

II. Analysis of and Response to Public Comments Received on FY 2003 Criteria and Standards

We received no comments in response to the February 28, 2003 **Federal Register** general notice with comment.

III. Criteria and Standards—General

Basic principles of the Medicare program are to pay claims promptly and accurately and to foster good beneficiary and provider relations. Contractors must administer the Medicare program efficiently and economically. The goal of performance evaluation is to ensure that contractors meet their contractual obligations. We measure contractor performance to ensure that contractors do what is required of them by statute, law, regulation, contract, and our directives.

We have developed a contractor oversight program for FY 2004 that outlines expectations of the contractor; measures the performance of the contractor; evaluates the performance against the expectations; and provides for appropriate contract action based upon the evaluation of the contractor's performance.

As a means to monitor the accuracy of Medicare FFS payments, we have established the Comprehensive Error Rate Testing (CERT) program—which produces error rates for claims payment decisions made carriers, DMERCs, and FIs. Beginning in November 2003, the CERT program produced claims payment error rates for each individual carrier and DMERC. (FI—specific rates will be available the following year.) These rates measure not only how well contractors are doing at implementing automated review edits and identifying which claims to subject to manual medical review but also measure the impact of the contractor's provider outreach/education and effectiveness of the contractor's provider call centers. As such, we will utilize these contractor-specific error rates as a means to evaluate a contractor's performance.

Several times throughout this notice, we refer to the "readability" of letters, decisions, or correspondence that are going to Medicare beneficiaries from intermediaries or carriers. In those instances, "readability" is defined as being below the 8th grade reading level unless it is obvious that an incoming request from the beneficiary contains language written at a higher level. In these cases, the readability level is tailored to the capacities and circumstances of the intended recipient.

In addition to evaluating performance based upon expectations for FY 2004, we may also conduct follow-up

evaluations throughout FY 2004 of areas in which contractor performance was out of compliance with statute, regulations, and our performance expectations during prior review years and thus required the contractor to submit a Performance Improvement Plan (PIP).

We may also utilize Statement of Auditing Standards–70 (SAS–70) reviews as a means to evaluate contractors in some or all business functions.

In FY 2001, we established the Contractor Rebuttal Process as a commitment to continual improvement of contractor performance evaluation (CPE). We will continue the use of this process in FY 2004. The Contractor Rebuttal Process provides the contractors an opportunity to submit a written rebuttal of CPE findings of fact. Whenever we conduct an evaluation of contractor operations, contractors have 7 calendar days from the date of the CPE review exit conference to submit a written rebuttal. The CPE review team or, if appropriate, the individual reviewer will consider the contents of the rebuttal before the issuance of the final CPE report to the contractor.

The FY 2004 CPE for intermediaries and carriers is structured into five criteria designed to meet the stated objectives. The first criterion is "Claims Processing" which measures contractual performance against claims processing accuracy and timeliness requirements as well as activities in handling appeals. Within the Claims Processing Criterion, we have identified those performance standards that are mandated by legislation, regulation, or judicial decision. These standards include claims processing timeliness, the accuracy of Medicare Summary Notices (MSNs), the appropriateness of determinations reversed by an administrative law judge (ALJ), the timeliness of intermediary reconsiderations, reviews and hearings and the timeliness of carrier reviews and hearings, and the readability of carrier reviews. Further evaluation in the Claims Processing Criterion may include, but is not limited to, the accuracy of claims processing, the percent of claims paid with interest, and the accuracy of reconsiderations, reviews, and hearings.

The second criterion is "Customer Service" which assesses the adequacy of the service provided to customers by the contractor in its administration of the Medicare program. The mandated standard in the Customer Service Criterion is the need to provide beneficiaries with written replies that are responsive, that is, provide in detail

the reasons for a determination when a beneficiary requests this information, have a customer-friendly tone and clarity, and are at the appropriate reading level. Further evaluation of services under this criterion may include, but is not limited to, the timeliness and accuracy of all correspondence both to beneficiaries and providers; monitoring of the quality of replies provided by the contractor's customer service representatives (quality call monitoring); beneficiary and provider education, training, and outreach activities; and service by the contractor's customer service representatives to beneficiaries who come to the contractor's facility (walk-in inquiry service).

The third criterion is "Payment Safeguards" that evaluates whether the Medicare Trust Fund is safeguarded against inappropriate program expenditures. Intermediary and carrier performance may be evaluated in the areas of Medical Review (MR), Medicare Secondary Payer (MSP), Overpayments (OP), and Provider Enrollment (PE). In addition, intermediary performance may be evaluated in the area of Audit and Reimbursement (A&R).

In FY 1996 the Congress enacted the Health Insurance Portability Act, Medicare Integrity Program giving us the authority to contract with other than, but not excluding, Medicare carriers and intermediaries to perform certain program safeguard functions. In situations where one or more program safeguard functions have been contracted to another entity, we may evaluate the flow of communication and information between a Medicare fee-for-service contractor and the Payment Safeguard Contractor. All Benefit Integrity functions have been transitioned from intermediaries and carriers to the Program Safeguard Contractors, but three DMERCs will continue to handle this work in FY 2004. Because some of the DMERC contractors still conduct Benefit Integrity activities, we may evaluate their performance of that function.

Mandated performance standards for intermediaries in the Payment Safeguards criterion are the accuracy of decisions on SNF demand bills, and the timeliness of processing Tax Equity and Fiscal Responsibility Act (TEFRA) target rate adjustments, exceptions, and exemptions. There are no mandated performance standards for carriers in the Payment Safeguards criterion. Intermediaries and carriers may also be evaluated on any Medicare Integrity Program (MIP) activities if performed under their agreement or contract.