MMA Mandate: Medicare Contract Reform

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Medicare Program

- Created in 1965
- Part A: Facilities, including hospitals and skilled nursing facilities
- Part B: Physician, laboratory and other services
- Part C: Medicare Advantage
- Part D: Prescription Drugs
Current Program Administration

- Part A – Fiscal Intermediaries
- Part B – Carriers
- Part C – Medicare Advantage
- Part D – Prescription Drug Plan
Program Scope

“Nearly 36 million or 86 percent of today’s Medicare beneficiaries receive benefits through the fee-for-service portion of the program”

- Over 1 billion claims each year from over 1 million providers

Report to Congress Medicare Contracting Reform: A Blueprint for a Better Medicare. 2005
Program Costs

- Consolidated Federal Funds Report released by the U.S. Census Bureau on December 27, 2005 (www.census.gov)
  - More than $1 trillion of the $2.2 trillion in Federal spending during FY 2004 went to Medicare, Medicaid and Social Security
Medicare Prescription Drug Improvement and Modernization Act of 2003

- Extensive overhaul of Medicare’s administrative structure through:
  - Elimination of all current contracts with Fiscal Intermediaries and Carriers
  - Replacement with Medicare Administrative Contractors (MACs)
Current Contract Operations

- 51 Insurance Companies around the country
  - 25 Fiscal Intermediaries
  - 18 Carriers
- Multiple overlapping jurisdictions
-Uneven distribution of workload
Lack of Full and Open Competition

- Part A – Competed to a limited number of contractors nominated by hospitals
- Part B – Secretary of HHS is required by law to choose from a small pool of companies, specifically only health insurance companies
Separate Claims Process for Part A and B Claims

- Part A and B claims processed by separate contractors using separate operational mechanisms that do not communicate with one another.
- Current systems have difficulty handling Medicare program changes and ensuring standardized application of program requirements.
- No single Medicare point of contact for either beneficiaries or providers!
Specialization Restrictions

- CMS is limited in its ability to award separate contracts for individual claims administration activities in which certain companies may excel
  - Operating data centers
  - Educating providers
Absence of Performance-Based Incentives

- Current Contractors work under cost-based reimbursement contracts
- No financial incentive to improve their performance

◆ Example: July 2004 GAO report noted that only 4% of responses GAO received in 300 test calls posing four policy oriented questions to FIs and Carriers were correct and complete
Cumbersome Termination Procedures

- Contractors can terminate contracts without cause and 180 days notice.
- CMS may only terminate contracts after demonstrating poor performance or unresponsive contractor has failed substantially to carry out contract.
- Contractor must be given opportunity for hearing before contract termination.
Outdated Information Technology

- Existing claims processing system composed of three separate systems for processing claims
- Antiquated / outdated IT is inadequate for program’s future needs
- Current system does not take full advantage of current technologies
  - i.e., use of Internet to track/submit claims
Fiscal Intermediaries - FY 2004

* Mutual of Omaha serves as a Fiscal Intermediary to providers throughout the United States.
Carriers - FY 2005
New Contract Model - Medicare Administrative Contractor

- 23 MAC contracts including:
  - 15 Primary A/B MACs
  - 4 Specialty MACs for home health and hospice
  - 4 Specialty MACs for DME
Primary A/ B Jurisdictions
DME MAC Contractors
Home Health/ Hospice
Jurisdiction Design

- CMS designed new MAC jurisdictions based on three criteria:
  - Promoting competition
  - Balanced allocation of work load
  - Account for integration of claims processing activities
Improved Medicare Contracting

- New contacting organization responsible for:
  - A/B Claims processing
  - Beneficiary services
  - Provider enrollment
  - Appeals
  - Provider education
Operational - Goals

- Deliver more efficient and effective services to both beneficiaries and providers, by
  - Integrating claims processing for Parts A and B
  - Creating modernized administrative IT platform that incorporates improved technology
Competition

- Full and open competition to “any eligible entity” – Not exclusive to current Medicare contractors
- Non-insurance companies can compete
- Must comply with Federal Acquisition Regulations’ conflict of interest standards
- Must have sufficient financial assets to support contract performance functions
- No limit on number of contracts for which one entity can compete or be awarded
Customer-Centered Administration

- Contracting services for both Parts A and B consolidated to provide unified point of contact for Medicare
- Beneficiary and provider access through improved consolidated, standardized administrative services
Contract Performance Incentives

- Contracts will pay for performance incentives, allowing contractors to earn profits for efficient, innovative and cost-effective services.
- Contracts will include specific performance requirements and standards for:
  - Timely and accurate claims payment
  - Education and outreach
  - Customer satisfaction
Improved Contract Management

- CMS will compete contracts among a broader range of private sector organizations to allow for:
  - Increased competition and cost efficiencies
  - Strengthened CMS ability to managed contractors based on performance
Re-competition

- CMS will compete all MAC contracts within the initial cycle
- Re-complete all contracts at least once every five years
- CMS can terminate contracts for poor performance or for government’s convenience
- No more automatic renewal
Unified Claims Management

- MACs will perform core claims processing for both A and B claims
- One Explanation of Benefits (EOB) for all health care services
Updated Information Technology

- Health Integrated General Ledger Accounting System
  - Single, integrated financial accounting system to perform payment calculation, formatting and accounting of claims
  - Web portal enables providers and beneficiaries to check claims status, beneficiary eligibility, and claims submission via secure Internet connection
Infrastructure for Comprehensive Care

- Current contract model with separate claims process make it difficult for Medicare to identify overall patterns of beneficiary care

- Under new model, Medicare data across all benefits will be collected and combined to provide comprehensive view of beneficiary’s care

- Also enables data-mining for patterns of fraud and abuse
Data Centers

- Current 16 data centers play key role in Medicare FFS claims processing as part of program’s IT platform
- CMS will consolidate number of data centers from 16 to 4, and contract directly with centers for claims processing support
- Distinct databases for beneficiaries, providers, claims data, and financial information
Contract Compliance Requirements

- Medicare Compliance Officer and committee

- Standards of conduct, policies and procedures
  - Education and training
  - Enforcing disciplinary policies and procedures
  - Auditing and monitoring
  - Responding to detected problems
  - Developing corrective action plans
  - Reporting to the Board
Liability Under False Claims Act

- MACs immune for payment errors unless they act with reckless disregard of contract obligations or with intent to defraud
- Liability includes Civil Monetary Penalties for conduct that constitutes violation of False Claims Act
Effect on Providers

- Single point of contact for all Part A and Part B claims related business
- MACs will assist providers with obtaining information on behalf of patients about items or services received from another provider or supplier that could affect claims payment
- Improved provider education and outreach
- Improved customer service - *must answer written inquiries within 45 business days*
- Role in contractor evaluation via surveys
Effect on Beneficiaries

- Single claim for Part A and Part B services
- Beneficiary Contact Centers - Single point of contact for program information needs, including
  - availability of prescription drug coverage and
  - other queries such as finding and comparing nursing homes
- 1-800-MEDICARE for beneficiary questions
Effect on Current Program Contracts

- All existing FI and Carrier contractors must compete if they wish to remain a contractor.

- CMS will not require A/B MACs to offer employment to staff of FIs and Carriers that do not successfully win a MAC contract ("outgoing" contractor).
Effect on Local Coverage Decisions (LCDs)

- MACs will consolidate all LCDs for its jurisdiction with input from local provider communities
- CMS will continue to issue National Coverage Decisions from time to time
Effect on Functional Contractors

- CMS will maintain its relationships with functional contractors that have increased the efficiency of Medicare services including:
  - Coordination of benefits contractor
  - Program safeguard contractors
  - Qualified independent contractors for Medicare appeals
Coordination of Benefits Contractor

- CMS established one COB contractor to consolidate pre-pay Medicare secondary payer activities among all FFS contractors
- COB responsible for identifying health benefits available to Medicare beneficiary and coordinating payment process
- Under reform, current COB will operate in conjunction with MACs
Program Safeguard Contractors

- MMA allows MACs to be awarded contracts that include some safeguard functions
- CMS expects PSCs to continue to perform these activities in close coordination with MACs
Qualified Independent Contractors

- QICs provide a second level of appeal, reviewing redeterminations of FIs and carriers.
- CMS expects to have QICs conducting all second-level appeals, through a more independent process, with greater reliance on physician reviews, standard protocols and an improved data system.
Quality Improvement Organizations

- QIOs make initial determinations and reconsiderations regarding certain hospital discharges and review complaints about quality of care.
- CMS expects QIOs to continue to perform these services in close coordination with MACs.
Unique Provider Identification Number Registry

- UPIN is a central registry, used by all contractors, that assigns numbers to all types of providers
- MACs will send requests to UPIN registry during enrollment process and receive number in return
National Provider Identifier

- CMS is currently replacing UPINs and Provider Identification Numbers with the National Provider Identifier (NPI)
- NPI implementation process as mandated by HIPAA will be used by MACs
Impact on Part C and Part D Programs

- MMA - New regional areas for Medicare Advantage preferred provider organization plans and for Prescription Drug Plans
- No impact on Part C or Part D
- MMA did not require that the MAC areas match up with Part C or Part D regions
MAC Transition Goals

- Minimize disruption to beneficiaries and providers
- Prevent disruption of claims processing
- Complete transition activities within the required period
- Ensure that costs represent effective and efficient use of resources
- Ensure that all relevant parties are informed of progress and status
Timeline - Start up Cycle

- **September 2005**
  - RFP released for Jurisdiction 3
    (Arizona, Montana, North Dakota, Utah and Wyoming)

- **June 2006**
  - CMS will award RFP for Jurisdiction 3 MAC and begin operational transition
Reform Timeline - Cycle 1

- **September 2006**
  - RFPs for A/B Jurisdictions 1, 2, 4, 5, 7, 12, and 13
- **September 2007**
  - Award date and operational transition
Reform Timeline - Cycle 2

- **September 2007**
  - RFP A/B Jurisdictions 6, 8, 9, 10, 11, 14 and 15 and Home Health/Hospice MACs
  - Award date for Jurisdictions 1, 2, 4, 5, 7, 12 and 13

- **September 2008**
  - Award date for Jurisdictions 6, 8, 9, 10, 11, and 15 and Home Health/Hospice MACs
DME MAC Awarded
January 2006

- DME MAC Contractors
- NHIC
- AdminaStar
- Palmetto GBA, LLC
- Noridian Administrative Services
Projected Savings

- $900 million by Fiscal Year 2010
- Beyond 2011, CMS estimates annual savings of $100 million, through administrative reductions alone
Trend - Emerging Focus on Federal Health Care Program Compliance

- OIG Roundtable discussions with Health Care Industry. (OIG/HCCA, July 30, 2004)
- Supplemental Compliance Guidance for Hospitals OIG (January 27, 2005)
- Draft OIG Compliance Program Guidance for Recipients of PHS Research Awards (November 28, 2005)
Civil False Claims Act 31
U.S.C. 3729-3733

- This act applies to any person who knowingly presents, or causes to be presented, a false or fraudulent claim to the United States government for payment.
- Knowingly means, actual knowledge, reckless disregard or deliberate ignorance of the falsity of the claim.
- Majority of providers are prosecuted under “reckless disregard standard” in that they “knew or should have known” that their conduct departed from generally accepted billing practices.
Civil Monetary Penalties
42 U.S.C. 1320a-7a

- The Secretary, DHHS has authority to impose civil monetary penalties
- $5,000 to $10,000 fine for each health care claim submitted for payment
- Treble damages - three times the amount unlawfully collected from the United States government
- Federal Healthcare Program exclusion,
  - Mandatory exclusion for no less than five years, or
  - Permissive exclusion for no less than three years
  - Civil monetary penalties will be imposed against those who contract with excluded parties
Corporate Transparency

- The organization must have dedicated and knowledgeable compliance professionals at the helm
- The organization must monitor and audit itself to prevent and detect violations of law
- The organization must implement ongoing risk assessment as an essential component of its compliance program
- Enhanced evaluation of program’s auditing and monitoring systems

Core principle is that health care providers must identify and address risk areas.
Enhance Compliance By:

- “Prevention and detection” - Gathering, evaluating and channeling compliance information
- Enhancing communications and developing strategies for MAC interactions
- Enhancing cooperation and communication among Part A and Part B providers and suppliers
- Setting priorities and focusing on “Material Risk Areas”
Additional Information on Medicare Contracting Reform

- CMS website:
  - [http://www.cms.hhs.gov/MedicarecontractingReform/](http://www.cms.hhs.gov/MedicarecontractingReform/)
  - Continually updated with new information

- Open Door Forums