MEDICARE FEE-FOR-SERVICE CONTRACTORS

A Current and Future Overview

Provider Open Door Forum

April 15, 2004

2:00pm – 4:00 pm EST

MEDICARE FEE-FOR-SERVICE CONTRACTOR OPERATIONS

OVERVIEW OF CURRENT ENVIRONMENT

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CURRENT ENVIRONMENT

Fiscal Intermediaries (FIs)

- Process claims for:
  - Hospital Services
  - Skilled Nursing Facility Services
  - Home Health Services
  - Hospice Care

Carriers

- Process claims for:
  - Durable Medical Equipment
  - Physician Services
  - Independent Laboratory Services

- *Currently, 26 FIs and 18 Carriers process Medicare Fee-for-Service (FFS) claims*
- *Several companies serve as both FIs and Carriers*

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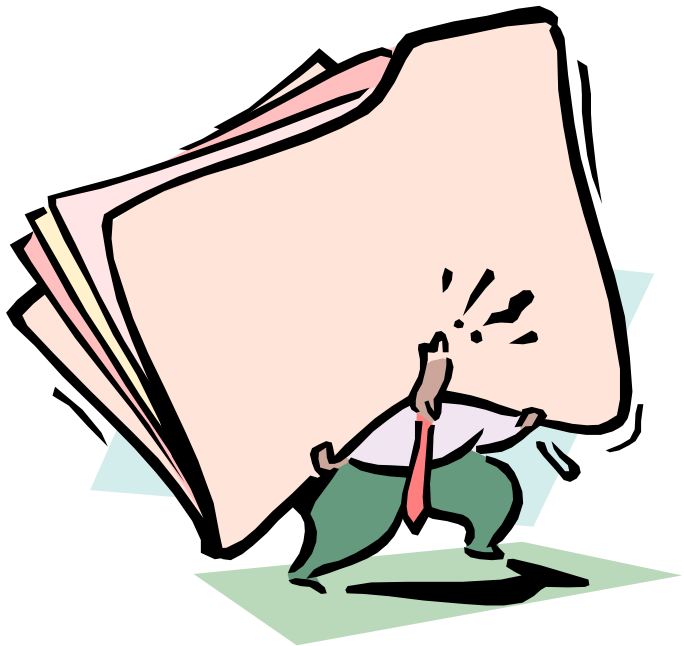
MAJOR ADMINISTRATIVE FUNCTIONS OF CONTRACTORS



- Claims Processing
- Customer Service
- Appeals
- Overpayments
- Medicare Provider Enrollment
- Medical Review

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STATISTICS AT A GLANCE

In FY 2003, the Medicare claims processing contractors:

Worked with approximately **1.1 million** health care providers.

Processed more than **1 billion** Medicare claims.

Provided claims processing and customer service to about **33 million** beneficiaries.

Paid more than **$200 Billion** for beneficiary health care services.

NOTE: *The majority of claims are submitted electronically*

- *Part A – 98.1%*
- *Part B – 84.5%*

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CURRENT CONTRACT EVALUATION ENVIRONMENT

- CMS manages and oversees contractors through various evaluation methods to provide reasonable assurance the following objectives are met:
  - Compliance with laws and regulations
  - Reliability of financial reporting
  - Effectiveness and efficiency of operations

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MEDICARE FEE-FOR-SERVICE CONTRACTOR OPERATIONS

OVERVIEW OF FUTURE CONTRACTING REFORM ENVIRONMENT

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MEDICARE MODERNIZATION ACT:
SECTION 911 (CONTRACTING REFORM)

- Integrates Medicare Part A and B contractors into a new single authority—Medicare Administrative Contractors (MACs)
- CMS has 6 years to competitively bid and transition all Medicare FFS contract workloads (10/2005-10/2011)
- MAC contracts may be renewed annually based on contractor performance for a period of 5 years, but they must be re-competed every 5 years
- Federal Acquisition Regulations (FAR) apply to MAC contracts, except to the extent that any provisions are inconsistent to any specific Medicare requirement
  - The FAR defines performance-based contracting methods to be included in written statements of work (SOWs)

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MAC SOW DEVELOPMENT:
PERFORMANCE-BASED CONTRACTING

- A performance-based contract specifies what is required and makes the contractor responsible for how it is to be accomplished.
- To be performance-based, a contract must:
  - Specify **performance requirements**
  - Establish **performance standards**

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PERFORMANCE-BASED CONTRACTING: DEFINITIONS

- **Performance Requirement**: A clear and concise statement of a desired outcome
  - e.g., Process claims timely
- **Performance Standard**: A defined level of (expected) performance against which the quality of a contractor's services can be determined.
  - e.g., 95% of claims processed within 30 days

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PROCESS FOR DEVELOPING MAC SOW

- Develop and include performance requirements in SOW
- Develop and include standards for defining a contractor's level of performance
- Make performance requirements and measurement standards available to public
- Include provider and beneficiary satisfaction levels as a measurement standard

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MAC SOW DEVELOPMENT

- CMS is currently developing its SOW for the MACs using performance-based principles defined in the FAR (to the extent applicable)
- In accordance with the Medicare Modernization Act, CMS must consult with providers, beneficiaries and contractors on performance requirements and standards

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DISCUSSION

- What do the current Medicare intermediaries and carriers do that you would like to see continue to be done by the future MACs?
- What aspects of the administration of Medicare (e.g., training, telephone service, overpayment notification and collection, website information) do you believe CMS' contractors could improve? Can you suggest ways that you would like to see these activities performed, e.g., increased timeliness, better consistency?
- What kind of performance standards would you recommend CMS require from a company with which it has a contract to do these functions? As an example, current law requires that 95% of Medicare claims submitted with all needed information be processed and paid within 30 days.
- What have you experienced when dealing with other health insurers that you might consider is a "best practice" and something that CMS should consider adopting to improve its services to you?

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CLOSING COMMENTS

- Given the timeframes we must meet in developing the first draft of a SOW for the future MAC competitive process, we will need your comments by April 30, 2004 in order to consider them for incorporation in the requirements and standards. Any comments received after April 30 will be given consideration in future revisions and rewrites.
- Please submit any additional responses on the discussion questions to:

  http://www.cms.hhs.gov/medicarereform/contractingreform/odf/mma911_odf_qs.asp

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