FY2021 QASP Performance Requirements Summary

Functional Area	Function Abbreviation	Performance Standard #	Performance Standard Name	Performance Standard Language	Government Operational Adjudication Level (GOAL)	Weight	Applicable to A/B and/or DME
Appeals	AP	8	Redetermination Timeliness - Part A	Timeliness requirements are found in the Social Security Act (SSA), §1869(a)(3)(C)(ii). In addition, regulations found at 42 Code of Federal Regulations (CFR) §405.950(b)(2) outline that redeterminations are successful (timely) when all redeterminations are processed and mailed within 60 calendar days of receipt in the corporate mailroom, or, within 60 calendar days of the latest filed request for consolidated redetermination requests made by different parties for the same claim.	100%	16.6%	A/B Only
Appeals	AP	9	Redetermination Notice Accuracy - Part A	Medicare Redetermination Notices (MRNs) are accurate, clear, and concise when all of the elements specified in 42 CFR §405.956(b) are included and fully addressed in the redetermination notices and the MRNs are responsive to all substantive issues raised by the appellant.	90%	16.8%	A/B Only
Appeals	AP	10	Effectuation Timeliness - Part A	Effectuations of appeal decisions (redeterminations, reconsiderations, and Administrative Law Judge (ALJ) hearings) are processed within 30 days of the date of the decision if a specific amount to be paid is stated, or within 30 days after the contractor computes the amount to be paid, which must be done no later than 30 days of the receipt of the decision. Timeframes noted above are tied to the date of the decision for redeterminations, the date of receipt of the effectuation notice from the QIC for reconsiderations, or the date of receipt of the effectuation notice from the Administrative QIC, for ALJ effectuations.	100%	16.6%	A/B Only
Appeals	AP	12	Redetermination Timeliness - Part B	Timeliness requirements are found in the SSA, §1869(a)(3)(C)(ii). In addition, regulations found at 42 Code of Federal Regulations (CFR) §405.950(b)(2) outline that redeterminations are successful (timely) when all redeterminations are processed and mailed within 60 calendar days of receipt in the corporate mailroom, or, within 60 calendar days of the latest filed request for consolidated redetermination requests made by different parties for the same claim.	100%	12.5%	A/B Only
Appeals	AP	13	Redetermination Notice Accuracy - Part B	Medicare Redetermination Notices (MRNs) are accurate, clear, and concise when all of the elements specified in 42 CFR §405.956(b) are included and fully addressed in the redetermination notices and the MRNs are responsive to all substantive issues raised by the appellant.	90%	12.5%	A/B Only
Appeals	AP	14	Effectuation Timeliness - Part B	Effectuations of appeal decisions (redeterminations, reconsiderations, and Administrative Law Judge (ALJ) hearings) are processed within 30 days of the date of the decision if a specific amount to be paid is stated, or within 30 days after the contractor computes the amount to be paid, which must be done no later than 30 days of the receipt of the decision. Timeframes noted above are tied to the date of the decision for redeterminations, the date of receipt of the effectuation notice from the QIC for reconsiderations, or the date of receipt of the effectuation notice from the Administrative QIC, for ALJ effectuations.	100%	12.5%	A/B Only
Appeals	AP	15	QIC Case File Submission Timeliness - Part B	Case files are forwarded to the QIC within seven (7) calendar days of the date of the QIC's request.	100%	12.5%	A/B Only
Appeals	AP	16	Redetermination Timeliness - DME	Timeliness requirements are found in the (SSA, §1869(a)(3)(C)(ii). In addition, regulations found at 42 Code of Federal Regulations (CFR) §405.950(b)(2) outline that redeterminations are successful (timely) when all redeterminations are processed and mailed within 60 calendar days of receipt in the corporate mailroom, or, within 60 calendar days of the latest filed request for consolidated redetermination requests made by different parties for the same claim.	100%	25.0%	DME Only
Appeals	AP	17	Redetermination Notice Accuracy - DME	Medicare Redetermination Notices (MRNs) are accurate, clear and concise when all of the elements specified in 42 CFR § 405.956(b) are included and fully addressed in the redetermination notices, and the MRNs are responsive to all substantive issues raised by the appellant.	90%	25.0%	DME Only

FY2021 QASP Performance Requirements Summary

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Appeals	AP	18	Effectuation Timeliness - DME	Effectuations of appeal decisions (redeterminations, reconsiderations, and Administrative Law Judge (ALJ) hearings) are processed within 30 days of the date of the decision if a specific amount to be paid is stated, or within 30 days after the contractor computes the amount to be paid, which must be done no later than 30 days of the receipt of the decision. Timeframes noted above are tied to the date of the decision for redeterminations, the date of receipt of the effectuation notice from the QIC for reconsiderations, or the date of receipt of the effectuation notice from the Administrative QIC, for ALJ effectuations.	100%	25.0%	DME Only
Appeals	AP	19	QIC Case File Submission Timeliness - DME	Case files are forwarded to the QIC within seven (7) calendar days of the date of the QIC's request.	100%	25.0%	DME Only
Audit & Reimbursement	AR	1	Late & Rejected Cost Reports: Payment Suspension	The Contractor will suspend the payments at either 100% or a reduced rate if the provider requested and was approved for a reduction in the suspension rate and issue a demand letter for all interim and lump sum payments made for the applicable fiscal year if an acceptable cost report was not timely filed. The Contractor will not remove the provider from suspension until a cost report is filed and determined acceptable.	100%	7%	A/B Only
Audit & Reimbursement	AR	2	Cost Report Reopening Quality: Compliance and Accuracy	Cost report reopenings will be considered accurate when they comply with Medicare rules and regulations. The STAR final information receipt date shall be validated with documentation contained in the reopening file which supports the final information receipt date.	95%	18%	A/B Only
Audit & Reimbursement	AR	4	Desk Review & Audit Quality	Cost reports are settled accurately when a CMS review determines compliance with Medicare rules and regulations.	95%	20%	A/B Only
Audit & Reimbursement	AR	6	Cost Report Acceptability Timeliness	The contractor is required to make a documentation of acceptability within 30 days of receipt of the provider's cost report.	99%	2%	A/B Only
Audit & Reimbursement	AR	7	Tentative Settlement Timeliness	Tentative Settlements – A tentative settlement is considered timely if completed within 90 days of acceptance of the cost report.	99%	2%	A/B Only
Audit & Reimbursement	AR	9	NPR Timeliness Audits	The Contractor shall issue the NPR and final adjustment report for cost reports that are audited in accordance with IOM Pub. 100-06, Chapter 8, §90.	99%	2%	A/B Only
Audit & Reimbursement	AR	10	NPR Timeliness: No Audits	The Contractor shall issue the NPR for cost reports that do not require an audit within 12 months of acceptance date of a cost report in accordance with IOM Pub. 100-06, Chapter 8, §90.	99%	2%	A/B Only
Audit & Reimbursement	AR	11	Cost Report Reopenings: Timeliness	The Contractor is required to issue a revised Notice of Program Reimbursement for all reopened cost reports within 180 days of receipt of all information/documentation necessary to resolve the reopening issue(s) per IOM Pub Chapter 8, Section 100.	99%	2%	A/B Only
Audit & Reimbursement	AR	13	Cost Report Appeal Quality: Issue Resolution Accuracy	An issue resolution is considered accurate when a CMS review determines that the issues resolved and adjusted in the RNPR were jurisdictionally valid in the appeal and the resolution was in compliance with Medicare Regulations and policy. This includes a reopening resulting from an appeal.	95%	18%	A/B Only
Audit & Reimbursement	AR	16	Cost Report Outlier Reconciliation	A cost report shall be forwarded to CMS for an outlier reconciliation prior to issuing the NPR if the cost report requires an outlier reconciliation based on thresholds contained in the Internet Only Manual. CMS IOM Pub. 100-04, Chapters 3 and 4.	100%	5%	A/B Only
Audit & Reimbursement	AR	24	Hospice CAPs [Applicable to Home Health and Hospice MACs]	The Hospice aggregate cap is considered accurately computed when the calculation conforms to Regulation and Policy.	100%	5%	A/B Only
Audit & Reimbursement	AR	25	Healthcare Cost Report Information System (HCRIS): Timeliness	The Contractor shall submit an extract of the following Medicare cost reports to CMS with HCRIS specifications within 210 days of the cost reporting period ending date or 60 days after receipt of the cost report, whichever is later. This submission must pass all level one edits and all HCRIS reject edits. The Contractor shall within 30 days after issuance of the Notice of Program Reimbursement (NPR) to the provider, submit to CMS an extract of the following Medicare cost reports in accordance with HCRIS specifications. This submission must pass all level one electronic cost report edits and all HCRIS reject edits.	99%	2%	A/B Only
Audit & Reimbursement	AR	26	STAR Database Maintenance	STAR database is maintained accurately and timely when a CMS review indicates that it is in compliance with the STAR manual.	95%	15%	A/B Only
Beneficiary Customer Service	BCS	1	Timeliness of Responses to Congressional Inquiries	All Congressional written inquiries shall be responded to in writing within 10 business days of receipt.	100%	15%	A/B and DME

FY2021 QASP Performance Requirements Summary

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Beneficiary Customer Service	BCS	2	Accuracy of Responses to Congressional Inquiries	Contractors shall ensure the responses are accurate, complete, and presented in a professional manner. QWCM is the primary way for CMS to assess if Medicare customer service is meeting the performance standards established for accuracy, completeness, courtesy, and professionalism.	100%	30%	A/B and DME
Beneficiary Customer Service	BCS	3	Timeliness of Responses to Complex Beneficiary Inquiries	MACs shall provide clear and accurate responses to complex beneficiary inquiries within 25 business days for at least 75 percent of inquiries referred by the BCC or the CMS ROs; and within 45 business days for 100 percent of all inquiries referred by the BCC or the CMS ROs.	100%	15%	A/B and DME
Beneficiary Customer Service	BCS	4	Accuracy of Responses to Complex Beneficiary Inquiries	MACs shall ensure that the written responses to complex beneficiary inquiries are accurate, complete, responsive, clearly written and presented in a professional manner. QWCM is the primary way for CMS to assess if Medicare customer service is meeting the performance standards established for accuracy, completeness, courtesy, and professionalism.	100%	30%	A/B and DME
Beneficiary Customer Service	BCS	5	NGD Acceptance and Tracking	Complex beneficiary inquiries will be identified and referred to the MACs by the BCC or the ROs via NGD. Once a complex beneficiary inquiry is referred to a MAC, the MAC shall respond directly to the beneficiary via telephone, written mail, fax, or e-mail and document the response in NGD.	95%	10%	A/B and DME
Claims Processing	CP	1	FISS Processing	Clean electronic media claims are processed timely on a monthly basis when 95% of the Part A and the Part B of A claims processed in the FISS are processed within the claims payment floor and ceiling.	100%	20%	A/B Only
Claims Processing	CP	2	MCS Processing	Clean electronic media claims are processed timely on a monthly basis when 95% of the Part B claims processed in the MCS are processed within the claims payment floor and ceiling.	100%	20%	A/B Only
Claims Processing	CP	4	VMS Processing	Clean electronic media claims (EMC) are processed timely on a monthly basis when 95% of the DME claims processed in the VMS are processed within the claims payment floor and ceiling.	100%	45%	DME Only
Claims Processing	CP	5	MSN Management in FISS	Medicare Summary Notice (MSN) management is successful when the Contractor accurately generates and mails 98% of Part A and Part B of A MSNs in FISS monthly.	100%	20%	A/B Only
Claims Processing	CP	6	MSN Management in MCS	Medicare Summary Notice (MSN) management is successful when the Contractor accurately generates and mails 98% of Part B MSNs in MCS monthly.	100%	20%	A/B Only
Claims Processing	CP	7	MSN Management in VMS	Medicare Summary Notice (MSN) management is successful when the Contractor accurately generates and mails 98% of MSNs in VMS monthly.	100%	45%	DME Only
Claims Processing	CP	8	Pending Part A & Home Health & Hospice Claims Processing in FISS	For Part A MACs only, the Contractor’s pending Claims Processing is timely, as measured on a monthly basis, when the Contractor processes 99.5% of pending claims within 45 days. For Part A and HHH MACs, the Contractor’s combined Part A pending Claims Processing and HHH pending Claims is timely, as measured on a monthly basis, when the Contractor processes 99.5% of both Part A and HHH pending claims within 45 days.	100%	10%	A/B Only
Claims Processing	CP	9	Pending Claims Processing in MCS	The Contractor’s pending Part B Claims Processing is timely, as measured on a monthly basis, when the Contractor processes 99.5% of pending claims within 45 days.	100%	10%	A/B Only
Claims Processing	CP	10	Pending Claims Processing in VMS	The Contractor’s pending Claims Processing is timely, as measured on a monthly basis, when the Contractor processes 99.5% of pending claims within 45 days.	100%	10%	DME Only
Debt Management	DM	1	Debt Referral Procedures	The Contractor's debt referral procedures are successful when its eligible delinquent debts are referred to Treasury by the 120th day of delinquency.	100%	10%	A/B and DME
Debt Management	DM	2	All Non-MSP Non-935 Recovery Process	The Contractors' overpayment procedures on Providers, Physicians, and other suppliers are successful when the recovery activities and processes are accurate and timely.	100%	20%	A/B and DME
Debt Management	DM	3	935 Limitation on Recoupment - Appeal Request Process *including the Receipt Letter*	The Contractor's 935 Limitation on Recoupment processes are successful when the Contractor updates all activity in the internal systems (MCS, VMS, FISS and HIGLAS) such as Monitoring Accounts Receivables in a Redetermination or Reconsideration Status and sending the acknowledgement letters timely upon receipt of a first or second level appeal request.	100%	20%	A/B and DME
Debt Management	DM	4	935 Interest Calculation	The Contractor's processes related to calculation of 935 interest are successful when 935 interest is calculated properly and is sent to the debtor timely.	100%	20%	A/B and DME
Debt Management	DM	5	Extended Repayment Schedule (ERS)	The Contractor's processes on Extended Repayment Schedules are successful when the MAC properly processes the ERS requests, sends the acceptance letter timely, applies the monthly ERS payments timely, if applicable, defaults the ERS timely. (IOM Pub. 100-6, Chapter 4, §50).	100%	10%	A/B and DME
Debt Management	DM	10	935 Limitation on Recoupment - Receipt of Appeal Decision Process	The Contractor's 935 Limitation on Recoupment processes are successful when the Contractor updates the internal systems (MCS, VMS and HIGLAS) and sends appropriate follow-up letters timely upon receipt of an appeal decision.	100%	10%	A/B and DME

FY2021 QASP Performance Requirements Summary

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Debt Management	DM	12	All Non-MSP (935 & Non-935) Undeliverable Demand Letter and ITR Letter Recovery Process.	The Contractors' overpayment procedures on Providers, Physicians, Other suppliers are successful when the recovery activities and processes are accurate and timely.	100%	10%	A/B and DME
Financial Management	FM	1	Trend Analysis	The Contractor shall perform and report accounts receivable trend analyses to ensure that the financial data reported are accurate.	100%	11%	A/B and DME
Financial Management	FM	2	Benefits Account Maintenance	The benefits account is maintained successfully when it is timely reconciled with the bank statement.	100%	16%	A/B and DME
Financial Management	FM	3	Cash Collection Deposits	The Contractor shall identify cash collections deposited in the Medicare Trust Funds related to Medicare overpayments on the Cash Collections Worksheet. The worksheet shall be submitted timely and reconcile to the Financial Statements and bank statements.	100%	9%	A/B and DME
Financial Management	FM	4	Accounts Receivable	The Contractor shall timely reconcile accounts receivable balances reported on the financial statements and all related transactions. (i.e., Currently-Not-Collectable and Write-off Closed) Financial data should be checked to ensure the validity, accuracy, completeness, and reconciliation of data before submission to CMS.	100%	16%	A/B and DME
Financial Management	FM	5	Use of Trust Fund Dollars	The Contractor's use of trust fund dollars is successful when it will not cause CMS to be cited for financial management related deficiencies on the CMS annual CFO audit.	100%	16%	A/B and DME
Financial Management	FM	8	Corrective Action Procedures	The Contractor's corrective action plans (CAPs) are successful when its deficiencies have been recommended for closure by the SSAE 18 Auditors or CMS Regional Office staff within 1 year of being formally communicated (e.g. Final SSAE 18 Report, Chief Financial Officer (CFO) Objective Attribute Recap Sheet (OARS) notification, etc.).	100%	16%	A/B and DME
Financial Management	FM	9	SSAE-18 Audit	Ability to obtain an unqualified opinion on annual SSAE 18 Audits.	100%	16%	A/B and DME
Freedom of Information Act	FOIA	1	Process FOIA Requests – Timeliness	FOIA requests are processed on a timely basis when completed within 20 working days of receipt. If it is not possible to furnish the records within 20 working days, the Contractor will send the requester, within 20 workdays, a substantive response that states that the records will be released and explains the reason for the delay.	97%	20%	A/B and DME
Freedom of Information Act	FOIA	2	Process FOIA Request – Accuracy	The processing of FOIA requests complies with the requirements of IOM Pub. 100-01, Chapter 6 and the FOIA Policy and Procedural Guide. (1) Replies to FOIA requests address all types of requested records. (2) If records are provided directly to the requester, direct release is proper. (3) If records are referred to CMS for action, the transfer is appropriate. (4) If a FOIA request is denied, the denial is appropriate. (5) Fee-related denials are issued as appropriate to requesters that are delinquent in payment for past requests. (6) FOIA requests are classified correctly for billing purposes and amounts billed are correct.	95%	30%	A/B and DME
Freedom of Information Act	FOIA	3	Process FOIA Requests – Privacy	FOIA requests for Protected Health Information are handled in accordance with instructions in IOM Pub. 100-01, Chapter 6 and the FOIA Policy and Procedural Guide	100%	30%	A/B and DME
Freedom of Information Act	FOIA	4	Process FOIA Requests – Reporting	Data elements on which CMS reporting of FOIA performance are based, are correct in accordance with IOM Pub. 100-01 Chapter 6, and the FOIA Policy and Procedural Guide.	97%	20%	A/B and DME
Medical Review	MR	3	Data Analysis & Information Gathering	The data analysis plan shall list the data resources and processes used in developing the strategy.	93%	30%	A/B and DME
Medical Review	MR	4	Edit Implementation and Effectiveness	Edits (Pre/Post, Provider/CMS approved service specific) Probe and/or TMR) are implemented and/or revised to select claims for targeted probe and educate reviews (or non-TPE reviews).	93%	25%	A/B and DME
Medical Review	MR	5	Medical Review of Claims and Documentation	The contractor shall conduct medical review of claims submitted by providers or suppliers.	93%	15%	A/B and DME
Medical Review	MR	6	PCA and Targeted Probe and Educate (TPE) Interventions	When an error has been validated through the TPE or PCA process, the corrective action imposed by the Contractor should match the severity of the error. PCA would only apply to MR activity performed before TPE was started by the MAC and/or in a CMS approved MR acitivity.	93%	30%	A/B and DME
Medicare Secondary Payer	MSP	1	"I" Record Accuracy	Following all policy and operation procedures identified in the IOM and CMS TDLs, an "I" record is to be added accurately to the CWF upon receipt of an MSP claim with complete primary payer notification (e.g. EOB, remittance advice, or information found within the electronic claim) if no MSP record with the same MSP type already exists in CWF. All complete primary payer information on hand must be included on the "I" record submission.	95%	11%	A/B and DME

FY2021 QASP Performance Requirements Summary

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Medicare Secondary Payer	MSP	2	ECRS "SCLM" Referral – Accuracy	Upon receipt of a claim with incomplete MSP primary payer notification, with or without attachments, the Contractor shall follow all policy and operational procedures identified in the IOM, and submit a complete and accurate MSP inquiry or assistance request transaction to the BCRC via the ECRS based on the information present with the notification.	95%	11%	A/B and DME
Medicare Secondary Payer	MSP	4	MSP Correspondence/Inquiries	MSP provider, physician and other supplier correspondence/inquiries, including those requiring ECRS "LTTR," shall be acknowledged or responded to accurately within 45 calendar days of receipt, absent IOM instructions to the contrary. "Inquiries" shall include both prepay and post pay correspondence. An adjustment will be considered a response. Checks are not included in this standard. When an ECRS transaction is initiated and an interim response is issued to meet the 45 day timeframe, a final response (letter or adjustment) is required once the ECRS response is received.	95%	11%	A/B and DME
Medicare Secondary Payer	MSP	5	Voluntary Refund Development- Checks (ECRs Referral)-Accuracy	Voluntary refunds that do not have an associated MSP record on CWF are referred to the BCRC via ECRS accurately. Accurately is defined as following all policy and operational procedures identified in the IOM in order to submit a complete and accurate MSP record to the BCRC via ECRS based on the information received in regards to the voluntary/unsolicited refund.	95%	11%	A/B and DME
Medicare Secondary Payer	MSP	6	Solicited Refund Adjudication (Established Debt)	Solicited refund checks, where an associated MSP record is on CWF, are to be posted and adjudicated within 20 calendar days from the check's date of deposit. (The A/Rs for these debts were established when the demand was issued.)	95%	11%	A/B and DME
Medicare Secondary Payer	MSP	7	Voluntary Refund Adjudication (Establishment of the A/R or Debt)	Upon receipt of a voluntary refund where no ECRS is needed, an AR is to be established. These voluntary refunds are to be posted accurately to establish the A/R or debt within 60 calendar days from the check's date of deposit.	95%	8%	A/B and DME
Medicare Secondary Payer	MSP	8	Hospital Audits	The Part A contractor shall perform hospital audits and reviews in accordance with IOM Pub 100-05, Chapter 3, §20 and §30 and Chapter 5, §70 (including associated exhibits, 70.5.1 – 70.5.4).	100%	4%	A/B Only
Medicare Secondary Payer	MSP	9	"I" Record Timeliness	When the creation of an "I" record is required, it is to be added to CWF within 10 calendar days from when the claim is suspended for MSP (internal system or CWF, whichever suspends first). The contractor shall retain suspense dates and be able to provide either screen prints or create upon request a report reflecting all status dates of claim suspensions. Note, that this standard is not impacting claims processing time standards.	95%	11%	A/B and DME
Medicare Secondary Payer	MSP	10	ECRS "SCLM" Referral –Timeliness	When an ECRS Inquiry or Assistance request is required due to receipt of a claim with incomplete primary payer information (with or without attachments), it is to be transmitted within 10 days from when the claim is suspended for MSP (CWF or internal system, whichever is first) or within 45 calendar days of receipt of claim.	95%	11%	A/B and DME
Medicare Secondary Payer	MSP	11	Voluntary Refund Development- Checks (ECRs Referral) - Timeliness	Voluntary refunds that do not have an associated MSP record on CWF are referred to the BCRC via ECRS timely. Timeliness is defined as voluntary/unsolicited refunds that do not have an associated MSP record on CWF are referred to the BCRC via ECRS within 20 calendar days from the check's date of deposit.	95%	11%	A/B and DME
Provider Customer Service Program	PCSP	1	Telephone Inquiry Responses – QCM	Of all telephone calls monitored for the quarter, the percentage of calls scoring as "Achieves Expectations" or higher for Knowledge Skills and Customer Skills and scoring as "Pass" for Adherence to Privacy Act using the Quality Call Monitoring tool shall be no less than 93% (cumulative for the quarter).	93%	18%	A/B and DME
Provider Customer Service Program	PCSP	2	Telephone Inquiry – Call Completion Rate	The provider contact center shall complete at least 95% of incoming calls on an IVR-only line, 80% of incoming calls on a CSR-only line, and 80% of incoming calls on an IVR/CSR combined line as measured on a quarterly basis.	100%	10%	A/B and DME
Provider Customer Service Program	PCSP	3	Telephone Inquiries – Average Speed of Answer	The provider contact center shall maintain an average speed of answer of 60 seconds or less when measured on a quarterly basis.	100%	18%	A/B and DME
Provider Customer Service Program	PCSP	4	Written Inquiry Responses – QWCM	Of all written responses monitored for the quarter (including Provider Relations Research Specialists' (PRRS) responses), the percentage of written inquiry responses scoring as "Achieves Expectations" or higher for Knowledge Skills and Customer Skills and scoring as "Pass" for Adherence to Privacy Act using the Quality Written Correspondence Monitoring tool (QWCM) shall be no less than 93% (cumulative for the quarter).	93%	18%	A/B and DME
Provider Customer Service Program	PCSP	5	Written Inquiry Responses - Timeliness	All (100%) written provider general and provider PRRS inquiries shall be responded to within 45 business days of receipt with either a final response or an interim response; and no more than 5% of the universe of written responses to provider inquiries shall be interim responses.	100%	18%	A/B and DME

FY2021 QASP Performance Requirements Summary

Functional Area	Function Abbreviation	Performance Standard #	Performance Standard Name	Performance Standard Language	Government Operational Adjudication Level (GOAL)	Weight	Applicable to A/B and/or DME
Provider Customer Service Program	PCSP	8	Quality Assurance Monitoring	The MAC shall achieve an average quality rate of at least 93% for all CSR calls monitored under QAM for the contract year. The average quality rate is represented by the percentage of QAM scorecards that were marked as "Passed" during the contract year. This percentage is determined by dividing the total number of QAM scorecards marked as "Passed" by the total number of QAM scorecards that were completed during the contract year. With respect to A/B MACs whose contracts include HH+H work, the CMS independent monitoring contractor shall generate separate scorecards and totals for A/B calls and for HH+H calls, but these scorecards shall be combined to determine the total number of scorecards completed, the total number of scorecards passed, and the total number of scorecards failed for the jurisdiction.	≥93	18%	A/B and DME
Provider Enrollment	PE	2	Overall Application Accuracy	The enrollment applications described in C.5.5.1 and C.5.5.2 of the SOW will be considered accurately processed when 98% of applications are processed in accordance with all of the instructions in IOM Pub. 100- 08, Section 15.6.1.2, 15.6.1.4, 15.6.2.2 and 15.6.2.4, with the exception of the timeliness standards identified in Standard 1 of C.5.5.2.	98%	18%	A/B Only
Provider Enrollment	PE	4	Revocation Processing Accuracy	Revocation actions will be considered accurate when the contractor processes them in full accordance with all revocation instructions in IOM Pub. 100-08, Ch. 15, Section 15.27.2.	100%	18%	A/B Only
Provider Enrollment	PE	5	Appeal Accuracy	Appeal actions will be considered accurate when the contractor processes them in full accordance with all appeals instructions in IOM PUB. 100-08, Ch. 15, Section 15.25.	100%	12%	A/B Only
Provider Enrollment	PE	6	PECOS Accuracy	The Contractor shall use the government-furnished Provider Enrollment, Chain and Ownership System (PECOS) in full accordance with all instructions in IOM Pub. 100-08, Ch. 15, Sections 15.6.1.2, 15.6.1.4, 15.6.2.2 and 15.6.2.4.	98%	12%	A/B Only
Provider Enrollment	PE	7	Appeals Timeliness	Appeal actions will be considered timely when the contractor processes them in full accordance with all appeals instructions in IOM PUB. 100-08, CH. 15, Sections 15.25.1.1B and 15.25.1.2E.	100%	6%	A/B Only
Provider Enrollment	PE	8	Revalidation Accuracy	Revalidations will be considered accurate when 98% of applications are processed in accordance with all of the instructions in IOM Pub. 100-08, Chapter 15, Section 15.29 using the government-furnished Provider Enrollment, Chain and Ownership System (PECOS) and in full accordance with all revalidation instructions in Change Requests (CRs) 7588, 8274, 8798 and any revalidation instruction CR and all Revalidation Technical Direction Letters (TDLs).	98%	10%	A/B Only
Provider Enrollment	PE	10	Opt Out Affidavit Processing Accuracy	The Opt Out Affidavits described in C.5.5.1 of the SOW will be considered accurately processed when 98% of affidavits are processed in accordance with all of the processing instructions in IOM Pub. 100-02, Chapter 15, Section 40 and Pub. 100-08, Chapter 15, Section 15.14.7.	98%	5%	A/B Only
Provider Enrollment	PE	11	Initial and Revalidation Application and Opt out Timeliness.	Initial Applications described in C.5.5.1 of the SOW will be considered timely when processed in the timeliness standards found in IOM Pub. 100-08, Chapter 15, Section 15.6.	98%	12%	A/B Only
Provider Enrollment	PE	12	Change of Information Application and Opt-Out Timeliness	Change Applications described in C.5.5.2 of the SOW will be considered timely when processed in the timeliness standards found in IOM Pub. 100-08, Chapter 15, Section 15.6.2.	98%	7%	A/B Only