Government
Business Services

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Medicare Environmental Assessment 2007

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INTRODUCTION

As the Centers for Medicare & Medicaid Services (CMS) continued to implement the Contracting Reform provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), many significant developments added to the complexity of the Medicare environment. This edition of the Medicare Environmental Assessment (EA) will provide Blue Cross and Blue Shield contractors an overview of the legislative, economic, operating, oversight and contracting developments that shaped the Medicare fee-for-service (FFS) environment in 2007. In general, the document summarizes events taking place in the Medicare program through December 2007. However, issues reported in this document may have progressed since publication.

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MEDICARE TRENDS WATCHLIST FOR 2008

We expect the Medicare landscape in 2008 to be dominated by the Centers for Medicare and Medicaid Services' (CMS) implementation of the Contracting Reform provisions of the MMA and the challenges of maintaining a stable operating environment. Additionally, several carryover issues from 2007 could influence Medicare's direction in 2008 and beyond. Among them: The 2008 Congressional agenda, the national economy, the Presidential election and the evolving CMS environment.

Here are the critical Medicare issues we plan to watch in 2008:

Temporary Solutions to Legislative Funding

With a flurry of year-end activity to wrap up this year's legislative session, Congress enacted two interim funding bills, the Consolidated Appropriations Act, 2008 and the Medicare, Medicaid and SCHIP Extension Act. Further Congressional action will be necessary to finalize these Medicare funding issues.

- **Contractor Funding.** Medicare contractors operated under Continuing Resolutions (CRs) through Dec. 31, 2007. Although the Congress passed the Consolidated Appropriations Act, 2008, the final Labor/HHS/Education appropriation remains an open question. See Chapters 1 and 2.
- **"Doc Fix."** The six-month fix under the Medicare, Medicaid and SCHIP Extension Act provides only a temporary solution until June 30, 2008 to the scheduled 10.1 percent cut to the Medicare physician fee schedule in 2008. *See Chapter 1.*
- **Children's Health Program.** By providing an extension of State Children's Health Insurance Program (SCHIP) through March 31, 2009, Congress delays further debate or action on the children's health program until the Presidential election is decided. *See Chapter 1.*

Medicare Funding Warning

For the first time, the Medicare Trustees issued a Medicare funding warning of projected "excess general revenue funding" in the Medicare Program. The warning, mandated by MMA, requires the President to submit proposed legislation to Congress in response to the warning; the President's plan is due within 15 days after the release of the FY2009 Budget, and the MMA requires Congress to consider the legislation on an expedited basis. *See Chapter 1.*

CMS Oversight

While CMS is evaluating Plans, several government agencies will be monitoring CMS initiatives. The Office of the Inspector General (OIG), Government Accountability Office (GAO) and Congressional Research Service (CRS) issued numerous reports in 2007 with long-range implications for Medicare contractor operations in the areas of fraud, Program Integrity and Recovery Audit Contractors (RACs).

Equally important are the emerging evaluations of CMS' contracting operations with significant implications for Medicare Administrative Contractor (MAC) contracting. In 2007 the GAO report recommended that CMS should take immediate action to resolve vulnerabilities in its contracting practices and internal controls. The OIG 2008 work plan will examine CMS contracting operations to understand the procedures that CMS uses to solicit and manage its contracts. *See Chapters 4 and 5.*

Continued Progress on CMS Implementation Schedules

In 2008 CMS will face the challenges associated with conducting critical initiatives linked by significant dependencies and integrated schedules. As seen in 2007, when problems occurred in one or more linked initiative such as National Provider Identifier (NPI) and Provider Enrollment and Chain Ownership System (PECOS), their impact was seen across multiple operational areas. Among the challenging operational schedules for 2008 are MAC transitions, NPI, PECOS systems security, Enterprise Data Centers (EDC) transitions and Health Care General Ledger Accounting System (HIGLAS). *See Chapters 2, 3 and 5.*

Achieving Success in Provider Satisfaction and CERT Scores

Despite a challenging operating environment, CMS and contractors will be expected to achieve strong Medicare provider satisfaction scores and a decline in the Comprehensive Error Rate Testing (CERT) program scores for a third consecutive year. *See Chapter 3.*

Combating Health Care Fraud

In keeping with the government's growing emphasis on fraud prevention, the government has launched multiple aggressive initiatives. These include Medicare fraud strike forces, new prosecution tactics directed at both companies and individuals and proposed legislation to amend the whistleblower provisions of the False Claims Act. *See Chapter 4.*

Nationalizing the RAC Program

Based on the initial recovery of hundreds of millions of dollars in the pilot states of Florida, New York and California, CMS determined Recovery Audit Contractors (RAC) are an effective tool for ensuring accurate payments. Thus, CMS plans to implement a permanent, nationwide program of four RAC jurisdictions by 2010 as required by law. It remains to be seen whether the controversy over RACs in the pilot program will modify CMS' plans. *See Chapters 3 and 4.*

Updating the FAR and CAS standards

Several developments in the Federal Acquisition Regulation (FAR) and Cost Accounting Standards (CAS) are expected to impact Title 18 Medicare contractors as well as Medicare Administrative Contractors (MACs). These developments include harmonizing the Pension Protection Act of 2006 (PPA) with the CAS standards, proposed cost or pricing updates to the FAR, proposed post-retirement benefits (PRB) updates to the FAR, and other issues selected for modification by the new CAS Board. *See Chapter 2.*

Redesigning Program Integrity

As CMS changes its Program Integrity strategies, contractor operations will be affected throughout 2008. CMS will implement the OIG's 2007 recommendations for improving its contracting with Program Safeguard Contractors (PSCs) and the agency has begun to implement a new strategy aligning PSC jurisdictions with the jurisdictions of claims processing contractors. Further, CMS announced its plans to replace PSCs with Zone Program Integrity Contractors (ZPICs). On the Quality Improvement Organizations (QIO) front, CMS is considering moving the current Medical Review workload for inpatient and Long-Term Care Hospitals (LTCH) from QIOs to fiscal intermediaries and A/B MACs in 2008. *See Chapters 3, 4 and 5.*

Preparing for ICD-10 Implementation

Recent reports indicate that CMS will move forward with the coding shift from ICD-9 to ICD-10. Both preliminary budget planning as well as the hiring of the American Health Information Management Association to assess the impact of ICD-10 implementation are strong signals that the agency is laying the foundation for this move. *See Chapters 1 and 3.*

Reforming Government Contracting

Amid concerns with waste in government contracting, the government increased its emphasis on compliance, ethics, transparency, accountability and competition in government contracting. If implemented, these measures have potential impact for MAC contracting.

- **Transparency, Accountability and Competition**

  Current legislation, including the Accountability in Government Contracting Act of 2007, could lead to significant changes in the business environment of government contracting. Increased oversight, federal spending transparency and acquisition workforce issues will be in the limelight. Implementing an optimal solution in the politically charged environment of reform and transition will certainly be a challenge for the new Congress. *See Chapters 4 and 5.*

- **Stricter Contractor Compliance and Ethics Requirements**

  A controversial proposed Federal Acquisition Regulation (FAR) rule includes a mandatory obligation to disclose criminal conduct to the government and "fully cooperate" with auditors and investigators. If finalized, the rule could add an additional layer to the already strict CMS requirements. *See Chapters 4 and 5.*

The Regulatory Environment

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OVERVIEW

The 109th Congress adjourned without completing work on an omnibus spending package, instead providing Medicare contractor funding for FY2007 through a series of Continuing Resolutions (CRs). Initially, it appeared legislators were taking the same tack in FY2008; the fiscal year began with a series of CRs; the fourth and final CR[1] provided funding through Dec. 31, 2007.

Legislative activity in FY2008 was shaped by the political climate of the upcoming presidential election and focused on the federal government's overarching need to control expenditures. According to the 2007 Annual Report of the Board of Trustees,[2] expenditures of Medicare's Hospital Insurance (HI) Trust Fund will exceed taxes and other dedicated revenues in 2007. Pursuant to Section 801 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), the Trustees issued the legislatively mandated Medicare Funding Warning which requires the President to propose legislation responding to the warning within 15 days of the submission of the FY2009 budget and for Congress to consider the proposal on an expedited basis. The outlook for the Medicare program raises serious concerns and the funding warning calls attention to Medicare's impact on the federal budget.

There were numerous attempts to enact a comprehensive Medicare package. Congressional efforts to override the President's veto of the Children's Health Insurance Program Reauthorization Act of 2007 failed. However, at the end of the 110th Congress' first legislative session, Congress approved the Medicare, Medicaid and SCHIP (State Children's Health Insurance Program) Extension Act[3] and an omnibus spending bill known as the Consolidated Appropriations Act, 2008.[4]

The Medicare, Medicaid and SCHIP Extension Act includes a six-month physician fee schedule payment fix. Instead of the scheduled 10.1 percent cut in Medicare physician payments, doctors will receive a 0.5 percent increase through June 30, 2008. The bill also provides for a straight extension of SCHIP through March 31, 2009, enabling legislators to defer the debate on the popular children's health program until after the Presidential election.

The Consolidated Appropriations Act, 2008 provides $2.16 billion in Medicare contractor funding, which is essentially the same amount as the FY2007 funding level. The omnibus spending bill did not include any provisions expanding federal mental health parity legislation; Congress extended the current parity provisions through Dec. 31, 2008 as part of H.R. 3997, a military tax relief bill.

RECENTLY ENACTED LEGISLATION

The Medicare, Medicaid and SCHIP Extension Act[5]

Signed by the President on Dec. 29, 2007, the Medicare, Medicaid and SCHIP Extension Act is a compromise bill providing $5.3 billion for Medicare, Medicaid and SCHIP programs. House leaders approved a more costly Medicare reform package earlier in the year, but saw most of their provisions deleted from the final bill. The Senate's primary objections to the House legislation centered on using Medicare Advantage (MA) funds to pay for enhanced benefits and/or new programs. In the final bill, the MA stabilization fund paid for what's known as the "doc fix," but there were no further cuts to MA plans. By providing a straight extension of SCHIP through March 31, 2009, Congress delays further debate or action on the children's health program until the Presidential election is decided. Highlights of the Medicare, Medicaid and SCHIP Extension Act include:

1 Pub. L. 110-149.
2 Retrieved from http://www.cms.hhs.gov/ReportsTrustFunds/01_Overview.asp#TopOfPage on Oct. 25, 2005.
3 S. 2499.
4 H.R. 2764.
5 Pub. L. 110-173.

Medicare Advantage

- **Extension of MA special needs plans (SNPs).** Section 108 of the Medicare Medicaid and SCHIP Extension Act extends through Dec. 31, 2009 the authority for specialized MA plans for beneficiaries with special needs. The current law sunsets SNP plans at the end of 2008.
  - *Moratorium on new SNP plans in 2009.* From Jan. 1, 2008 through Dec. 31, 2009, prohibits the U.S. Department of Health and Human Services (HHS) from exercising authority to designate any new SNP plans.
  - *Moratorium on service area expansions.* From Jan. 1, 2008 through Dec. 31, 2009, prohibits HHS from permitting enrollment in a SNP plan unless the plan was available in the area on Jan. 1, 2008.
- **Extension of cost contracts.** Section 109 extends through Dec. 31, 2009 the deadline for application as a reasonable cost contract.
- **Regional PPO stabilization fund.** Section 110 provides for a cut of $1.5 billion from the MA regional Preferred Provider Organization (PPO) stabilization fund that would have become available in 2012. The remaining $1.79 billion will be available for use in 2013. The original $10 billion fund was included in the MMA to help ensure access to regional PPO plan options in MA.

SCHIP

- **SCHIP extension.** Section 201 provides a short-term extension of the current SCHIP through March 31, 2009 by making $1.6 billion available over this period in addition to the $5 billion currently available for SCHIP.
- **Data collection.** Section 205 provides an additional $10 million to improve data collection on uninsured children by the U.S. Census Bureau.

Medicare Secondary Payor

Group health plans (or their insurers and third-party administrators) and certain other insurers (liability insurers, no-fault insurers and workers' compensation plans) are required to report to HHS any information necessary to identify individuals for whom Medicare is the secondary payor.

- Group health plans (or their insurers and third-party administrators) must submit data for identifying situations where the group health plan is or has been a primary plan to the Medicare program.
- HHS has discretion to specify the information that group health plans are required to provide and to define the form and manner of submission. HHS may implement changes through program notices, bypassing the public comment process set forth in the Administrative Procedures Act.
- Penalties for failure to comply are $1,000 per individual per day.
- Section 111 states provisions are effective for group health plans the first quarter following the date that is one year after enactment of the bill.

Medicare Provider Payment Provisions

- **Physician payments.** Section 101 replaces the scheduled 10.1 percent cut to the Medicare physician fee schedule in 2008 with a 0.5 percent increase through June 30, 2008. Section 101 also provides additional funding for the Physician Assistance and Quality Initiative fund and extends the physician quality reporting system.

- **Extension of existing provider payment provisions.** Six-month extensions (through June 30, 2008) are provided for a number of current Medicare payment provisions:
  - The 5 percent bonus payment to physicians practicing in physician shortage areas (§102)
  - The work geographic index floor of the Medicare physician fee schedule (§103)
  - Allowing independent laboratories to continue to bill Medicare directly for the technical component of certain physician pathology services provided to hospitals (§104)
  - An exceptions process for Medicare therapy caps (§105)
  - Separate payment for brachytherapy services. This section also adds therapeutic radiopharmaceuticals to this provision (§106)
  - Reasonable cost reimbursement for clinical lab tests performed by certain small rural hospitals as part of their outpatient services (§107)

Other Medicare Changes

- **Payment for Part B drugs.** Section 112 requires the Centers for Medicare & Medicaid Services (CMS) to adjust its Average Sales Price (ASP) calculation to used volume-weighted ASPs based on actual sales volume. Includes a special payment rule for generic albuterol.
- **Payment for certain diabetes tests.** Section 113 provides for reimbursement, beginning April 1, 2008, of certain diabetes laboratory tests approved for home use at the same rate as other glycated hemoglobin tests.
- **Long-term care hospitals.** Section 114 delays for three years a payment adjustment for long-term care (LTC) hospitals, while also imposing a three-year moratorium on the development of new LTC facilities. It provides for expanded review of medical necessity at LTC facilities and freezes the market basket update for the last quarter of rate year 2008. Section 114 also requires a study focused on determining medical necessity, appropriateness of admission and other determinations regarding LTC hospitals.
- **Payments for inpatient rehabilitation facilities (IRF) services.** Section 115 permanently freezes the IRF services compliance threshold at 60 percent, effective for cost reporting periods starting July 1, 2006 and allows comorbid conditions to count toward this threshold after July 1, 2007. The section sets the market basket update factor at zero percent from April 1, 2008 through FY2009. The provision requires HHS to study beneficiary access to inpatient rehabilitation services and care at IRFs and make recommendations for classifying IRF hospitals and units.
- **Physicians in the armed services.** Section 116 extends, until June 30, 2008, a provision that permits physicians in the armed services to engage in substitute billing arrangements for longer than 60 days when ordered to active duty.
- **Treatment of certain hospitals.** Section 117 extends, until Sept. 30, 2008, provisions that have allowed certain hospitals to be eligible for wage index reclassification.
- **Medicare enrollment assistance.** Section 118 provides $15 million to State Health Insurance Assistance Programs and $5 million for area agencies on aging and Aging Disability Resource Centers for beneficiary outreach and assistance.

Medicaid

- **Extension of transitional medical assistance (TMA) and abstinence education programs.** Section 202 extends the TMA program (which helps low-income individuals transition from welfare to work by maintaining healthcare for their children) through June 30, 2008. It also extends the current abstinence-only education program until June 30, 2008.

- **Extension of qualifying individual (QI) program.** Section 203 extends the QI program (which provides assistance through Medicaid for low-income seniors and individuals who need help paying their Medicare premiums) through June 30, 2008.
- **Medicaid DSH extension.** Section 204 extends authority for disproportionate share hospital funding for Tennessee and Hawaii through June 30, 2008.
- **Moratorium on certain payment restrictions.** Section 206 imposes a six-month delay on implementation of proposed administrative regulations relating to school-based services and rehabilitation services.

Other

- **Medicare Payment Advisory Commission (MedPAC) status.** Section 301 clarifies the Medicare Payment Advisory Commission's status as an agency of Congress.
- **Special Diabetes Program.** Section 302 extends the Special Diabetes Program under the Public Health Services Act through Sept. 30, 2009 to fund Type 1 diabetes research and Type 2 treatment and prevention programs for Native Americans and Alaska Natives.

CONTRACTOR FUNDING

The Consolidated Appropriations Act, 2008[6]

Congress passed an omnibus bill combining the 11 unfinished spending bills for FY2008, including the Labor/HHS/Education Appropriations bill.

Signed by the President on Dec. 26, 2007, the bill provides approximately $500 billion in appropriations for federal program and agencies starting Oct. 1, 2007 including the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC) and CMS. Of interest to Plans, the bill includes $2.16 billion in Medicare contractor funding for Medicare Operations - essentially the same amount as the FY2007 level. The bill also includes $49.1 million for FY2008 to assist states in operating high-risk pools. The bill includes additional funding for clinical effectiveness research through AHRQ's Effective Healthcare Program. BCBSA has been working as part of a coalition to advocate for additional funding and AHRQ has been appropriated $30 million – $15 million more than last year – for this important program in FY2008.

Importantly, the omnibus bill does not include any provisions expanding federal mental health parity legislation. Instead, Congress will simply extend the current law parity provision through Dec. 31, 2008 as part of a military tax relief bill (H.R. 3997). Current law provides for parity with regard to lifetime and annual maximums, whereas the House and Senate proposals would have broadened parity to apply to financial requirements and treatment limitations under group health plans (excluding small employers).

Contractors significantly contributed to the legislative outcomes, with lobbying and outreach efforts throughout the year. The legislative environment will continue to challenge Congress, contractors, beneficiaries and the public; BCBSA looks forward to continuing to work with Plans on the legislative agenda in the upcoming year.

6 Pub. L. 110-161.

4th Continuing Appropriations Joint Resolution for FY2008

The President signed the final CR for FY2008 on Dec. 21, 2007. Pub. L. 110-149 provided funding for Medicare Contractors at 2007 funding levels through Dec. 31, 2007.

3rd Continuing Appropriations Joint Resolution for FY2008

This CR, signed by the President on Dec. 14, 2007, became Pub. L. 110-137. It extended the previous CR and provided funding for Medicare contractors through Dec. 21, 2007.

2nd Continuing Appropriations Joint Resolution for FY2008

Congress funded Medicare contractor operations through a stop-gap spending bill included in the FY2008 U.S. Department of Defense appropriations bill. Signed by the President on Nov. 13, 2007 and enacted as Pub. L. 110-116, the Defense Department legislation provides Medicare contractor financing at 2007 funding levels through Dec. 14, 2007.

1st Continuing Appropriations Joint Resolution for FY2008

Pub. L. 110-92, which makes continuing appropriations for the FY2008 and for other purposes, authorizes HHS to continue the revisit user fees applicable to healthcare facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys until Nov. 16, 2007.

UPDATES ON PREVIOUSLY ENACTED LEGISLATION

In 2007, CMS implemented regulations for various provisions of previously enacted legislation. We have listed final rules, interim final rules, proposed rules and notices under each relevant public law, according to title. All information appeared in the *Federal Register*, as noted within each section.

Revised Continuing Appropriations Resolution, 2007[7] (Continuing Resolution)

Title II – Elimination of Earmarks, Adjustments in Funding and Other Provisions (Chapter 6-Departments of Labor, Health and Human Services and Education and Related Agencies)

Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities

CMS' Sept. 19, 2007 final rule[8] establishes a system of revisit user fees applicable to healthcare facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys and requiring a revisit to confirm remediation of previously identified deficiencies. Congress directed HHS to implement the revisit user fees in FY2007, pursuant to section 20615(b) of the Continuing Resolution.

7 Pub. L. 110-5.
8 72 FR 53628 - 53649.

Tax Relief and Health Care Act of 2006[9] (TRHCA)

Division B—Medicare and Other Health Provisions

TRHCA Title I – Medicare Improved Quality and Provider Payments

Extension of Certain Hospital Wage Index Reclassifications

CMS' notice,[10] published March 23, 2007, announced the extension permitted under Division B, Title I, section 106 of the TRHCA of any geographic reclassification that was set to expire on March 31, 2007, by six months until Sept. 30, 2007.

TRHCA Title IV – Medicaid and Other Health Provisions

Citizenship Documentation Requirements

CMS' July 13, 2007 final rule[11] amends Medicaid regulations to implement the provision of the DRA that requires states to obtain satisfactory documentary evidence of an applicant's or recipient's citizenship and identity in order to receive federal financial participation. It also incorporates changes made to these requirements through section 405(c)(1)(A) of Division B of the TRHCA.

Medicare Prescription Drug, Improvement and Modernization Act of 2003[12] (MMA)

MMA Title I – Medicare Prescription Drug Benefit

Proposed Standards for E-Prescribing Under Medicare Part D

CMS published a proposed rule on Nov. 16, 2007[13] regarding the adoption of final uniform standards for an electronic prescription drug program as required by section 1860D–4(e)(4)(D) of the Social Security Act (SSA). CMS also proposes the adoption of a standard identifier for providers and dispensers for use in e-prescribing transactions under sections 1860D–4(e)(3) and 1860D–4(e)(4)(C)(ii) and section 1102 of the SSA. The standards proposed under section 1860D–4(e)(4)(D) have been pilot tested and evaluated and the findings indicate that the proposed standards meet the requirements for final standards that can be used for the Medicare Part D e-prescribing programs. The standards proposed in CMS' rule, in addition to the foundation standards that were already adopted as final standards (see 70 FR 67568), represent an ongoing approach to adopting standards that are consistent with the MMA objectives of patient safety, quality of care and efficiencies and cost saving in the delivery of care.

9 Pub. L. 109-432.
10 72 FR 13799 - 13801.
11 72 FR 38662 - 38697.
12 Pub. L. 108-175.
13 72 FR 64900 - 64918.

MMA Title III – Combating Waste, Fraud and Abuse

Notice of Supplemental Election Period for Provider Participation in CY2007 Competitive Acquisition Plan for Part B Drugs

CMS' notice published Feb. 23, 2007[14] announced an additional physician election period for physicians not currently participating in the competitive acquisition program (CAP) for Medicare Part B drugs for CY2007. The additional physician election period began on May 1, 2007 and ended on June 15, 2007. Physicians who elected to join the CAP during this additional election period entered into a physician election agreement effective Aug. 1, 2007 through Dec. 31, 2007.

Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies; Extension of Timeline for Publication of Final Rule

CMS' April 10, 2007 final rule[15] establishes competitive bidding programs for selected Medicare Part B covered items of durable medical equipment, prosthetics orthotics and supplies (DMEPOS) throughout the country in accordance with sections 1847(a) and (b) of the SSA. CMS plans to phase in these competitive bidding programs over several years, utilizing bids submitted by DMEPOS suppliers to establish applicable payment amounts under Medicare Part B.

Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project

Section 302 of the MMA requires CMS to conduct a demonstration project on the application of competitive acquisition for clinical laboratory services otherwise payable under the Medicare Part B fee schedule. The purpose of the demonstration project, outlined in the *Federal Register* notice issued on Oct. 17, 2007,[16] is to determine whether competitive bidding successfully provides outpatient clinical laboratory services at fees below current Medicare rates while maintaining quality and access to care. On Nov. 21, 2007, CMS published a notice[17] announcing a Bidder's Conference on Dec. 5, 2007, in the San Diego-Carlsbad-San Marcos, California MSA.

MMA Title V – Provisions Relating to Part A

Section 506 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003–Limitation on Charges for Services Furnished by Medicare Participating Inpatient Hospitals to Individuals Eligible for Care Purchased by Indian Health Programs

Section 506 of the MMA amended section 1866 (a)(1) of the SSA. The provision added subparagraph (U), which requires hospitals furnishing inpatient hospital services payable under Medicare to participate in the contract health services program (CHS) of the Indian Health Service (IHS) operated by the IHS, Tribes and Tribal organizations. It also requires participation in programs operated by urban Indian organizations that are funded by IHS (collectively referred to as I/T/Us) for any medical care purchased by those programs. Such participation must be in accordance with the admission practices, payment methodology and payment rates set forth in regulations established by the Secretary, including acceptance of no more than such payment rates as payment in full. On June 4, 2007, CMS published the final regulations,[18] which are effective July 5, 2007.

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14 72 FR 8176 - 8177.
15 72 FR 17992 - 18090.
16 72 FR 58856-58857.
17 72 FR 65581.
18 72 FR 30706 - 30711.

Agency Information Collection Activities: Proposed Collection; Comment Request

CMS published a notice on Oct. 5, 2007[19] regarding its new information collection titled Submission of Information for the Hospital Outpatient Quality Data Program. The submission of outpatient hospital quality of care information builds on the requirement to submit such data for inpatient hospital care as required under 501(b) of the MMA. The intent of the requirement to submit hospital quality of care information is to empower consumers with quality of care information to make better decisions about their healthcare while also encouraging hospitals and clinicians to improve the quality of patient care. CMS will use this information to direct its contractors, including Quality Improvement Organizations (QIOs), to focus on particular areas of improvement and to develop quality improvement initiatives.

MMA Title VI – Provisions Relating to Part B

Agency Information Collection Activities: Proposed Collection; Comment Request

CMS invited comments in its publication in the *Federal Register* on Nov. 29, 2007[20] regarding the proposed revision of a currently approved information collection activity related to the Medicare Care Management Performance (MCMP) Demonstration, mandated by Section 649 of the MMA.

MMA Title IX – Administrative Improvements, Regulatory Reduction and Contracting Reform

Appeals of CMS or Contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges

CMS' March 2, 2007 proposed rule[21] establishes an appeals process for providers and suppliers regarding denied applications for enrollment or renewal of enrollment. The proposed rule implements section 936(b)(1) of the MMA, which specifies the timeframes in which contractors must process all provider and supplier enrollment actions (initial enrollments, change of information actions, revalidations, etc.).

Public Meeting in CY2007 for New Clinical Laboratory Tests Payment Determinations

Section 942(b) of the MMA added section 1833(h)(8)(B)(iii) of the SSA, which required that CMS establish by regulation procedures for determining the basis for and amount of, payment for new clinical laboratory tests. In the CY2007 physician fee schedule final rule (71 FR 69701 through 69704), CMS adopted new 42 CFR subpart G regarding payment for new clinical diagnostic laboratory tests. Under 42 CFR 414.506, CMS annually convenes a meeting that includes representatives of CMS officials involved in determining payment amounts to receive individual comments and recommendations. The May 25, 2007 notice[22] announces a public meeting to discuss payment determinations for specific new Physicians' Current Procedural Terminology (CPT) codes for clinical laboratory tests.

Revised Civil Money Penalties, Assessments, Exclusions and Related Appeals Procedures

CMS' July 20, 2007 final rule[23] establishes the procedures for imposing exclusions for violations of the Medicare program. CMS based its procedures on those the Office of Inspector General (OIG) has published for civil money penalties, assessments and exclusions under their delegated authority. This final rule also implements provisions

19 72 FR 57034 - 57035.
20 72 FR 67605.
21 72 FR 9479 - 9491.
22 72 FR 29330 - 29331.
23 72 FR 39746 - 39756.

of Section 949 of the MMA. The amendment required CMS to establish procedures enabling a person targeted for exclusion from the Medicare program to request the CMS to act on its behalf to recommend to the Inspector General that the exclusion from Medicare be waived due to hardship that would be placed on Medicare beneficiaries resulting from the person's exclusion.

Waiver of Disapproval of Nurse Aide Training Program in Certain Cases and Nurse Aide Petition for Removal of Information for Single Finding of Neglect

CMS' Nov. 23, 2007 proposed rule,[24] published pursuant to a statutory provision enacted by section 932 of the MMA, would permit a waiver of nurse aide training disapproval for skilled nursing facilities in the Medicare program and nursing facilities in the Medicaid program that are assessed a civil money penalty of at least $5,000 for noncompliance that is not related to quality of care.

Deficit Reduction Act of 2005[25] (DRA)

DRA Title V – Medicare

Listening Session on the Draft Plan for Medicare Hospital Value-Based Purchasing–April 12, 2007

Section 5001(b) of the DRA specifies that CMS develop a plan to implement a Value-Based Purchasing (VBP) Program for payments under the Medicare program for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the SSA) beginning with FY2009. The notice published Feb. 23, 2007[26] announced the second Listening Session conducted as part of the development of a plan for Medicare hospital VBP, as authorized by section 5001(b) of the DRA. The purpose of the second Listening Session was to solicit comments on the Draft Plan CMS developed.

Notice of Single-Source Grant Award to the States of Alabama, Louisiana and Mississippi for the Grant Entitled Deficit Reduction Act-Hurricane Katrina Healthcare Related Provider Stabilization

CMS announced, in its notice dated March 2, 2007,[27] that the Secretary has authorized a total of $160 million in grant funds available to all three states, in the following proportions: 45 percent to Louisiana ($71.6 million), 38 percent to Mississippi ($60.5 million) and 17 percent to Alabama ($27.8 million). This grant program funds the state payments to general, acute care hospitals and skilled nursing facilities in impacted communities that may face financial pressures because of changing wage rates that are not yet reflected in Medicare PPS payment methodologies.

As stated in CMS' notice published on Aug. 24, 2007,[28] the Secretary has authorized an additional $60 million in supplemental DRA grant funds allocated for each state in the following proportions: 44 percent to Louisiana ($26.2 million), 38 percent to Mississippi ($23.2 million) and 17 percent to Alabama ($10.5 million). The supplemental grant program is to fund state payments to general, acute care hospitals, inpatient psychiatric facilities (IPFs), community mental health centers (CMHCs) and skilled nursing facilities (SNFs) in impacted communities that face financial pressures because of changing wage rates not yet reflected in Medicare PPS payment methodologies. The performance period is June 18, 2007 through Sept. 30, 2009.

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24 72 FR 65692 - 65697.
25 Pub. L. 109-171.
26 72 FR 8179 - 8180.
27 72 FR 9538.
28 72 FR 48648 - 48649.

Notice of Single-Source Grant Award to the State of Louisiana for the Grant Entitled Deficit Reduction Act-Hurricane Katrina Healthcare Related Professional Workforce Supply

In its May 22, 2007 notice,[29] CMS announced that the Secretary has made a $15 million grant program available to the state of Louisiana to fund state payments for professional healthcare workforce fulfillment in Greater New Orleans, which has continued to face unique health professional shortages resulting from Hurricane Katrina and its subsequent floods. The notice indicates the state must use the funds to make payments for purposes of recruitment and retention of professional healthcare staff for the impacted communities. The performance period is March 1, 2007 through Sept. 30, 2009.

On Aug. 24, 2007[30] CMS announced it would make $35 million in supplemental grant funds available to the state of Louisiana to fund additional state payments for professional healthcare workforce fulfillment in Greater New Orleans. With nearly 4,500 doctors displaced and approximately 50 percent of the physicians who worked in Region 1 before Hurricane Katrina no longer practicing there, Greater New Orleans is experiencing a shortage of primary care doctors to see Medicaid and uninsured patients. The performance period is June 18, 2007 through Sept. 30, 2009.

Solicitation for Proposals from Rural Hospitals to Participate in the Medicare Hospital Gainsharing Demonstration Program under Section 5007 of the Deficit Reduction Act

CMS' July 5, 2007 notice[31] informs rural inpatient hospitals of an opportunity to apply to participate in the Medicare Hospital Gainsharing Demonstration that CMS is implementing. The demonstration, authorized under section 5007 of the DRA, will test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work. The purpose of the demonstration is to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with the sharing of remuneration payments between hospitals and physicians.

Agency Information Collection Activities; Proposed Collection; Comment Request

On Aug. 31, 2007, CMS published for public comment a summary[32] of its proposed collection titled, Administrative Requirements for section 6071 of the DRA. CMS will use an Operational Protocol Instruction Guide and template for the development of Operational Protocols for the states selected to participate in the Money Follows the Person (MFP) Rebalancing Demonstration.

Notice of Single Source Grant Award to the State of Louisiana for the Grant Entitled Deficit Reduction Act–Hurricane Katrina Healthcare Related Primary Care Access Stabilization Grant

CMS published a notice on Sept. 6, 2007[33] announcing a $100 million grant program to the state of Louisiana to restore and expand access to primary care, including primary mental healthcare, in the Greater New Orleans area. The grant is authorized under the provisions of Section 6201(a)(4) of the DRA and the performance period is from July 23, 2007 through Sept. 30, 2010.

29 72 FR 28698.
30 72 FR 48649 - 48650.
31 72 FR 36710 - 36711.
32 72 FR 50372 - 50373.
33 72 FR 51230 - 51231.

Agency Information Collection Activities: Proposed Collection; Comment Request

On Sept. 21, 2007,[34] CMS announced a new collection titled State Plan Preprint for Integrated Medicare and Medicaid Programs. CMS Central and Regional Offices will use the Information submitted via the State Plan Amendment (SPA) preprint to analyze a state's proposal to implement integrated Medicare and Medicaid programs.

Privacy Act of 1974; Report of a New System of Records (SOR)

CMS published a notice Sept. 28, 2007,[35] proposing to establish a new SOR, Post-Acute Care Payment Reform/ Continuity of Assessment Record and Evaluation Demonstration and Evaluation (PAC–CARE), System No. 09–70–0569. Authorized under Section 5008 of the DRA, this system will enable CMS to understand the relationships among patient needs, post-acute care placement, patient outcomes and post-acute care related costs in the Medicare program.

Listening Session on Hospital-Acquired Conditions and Present on Admission Indicator Reporting, Dec. 17, 2007

In its notice published Nov. 23, 2007,[36] CMS announced a listening session being conducted as part of the selection of Hospital-Acquired Conditions (HAC) and implementation of Present on Admission (POA) Indicator Reporting, as authorized by section 5001(c) of the DRA. The purpose of this listening session is to solicit informal comments in preparation for the FY2009 inpatient prospective payment system (IPPS) rulemaking process.

Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)[37]

BIPA Title V – Provisions Relating to Parts A and B

Public Meetings in CY2007 for All New Public Requests for Revisions to the Healthcare Common Procedure Coding System (HCPCS) Coding and Payment Determinations

Section 531(b) of BIPA mandated that CMS establish procedures that permit public consultation for coding and payment determinations for new durable medical equipment (DME) under Medicare Part B of title XVIII of SSA. The notice published on Feb. 23, 2007[38] announces the dates, time and location of the Healthcare Common Procedure Coding System (HCPCS) public meetings scheduled in CY2007 to discuss CMS' preliminary coding and payment determinations for all new public requests for revisions to the HCPCS. These meetings provide a forum for interested parties to make oral presentations or to submit written comments in response to preliminary coding and payment determinations.

34 72 FR 54043 - 54044.
35 72 FR 55225 - 55231.
36 72 FR 65740 - 65741.
37 Pub. L. 106-554.
38 72 FR 8177 - 8179.

The Balanced Budget Act of 1997[39] (BBA)

BBA Title IV—Medicare, Medicaid and Children's Health Provisions

Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Consistent with section 4312(a) of the BBA, CMS' proposed rule published Aug. 1, 2007[40] implements section 1834(a)(16)(B) of the SSA by requiring all Medicare suppliers of durable medical equipment, prosthetics orthotics and supplies (DMEPOS) to furnish CMS with a $65,000 surety bond. CMS never finalized the proposed rule originally published Jan. 20, 1998.[41]

Waiver of Disapproval of Nurse Aide Training Program in Certain Cases and Nurse Aide Petition for Removal of Information for Single Finding of Neglect

CMS' proposed rule published on Nov. 23, 2007[42] would codify a statutory provision enacted by section 4755 of the BBA requiring the state to establish a procedure to permit a nurse aide to petition the state to have a single finding of neglect removed from the nurse aide registry if the state determines that the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect and the neglect involved in the original finding was a single occurrence.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[43]

HIPAA Title II – Preventing Health Care Fraud and Abuse; Administrative Simplification, Medical Liability Reform

HIPAA Administrative Simplification: National Plan and Provider Enumeration System Data Dissemination

CMS' May 30, 2007 notice[44] establishes the data that are available from the National Plan and Provider Enumeration System (NPPES). In addition, this notice addresses who may access the data or may receive data from the system, the processes for requesting and receiving data and the conditions for disclosing data.

Report of a New System of Records

CMS proposed on Aug. 7, 2007[45] to establish a new system titled, "Healthcare Common Procedure Coding System (HCPCS) Level II, System No. 09–70–0576." In October 2003, the Secretary of HHS delegated authority under HIPAA to CMS to maintain and distribute HCPCS Level II Codes. There are about 4,000 HCPCS Level II codes available for assignment by insurers in accordance with their policies. The primary purpose of this system is to facilitate the management and maintenance of the HCPCS Level II code set. Information in this system will also be used to:

39 Pub. L. 105-33.
40 72 FR 42001 - 42011.
41 63 FR 2926 - 2939.
42 72 FR 65692 - 65697.
43 Pub. L. 104-191.
44 72 FR 30011 - 30014.
45 72 FR 44155 - 44159.

- Support regulatory and policy functions performed within CMS or by a contractor, consultant or grantee.
- Assist another federal or state agency.
- Support litigation involving CMS related to this system.
- Combat fraud, waste and abuse in certain health benefits programs.

Medicare Integrity Program, Fiscal Intermediary and Carrier Functions and Conflict of Interest Requirements

CMS' Aug. 24, 2007 final rule[46] establishes the Medicare Integrity Program (MIP) and implements program integrity activities funded from the Federal Hospital Insurance Trust Fund. The final rule sets forth the definitions related to eligible entities; scope of services, competitive requirements based on Federal Acquisition Regulations (FAR) and exceptions (guidelines for automatic renewal); procedures for identification, evaluation and resolution of conflicts of interest; and limitations on contractor liability. The final rule brings certain sections of the Medicare regulations concerning fiscal intermediaries (FIs) and carriers into conformity with SSA. The rule distinguishes between those functions that the statute requires to be included in agreements with FIs and those that may be included in the agreements. It also provides that some or all of the functions may be included in carrier contracts.

PROPOSED LEGISLATION

None of the measures Government Business Services (GBS) included in the *Medicare Environmental Assessment 2006: Transition and Transformation* saw much movement in the 110th Congress with the exception of the Health Information Technology legislation, reintroduced in the Senate in June 2007. Although Congress dropped many of the previously reported measures, there was a significant amount of new legislation introduced by both the House and Senate during the 110th Congress. On the fee-for-service side, the new bills addressed various aspects of Medicare program including increasing services to beneficiaries,[47] funding,[48] access of care to rural populations,[49] contractor oversight,[50] extensions of coverage and payment provisions[51] and long-term care[52] in addition to HIT.[53] Bills related to the Medicare Advantage[54] and Part D[55] programs enjoyed wide support among Congressional committee members, but ultimately failed to pass as did bills to modernize Medicare Quality Improvement Organizations.[56] Legislation directed at end-of-life issues[57] for Medicare beneficiaries, as well as bills[58] to expand existing mental health parity provisions also failed passage; Congress extended current mental health parity provisions through Dec. 31, 2008, as part of H.R. 3997, a military tax relief bill.

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46 72 FR 48870 - 48888.
47 S. 1003/H.R. 882, S. 1507, S. 1338/H.R. 1293, S. 1240/H.R. 464, S. 1340/H.R. 2244, S. 1200/H.R. 1328, S. 450/H.R. 748, S. 932/H.R. 1552, S. 507/H.R. 864, S. 1428/H.R. 1845, S. 458, S. 2099, S. 543 and S. 1842/H.R. 2122.
48 S. 15.
49 S. 1605.
50 S. 680/H.R. 1362, H.R. 2198, H.R. 1870 and H.R. 3033.
51 S. 1212, S. 1595, S. 1737, S. 1484, S. 1310/H.R. 2164, S. 2056/H.R. 2053, S. 130/H.R. 1990 and S. 1161.
52 S. 1980, S. 2103/H.R. 1809, S. 338/H.R. 562, S. 1958/H.R. 3057 and S. 1577/H.R. 3078.
53 S. 1693, H.R. 3800 and S. 1408.
54 H.R. 2945.
55 S. 1883, S 1103/H.R. 2058, S. 1887, S. 1108, S. 250, S. 2089, S. 3/H.R. 4, S. 1102 and S. 1954.
56 S. 2396, S. 1947 and H.R. 1046.
57 S. 464, S. 465 and S. 466.
58 S. 1715/H.R. 1571, S. 921/H.R. 1588 and S. 1854.

Health Information Technology

Senator Kennedy reintroduced S. 1693, The Wired for Health Care Quality Act, to the Senate in June 2007 and submitted a written report from the Committee on Health, Education, Labor and Pensions on Oct. 1, 2007. S. 1693 promotes the adoption of a nationwide interoperable health information technology system, improvement in quality and reduction in costs of healthcare in the United States.

BCBSA is committed to the widespread adoption of interoperable health information systems based on standards that support the exchange of information among providers, payers, government and consumers. BCBSA supports legislation to advance adoption of health IT by:

- Setting interoperability standards in a public-private collaborative process.
- Harmonizing state and federal privacy and health IT laws.
- Providing federal grants to providers and regional health information exchanges.
- Requiring pilot-testing of standards and setting reasonable implementation dates.
- Giving the industry until at least 2012 to implement ICD-10.

On Oct. 2, 2007, CMS announced the award of a contract to the American Health Information Management Association (AHIMA) to assess the impact on CMS of replacing the ICD-9 code sets currently in use in reporting healthcare transactions with the ICD-10 versions. See Chapter 3 for a discussion of the operational impact of the move toward implementing ICD-10.

EMERGING ISSUES

Legislative Funding

Medicare contractors operated under CRs through Dec. 31, 2007, as noted in the overview section of this chapter. With a flurry of year-end activity to wrap up this year's legislative session, Congress enacted two bills, the Medicare, Medicaid and SCHIP Extension Act and the Consolidated Appropriations Act, 2008.

The President strongly opposed cutting MA to pay for the reversal of the statutorily mandated physician fee reduction and the agreed-upon compromise in the Medicare, Medicaid and SCHIP Extension Act was a six-month "doc fix," offset, in part, by eliminating $1.5 billion from the MA regional PPO stabilization fund. However, the six-month fix provides only a temporary solution. Congress must act quickly in 2008 to address many issues, especially the scheduled 10.1 percent reduction to the physician fee schedule. Implementing an optimal solution in the politically charged environment of reform and transition will certainly be a challenge for Congress. As discussed in the following sections and throughout the EA, long-term solutions are necessary as the Medicare program continues to evolve and respond to its challenges in the 21st century.

21st Century Challenges: Re-examining the Base of the Federal Government[59]

As part of its statutory responsibility for monitoring federal finances, the General Accountability Office (GAO), in February 2005, identified 12 areas for re-examination, one of which was healthcare. The GAO's report cautioned that the price tag of healthcare in the United States is too high and that public and private healthcare systems are in crisis. With spending reaching the highest levels in decades, the GAO poses critical questions, which include the following:[60]

59 GAO-05-325SP, *21st Century Challenges: Reexamining the Base of the Federal Government*, February 2005.
60 Ibid, pp. 33-38.

- How can we make our current Medicare and Medicaid programs sustainable? For example, should the eligibility requirements (e.g., age, income requirements) for these programs be modified?
- How can the federal government best leverage its purchasing power for healthcare produces and services?
- What options are there for rethinking the federal, state and private insurance roles in financing long-term care?
- How can technology be leveraged to reduce costs and enhance quality while protecting patient privacy?
- How can industry standards for acceptable care be established and payment reforms be designed to bring about reductions in unwarranted medical practice variation? For example, what can or should the federal government do to promote uniform standards of practice for selected procedures and illnesses?
- How can a medical information infrastructure be fostered, complete with privacy safeguards that will help reduce the occurrence of medical errors and malpractice litigation and will furnish health outcomes data to better inform consumer choice?

In testimony to Congress on Sept. 20, 2007, the GAO reiterated its 21st Century recommendations to reexamine the base of the federal government and urged Congress' full support and cooperation. Additionally, the GAO called for the use of a broader perspective in the overall reexamination effort. Specifically, the GAO urged Congress to consider structures to facilitate crosscutting reviews. Congress cannot evaluate programs as stand-alone; rather they are part of "a broader portfolio of programs, tools and strategies to accomplish federal missions and goals."[61]

Message to 110th Congress

The GAO offered recommendations in November 2006 for the 110th Congress' planning considerations. The GAO offered three sets of recommendations:[62]

1. Targets for near-term oversight.
2. Policies and programs that are in need of fundamental reform and re-engineering.
3. Governance issues that should be addressed to help ensure an economical, efficient, effective, ethical and equitable federal government capable of responding to various challenges and capitalizing on related opportunities in the 21st century.

With respect to the first goal, the GAO recommended among other things reducing the tax gap, addressing government-wide acquisition and contracting issues, enhancing computer security and deterring identity theft, all of which affect the Medicare program. Congress has introduced legislation addressing all three areas; its most recent effors resulted in the Medicare, Medicaid and SCHIP Extention Act.

The GAO identified Medicare and Medicaid as programs in need of fundamental reform and re-engineering. Without reform, the GAO considers the programs in jeopardy; the Part D benefit added to the program's size and complexity, making it vulnerable to inefficiencies and improprieties in payment systems. The GAO advised Congress to address the following relative to Medicare:[63]

61 GAO-07-1194T, Sept. 20, 2007. p. 6.
62 GAO-07-235R *Potential Oversight Issues*, Nov. 17, 2006.
63 Ibid, p. 25.

- Modernize Medicare payment policies to reward quality and efficiency and foster fiscal discipline while preserving access to care.
- Assess CMS' managerial oversight of Medicare, including efforts to ensure program integrity and provide information to assist beneficiaries in making choices about the prescription drug benefit.

Finally, the GAO advised the Congress to address ways in which the government could meet the challenges it faces in the 21st Century. The GAO highlighted governance issues in eight areas, including revisions to budget controls and the legislative process, development of key national indicators, impact and effectiveness of management reforms, effectiveness of oversight, structure and division of responsibility within the federal audit and accountability community and ensuring transparency over executive policies and operations. Medicare reforms, mandated by the MMA and other laws, are in process and analyzing the effectiveness of the reforms will a continued focus of the GAO. See Chapter 4 for a discussion of GAO Report 08-54 on CMS: Internal Control Deficiencies Resulted in Millions of Dollars of Questionable Contract Payments.

Healthcare Challenges for the 21st Century

In an address at the KPMG Partners Meeting on Oct. 3, 2007, the Comptroller General of the United States discussed fiscal and healthcare challenges. Medicare spending for 2006 represented 19 percent of total federal spending and the Comptroller General advised that "status quo" is not an option. The growing structural deficits are largely due to known demographic trends and rising healthcare costs. Specifically, the Comptroller General addressed the following, highlighting the significant challenges facing legislators for the 21st Century:

- The aged population as a share of total U.S. population will continue to increase.
- U.S. labor force growth will continue to decline.
- The U.S. personal savings rate became negative in 2006.
- The increasing number of non-elderly uninsured Americans between 1999 and 2006.
- The percentage of firms offering health benefits decreased from 69 percent in 2000 to 61 percent in 2006.
- Healthcare spending as a percentage of GDP is projected to be 19.2 percent by 2015, compared to 16 percent in 2005.
- The cumulative growth in health insurance premiums for employer-sponsored health insurance has outpaced the growth in workers' earnings and overall inflation. Health insurance premiums have increased 101.8 percent since 2000, compared to increases of 24.3 and 21.2 percent since 2000 in workers' earnings and overall inflation, respectively.
- The following chart illustrates the need for legislators to enact measures addressing the long-term sustainability of the Medicare program.

Key Dates Highlight Long-Term Challenges of the Medicare Program

Date	Event
2007	Medicare Part A outlays exceed cash income
2007	Estimated trigger date for "Medicare funding warning"
2013	Projected date that annual "general revenue funding" for Part B will exceed 45 percent of total Medicare outlays
2019	Part A trust fund exhausted, annual income sufficient to pay about 80 percent of promised Part A benefits

Source: 2007 Annual Report of The Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Washington, DC, April 2007).

According to the GAO, an ideal solution will address access, cost, quality and personal responsibility. It will be critical to enact proposals, which will accomplish the following:

- Align incentives for providers and consumers to make prudent decisions about the use of medical services.
- Foster transparency with respect to the value and costs of care.
- Ensure accountability from insurers and providers to meet standards for appropriate use and quality.

The Economic Environment

2

OVERVIEW

In FY2007, Medicare contractors' budgets remained tight, while additional Congressional mandates were imposed on the contractors. Credits collected for Medicare contractors by independent contractors were considerably behind budgeted levels. The difference between actual and budgeted credit payments collected increased budget pressure on the Medicare contractors, especially on the larger Part B carriers. Despite the under-budget situation for credit payments, Medicare contractors were able to come in under budget in other areas, such as claims processing and medical review. By coming in under budget, Medicare contractors were able to offset being under budget in crossover credit payments.

In FY2007, CMS and the contractors implemented Medicare program changes that are designed to reduce costs. These efforts resulted in significant cost reductions for paper claims costs and postage costs.

HEALTHCARE ECONOMIC TRENDS

Healthcare spending in the United States rose to $2.1 trillion in 2006 and is projected to rise to $4 trillion by 2015. As a percentage of the Gross Domestic Product (GDP), healthcare expenditures were 16 percent of GDP at the end of 2006 or an increase of only 0.1 percent from 2005.[1] Yet by 2016, healthcare spending is expected to rise to 19.6 percent of GDP.[2]

A CMS study found that national health expenditures averaged $7,026 per person in 2006 compared to $6,649 in 2005.[3] Per capita costs for health expenditures are projected to rise to $12,357 by 2015. CMS states that spending on Medicare benefits was 20 percent of the nation's total healthcare spending.[4]

As healthcare spending has increased, so has spending on the Medicare program. In 1966, Medicare program spending was $1.8 billion. By FY2007, total spending on the Medicare program had increased to $425.6 billion.[5]

The Congressional Budget Office (CBO) estimates that Medicare spending is 3.2 percent of GDP and is projected to increase to 4.0 percent of GDP by 2017.[6]

Out-of pocket spending by Medicare beneficiaries has also increased. An article published in the November/December 2007 issue of the *Journal of Health Affairs* discussed a previous study on beneficiary out-of-pocket spending. Out-of-pocket spending by beneficiaries increased from 11.9 percent of income in 1997 to 15.5 percent in 2003. During the period 1997 to 2003, median beneficiary out-of-pocket health spending increased by $1,116 or an increase of 50 percent, while individual income rose just 15 percent. Medicare and supplemental insurance payments made up the largest component of the percentage increase in spending followed by medical provider and services payments. The beneficiary out-of-pocket study noted that in 2003 nearly four in ten beneficiaries spent one-fifth of their income on healthcare.[7]

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1 CMS, Office of Research, Development and Information retrieved from http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp on Jan. 9, 2008.

2 Henry J. Kaiser Family Foundation, Medicare Spending and Financing Fact Sheet, June 2007, retrieved from http://www.kff.org/medicare/upload/7305-02.pdf on Aug. 30, 2007.

3 CMS, Office of Research, Development and Information retrieved from http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp on Jan. 9, 2008.

4 CMS, Office of the Actuary, retrieved from http://www.cms.hhs.gov/TheChartSeries/downloads/Chartbook_2007_pdf.pdf on June 13, 2007.

5 CMS, Office of Research, Development and Information retrieved from http://www.cms.hhs.gov/CapMarketUpdates/02_CMSStatistics.asp on Nov. 6, 2007.

6 Orzag, P., Congressional Budget Office's Budget Outlook and Health Care Challenges, presented at The Tax Council meeting on Nov. 14, 2007.

7 Neuman P., Cubanski J., Desmond K. & Rice, T., How Much Skin is in the Game? Increasing Financial Burden of Health Care Spending, 1997-2003, Health Affairs, Nov/Dec 2007 retrieved from http://content.healthaffairs.org/cgi/content/abstract/26/6/1692 on Nov. 8, 2007.

As Medicare costs increased, enrollment in the Medicare program also increased. Enrollment in the Medicare program increased from 24.5 million individuals in 1975 to 43.8 million in 2007.[8] Enrollment in the Medicare program is projected to increase to 86.4 million individuals by 2040.[9]

MEDICARE BENEFIT SPENDING

Here is a breakdown of Medicare program spending by type for FY2007.

FY2007 Medicare Spending by Type of Service	Billions of Dollars	Percent of Total Spending
Inpatient Hospital	$125.5	29.5%
Skilled Nursing Facilities	$21.0	4.9%
Home Health Agencies	$14.2	3.3%
Hospice	$9.7	2.3%
Managed Care	$76.3	17.9%
Physicians/Suppliers	$59.5	14.0%
Durable Medical Equipment	$8.6	2.0%
Other Carrier	$16.8	3.9%
Outpatient Hospital	$23.6	5.6%
Other Intermediary	$14.1	3.3%
Laboratory	$7.1	1.7%
Part D (Drug Program)	$49.2	11.6%
Total	**$425.6**	**100.0%**

Source: CMS FY2008 President's Budget (excludes Quality Improvement Organizations (QIO) expenditures)

Inpatient hospital care remains the single largest expense with 30 percent of total dollars spent in Medicare. Managed care is the second largest expense with 18 percent of dollars spent. The new drug benefit program is nearly 12 percent of Medicare dollars spent.

Medicare Trust Fund

On April 23, 2007, the Medicare trustees released the annual report on the Medicare Trust Fund's fiscal health.[10] The trustees' report noted that the Hospital Insurance (HI) Trust Fund is not adequately funded over the next ten years.

The assets in the HI trust fund are projected to decrease from $305 billion at the beginning of 2007 to $221 billion in 2016. In 2016, the trust actuaries project that the HI trust fund amount will be less than the recommended minimum level of one year's expenditures. HI trust fund assets are projected to be exhausted by 2019 in the absence of changes to current law.

8 CMS FY2008 Budget Report.

9 CMS FY2007 Financial Statement, http://www.cms.hhs.gov/CFOReport/.

10 2007 Annual Report of the Board of Trustees of the Federal HI and SMI Trust Funds, retrieved from http://www.cms.hhs.gov/ReportsTrustFunds/ on Sept. 14, 2007.

HI tax income is estimated to fall short of expenditures in 2007 and is projected to fall short in all future years. HI expenditure growth is estimated to average 7.2 percent per year over the next 10 years, while income growth is projected to increase 4.9 percent over the same period.

The HI payroll tax is expected to remain constant at 2.9 percent. The cost rate is projected to increase as baby boomers retire and the rate of growth of healthcare costs remains high. In 2019, the HI payroll tax is expected to cover only 79 percent of expenditures. By 2050, the HI payroll tax is projected to only cover 38 percent of expenditures.

The Supplementary Medical Insurance (SMI) trust fund consists of Part B (physician expenses) and Part D (drug benefit program) expenditures. The SMI trust fund premiums and general revenue financing are reset annually to match the expected costs for the year. After SMI trust fund assets declined from 1999 through 2003, since 2004 SMI fund assets have been increasing. Transfers from the government general fund to the SMI trust fund are covering 75 percent of program costs, while beneficiary monthly premiums are covering 25 percent.

The Medicare expenditures for the HI and SMI trust funds combined were $408 billion in 2006. The Medicare expenditures are expected to continue increasing in future years at rates greater than workers' earnings or the economy. As a percent of gross domestic product (GDP), Medicare trust expenditures are currently 3.1 percent of GDP. By 2081, trust payments are projected to increase to 11.3 percent of GDP.

MEDICARE CONTRACTOR FUNDING

The tables below show Part A and Part B contractor administrative costs and unit cost per claim from FY2002 through FY2006. Total administrative costs are based on the contractors' Final Administrative Cost Proposal (FACP). The unit cost per claim is derived by dividing total administrative cost by claims volume.

Program Management (PM) and Medicare Integrity Program (MIP) Funding 2002-2006

Part A (In $M)	PM	MIP	Total Adm. Costs	Unit Cost Per Claim
FY2002	$253	$274	$593	$3.56
FY2003	$255	$276	$598	$3.51
FY2004	$266	$274	$612	$3.41
FY2005	$266	$274	$610	$3.29
FY2006	$249	$280	$596	$3.22

Part B (In $M)	PM	MIP	Total Adm. Costs	Unit Cost Per Claim
FY2002	$581	$157	$1,031	$1.23
FY2003	$650	$157	$1,081	$1.23
FY2004	$649	$151	$1,070	$1.13
FY2005	$642	$144	$1,031	$1.05
FY2006	$603	$133	$969	$1.01

Source: CMS CAFM II System

Medicare contractors' unit cost per claim for both Part A and Part B continues to decrease. The key reason for the unit cost per claim decreases is the decline in Medicare contractor budgets.

FY2007 Funding

In FY2007, Congress funded Medicare program management costs through a series of continuing resolutions through Sept. 30, 2007. Congress funded the Medicare program management budget at $3.1 billion. The program management funding included $49 million for HIGLAS contract costs and $106 million for Medicare contractor reform activities. The $106 million funding for contractor reform activities was over a two-year period ending Sept. 30, 2008.[11]

Within the program management budget, funding for ongoing operations, which funds Medicare contractors, was $1.07 billion. The largest portion of ongoing operations funding was for Bills/Claims payments at $717.4 million. The MIP program was funded at $744 million.[12]

FY2007 Blue Cross Blue Shield Contractors' Expenditures

The FY2007 budget to actual administrative cost comparison shows Blue Cross and Blue Shield contractors' costs met their lower targets as operating budgets continued to decrease. In one area, provider enrollment, reduced funding is impacting customer services. Additional details on the provider enrollment program are included in Chapter 3.

Blue Cross and Blue Shield contractors' total administrative costs at year-end FY2007 were $4.1 million less than the final Notices of Budget Approval (NOBA). Final approved budgets and actual administrative costs, based on the year-end FY2007 Interim Expenditure Reports (IERs) are shown below.

FY2007 NOBA (In $M)	PM	MIP	Total
Part A	$225.9	$220.1	$446.0
Part B	$475.2	$111.1	$586.3
Total	$701.1	$331.2	$1,032.3

FY2007 Actual (In $M)	PM	MIP	Total
Part A	$223.9	$210.3	$434.2
Part B	$487.8	$106.2	$594.0
Total	$711.7	$316.5	$1,028.2

Source: CMS CAFM II System

Part A FY2007 Contractor Budget vs. Actual Costs

Total Part A administrative costs (PM and MIP) were $434.2 million, which were 2.6 percent less than the final budgeted amounts.

- Part A PM administrative costs were $2.0 million or 0.9 percent under the final budget.
- MIP costs were $9.8 million or 4.5 percent less than the final budget.

11 Pub. L. 110-5.
12 CMS FY2008 President's Budget.

Part B FY2007 Contractor Budget vs. Actual Costs

Part B administrative costs (PM and MIP) were $594.0 million, which were $7.7 million or 1.3 percent greater than budgeted.

- Part B PM administrative costs were $12.6 million or 2.7 percent over budget. Claims payments were $20.1 million less than budgeted. There was a $33.2 million difference between actual and budgeted credits payments resulting in total program management costs exceeding the budget.
- MIP costs were $4.9 million or 4.5 percent less than the budget.

Detailed reports on the FY2007 Medicare contractors' budget to actual costs are posted on BlueWeb under GBS Proprietary Reports/GBS Financial Reports.

Claims Workload

The following tables compare FY2006 and FY2007 claims workload volume for Medicare contractors.

Volumes (In Millions)	FY2006	FY2007	Percent Increase / (Decrease)
Part A	174.4	178.8	2.5%
Part B	949.3	909.2	(4.2%)
Total *	1,123.7	1,088.0	(3.2%)

** Excludes Specialty Jurisdictions Volumes*

Volumes (In Millions)	FY2006	FY2007	Percent Increase / (Decrease)
HHA	6.2	6.7	8.1%
Hospice	3.4	3.8	11.8%
DMERCs **	66.9	20.7	(69.1%)
Spec. Jurisdictions	76.5	31.2	(59.2%)

Source: CMS CROWD Reports

*** During FY2007, Durable Medicare Equipment (DME) claims were transitioned to DME Medicare Administrative Contractors (DME MAC). Volumes for DME MACs are not available.*

Medicare contractor claims volume decreased 2.9 percent from FY2005 to FY2006. Over the last three years, claims volume has declined. This decrease in claims volume is shown by the 3.2 percent decrease from FY2006 to FY2007.

The primary reason for the claim decreases over the last few years is the movement of enrollees into Medicare Advantage programs. CMS is projecting that the number of enrollees in the Medicare Advantage programs will continue to increase.

Medicare contractors' workload volume reports are posted on BlueWeb under GBS Proprietary Reports/GBS Financial Reports.

FY2008 MEDICARE CONTRACTOR BUDGET

FY2008 Funding

The President's FY2008 budget requests $2.3 billion for Medicare operations. The Medicare operations budget includes funding for fee-for-service (FFS) Medicare contractors and the Medicare Administrative Contractors (MACs) operational costs such as claims processing, inquiries, appeals and other costs. Within the operations budget, $254 million is budgeted for Medicare contracting reform, $163 million is to be used for the Healthcare Integrated General Ledger and Accounting System (HIGLAS) and $378.5 million for Information Technology (IT) systems and infrastructure.

The largest portion of the FY2008 Medicare operations budget is for contractors' ongoing operations costs. Ongoing operations costs are funded at $1.1 billion in FY2008. The largest costs within ongoing operations are:

- Bills/claims payments: $747.8 million
- Inquiries: $206.9 million
- Appeals: $96.4 million
- Provider reimbursement: $42.7 million

In FY2008, MIP funding increases to $756.0 million. The largest costs within MIP are provider audit at $182.6 million and medical review at $132.0 million.

Contractor Budgets – FY2007 and FY2008

The following table compares Medicare contractors' fiscal year budgets for 2007 and 2008.

Contractor Budgets ($M)	FY2007	FY2008	Increase/ Decrease
Ongoing Operations	$1,066	$1,113	$47
Medicare Integrity Program	$744	$756	$12
Total Contractor Budget	$1,810	$1,869	$59

Source: CMS FY2008 Budget Report

Contractors' "Agreed to Budgets" Compared to Final Budget Requests

Here is a comparison of the FY2008 Blue Cross and Blue Shield contractors' "agreed to budgets" costs compared to the Medicare contractors' final budget requests.

Part A "agreed to budgets" costs are $417.8 million compared to the final budget requests of $424.4 million.

- Part A program management (PM) "agreed to budgets" costs are $196.4 million or 3.0 percent less than the final budget requests.
- MIP "agreed to budgets" costs are $221.4 million or 0.2 percent less than the final budget requests.

Part B "agreed to budgets" costs are $501.0 million compared to the final budget requests of $512.7 million.

- Part B PM "agreed to budgets" costs are $410.5 million or 2.3 percent less than the final budget requests.
- MIP "agreed to budgets" costs are $90.5 million or 2.3 percent less than the final budget requests.

Part A and Part B reports comparing the "agreed to budgets" costs and final budget request costs are posted on BlueWeb under GBS Proprietary Reports/Ad Hoc Financial Reports.

FY2008 Budget Process

The budget process was unchanged from FY2007 to FY2008. Prior to FY2007, CMS developed draft budget instructions. Before the budget instructions were final, CMS gave contractors an opportunity to comment on the draft budget instructions. Since FY2007, CMS has been developing the final budget instructions and budget targets using CMS operational components only.

CMS issued the final budget instructions for FY2008 in late March 2007. Contractors were required to submit a preliminary budget estimate by April 30, 2007. The final contractors' budget requests were to be submitted to CMS Central Office (CO) by June 5, 2007.

Key assumptions the Medicare contractors were to include in their budget requests were:

- Contractors' information systems costs will decrease after the transition to an Enterprise Data Centers (EDC).
- Medicare Administrative Contractors' (MAC) transitions will occur as scheduled during FY2008.
- Beneficiary inquiries will be transferred to Beneficiary Call Centers (BCC) by the end of FY2007 (except for second level fraud and complex inquiries).[13]

Cost Efficiencies

In FY2007, CMS implemented cost efficiencies designed to reduce mail costs and paper claims costs. CMS estimates that these costs efficiencies resulted in over $37 million in cost savings. [14]

To increase mail cost savings, CMS changed the requirements for issuing Medicare Summary Notices (MSNs) from monthly to quarterly. This MSN change is a key reason for the savings. CMS assumes mail cost savings will continue in FY2008.

CMS' efforts to reduce paper claims were successful. Paper claims workload decreased significantly, especially for Part B contractors. Part B paper claims workload decreased from 80 million in FY2006 to 53 million in FY2007.

In FY2007, CMS increased the number of Administrative Simplification Compliance Act (ASCA) reviews. ASCA reviews target medium to large providers to ensure that these providers are eligible to submit paper claims. Due to the increase in ASCA enforcement, fewer providers are submitting paper claims.

As paper claims decrease, less expensive electronic claims and electronic payment remittances increase. CMS projects there will be further reductions in paper claims in FY2008.

FY2008 Appropriations Update

As discussed in Chapter 1, Congress passed an omnibus spending bill on Dec. 20, 2007, the Consolidated Appropriations Act, 2008, which combines 11 unfinished spending bills for FY2008, including the HHS appropriations bill. The bill funds $2.159 billion in Medicare contractor funding for Medicare Operations, which is nearly the same amount as the FY2007 funding level.[15]

Since Oct.1, 2007, the Medicare program and the Medicare contractors had been funded through a series of Continuing Resolutions. Under these Continuing Resolutions, Medicare contractors were funded for their program management costs based on their FY2008 "agreed to budget" amounts.

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13 FY2008 Budget Performance Requirements (BPRs).

14 Horneman, L., Medicare Contractor Budget FY2007/2008, CMS Contractor Executives Meeting, Oct. 24, 2007.

15 H.R. 2764.

For MIP costs, most contractors were funded based on the FY2008 "agreed to budget" amounts. For contractors affected by MAC transitions in FY2008, CMS funded MIP costs based on 25 percent of the "agreed to budget" amounts.

EMERGING ISSUES

Coordination of Benefits Contractor (COBC) Issues

The implementation of the national Coordinator of Benefits Contractor (COBC) has resulted in lower and slower crossover credit payments to Medicare contractors. Although the COBC has improved the amounts and timeliness of credit repayments to Medicare contractors during the year, crossover credit repayments continue to be slower than expected and crossover claims are behind CMS' projections.

The COBC's repayment process is the primary reason for slow crossover credit payments. The COBC does not repay contractors for crossover credits until the COBC receives collection on credits that were crossed. This repayment process results in credit payments being made several months after crossover occurred. This credit repayment process has resulted in cash flow problems for Medicare contractors, especially the larger Part B contractors.

A key reason for the smaller credit payments to Medicare contractors is the reduced complementary credit rate of 48 cents per claim transferred. CMS projected that reducing the rate would result in an increase in crossover claims workloads, resulting in a net increase in crossover claim payments. Several Blue Cross and Blue Shield contractors have reported the increase in crossover claims volume has not materialized, thus net crossover payments are reduced.

At year-end FY2007, crossover claims payments for Blue Cross and Blue Shield contractors were running behind the budgeted amounts by $37 million. As the FY2007 FACPs are filed, CMS projects the gap between budgeted and actual credit payments will close.

Issues related to the COBC's slow crossover repayments were brought to CMS' attention at the Contractor Consultation Group (CCG) conference call. Due to the attention on credit repayment at the CCG conference call, CMS Central Office is now working directly with the COBC and Part B contractors to improve the credit repayment process.

Healthcare Integrated General Ledger and Accounting System (HIGLAS) Implementation

CMS scaled back the HIGLAS transition schedule in FY2007 and FY2008. CMS is now concentrating on transitioning only FFS Medicare contractors with the largest claims volumes.[16] CMS' previous HIGLAS schedule was linked to MAC transitions. CMS had planned to have all FFS Medicare contractors in a MAC region converted to HIGLAS prior to the MAC transition.

During FY2005 and FY2006, seven workloads from five Medicare contractors were transitioned to HIGLAS. During FY2007, three Medicare contractors' contracts were converted to HIGLAS. In FY2008, CMS projects four additional contracts will be converted to HIGLAS.

16 Beam, S., HIGLAS, CMS Financial Management Conference, May 30, 2007.

Here is a table with details of the HIGLAS conversions completed during FY2007 and the planned conversions during FY2008.

Medicare Contractors	Contracts	Actual or Projected Transition Dates
Palmetto GBA	Part B	First Qtr. FY2007
Highmark – Part B	Part B	Second Qtr. FY2007
National Government Services (NGS), Wisconsin	Part A	Third Qtr. FY2007
Wisconsin Physician Services	Part B	Projected 1st Qtr. FY2008
NGS, Maine	Part A	Projected 2nd Qtr. FY2008
NGS, Midwest	Part A	Projected 3rd Qtr. FY2008
Cahaba GBA	Part A & RHHI	Projected 4th Qtr. FY2008

Source: CMS HIGLAS Presentation, May 30, 2007

Impact of the Pension Protection Act on CAS Standards

The Pension Protection Act (PPA)[17] of 2006 affects employers' funding of pension programs. A provision in the PPA requires the Cost Accounting Standards (CAS) Board to harmonize the CAS pension regulations with the PPA by Jan. 1, 2010. The CAS harmonization project is an important issue for federal contractors since this project affects a contractor's pension reimbursement under the CAS 412 and 413 pension regulations.

On July 3, 2007, the CAS Board published a Staff Discussion Paper requesting comments from federal contractors.[18] Private contractor groups commented that they support the harmonization effort. The private contractors recommended that the CAS Board adopt the PPA minimum funding requirement as the basis for measuring and assigning CAS pension costs.

Adopting the PPA minimum funding requirements may increase the government's reimbursement for pension expenses. Private employers oppose any efforts by government agencies to limit reimbursable pension expenses.

In May 2007, the Defense Contract Audit Agency (DCIA) issued guidance directing their auditors to question any contractor's pension costs exceeding the CAS 412 and 413 costs. The DCIA is the federal government's key audit agency of cost accounting standards. DCIA's action to limit pension cost reimbursements provides an indication of how the federal government could react if future CAS pension guidelines increase pension reimbursements.

Since October 2007, BCBSA has initiated monthly newsletters dealing with pension and retirement issues. BCBSA recently published a newsletter that describes the effort to harmonize the CAS pension standards and the PPA.

These monthly newsletters are written by two actuaries, John B. McQuade, F.S.A. and James F. Buss, F.S.A. from Pine Cliff Consulting Inc. Mr. McQuade and Mr. Buss are nationally recognized pension actuaries with expertise in the relationship between contractor pension programs and the federal government. The newsletters cover topics such as pension reimbursement, pension segmentation, settlement of pension costs after termination and post-retirement benefits funding.

This newsletters are posted on BlueWeb under Medicare Publications and Conferences/Medicare Contractors Pension and Retirement Newsletters.

17 Pub. L. 109-280.
18 72 FR 36508-36511.

Post-Retirement Benefits Update

A proposed update to the Federal Acquisition Regulations (FAR) issued Nov. 15, 2007 would allow federal contractors to have a choice of accounting for post-retirement benefits (PRBs).

When contractors use the accrual method of accounting to measure post-retirement benefit costs for federal reimbursement, contractors must fund the entire Financial Accounting Standards (FAS) No. 106 amount to obtain full cost reimbursement.

The post-retirement benefit costs that are tax deductible under Internal Revenue Code (IRC) 419 are usually less than the FAS No. 106 costs. Federal contractors must decide whether to fund all FAS 106 costs or fund only the amount that is tax-deductible under IRC 419.

Under the proposed FAR rule change, FAR 31.205-6(o) would be amended allowing contractors the option of measuring accrued PRB costs using the IRC 419 criteria rather than the FAS 106 criteria. This change would allow contractors to fund the entire tax deductible amount of their PRB benefit costs without having a portion of the PRB costs disallowed.

Currently, most contractors are opting to fund the PRB amount calculated under IRC 419 rather than the full FAS 106 amount. Due to increased contractor PRB funding, the FAR proposal could result in higher government reimbursements for post-retirement benefit costs.

Comments on the proposed FAR rule change on PRB funding are due to the FAR council on Jan. 14, 2008. The proposed FAR change was published in the *Federal Register* notice issued on Nov. 5, 2007.[19]

CAS Cost or Pricing Data Update

A proposed FAR rule was published in the *Federal Register* on April 23, 2007.[20] The proposed rule is intended to resolve confusion regarding when an agency's contracting officers may obtain "certified" contactor cost and pricing data. The federal government uses cost or pricing data to determine whether a contract price is fair and reasonable.

In certain contract proposals, the Truth in Negotiations Act (TINA) requirements require that cost or pricing data be "certified" as accurate, current and complete" and provide for a contract price adjustment and potential penalties when the data is defective.

Currently, the TINA requirements apply to federal contacts, modifications or subcontracts valued at $650,000 or more for "non-commercial" items. TINA defines "non-commercial" items as items that are not "commercial". Common examples of "commercial" items are desktop computers or LAN hardware. The proposed FAR rules appears to expand the contracting officer's ability to request "certified" cost and pricing data.

A public hearing on the proposed rule were held on Nov.15, 2007. Private contractor representatives opposed to the proposed FAR rule. Private industry contractors stated that the proposed FAR rule would expand the TINA standards to government purchases of "commercial" items. Many businesses that sell "commercial" items to the government do not maintain the extensive systems and information necessary to provide data required under TINA.

At the hearing, Government representatives argued the proposed rules would not expand application of the TINA requirements and is only designed to help solve financial information disclosure issues. In arguing that the proposed FAR change is needed, the government's representatives referred to a U.S. Department of Defense (DOD) study on financial information disclosure issues.

19 72 FR 64185.
20 72 FR 20092.

The DOD study covered issues related to the financial information disclosure under a failed Boeing contract. Under the proposed contract, Boeing would have leased aircraft to the U.S. Air Force for use as refueling tankers. The contract failed after Congress started questioning the validity of the financial information.

Industry representatives stated they cannot determine the relevance of the DOD study. The DOD has not made the study available to the public, despite a Freedom of Information Act (FOIA) request. The comment period for the proposed FAR rule on cost and pricing data ended on Nov. 22, 2007.

Proposed Updates to the CAS Standards

The Cost Accounting Standards (CAS) Board was inactive from July 2005 until February 2007 when the CAS board started reviewing CAS standards again.

The CAS board is considered new since there is a new director and all new members. The first item the new CAS Board proposed was the harmonization of the CAS standards and the Pension Protection Act of 2006.

There were several initiatives pending before the prior CAS Board that disbanded in July 2005. Here are initiatives that were pending before the prior CAS board that may become part of the new CAS board's agenda:

- Finalize amendments to CAS 412 and CAS 415 concerning recognizing costs of employee stock ownership plans (ESOPs) under federal contracts.
- Revise CAS disclosure requirements and disclosure statements.
- Revise the capitalization thresholds and recordkeeping requirements under CAS 403, CAS 404 and CAS 409.
- Amend CAS 410 provisions relating to the transition from a cost of sales base to a total cost input base.
- Revise rules and standards regarding calculating the cost impact when a contractor makes multiple accounting practice changes on the same date.
- Determine if it is appropriate for CAS clauses to apply to contracts with foreign concerns.
- Resolve conflicting definitions of what constitutes catastrophic losses in the FAR and CAS standards.

The Operating Environment

3

OVERVIEW

As the Centers for Medicare & Medicaid Services (CMS) moved to its third year of modernizing the fee-for-service (FFS) operational infrastructure under Contracting Reform, maintaining a stable operating environment became increasingly challenging for Medicare contractors. As CMS continued transitions to Medicare Administrative Contractor (MAC) contracting, modernized its IT platform and enhanced its financial management systems, the agency and contractors experienced the challenges associated with conducting critical initiatives linked by significant dependencies and integrated schedules. When problems occurred in one or more linked initiative, their impact was seen across multiple operational areas. Responding to these problems required heightened coordination and contingency planning between CMS and its stakeholders. Throughout these multiple initiatives, contractors succeeded in maintaining stable operations, achieving strong provider satisfaction scores and reducing payment error rates.

FINAL REGULATIONS AND NOTICES

The following sections include a review of the major final rules and notices affecting the operating environment. The issuances include updates to provider reimbursement payment systems for 2008 (calendar year, rate year or fiscal year), performance evaluation criteria and standards and notices of Medicare premiums and deductibles.

The General Accountability Office (GAO) reviewed 11 of CMS' major rules pursuant to section 801(a)(2)(A) of title 5, U.S. Code. GAO's statement for the record[1] on its responsibilities under the Congressional Review Act (CRA) stated, "A consistent difficulty in implementing CRA has been the failure of some agencies to delay the effective date of major rules for 60 days as required by CRA." For seven of the 11 CMS rules reviewed, the GAO reported all or portions of the rule did not have the required 60-day delay in the effective date.

The information below appeared in the *Federal Register* as indicted within each section; it reflects items published through Nov. 30, 2007.

CPE Standards FY2008

CMS' Oct. 1, 2007 notice[2] describes the criteria and standards for evaluating the performance of fiscal intermediaries (FI) and carriers in the administration of the Medicare program.

QIO Evaluation Criteria

On Aug. 7, 2007, CMS published a notice[3] describing the criteria it intends to use to evaluate the efficiency and effectiveness of Quality Improvement Organizations (QIOs) currently under contract with CMS in accordance with the Act.

Medicare Part A Deductible and Coinsurance Amounts CY2008

CMS' Oct. 5, 2007 notice[4] announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in CY2008 under Medicare Part A. For CY2008, the inpatient hospital deductible will be $1024. The daily coinsurance amounts for CY2008 will be:

1 GAO-08-268T.
2 72 FR 55775-55780.
3 72 FR 44150-44155.
4 72 FR 57035–57037.

- $256 for the 61st through 90th day of hospitalization in a benefit period;
- $512 for lifetime reserve days; and
- $128 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

Medicare Part A Premium CY2008

CMS announced Medicare's Hospital Insurance (Part A) premium for uninsured enrollees in CY2008 in its Oct. 5, 2007 notice.[5] This premium is to be paid by enrollees age 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the "uninsured aged") and by certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning Jan. 1, 2008 for these individuals will be $423. The reduced premium for certain other individuals as described in this notice will be $233.

Medicare Part B Actuarial Rates, Premium Rate and Annual Deductible CY2008

In its Oct. 5, 2007 notice,[6] CMS announced the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning Jan. 1, 2008. In addition, the notice announced the monthly premium for aged and disabled beneficiaries as well as the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts. The monthly actuarial rates for 2008 are $192.70 for aged enrollees and $209.70 for disabled enrollees. The standard monthly Part B premium rate for 2008 is $96.40, which is equal to 50 percent of the monthly actuarial rate for aged enrollees or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees. The 2007 standard premium rate was $93.50. The Part B deductible for 2008 is $135.00 for all Part B beneficiaries. If a beneficiary has to pay an income-related monthly adjustment, they may have to pay a total monthly premium of about 35, 50, 65 or 80 percent of the total cost of Part B coverage, by the end of the three-year transition period. However, for 2008, the beneficiary is only responsible for 67 percent of any applicable income-related monthly adjustment amount. For 2007, the beneficiary was responsible for 33 percent of the applicable amount.

Ambulatory Surgical Centers (ASCs)

Revisions to the payment policies of ambulance services under the ambulance fee schedule for CY2008 were included in a final rule CMS published on Nov. 27, 2007 final rule.[7] The final rule also included changes mandated by TRHCA, Pub. L. 109-432, including the following:

- Revisions to Payment Policies Under the Physician Fee Schedule and Other Part B Payment Policies for CY2008 and;
- The Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions.

Health Policy Alternatives prepared a detailed analysis of the final rule with respect to ASCs; BCBSA's Office of Policy and Representation (OPR) distributed the summary on Nov. 13, 2007.[8] As regards the ASCs, the final rule completes the transformation of the ASC payment system, which, according to CMS, could have major implications for ASCs for years to come. The final rule sets forth the applicable relative payment weights and amounts for services furnished in ASCs, specific Healthcare Common Procedure Coding System (HCPCS)

5 72 FR 57037-57039.
6 72 FR 57039-57047.
7 72 FR 66222-66578.
8 Available upon request. Please contact Raminta Jacobs at Raminta.Jacobs@bcbsa.com.

codes to which the final policies of the ASC payment system apply and other pertinent rate setting information for the CY2008 revised ASC payment system.

Key elements of the revised ASC payment system include:

- The number of approved ASC surgical procedures will be significantly expanded.
- The ASC payment system will move from a limited fee schedule based on nine disparate payment groups to a payment system incorporating relative payment weights for groups of procedures with similar clinical and resource characteristics.
- The new revised ASC payment system will be phased-in over four years using a blended CY2007 and CY2008 payment amount. Beginning Jan. 1, 2011, ASCs will be paid using 100 percent of the new payment amounts.
- As required, CMS calculated a budget neutrality adjustment factor. For CY2008 the adjustment factor is 0.65. Thus, for CY2008, the Outpatient Hospital Prospective Payment System (OPPS) conversion factor of $63.694 will be reduced to $41.401 ($63.694 x 0.65 = $41.401) to produce the revised ASC payment system conversion factor amount for CY2008.

Home Health PPS Rate Update CY2008

CMS' Aug. 29, 2007 final rule[9] sets forth an update to the 60-day national episode rates and the national per-visit amounts under the Medicare PPS for home health services, effective on Jan. 1, 2008.

Beginning in CY2008, payments will be reduced by 2.75 percent for three years, then by 2.71 percent in CY2011.

The final rule reflects CMS' initiatives to support beneficiary access to home health services and improve the quality and efficiency of care provided to Medicare beneficiaries through more accurate payments for services rendered. Refinements to the Medicare Home Health (HH) PPS as well as the annual update to the Medicare payment rates for home health services will disburse an estimated additional $20 million in payments to home health agencies in CY2008, which is due largely to an update factor of 3.7 percent for those reporting 12 quality measures.

CMS published corrections[10] to the final rule on Nov. 30, 2007.

Hospice Wage Index for FY2008

CMS' Aug. 3, 2007 final rule[11] and Oct. 1, 2007 technical corrections[12] set forth the hospice wage index for FY2008. The final rule also revises the methodology for updating the wage index for rural areas without hospital wage data and provides clarification of selected existing Medicare hospice regulations and policies.

Effective Jan. 1, 2008, all payment rates for routine home care, continuous home care, inpatient respite and general inpatient care will be adjusted by the geographic wage index value of the area where hospice services are provided. CMS holds that such application results in a reimbursement rate that is a more accurate reflection of the wages paid by the hospice for the staff used to furnish care. Additionally, CMS believes that payment should reflect the location of the services provided rather than the location of an office.

The 2007 update is effective Oct. 1, 2007 through Sept. 30, 2008.

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9 72 FR 49762-49945.
10 72 FR 67656–67663.
11 72 FR 50214–50249.
12 72 FR 55672–55673.

Hospital Conditions of Participation Critical Access Hospitals (CAHs)

CMS' Nov. 27, 2007 interim and final rule[13] with comment period made changes to the policies relating to the necessary provider designations of CAHs and changes to several of the current conditions of participation requirements. These changes affect CAHs in two situations:

- When the CAH enters into a new co-location arrangement with another hospital or CAH. CMS no longer allows a necessary provider CAH to enter into co-location arrangements between CAHs and hospitals, unless such arrangements were in effect before Jan. 1, 2008 and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change.
- When the CAH creates or acquires a provider-based off campus location.

CMS clarified that if a necessary provider CAH or a CAH that does not have a necessary provider designation, operates a provider-based facility as defined in §413.65(a)(2) or a psychiatric or rehabilitation distinct part unit as defined in §485.647 that was created or acquired on or after Jan. 1, 2008, it must comply with the distance requirement of a 35-mile drive to the nearest hospital or CAH (or 15 miles in the case of mountainous terrain or in areas with only secondary roads).[14]

Hospital Conditions of Participation: Laboratory Services

CMS' Aug. 24, 2007 interim final rule[15] requires hospitals that transfuse blood and blood components to:

- Prepare and follow written procedures for appropriate action when it is determined that blood and blood components the hospitals received and transfused are at increased risk for transmitting hepatitis C virus (HCV);
- Quarantine prior collections from a donor who is at increased risk for transmitting HCV infection;
- Notify transfusion recipients, as appropriate, of the need for HCV testing and counseling; and
- Extend the records retention period for transfusion-related data to 10 years.

Hospital Conditions of Participation: Requirements for Approval and Re-Approval of Transplant Centers to Perform Organ Transplants

CMS' March 30, 2007 final rule[16] and Oct. 26, 2007 correction[17] establish, for the first time, Medicare conditions of participation for heart, heart-lung, intestine, kidney, liver, lung and pancreas transplant centers.

In recent decades, remarkable strides in transplantation technology and pharmacology have turned organ transplantation into a mainstream treatment for many patients in end stage organ failure. This rule consolidates all transplant center requirements into one regulation and sets forth clear expectations for safe, high quality transplant service delivery in Medicare-participating facilities.

13 72 FR 66580–67225.
14 72 FR 66878.
15 72 FR 48562–48574.
16 72 FR 15198–15280.
17 72 FR 60787–60789.

Hospital Direct and Indirect GME Policy Changes

CMS finalized policy changes, which include revisions to the Graduate Medical Education (GME) and Indirect Medical Education (IME) policies as part of its May 11, 2007 final rule[18] on Long-Term Care Hospitals Prospective Payment System (LTCH-PPS) for RY2008. The rule also added a technical amendment correcting the regulations text at § 412.22.

In the final rule, CMS revised §413.75(b) to introduce a new definition of "all or substantially all of the costs for the training program in the non-hospital setting" to mean, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to non-patient care direct GME activities. In addition, CMS revised §412.105(f)(1)(ii)(C) for IME and §413.78 to reflect this new definition of "all or substantially all" of the GME costs in a non-hospital setting, effective for cost reporting periods beginning on or after July 1, 2007. CMS published a clarification to the final rule on July 5, 2007.[19]

In its Nov. 27, 2007 interim final rule,[20] CMS modified its regulations to GME payments made to teaching hospitals that have Medicare affiliation agreements for certain emergency situations.

Hospital Inpatient PPS FY2008

BCBSA's OPR issued a complete summary of CMS' Aug. 22, 2007 final rule[21] on Inpatient Hospital Prospective Payment System (IPPS) and FY2008 rates. The payment rates and policies will affect Medicare's operating and capital payments for hospital inpatient services as well as inpatient services provided by certain "IPPS-Exempt" providers. The final rule also includes updates to the LTCH-PPS patient classification system.

BCBSA's summary,[22] prepared by Health Policy Alternatives, a Washington, DC based policy group, included a listing of the 32 most current hospital quality reporting measures which qualify hospitals for their annual payment update and provisions related to physician ownership of facilities. Physicians who co-own and operate within the same hospital would have to disclose their ownership relationship to patients referred to the hospital with which they have a financial relationship.

CMS estimates that payments to all hospitals under the IPPS will increase by an average of 3.5 percent in FY2008 or by more than $3.8 billion, taking into account all changes in the final rule.

Most of the new payment provisions and policy changes are effective Oct. 1, 2007. CMS published corrections to the final rule on Oct. 10, 2007[23] and Nov. 6, 2007.[24]

CMS' Nov. 27, 2007 interim and final rule,[25] which addressed various program issues, included a change in the provisions of CMS' previously issued FY2008 IPPS final rule. It established a new policy, retroactive to Oct. 1, 2007, of not applying the documentation and coding adjustment to the FY2008 hospital-specific rates for Medicare-dependent, small rural hospitals (MDHs) and Sole Community Hospitals (SCHs).

18 72 FR 26870–27029.
19 72 FR 36612–36613.
20 72 FR 66580-67225.
21 72 FR 48161-48163.
22 Available upon request. Please contact Raminta Jacobs at Raminta.Jacobs@bcbsa.com.
23 72 FR 57634-57738.
24 72 FR 62585-62587.
25 72 FR 66580–67225.

Inpatient Psychiatric Facilities PPS RY 2008

CMS' May 4, 2007 notice[26] updates the prospective payment rates for Medicare inpatient psychiatric hospital services provided by Inpatient Psychiatric Facilities (IPFs). These changes are applicable to IPF discharges occurring during the rate year beginning July 1, 2007 through June 30, 2008. The updated IPF prospective payment rates are effective for discharges occurring on or after July 1, 2007 through June 30, 2008.

Inpatient Rehabilitation Facility PPS FY2008

CMS issued its final rule[27] on Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for FY2008 on Aug. 7, 2007. The final rule applies to discharges occurring on or after Oct. 1, 2007 and on or before Sept. 30, 2008. Highlights include:

- A $150 million increase in IRF payments in FY2008. CMS estimates the total impact of the changes included in the final rule for estimated FY2008 payments compared to estimated FY2007 payments will be approximately $150 million. The amount reflects a $195 million increase from the update to the payment rates and a $45 million decrease due to the update to the outlier threshold amount to decrease estimated outlier payments from approximately 3.7 percent in FY2007 to 3 percent in FY2008.
- An update to the FY2008 IRF PPS payment rates by the market basket (3.2 percent).
- An update to the FY2007 IRF PPS payment rates by the labor-related share (75.818 percent), the wage indexes and the final year of the hold harmless policy in a budget neutral manner.
- An update to the outlier threshold amount for FY2008 to $7,362 to decrease estimated outlier payments from approximately 3.7 to 3 percent of total estimated aggregate IRF payments for FY2008.
- An update to the urban and rural national cost-to-charge ratio ceilings for purposes of determining outlier payments under the IRF-PPS;
- Regarding the 75 percent rule, CMS is continuing its existing policy, which expires the use of comorbidities in determining compliance with the 75 percent rule for cost reporting periods beginning on or after July 1, 2008.

PPS Long-Term Care Hospitals RY 2008

CMS' May 11, 2007 final rule[28] and July 5, 2007 correction[29] update the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). The final payment amounts and factors used to determine the updated federal rates that are described in the final rule were determined based on the LTCH PPS rate year July 1, 2007 through June 30, 2008.

The annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights remains linked to the annual adjustments of the acute care hospital inpatient diagnosis-related group system and continue to be effective each Oct 1. The final outlier threshold for July 1, 2007, through June 30, 2008, is derived from the LTCH PPS rate year calculations.

These regulations are effective on July 1, 2007.

26 72 FR 25602–25673.
27 72 FR 44284–44335.
28 72 FR 26870–27029.
29 72 FR 36613–36616.

Outpatient PPS CY2008

CMS' Nov. 27, 2007 final rule[30] with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from CMS' continuing experience with the system. These changes are applicable to services furnished on or after Jan. 1, 2008.

Overall CY2008 payment under the OPPS will increase by $3.3 billion or about 10 percent, from $32.7 billion in CY2007 to approximately $36 billion in CY2008. In its rule, CMS expresses concern about the high rate of growth in outpatient costs and made several changes in the rule to help improve efficiencies in this area.

OPR issued an extensive summary of the rule on Nov. 9, 2007. The summary, prepared by Health Policy Alternatives, included an overview of the rule and discussions regarding the following:

- Changes Affecting OPPS Payment
- Ambulatory Payment Classification (APC) Group Policies
- Payment for Devices
- Payment Changes for Drugs, Biologicals and Radiopharmaceuticals
- Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmacuticals and Devices
- Payment for Brachytherapy Sources
- Drug Administration Coding and Payment
- Hospital Coding and Payments for Visits
- Payment for Blood and Blood Products
- Payment for Observation Services
- Procedures That Will Be Paid Only as Inpatient Procedures
- Nonrecurring Technical and Policy Changes
- Payment Status and Comment Indicators
- Policy and Payment Recommendations
- Update of the Revised Ambulatory Surgical Center Payment System
- Reporting Quality Data for Annual Payment Rate Updates

PPS and Consolidated Billing for Skilled Nursing Facilities (SNF) FY2008

CMS' Aug. 3, 2007 final rule[31] updates the payment rates used under the prospective payment system (PPS) for SNF for FY2008. In addition, this final rule revises and rebases the SNF market basket and modifies the threshold for the adjustment to account for market basket forecast error.

The final rule becomes effective on Oct. 1, 2007. CMS published technical corrections on Sept. 28, 2007[32] and Nov. 30, 2007.[33]

30 72 FR 66580-67225.
31 72 FR 43412–43463.
32 72 FR 55085–55089.
33 72 FR 67652–67653.

Provider Reimbursement Determinations and Appeals

CMS extended the timeline for publication of a Medicare final rule, Provider Reimbursement Determinations and Appeals, in accordance with section 1871(a)(3)(B) of the Social Security Act (SSA).

CMS was unable to meet the three-year timeline for publication due to the complexity of the public comments received and the complex policy and legal issues raised by those comments, which require extensive consultation and analysis. The extraordinary circumstances require an extension of the timeline; therefore, CMS' June 22, 2007 notice[34] extended the timeline for publication of the final rule until June 25, 2008.

Revised Civil Money Penalties, Assessments, Exclusions and Related Appeals Procedures

CMS' July 20, 2007 final rule[35] and Aug. 17, 2007 correction[36] establish the procedures for imposing exclusions for certain violations of the Medicare program. CMS based the rule on the procedures that the Office of Inspector General has published for civil money penalties, assessments and exclusions under their delegated authority. Implementation of this final rule protects beneficiaries from persons (that is, healthcare providers and entities) found in noncompliance with Medicare regulations and otherwise improves the safeguard provisions under the Medicare statute.

The final rule also establishes procedures that enable a person targeted for exclusion from the Medicare program to request CMS to act on its behalf to recommend to the Inspector General that the exclusion from Medicare be waived due to hardship that would be placed on Medicare beneficiaries as a result of the person's exclusion.

Medicare Physician Fee Schedule CY2008

CMS' Nov. 27, 2007 final rule[37] with comment period addresses certain provisions of the Tax Relief and Health Care Act of 2006, as well as making other proposed changes to Medicare Part B payment policy.

This rule is effective for Medicare physicians and other Part B services as of Jan. 1, 2008, except with respect to the "doc fix" included in the Medicare, Medicaid and SCHIP Extension Act. As discussed in Chapter 1, Congress postponed the scheduled 10.1 percent reduction in the physician fee schedule until June 30, 2008; this action supersedes the physician fee schedule provisions of the final rule.

As was the case with the proposed rule, significant portions of the final rule are unrelated to the physician fee schedule, including issues related to Part B drug payment, the clinical laboratory fee schedule, payments to ESRD facilities for renal dialysis services, comprehensive outpatient rehabilitation facilities (CORFs), physician self-referral and the Physician Quality Reporting Initiative (PQRI).

Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase III)

On Sept. 5, 2007, CMS published a final rule,[38] which is Phase III of a final rulemaking amending its regulations on the physician self-referral prohibition in section 1877 of the Act. Specifically, this rule finalizes and responds to public comments regarding the Phase II interim final SSA rule with comment period published on March 26, 2004,[39]

34 72 FR 34425.
35 72 FR 39746–39756.
36 72 FR 46175.
37 72 FR 66222–66578.
38 72 FR 51012–51099.
39 69 FR 16054-16146.

which set the self-referral prohibition and applicable definitions, interpreted various statutory exceptions to the prohibition and created additional regulatory exceptions for arrangements that do not pose a risk of program or patient abuse.

Based on public comments on the Phase II rule, this final regulation includes the following actions:

- Provides enhanced flexibility in structuring non-abusive compensation arrangements. For example, CMS expanded the rules regarding physician recruitment and retention payments to permit recruitment of more physicians into extended areas when needed.
- Provides relief for inadvertent violations of the self-referral prohibition under certain circumstances. For example, the rules permit parties that inadvertently exceed the limit on non-monetary compensation to continue to satisfy the requirements of the exception if the excess non-monetary compensation did not exceed 50 percent of the permitted amount and is repaid within 180 days of its receipt or the end of the calendar year, whichever is earlier.
- Reduces the regulatory burden for compliance with certain exceptions. For example, the Phase III final rule eliminates the requirement that entities providing professional courtesy provide written notice to an insurer of a reduction of any coinsurance obligation.
- Clarifies the agency's interpretation of existing regulations. For example, the rule clarifies which provisions in office space and equipment lease agreements may be amended during the initial and subsequent terms of the agreements.

In its Nov. 15, 2007 final rule[40] CMS delayed the date of applicability of the provisions of § 411.354(c)(1)(ii), § 411.354(c)(2)(iv) and § 411.354(c)(3) with respect to certain compensation arrangements involving physician organizations and academic medical centers or integrated section 501(c)(3) healthcare systems, until Dec. 4, 2008.

OPERATIONAL SUCCESSES

Medicare Contractor Provider Satisfaction Survey Results (MCPSS)

In 2007, CMS expanded the 2nd annual Medicare Contractor Provider Satisfaction Survey (MCPSS) to include hospices and federally qualified health centers. 65 percent of 36,000 randomly selected providers responded to the survey, which revealed that for the second consecutive year, 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale.[41]

The key findings from the 2007 survey include:

- The national average contractor score is 4.56.
- On a scale of 1 to 6 with 1 representing "Not at all Satisfied" and 6 representing "Completely Satisfied," 85 percent of the respondents scored their Contractors between 4.0 and 6.0.
- Fiscal intermediaries (FI) received a score of 4.66; Regional Home Health Intermediaries (RHHI) received 4.77; Carriers received 4.42; and Durable Medical Equipment Contractors received 4.34.
- In general, business function A-provider inquiries was the strongest predictor of satisfaction. Business function C-claims processing was the second strongest predictor of satisfaction.

40 72 FR 64161-64162.
41 http://www.cms.hhs.gov/MCPSS/downloads/MCPSS_Report.pdf.

- For all contractor types, the key predictor of a provider's satisfaction was the contractor's handling of provider inquiries.
- Provider characteristics such as number of reporting facilities, volume of claims and membership in a chain and provider time in Medicare were not significant predictors of satisfaction for any of the contractor types.

CMS plans to administer the survey annually to establish provider satisfaction performance standards for contractors. CMS plans to distribute MCPSS 2008 to a new sample of Medicare providers in January 2008.

Comprehensive Error Rate Testing (CERT) Program

In the second consecutive year, Medicare contractors achieved a significant decline in the national paid claims error rate. As reported by CMS, the number of improper Medicare claims payments decreased at each semi-annual interval to 3.9 percent in 2007 from 4.4 percent in 2006. CMS cites that a large factor in the reduction from 2006 to 2007 involved improvements in resolving insufficient documentation errors.[42] During the past three years, CMS reports that error rate reductions have led to approximately $11 billion less in improper payments. [43]

May 2007 Report

CMS selected a random sample of 144,345 claims submitted to carriers, DMERCs and FIs for the 12-month period ending Sept. 30, 2006. As shown in the table below, the rate fell to 4.2 percent in this time period.[44]

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$72.9B	$3.3B	4.6%	$0.2B	0.2%	$3.5B	4.8%
DMERC	$9.2B	$0.9B	10.0%	$0B	0.0%	$0.9B	10.0%
FI	$63B	$0.8B	1.2%	$0.2B	0.2%	$0.9B	1.4%
QIOs	$101.8B	$4.4B	4.3%	$0.6B	0.6%	$5.1B	5.0%
All Medicare FFS	$246.9B	$9.4B	3.8%	$1B	0.4%	$10.4B	4.2%

November 2007 Report

On Nov. 16, 2007, CMS released its FY2007 CERT results as shown in the following table.[45] Based on a random sample of 133,333 claims submitted to carriers, DMERCs and FIs for the 12-month period ending March 31, 2007, the improper Medicare claims payments rate decreased to 3.9 percent.[46] Achieving a 3.9 percent national improper claims payment rate exceeded CMS' Government Performance and Results Act (CPRA) goal of reducing the rate to 4.3 percent by November 2007.

42 Retrieved from http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2633 on Dec. 2, 2007.
43 Ibid.
44 https://www.cms.hhs.gov/apps/er_report/preview_er_report.asp?from=public&which=long&reportID=6&tab=2.
45 https://www.cms.hhs.gov/apps/er_report/edit_report_1.asp?from=public&reportID=7.
46 https://www.cms.hhs.gov/apps/er_report/preview_er_report_print.asp?from=public&which=long&reportID=6.

Type of Contractor	Total Dollars Paid	Overpayments		Underpayments		(Overpayments + Underpayments)	
		Payment	Rate	Payment	Rate	Improper Payments	Error Rates
Carrier	$74.9B	$3.4B	4.5%	$0.2B	0.2%	$3.6B	4.8%
DMERC	$9.9B	$1.0B	10.2%	$0.0B	0.0%	$1.0B	10.3%
FI	$89.4B	$1.2B	1.3%	$0.1B	0.2%	$1.3B	1.5%
QIOs	$102.0B	$4.3B	4.2%	$0.7B	0.7%	$4.9B	4.8%
All Medicare FFS	$276.2B	$9.8B	3.6%	$1.0B	0.4%	$10.8B	3.9%

In future years, CMS' GPRA goals seek to further reduce the national paid claims error rate to 3.8 percent by November 2008 and 3.7 percent by November 2009. [47]

OPERATIONAL ISSUES

Health Insurance Portability and Accountability Act (HIPAA) Administration

National Provider Identifier (NPI)

FY2007 NPI Implementation

CMS and the Medicare contractors are making progress on the National Provider Identifier (NPI) HIPAA administrative simplification provision. Entities were originally to be in compliance with the NPI final rule requirements no later than May 23, 2007. On May 23, 2007, CMS declared that a NPI contingency plan would go into effect. All Medicare contractors and providers were required to operate under the CMS NPI contingency plan.

CMS' contingency plan works toward full NPI compliance by May 23, 2008. For providers to comply with the contingency plan, providers are required to work on testing their NPI information with their clearinghouse and their local Medicare contractor. Under the contingency plan, Medicare contractors are required to accept provider claims with a NPI only or a combination of the NPI and legacy identifiers.

Prior to NPI contingency plan implementation, CMS developed a NPI crosswalk that matches the providers' NPIs and legacy numbers. Due to mismatches in the crosswalk of NPIs and legacy numbers, CMS started using a crosswalk "bypass" in October 2006. The NPI crosswalk "bypass" allowed claims with only the legacy number to be processed, thus avoiding mismatches between the NPI and legacy numbers.

Part A contractors completed lifting their crosswalk "bypass" in August 2007. In Oct. 2007, Part B carriers and DME MACs lifted their crosswalk "bypass." Lifting the crosswalk "bypass" resulted in an increased level of NPI and legacy number mismatches. A higher level of mismatches produced in a higher rate of rejected claims.

47 https://www.cms.hhs.gov/apps/er_report/preview_er_report_print.asp?from=public&which=long&reportID=6.

To lower the level of rejected claims, CMS requested that contractors compare the NPI information submitted to PECOS on the CMS-855 be compared to the NPI information submitted to the NPI enumerator, referred to as the National Provider and Plan Enumeration System (NPPES).

Due to numerous operating difficulties with the PECOS system, processing and corrections changes to the NPI information in PECOS has been delayed over a period of weeks and months. In contrast, NPI changes and corrections in NPESS are processed quickly. [48]

The timing differences between Provider Enrollment and Chain Ownership System (PECOS) and NPESS have created inconsistencies in the NPI information in the two systems. To correct these inconsistencies, CMS and the contractors have started a NPI "clean-up" project. CMS issued instructions to the Medicare contractors on the NPI "clean-up" project in a Joint Signature Memorandum (JSM) issued on Dec. 3, 2007. [49]

The "clean-up" project is designed to correct NPI inconsistencies and errors in PECOS and NPESS. The PECOS revalidation project has lessened the impact of the NPI "clean-up" project. Contractors are not required to request NPI information from providers that are affected by the PECOS revalidation project.

CMS and the Medicare contractors are working on ways to make the NPI "clean-up" project more efficient. CMS is allowing providers with NPI information in PECOS to fax a revised CMS-855A form, with corrected NPI information, rather than resubmitting the full 855A form.

A result from the NPI "clean-up" project is that contractors are finding that there are long-time Medicare providers that had never filed a CMS-855A form. These providers were participating in the Medicare program before provisions required filing a formal provider enrollment form. If a provider is not in PECOS, the provider is required to complete a new CMS-855A form.

FY2008 NPI Update

CMS has established that other NPI activities will be necessary for the completion of NPI implementation. These activities and the projected dates are:

- As of Jan. 1, 2008, electronic claims (837I) and paper claims (UB04) without an NPI in the fields identifying the primary provider, for billing and pay-to, will be rejected. NPI and legacy number combinations will continue to be accepted in the primary fields, while legacy numbers will be accepted in the secondary field.
- As of March 8, 2008, fee-for-service claims (837P) and CMS-1500 claims must include an NPI in the primary claim fields. The primary claim fields are the billing, pay-to and rendering. Claims without an NPI in the primary field will be returned to the provider as an unprocessable or rejected claim.
- On May 23, 2008, CMS will lift the NPI contingency plan. Only NPIs will be accepted on HIPAA electronic transactions, paper claims and standard paper remittance advice notices. HIPAA electronic transactions include the X 12 270/ 271 (eligibility inquiry/response) and 835 (remittance advice transactions). Claims, transactions or advice notices without a NPI will be rejected. CMS will also discontinue sending legacy identifiers on COB claims.[50]

Provider Enrollment

The provider enrollment program had a difficult year in FY2007. The timeliness of provider enrollment processing was impacted by various projects.

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48 Carter C., Medicare Fee For Service NPI Initiative, CMS Contractor Executives Meeting, Oct. 25, 2007.

49 JSM/TDL 08044.

50 CMS MM5595, retrieved from http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp on Nov. 30, 2007.

PECOS Revalidation Program

A revalidation project has been underway in PECOS that targets the contractors' 100 largest billing providers. Medicare contractors are required to have these providers re-resubmit the CMS-855A provider enrollment form. Using the re-submitted form, contractors must revalidate the providers' enrollment information, including the provider's NPI and/or legacy identifiers.

The revalidation project has been a very time consuming project for Medicare contractors' enrollment staff. At the CMS national meeting, Medicare contractors commented that the revalidation project is a larger effort than CMS had estimated. Two of the largest Medicare contractors noted the revalidation project requires more than just revalidating the largest 100 providers. These two contractors estimate that they are revalidating 1,500 and 2,000 providers, respectively. [51]

Provider Enrollment, Chain and Ownership System (PECOS)

In Sept. 2007, the PECOS system had a significant amount of downtime, with one period of downtime lasting six to seven days. CMS explained that the PECOS downtime problems were primarily due to the switch to the Oracle platform from the DDT platform.

CMS projects PECOS timeliness standards will improve as the system is transitioned to a Web-based program. The PECOS Web-based program is being released in mid-January 2008. CMS is currently scheduling PECOS Web-based transitions. CMS projects that all of the transitions to the Web-based system will be completed by the end of March 2008.

Medicare contractors' PECOS Web-based transitions will be implemented on a staggered basis. Before the transitions occur, CMS is requiring contractors to conduct an extensive data review of provider enrollment information. As part of the data review, contractors are required to complete a one-time site audit of their provider enrollment data.

HIPAA Systems Security

Systems Security Material Weakness

In CMS' FY2007 financial statement audit, the independent auditors, PricewaterhouseCoopers (PWC), noted that there was a material weakness related to the internal controls for systems security. The systems security material weakness is based on problems in the areas of:

- Direct access to data and claims,
- Edit control criteria,
- Audit adjudication software,
- Change control monitoring; and
- CMS oversight.[52]

51 Bossenmeyer, J., Provider and Supplier Enrollment, CMS Contractor Executives Meeting, Oct. 24, 2007.

52 Boughn J., FY2007 CFO EDP Audit Results and CMS Executive Level Expectations Going Forward, CMS Contractor Executives Meeting, Oct. 25, 2007

As part of a Corrective Action Plan (CAP) for the material weakness, CMS is requiring that Medicare contractors attest to their compliance with these systems security internal controls:

1. Physical access and system access is revoked no later than 72 hours of a termination. Access lists are maintained for employees and contractors and include their respective job and title responsibilities and level of access privileges.
2. Re-certifications are performed annually of the physical, system, application and production data access privileges (greater than "read-only") for employees and contractors.
3. Monitoring procedures are developed and enforced for system level access, application level access, production level access and production data files access.
4. Baseline configuration standards are developed for each platform in accordance with CMS requirements. Exceptions to the standards are documented, baselines are tracked and updates are applied.
5. Systems software changes are tested, approved and documented in accordance with the contractor's configuration/change and patch management policies and procedures.
6. The status of the standard systems' reason codes activation or deactivation are in compliance with CMS requirements.
7. Written evidence of compliance with the standards for processing automated adjudication systems exists for peer review performance of the code, testing of the code (including specific cases and results) and management approval of programs prior to their implementation into production use. Expert Claims Processing System (ECPS), formerly known as SuperOps, is an example of an automated adjudication system.

The contractor's statement of compliance with the subset of systems security internal controls must state that the organization has:

- A policy governing the particular systems security internal control;
- An operating procedure to implement the policy requirement; and
- Evidence the contractor is in compliance with the systems security internal controls.

CMS requires that documentation supporting compliance with the systems security internal controls be maintained in the Medicare contractor's systems security profile. The compliance documentation must be available for review by CMS personnel, CMS' contract representatives or authorized auditors.

As described in a joint signature memo issued on Oct. 16, 2007, Medicare contractors are required to submit the systems security internal controls attestation to CMS by April 1, 2008.[53]

UB92 Transition to UB04 Claims Form

Effective May 2007, all providers were required to submit paper claims on the UB-04 form, rather than the UB92 form. The primary difference between the UB-04 and UB92 forms is the UB-04 form includes a HIPAA compliant field for NPI information.

53 JSM/TDL 08019.

Enterprise Data Centers (EDC) Transitions

CMS is currently working with the EDCs, the legacy FFS data centers and the Medicare contractors to transition claims processing operations to the EDCs. Two contractors were selected by CMS as EDCs, Electronic Data Systems (EDS) and Companion Data Systems (CDS).

CMS' goals for the EDC transitions are to reduce the number of data centers, standardize the hardware and software platforms, complete EDC transitions before MAC contract cutovers and allow MACs to have one EDC.

Numerous EDC transitions have been completed or are in the process of being completed. The EDC transitions are scheduled to be completed by the end of FY2008.

During CY2007, CMS awarded the third EDC final task order award to EDS and CDS on Jan. 19, 2007. The task order, Task Order 3 (TOC3), covers over 842 million claims in 13 MAC jurisdictions. This task order impacts eleven legacy FFS data centers.

On Jan. 22, 2007, the fourth task order was issued to CDS for the CMS National Data Warehouse. EDS was awarded the fifth task order on May 15, 2007 for the four DME MAC jurisdictions which have over 74 million claims.

EDCs are not responsible for all claims processing activities. The activities EDC's are responsible for are referred to as base services. Other claims processing services that remain with the individual Medicare contractors are referred to as non-base services. Examples of non-base services are the front-end and back-end systems.

In June 2007, through the Contractor Consultation Group (CCG), CMS and the contractors started exploring options to provide non-base services. The options for providing non-base services include separate contracts between the contractor and the EDCs or separate contracts between the contractor and the legacy FFS data centers.

Other functions that are remaining at the FFS Medicare contractors are electronic media claims and print functions.[54]

CMS Agency Administrative Changes

Following the resignation of Mark B. McClellan, M.D., Ph.D. on Oct. 14, 2006, CMS leadership changed hands three times in 2007. Leslie V. Norwalk served as Acting Administrator from Oct. 15- July 21 and Herb B. Kuhn served as Acting Deputy from July 22 - Sept. 4. Kerry Weems, the Deputy Chief of Staff to DHHS Secretary Michael Leavitt, was announced as the Acting Administrator on Sept. 5, 2007. As CMS reported at the Oct. 24-25, 2007 meeting, his priorities include further development of HHS health IT initiatives such as electronic healthcare records, increased contractor oversight for effective contractor administration, moving HHS from a passive to an active purchaser of services and implementing quality of care initiatives. With less than 15 months toward the end of the Bush Administration at the time of Leavitt's appointment, it's anticipated that the CMS leadership will change again fairly soon.

54 Schulterbrandt, S., Enterprise Data Centers Update, CMS Best Practices Conference, Aug. 7, 2007.

Recovery Audit Contractor (RAC) Program

Pilot Program

Under the current three-year RAC demonstration pilot which expires March 27, 2008, CMS pays RACs on a contingency basis allowing RACs to receive a portion of what they identify and collect. However, acknowledging concerns with aggressive tactics when reviewing inpatient rehabilitation facilities (IRFs) in California, CMS put the California RAC program on temporary suspension they call a "pause" [55] until March 27, 2009. During the current demonstration project, CMS began expanding the RAC program to include the Part A providers in South Carolina, Massachusetts and Arizona as well as providers in the six states that are serviced by Mutual of Omaha.[56] As the demonstration project winds down, CMS instructed the RACs to stop requesting medical records for complex reviews effective Dec. 2, 2007. [57]

National RAC Program Contract Awards

Based on the initial recovery of hundreds of millions of dollars in the pilot states of Florida, New York and California, CMS determined RACs are an effective tool for ensuring accurate payments. Thus, CMS plans to implement a permanent, nationwide program of four RAC jurisdictions by 2010, as required by law.[58] It remains to be seen whether the controversy over RACs, as discussed in Chapter 4, will alter CMS' timetable and scope. However, the agency plans to adopt lessons learned from the pilots to prevent unfair audits.[59] CMS will require RACs to:

- Appoint a Medical Director
- Limit searches for improper payments to three years
- Return Contingency fees if the overpayment determination is rebuffed at any level of appeal
- Limit the number of medical records to be requested
- Apply new safeguards for audit areas

CMS plans to conduct full and open competitions to award the RAC contracts. The scope of work, RFP-CMS-2007-0022,[60] was issued on Nov. 7, 2007 with subsequent amendments. The solicitation synopsis identifies the following tasks:

- Identify claims with non-MSP underpayments.
- Identify and recoup claims that contain non-MSP overpayments.
- Support CMS through the administrative appeals process when providers appeal a RAC-identified overpayment.
- For any RAC-identified vulnerability support CMS in developing an Improper Payment Prevention Plan.
- Provider outreach to notify provider communities about the RAC's purpose and direction.

Contractors should be interested to know that the proactive education of Medicare providers about Medicare coverage and rules is not a task under the Statement of Work. Instead, CMS will require Quality Improvement Organizations (QIOs), fiscal intermediaries, carriers and MACs to educate providers about avoiding improper payments. For more information on the RAC program, go to Chapter 4.

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55 Report on Medicare Compliance, Volume 16, Number 37, Oct. 22, 2007.
56 http://www.cms.hhs.gov/rac/10_expansionstrategy.asp.
57 Report on Medicare Compliance, Volume 16, Number 44, Dec. 17, 2007.
58 Retrieved from http://www.cms.hhs.gov/rac/ on 12/18/07.
59 Report on Medicare Compliance, Volume 16, Number 44, Dec. 17, 2007.
60 Retrieved from http://vsearch2.fbo.gov/servlet/SearchServlet on Nov. 8, 2007.

Impact of Medicare Advantage on A/B Operations

Enrollment in Medicare Part C grew again this year from 16 percent in 2006[61] to almost 20 percent in 2007.[62] As discussed in Chapter 2, the movement of enrollees into Medicare Advantage programs has resulted in claims volume declining by the 3.2 percent from FY2006 to FY2007. This trend would be expected to continue, provided that Medicare Advantage (MA) plans continue to thrive with stable funding.

While the impact of MA on claims volume was minimal, MA's impact was felt throughout several operational areas. Several additional Part D eligibility system problems in the Master Beneficiary Database, Common Working File and Shared Systems created significant call volumes in the FFS provider customer service call centers, caller dissatisfaction and claims problems for FFS contractors, beneficiaries, providers and private insurers.

Beneficiary Contact Center (BCC)

The Beneficiary Contact Center contracts have still not been implemented, but the last of the Medicare Part A and B beneficiary call centers did migrate to the 1-800-Medicare contractor during 2007. The greatest impact of this migration has been decreased service levels to the beneficiaries, who are now facing significantly longer wait times for service. According to an OIG report released Sept. 24, 2007, 71 percent of beneficiaries who called were satisfied with the service they received, which is a decrease of 13 percentage points from baseline data gathered in 2004 when contractors had accountability for beneficiary call centers. [63]

Fee-for-service (FFS) Medicare contractors were impacted by the loss of talent as call centers migrated, but have also seen an impact to the provider customer service operations that now take in complex inquiries. They have also had to deal with frustrated beneficiaries and their related providers that try to sidestep the 1-800 wait times by calling FFS contractors instead.

Medicare Secondary Payer (MSP)

Overall efforts in the MSP area saved the Medicare trust funds approximately $4.9 billion through the first nine months of FY2006.[64] The migration of MSP recoveries to the Chickasaw Nation Industries (CNI) completed the migration of Medicare Secondary Payer (MSP) recoveries leaving limited MSP functions at FFS contractors. Contractors may face new MSP transition issues in the next year since the current Coordination of Benefits Contractor (COBC), which is the hub of MSP record maintenance, is more than two years overdue for competitive bid. On Mar. 23, 2007, CMS also issued a sources sought/request for information in March 2006[65] to identify small businesses with the necessary technical capabilities to perform the COBC statement of work.

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61 July 2006 Medicare Fact Sheet retrieved from the Kaiser Family Foundation, retrieved from http://www.kff.org/medicare/upload/1066-09.pdf on Dec. 19, 2007.

62 June 2007 Medicare Fact Sheet retrieved from the Kaiser Family Foundation, retrieved from http://www.kff.org/medicare/upload/2052-10.pdf on Dec. 19, 2007.

63 Retrieved from http://oig.hhs.gov/oei/reports/oei-07-06-00530.pdf on Oct. 14, 2007.

64 CMS Fiscal Year 2006 Financial Report, retrieved from http://www.cms.hhs.gov/CFOReport/Downloads/2006_CMS_Financial_Report.pdf on Dec. 19, 2007.

65 Retrieved from http://www.fbo.gov/servlet/Documents/R/656180/299074 Dec. 19, 2007.

EMERGING ISSUES

Program Integrity (PI)

After completing the transition of contractors' Benefit Integrity functions to Program Safeguard Contractors (PSCs) in 2006, CMS announced plans in 2007 to replace the PSCs with new contractors, the Zone Program Integrity Contractors (ZPICs). For more detail, turn to Chapter 4.

In addition to ZPICs, CMS' program integrity functions will be carried out by other contractors. As part of this approach, CMS is updating the Program Integrity Manual to emphasize that legacy contractors and MACs are required to coordinate with Quality Improvement Programs (QIPs), MACs, PSCs, ZPICs and RACs. Specifically, contractors will be required to work closely with the RACs in their jurisdiction to determine the specific claim types the RAC is authorized to review. If RACS are authorized to do post-payment review, then contractors should consider reducing that review activity.

QIO Quality Management

QIOs are private organizations that work under three-year performance-based contracts with Medicare to increase the safety and effectiveness of healthcare. At the time of publication, CMS was negotiating the ninth scope of work with the Quality Improvement Organizations. As part of that negotiation, CMS is considering a transition of the current QIO medical review workload for inpatient and Long-Term Care Hospital (LTCH) to the fiscal intermediaries and A/B MACs effective April 1, 2008.[66] If this transition is made, contractors potentially face significant issues concerning:

- Implementing necessary software (InterQual criteria and Medicare Code Editor)
- Providing qualified staffing with Diagnosis Related Group (DRG) experience
- Managing the impact on provider outreach and education (POE), appeals, claims and provider Inquiries and CERT
- Funding

ICD-10 Implementation

In October 2007 Acting CMS Administrator Kerry Weems said that the hiring of the American Health Information Management Association to assess ICD-10 implementation costs, analyze Medicare policies, processes and workload associated with the replacement of ICD-9 should be seen as a signal that the agency is moving forward with implementation.[67] Another signal is the report that CMS will ask Congress for about $40 million to begin to implement a comprehensive new diagnosis coding set in 2009. [68] As discussed in Chapter 1, the coding shift is expected to be a very expensive transition, both for the agency and for hospital, physician and other provider stakeholders.

According to the budget documents, CMS appears to accept that 5010 should be in place before an ICD-10 conversion as recommended by a coalition of Medicare stakeholders led by BCBSA. [69]

66 JSM/TDL-08035.
67 Inside Washington Publishers, Dec. 13, 2007, CMS Will Ask Congress for Funding to Implement ICD-10.
68 Ibid.
69 Ibid.

Medicare FFS Personal Health Records

CMS has begun assessing how to provide personal health records through Medicare FFS contractors.[70] BCSBA will work with CMS and contractors to evaluate options for implementing this initiative.

Provider Access to CMS Computer Services

CMS issued MedLearn Network SE0747[71] on Nov. 19, 2007, to encourage providers to register for "future access to CMS online computer services through the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC)." IACS-PC is a security system CMS will use to control issuance of electronic identities and access to new CMS provider Web-based applications. An announcement specifying their functions should be released in January 2008.

70 Handelman, J. (2007, Dec. 17). Report. GBS Town Hall Teleconference.

71 Retrieved from http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on Nov. 20, 2007.

The Contractor Oversight Environment

4

OVERVIEW

The steady increase in Medicare spending and recent high-profile criminal and civil matters involving healthcare fraud have resulted in increased emphasis on accountability for the Centers for Medicare & Medicaid Services (CMS), providers and contractors. To safeguard the Medicare trust fund expenditures, the government has increased its scrutiny of Medicare contractors' compliance with applicable statutory and regulatory requirements, effectiveness of compliance programs and the efficiency of internal controls designed to ensure overall compliance with government contracting requirements. In keeping with the government's growing emphasis on ethics and fraud prevention, prosecutors have implemented aggressive new investigative tactics targeting employees as well as healthcare companies.

OFFICE OF THE INSPECTOR GENERAL

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) acts independently within HHS to control fraud and abuse in healthcare financing programs. The OIG investigates suspected fraud or abuse and performs audits, inspections and special studies of various HHS programs.

Semiannual Reports to Congress

In its Semiannual Reports to Congress, the OIG highlighted audit, evaluation and investigation accomplishments for the periods Oct. 1, 2006 through March 31, 2007[1] and April 1, 2007 through Sept. 30, 2007.[2]

For FY2007, the OIG reported savings and expected recoveries of over $43 billion resulting from:

- Implemented recommendations and other actions to put funds to better use ($39 billion).
- Audit Receivables ($1.9 billion).
- Investigative Receivables[3] ($2.18 billion).

For FY2007, the OIG reported:

- Exclusions of 3,308 individuals and organizations for fraud or abuse of federal healthcare programs and/or their beneficiaries.
- 447 criminal actions against individuals or entities that engaged in crimes against departmental programs.
- 262 civil actions, which include False Claims Act and unjust enrichment suits filed in federal court, Civil Monetary Penalties Law settlements and administrative recoveries related to provider self-disclosure matters.

Highlights of OIG Medicare Accomplishments – Oct. 1, 2006 through March 31, 2007

$900 Million Settlement with Tenet Healthcare Corporation

The Nation's second largest hospital chain, Tenet Healthcare Corp., agreed to pay the Government $900 million plus interest and enter into a five-year Corporate Integrity Agreement (CIA) to resolve its liability under

1 HHS OIG Semiannual Report to Congress Oct. 1, 2006 – March 31, 2007 retrieved on Dec. 11, 2007 from http://www.oig.hhs.gov/publications/semiannual.html#1.

2 HHS OIG Semiannual Report to Congress April 1, 2007 – Sept. 30, 2007 retrieved on Jan. 2, 2008 from http://www.oig.hhs.gov/publications/semiannual.html#1.

3 This amount represents HHS investigative receivables only; receivables of other federal agencies, States and other entities are not included here.

the False Claims Act (FCA) and related authorities. Of the settlement amount, $788 million related to outlier payments Tenet received based on inflated charges for inpatient and outpatient care.

South Florida Durable Medical Equipment (DME) Suppliers' Compliance with Medicare Standards: Results from Unannounced Visits

In 1,581 unannounced visits to suppliers of DMEPOS in three South Florida counties, the OIG found 31 percent of suppliers did not maintain facilities or their facilities were not open for business or staffed. The OIG recommended CMS strengthen its Medicare Durable Medical Equipment, Prosthetics orthotics and Supplies (DMEPOS) supplier enrollment process and ensure that suppliers meet Medicare supplier standards.

Medicare Home Oxygen Equipment

The OIG found, based on the 2006 median fee schedule amount, Medicare will allow $7,215 for 36 months' rental of concentrators that cost, on average, $587 to purchase new. OIG recommended CMS work with Congress to reduce the rental period allowed for oxygen equipment.

Former Dermatologist Sentenced for Performing Unnecessary Surgeries

A dermatologist who falsely diagnosed patients with skin cancer in order to bill Medicare for expensive surgeries was sentenced to 22 years in prison, ordered to pay $3.7 million in restitution, forfeited an additional $3.7 million and was required to pay a $25,000 fine for performing 3,086 medically unnecessary surgeries on 865 Medicare beneficiaries.

Department Financial Statement Audit

HHS received a "clean" opinion on its FY2006 consolidated/combined financial statements for the eighth consecutive year. The department's statements were reliable and presented fairly. However, auditors noted material weaknesses in financial management systems and reporting and in controls over information systems.

Highlights of OIG Medicare Accomplishments – April 1, 2007 through Sept. 30, 2007

South Florida Medicare Fraud

Working with the U.S. Attorney's Office for the Southern District of Florida, the OIG developed innovative methods to identify and prosecute Medicare fraud in South Florida. The efforts resulted in $54.3 million in investigative receivables and a number of indictments. OIG found CMS and its contractors did not effectively control aberrant billing practices, especially for HIV/AIDS infusion therapy. OIG recommended CMS:

- Treat South Florida as a high-risk area;
- Mandate site visits for certain providers;
- Adjust contractor standards for processing new applications;
- Modify the Statement of Work for the jurisdiction that includes South Florida;
- Review all reassignments in high-risk areas; and
- Strengthen revocations.

Certification and Oversight of Medicare Hospices

The OIG found, as of July 2005, 86 percent of Medicare hospices were certified by state agencies within six years as required at that time and 14 percent averaged three years past due. Additionally, 46 percent of the

hospices surveyed had health deficiencies, as did 26 percent of the hospices investigated for complaints and many deficiencies related to patient care. OIG recommended CMS:

- Provide guidance to state agencies and CMS regional offices regarding analysis of existing data and identification of at-risk hospices;
- Include hospices in federal comparative surveys and annual state performance reviews;
- Seek regulatory or statutory changes to establish specific requirements for the frequency of hospice certification; and
- Seek legislation to establish enforcement remedies, in addition to termination, for poor hospice performance.

Outpatient Outlier Payment Adjustments

Medicare makes outlier payments to healthcare providers for extremely costly cases; prior OIG reviews found that some providers received significant outpatient outlier overpayments as a result of providers' and fiscal intermediaries' errors and providers' manipulation of charge data. Because CMS did not adjust the overpayments, the Medicare Trust fund incurred losses and provider payments were inequitable. OIG recommended CMS issue regulations to require retroactive adjustments of outpatient outlier payments within appropriately established thresholds.

OIG FY2008 Work Plan

The OIG spends about 80 percent of its resources on work related to programs under the management of CMS: Medicare, Medicaid and SCHIP. OIG's emphasis on these healthcare programs reflects the spending of HHS; CMS expenditures accounted for about 80 percent of the HHS budget over the last several years. The OIG's focus is also rooted in statutory mandates such as Health Insurance Portability and Accountability Act (HIPAA), Deficit Reduction Act (DRA) and the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).[4]

Through its previous work, OIG has identified management and performance challenges facing the Medicare and Medicaid programs:

- Oversight of Medicare Part D
- Integrity of Medicare payments
- Appropriateness of Medicaid payments
- Medicaid and SCHIP administration
- Quality of care in institutional and community-based settings

In order to accomplish its work, the OIG plans the following ongoing and proposed work related to current challenges and other high-priority issues identified:

- Medicare Hospitals (20 reviews scheduled; nine new)
- Medicare Home Health (three reviews scheduled; two new)
- Medicare Nursing Homes (three reviews scheduled; two new)
- Medicare Hospice Care (one ongoing review scheduled)
- Medicare physicians and Other Health Professionals (15 reviews scheduled; nine new)

4 FY2008 OIG Work Plan, p. 1 retrieved on Oct. 1, 2007 from http://www.oig.hhs.gov/publications/workplan.html.

- Medicare Medical Equipment and Supplies (14 reviews scheduled; four new)
- Medicare Part B Drug Reimbursement (eight reviews scheduled; three new)
- Medicare Part D Administration (29 reviews scheduled; 14 new)
- Other Medicare Services (11 reviews scheduled; six new)
- Medicare Advantage (nine reviews scheduled; five new)
- Medicare Cross-Cutting Issues (two new reviews scheduled)
- Medicare and Medicaid Nursing Home Issues (two reviews scheduled; one new)
- Information Systems Controls (14 reviews scheduled; 11 new)
- Medicare/Medicaid Gulf Coast Hurricane Response (five ongoing reviews scheduled)
- Investigations (healthcare Fraud, Medicaid program, exclusions, provider self-disclosure)
- Legal Counsel (resolution of False Claims Act cases and negotiation of CIAs; providers' compliance with CIAs; advisory opinions, fraud alerts and other industry guidance; and civil monetary penalties)

Reviews of Medicare Contractor Operations

The excerpts below are from the HHS OIG FY2008 Work Plan for the 18 reviews scheduled within Medicare Contractor Operations.

Pre-Award Reviews of Contract Proposals

OIG will review the cost proposals of various bidders for Medicare contracts based on criteria in Office of Management and Budget (OMB) Circular A-122, "Cost Principles for Non-Profit Organizations." The reports produced by these reviews assist CMS in negotiating favorable and cost-beneficial contract awards.

Contractors' Administrative Costs

OIG will review administrative costs claimed by various contractors for their Medicare activities, focusing on costs claimed by terminated contractors. OIG will determine whether the costs claimed were reasonable, allocable and allowable under Appendix B of the Medicare contract with CMS as well as Federal Acquisition Regulation (FAR), Part 31. The selection of contractors will be coordinated with CMS.

Fiscal Integrity of Quality Improvement Organizations

OIG will review the fiscal integrity of Quality Improvement Organizations (QIOs), QIOs receive payments to ensure that medical care is reasonable and medically necessary, provided in the most economical settings and meets professionally recognized standards. In FY2004, QIOs received $367 million from CMS as part of their three-year $1.1 billion contract. OIG will determine whether Medicare payments for board member and executive staff compensation and travel, legal fees and administrative charges and equipment were reasonable and allowable pursuant to Federal requirements set out in OMB Circular A-122. OIG will also determine whether there were any conflicts of interest in these payments and whether contract modifications were appropriate. In EA Chapter 1, GBS reported bills in both the Senate and the House intended to modernize the QIO program. CMS will begin awarding state-based QIO contracts in August 2008.[5]

5 Inside CMS, *New Senate Bill Refuels Debate on QIO Scope of Work*, Nov. 29, 2007.

Contracting Operations

OIG will review CMS' Office of Acquisition and Grants Management (OAGM) contracting operations to understand the procedures that CMS uses to solicit and manage its contracts and determine compliance with various FARs. In FY2005, OAGM initiated an estimated $1.6 billion in contracts and OIG will initially document OAGM's operations by addressing activities for presolicitations, solicitations, evaluations, awards and post-awards.

Contractors' Accounting System Audits

OIG will review prospective Medicare contractors' accounting systems to determine whether the systems are capable of identifying, gathering, segmenting and reporting costs by project and comply with applicable FARs, specifically FAR 16.301.

Contractors' Provisional Billing Rates

OIG will review contractors' indirect cost rate proposals to determine whether the costs claimed were reasonable, allocable and allowable and can be used for provisional billing purposes in accordance with FAR 42.7.

Pension Segmentation

To determine and separately account for the assets and liabilities of the Medicare segments of their pension plans, OIG will review whether Medicare contractors have fully implemented contract clauses requiring them. OIG will also assess Medicare's share of future pension costs on a segmented basis.

Pension Costs Claimed

OIG will review whether Medicare contractors have calculated pension costs claimed for reimbursement in accordance with their Medicare contracts and CAS. OIG will also determine whether the costs claimed were allocable and allowable under the Medicare contracts according to FAR 31.205; CAS 412 and 413; and the Medicare contract Appendix B, section XVI.

Unfunded Pension Costs

OIG will review whether Medicare contractors identified and eliminated unallowable costs when computing pension costs charged to the Medicare program. OIG will also determine whether pension costs that would otherwise been tax deductible had they been funded were properly reassigned to future periods to ensure that only allowable pension costs were claimed for reimbursement.

Pension Segment Closing

OIG will review Medicare carriers and FIs whose Medicare contracts have been terminated, resulting in the closing of their Medicare segments. OIG will determine the amount of any excess pension assets related to each Medicare segment as of the segment closing date. Applicable sections of FAR 31.205; CAS 412 and 413; and the Medicare contract, Appendix B, section XVI, of the Medicare contract provide that the Medicare program is credited for pension gains that occur when a Medicare segment closes.

Postretirement Benefits and Supplemental Employee Retirement Plan Costs

OIG will review the postretirement health benefit costs and the supplemental employee retirement plans of FIs and carriers. OIG's reviews will determine the allowability, allocability and reasonableness of the benefits and plans, as well as the costs charged to Medicare contracts in accordance with FARs 31.201 through 31.205.

Medicare Appeals Process: Administrative Law Judges

OIG will review the early implementation of the use of videoconferencing in Administrative Law Judge (ALJ) hearings of Fee for-Service (FFS) appeals. Generally, section 1869 of the Social Security Act (SSA) governs ALJ hearings for Medicare FFS claims appeals. Section 931 of the MMA (Pub. L. No. 108-173) amended this statutory section and authorized the Secretary of HHS to examine the feasibility of conducting hearings by teleconference or by video.

Previous OIG work has identified significant problems in the Medicare appeals process that resulted in the system being backlogged and untimely. The authorities have addressed several recommendations, including the transfer of the Medicare ALJ hearings function from the responsibility of the Commissioner of the Social Security Administration to the Secretary of HHS and modifying the timeframes for the various levels of appeals to provide adequate time for fair and effective processing, while still ensuring timely and efficient resolution of appeals.

Medicare Appeals Process: Qualified Independent Contractor Reconsiderations

OIG will review whether qualified independent contractors (QIC) are meeting statutory and regulatory requirements regarding decision timeframes and reviewer qualifications. Medicare administrative appeals provide important beneficiary and provider protection. Federal regulations at 42 CFR Part 405, Subpart I, specify the requirements of the FFS claims appeals process. Since the implementation of section 521 of the BIPA and section 933 of the MMA, which amended the Medicare administrative appeals process, work has not been conducted to assess the level two reconsideration process, which includes QICs' performance regarding initial Medicare coverage determinations. OIG will determine whether CMS is providing adequate oversight of the QICs.

Contractors' Provider Education and Training Efforts

OIG will review whether contractors are meeting CMS' Medicare Integrity Program (MIP) requirements for provider education and training. One of the program's goals is to reduce payment errors through provider education and training efforts. Section 921 of the MMA instructed the Secretary of HHS to take steps to provide education and training to Medicare participating providers. The MIP budget for FY2007 totaled $829.6 million, of which CMS intended $52.8 million for provider education and training efforts. OIG will determine whether contractors have met CMS' requirements for provider outreach and education and training activities.

Medicare Summary Notice

OIG will review beneficiaries' use and understanding of Medicare Summary Notices (MSNs). MSNs advise beneficiaries of claims paid for healthcare services and supplies. Chapter 21, section 10, of the "Medicare Claims Processing Manual," Pub. No. 100-04, contains contractor requirements for issuing MSNs. The MSN is CMS' primary means to address Medicare fraud. On its Web site and in the "Medicare & You" publication, CMS emphasizes the importance of beneficiaries checking their MSNs for any services or supplies that they do not recognize. OIG will review beneficiaries' experiences with MSNs and the results of their inquiries about unrecognized services.

The Medicare and Medicaid Data Matching Project

OIG will review CMS' oversight and monitoring of Medicare and Medicaid Data Matching Project (Medi-Medi) contractors to determine whether they are meeting contractual requirements outlined in the Medi-Medi Task Orders. CMS initiated the Medi-Medi Project in 2001, in partnership with the state of California. The project

continues, pursuant to section 1893 of the SSA, to improve coordination of Medicare and Medicaid program integrity efforts. The objective of the project is to match Medicare and Medicaid data to identify, on a proactive basis, program vulnerabilities and potential fraud and abuse that may have gone undetected by reviewing Medicare and Medicaid program data individually. As of 2007, there were 10 active Medi-Medi Task Orders in the states of California, Texas, Washington, Pennsylvania, North Carolina, New Jersey, New York, Florida, Ohio and Illinois. FARs at 48 CFR § 42.1500, et seq., provide policies and establish responsibilities for agencies recording and maintaining contractor performance information.

Accuracy and Completeness of the National Provider Identifier

OIG will review the accuracy and completeness of the National Provider Identifier (NPI). NPI is a unique identification number for healthcare providers. CMS regulations at 45 CFR § 162.404 require that, beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI be used in lieu of legacy provider identifiers when submitting claims. Providers failing to obtain their NPIs risk losing their ability to receive payment for services provided to Medicare and Medicaid beneficiaries. By May 23, 2008, all Medicare providers must include their NPIs when submitting claims. OIG will determine whether CMS has met program goals for implementation of the NPI.

Recovery Audit Contractors: Reducing Medicare Improper Payments

OIG will review CMS' oversight and monitoring of recovery audit contractors (RAC) to determine whether they meet contractual requirements outlined in the RAC Task Orders. MMA Section 306 authorized the RAC program, which is designed to reduce Medicare improper payments through detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments. Section 302 (included in Division B of the Tax Relief and Health Care Act of 2006 [Pub. L. No. 109-432]), requires the Secretary of HHS to utilize RACs in the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments associated with services for which payments are made under Medicare Part A or Part B.

Medicare Cross-Cutting Issues

The OIG will begin two new studies in FY2008 to focus on Medicare cross-cutting issues:

Serious Medical Errors (Never Events)

The Tax Relief and Health Care Act of 2006 (TRHCA), Pub. L. 109-432, requires the OIG to conduct a study of never events. The OIG will review the incidence, facility response and payments associated with serious medical errors, known as never events. The OIG will conduct a series of studies, including an evaluation of medical error reporting and provider response, among other targeted areas. Legislative mandates require OIG to study incidences of never events for Medicare beneficiaries, including types of events and payments by any party; the extent to which the Medicare program paid, denied payment or recouped payment for services furnished in connection with such events; and the extent to which beneficiaries paid for such services. OIG is also required to review CMS' administrative processes to detect such events and to deny or recoup payments for services furnished in connection with such events. OIT will assess the utility of current state and voluntary reporting systems and examine CMS' oversight of and processes for identifying and responding to never events.

Doctors' Office Quality Information Technology Initiatives

OIG will assess CMS' efforts to promote the implementation and use of HIT in physicians' offices through QIOs. Through the Doctor's Office Quality Information Technology project, QIOs are to assist independent

physician practice groups (IPGs) with the adoption and implementation of interoperable HIT, including electronic health records, electronic prescribing and chronic care management technologies. OIG will evaluate whether QIOs are meeting contractual obligations and describe how IPG HITs differ across QIOs. OIG will also describe variations in achievements and identify obstacles for adoption of HIT in IPGs.

GOVERNMENT ACCOUNTABILITY OFFICE

The Government Accountability Office (GAO) supports the Congress in meeting its constitutional responsibilities and helps improve the performance and ensure the accountability of the federal government for the benefit of the American people.

GAO's work includes oversight of federal programs; insight into ways to make government more efficient, effective, ethical and equitable; and foresight of long-term trends and challenges. GAO's reports, testimonies, legal decisions and opinions make a difference for Congress and the nation.[6]

As addressed in Chapter 1, the GAO advises Congress, providing insight, oversight and foresight to assist in setting the Congressional legislative agenda. In addition to the key documents listed above, the GAO issues a steady stream of reports and testimonies by GAO officials each year.

For FY2007, GAO posted 954 reports; 121 reports were for agencies within HHS, 56 of which focused on CMS operations. Reports affecting CMS Medicare operations included the following:

- Ambulance Providers (GAO-07-383)
- Competitive Acquisition for DMEPOS (GAO-07-748R)
- End-Stage Renal Disease (GAO-07-1117, GAO-07-1050T, GAO-07-266T)
- Hospital Accreditation (GAO-07-79)
- Hospital Quality Data (GAO-07-320)
- Improper Payments DMEPOS (GAO-07-59)
- Long-Term Care Insurance (GAO-07-231)
- Medicare Advantage (GAO-07-945)
- Medicare Inpatient Hospital Payments (GAO-07-46)
- Medicare Part B Providers Abuse of Tax System (GAO-07-587T)
- Medicare Part D (GAO-07-824T, GAO-07-858T, GAO-07-272)
- Medicare Physician Payments (GAO-07-463, GAO-07-466)
- Medicare Physician Practice Patterns (GAO-07-307, GAO-07-862T, GAO-07-567T)
- Medicare Ultrasound Procedures (GAO-07-734)
- Nursing Homes (GAO-07-373, GAO-07-794T, GAO-07-241)
- Prescription Drugs (GAO-07-1201R, GAO-07-481T, GAO-07-358T)
- Retiree Health Benefits (GAO-07-572)

6 http://www.gao.gov/.

GAO Report 08-54, CMS: Internal Control Deficiencies Resulted in Millions of Dollars of Questionable Contract Payments

At the close of the year, the GAO issued a report requested by the Senate Finance Committee on the use of the $1 billion appropriation for implementing the CMS-administered prescription drug benefit implemented under MMA. Because CMS had full discretion on how to use the appropriations, Congress requested the GAO to answer three questions:

1. How did CMS use the $1 billion appropriation?
2. Were CMS' contracting practices and related internal controls adequate to avoid waste and to prevent or detect improper payments?
3. Did CMS properly support payments to contractors as a valid use of government funds?

In its report published Nov. 15, 2007,[7] the GAO explained its findings and made nine recommendations to improve internal control and accountability in the contracting process and related payments to contractors. The reaction of Congress was strong and swift. Senate Finance Committee Chairman Max Baucus called the findings, "alarming and intolerable," adding, "CMS did not spend this money wisely and responsibly and so CMS failed to ensure the best service to America's seniors."[8]

The GAO found that CMS spent over 90 percent of the MMA appropriation by the end of December 2006; CMS paid about $735 million to contractors and vendors for a variety of services. The 1-800-MEDICARE help line experienced increased call volume and CMS paid about $234 million to two contractors to support it. Federal agencies received payments for printing and mailing services ($105 million); state agencies received payments to fund education programs for the public ($23.8 million); CMS paid employee payroll and travel costs ($42.1 million); and CMS paid for purchase card transaction to acquire office supplies, equipment and outreach materials ($2 million).

The GAO found CMS lacked resources to keep pace with increases in contract awards and adequately perform contract and contractor oversight; the operating environment created vulnerabilities in the contracting process. CMS did not work with contractors to establish indirect cost rates and increased risks to CMS through contracting practices such as the use of cost reimbursement contracts. Pervasive internal control deficiencies increased the risk of improper payments; CMS did not have clear guidance regarding invoice review and when invoice review did take place, it was often flawed. As of Sept. 30, 2007, CMS' backlog of contract closeouts was approximately 1,300.

GAO identified nearly $90 million in questionable payments, represented by costs not in compliance with contract terms and therefore, potentially improper ($24.5 million). The GAO also found costs for which adequate support was not available in order to make a determination on propriety ($62.7 million) and noted potential waste due to CMS' contracting practices ($6.6 million). The GAO recognizes that due to lack of supporting documentation, some of the questioned amounts may relate to allowable costs that are not recoverable.

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7 GAO-08-54, CMS: *Internal Control Deficiencies Resulted in Millions of Dollars of Questionable Contract Payments*, retrieved on Jan. 2, 2008, from http://www.gao.gov/new.items/d0854.pdf.

8 *GAO: Medicare contracting Weaknesses Resulting in $90M in Questionable Payments, Federal Contracts Report*, Volume 88, No. 23, Dec. 25, 2007.

The GAO made the following recommendations based on the results of its study:

- Develop policies and criteria for preaward contracting activities including:
  1. Appropriate use of competition exemptions such as logical follow-on agreements, unusual and compelling urgency and SBA's 8(a) program;
  2. Analysis to justify contract type selected, as well as, if applicable, verification of the adequacy of the contractor's accounting system prior to the award of a cost reimbursement contract; and
  3. Consideration of the extent to which work will be subcontracted.
- Develop policies and procedures to help ensure that cognizant federal agency responsibilities are performed, including:
  1. Monitoring CAS compliance;
  2. A mechanism to track contractors for which CMS is the cognizant federal agency; and
  3. Coordination of tracking efforts with other agencies.
- Develop agency-specific policies and procedures for the review of contractor invoices so that key players are aware of their roles and responsibilities, including:
  1. Specific guidance on how to review key invoice elements;
  2. Methods to document review procedures performed; and
  3. Consideration of circumstances that may increase risk such as contract type or complex subcontractor agreements.
- Prepare guidelines to contracting officers on what constitutes sufficient detail to support amounts billed on contractor invoices to facilitate the review process.
- Establish criteria for the use of negative certification in the payment of a contractor's invoices to consider potential risk factors such as contract type, the adequacy of the contractor's accounting and billing systems and prior history with the contractor.
- Provide training on the invoice review policies and procedures to key personnel responsible for executing the invoice review process.
- Create a centralized tracking mechanism that records the training taken by personnel assigned to contract oversight activities.
- Develop a plan to reduce the backlog of contracts awaiting closeout.
- Review the questionable payments identified in the GAO's report to determine whether CMS should seek reimbursement from contractors.

CMS has acted or agreed to act on GAO's recommendations; however, CMS disagreed with some of the findings. For example, CMS asserted that the contract actions reviewed by GAO are not representative of CMS' normal contracting procedures. Because of the short implementation period, Congress allowed CMS to deviate from its usual practices; CMS states that in FY2007, it has been exemplary in its use of competitive contracts. CMS disagreed with GAO's conclusion that $90 million in payments to contractors was questionable; CMS made interim payments on the cost reimbursement contracts and will obtain audits of all costs claimed for reimbursement under the contracts. CMS will obtain the repayment of any costs found to be unallowable and GAO's conclusion is premature regarding the $90 million in questionable payments.

GAO's overall conclusion was that CMS' "preaward contracting practices were driven by expediency rather than obtaining the best value and minimizing the risk to the government."[9] Because CMS did not timely perform audits to closeout contracts, it may have missed the opportunity to discover and ultimately recover improper payments. CMS is vulnerable to continued waste and improper payments without immediate action to repair systemic flaws; billions of dollars called for in MMA contracting reform provisions are at risk. As discussed in Chapter 5, this report has implications for MAC contracting.

Congressional Research Services Report for Congress: Medicare Program Integrity

The Congressional Research Service (CRS) works exclusively for the U.S. Congress, providing policy and legal analysis to committees and Members of both the House and Senate, regardless of party affiliation. As a legislative branch agency within the Library of Congress, CRS has been a valued and respected resource on Capitol Hill for nearly a century.[10]

CRS October 2007 report on Medicare Program Integrity highlights current issues in maintaining program integrity in a challenging and changing environment.[11] In FY2008, Medicare will spend $456 billion to cover an estimated 44.6 million beneficiaries. The Congressional Budget Office estimates Medicare costs will double over the next ten years due to a number of factors:

- An aging population
- Increasing medical costs
- Part D prescription drug benefit

Efforts to protect and preserve the Program's integrity continue to receive attention from lawmakers. The size and scope of the Medicare program necessitates the involvement of many government entities to preserve Medicare's integrity. CMS oversees contractors charged with ensuring program integrity:

- Claims Administration Contractors
- Program Safeguard Contractors
- Recovery Audit Contractors
- Coordination of Benefits Contractor
- Medicare Managed Care Program Integrity Contractor
- Medicare Drug Integrity Contractors
- Quality Improvement Organizations
- Other (National Supplier Clearinghouse, Data Analysis and Coding, DME PSCs)

Current Issues Identified by CRS

Oversight is a collaborative effort; Medicare Integrity Contractors develop and refer suspected cases of fraud to the HHS Office of Inspector General and Department of Justice for further investigation and prosecution. The CRS Report prepared for Congress on Medicare Program Integrity[12] included highlights of three pressing Medicare fee-for-service program integrity issues: DME, RAC Program and PSCs.

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9 Ibid, Page 45.

10 From CRS Web site, http://www.loc.gov/crsinfo/ retrieved Dec. 13, 2007.

11 CRS Report for Congress, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud and Abuse* (RL34217), Oct. 24, 2007, Retrieved on Dec. 12, 2007 from http://opencrs.com/.

12 Ibid.

Durable Medical Equipment (DME)

The GAO and OIG have focused investigations on issues related to fraudulent billing for DME. A July 2007 HHS Press Release[13] highlighted efforts in South Florida and Southern California to combat fraudulent business practices and prevent deceptive companies from operating as Medicare DMEPOS suppliers.

As noted under the Highlights of OIG accomplishments, the OIG conducted unannounced site visits to of suppliers of DMEPOS in three South Florida counties (Miami-Dade, Broward and Palm Beach) to determine their compliance with selected Medicare supplier standards. The OIG found 45 percent of Medicare participating DME companies operating in South Florida did not comply with at least one of five Medicare enrollment standards for CY2005 and raised the question of whether DMEPOS suppliers in South Florida comply with the most basic of supplier standards.[14]

On July 2, 2007, HHS announced a demonstration project requiring all DMEPOS suppliers in South Florida and Southern California to reapply for participation in Medicare in order to maintain their billing privileges.[15] An estimated 7,500 DMEPOS suppliers are affected; CMS' plans to combat fraud include conducting random, unannounced site visits to supplier locations in these areas.[16]

MMA Section 302(a)(1) requires Medicare to develop and implement quality standards for DMEPOS suppliers. Beginning in FY2008, the National Supplier Clearinghouse, which enrolls and screens potential suppliers for Medicare participation, will not issue a Medicare billing number to any supplier not accredited under the new rule.[17]

Recovery Audit Contractor Program (RAC)

MMA, Section 306 authorized the Secretary to contract with RACs to identify and recoup over- and underpayments in Medicare Parts A and B. The program began in March 2005 as a demonstration project in California, Florida and New York over concerns that Medicare needed extra protection over improper payments. The RAC program became permanent with the passage of TRHCA; CMS plans to contract with RACs in all 50 states by 2010.[18]

The contingency method of payment for RAC contractors has caused controversy; each RAC receives a percentage of collected amounts and industry groups argue RACs have an incentive to perform aggressively in their reviews. CMS reports providers filed 2,596 appeals in FY2006 to challenge RAC overpayment determinations in the demonstration states. Currently, RACs return overpayments and contingency payments if providers win first-level appeals; beginning in March 2008, RACs will be required to return all contingency payments, if a provider wins at any appeal level.[19] As discussed in Chapter 3, despite the controversy, CMS plans to move forward with a national RAC program.

CMS hired AdvanceMed, a contractor with CERT program experience, to conduct random reviews of RAC demands on physicians and other providers. A physician interviewed by *Part B News*[20] commented on the

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13 HHS Press Release, *Medicare Provider Enrollment Demonstration Involving Suppliers of Durable Medical Equipment, Prosthetics or orthotics and and Supplies (DMEPOS) in High-Risk Areas,* July 2, 2007 retrieved on Dec. 12, 2007, from http://www.hhs.gov/news/press/2007pres/07/pr20070702a.html.

14 OEI-03-07-00150, *South Florida Suppliers' Compliance with Medicare Standards: Results from Unannounced Visits, March 2007* http://www.oig.hhs.gov/oei/oeisearch.html.

15 HHS Press Release, *Medicare Provider Enrollment Demonstration Involving Suppliers of Durable Medical Equipment, Prosthetics or orthotics and and Supplies (DMEPOS)* in High-Risk Areas, July 2, 2007 retrieved on Dec. 12, 2007, from http://www.hhs.gov/news/press/2007pres/07/pr20070702a.html.

16 CRS Report for Congress, *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud and Abuse* (RL34217), Oct. 24, 2007, Retrieved on Dec. 12, 2007 from http://opencrs.com/.

17 Ibid.

18 Ibid.

19 *CMS RAC Status Document (FY2006),* p. 17, Retrieved on Dec. 12, 2007, from http://www.cms.hhs.gov/RAC/ (Downloads).

20 Part B News, *Who's Reviewing the RACs?,* Oct. 15, 2007.

costly and time-consuming appeals process, commenting that for a physician wining an appeal, "It's a Pyrrhic victory … even if you win, you lose."

Program Safeguard Contractors (PSCs)

HIPAA, which created the Health Care Fraud and Abuse Control Program (HCFAC) and MIP programs, authorized the Secretary to contract with PSCs to conduct program integrity activities. Formerly, such activities were the responsibility of Part A and Part B contractors (FIs and Carriers). PSC oversight has been an area of continued concern for CMS.

In a July 2007 report,[21] the OIG found:

- PSCs differed substantially in the number of new investigations and case referrals to law enforcement produced in 2005.
- Most PSCs had minimal results from proactive data analysis.

OIG recommended CMS should:

- Review PSCs with especially low volumes of activity in investigations and case referrals for Medicare Parts A and B.
- Require PSCs to provide, in their monthly reports, more detail in their explanations of investigations, case referrals and proactive data analysis activities.

CMS concurred in part with OIG's first recommendation. CMS stated that currently it is difficult to compare PSCs. However, CMS has begun implementing a new strategy of aligning PSC jurisdictions with the jurisdictions of claims–processing contractors. The alignment will make it easier to compare PSCs in the future. CMS also noted that it has begun allocating funds to PSCs based on PSC performance, workload and Medicare program vulnerabilities.

The development of cases for referral to law enforcement is not the only basis for determining acceptable performance for PSCs. CMS reports that law enforcement often indicates its preference is that PSCs pursue administrative actions rather than referrals.

CMS concurred with OIG's second recommendation, stating it has revised the monthly reporting system to collect more information and to improve reporting consistency across PSCs. Regarding proactive data analysis, CMS stated that this activity has other goals besides referring cases to law enforcement, such as identifying targets for edits, assessing the effectiveness of administrative actions and assisting law enforcement with open cases.

As discussed in Chapter 3, CMS announced it is replacing PSCs with seven "Zone Program Integrity Contractors" (ZPICs) to handle benefit integrity activities across the country.[22] Part of CMS' new approach is to form "rapid response teams," for which the following benefits are anticipated:

- Utilizing teams of Medicare and Medicaid Central Office and Field Office staff to address identify and prevent fraud in emerging hot spots.
- Sharing resources across Field Offices to address a flare-up in another Field Office's area.
- The ZPICs will support the Field Offices and the Rapid Response Teams in special fraud initiatives.

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21 OEI-03-06-00010, *Medicare's Program Safeguard Contractors: Activities to Detect and Deter Fraud and Abuse,* July, 2007, Retrieved on Dec. 12, 2007 from http://www.oig.hhs.gov/oei/oeisearch.html.

22 PowerPoint Presentation, The New Frontier: The Changing Landscape of CMS Program Integrity, Kimberly Brandt, Director, Program Integrity Group, CMS, Sept. 24, 2007, Fraud and Compliance Forum sponsored by the Health Care Compliance Association and American Health Lawyers Association.

As discussed in Chapter 5, the transitions, based on Medicare Administrative Contractor (MAC) jurisdictions, will place five of the seven ZPICs in "hot spot" zones: California, Florida, Illinois, New York and Texas, with an increased focus on quick response to fraud and administrative actions. The two other zones will serve 24 states with limited incidence of fraud and will continue using proven PSC processes.

CMS will transition the medical review function from DME PSCs to DME MACs. By May 2009, CMS will award all new PSC contracts and Medi-Medi expansion contracts. Benefits of the PSC Strategy include:

- Increased efficiency to look at providers across all benefit categories.
- Economies of scale through the consolidation of contractor management, data/IT requirements, facility costs, etc.
- Streamline CMS costs in acquisition, management and oversight.
- Better coordination and fewer resources required for the states.
- Increased security of protected health information (PHI) due to fewer contractors handling the data.

CMS OVERSIGHT OF CONTRACTORS

FY2006 Reports of Contractor Performance (RCPs)

Reports of Contractor Performance (RCPs) reflect a contractor's performance of Medicare fee-for-service (FFS) business functions performed under contract and reviewed by CMS during the fiscal year. Each RCP reflects the respective contractor's performance in meeting key financial management objectives and in achieving CMS' goals of accurate and timely claims processing, effective payment safeguards and responsive customer service. On average, the FY2006 RCP's were generally more positive than previous years.

All RCPs are public documents and are available to any interested party. A compilation and analysis of the FY2006 RCPs by Government Business Services (GBS) is available on BlueWeb.[23] The following are highlights from that report.

CERT Program

CMS exceeded its goal to reduce the percentage of improper payments made under the FFS program to 5.1 percent or less by the November 2006 reporting period,[24] primarily because 47 of the 53 contract areas reviewed actually met or exceeded the goal. This year CMS rated each contractor's CERT performance as Excellent, Very Good, Good, Satisfactory or Unsatisfactory in the RCP. The vast preponderance of contracts received an "Excellent" rating.

Contractor Performance Evaluations (CPEs)

Nationally, CMS evaluated 23 different standards among the five standard criteria; evaluating at least one standard at each contractor. This resulted in 299 evaluations with a total of 39 major findings and 31 minor findings, which is a significant decrease compared to the previous year. The Reimbursement standard was the most problematic at a national level. In fact only one contractor received an acceptable rating.

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23 GBS Fiscal 2006 Reports of Contractor Performance Analysis http://blueweb.bcbs.com/federal_programs/attachments/gbs/SS_msm_229_RCP_Analysis_FY2006_Final_062207.pdf.

24 CMS, *"2006 Improper Medicare Fee-For Service Payments Report"* (Nov. 15, 2006).

Systems Initiatives

The RCPs included a qualitative, overall assessment of each contractor's Medicare security program as High Risk, Moderate Risk or Low Risk. Almost two-thirds of contractors received a High Risk rating.

912 Security Audits

In FY2006 the CMS assessed each of the Medicare contractor's systems security programs for compliance with the Federal Information Security Management Act (FISMA) requirements identified in the Medicare Modernization Act (MMA) of 2003. Although fewer contractors were reviewed this year (as a result of program departures), there was a 26 percent increase in total findings. The three most common narrative findings identified by CMS in the Section 912 audits were in systems security plans, policies and procedures and testing and evaluation information technology controls.

Chief Financial Officer/Electronic Data Processing (CFO/EDP)

Each contractor received a Systems Initiatives Chief Financial Officer/Electronic Data Processing (CFO/EDP) audit during FY2006. The majority of findings were assessed as Medium Risk. The most common narrative findings identified by CMS in the CFO/EDP audits were Access Controls and Entity-Wide Security Program Planning and Management.

Systems Initiatives Statement on Auditing Standards Number 70 (SAS-70)

There was a significant reduction in the number of contractors reviewed and the number of findings assessed as part of the Systems Initiatives SAS-70 audits in FY2006 when compared to FY2005. The majority of those contractors reviewed received two or fewer findings. The most common narrative finding identified by CMS in the System Initiative-related portions of the SAS-70 audits was Access Controls.

Financial Management Reviews

Prior Year Financial Reviews

Contractors were reviewed under the annual CFO audit, accounts receivable (AR) AUP review and SAS-70 in prior fiscal years. Collectively, these reviews resulted in a total of 1,728 findings. Contractors submitted corrective action plans (CAPs)[25] to address all identified weaknesses and the CMS business owners and the consultants were able to validate the closure of 1549 of the 1728 or 89.6 percent of the findings. The total number of open findings decreased 43.8 percent from FY2005 to FY2006.

Current Year Financial Reviews

Although contractors were eligible for financial reviews under the annual CFO audit, accounts receivable (AR) AUP review, Certification Package for Internal Controls (CPIC) Protocol Reviews and SAS-70 in FY2006, no AR AUP reviews were done and only two CPIC reviews were done. There were only 28 current year financial management findings for all audits combined and most of those findings were assessed to small contractors.

25 The CMS staff requests a CAP when they detect serious performance problems through ongoing monitoring.

Reportable Events

More than two years after issuing the initial Reportable Events requirements,[26, 27] CMS issued the long-awaited clarification,[28] Frequently Asked Questions (FAQs) – Reportable Events, on Oct. 4, 2007. As reported by CMS,[29] nearly 300 reportable events were submitted since June 2005 before CMS issued the FAQ. Three contractors represented nearly two thirds of all reportable events; 78 percent of the events were PHI-related. CMS planned to remedy this inconsistent level of reporting among contractors through on-site contractor visits.

Medicare Integrity Program (MIP) Conflict of Interest

On Aug. 24, 2007 CMS released the Final Rule[30] concerning the MIP, fiscal intermediary and carrier functions and conflict of interest requirements. CMS amended part 421 of the SSA by adding a new subpart D entitled Medicare Integrity Program Contractors. Subpart D would apply to entities that seek to compete for or receive award of, a contract under section 1893 of the SSA. This subpart D defines the types of entities eligible to become MIP contractors and clarifies that, in accordance with section 1874A of the SSA, a MAC may perform MIP functions under certain conditions;

- Identify program integrity functions a MIP contractor may perform;
- Describe procedures for awarding and renewing contracts;
- Establish procedures for identifying, evaluating and resolving organizational conflicts of interest consistent with the FAR;
- Prescribe responsibilities; and
- Set forth limitations on MIP contractor liability.

SAS 70 Audit Findings

SAS 70 audit findings from Blue Cross Blue Shield contractors decreased from FY2006 to FY2007. In FY2007, there were 10 findings from eight contractors, compared to 29 findings from 10 contractors in FY2006.

In FY2006, the largest number of findings was in Information Systems with 11. The number of information systems SAS 70 findings decreased to four in FY2007.

The table below lists the number of findings by category for FY2006 and 2007.

No. of Findings by Category	FY2006	FY2007
Information Systems	11	4
Medicare Secondary Payer	4	2
Debt Collection/Referral	4	3
Provider Audit	1	0
Medical Review/POE*	4	1
Financial	5	0

** Provider Outreach and Education (POE) replaced Local Provider Education & Training (LPET).*

26 JSM 05330.
27 JSM 05479.
28 JSM 07529.
29 Heffron, W. (Oct.24, 2007). Reportable Events, CMS Contractor Executive Group Meeting, Baltimore, MD.
30 72 FR 48870-48888.

A list of the FY2007 SAS 70 audit findings is posted on BlueWeb under GBS Proprietary Reports/GBS Policy and Performance Reports.

FY2007 CPIC Material Weaknesses and OMB A-123 Compliance

The FY2007 Certification Program of Internal Controls (CPIC) filing included new requirements related to compliance with the Office of Management and Budget (OMB) Circular A-123. OMB A-123 requires testing of the internal controls over financial reporting. Medicare contractors may use the results from recent SAS 70 audits to comply with the testing requirements.

CMS notes that they rely on management to choose the most effective type of testing. For guidance on the A-123 testing, CMS recommends that contractors refer to the Medicare Financial Management Manual, Chapter 7, Sections 20.4 (testing methods) and Section 20.5 (documentation and working papers). Additional guidance on testing is contained in the OMB A-123 Implementation Guide and the Public Company Accounting Board's Auditing Standard No. 2.

To certify compliance with OMB A-123, contractors are required to submit an assurance statement for internal controls over financial reporting. The assurance statement will be Unqualified, Qualified or No Assurance.

- Unqualified Statement - Contractor has effective internal controls over financial reporting per OMB A-123
- Qualified Statement – Contractor has effective internal controls over financial reporting per OMB A-123, except for the material weaknesses reported in the CPIC Report of Material Weaknesses.
- Statement of No Assurance – Contractor is unable to provide assurance that its internal controls over financial reporting were operating effectively due to the material weaknesses included in the CPIC Report of Material Weaknesses or the contractor did not fully implement the requirements included in OMB A-123.

A list of CPIC material weaknesses reported on the July 20, 2007 CPIC filing was compiled from BCBSA contractors. In FY2007, there were 12 material weaknesses reported compared to 40 weaknesses in FY2006.

In both years, information systems had the largest number of CPIC material weaknesses. The number of information systems material weaknesses decreased from 21 weaknesses in FY2006 to eight weaknesses in FY2007.

The table below lists the number of CPIC material weaknesses by category for FY2006 and 2007.

No. of Findings by Category	FY2006	FY2007
Information Systems	21	8
Financial	3	3
Medicare Secondary Payer	2	1
Medical Review/POE	3	0
Provider Audit	4	0
Other Categories*	7	0

** Categories include claims processing, appeals, administrative, debt referral and non-MSP debt collection.*

CPIC material weaknesses are posted on BlueWeb under GBS Proprietary Reports/GBS Policy and Performance Reports.

Healthcare Fraud

Whistleblowers' Continued Success

The Justice Department announced on Nov. 1, 2007 that during the last year, the U.S. Treasury reclaimed $2 billion in settlements and judgments overall under the False Claims Act (FCA).[31] Of that $2 billion, $1.45 billion was associated with lawsuits initiated by whistleblowers. Healthcare fraud cases involving Medicare, Medicaid, and other government programs generated $1.54 billion, more than 75 percent of the total recoveries due to the continued effectiveness of whistleblower suits and targeted government initiatives.[32]

With recoveries at these high levels, HHS and CMS continue their aggressive approach by focusing on high risk areas as discussed below.

CMS Anti-fraud Initiatives

According to CMS, fraudulent Medicare billings submitted by medical equipment suppliers nationwide could reach several billion dollars annually.[33] In 2007 CMS launched a two-year pilot program in the high fraud regions of south Florida and south California that will focus on fake bills and overcharges submitted by suppliers of prosthetic limbs orthotics, diabetic supplies and durable medical equipment. If the pilot is effective in reducing fraud in these two high fraud regions, CMS will likely roll it out nationwide.

In the south Florida region, a "Medicare Fraud Strike Force" implemented by the combined efforts of the HHS, the U.S. Department of Justice, state and local investigators focused on two types of fraud. The first was the unnecessary pharmacy compounding of more costly medications instead of less expensive drugs. The second concerned fraud caused by billing for unneeded drugs for intravenous therapy.[34]

EMERGING ISSUES

False Claims Correction Act

To respond to recent federal court decisions that could limit the scope of the FCA, a bipartisan Senate bill,[35] the False Claims Correction Act, would amend the qui tam or whistleblower provisions of the False Claims Act. The key provisions could potentially expand quit ams by:

- Removing the "presentment requirement" that currently demands that false claims be properly "presented" to a federal government employee and provide for liability when a false claims concerns government money or property.
- Modifying the public disclosure bar that currently allows the dismissal of FCA cases that are based on publicly disclosed information unless the qui tam relator is an "original source" of the information.
- Establishing that false claims against non-U.S. government funds that are under the control of the U.S. government are subject to recovery under the FCA.
- Clarifying that federal employees may act as qui tam relators "in limited circumstances when they have reported activities up the chain of command, to the inspector general, to the attorney general and only if no action was taken after 12 months."

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31 Retrieved from http://www.whistleblowerlawyerblog.com/2007/11/ on Dec. 20, 2007.
32 Ibid.
33 Retrieved from http://www.hhs.gov/news/facts/medicarefraud/index.html on Dec. 21, 2007.
34 Retrieved from http://www.usdoj.gov/usao/fls/PressReleases/070510-01.html on Dec. 19, 2007.
35 S. 2041.

- Setting a ten-year statute of limitations for all FCA cases.
- Implementing changes intended to expand use by the DOJ of the civil investigative process (CID) in investigating potential FCA violations and permit the attorney general to delegate authority for issuing CIDs.

Personal False Claims Liability Prosecutions

As the government continues and expands its extensive efforts against healthcare fraud, it is utilizing a variety of creative and aggressive tactics directed at both healthcare companies and individuals employed by those companies. As seen in recent cases, legal counsel and corporate compliance officers may now face new personal false claims liability risks. Three recent high-profile cases include:

- The DOJ filed a complaint[36] on Sept. 18, 2007 against the former general counsel of Tenet Healthcare Corp. for violating the FCA when she submitted false certifications to Medicare. The government alleges that Christi Sulzbach, who acted as both the general counsel and the compliance officer, submitted false declarations that allowed Tenet to bill Medicare for millions of dollars in claims that Tenet was not legally entitled to receive under the Stark physician employment arrangements statute. As a result of the treble damages provision of the FCA, she is potentially personally liable for as much as $350 million. This case highlights the government's concerns about general counsel holding the compliance officer position.
- The DOJ indicted Patricia Syling, the former compliance officer of the Queen's Medical Center in Hawaii, for mail fraud alleging that she secretly awarded HIPAA and compliance consulting contracts to herself.[37]
- Robert Riley, the regulatory compliance officer at AbTox, a medical device manufacturer, was sentenced to a six-year prison term for lying to the FDA.[38]

Mandating Contractor Compliance

On Nov. 23, 2007 the FAR council issued a final rule that mandates contractor compliance programs for contractors and subcontractors performing covered contracts.[39] Effective Dec. 24, 2007 contractors awarded contracts worth more than $5 million and involving work over 120 days will be required to establish minimum standards of conduct. These include putting in place a written "code of business conduct" and displaying OIG fraud hotline posters, unless contractors have "established a mechanism by which employees may report suspected instances of improper conduct along with instructions that encourage employees to make such reports." Given the requirements of the CMS Compliance Guidance, these requirements would not be new to Medicare contractors.

However, a related proposed rule[40] issued Nov. 14, 2007 carries potential implications for Medicare contractors. The proposed government-wide rule includes a mandatory obligation to disclose criminal conduct to the government and to "fully cooperate" with the government auditors and investigators if they discover violations of federal criminal law in connection with the award or performance of federal contracts or subcontracts valued at $5 million or more and would provide for their suspension or debarment from federal contracting if they fail to do so in a timely fashion.

36 United States v. Sulzbach, S.D. Fla., No 07-61329.
37 Retrieved from http://www.aishealth.com/ on Dec. 18, 2007.
38 Reviewed from http://www.newsinferno.com/archives/1144 on Dec. 18, 2007.
39 72 FR 65873–65882.
40 72 FR 64019–64023.

Growing Importance of Auditors in Fraud Prevention

Auditors play an extremely important role in fraud detection and should be mindful that no news is not necessarily good news. Maintaining independence of mind and in appearance allows auditors to be free of influences that compromise professional judgment and act with integrity and exercise objectivity and professional skepticism. Auditors must think and act independently, taking care not to call into question their ability to remain objective.

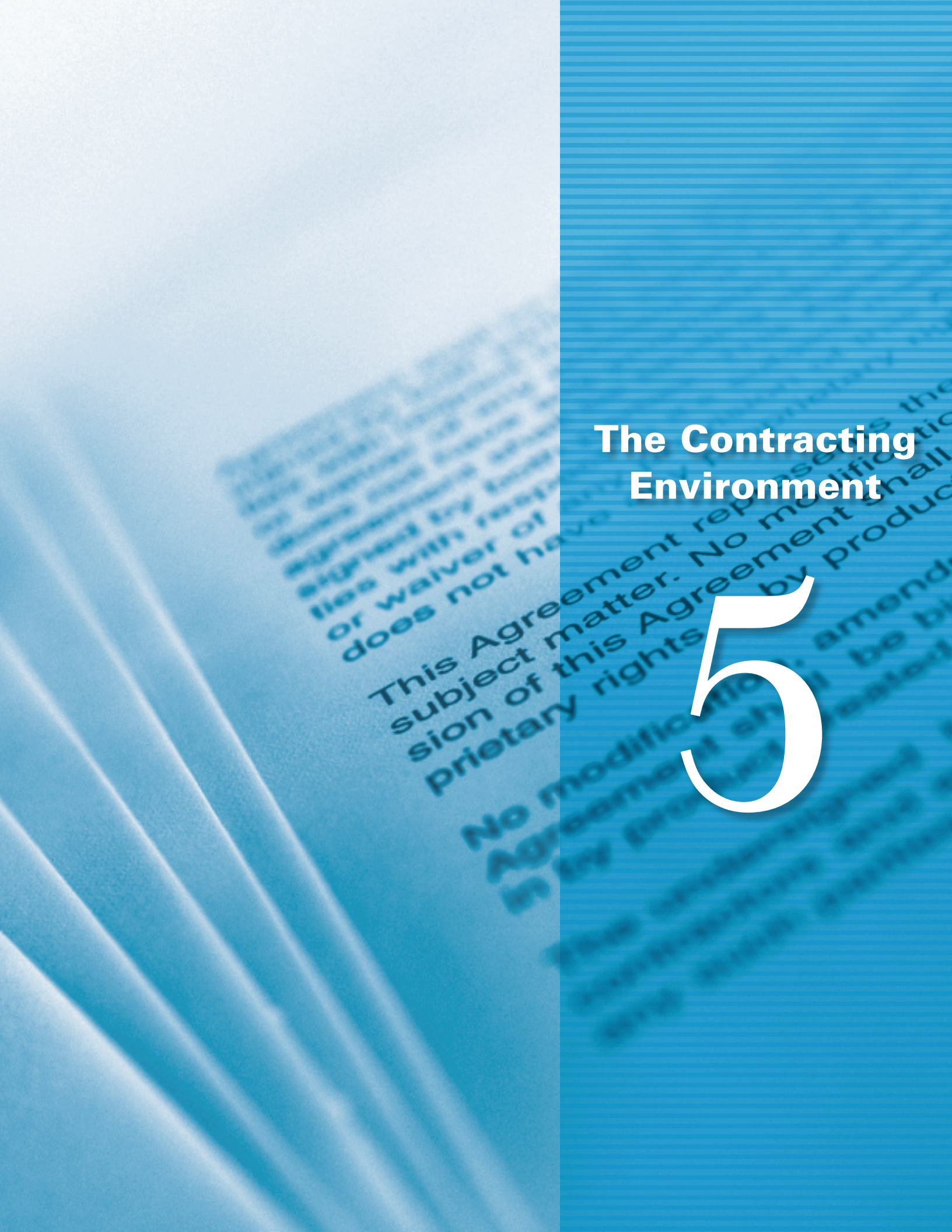
In a survey by accounting firm Grant Thornton,[41] 62 percent of the 221 finance chiefs surveyed from organizations nationwide answered "yes" to the question, "Do you believe it would be possible to intentionally misstate your financial statement to your auditor?" While CFOs may believe they can fool auditors, most (83 percent) do not think it is possible for auditors to detect any and all, corporate fraud, illustrating the magnitude of the auditor's task. According to a published article[42] the formation of the Center for Audit Quality,[43] with its mission to "foster confidence in the audit process . . . by advancing constructive suggestions for change rooted in the profession's core values of integrity, objectivity, honesty and trust,"[44] will address the state of the profession and provide the impetus for change.

41 Press release, Nov. 7, 2007, *Nearly Two Thirds of CFOs Feel They Could Intentionally Misstate Financial Statements; Only Half Aware of XBRL,* Retrieved from http://www.grantthornton.com/portal/site/gtcom on Dec. 13, 2007.

42 Rappeport, A., *Is the Auditor the CFO's Fool?,* Nov. 15, 2007, available at http://www.cfo.com/article.cfm/10131484?f=rsspage.

43 Launched by the American Institute of Certified Public Accountants and supported by nation's largest accounting firms.

44 http://www.thecaq.org/.



The Contracting Environment

5

OVERVIEW

In 2007 the Centers for Medicare & Medicaid Services (CMS) advanced its Medicare Administrative Contractor (MAC) contracting strategy by awarding four new A/B MAC contracts. To keep pace with evolving Medicare Program needs, CMS modified MAC procurements and initiated plans to align the benefit integrity functional contractors (known as program safeguard contractors) to the MACs.

As CMS' federal contracting increased, oversight of MAC contracting by government agencies increased accordingly. The Government Accountability Office (GAO) reviewed CMS contracting practices to ensure effective implementation of start-up administrative funding provided under the MMA. The OIG announced CMS contracting practices will be evaluated under its 2008 WorkPlan. CMS' contracting environment is influenced by dynamics in the U.S. Department of Health and Human Services (HHS) acquisition environment as well as the significant regulatory and legislative developments affecting all federal contractors. In response to investigations into significant waste in government contracting,[1] Congress in 2007 increased its emphasis on transparency, accountability and competition in government contracting.

MAC PROCUREMENT STATUS

CMS has begun the process of selecting MACs using a competitive bidding process. The agency estimates that each MAC acquisition cycle will take approximately nine to 12 months from solicitation to award. After the jurisdictions are awarded, the transitions leading to cutover will take approximately six to 13 months. According to CMS' schedule,[2] all workloads will be transitioned to MACs by October 2009.

The Durable Medical Equipment MAC and Jurisdiction 3 A/B MAC contracts were awarded in 2006 and fully implemented in 2007.

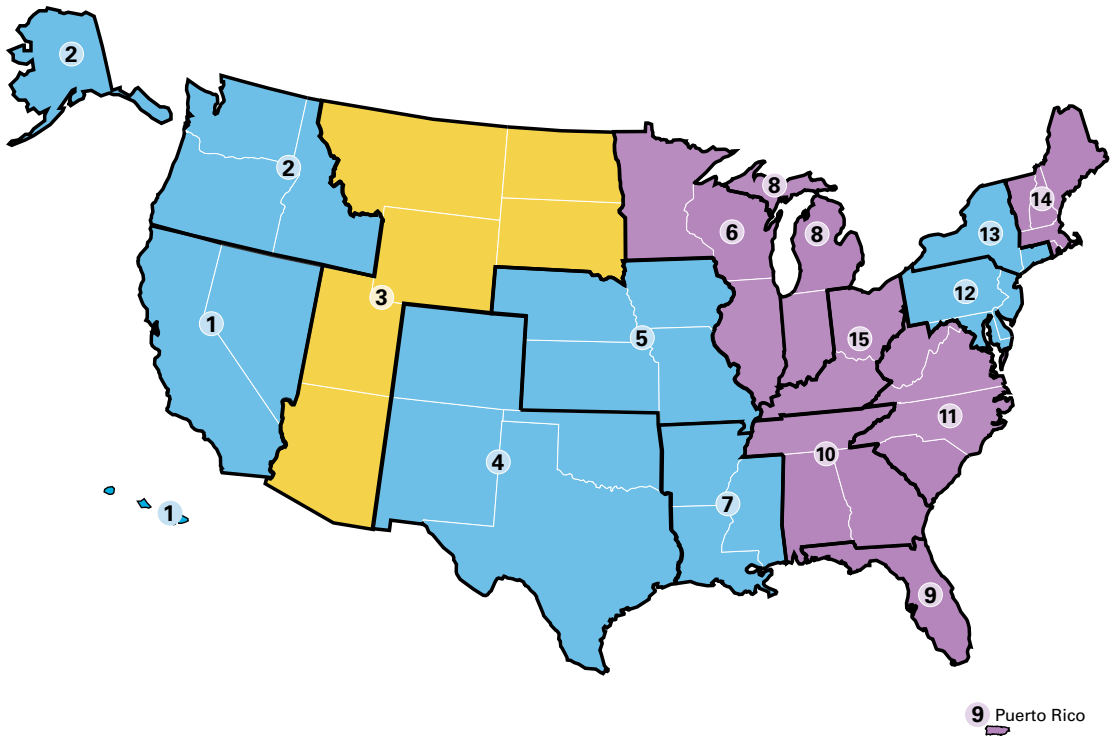
In March 2007, CMS announced that the home health and hospice workloads would be consolidated into four of the A/B MAC contracts instead of being procured separately under Cycle Two. CMS integrated the four home health and hospice jurisdictional claims workloads into the following four A/B MAC competitions:

- Jurisdiction 6 will include home health and hospice Jurisdiction D;
- Jurisdiction 11 will include home health and hospice Jurisdiction C;
- Jurisdiction 14 will include home health and hospice Jurisdiction A; and
- Jurisdiction 15 will include home health and hospice Jurisdiction B.[3]

The following map and table indicate the status of the A/B MAC procurements as of Dec. 31, 2007.[4] As of the date of publication, MAC Cycle One awards for Jurisdictions 2, 7 and 13 are pending.

1 BNA's Federal Contracts Report, Volume 88, Number 18, Tuesday, Nov. 13, 2007.
2 Retrieved from http://www.cms.hhs.gov/MedicareContractingReform/ on Dec. 21, 2007.
3 Retrieved from http://www.cms.hhs.gov/MedicareContractingReform/ on Dec.23, 2007.
4 Ibid.

Future Contracting Environment: Primary A/B Jurisdictions



2007 MAC Award Status

	Jurisdiction	MAC Award Status
Start-Up	3	Noridian (Fully Implemented)
Cycle 1	1	Palmetto GBA (Under Protest)
	2	Award due Sept. 28, 2007
	4	Trailblazer (Spring 2008 Cutover)
	5	Wisconsin Physician Services (September 2008 Cutover)
	7	Award due Sept. 28, 2007
	12	Highmark Medicare Services (Protest Dismissed 12-17-07)
	13	Award due Sept. 28, 2007
Cycle 2	6	Award due between July and September 2008
	8	Award due between July and September 2008
	9	Award due between July and September 2008
	10	Award due between July and September 2008
	11	Award due between July and September 2008
	15	Award due between July and September 2008

Federal Acquisitions Regulations (FAR) Clauses in MAC Procurements

Each A/B MAC procurement cycle has been slightly different from the previous procurement. One of the key differences amongst the procurements has been which FAR clauses were included in the solicitation; some clauses were dropped and others added. Clauses related to cost or pricing data and small business requirements have had the most fluctuation.

ZPICs/MAC Alignment

As discussed in Chapter 3, CMS is changing the current contracting structure with program safeguard contractors (PSCs) to better align with the MACS. As part of this realignment, CMS has established seven jurisdictional zones and started procurement for three separate cycles of Indefinite Delivery Indefinite Quantity (IDIQ) contracts to Zone Program Integrity Contractors (ZPICs).

The first three zones are Zone 4 (Texas, Oklahoma, Colorado and New Mexico), Zone 5 (West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas and Louisiana) and Zone 7 (Florida, Puerto Rico and the U.S. Virgin Islands).

The second cycle includes Zone 1 (California, Nevada, Hawaii, American Samoa, Guam and the Mariana Islands) and Zone 2 (Alaska, Washington Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa and Missouri).

The final cycle contains Zone 3 (Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio and Kentucky) and Zone 6 (Pennsylvania, New York, Maryland, Washington, D.C., Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire and Vermont).

FY2007 Bid Protest Environment

All contracts awarded under full and open competitions, such as the MAC contracts, are subject to bid protest activity with the potential to delay the award timetable. As reported in the Government Accountability Office's annual report[5] to Congress on Dec. 10, 2007, there was a 6 percent increase relative to FY2006 for the total number of cases filed.

In the same year, the number of decisions on the merits–that is, those in which GAO either sustained or denied the protest–increased as well to 335 merits decisions in FY2007, relative to 249 issued in FY2006. The percentage of merit decisions relative to total cases closed also went up to 24 percent in FY2007 relative to 19.5 percent in FY2006.

However, the sustain rate, which validates the protestor's premise that the award was flawed, dropped slightly. This rate was 27 percent in FY2007, down from 29 percent in FY2006.

At the same time, the effectiveness rate, which means that the protester obtained some relief from the agency, dropped slightly as well, to 38 percent in FY2007 from 39 percent the previous year.

The following table shows the trends across the last five years.

5 Retrieved from http://www.gao.gov/decisions/bidproan.htm on Dec.13, 2007.

Bid Protest Statistics for Fiscal Years 2003-2007

	FY2007	FY2006	FY2005	FY2004	FY2003
Cases Filed	1,411 (up 6%)	1,327 (down 2%)	1,356 (down 9%)	1,485 (up 10%)	1,352 (up 12%)
Cases Closed	1,393	1,274	1,341	1,405	1,244
Merit (Sustain + Deny) Decisions	335	249	306	365	290
Number of Sustains	91	72	71	75	50
Sustain Rate	27%	29%	23%	21%	17%
Effectiveness Rate (reported)	38%	39%	37%	34%	33%
ADR (cases used)	62	91	103	123	120
ADR Success Rate	85%	96%	91%	91%	92%
Hearings	8% (41 cases)	11% (51 cases)	8% (41 cases)	9% (56 cases)	13% (74 cases)

Bid Protests of CMS MAC Awards

As reported by CMS,[6] bid protests were filed against two recent MAC awards.[7]

File Number	Protestor	Solicitation Number	Status	Due Date
B-310760.001	Palmetto GBA, LLC	CMS-2006-0033	Dismissed 12-17-07	13 Feb 2008
B-310760.002	Palmetto GBA, LLC	CMS-2006-0033	Dismissed 12-17-07	17 Mar 2008
B-310801.001	NHIC Corporation	RFP-CMS-2007-0002	Open	21 Feb 2008
B-310801.002	NHIC Corporation	RFP-CMS-2007-0002	Open	19 Mar 2008

The bid protest for CMS-2006-0033 concerned the Jurisdiction 12 award while the bid protest for RFP-CMS-2007-0002 concerns Jurisdiction 1.

CMS/HHS ACQUISITION ENVIRONMENT

HHS Acquisition Priorities

Since CMS' new contracting strategy takes place within HHS' parameters, HHS acquisition strategy is of particular interest to Medicare contractors. As reported by Marty Brown, Senior Procurement Executive and

6 Retrieved from http://www.cms.hhs.gov/MedicareContractingReform/ on Dec.23, 2007.
7 Retrieved from http://www.gao.gov/decision/docket on Dec. 18, 2007.

Deputy Assistant Secretary for Acquisition Management and Policy at HHS,[8] the Department's top priorities include:

- Recruiting and retaining a high-quality acquisition workforce
- Measuring acquisition performance in a meaningful way to produce improved results across the HHS enterprise
- Maintaining a deployable emergency contracting capability
- Consolidating acquisition systems
- Improving oversight of major acquisitions
- Increasing small business participation
- Detecting and preventing healthcare fraud
- Increasing competition

GAO Report on CMS Contracting Practices

The increase in CMS contract awards and CMS' acquisition workforce were among the issues reviewed in the GAO report CMS Internal Control Deficiencies Resulted in Millions of Dollars of Questionable Contract Payments.[9]

While the majority of the report explores CMS expenditures for the Part D drug benefit, 1-800-Medicare, IT and various goods and services, the report monitors the potential impact on Medicare fiscal intermediaries and carriers. In Table 1 of the report, Payment to Major Contractors and Vendors from January 2004 through December 2006, Medicare fiscal intermediaries and carriers represent $26.7 million for outreach/education activities. The table endnotes clarify that "these contractors, such as Blue Cross Blue Shield, administer Medicare benefits on behalf of CMS."

As discussed in Chapter 4, the GAO report stated that "CMS management has not allocated sufficient resources, both staff and funding, to keep pace with recent increases in contract awards and adequately perform contract and contractor oversight . . . This poor operating environment created vulnerabilities in the contracting process . . . Without immediate corrective actions and appropriate high level management accountability to fix systemic issues, CMS will continue to be highly vulnerable to waste and improper payments."

In its conclusions, the report ended with a caution for the MAC environment. The report stated, "Moreover, if these issues are not promptly corrected, the Medicare claims administration contracting reform called for in MMA will result in billions of additional dollars of contracting activities being subject to the same deficient contracting practices and internal controls and exacerbate the potential waste and improper payments."

OIG FY2008 WorkPlan

CMS contracting practices will be evaluated in two upcoming OIG studies. As discussed in Chapter 4, the OIG will evaluate CMS Pre-Award Reviews of Contract Proposals and the operations of CMS' Office of Acquisition and Grants Management.

8 Brown, M. (2007, Dec. 13). Speech presented to. Professional Services Council HHS Task Force Meeting, Baltimore, MD.
9 Retrieved from http://www.gao.gov/new.items/d0854.pdf on Dec. 23, 2007.

EMERGING ISSUES

Mitigating Organizational Conflicts of Interest (OCI)

Mitigating OCI continues to be an important issue to CMS. The agency has taken actions such as modifying the Quality Improvement Organizations' (QIO) scope of work so that it will not be regulating and supervising providers while focusing on technical assistance activities that help promote better care for beneficiaries. The MAC solicitations also contain more prescriptive OCI requirements than other previous CMS procurements.

The Court of Federal Claims' decision on *Axiom Resource Management v. United States,*[10] is an example of the trend toward greater scrutiny in the judicial review of organizational conflict of interest (OCI) allegations. The first paragraph of the opinion seems to indicate the courts intend to take a more active role in shaping the OCI landscape:

> The federal government's increased use of and dependence on outside contractors to perform essential government functions often entails providing these contractors with governmental, business proprietary and otherwise private information to perform their duties. This has increased potential and actual conflicts of interest regarding how and the extent to which, such information is utilized in performing contract services and otherwise. Establishing the parameters of access to and use of this information will be among the most important decisions that the United States Court of Federal Claims and the United States Court of Appeals for the Federal Circuit will make in the next few years – not only for government contract jurisprudence, but to maintain competition in this growing segment of the economy.[11]

Contractors should consider that merely proposing an OCI mitigation plan is not enough. It has to mitigate the type of OCI at issue. However, this case also suggests that contractors must now consider whether their OCI mitigation plans will restrict future competition.

Up until now, the primary concern of OCI has been that unequal access to information gives the contractor an unfair competitive advantage in future procurements. However in this case, the court expressed that restrictions on the disclosure of information may unduly restrict competition. The court's analysis suggests that a contractor may be required to mitigate the risk of unequal access to competitively useful, non-public information and avoid restricting future competition for related requirements.

Transparency, Accountability and Competition

As the government's purchases through federal contracts steadily increased to over $400 billion a year amid reports of significant waste,[12] new federal initiatives emerged to improve the transparency and integrity of government contracts. If successful, the public would have greater access to government contracting information and the federal government would more effectively safeguard its sizeable investment in government contractors.

Federal Spending Database

Pilots and databases related to contractor performance, suspensions and misconduct are beginning to gain favor and attention. For example, www.USAspending.gov provides easy access to government contract, grant and other award data, including subcontracting information. This site was created in response to the Federal Funding Accountability and Transparency Act of 2006 which required a single searchable Web site, accessible by the public for free that includes for each Federal award:

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10 Retrieved from http://www.governmentcontractslawblog.com/2007/10/articles/organizational-conflicts-of-in/axiom-resource-management-v-united-states-judicial-scrutiny-of-organizational-conflicts-of-interest-intensifies/#more on Dec. 23, 2007.

11 BNA's Federal Contracts Report, Volume 87, Number 14, Tuesday, Oct. 16, 2007.

12 BNA's Federal Contracts Report, Volume 88, Number 18, Tuesday, Nov. 13, 2007.

- The name of the entity receiving the award
- The amount of the award
- Information on the award including transaction type, funding agency, etc.
- The location of the entity receiving the award
- A unique identifier of the entity receiving the award

The site is currently in a pilot mode and many concerns have been raised around national security risks, violation of nondisclosure pacts and administrative reporting burdens for the prime contractors among other things.[13]

Public databases have been proposed or implemented to monitor contractor debarments, involvement in civil, criminal and administrative proceedings initiated by the federal government and past performance. Some industry experts have predicted that federal contracting is moving back towards adversarial audits and investigations.[14]

FOIA Reform

The President signed a comprehensive bill (S. 2488) to reform the Freedom of Information Act (FOIA) on Dec. 31, 2007.[15] Supporters of the bill say it would increase transparency in the government by these means:

- Impose tighter deadlines on agencies to respond to FOIA request;
- Clarify that FOIA applies to agency records held by private contractors;
- Establish a FOIA hotline to help requesters;
- Expand the availability of copying fee waivers to members of the news media; and
- Create a FOIA ombudsman to mediate disputes.

Accountability in Government Contracting Act of 2007

On Nov. 7, 2007 the Senate voted unanimously in favor of the Accountability in Government Contracting Act. The bill focuses on strengthening the acquisition workforce, increasing competition for government contracts and improving oversight of those contracts. In March the House passed the Accountability in Contracting Act (H.R. 1362), which differs significantly from the Senate bill, but shares the common goals of addressing the needs of the acquisition workforce, ensuring that government contracts are awarded competitively and holding companies accountable for contract performance. Both bills have influential sponsors. The Senate bill is sponsored by Sens. Joseph Lieberman (D-Conn.) and Susan Collins (R-Maine). The House bill, which passed 347-43, is sponsored by Oversight and Government Reform Committee Chair Henry Waxman (D-Calif.). The key issues addressed by the Senate bill include:[16]

- Acquisition Workforce Shortage Leads to Problems

  The Senate report cited a “severe and growing shortage of qualified acquisition professionals,” which contributes to such problems as an over-reliance on sole source and other non-competitive contracts and the inadequate specification of requirements and delivery dates. Further, the report cited concerns related to the government’s payment of too many award fees in the face of poor performance, a lack of transparency in the process, deficient monitoring and evaluation and decision-making corrupted by individuals accepting gifts or seeking future private employment.

13 BNA’s Federal Contracts Report, Volume 87, Number 22, Tuesday, June 12, 2007.
14 BNA’s Federal Contracts Report, Volume 87, Number 14, Tuesday, April 10, 2007.
15 BNA’s Federal Contracts Report, Volume 89, Number 1, Tuesday, Jan. 8, 2008.
16 BNA’s Federal Contracts Report, Volume 88, Number 18, Tuesday, Nov. 13, 2007.

- Provisions Aimed at Increasing Competition

  The report identified the "absence of effective competition" in "too many acquisitions" as one of a number of systemic problems. According to the Senate committee, task orders increased in volume and size beyond what was envisioned when the Federal Acquisition Streamlining Act of 1994 was passed to simplify the acquisition process. Title II of the bill includes a key provision that would prohibit the award of task or delivery service contracts expected to be worth more than $100 million to only one contractor. The aim is to promote competition for task orders under such contracts. Other provisions meant to increase competition would:

  1. Mandate competition for each task or delivery order over the $100,000 simplified acquisition threshold.
  2. Require that all task or delivery orders include a statement of work that clearly specifies the tasks to be performed under the order.
  3. Provide for protests in connection with the issuance of a task or delivery order valued at more than $5 million.
  4. Limit the length of noncompetitive contracts for civilian agencies and the U.S. Defense Department to less than 270 days, absent a determination that exceptional circumstances apply.
  5. Restrict use of "tiered evaluations," also known as cascading set-asides.
  6. Require development of new regulations on use of cost-reimbursement contracts.
  7. Call for development of new uniform, government-wide policies aimed at preventing and mitigating organizational and personal conflicts of interest.
  8. Link award and incentive fees to performance outcomes.

- Improving Accountability

  The bill contains provisions intended to improve accountability where currently the complexity of the Federal Acquisition system diffuses responsibility for actions among many participants. Further, it addresses the proper use of interagency contracts by calling for:

  1. Office of Management and Budget guidelines on appropriate use of these contracting vehicles;
  2. Changes to the FAR to require documentation that assisted acquisitions represent the best alternative in a particular procurement;
  3. A review by the head of the General Services Administration to determine if there is duplication among existing contracts under the Multiple Award Schedules program; and
  4. "More proactive leadership" by OFPP to ensure that only those contracts that "provide the best overall value for the government and adhere to sound contracting practices," whether awarded and managed by the U.S. General Services Administration (GSA) or another agency, are allowed to continue.

FY2008 National Defense Authorization Act

Of particular interest to Medicare contractors is the FY2008 defense authorization bill[17] which includes numerous government-wide provisions for acquisition improvement and accountability.[18] The government-wide provisions that would have potential impact on MAC contracting would:

- Provide for bid protests of awards of task orders valued at more than $10 million;
- Call for enhanced competition for task orders;

17 H.R.1585.

18 BNA's Federal Contracts Report, Volume 88, Number 21, Tuesday, Dec. 11, 2007.

- Prohibit the award of a task order or delivery order contract estimated to exceed $100 million to a single contractor unless the head of the agency makes certain determinations;
- Require agencies to publicly disclose their justification for using noncompetitive procedures in awarding a contract; and
- Highlight reports of significant audit findings by requiring the semiannual reports of agency inspector generals to include a separate annex.

Use of Incentive Fee Contracts

In response to concerns raised by the GAO on incentive fee payments, the Office of Federal Procurement Policy Administrator Paul Denett issued a memo to chief acquisition officers and senior procurement executives calling for a review of their agencies policies on incentive fee contracts on Dec. 4, 2007.[19] The purpose of reviews is to ensure that the fees paid to contractors are linked to specific acquisition outcomes, such as cost, schedule and performance results, in accordance with the FAR.[20]

Denett's memo included as an attachment an "incentive contract checklist" as guidance for the agency policy reviews. The memo and checklist advised contracting officers to:

- Conduct risk and cost-benefit analyses to determine whether to use incentive fee contracts, including award fee contracts.
- Predetermine incentive fees in writing and include the processes for awarding the fees in the acquisition plan.
- Ensure that acquisition plans include standards for evaluating contractor performance and appropriate incentive fee amounts; distinguish between earning potential for satisfactory versus excellent performance; and clearly describe "what is required and at what point a contractor is considered successful."

Similar requirements with respect to the payment of award fees to contractors also were included in S. 680, Accountability in Government Contracting Act of 2007.

Acquisition Workforce

The OFPP launched several initiatives to strengthen the federal acquisition workforce. These include:

- On March 7, 2007, OFPP announced a self-assessment survey of government contracting professionals to assess skills and improve human capital planning.[21]
- On Sept. 4, 2007, OFPP instructed agencies to carry out their new authority to hire retired annuitants to fill critical acquisition positions. The General Services Modernization Act (Pub. L. No. 109-313) signed Oct. 6, 2006 allows qualified retirees to be hired to fill key acquisition-related positions without discontinuing their retirement benefits.
- OFFP announced a new certification plan for contracting officer technical representatives (COTRs) on Nov. 26, 2007. The certification program sets training requirements and requires that COTRs achieve competencies for certification and maintain the certification through continuous learning.[22]

19 Retrieved from http://www.whitehouse.gov/omb/procurement/memo/incentive_contracts_120407.pdf. on Dec. 7, 2007.
20 BNA's Federal Contracts Report, Volume 88, Number 21, Tuesday, Dec. 11, 2007.
21 BNA's Federal Contracts Report, Volume 87, March 13, 2007.
22 BNA Federal Contracts Report, Volume 88, Number 20, Dec. 4, 2007.

Small Business Contracting Opportunities

In an effort to improve federal procurement opportunities for small business, Congress drafted S. 2300, the Small Business Contracting Revitalization Act of 2007 and H.R. 3867, the Small Business Contracting Program Improvement Act. Each bill focuses on additional oversight and reporting on contract bundling, which is a practice that involves consolidating previously separate, smaller federal requirements into large packages that discourage small business competition.[23]

A new interim FAR rule published July 5, 2007 amends the FAR to require the new Small Business Administration (SBA) size recertification rules that took effect June 30, 2007.[24] The recertification requirements are intended to properly update small business classifications. Small business contracts acquired by large companies will no longer be counted as small. Under the old terms, contracts originally awarded to small businesses remained classified as small for up to 20 years even when the small business were acquired by large companies.

Professional Services Council (PSC)

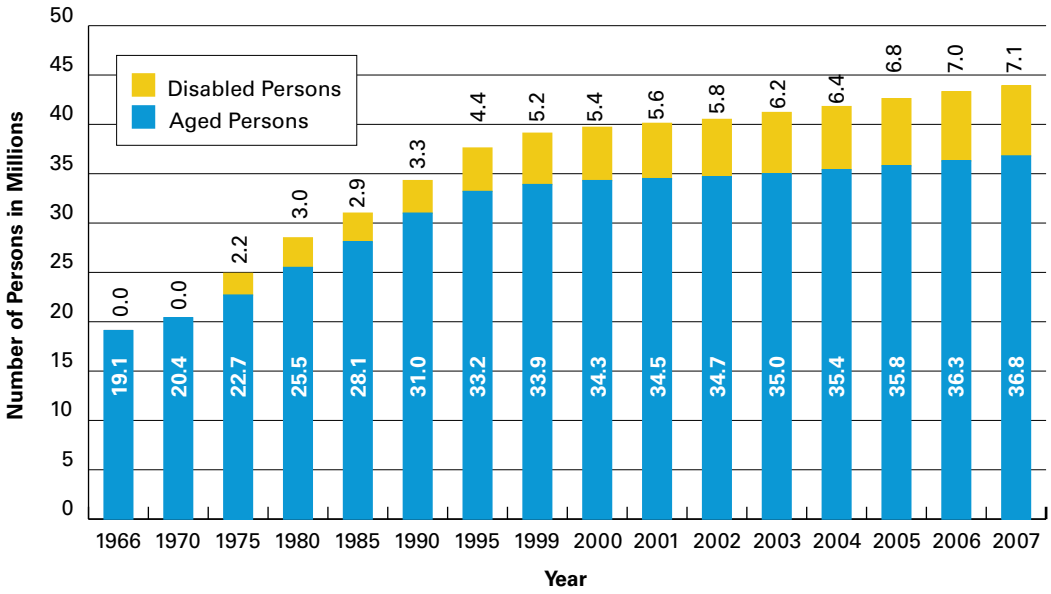
To support Blue contractors in the evolving government contracting environment, BCBSA provided its Blue Medicare contractors a one-year introductory membership to the Professional Services Council in FY2008. The PSC is the principal national trade association of federal government's professional and technical services industry. The PSC works closely with Congress and acquisition leaders in government agencies to comment on and affect emerging regulatory, legislative and policy issues. The PSC's reporting on emerging government contracting trends provides a useful resource in monitoring the initiatives that may impact MAC contracting.

23 BNA's Federal Contracts Report, Volume 88, Number 18, Nov. 13, 2007.
24 BNA's Federal Contracts Report, Volume 88, Number 2, Tuesday, July 10, 2007.

Selected Medicare Statistics 2007

Populations

Medicare Enrollment/Trends

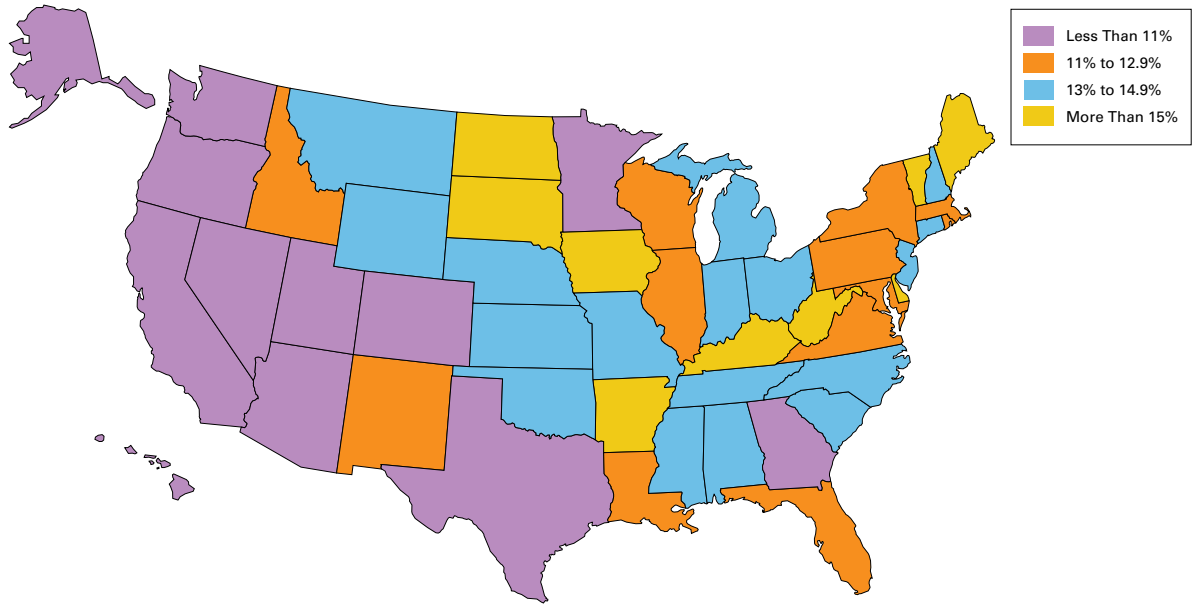


Note: Data for 1966 - 1998 are as of July. Data for 1999 - 2007 represent average actual or projected monthly enrollment. Numbers may not add to totals because of rounding. Based on FY 2008 President's Budget.

Source: CMS, Office of the Actuary

Populations

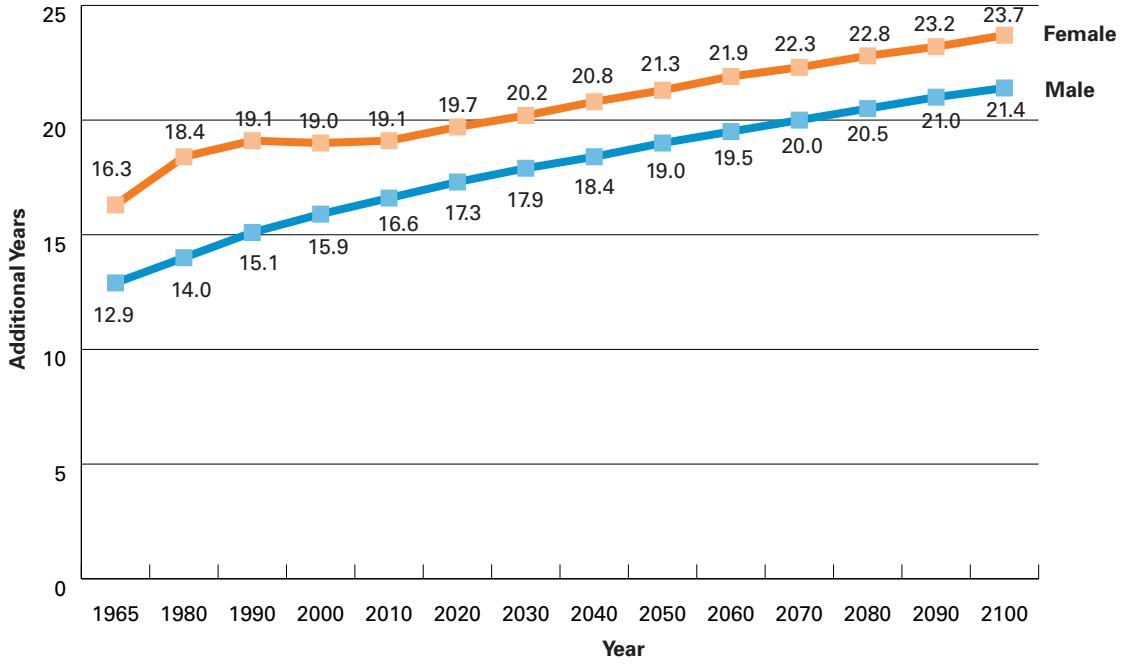
Medicare Beneficiaries as a Percent of State Populations, 2006



Source: Centers for Medicare and Medicaid Services Medicare State Enrollment data and Census Bureau 2006 population estimates (as of July 2006)

Populations

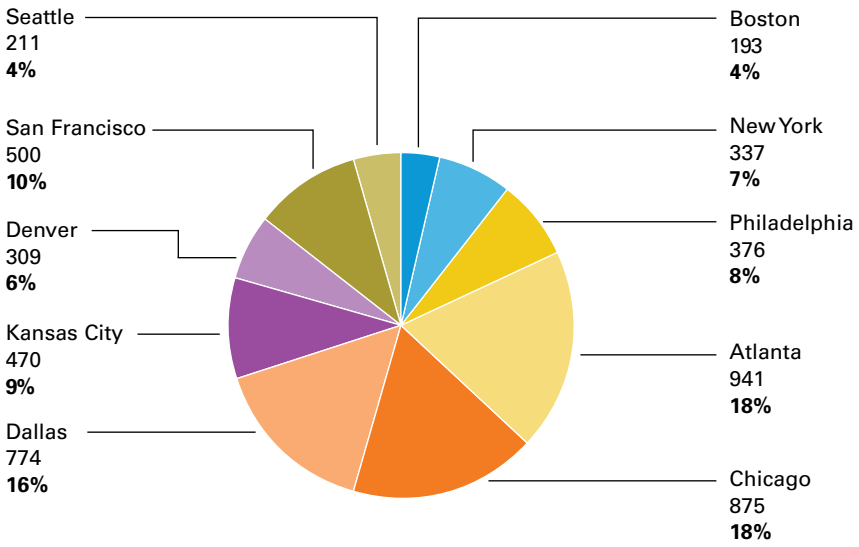
Additional Life Expectancy at Age 65 (Projected From 2010)



Sources: Social Security Administration, Office of the Actuary

Providers/Suppliers

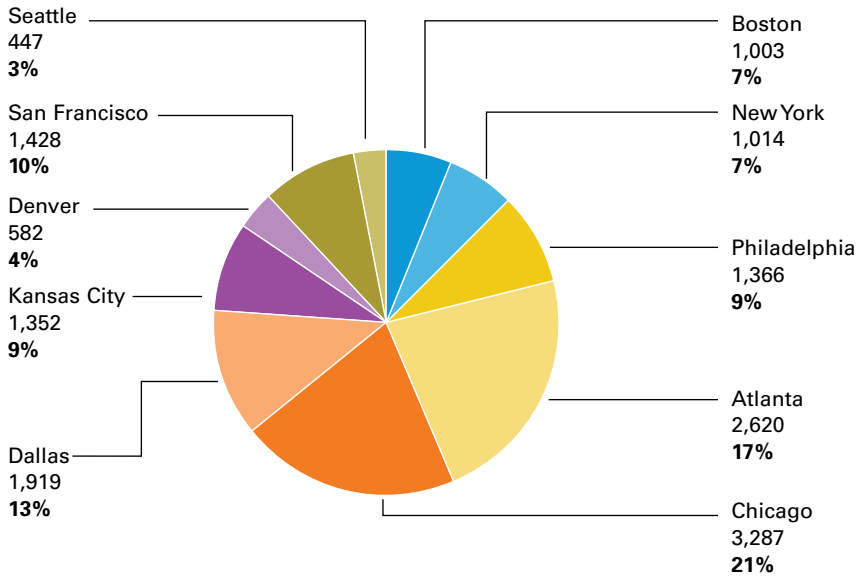
Inpatient Hospitals (Short-Stay and Critical Access) by CMS Region: December 2006
(All Regions: 4,986)



Source: CMS, Office of Research, Development and Information

Providers/Suppliers

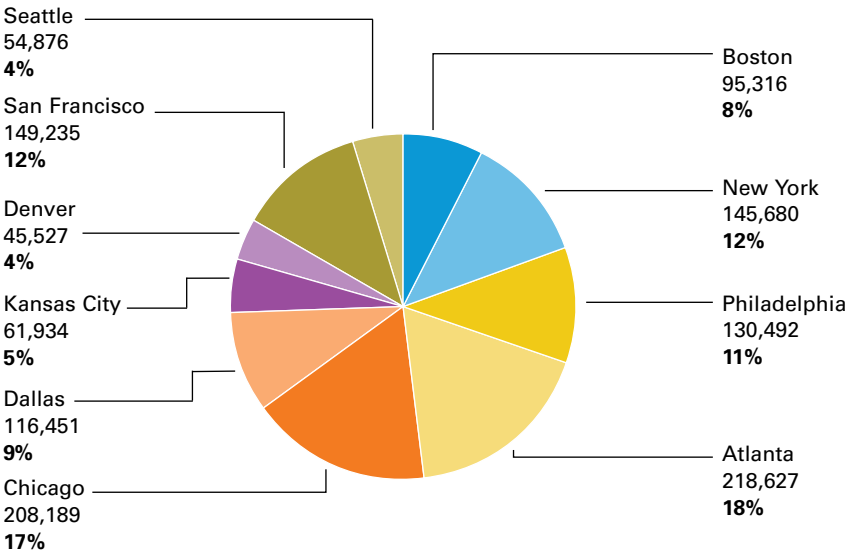
Skilled Nursing Facilities by CMS Region: As of December 2006
(All Regions: 15,018)



Source: CMS, Office of Research, Development and Information

Providers/Suppliers

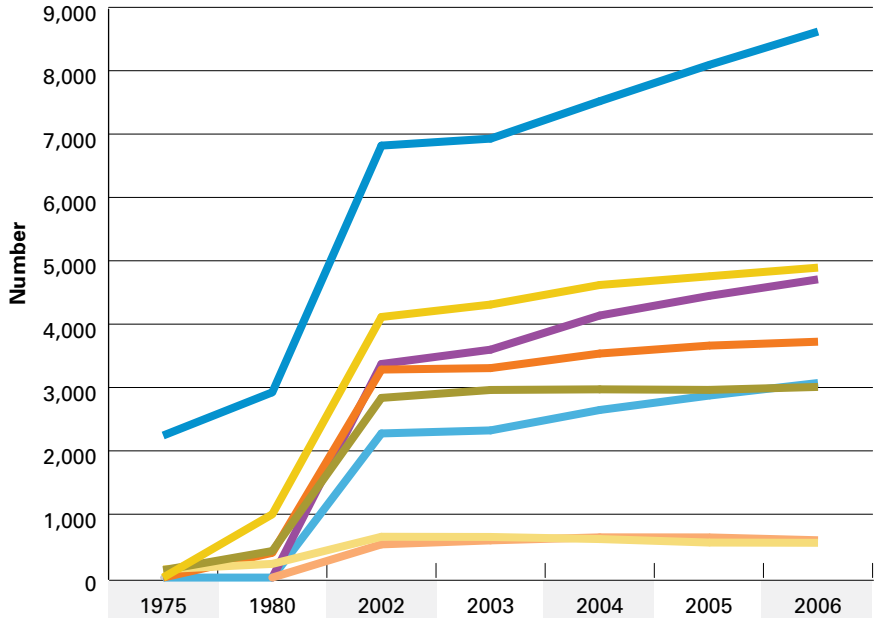
Practitioners Active in Patient Care by CMS Region: March 2007
(All Regions: 1,226,327)



Source: CMS, Office of Research, Development and Information and the Bureau of the Census

Providers/Suppliers

Other Medicare Providers and Suppliers: Trends

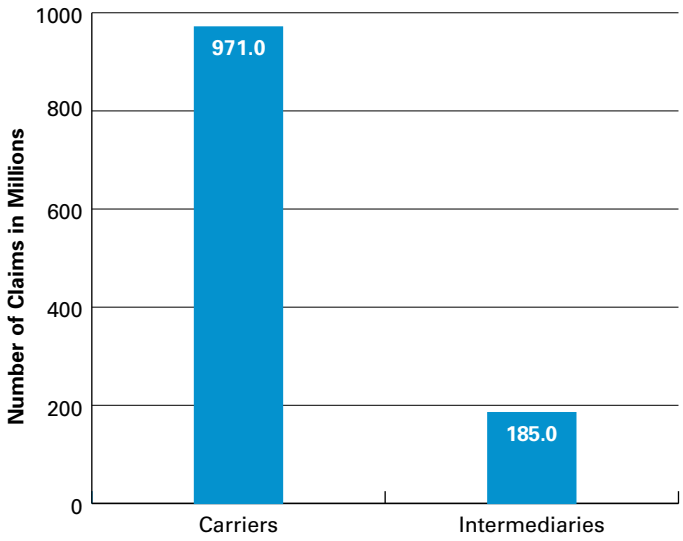


	1975	1980	2002	2003	2004	2005	2006
Home Health Agencies	2,242	2,924	6,818	6,928	7,519	8,090	8,618
End Stage Renal Disease Facilities	0	999	4,113	4,309	4,618	4,755	4,892
Outpatient Physical Therapy	117	419	2,836	2,961	2,971	2,962	3,009
Portable X-ray	132	216	644	641	608	553	549
Rural Health Clinics	0	391	3,283	3,306	3,536	3,661	3,723
Comprehensive Outpatient Rehabilitation Facilities	0	0	524	587	635	634	589
Ambulatory Surgical Centers	0	0	3,371	3,597	4,136	4,445	4,707
Hospices	0	0	2,275	2,323	2,645	2,872	3,071

Source: CMS, Office of Research, Development and Information

Workloads

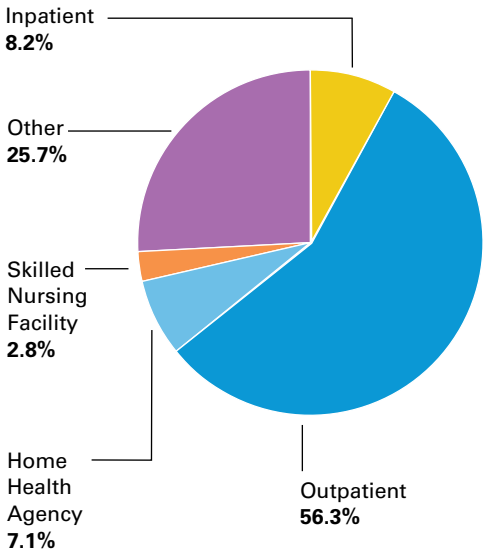
Claims Processed in Millions: FY 2006



Source: CMS, Office of Financial Management

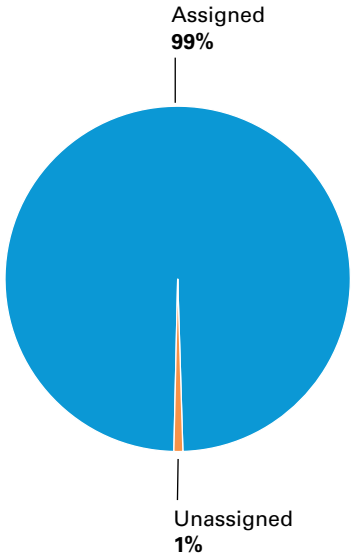
Workloads

Intermediary Claims Received: CY 2006



Source: CMS, Office of Financial Management

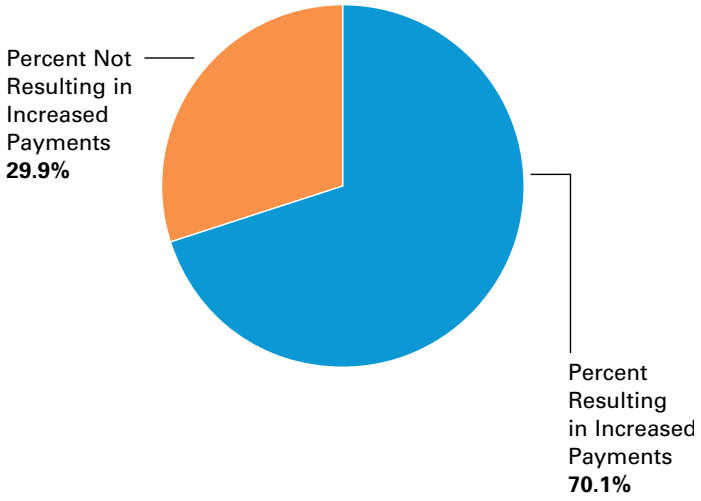
Carrier Claims Received: CY 2006



Source: CMS, Office of Financial Management

Workloads

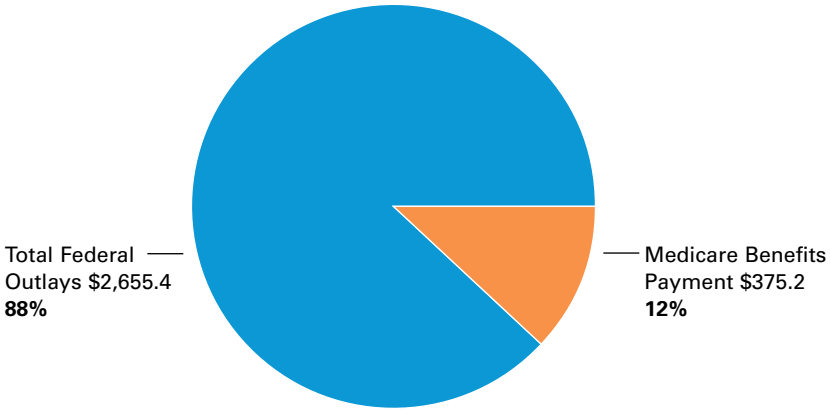
Medicare Carrier Reviews: FY 2006



Source: CMS, Office of Financial Management

Expenditures

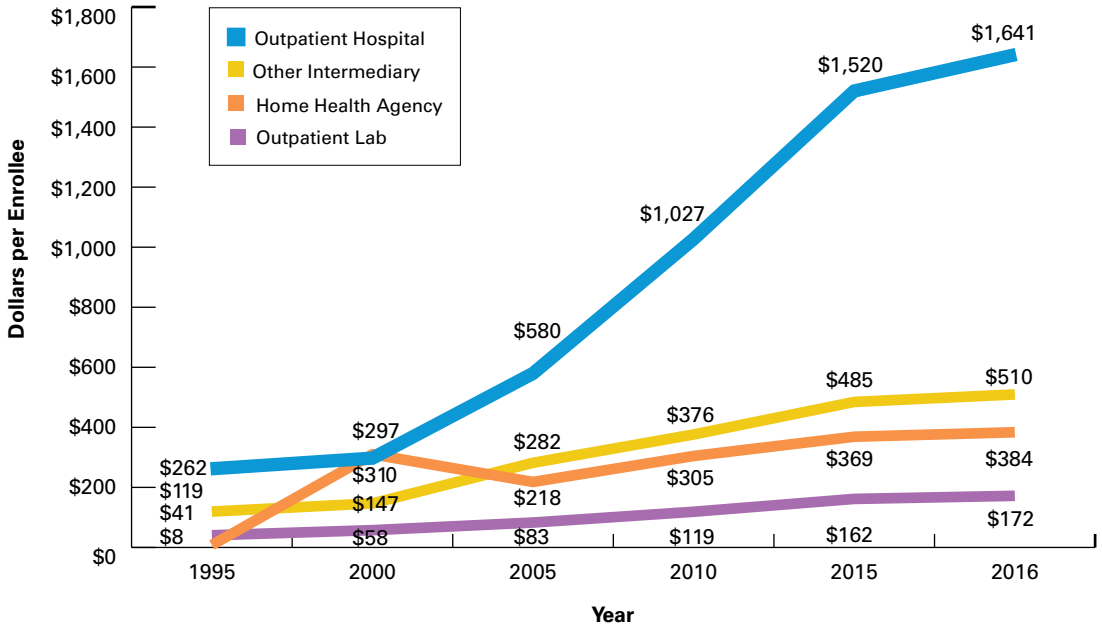
Medicare Benefit Payments as a Part of the Total Federal Outlay: FY 2006



Source: CMS, Office of Financial Management

Expenditures

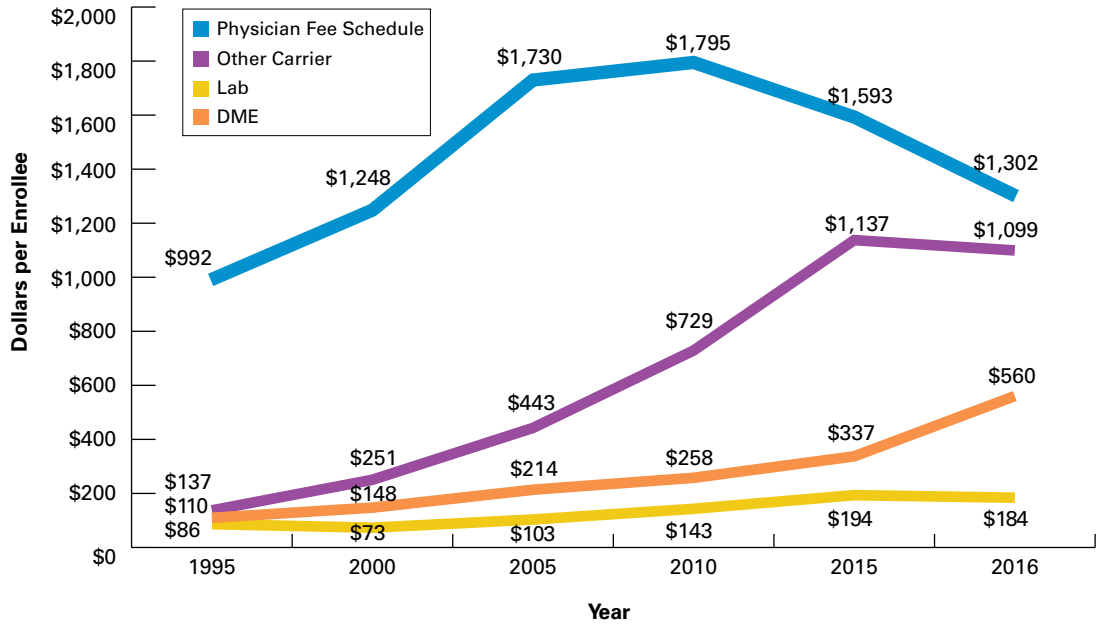
Incurred Reimbursement Amounts per Fee-For-Service Enrollee for Intermediary Services (Aged)



Source: Annual Medicare Trustees Report 2007

Expenditures

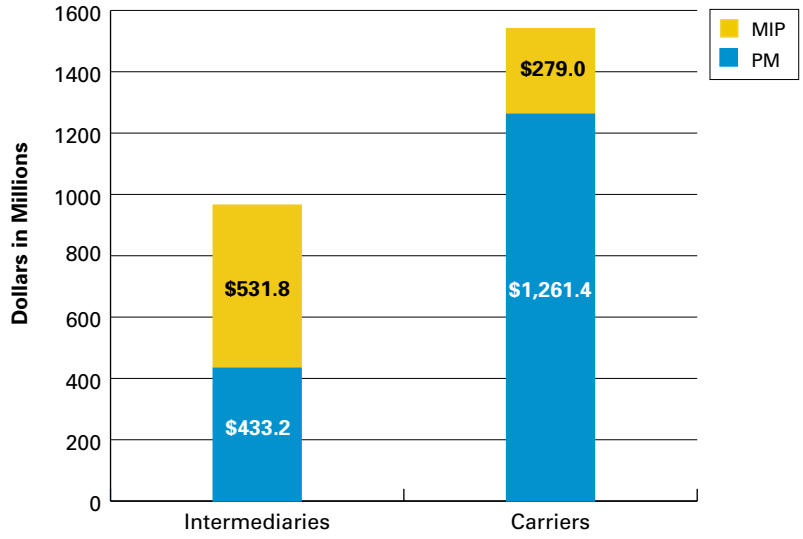
Incurred Reimbursement Amounts per Fee-For-Service Enrollee for Carrier Services (Aged)



Source: Annual Medicare Trustees Report 2007

Expenditures

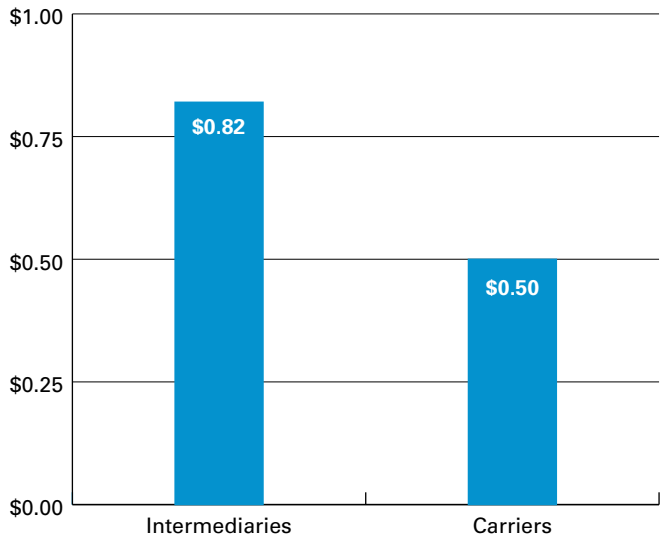
PM vs. MIP Costs: FY 2006



Source: CMS, Office of Financial Management

Expenditures

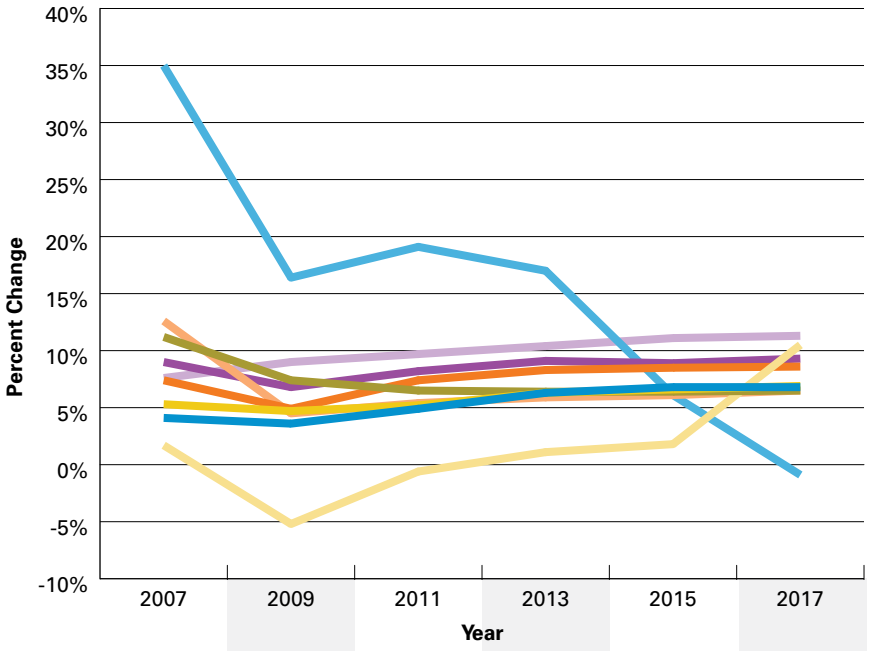
Average Medicare Claims Processing Unit Costs FY 2006
(Intermediary Range: $0.52 - $1.74; Carrier Range: $0.34 - $1.09)



Source: CMS, Office of Financial Management

Expenditures

Medicare Benefit Payments by Type of Service (Projected)

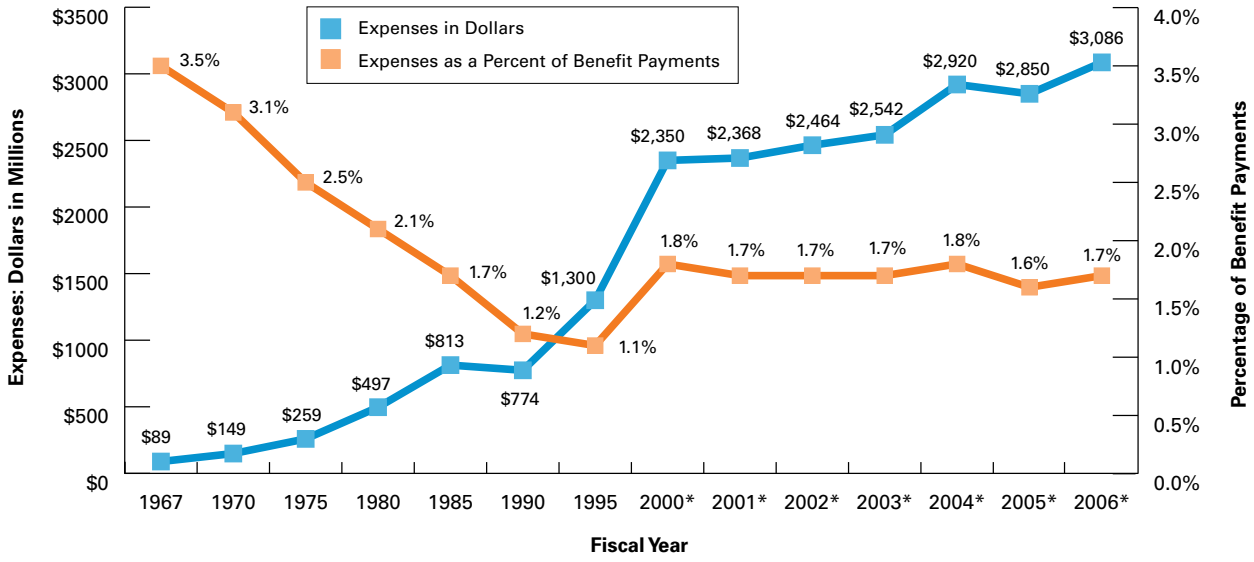


	2007	2009	2011	2013	2015	2017
Hospital Inpatient	4.1%	3.6%	4.9%	6.3%	6.8%	6.8%
Skilled Nursing Facilities	5.3%	4.7%	5.2%	6.3%	6.6%	6.9%
Hospice	11.2%	7.4%	6.5%	6.4%	6.4%	6.5%
Physician Fee Schedule	1.7%	-5.2%	-0.6%	1.1%	1.8%	10.5%
Other Professional & Ancillary Services	7.4%	4.9%	7.4%	8.3%	8.5%	8.6%
Other Facilities	12.6%	4.5%	5.4%	5.9%	6.1%	6.5%
Hospital Outpatient PPS	9.0%	6.8%	8.2%	9.1%	8.9%	9.3%
Group Plans	35.0%	16.4%	19.1%	17.0%	6.1%	-0.9%
Home Health	7.6%	9.0%	9.7%	10.4%	11.1%	11.3%

Source: Congressional Budget Office Fact Sheet for March 2007 Baseline

Expenditures

Medicare Administrative Expenses by Fiscal Year: Expense Dollars Compared to the Percentage of Benefit Payments Health Insurance (Part A)

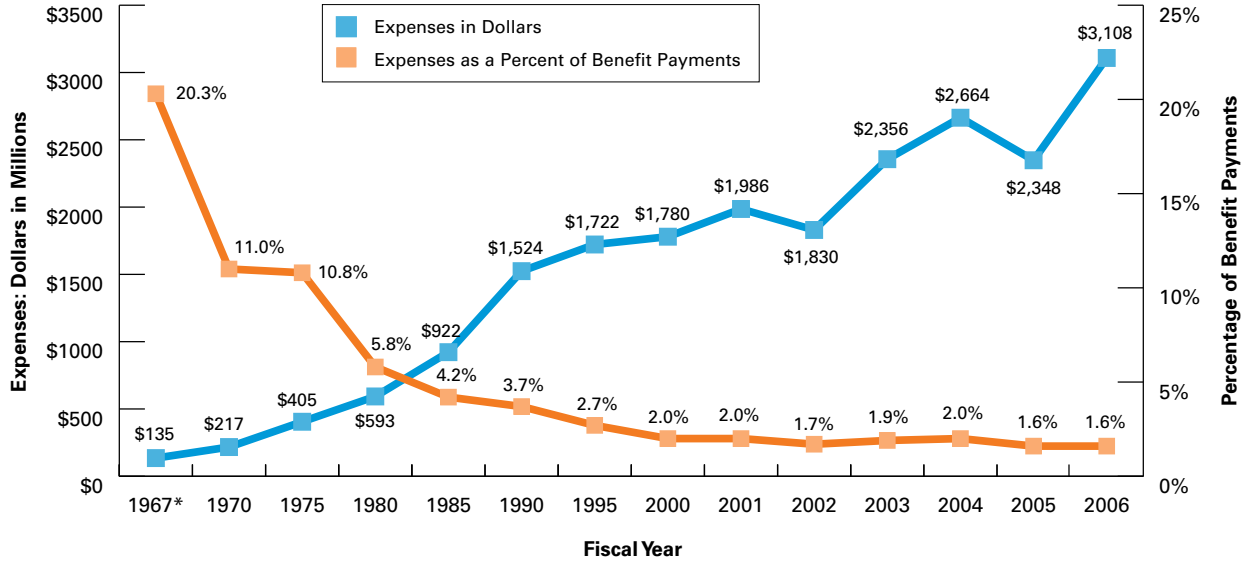


*Note: *Includes non-expenditure transfers for Health Care Fraud and Abuse Control*

Source: CMS, Office of the Actuary

Expenditures

Medicare Administrative Expenses by Fiscal Year: Expense Dollars Compared to the Percentage of Benefit Payments Supplemental Medical Insurance (Part B)

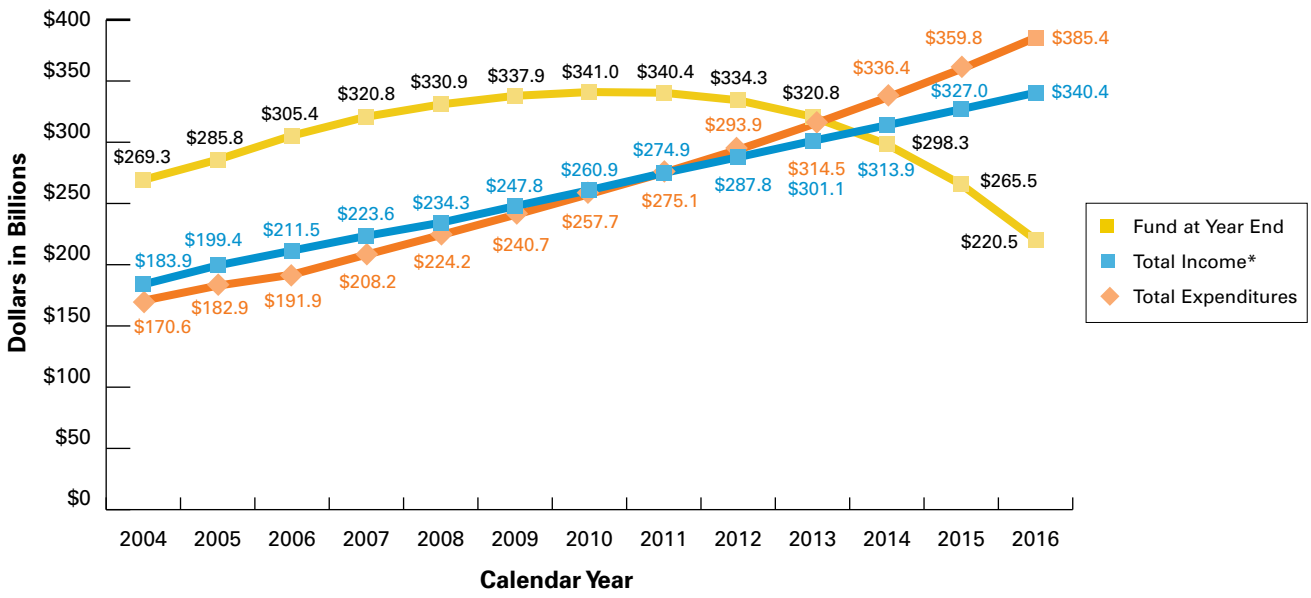


*Note: *Includes expenses paid in fiscal years 1966 and 1967 and Starting in FY 2004 includes transactions to the Part D account*

Source: CMS, Office of the Actuary

Expenditures

Estimated Operations of the Part A Trust Fund Under Intermediate Assumptions, Calendar Years 2004-2016

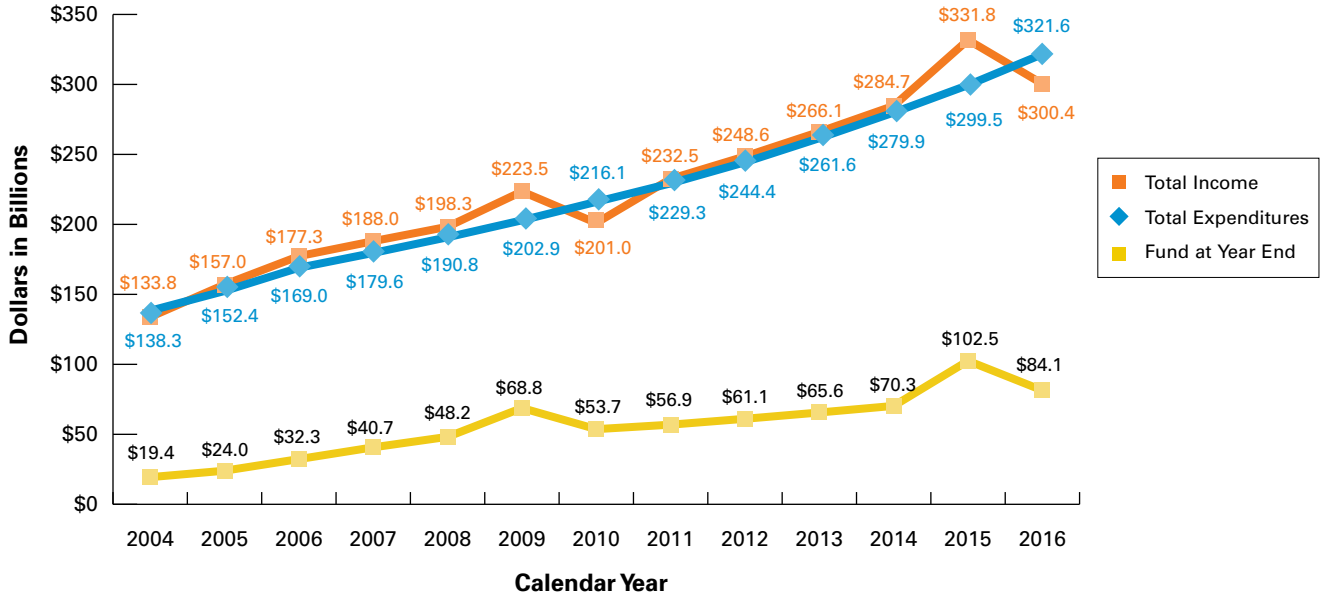


*Note: *Includes interest income; figures for 2005 and prior represent actual experience.*

Source: Annual Medicare Trustees Report 2007

Expenditures

Estimated Operations of the Part B Trust Fund Under Intermediate Assumptions, Calendar Years 2004-2016 (Part B Only)

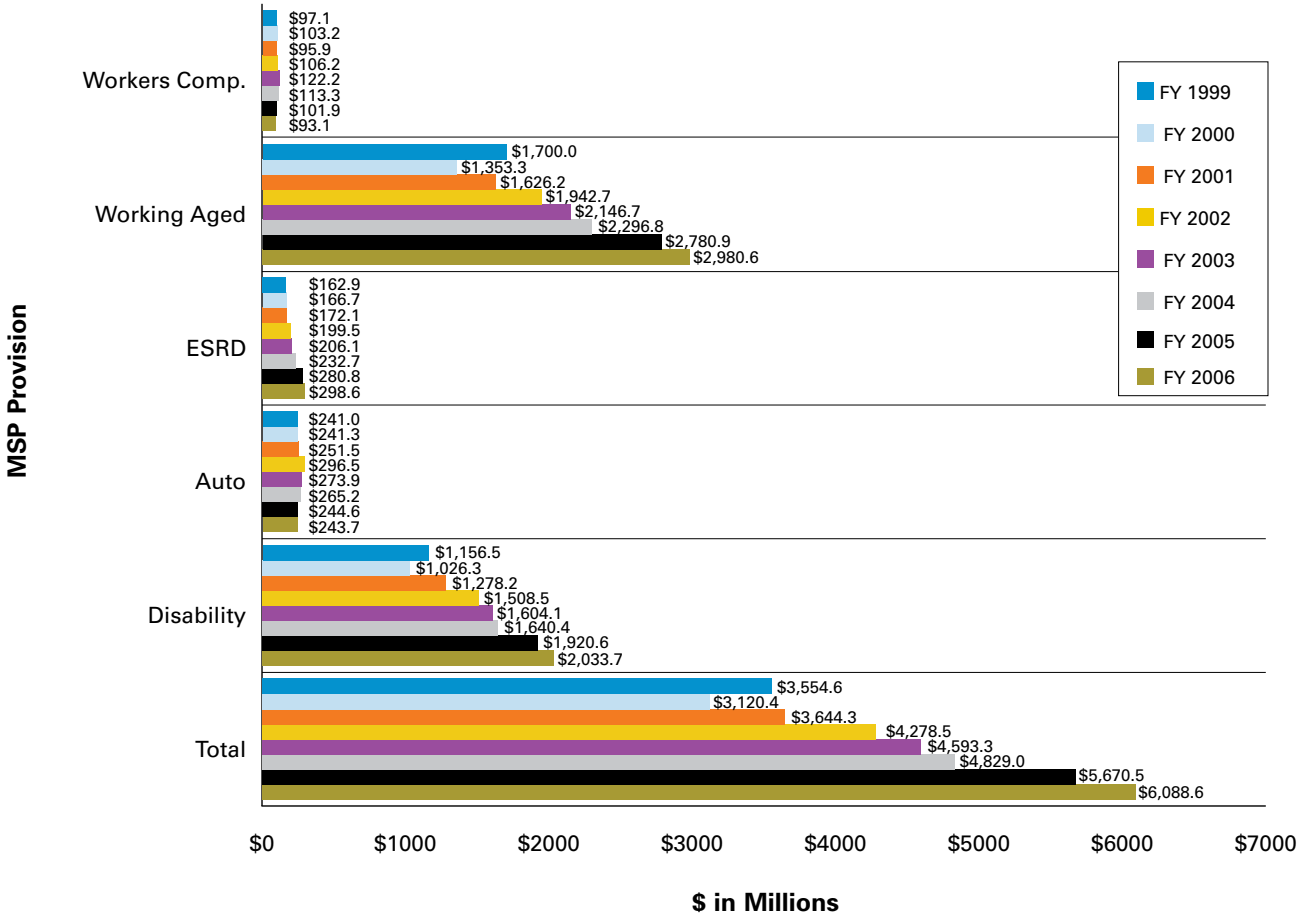


Note: Figures for 2005 and prior represent actual experience.

Source: Annual Medicare Trustees Report 2007

Benefit Savings

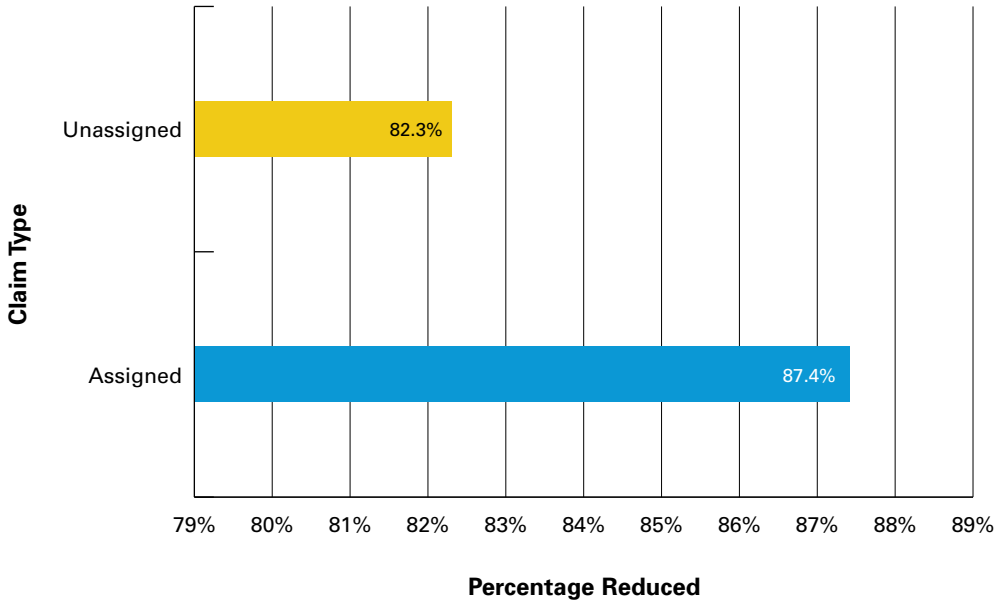
Medicare Savings Attributable to Secondary Payor Provisions by Type of Provision



Source: CMS, Office of Financial Management

Benefit Savings

Percent of Claims Reduced: CY 2006



Source: CMS, Office of Financial Management

Acronym List

Acronym	Term
Act	Social Security Act
ADR	Additional Documentation Request
AICPA	American Institute of Certified Public Accountants
ALJ	Administrative Law Judge
APC	Ambulatory Payment Classification
AR	Accounts Receivable
ASA	Average Speed of Answer
ASC	Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASP	Acquisition Strategy Plan
ATAG	Appeals Technical Advisory Group
ATB	All Trunks Busy
AUSA	Assistant U.S. Attorney
BBA	Balanced Budget Act
BBRA	Balanced Budget Reform Act
BCBSA	Blue Cross Blue Shield Association
BCC	Beneficiary Contact Center
BI	Benefit Integrity
BIPA	Benefits Improvement and Protection Act
BISG	Beneficiary Information Services Group
BNS	Beneficiary Network Services Center
BPR	Budget Performance Requirements
BPSSM	Business Partners System Security Manual
BR	Budget Request
CAC	Carrier Advisory Committee
CAFM	Contractor Administrative, Budget & Financial Management
CAH	Critical Access Hospital
CAP	Corrective Action Plan
CAS	Cost Accounting Standards
CASR	Contractor Auditing and Settlement Report
CAST	Contractor Assessment Security Tool
CBO	Congressional Budget Office
CBR	Contractor Auditing and Settlement Report Budget Request
CCMO	Consortia Contractor Management Officer

Acronym	Term
CCMS	Consortium Contractor Management Staff
CCR	Coverage Compliance Review
CCUG	Call Center User Group
CDC	Center for Disease Control
CDC	Corporate Data Center
CDT	Common Dental Terminology
CERT	Comprehensive Error Rate Testing
CET	Continued Education and Training
CFO	Chief Financial Officer
CFOA	Chief Financial Officers Act
CFR	Code of Federal Regulations
CLCCP	Comprehensive Limiting Charge Compliance Program
CMD	Contractor Medical Director
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
CMS - 750	Chief Financial Officer Summary
CMS - 751	Status of Accounts Receivables
CMS - 855	Application for Health Care Provider
CMSDC	CMS Data Center
CNC	Currently Not Collectible
CO	CMS Central Office
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
CORF	Comprehensive Outpatient Rehabilitation Facility
CP	Claims Processing
CPA	Certified Public Accountant
CPE	Contractor Performance Evaluation
CPIC	Certification Program of Internal Controls
CPIM	Coverage Provision Interpretive Manual
CPT	Current Procedural Terminology
CPT	Claims Processing Timeliness
CR	Change Request
CRA	Collection Reconciliation Acknowledgement
CROWD	Contractor Reporting of Operational and Workload Data

Acronym List

Acronym	Term
CRS	Congressional Research Service
CRSL	Cost Report Settlement Log
CSAMS	Customer Service Assessment Management System
CSP	Customer Service Plan
CSR	Core Security Requirements
CSR	Customer Service Representative
CWF	Common Working File
CY	Calendar Year
DAP	DMERC Advisory Process
DAVE	Data Assessment and Verification
DBMS	Database Management System
DCBS	Division of Contractor Beneficiary Services
DCC	Debt Collection Center
DCIA	Debt Collection Improvement Act
DCS	Debt Collection System
DDRPCC	Disclosure Desk Reference for Provider Call Centers
DHHS	Department of Health and Human Services
DM	Data Match
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carriers
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DRA	Deficit Reduction Act
DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospital
eCHIMP	Electronic Change Information Portal
ECR	Electronic Cost Reports
ECPS	Expert Claims Processing System (formerly known as SuperOp)
ECRS	Electronic Correspondence Referral System
EDB	Enrollment Database

Acronym	Term
EDC	Enterprise Data Centers
EDI	Electronic Data Interchange
EDP	Electronic Data Processing
EFT	Electronic Funds Transfer
EGHP	Employer Group Health Plan
EMC	Electronic Media Claims
eMMORP	electronic Medicare Management and Operations Review Program
EMTALA	Emergency Medical Treatment and Labor Act
EOB	Explanation of Benefits
ER	Emergency Room
ERA	Electronic Remittance Advice
ERP	Extended Repayment Plan
ERRP	Error Rate Reduction Plan
ESD	Enterprise System Development
ESOP	Employee Stock Ownership Plan
ESRD	End Stage Renal Disease
FACP	Financial Administrative Cost Proposal
FAQ	Frequently Asked Questions
FAR	Federal Acquisition Regulation
FASAB	Financial Accounting Standards Advisory Board
FAS	Financial Accounting Standards
FASB	Financial Accounting Standards Board
FBI	Federal Bureau of Investigation
FBO	FedBiz Ops
FCD	First Claim Development
FEP	Federal Employee Health Benefit Program
FFS	Fee-For-Service
FFS BIU	Fee-For-Service, Benefit Integrity Unit
FHIBA	Federal Health Insurance Benefits Account
FI	Fiscal Intermediary
FID	Fraud Investigation Database
FISCAM	Federal Information Controls Audit Manual
FISMA	Federal Information Security Management Act

Acronym List

Acronym	Term
FISS	Fiscal Intermediary Shared System
FM	Financial Management
FMFIA	Federal Managers' Financial Integrity Act
FOI	Freedom of Information
FOIA	Freedom of Information Act
FQHC	Federally Qualified Health Centers
FR	Federal Register
FSS	Frequent and Substantial Servicing
FY	Fiscal Year
FYE	Fiscal Year End
GAAP	Generally Accepted Accounting Principles
GAO	Government Accountability Office
GAS	Government Auditing Standards
GBS	Government Business Services
GDP	Gross Domestic Product
GHI	Group Health Incorporated
GHP	Group Health Plan
GME	Graduate Medical Education
GMRA	Government Management Reform Act
GPCI	Geographic Practice Cost Indices
GSA	General Services Administration
GSS	General Support System
HC	Hardcopy Claims
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA	Health Care Financing Administration (CMS)
HCPCS	Healthcare Common Procedure Coding System
HCRIS	Hospital Cost Report Information System
HH	Home Health
HH PPS	Home Health Agencies Pricing
HHA	Home Health Agencies
HHS	Health and Human Services
HI	Hospital Insurance
HICN	Health Insurance Claim Number
HIGLAS	Health Care General Ledger Accounting System
HIMR	Health Insurance Master Record
HIPAA	Health Insurance Portability and Accountability Act
HIPDB	Healthcare Integrity and Protection Data Bank
HIPPS	Health Insurance Prospective Payment Code System
HIQA	Health Insurance Query A
HO	Hearing Officer
HOCS	Home Office Cost Statements
HPMP	Hospital Payment Monitoring Program
HPSA	Health Professional Shortage Area
HPTC	Healthcare Provider Taxonomy Codes
HRG	Health Research Group
HRSA	Health Resources and Services Administration
HSA	Health Savings Accounts
HSRV	Hospital Specific Relative Value
HUQA	Part A of Inquiry Data
ICD	International Classification of Diseases
ICN	Inter-Contractor Notices
ICOR	Interactive Correspondence Online Reporting
IDIQ	Indefinite Delivery/Indefinite Quantity
IDTF	Independent Diagnostic Testing Facilities
IER	Interim Expenditure Report
IM	Information Memorandum
IM	Intermediary Manual
IME	Indirect Medical Education
IOM	Internet-Only Manual
IPF	Inpatient Psychiatric Facility
IPPS	Inpatient Hospital PPS
IQC	Internal Quality Control
IRC	Internal Revenue Code
IRF	Inpatient Rehabilitation Facility
IRF PPS	Inpatient Rehabilitation Facility
IRIS	Intern and Resident Information System
IRL	Intent to Refer Letters
IRS	Internal Revenue Service

Acronym List

Acronym	Term
IS	Information Systems
IT	Information Technology
IVR	Interactive Voice Response
JSM	Joint Signature Memo
JOA	Joint Operating Agreement
LAN	Local Area Network
LCA	Least Costly Alternative
LCD	Local Coverage Determination
LCER	Limiting Charge Exception Reports
LCMR	Limiting Charge Management Reports
LGHP	Large Group Health Plan
Listserv	Electronic Mailing Lists
LMRP	Local Medical Review Policy
LPET	Local Provider Education and Training
LPIC	Limited Purpose Insurance Company
LSA	Local System Administrators
LTC	Long-Term Care
LTCH	Long-Term Care Hospitals
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAC	Medicare Appeals Council
MBR	Master Beneficiary Record
MCD	Medicare Coverage Database
MCM	Medicare Carrier Manual
MCO	Managed Care Organization
MCPSS	Medicare Contractor Satisfaction Survey
MCR	Medicare Cost Report
MDS	Minimum Data Set
MED	Medicare Exclusion Database
MEDICS	Medicare Drug Integrity Contracts
MEDPARD	Medicare Carriers Provide Callers with Participating Physician and Supplier Directory
MFIS	Medicare Fraud Information Specialist
MFSR	Medicare Focus Medical Review Status Report
MGI	Medicare General Information Eligibility Enrollment

Acronym	Term
MIM	Medicare Intermediary Manual
MIP	Medicare Integrity Program
MIP PCOM	Medicare Integrity Program Provider Communications
MMA	Medicare Modernization Act of 2003
MMORP	Medicare Management Operations and Review Program
MPaRTS	Mistaken Payment and Recovery Tracking System
MPFSDB	Medicare Physician Fee Schedule Database
MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MSPRC	Medicare Second Payer Recovery Claims
NCD	National Coverage Decision
NDC	National Drug Codes
NGD	Next Generation Desktop
NOBA	Notice of Budget Approval
NPI	National Provider Identifier
NPR	Notice of Program Reimbursement
NPRM	Notice of Proposed Rule Making
NSF	National Standard Format
OGC	Office of General Counsel
OHA	Office of Hearing and Appeals
OI	Office of Investigation
OCI	Organizational Conflict of Interest
OIG	Office of the Inspector General
OMB	Office of Management and Budget
OPPS	Outpatient Hospital PPS
OSCAR	Online Survey Certification and Reporting
OTN	One-Time Notice
OTR	On-the-Record
OTSN	One Time Special Notification
PCA	Progressive Corrective Action
PCC	Provider Contact Center
PCOM	Provider Communication
PCSP	Provider Customer Service Program
PCUG	Provider Customer Service User Group

Acronym List

Acronym	Term
PE	Provider Enrollment
PECOS	Provider Enrollment and Chain Ownership System
PET	Provider Education and Training
PHI	Protected Health Information
PI	Program Integrity
PIM	Program Integrity Manual
PIP	Periodic Interim Payment
PM	Program Memoranda
PM	Program Management
PO	Project Officer
POC	Point of Contact
POC	Period of Comment
POE	Provider Outreach and Education
POR	Provider Overpayment Report
PPO	Preferred Provider Organization
PPA	Pension Protection Act
PPS	Prospective Payment System
PR&A	Provider Reimbursement and Audit
PRO	Peer Review Organization
PRB	Post-Retirement Benefits
PRP	Provider Reimbursement Profile
PRRB	Provider Reimbursement Review Board
PRRS	Provider Relations Research Specialists
PS&R	Provider Statistical & Reimbursement
PSA	Physician Scarcity Area
PSC	Program Safeguard Contractor
PSC	Professional Services Council
PSC	Program Support Center
PSOR	Physician and Supplier Overpayment Report
PSP	Provider/Supplier Service Plan
PSRR	Provider Statistical & Reimbursement Report
PSS	Provider Self-Service Technology
PTS	Provider Tracking System
QA	Quality Assurance
QAR	Quarterly Activity Reports
QCM	Quality Call Monitoring

Acronym	Term
QI	Quality Improvement
QIC	Quality Independent Contractors
QIO	Quality Improvement Organizations
QIP	Quality Improvement Program
QPU	Quarterly Provider Update
QSA	Quarterly Strategy Analysis
RA	Remittance Advice
RA	Risk Assessment
RAC	Recovery Audit Contractor
RAP	Request for Anticipated Payment
RBS	Report of Benefit Savings
RCE	Reasonable Compensation Equivalents
RCP	Report on Contractor Performance
ReMAS	Recovery Management and Accounts System
RFP	Request for Proposals
RHC	Rural Health Clinics
RHHI	Regional Home Health Intermediaries
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
RLCD	Regional Local Coverage Determination
RNHCI	Religious Non- Medical Health Care Institution
RO	CMS Regional Office
RPL	Rehabilitation, Psychiatric, Long-Term Care
RRB	Railroad Retirement Board
RTP	Return To Provider
RUG-III	Resource Utilization Groups, Version III
RVU	Relative Value Unit
RY	Rate Year
SADBUS	Small and Disadvantaged Business Utilization Specialist
SAS	Single Award Schedules
SAS	Statement of Auditing Standards
SAS	Statistical Analysis Software
SAS	Statistical Analysis System
SBR	Supplemental Budget Request
SCH	Sole Community Hospitals

Acronym List

Acronym	Term
SCHIP	State Children's Health Insurance Program
SCIP	Surgical Care Improvement Project
SFE	Standard Front End
SLI	Service Level Indicator
SMI	Supplementary Medical Insurance
SMI Trust	Supplementary Medical Insurance Trust Fund
SMS	Shared Maintenance System
SNF	Skilled Nursing Facility
SNP	Special Needs Plans
SOP	Standard Operating Procedures
SOW	Statement of Work
SOW	Scope of Work
SPR	Standard Paper Remittance Advice
SSA	Social Security Administration
SSA	Social Security Act
SSM	System Security Manual
SSM	Standard System Maintainer
SSO	System Security Officer
SSO	Short Stay Outlier
STC	Single Testing Contractor
SVRS	Statistically Valid Random Sampling

Acronym	Term
TBD	To Be Determined
TC	Technical Component
TEFRA	Tax Equity Fiscal Responsibility Act
TOP	Treasury Offset Program
TPA	Third Party Administrator
TRICARE	Office for Civilian Health and Medical Program of the Uniformed Services (Previously known as CHAMPUS)
TRNA	Transfer Request Notification Form
TSC	Technical Support Contractor
UB	Uniform Bill
UPIN	Unified Provider Identification Number
UPIN	Unique Provider Identification Number
USPS	U.S. Postal Service
VMS	Viable Medicare Systems
WAN	Wide Area Network
WC	Workers' Compensation
ZPIC	Zone Program Integrity Contractor