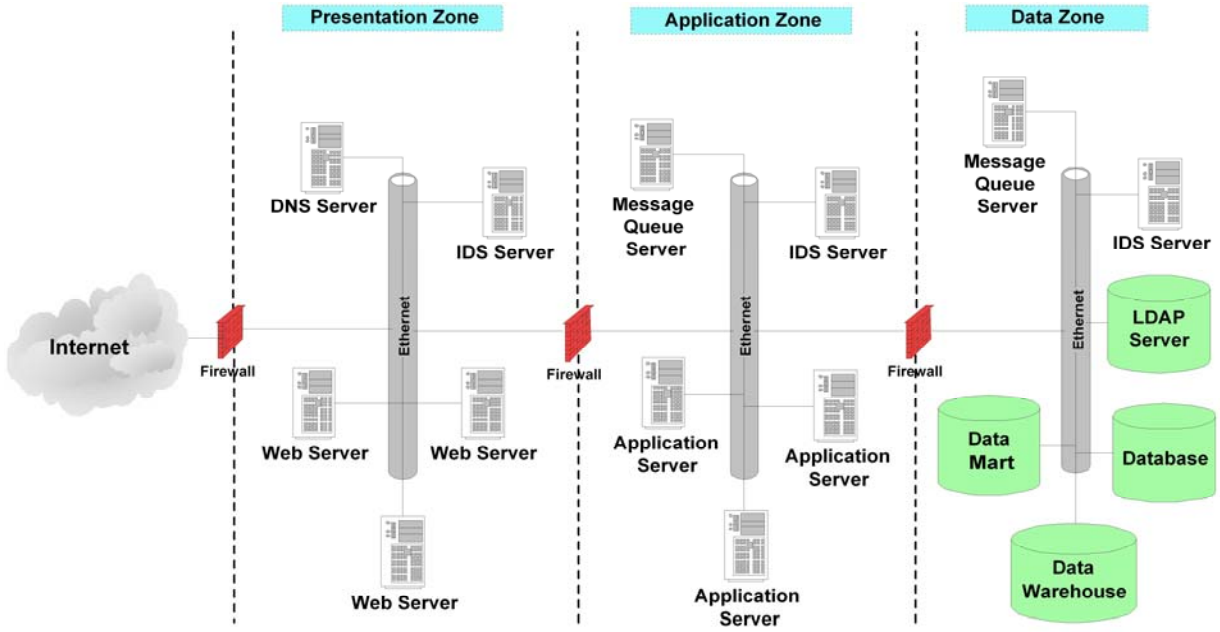
The EDCs are the foundation of the enterprise infrastructure supporting a key portion of the modernization initiative. Operated by industry leaders, the EDCs provide CMS with world-class application hosting centers that are capable of operating a highly redundant and scalable environment for mainframe and mid-tier computing.

The EDCs are designed for interoperability. Toward this end, CMS is establishing a common enterprise infrastructure that facilitates highly integrated operations (e.g., cyber security), seamless handoffs between EDCs and CMS, and common reporting and management in a distributed environment.

In addition to legacy CMS claims applications; the EDCs operate a web services environment for new CMS applications where most services for internal and external users and customers are provided through a web interface.[3] The EDC enterprise architecture for new applications is designed to facilitate robust security through three zones, as depicted in Figure 4-2 and defined in *CMS Internet Architecture* (including minimum platform security requirements) published in July 2003.

[3] The three-zone architecture will be developed and implemented incrementally. As an A/B MAC requires services, it will work through the CMS EDC PMO to ensure adequate capacity and connectivity. Any requirements for FY06 will be accomplished through the CMS Data Center, with transition planned into the new EDC facilities in FY07.

Figure 4-2. The EDC Three-Zone Architecture for New CMS Applications



Each zone in the three-zone architecture is separated by firewalls to support web application systems. The presentation zone is the first or outermost zone. This zone supports web servers only. The application zone is the second or middle zone, which supports only business logic for the applications. The data zone is the third or innermost zone, which represents the most secure or protected region of the architecture and contains the database servers used by the web applications. Additional network segments support such specialized network services as Public Key Infrastructure (PKI), Domain Name Services (DNS), etc.

The CMS three-zone architecture supports a single, unified interface for both CMS internal and external users and customers, as well as an operational approach to web applications developed and implemented by or for CMS. Applications hosted in this three-zone environment can access data in the data warehouse or data marts and in a variety of operational databases, where and when appropriate, located within CMS and its contracted sites in the data zone.

The databases accessed by web applications may be on operational database servers or may reside in the data warehouse or data marts. Thus, the data zone houses database servers supported within CMS as well as databases accessed across all CMS. In this fashion, the data zone supports the secure linkage of CMS data to its internal and external users and customers.

Access to the various databases at various physical sites is facilitated by the use of a common message-oriented interface between application zone servers and data zone servers at various sites.

CMS has established the CMS EDC PMO as part of the EDC implementation. The CMS EDC PMO is the management organization responsible for EDC oversight. It serves as the customer-facing organization responsible for the following:

- Monitoring the EDCs' relationships with all customers and assisting the them with using the EDCs and other CMS data center capabilities
- Providing "one-stop shopping" for EDC services and the focal point for resolution of EDC-related issues
- Overseeing and managing the program for deploying new applications and functionality to the EDCs
- Ensuring the quality of EDC service delivery.

Front-End Processing

The MACs support the principal access for providers submitting claim and other information through their front-end systems. The components required for front-end functional and technical processes consist of the following:

- Data communications portals for connectivity with Medicare business partners via conventional telephone lines, leased T1 lines, and secured private networks for the receipt of electronic data interchange (EDI) transactions; Direct Data Entry connectivity; and submitter/receiver connectivity for downloading Medicare transactions by business partners
- Security hardware and software, together with internal and external controls and procedures, that fully meet all CMS security requirements and privacy responsibilities to protect against the access of unauthorized entities into the Medicare systems environment either by online connectivity or the submission of EDI transactions
- Processes to ensure that EDI transactions received from clearinghouses, billing services, data and telecommunications service providers, and others are accepted only for Medicare providers from whom the contractor has received written authorization to submit or receive EDI transactions on their behalf
- A validation translator, for inbound and outbound HIPAA transactions, that uses only the standard CMS flat-files to interface with Medicare standard claims processing systems
- An EDI help desk to provide information and assistance to all Medicare EDI business partners

- A test environment for trading partners and EDI transactions and for testing new hardware and new software releases and fixes prior to their being put into production
- Processes to accept claims submitted on paper.

Back-End Processing

The MACs also support the output of the claims processing, often referred to as "back-end" processing. The components required consist of the following:

- Processes to return EDI transactions to submitters, and to transmit EFT to banks.
- Printing equipment for checks and notices.
- Bulk mailing hardware and software.

Continuity of Operations

The MACs also provide backup, risk mitigation, and disaster recovery plans to ensure minimal disruption to the receipt, processing, and return of Medicare EDI transactions during regularly scheduled business hours.

GFE VS. MAC-SUPPLIED EQUIPMENT

The infrastructure components used in claims processing come from CMS GFE, the MDC, or the MAC. The MAC provides systems hardware for EDI processing, databases, database management systems, interactive response unit (IRU) systems, security management systems, websites, e-mail and data communications functions, and print and mail functions. The computing hardware utilized in performing these business functions varies from mainframes to mid-tier servers in varying configurations. CMS does not prescribe the hardware used to carry out the FFS business functions, beyond that which is needed to interface or operate the applications provided to the contractor. Figure 4-3 illustrates the components needed and identifies the roles and responsibilities that are split between CMS, the data center, and the MAC. The products shown in the figure are generic; details of the infrastructure required are in the companion EA document.

Figure 4-3. Part A/B MAC Infrastructure Environment

INTERFACES

EDCs, the MACs, and other contractors supporting the FFS environment design, develop, and control the processes and procedures needed for the MACs to interface with other FFS contractors and systems. An interface exists wherever there is a defined set of information that needs to be exchanged, particularly on a routine basis. The design and development of the interfaces and the management of their operation evolve as new CMS initiatives are implemented and as technology continues to change. The use of multiple contractors in the FFS processes requires careful management to ensure that each is able to carry out their work on time.

FUTURE CMS TECHNOLOGY INITIATIVES

To improve the IT supporting Medicare, CMS is evaluating a number of options and has already undertaken several modernization initiatives. The agency is interested in maximizing its use of the Internet, which it views as an important part of improving service to providers. For example, web-enabling many of Medicare's current business functions would reduce the administrative burden on providers, help to ensure more accurate payments, and improve agency-to-provider communication (e.g., targeting information about policy and operational changes directly to affected providers instead of sending a mass mailing to all).

The IT modernization initiatives already underway will have a major impact on both infrastructure and applications, and will result in FFS claims processing and

related systems that are scalable, flexible, responsive to policy changes, supportive of queries, and maintained on platforms that facilitate easy system-to-system communication. Modernized systems will produce consistency in the use of Medicare data and predictability in systems changes, and they will increase the reliability of information used by the program's stakeholders. This, in turn, will lead to improved quality of care and a better level of service for beneficiaries and providers.

Medicare System Architecture Modernization

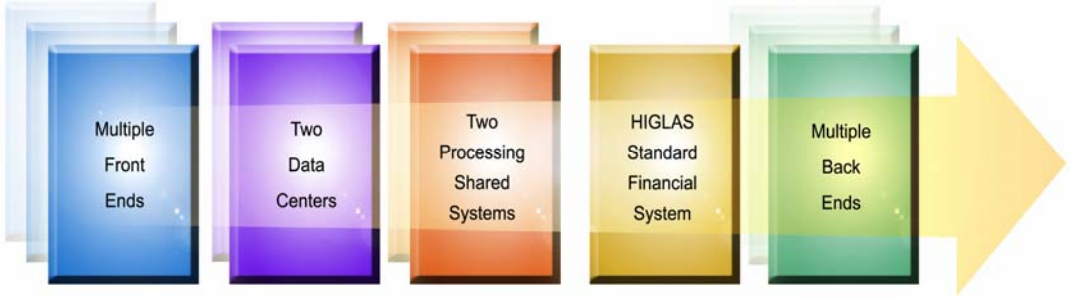
The Medicare System Architecture Modernization (MediSAM) initiative replaces the Medicare Claims Processing Redesign (MCPR) effort but incorporates the overall goals of MCPR. MediSAM is a long-range initiative to transform and modernize the IT applications that support Medicare FFS program operations. MediSAM will reorganize business process automation, including FFS claims processing, along major customer lines—beneficiary and provider—and incrementally transform and modernize the independent contractor systems, shared systems, and CWF.

For Medicare FFS claims processing systems, the new approach will combine newer technologies with existing system components to make incremental improvements rather than completely replacing the existing systems all at once. A unified, modernized FFS claims processing system will evolve from this incremental modernization approach. The following are the key characteristics of this approach:

- Eliminate duplicate functions and data among the current systems
- Modernize and renovate existing system components and data
- Strategically inject new technology to allow for greater flexibility and interoperability
- Modernize auxiliary systems and utilities that support claims adjudication (for example, back-end print).

The long-term MediSAM vision and concept of operations calls for Medicare FFS operations to be hosted in a geographically dispersed EDC environment. A unified claims processing system, operating at multiple EDCs, will replace the existing shared systems and CWF and will interacts with front-end and back-end services as well as related CMS systems such as HIGLAS. Figure 4-4 depicts the concept. This unified system will organize processing into provider-centric and beneficiary-centric subsystems to make better use of trusted data sources and match platform capabilities with process characteristics. This partitioning better reflects the nature of FFS business processes and customer views.

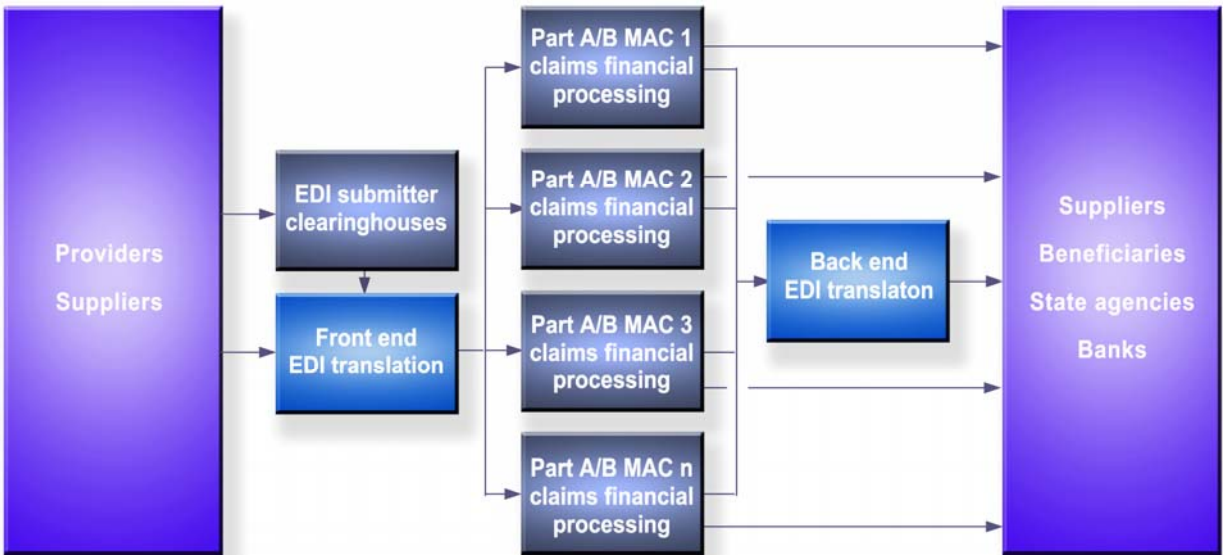
Figure 4-4. Concept for Medicare Claims Processing Redesign



Front- and Back-End Processing

CMS continually seeks ways to standardize and consolidate front-end and back-end claims processing. Figure 4-5 shows the relationship of the front-end and back-end translations and the Part A/B MACs.

Figure 4-5. Relationship of Front-End and Back-End Translations and Part A/B MAC Contractors



The front end and back end provide EDI translation, editing, and file and trading partner management for HIPAA-formatted claims or bills from suppliers. The Medicare Electronic Data Interchange System (MEDIS) contractor forwards bulk flat files to each MAC based on the provider's location. The MEDIS contractor performs similar services at the completion of claims and financial processing, routing files that require EDI translation to the MAC trading partners.

Pilot Initiatives and Exploratory Projects

CMS is planning a number of other initiatives that will potentially affect the FFS environment. Below is a list of several of the more significant initiatives:

- Electronic Medicare Summary Notices (EMSN) pilot project (with Palmetto GBA), which will provide registered beneficiaries within its jurisdiction an electronic version of any MSN
- Internet claims submission pilot project
- Claims status and eligibility pilot project
- Internet security pilot project.

Chapter 5
Managing the New Environment

This chapter describes how the new FFS environment will be managed. It addresses implementing the MAC transitions, managing the MAC contracts, and managing MAC performance.

IMPLEMENTING THE MEDICARE ADMINISTRATIVE CONTRACTORS

The Part A/B MACs will operate in 15 distinct, nonoverlapping geographic jurisdictions, which will form the basis of the Medicare FFS claims processing operation. The jurisdictions will be implemented in cycles. Appendix A describes the Part A/B MAC jurisdictions and presents the transition schedule.

The transition to the MAC environment will be complex, as work is consolidated from multiple FIs and carriers in a region. From an incoming MAC's perspective, a contractor transition encompasses all of the tasks it must perform to assume the duties of an incumbent contractor running a Medicare FFS claims processing operation. Among those duties are

- successful transfer of claims processing and all related files, processes, and other activities from the outgoing contractors, and
- education of providers, beneficiaries, and other affected parties regarding the change.

From an outgoing contractor's perspective, a contractor transition encompasses all of the tasks it must perform to relinquish all of the duties of running a Medicare FFS claims processing operation, in full cooperation with CMS and the incoming contractor and with as little disruption as possible to the providers and beneficiaries in its jurisdiction. CMS has developed an Outgoing Contractor Transition Handbook to assist outgoing contractors with the transitions.

The new MAC will be guided in its transition efforts by the MAC Transition Handbook and a Jurisdiction Implementation Project Plan (JIPP). Also, the MAC will use a segment plan to guide the activities for individual FIs and carriers. Major MAC transition activities include the following:

- Ensure the orderly transfer of all Medicare data, records, and operations from all outgoing carriers and intermediaries within its jurisdiction in accordance with the JIPP.

- Maintain and update the JIPP, which contains a detailed description of all activities required to transfer all Medicare operations from each carrier and intermediary in the contractor's jurisdiction.

- Develop, update, and follow a detailed segment implementation project plan for the transfer of each segment's workload.

- Develop, execute, and maintain a risk management plan for the contractor's jurisdiction as well as each segment.

- Develop, maintain, and follow a communication project plan for each segment.

- Conduct implementation activities for each segment in its jurisdiction and make the cutover in accordance with the project plan.

- In cooperation with the outgoing contractors in its jurisdiction, achieve successful transfer and reconciliation of accounts receivable from each contractor.

- Consolidate the existing Local Coverage Determinations (LCDs) of the outgoing contractors so that they are the same for the entire jurisdiction. The MAC must also educate the provider community of any changes in LCDs during the implementation period and prior to the cutover of any workload from an outgoing contractor to the incoming contractor.

- Exercise due diligence in taking over the outgoing contractors' work. The MAC should be aware of any significant issues, documentation, etc., that it may be inheriting.

MANAGING THE MAC CONTRACTS

The CMS approach to ensuring the effective management of the MAC contracts has the following key features:

- Cost-plus-award-fee (CPAF) and other contract types

- Voucher management

- Formal contract modification process

- Cost Accounting Standards (CAS)

- Compliance and internal controls.

CPAF and Other Contracts

CMS will award MAC contracts for 1 year. Each award will be renewable at CMS' discretion for a total of 4 subsequent option years. CMS has the right, but is not obligated, to exercise each option or otherwise to compete the work. CMS' decision whether to exercise an option is a strong incentive for contractor excellence. It also helps promote some of the benefits of competition without creating further contractor consolidation. CMS will recompete each MAC contract, as defined in the MMA, at least every 5 years.

CMS will use a CPAF arrangement for MACs in the initial MAC awards. The agency believes it has an insufficient amount of data and experience to establish an exact cost estimate for the MACs. CMS also is uncertain as to workload projections and believes that costs are very sensitive to actual workloads. Once it has established a baseline cost and level of effort, CMS will revisit those statement of work (SOW) requirements that may benefit from different contracting and pricing strategies, such as fixed-price or incentive contracts.

Voucher Management

In the existing environment, Medicare contractors draw funds from specific accounts for reimbursement of costs for performing the functions of the contract. In the new environment, MACs will submit vouchers (SF 1034) using the Account Reporting and Tracking (ART) system. The vouchers will require submission of supporting cost information as is currently done, but reimbursement will be made electronically by CMS after review of the voucher and supporting information.

Formal Contract Modification Process

The existing environment relies on a contract cost change process that does not include the use of formal contract modification documents. The new environment will formalize this existing process and use contract modifications to adjust the negotiated contract prices based on changed requirements.

Cost Accounting Standards

The existing environment employs a CMS-defined structure for managing contract costs. The new environment will include this structure plus the added discipline of the CAS when the applicable contract amounts trigger the appropriate CAS compliance requirements.

Compliance and Internal Controls

Compliance programs are designed to establish a culture within an organization that promotes the prevention, detection, and resolution of instances of conduct that do not conform to federal and state law or to federal health care program

requirements. An effective compliance program both articulates and demonstrates the MAC's commitment to ethical and legal business conduct. The management of the MAC is responsible for providing ethical leadership and ensuring that adequate systems are in place to facilitate the desired conduct, and certifying to the same.

The MACs will tailor their program to their own business model, including the size of their operations, but in general, the compliance program will consist of several elements:

- Written policies and procedures on the standards of conduct and how they will be implemented
- A policy that describes the retention of records and information systems
- A compliance officer whose primary responsibility is to oversee the implementation and maintenance of the program
- A training program
- Lines of communication for reporting problems
- Auditing and monitoring
- Enforcement through publicized disciplinary guidelines and policies.

Internal controls are the tools—organizational, policy, and procedural—that help program and financial managers achieve results and safeguard the integrity of their programs. The internal control program of the MAC ensures the timely prevention and detection of significant weaknesses in the design or operation of internal controls that could adversely affect the MAC's ability to meet its objectives.

CMS uses Statement of Auditing Standards 70 (SAS 70) audits to ensure that MACs are conducting their business appropriately. The audits are conducted by an independent and certified public accounting firm, with experience in Medicare operations and in SAS 70 Type II reviews. All CMS Control Objective areas must be reviewed in accordance with CMS guidelines. Any material weaknesses or exceptions will be corrected by the MAC and reported to CMS.

MANAGING MAC PERFORMANCE

Performance-based contracting is a method that structures all aspects of an acquisition around the desired outcomes of the work to be performed, as opposed to the design or process to be followed in performing the work. Performance-based contracting is designed to ensure that contractors meet the government's performance requirements, that appropriate performance quality levels are achieved, and that

payment is made only for services that meet these levels. Performance management has two key components: performance measures and incentives.

Performance Measures

Performance measures are used to assess an organization's progress toward achieving predetermined objectives. (A key objective of performance-based contracting is to avoid imprecise SOWs that preclude effective assessment of contractor performance.) Performance measures are also termed "outcome measures" because they are specifically used to measure the outcome of services rendered. The SOW for the MAC acquisitions will lead to the implementation of performance-based contracts by CMS.

The government's Quality Assurance Surveillance Plan (QASP) (sometimes known as a Quality Assurance Plan, or QAP) contains the performance measures, which are clearly defined qualitative or quantitative methods for determining the level of performance that the contractor has actually achieved. The QASP directly corresponds to the performance requirements and standards in the SOW and identifies how contractor performance against the standards will be measured. The QASP also clearly identifies how the government will determine, at specific intervals during contract performance, whether the contractor is meeting contract requirements. The QASP is not part of the contract and is provided to the contractor solely for informational purposes. The government may make unilateral changes to the evaluation methods outlined in the QASP during the contract performance period, but any changes to the QASP performance measures would require a contract modification because they are derived directly from the SOW.

Performance-based contracts generally do not identify a performance measure for each contract standard. Organizations letting these contracts identify key indicators of overall contractor performance and employ measures for monitoring those indicators to permit effective evaluation of contractor performance. An example of a key indicator for the MAC is the paid claims error rate. Many performance requirements (and their associated standards) for the MAC are specifically aimed at reducing the number of erroneously paid claims. These requirements are in various functional areas, including claims processing, provider education and training, continuous quality improvement, appeals, financial management, and medical review. Thus, the paid claims error rate serves as a key indicator of overall contractor performance for a MAC.

Incentives: Award Fee

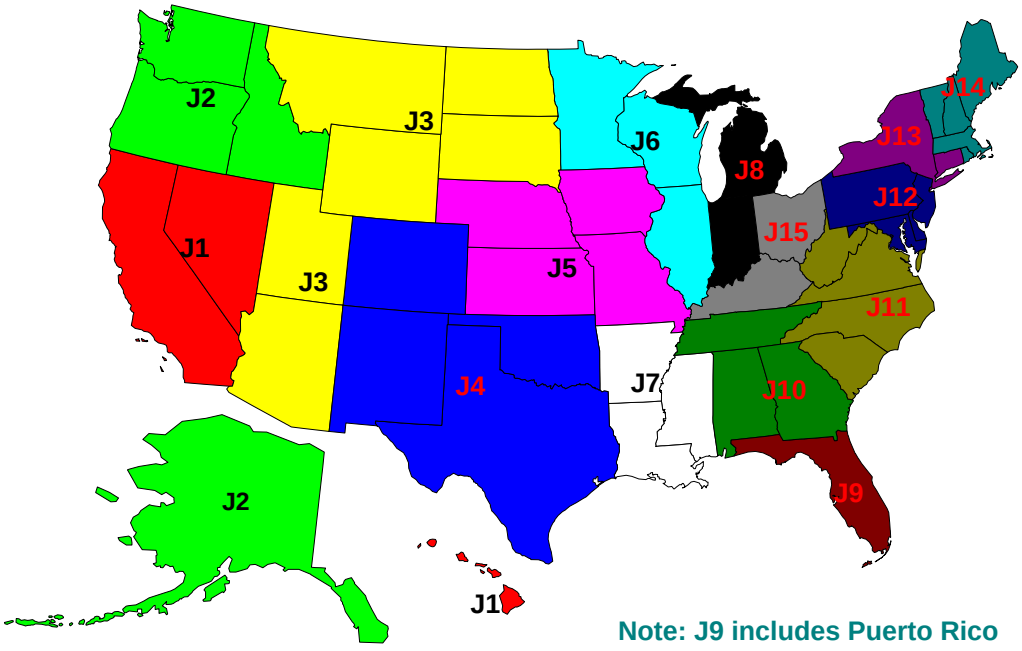
The purpose of an award-fee process is to motivate and reward contractor excellence in performance of contract requirements critical to program success, while meeting at least minimum acceptable performance levels in all other areas. Using cost-plus-award fee (CPAF) contracts, the MAC is reimbursed for all allowable, allocable, and reasonable costs incurred during contract performance in accordance with the terms of the contract. The fee arrangement for CPAF contracts

includes a base fee/profit negotiated at the time of contract award, as well as an award fee. The award fee is the amount of fee set aside in the contract that is available to be earned by the contractor. The contractor may earn none, some, or the entire maximum available award fee based on evaluated performance. The MMA requires contract incentives to encourage performance quality and efficiency.

Appendix A
Part A/B MAC Jurisdictions and Transition Schedule

CMS designed the new MAC jurisdictions to satisfy three criteria: promote competition, balance the allocation of workloads, and account for integration of claims processing activities. The resulting jurisdictions—shown in Figure A-1—reasonably balance the number of FFS beneficiaries, practitioners, and claims. Although these jurisdictions exhibit some variations in size and workload, they are significantly more balanced than the existing FI and carrier jurisdictions.

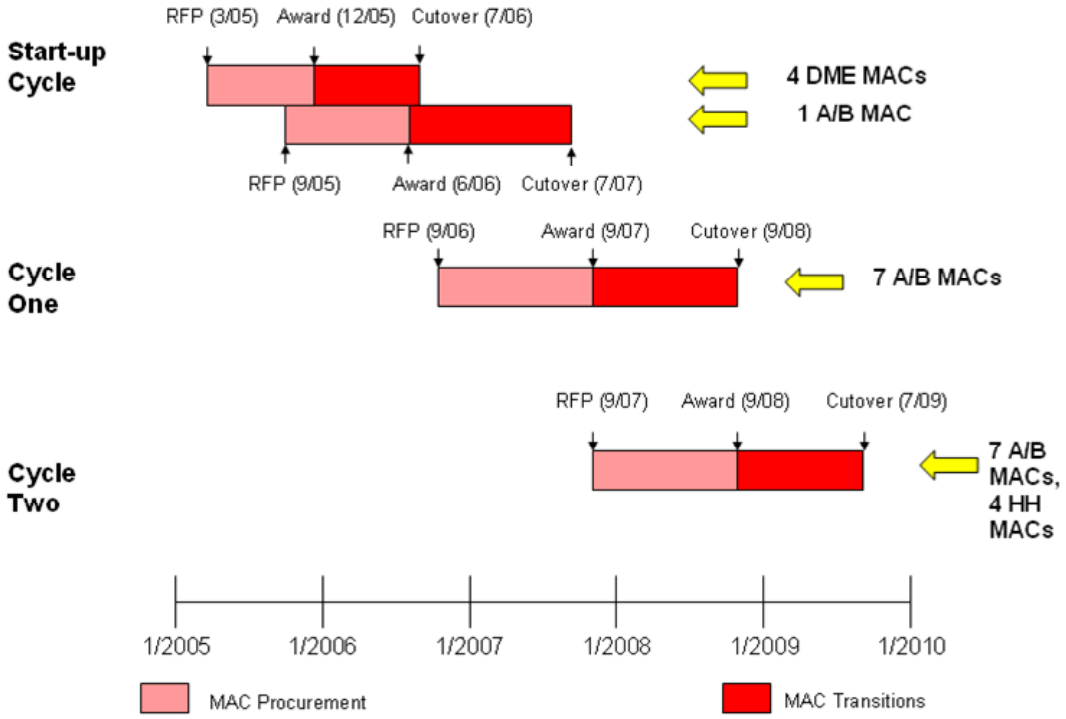
Figure A-1. Part A/B MAC Jurisdictions



CMS plans to compete the existing FI, carrier, RHHI, and DMERC workloads beginning with a start-up acquisition and transition cycle focused on a relatively small discrete workload followed by two MAC acquisition and transition cycles. CMS anticipates that each acquisition cycle—from solicitation to award—will take approximately 9 to12 months and estimates that the subsequent transition of workload from existing contractors to new MACs will take 6 to 13 months after a MAC award. The full FFS contracting workload will be transitioned to MACs by the MMA-mandated date of October 2011.

The start-up cycle shown in Figure A-2 will compete the current DMERC workloads and one A/B MAC jurisdiction. The comparatively small and stable nature of these workloads will allow CMS to examine its acquisition and transition efforts and to apply lessons learned to future cycles as well as train new personnel on specific activities. Cycles one and two will compete and transition the balance of the FFS workload. These cycles will each subject greater than 40 percent of the national workload to competition and transition at a single time. In addition, the cycles will require substantial risk management and contingency planning to minimize possible operational disruption.

Figure A-2. MAC Procurement and Transition Schedule



Note: CMS transition monitoring continues for three months post cutover.

Appendix B
Key Terms

This appendix defines key terms related to FFS claims processing. Additional definitions are available at www.cms.hhs.gov.

Table B-1. Key Terms

Term	Definition
Adjudicate	Processing of a claim to a finalized status. Adjudicate also means the process of rendering a decision on a pending appeal.
Beneficiary Contact Center (BCC)	Customer service center handling telephone and written inquiries from Medicare beneficiaries and other authorized people.
Bill	See “claim.”
Claim	Transaction submitted by a provider or beneficiary that meets all the requirements in 42 CFR 424.30–424.44. (See also “recovery claim.”)
Common Working File (CWF)	Medicare prepayment validation and authorization system that forms the cornerstone for Medicare transactions processing. It is the single data source that verifies beneficiary eligibility and provides approval of claims.
Complaint	See “fraud and abuse complaints” and “supplier complaint.”
Complex Inquiries	Inquiries (telephone or written) from Medicare beneficiaries that cannot be resolved by the Beneficiary Contact Center because further research is required or the inquiry involves a complex program issue.
Comprehensive Error Rate Testing (CERT)	CMS program to produce national, contractor-specific, and service-specific paid claim error rates.
Cutover	Actual point at which the outgoing contractor ceases Medicare operations and the new contractor begins to perform its Medicare functions.
Days	Federal business days unless otherwise specified.
Determination	See “initial determination” or “determination of program eligibility.”
Fraud and Abuse Complaints	Statement, oral or written, alleging that a provider, supplier, or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.
Function	Unique operation, which is separately identifiable, such as claim or bill payment, appeals, or medical review. Functions consist of a series of activities.
Good Cause	Sufficient ground or reason exists to take a specific action, principally in the claim appeals process.

Table B-1. Key Terms

Term	Definition
Healthcare Integrated General Ledger Accounting System (HIGLAS)	CMS integrated general ledger accounting system to account for Medicare payments. HIGLAS will replace the accounting systems currently used by Medicare contractors.
Implementation	Period of time beginning with the award of the MAC contract and ending with the operational date of the MAC. During this period, the MAC performs all of the activities specified in its implementation project plan to ensure the effective transfer of Medicare functions from the outgoing contractor. See "workload transition."
Initial Determination	Decision made to pay in full, pay in part, or deny a claim. However, other actions are also considered initial determinations and specific regulatory provisions define what constitutes an "initial determination for purposes of fee-for-service administrative appeal rights attaching." See specifically 42 CFR 405.924 and 405.926.
Interface	Entity with which the contractor must interact to ensure consistency of Medicare program operations.
Interface Requirement	Requirement that necessitates a mechanism—e.g., contract clause, Joint Operating Agreement (JOA), or Service-Level Agreement—to address ongoing activities contractors must conduct and entities they must interact with to ensure consistency of Medicare program operations. When there are interdependencies, these requirements serve to ensure that all parties understand their respective responsibilities.
Joint Operating Agreement (JOA)	Agreement between two or more contractors working for CMS who must interact with each other.
Jurisdiction	Geographic territory that the MAC will serve.
Local Coverage Determination (LCD)	A determination made by the PSC as to whether a particular item or service is reasonable and necessary.
Material Weakness	Failing to meet a control objective due to a significant deficiency in the design or operation of internal control policies and procedures.
Medicare Secondary Payer (MSP)	Series of statutory provisions that require other payers (including those that are self-insured) of medical items and services (e.g., group health plans, liability, and no-fault insurers) to make payment before Medicare pays when certain specific conditions are satisfied.
Medicare Summary Notice (MSN)	Monthly notice that a beneficiary receives once a claim has been filed for either Part A or B services with the MAC. It provides an explanation of what the provider billed for, how much Medicare paid, and the amount that is the beneficiary's responsibility.
National Provider Identifier (NPI)	Standard unique identifier for providers. The NPI is a numeric 10-digit identifier adopted by DHHS as the standard identifier for health care providers. The NPI will eventually replace the UPIN.
Paid Claims Error Rate	Rate that is based on dollars paid after the contractor made its payment decision on the claim/admission. It excludes any claim or admission that the contractor completely disallowed. The paid claims error rate is the percentage of dollars that the contractor erroneously paid and is a good indicator of how claim errors in the Medicare FFS program impact the trust fund. This error rate is based on dollars.

Table B-1. Key Terms

Term	Definition
Performance Measure	Clearly defined qualitative or quantitative method for determining the level of performance that a contractor has actually achieved.
Performance Requirement	Clear and concise statement of a desired outcome.
Performance Standards	Defined level of (expected) performance against which the quality of the contractor's services can be determined.
Program Safeguard Contractors (PSCs)	Contractor that performs specific program integrity functions under Section 1893 of the Act such as audit, medical review, and potential fraud and abuse investigations and case referrals, and some specialty functions (CERT, DAVE, etc.).
Provider	Any organization, institution, or individual (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.) that provides medical services covered under Medicare Part B.
Reconsideration	Second level of the Medicare fee-for-service claims appeals process. It is an independent review of the redetermination decision, including the initial determination, and is conducted by a Qualified Independent Contractor (a separate entity from the Medicare contractor). The person conducting the reconsideration must not have been involved in either the initial determination decision or the redetermination decision.
Redetermination	First level of the Medicare fee-for-service claims appeals process. It is an independent review of the initial claims determination and is conducted by the Medicare contractor. The individual conducting the redetermination must not have been a part of the initial determination decision. A redetermination decision is considered to be part of the initial determination and is performed by the MAC.
Regional Home Health Intermediary (RHHI)	Business entity that contracts with Medicare to pay home health and hospice bills and check on the quality of home health and hospice care.
Shared System (previously known as standard system)	System provided by CMS to process Medicare claims. For professional claims (e.g., physician claims), the system is Multi Carrier System (MCS); for institutional providers (e.g., hospital nursing homes), the system is the Fiscal Intermediary Standard System (FISS).
Supplier	Provider that generally provides supplies or specific medical services (e.g., independent diagnostic testing facility, laboratory services, or ambulance services). The term "provider" encompasses "supplier." See "provider."
Suspended Claim	Claim that is flagged by the claims processing system and must be resolved before the claim can be processed to completion.
Unique Physician/ Practitioner Identification Number (UPIN)	Unique identifier for each physician, practitioner, or group practice that provides services for which Medicare payment is made.

Appendix C
Demonstration Projects and Jurisdiction-Specific Activities

Table C-1 lists the demonstration projects as of June 2007.

Table C-1. Demonstration Projects

Name
Lab Competitive Bidding
Frontier Extended Stay
ACE–Global Payment
Adult Day Care Home Health
Vision Rehab
Rural Hospice Demonstration

Table C-2 lists types of jurisdiction-specific activities.

Table C-2. Jurisdiction-Specific Activities

Title	Jurisdiction
Centralized Billing for Mass Immunizers	4
Indian Health Services	4
Low Vision Demonstration	2, 5, 10, 11, 13, 14
Rural Community Hospital	1, 2, 3, 4, 5
Veterans Affairs Medicare Equivalent Remittance Advice Project	4
Chiropractic Care Services Demonstration	4, 5
Utah Graduate Medical Demonstration Project	3
Provider Internet Portal	3
Frontier Extended Stay Clinic Demonstration	2, 3, 4
Pay for Performance Check-Writing	4
Medicare Part B Drug Code Crosswalk File	11
Home Health Third Party Liability Demonstration Project	14
Medicare Adult Day Care Demonstration	11, 14, 15
Limited Purpose Insurance Company	10
Organ Procurement Organizations	10
Religious Nonmedical Health Care Institution	10

Table C-2. Jurisdiction-Specific Activities

Title	Jurisdiction
Histocompatibility Lab	10
Spanish Translation of HCPCS Code Descriptors	9
High Risk Fraud and Abuse Areas	1, 4, 8, 9, 13
Medicare Home Health Agency Provider Enrollment Demonstration	6, 11
Infusion Demo	9

Appendix D
Abbreviations

ALC	Assembler Language Code
ALJ	Administrative Law Judge
BCC	Beneficiary Contact Center
BIPA	Benefits Improvement and Protection Act of 2000
CAFM	Contractor Administrative Budget and Financial Management System
CAS	Cost Accounting Standards
CERT	Comprehensive Error Rate Testing Database
CFO	Chief Financial Officer
CICS	Customer Information Control System
CMIS	Contractor Management Information System
CMS	Centers for Medicare and Medicaid Services
COBC	Coordination of Benefits Contractor
CPAF	Cost Plus Award Fee
CROWD	Contractor Reporting of Operational and Workload Data System
CWF	Common Working File
DAB	Departmental Appeals Board
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
DNS	Domain Name Services
EA	Enterprise Architecture
EDC	Enterprise Data Center
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EMC	Electronic Media Claim
EMSN	Electronic Medicare Summary Notice

FAR	Federal Acquisition Regulation
FBI	Federal Bureau of Investigation
FFS	Fee for Service
FI	Fiscal Intermediary
FISS	Fiscal Intermediary Standard System
GFE	Government-Furnished Equipment
GHP	Group Health Plan
HH	Home Health and Hospice
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act
IRU	Interactive Response Unit
IT	Information Technology
IVR	Interactive Voice Response
JIPP	Jurisdiction Implementation Project Plan
JOA	Joint Operating Agreement
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MCMG	Medicare Contractor Management Group
MCPR	Medicare Claims Processing Redesign
MCS	Multi-Carrier System
MDC	Medicare Data Center
MDCN	Medicare Data Communications Network
MEDIS	Medicare Electronic Data Interchange System
MIP	Medicare Integrity Program
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MOU	Memorandum of Understanding
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OSCAR	Online Survey, Certification and Reporting
PECOS	Provider Enrollment, Chain and Ownership System

PKI	Public Key Infrastructure
PMO	Program Management Office
PS&R	Provider Statistical and Reimbursement System
PSC	Program Safeguard Contractor
QAP	Quality Assurance Plan
QASP	Quality Assurance Surveillance Plan
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
ReMAS	Recovery Management and Accounting System
RHHI	Regional Home Health Intermediary
SAS	Statement of Auditing Standards
SCF	System Control Facility
SOW	Statement of Work
TRM	Technical Reference Model
UPIN	Unique Provider Identification Number