

for the anticipated passage of contracting reform we will be doing even more to seek provider input into customer service performance objectives.

Comment: A commenter requested that we publish the annual evaluations of all of the contractors so that the affected public will know whether contractors meet performance requirements. The commenter advised that currently, the evaluations are available only through a Freedom of Information Act (FOIA) request. Many providers, particularly smaller providers, are not aware of the procedures for making a FOIA request.

Response: The current evaluation reports for Medicare fee-for-service contractors are lengthy narratives, which are not conducive to publication. They are, however, available to the public upon written request. The policy that governs releasing these reports is explained at §§ 401.133(c), 401.135, 401.136, and 401.140. There is no requirement that reports be requested under the FOIA. Written requests for reports may be addressed to: Centers for Medicare & Medicaid Services, ATTN: Center for Medicare Management, Mailstop S2-21-28, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Comment: A commenter remarked that the Contractor Performance Evaluation (CPE) Rebuttal Process introduced in FY 2001 which gives contractors an opportunity to submit a written rebuttal within 7 calendar days from the CPE exit conference, needs to be clarified as to how it applies to the review of provider audit worksheets under our Audit Quality Review Program (AQRP). The commenter believes we should have a consistent policy for responding to all CPE findings. The commenter further suggests that CMS needs to clarify its policies with respect to AQRP findings and how they relate to the summarized annual CPE for Provider audit.

Response: The AQRP has an established procedure allowing contractors 30 days to review and respond to draft findings prepared as a result of the AQRP review. We review the contractor's responses for each individual AQRP review, delete or modify the findings as appropriate, prepare a rebuttal for those findings that are not modified, and issue a Management Letter. We then prepare and send to the contractor an Executive Summary of the results of all the individual AQRP reviews. This Executive Summary is then used as a basis for the preparation of a CPE report. Because the contractor has already been

given a formal review and rebuttal type process under AQRP that exceeds the 7 calendar day CPE rebuttal process, and because the CPE report adopts the final AQRP findings, we have determined the CPE rebuttal process is unnecessary for AQRP reviews.

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 law, regulation, contract, and our directives.

We have developed a contractor oversight program for FY 2003 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.

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 such 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 2003, we may also conduct follow-up evaluations throughout FY 2003 of areas in which contractor performance was out of compliance with laws, regulations, and our performance expectations during prior review years and thus required the contractor to submit a Performance Improvement Plan (PIP).

In FY 2001, we established the Contractor Rebuttal Process as a commitment to continual improvement of CPE. We will continue the use of this process in FY 2003. 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 2003 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 Explanations of Medicare Benefits (EOMBs) and Medicare Summary Notices (MSNs), the appropriateness of determinations reversed by ALJs, the timeliness of intermediary reconsideration cases, 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 such 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" which evaluates whether the Medicare Trust Fund is safeguarded against inappropriate program expenditures. Intermediary and carrier performance may be evaluated in the areas of Benefit Integrity (BI), Medical Review (MR), Medicare Secondary Payer (MSP), Overpayments (OP), and Provider Enrollment (PE). In addition,