

Background for the ABC Study

CMS has made it a priority to establish a strong link in its budget requests between program outcomes and contractor administrative funding levels. We have made this a priority in order to emphasize the inherent relationship between the two factors: that when administrative funding is reduced (i.e., contractor operations), the Medicare program suffers.

The current contractor budget categories in our national submissions are aggregations of a large number of functions grouped under broad and equally large dollar amounts. For example, our FY 2000 President's budget submission requests \$772 million under the general heading of "Claims Processing." As a result of this composite view of contractor operations, the internal and external reviewers of our budget have a less than optimal comprehension of the real impacts of funding variations. In order to identify and underscore the linkage between contractor operations, funding, and program outcomes, we wish to disaggregate the national budget categories into discrete and meaningful activities.

The Contractor Processes Workgroup, comprised of 10 contractor representatives and CMS regional and central office staff from throughout the agency, began work on the ABC Study in April 1998. The workgroup's first task was to identify and define key processes for two select Medicare functions, claims processing and Provider Education and Training (PET). The group subsequently identified **8** key activities for claims processing and **5** key activities for PET, which are described in Attachment B. Additional detail on the interrelationships between the activities is included in Attachment C.

The workgroup crafted its final product by applying the tenets of ABC. ABC is a management reporting system that focuses on the costs of the work **activities** associated with operating the business in lieu of the standard **cost centers** (e.g., lump sum salaries, fringe benefits) in the traditional cost accounting structure. ABC identifies all the "end to end" business processes for both people and systems in each activity so that the total costs of the activity are fully visible to program managers. The workgroup's product balanced the introduction of an ABC approach with CMS's need to collect information from the contractors with a minimum of operational disruption.

After the Contractor Processes Workgroup identified the key activities for claims processing and PET, we solicited volunteers from the

contractor community to estimate the proportion of their FY 1999 budgets associated with each of the activities. Sixteen contractors volunteered to participate in this exercise and submitted percentages that totaled 100% of the entire amount for that line item in their budget. After receiving the numbers from the contractor volunteers, we averaged the percentages to develop a national consensus estimate of the respective funding associated with each activity.

Claims Processing Activities

We have identified 8 activities that represent the entire gamut of claims processing operations and costs. (Note: The term "claims" includes both bills **and** claims as processed by the fiscal intermediaries and carriers, respectively).

Activity #1 includes all Overhead and General and Administration (G&A) costs for claims processing.

Activities #2-7 represent core claims processing activities and include direct costs for the salaries/fringe benefits, facilities occupancy, furniture, personal computers, materials, supplies, travel, and training costs of the staff and management performing each activity. All postage costs for claims processing are also aggregated in Activity #4.

Activity #8 represents all costs associated with maintaining the claims processing hardware and software and processing the claims, as well as the direct costs for the programmer staff and management who oversee the system.

1. Support Overall Administrative and Management Functions for Claims Processing

This is a support activity that includes the contractors administrative, management, and support costs associated with the overall, macro-level claims processing function, such as salaries for the managers (e.g., a Vice-President for Medicare Operations) responsible for supporting the entire claims processing function. However, costs for the clericals and supervisors **specifically dedicated** to one of the other following 7 activities should be included in their respective activity. All Overhead and G&A costs for claims processing are included here, as well as any claims processing "help desk" costs.

Activity #1 includes but is not limited to:

- Tracking and reporting workload and budget for claims processing
- Inputting data to CMS maintained systems such as CAFM and CROWD
- Monitoring "Line 1" operations for CPE purposes
- Recruiting, hiring and orienting claims processing staff
- Managing the **overall** claims processing function
- Performing clerical and support activities (e.g., typing and maintaining files/supplies) for the overall claims processing function
- Contributing claims processing's share of corporate Overhead costs, including Service Departments such as the Accounting and Personnel Departments
- Contributing claims processing's share of macro-level management costs of Medicare operations (e.g., the Medicare Coordinator)
- FMFIA/CFO certification as related to the claims processing function
- Ensuring compliance with records retention policies as related to claims
- Overseeing facility security and disaster recovery procedures as related to the claims processing function

2. Conduct Provider Enrollment

Provider Enrollment includes review by the contractor of the providers requests for Medicare reimbursement through the National Provider Enrollment Application (CMS-855). Contractors review and validate CMS-855s; input CMS-855s into the Provider Enrollment Module File; assign PINs/ billing numbers and request UPINs (carriers only); handle individual provider inquiries, and; coordinate with State Survey Agencies.

Activity #2 includes but is not limited to:

- Identifying, verifying, and registering physicians, suppliers, non-physician practitioners, and institutional providers for purposes of billing under the Medicare program
- Receiving, controlling, and processing Medicare physician and supplier enrollment applications and supporting documentation
- Receiving, controlling, and processing provider nominations of fiscal intermediaries

- Verifying certification or licensure from a variety of sources, e.g., the On-Line Survey, Certification, and Reporting (OSCAR) system, State licensing boards, OIG, and professional organizations

3. Perform EDI Oversight Functions

Electronic Data Interchange (EDI) arrangements are becoming an increasingly important part of contractor activities as providers are continuously encouraged to submit claims and receive payment electronically. CMS defines EDI as the fully automated transfer of data between a biller (provider or agent) and Medicare for billing, remittance advice, eligibility query, claims status query, and other purposes; between Medicare and a bank for electronic funds transfer or remittance advice; or between Medicare and another payer for coordination of benefits. Successfully managing the EDI function entails a significant amount of up-front work by contractor staff to ensure the requisite infrastructure is in place to initiate and maintain the EDI between the contractor and the billing/financial agent or provider. Activity #3 represents this staff work, including the costs of preparing and maintaining free Medicare electronic billing PC-Print software. Please note that any "extra" EDI services to providers (and billed for profit by the contractor) are **not** to be included in this activity, either as a cost or as a cost offset (i.e., credit). This activity includes but is not limited to:

- Training of individual providers and their staff on the use of EDI
- Obtaining an EDI Enrollment Form from each provider and issuing system passwords and billing numbers
- Coordinating with vendors/clearinghouses, providers, and third-party billers
- Providing free EDI software and revised EDI specifications to providers/agents (including the distribution of updated PC-Print software)
- Assisting with software installation and alpha testing/validating
- Resolving dial-in problems
- Retaining statistics on EDI performance for workload reporting and to monitor the effectiveness of EDI marketing activities

4. Receive, Sort and Control Incoming and Outgoing Mail

This activity includes opening envelopes and sorting claims; assigning control numbers to incoming mail, including Medicare claims and

claims certifications (e.g., DME); imaging and microfiching; processing outgoing mail; mailroom equipment and supply costs; and **all** postage (metering) costs associated with the claims processing function.

Medicare operations often share a corporate mailroom with other sections of the contractor's activities. However, even when this is true, Medicare is assessed its share of the associated costs for the mailroom function. This activity includes but is not limited to:

- Opening envelopes and sorting (e.g. specialty) claims
- Assigning control numbers to incoming mail including:
 - CMS 1500s
 - CMS 1490s, 1450s
 - Claims Certifications (e.g., DME)
 - Supporting Documentation for Claims
 - Claims Attachments
- Imaging and microfiching
- Processing outgoing mail (includes postage metering and mailroom staff costs)
 - Applying zip + 4 sorting
 - Mailing MSNs/EOMBs/NOUs/remittance notices
 - Mailing development letters (i.e., solicit missing claims information)
 - Returning unprocessable claims to providers
 - Returning misdirected claims (e.g., RRB)
 - Forwarding misdirected mail to the appropriate recipient within the contractor's shop
 - Mailing EDI disks to providers

5. Enter and Pay Claims

This activity is multi-faceted and includes but is not limited to:

Claims Entry: Determining If a Claim Can Be Processed

Contractors make an initial determination as to whether or not a claim can be processed. This activity first requires data entry, optical character reading, and processing electronic through-puts, and then includes:

- identifying claim that can not be processed, incomplete claims, and applying eligibility consistency edits and routine edits to claims (e.g., verifying HIC #s, provider IDs, and beneficiaries' addresses);
- suspending claims because of problems with not-otherwise-classified pricing issues, eligibility, diagnostic/procedure codes and modifiers, provider IDs, duplicate claims, and invalid procedures;
- developing non-clean claims (resolving edit errors);
- returning claims that failed front-end edits to the provider for correction and resubmission;
- scheduling claims for processing and storage, and;
- reentering corrected/developed claims adjustment actions.

Claims Payment: Maintaining and Updating Pricing Mechanisms

After the claims are entered, and the initial edits applied, contractors must determine whether or not to pay a claim. Most of this process is fully automated with the costs included in Activity #8. However, "front-end" technical staff time is also required to support claims pricing and payment in conjunction with the programming activities included in Activity #8. Specifically, contractors must create, maintain and oversee reasonable charge screens, fee schedules, and other pricing determination mechanisms that support the following processes.

- After claims entry, payment is computed by applying Diagnostic Related Groups (DRGs), interim payments, fee schedule amounts, customary and prevailing charges, deductibles, interest, co-insurance, and approved charges.
- PROBILLS are created and sent to the PRO (FIs), and claims are forwarded to Common Working File for verification of beneficiary eligibility, benefits, deductibles, and utilization, an A/B data exchange, pre-payment authorization, and updates to beneficiary entitlement data. Payment is generated (check runs/EFTs) or claims are denied, and MSNs/NOUs/EOMBs, remittance notices, Notice of Medigap, or crossover data are issued.
- Contractors process complementary credits, and both the Claims History and the Provider Statistical & Reimbursement (PS&R) systems are updated after the claim is accepted.

Reopening Claims

At times, claims must be reopened by contractors because of changes in policy, statute or coverage, or contractor error. When these situations occur, contractors retro-adjust paid claims and either reverse payment on the claim or determine that payment should stand.

6. Set-Up Crossover/Medigap Arrangements -- Coordinating with other Payers

The actual processing of crossover and Medigap claims information is an automated and routine function and is reflected in Activity #8. However, significant contractor staff time is invested in effectuating and maintaining arrangements with third party insurers (e.g., Medicare supplemental insurers), since contractors are strongly encouraged to solicit these agreements. This activity includes researching and instituting arrangements with Medigap and other third party insurers, and creating Trading Agreements. This activity includes but is not limited to:

- Researching and instituting arrangements with Medigap insurers
- Creating Trading Agreements

7. Conduct Quality Assurance Activities

Contractors develop mechanisms to ensure quality in their claims processing operations. Within some contractors, this activity is completed by a unit of staff dedicated to the QA function (e.g., end-of-line review for Part B claims or Part A claims processing test beds); however, other contractors view this as a responsibility of management and supervision. The QA activity includes all costs related to routine quality control procedures used to measure the competency and performance of claims processing operations, and includes but is not limited to:

- Reviewing suspended and reopened claims for correct processing
- Reviewing paper/EMC claims for accuracy

8. Run and Maintain Systems

This function includes the costs of the procurements and the programmer/management staff time associated with the systems support of claims processing. This activity also includes, but is not limited to CPU costs for claims processing; claims processing's share of the fees for shared processing; testing and validating new software

releases (e.g., updated fee schedules, PRICERs and GROUPErS); maintaining interfaces and testing data exchanges with standard systems, CWF, HDC, State Medicaid Agencies, Trading Partners, Third Party Billing Services, and

Financial Institutions; purchasing software to support claims processing; maintaining the Print Mail function, on-line systems, telecommunications systems, and mainframe hardware; providing LAN/WAN support; ongoing costs of transmitting claims data to and from the CWF host, as well as other telecommunications costs; and establishing and maintaining systems security controls for LANs/WANs, systems software, application programs, operating systems, data centers, EDI transmissions and data storage facilities.

Provider Education and Training Activities

PET's Funding Sources

PET has two funding sources that significantly influence the nature of its work: CMS's Program Management (PM) appropriation, and the Medicare Integrity Program (MIP). PM-PET and MIP-PET are separated by this funding "firewall," but the intent of the two programs is the same; i.e., to inform and educate providers. However, while the basic activities are the same for both groups, PM-PET activities are of a more generic nature and geared to the provider community in general. Contrarily, MIP-PET activities are more provider-targeted and specifically oriented to ensuring program integrity.

Program Management-PET

PM-PET activities include orienting new providers and resolving problems and issues raised by groups of providers. These may be policy, billing, and/or systems issues and are often

determined based on the frequency of inquiries and claim submission errors. Unlike MIP funded activities, PM-PET activities are, for the most part, **not** targeted to individual providers based upon billing practices. The scope of PM-PET is to identify and address issues that are raised by large numbers of providers.

We have identified five activities that represent the gamut of PM-PET processes and costs.

Activities #1-5 are core MP-PET activities and include direct costs for salaries/fringe benefits, facilities occupancy, furniture, EDP equipment, materials, supplies, travel, and training costs for the staff and management performing each activity.

1. Develop an Empirically-Based Provider/Supplier Service Plan (PSP)

The PSP is based on trend analysis of problematic issues, and includes a strategy for ensuring and strengthening the quality of written and verbal correspondence with providers/suppliers through an internal review process. The PSP also includes methods to quantitatively analyze and demonstrate the effectiveness of individual initiatives. Contractors actively solicit feedback related to the Medicare program and contractor service at every opportunity. This includes requesting provider feedback on the effectiveness of Audio Response Units (ARUs). PET's share of the contractor's Overhead and General Administration (G&A) costs is also included in this activity.

2. Review and Analyze Trends in Inquiries and Claims Submission Errors

This activity allows the contractor to target the contractor's provider educational effort in the most efficacious manner by reviewing data and formulating conclusions, and implementing and operating a provider inquiries analysis program which includes an updated list of the most frequently asked questions/areas of concern and confusion for providers. PET's share of the contractor's systems costs is also included in this activity.

3. Orient New Providers

Orienting new providers is a critical PET function. Through this forum, providers are encouraged to enter into participation and EDI agreements with Medicare, and are also introduced to the contractor's myriad functions and oversight responsibilities.

4. Disseminate Educational Information to Providers

Contractors use a myriad of tools and techniques to educate providers. These include, but are not limited to, regular/special bulletins and contractor-sponsored seminars, conferences, workshops, teleconferences, and conventions that include program, billing information, and general EMC/EDI updates; provider training on billing

and program issues; stuffers or inserts mailed with checks and remittance notices; regular briefings with State medical societies, provider organizations, billing staffs, etc., addressing educational needs identified by tracking initiatives; workshops on current legislation covering program and billing issues; presenting at (non-contractor) conferences or conventions on program, billing and general EMC/EDI issues; creating and maintaining a web site for electronic bulletins on program and billing issues; developing educational materials (including videos); exploring and implementing new technologies (i.e., Internet) and other electronic means of educating and training providers; providing general education and information to providers; issuing advisories from the contractor's Medical Director to area physicians; and, issuing quarterly informational newsletters approximately 45 days in advance of standard systems releases. All PET related postage costs are also included in this activity.

5. Partner with Other Agents and Entities in Outreach Efforts (e.g., PROs, State Survey Agencies, Medicaid State Agencies, State Ombudsmen, DME Regional Carriers, SADMERCs, and other Medicare contractors):

Increasingly, all Medicare agents are encouraged to work with one another and to link their efforts. As the fiduciary agents for Medicare with first hand knowledge of providers' billing practices, contractors provide critical information to other entities engaged in ensuring quality care is provided to beneficiaries. Exchanges of information and coordination are vital to ensuring optimal protection and service for beneficiaries.

Medicare Integrity Program-PET

MIP-PET focuses on activities involving individuals or groups of identified aberrant, abusive, or fraudulent providers and suppliers who have been detected through the contractor's program integrity operations (i.e., medical review, MSP, and benefit integrity). MIP-PET activities also include educating the general provider population on issues related to fraud and abuse.

1. Individual Provider Feedback

This activity includes expenses associated with providing one on one feedback to individual providers/suppliers on specific problems identified through prepay and postpay medical review. This includes feedback activities associated with progressive corrective action.

2. Community Feedback

This activity includes costs associated with providing feedback to the larger provider/supplier community on;widespread errors. Typically, this feedback is the result of patterns emerging from data analysis and medical review.

3. Provider Bulletins /Letters

This activity includes expenses related to bulletins and letters or portions of general bulletins and letters to providers/suppliers containing program integrity information.

4. General MIP PET activities

This activity includes expenses related to general MIP PET activities should be captured here. This includes presentations at fraud and abuse programs, outreach activities with special groups and provider associations and general education to Administrative Law Judges.

Significant Interrelationships for Claims Processing Activities

1. Support Overall Administrative and Management Functions for Claims Processing

Direct Relationship:	Oversight of Claims Processing Operations
Tangential Relationship:	<ul style="list-style-type: none"> Appeals Inquiries Staffing Productivity Accuracy and Quality of Work Accuracy and Timeliness of Contractor Reporting to CMS Systems Operations Number of Suspended Claims CPE Evaluations
Direct Relationship	Administrative Financial Integrity
Tangential Relationship:	<ul style="list-style-type: none"> Appropriate Allocation of Costs FMFIA/CFO Certification

2. Conduct Provider Enrollment

Direct Relationship:	Quality of Contractors' Provider Files
Tangential Relationship:	Fraud, Waste and Abuse efforts (screening fraudulent providers) Appeals Inquiries Reimbursement (Pricer and interim rate setting) EDI Arrangements Provider Enrollment Changes(e.g., mergers) CMS-Mandated Process Changes (e.g., mass provider recertifications)

Direct Relationship:	Number of Enrolled Providers
Tangential Relationships:	Inquiries Appeals EDI Arrangements Beneficiary Access to Care Number of Participating Physicians Claims Volume Fraud, Waste and Abuse Efforts MIP Activity Levels (MR, MSP, Audit) Provider Education Activities Medicare Handbook (costs) Systems Operations

3. Perform EDI Oversight Functions

Direct Relationship:	Administrative Costs (EDI is less costly than hardcopy)
Tangential Relationships:	Mailroom Operations Claims Processing Operations MIP Activities (re: exchange of electronic medical records and secondary payor trailers)

Direct Relationship:	Claims Processing Operations
Tangential Relationships:	Data Entry Workload Claims Adjustments Provider Relations Systems Operations Provider Enrollment

4. Receive, Sort and Control Incoming and Outgoing Mail

Direct Relationship:	Volume of Claims-Related Mail
Tangential Relationships:	MIP Activity Level (MR, MSP, Audit)
Direct Relationship:	Compliance with Claims Processing Timeliness Statue
Tangential Relationships:	Interest Payments Provider Relations Beneficiary Relations Systems Operations

5. Enter and Pay Claims

Direct Relationship:	Number of Claims Processed
Tangential Relationships:	Claims Backlogs Inquiries Appeals Mailroom Operations Systems Operations Systems (Run) Costs Systems Changes (e.g., revised fee schedules and changes to Print Mail functions) Provider Enrollment Check runs/EFT transmissions Benefit Outlays Interest Payments Provider Relations MIP Activity Level (MR, MSP, Audit) Number of Suspended Claims
Direct Relationship:	Substance of MSNs/NOUs/EOMBs
Tangential Relationships:	Fraud, Waste and Abuse efforts Postage Costs (number of mandated messages and pages) Inquiries
Direct Relationship:	Accuracy and Quality of Claims Payment

Tangential Relationships:	Systems Changes (e.g., to Print Mail functions) MIP Activity Level (MR, MSP, Audit) Fraud, Waste and Abuse efforts Appeals Inquiries FMFIA/CFO Certification Provider Enrollment Changes (e.g., mergers) CWF Host and Maintainer Standard Systems Maintainer Data Centers Changes in Complementary Credit Rates Agreements with Trading Partners Costs to Beneficiaries and Provider (Medigap) Costs to contractors (complementary credits) PS&R Report Mailroom Operations Programmatic or Legislative Changes to Coverage, Eligibility, or Payment rates (e.g., fee schedules)
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6. Set-Up Crossover/Medigap Arrangements -- Coordinating with other Payers

Direct Relationship:	Number of Arrangements
Tangential Relationships:	Costs to Beneficiaries and Providers (Medigap) Costs to Contractors (complementary credits) Systems Operations

7. Conduct Quality Assurance Activities

Direct Relationship:	Accuracy and Quality of Claims Payment
Tangential Relationships:	MIP Activity Level (MR, MSP and Audit) Fraud, Waste and Abuse Efforts Appeals Inquiries Claims Adjustments FMFIA/CFO Certification Systems Operations

8. Run and Maintain Systems (Systems Operations Impacts All Activities)

Direct Relationship:	Overall Administrative and Management of Claims Processing
Tangential Relationships:	Accuracy and Timeliness of Contractor Reporting to CMS FMFIA/CFO Certification CPE Evaluations
Direct Relationship:	Provider Enrollment
Tangential Relationships:	Provider Relations Provider Enumeration
Direct Relationship:	EDI Oversight
Tangential Relationships:	Alpha-testing/Validating EDI Provider Relations Claims Processing Costs Inquiries
Direct Relationship:	Incoming and Outgoing Mail
Tangential Relationships:	Print Mail Function Entering Claims/Assigning Controls #s
Direct Relationship:	Enter Pay Claims
Tangential Relationships:	Number of Suspended Claims Number of Claims Processed Accuracy of Claims Payment Number of Reopened Claims Programmatic or Legislative Changes --Revised Fee Schedules --Changes to Complementary Credit Rates MIP Activity Levels (MR, MSP, Audit)
Direct Relationship:	Setting Up Crossover/Medigap Arrangements
Tangential Relationships:	Honoring Agreements with Trading Partners
Direct Relationship:	Conducting Quality Assurance
Tangential Relationships:	Quality of Claims Payment

	MIP Activity Levels (MR, MSP, Audit)
Other Relationships:	CWF Host and Maintainer Standard Systems Maintainer Data Centers CMS Data Center

Significant Interrelationships for PET Activities

Direct Relationship:	Claims Processing Operations
Tangential Relationships:	Provider Enrollments EDI Arrangements Accuracy of Submitted Claims Number of Suspended Claims Number of Claims Requiring Development Third Party Arrangements (Coordination of Benefits)

Direct Relationship:	Systems Operations
Tangential Relationships:	PSP Development Review and Analysis of Inquiries and Claims Error
Other Relationships:	Appeals Inquiries Provider Relations Number of Participating Providers Consistency in Medical Coverage Policies MIP Activity Levels (MR, MSP, Audit) Fraud, Waste and Abuse Efforts Efficiency and Coordination of the Medicare Program (i.e., Outreach and Partnerships)