

intermediary performance may be evaluated in the area of Audit and Reimbursement (A&R). Mandated performance standards for intermediaries in the Payment Safeguards criterion are the accuracy of decisions on Skilled Nursing Facility (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.

The fourth criterion is "Fiscal Responsibility" which evaluates the contractor's efforts to protect the Medicare program and the public interest. Contractors must effectively manage Federal funds for both the payment of benefits and costs of administration under the Medicare program. Proper financial and budgetary controls, including internal controls, must be in place to ensure contractor compliance with its agreement with HHS and CMS.

Additional functions reviewed under this criterion may include, but are not limited to, adherence to approved budget, compliance with the Budget and Performance Requirements (BPRs), and compliance with financial reporting requirements.

The fifth and final criterion is "Administrative Activities" which measures a contractor's administrative management of the Medicare program. A contractor must efficiently and effectively manage its operations. Proper systems security (general and application controls), Automated Data Processing (ADP) maintenance, and disaster recovery plans must be in place. A contractor's evaluation under the Administrative Activities criterion may include, but is not limited to, establishment, application, documentation, and effectiveness of internal controls which are essential in all aspects of a contractor's operation, and the degree to which the contractor cooperates with us in complying with the Federal Managers' Financial Integrity Act of 1982 (FMFIA). Administrative Activities evaluations may also include reviews related to contractor implementation of our general instructions and data and reporting requirements.

We have developed separate measures for RHHIs in order to evaluate the distinct RHHI functions. These functions include the processing of claims from freestanding HHAs,

hospital-affiliated HHAs, and hospices. Through an evaluation using these criteria and standards, we may determine whether the RHHI is effectively and efficiently administering the program benefit or whether the functions should be moved from one intermediary to another in order to gain that assurance.

Below, we list the criteria and standards to be used for evaluating the performance of intermediaries, RHHIs, carriers, and DMEPOS regional carriers.

IV. Criteria and Standards for Intermediaries

A. Claims Processing Criterion

The Claims Processing criterion contains the following four mandated standards:

Standard 1. 95.0 percent of clean electronically submitted non-Periodic Interim Payment claims are paid within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare intermediaries to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, clean, non-Periodic Interim Payment electronic claims can be paid as early as the 14th day (13 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 2. 95.0 percent of clean paper non-Periodic Interim Payment claims are paid within specified time frames. Specifically, clean, non-Periodic Interim Payment paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 3. The percentage of reconsideration determinations reversed by ALJs is acceptable. We have defined an acceptable reversal rate by ALJs as one that is at or below 5.0 percent.

Standard 4. 75.0 percent of reconsiderations are processed within 60 days, and 90.0 percent are processed within 90 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 5. 95.0 percent of Part B review determinations are completed within 45 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Standard 6. 90.0 percent of Part B hearing decisions are completed within 120 days. Our expectation is that contractors will meet this percentage on a monthly basis.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Claims processing accuracy.
- Establishment and maintenance of relationship with Common Working File (CWF) Host.
- Accuracy of processing reconsideration cases with determination letters that are clear and have appropriate customer-friendly tone.

Because intermediaries process many claims for benefits under the Part B Medical Insurance portion of the Medicare Program, we also may evaluate how well an intermediary follows the procedures for processing appeals of any Part B claims. This includes accuracy of reviews and hearings, as well as the appropriateness of the reading level of any review determination letters. (See Claims Process Criterion for carriers under section VI.)

B. Customer Service Criterion

Functions that may be evaluated under this criterion include, but are not limited to, the following:

- Providing timely and accurate replies to beneficiary and provider telephone inquiries.
- Quality Call Monitoring.
- Training of Customer Service Representatives.
- Ensuring the validity of the call center performance data that are being reported in the Customer Service Assessment and Management System.
- Providing timely and accurate replies to beneficiaries and providers that address the concerns raised and are written with appropriate customer-friendly tone and clarity and that those written to beneficiaries are at the appropriate reading level.
- Walk-in inquiry service.
- Conducting beneficiary and provider education, training and outreach activities.
- Effectively maintaining an Internet Website dedicated to furnishing providers and physicians timely, accurate, and useful Medicare program information.

C. Payment Safeguards Criterion

The Payment Safeguard criterion contains the following two mandated standards:

Standard 1. Decisions on SNF demand bills are accurate.

Standard 2. TEFRA target rate adjustments, exceptions, and exemptions are processed within mandated time frames. Specifically, applications must be processed to completion within 75 days after receipt