

WHITE PAPER ◀

Medicare Contracting Reform

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1. Background/History

Since the inception of the Medicare program in 1965, the contractors that process and administer medical claims have played a critical role in serving both beneficiaries and providers. Until recently, these contractors either administered Part A claims (hospital/facility) or Part B claims (professional/clinician services). If a patient received a medical service that had both a facility and a professional component, such as a radiology exam or emergency room visit, the hospital would send its claim form (CMS-1450) to one contractor, and the clinician would send their claim form (CMS-1500) to a different contractor.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires significant changes to the contracting for the administration of claims, impacting both Part A, Medicare's hospital insurance and Part B, Medicare's professional services coverage. CMS refers to these changes, which are intended to improve services to beneficiaries and healthcare providers, as [Medicare contracting reform](#). The implementation of this contracting reform fundamentally changes Medicare claims administration contracting practices.

As required by section 911 of the MMA, CMS must replace its current claims payment contractors (also known as fiscal intermediaries or carriers) with new contract entities called Medicare Administrative Contractors (MACs)¹. CMS plans to award a total of 23 MAC contracts through three procurement cycles. During the initial implementation phase (2005-2011), CMS plans to bid and award contracts for 15 A/B MACs that will adjudicate claims for both Part A and Part B services within their defined regions.

CMS designed the new A/B MAC jurisdictions to balance the allocation of workloads, promote competition, account for integration of claims processing activities, and mitigate the risk to the Medicare program during the transition to the new contractors. The new jurisdictions reasonably balance the number of fee-for-service (FFS) beneficiaries and providers. These jurisdictions will be substantially more alike in size than the existing fiscal intermediary and carrier jurisdictions, and they will promote much greater efficiency in processing one billion Medicare claims a year.

On November 24, 2006, CMS issued the final rule that would implement certain related provisions of the MMA, including a portion of the Medicare Contracting Reform provision from section 911. A portion of the rule deals with the agency's plans to revise parts of the current regulatory language concerning Medicare intermediary and carrier contracting authorities with wording pertinent to the new A/B MACs. The rule entitled "Medicare

1. Background/History - continued

Program–Revisions to Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates” is 443 pages in length. The language pertinent to the changes associated with Medicare Contracting Reform is contained in about nine pages (223-231) of the regulation.

Included in the rule is language explaining that the MMA section 911(b) amended section 1816 of the Social Security Act to remove the authority for groups or associations and individual providers of services to nominate (appoint) their intermediary. It also contains a description of CMS’ rule that all providers and suppliers will generally be assigned to a MAC based on geographic location.

On July 31, 2006, CMS announced that Noridian Administrative Services (NAS) was awarded the first contract for the combined administration of Part A and Part B Medicare FFS claims. The award of the Jurisdiction 3 (J3) Part A/Part B Medicare Administrative Contractor (A/B MAC) contract is a first step in support of improved service to providers, physicians and practitioners, as well as greater administrative efficiency and effectiveness for FFS Medicare. (See Medicare Administrative Contractor Implementation Rollout section below for states included in Jurisdiction 3). This award is indicative of the efforts under way to significantly re-engineer the Medicare claims administration process and change from the “business as usual” of the past 40 years.

2. MAC Responsibilities

According to CMS staff, the greatest savings would likely come through computerized medical reviews to automatically examine and compare Part A and Part B claims before they are paid.

Currently, Part A and Part B medical reviews are generally conducted by different contractors (Fiscal Intermediaries for Part A and Carriers for Part B). As a result, it is very difficult to identify inconsistencies between the Part A and Part B coding and claims. MACs will be able to detect a larger amount of improper payments because they will be responsible for adjudicating both Part A and Part B claims. According to CMS staff, the greatest savings would likely come through computerized medical reviews to automatically examine and compare Part A and Part B claims before they are paid. These automated claims reviews are expected to detect incorrect payments, thus resulting in lower levels of improperly paid claims.

If the coding and billing for a service provided to a patient has facility and professional components, and the facility claim (Part A CMS-1450) is different from the professional claim (Part B CMS-1500), it is the responsibility of the MACs to determine why there is a discrepancy and how to reimburse both providers. This process will likely require additional time to adjudicate the claims, and may result in one or both healthcare providers receiving lower reimbursement than they expected, including the possibility of increased claim denials.

The MACs will serve as healthcare providers' primary point of contact for enrollment, training on Medicare coverage and billing requirements, and the receipt, processing, and payment of Medicare FFS claims within their respective jurisdictions. As they perform all core claims processing operations for both Part A and Part B, MACs will need to maintain a staff of experts knowledgeable in all aspects of the fee-for-service program.

As one of the Part A/B MACs' major FFS claims processes, [managing claims](#) means establishing all of the environmental business processes and rules that are needed to complete an individual claim, from original receipt through determination of disposition, including:

- The receipt, editing, and adjudication of claims;
- The analysis and reporting associated with claims files created during these processes;
- Determining local medical policies;
- Establishing pre-pay processing rules;
- Performing internal claims edits;
- Performing claim validation edits;
- Establishing and maintaining pricing and user files; and
- Generating reports.

¹ <http://www.gpoaccess.gov/fr/index.htm>

Federal Register: November 24, 2006 (Volume 71, Number 226)

2. MAC Responsibilities - continued

In support of [claims analysis and reporting](#), MACs must:

- Conduct error analysis;
- Conduct routine and ad hoc reporting;
- Perform medical claims review; and
- Report claims payments to other insurance carriers the patient may have (e.g., Medicaid and other third-party insurance companies).

As part of the establishment and maintenance of the claims processing environment for its workforce, a MAC must establish the appropriate [workflow](#). In addition to the above, this includes defining edits that will be used to validate the claims, establishing prices, and integrating the definitions and restrictions associated with demonstration projects and specialty claims processing.

3. MAC Implementation Rollout

As of March 1, 2007, the implementation for the first contract, awarded to NAS (for Jurisdiction 3), was completed. The following six states are covered by NAS, with a total of 350 Medicare hospitals, as part of Jurisdiction 3:

- Arizona
- Montana
- North Dakota
- South Dakota
- Utah
- Wyoming

Cycle 1 includes the following jurisdictions, with awards being completed by September 2007, but not fully implemented until the end of 2008:

J1 - California, Hawaii and Nevada
J2 - Alaska, Idaho, Oregon, Washington
J4 - Colorado, New Mexico, Oklahoma, Texas
J5 - Iowa, Kansas, Missouri and Nebraska
J7 - Arkansas, Louisiana and Mississippi
J12 - Delaware, Maryland, New Jersey, Pennsylvania
J13 - Connecticut, New York

Cycle 2 includes the following jurisdictions:

J6 - Illinois, Minnesota and Wisconsin
J8 - Michigan and Indiana
J9 - Florida and Puerto Rico
J10 - Alabama, Georgia and Tennessee
J11 - North Carolina, South Carolina, Virginia, West Virginia
J14 - Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
J15 - Ohio and Kentucky

4. CFO Impact

If the hospital's and clinicians' coding and billing efforts are not coordinated, the clinician-hospital relationship will experience increased adversarial pressure. Potential bill denials and compliance concerns will increase for both the hospital and the clinician, due to inconsistent coding and billing for the services provided in the outpatient departments noted above.

The clinician-hospital relationship has changed over time from a cooperative to a sometimes competitive one. Both parties face growing economic pressures. As a result, the clinician-hospital bond is subject to a variety of contracts and contractual provisions, especially in outpatient departments where these services are typically contracted (e.g., Emergency Department, Clinics, Radiology and Pathology).

When hospitals and clinicians work well together, they provide better, more cost-effective and efficient patient care. For optimal relationships with clinicians, hospitals need to continue to look for strategies that align economic interests and patient care. Medicare contracting reform presents CFOs with another opportunity to strengthen the relationship between hospital administration and clinicians.²

Payment for services provided by a contracted physician is a crucial issue for hospitals. Therefore, the contract between a hospital and a physician will typically deal with this issue in depth, especially with respect to the billing of services to Medicare and Medicaid. With this new reform, it will become even more mission-critical for CFOs to take a look at these contracts, specifically related to the coding and billing of professional services in outpatient departments.

² Press Ganey Associates, The Growing Importance of Physician-Hospital Relations, January 30, 2007. www.pressganey.com/news/ceo_letter.php

5. Conclusion

It is recommended that hospital CFOs take this opportunity to evaluate their current contracts with their hospital-based physicians. It may be beneficial for the hospital to perform the coding for its hospital-based physicians, to ensure that the Part A and Part B coding are consistent. In addition, hospitals may want to offer billing and collection services as a “value-add” to the physicians’ contract. These types of contractual provisions can effectively decrease costs, including physician administrative overhead costs and the hospital’s contract costs, while enhancing coding and billing compliance efforts.

CFOs should also meet with their hospital-based physicians and educate them on the potential consequences of the A/B MACs on their coding and billing process, as well as their reimbursement. If the hospital and physician coding do not match, either or both parties may see payment delays, possible reduction in reimbursement due to increased bill denials, and/or increased likelihood of audits. It is in both the hospital’s and physicians’ best interests to coordinate their efforts to support consistent coding.

Currently, the coding and billing for services provided in outpatient departments such as Emergency, Radiology, Cardiology, and Pathology are fragmented and not under the responsibility of a hospital’s Health Information Management (HIM) department. The HIM department traditionally focuses on inpatient coding and billing. From an outpatient perspective, the HIM department did take on the coding and billing for outpatient surgical departments with the advent of the Ambulatory Patient Groups in 1996. However, even with the Outpatient Prospective Payment System–Ambulatory Payment Classifications implemented in 2000, the HIM department has not universally taken on the Emergency, Clinic and Radiology departmental coding and billing.

As a result of the A/B MAC legislation, the time is right for the HIM department to take on a larger role, and code for both the facility and professional components. Hospital CFOs should assess their facility’s infrastructure and organization to determine the most efficient and cost-effective way to assume full accountability and responsibility for the coding, and possibly billing, of both Part A and Part B for all outpatient services. This strategy can reduce administrative costs, improve operational efficiency, and increase employee productivity, while maintaining quality and enhancing compliance.



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