

FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS PROGRAM MANAGEMENT

June 25, 2003

Bills Payment (Intermediary)

The following is a list of major activities related to Bills Payment. The Activity Codes listed below are also described in the Activity Dictionaries (Attachment 1 to the BPRs). However, these should not be construed as an all-inclusive list of tasks. Intermediaries should continue to budget for all activities currently performed, unless directed otherwise for specific tasks by CMS. If there is a significant activity that you perform that is not listed below or included in the Activity Dictionary for Bills Payment, please add a statement in your narrative justification describing that activity. All of these activities are covered in the Medicare Intermediary Manual (MIM) Part 3, Chapters VII and VIII, the CMS Business Partner Systems Security Manual, and related program memoranda (PM).

The Bills Payment BPRs for FY 2004 relates to CMS' goal to promote sound financial management and fiscal integrity of CMS programs.

Perform Electronic Data Interchange (EDI) Oversight (Activity Code 11201)

This activity includes establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic billing, electronic remittance advice, electronic claim status query, electronic eligibility query, and for other purposes as required by direct data entry (DDE) screens and Medicare-supported formats for the electronic exchange of data; and/or between Medicare and a bank for electronic funds transfer. Successful operation of EDI entails establishment and maintenance of records to enable EDI to occur; support of providers, clearinghouses, software vendors, and other third party provider agents to assure continued submission and processing of compliant transactions; maintenance of connectivity; and detection and corrective action related to potential misuse of electronic transactions. The requirements for these activities are included in the following PM and MIM references:

- CR 1704/PM AB-01-96, CR 2039/PM AB-02-020, CR 2364/PM AB-02-133, CR 2547, CR 2576, and
- The EDI requirements currently in MIM, Part 2, Section 2982 and Part 3, Sections 3508-3508.6, 3601.1, .2, .3, .4, 3602.1, .2, and .3, to the extent these manual references were not overridden by one of the listed PMs.

The tasks in this activity include:

- a. Obtaining valid EDI and Electronic-Funds Transferred (EFT) agreements, provider authorizations for third party representation for EDI, and network service vendor

- agreements. Entry of that data into the appropriate provider-specific and security files, and processing reported changes involving those agreements and authorizations;
- b. Issuance, control, updating, and monitoring of system passwords and EDI billing/inquiry account numbers to control electronic access to beneficiary and provider data;
 - c. Sponsorship of providers and vendors for establishment of connectivity via IVANS, other private network or LU 6.2 connections where supported to enable the electronic exchange of data via DDE and EDI;
 - d. System testing with electronic providers/agents as directed by CMS to assure compatibility between systems for the successful exchange of data;
 - e. Submission of EDI data, status reports on the progress of HIPAA transactions implementation, monthly reports on the progress of submitter testing, and other EDI status reports as directed by CMS;
 - f. Investigation of high provider eligibility query to claim ratios to detect potential misuse of eligibility queries, and taking of corrective action as needed when problems are detected;
 - g. Monitoring and analysis of recurring EDI submission and receipt errors, and coordination with the submitters and receivers as necessary to eliminate the identified errors;
 - h. Maintenance of a list of software vendors whose EDI software has successfully tested for submission of transactions to Medicare;
 - i. Furnish support to the providers on the use of the free/low cost billing software; and
 - j. Furnish basic support to providers in the interpretation of transactions as issued by Medicare.

Manage Paper Bills/Claims and the Standard Paper Remittance (SPR) Advice Format (Activity Code 11202)

This activity includes all costs related to the receipt, control, and entry of paper bills (i.e., the UB-92/CMS-1450 forms submitted by institutional providers) as required by the MIM, Part 3, Chapter VII (Bill Review, 3600ff), and for maintenance of the format for reporting of paper remittance advice (pending CR for maintenance of the standard paper remittance advice format), including:

- a. Opening, sorting, and distribution of incoming bills, including paper adjustment bills, submitted by intermediary institutional providers;
- b. Assigning control number and date of receipt;
- c. Imaging of paper bills and attachments;
- d. Data entry (manual or optical character recognition scanning) of paper claim data, and re-entry of data for corrected/developed paper bills;
- e. Identification of paper bills during the data entry process that cannot be processed due to incomplete information;
- f. Resolution of certain front-end edits related to paper claims;
- g. Return of incomplete paper bills, and paper bills that failed front-end edits to submitters for correction and resubmission;
- h. Re-enter corrected/developed paper claims adjustment actions; and
- i. Update the paper remittance advice format once a year as directed by CMS to keep corresponding fields in sync with certain updates made to the electronic remittance advice

format.

See the Productivity Investment (PI) section for information on additional activities planned for FY 2004. Do not include incremental costs for those PI activities in your estimates for this operational activity.

Workload

The paper bills workload (Workload 1) is the difference between the total claims reported on the CMS-1566, p.11, line 38, column 1, minus the EMC bills reported in line 38, column 8.

Manage EDI Bills/Claims and Related EDI Transactions (Activity 11203)

This activity includes establishment, maintenance, and operation of the EDI infrastructure to assure efficient operation of EDI processes that permit the fully automated transfer of data between a biller (provider or agent) and Medicare. This includes costs related to your software, hardware, staff support, and other resources to enable electronic submission of bills, issuance of electronic remittance advice, electronic funds transfer, electronic claim status and eligibility query processing, and for other purposes as supported by direct data entry (DDE) screens and Medicare-supported formats for the electronic exchange of data; and/or between Medicare and a bank for electronic funds transfer, except as included in activity 11201.

Medicare expects there will be a need to maintain up to two HIPAA formats at any given time: the current format, and a subsequent format during a transition period between them. Contractors must include in this ongoing activity estimated costs to implement an upgrade in FY 2004 of each implemented HIPAA transaction format, including any related adjustment to their translator and maps. Retesting of existing submitters will not be required in conjunction with any such upgrades. In early FY 2004, however, it will at least initially be necessary to maintain both pre-HIPAA and HIPAA formats. As a result of the Administrative Simplification Compliance Act (ASCA) extension requested by Medicare and most other covered entities, Medicare contractors will be required to continue to support the pre-/non-HIPAA formats/versions through October 2003, or until directed by CMS to eliminate their support.

Although no version upgrade is expected to be adopted under HIPAA in FY 2004, it is possible that errors could be detected during submitter testing in FY 2003 or FY 2004 that could identify the need for further modification of the flat files used by Medicare to support the HIPAA formats. The FY 2004 upgrade would be related to such changes.

Requirements under this activity are included in the following Program Memoranda (PM) and MIM references:

- CR 1391/PM A-00-89, CR 1483/PM AB-01-29, CR 1522/PM A-01-57, CR 1533/PM A-01-20, CR 1611/PM A-01-63, CR 1959/PM AB-02-067, CR 2021/PM AB-02-54, CR 2028/PM A-02-014, CR 2134/PM A-02-069, CR 2135/PM A-02-036, CR 2137/PM A-02-037, CR 2211/PM A-02-078, CR 2233/PM A-02-070, CR 2271, CR 2364/PM AB-02-133, CR

2385/PM AB-03-026, CR 2387/PM A-02-119, CR 2395/PM AB-02-142, CR 2437/PM AB-02-166, CR 2498/PM A-02-005, CR 2505, CR 2538, CR 2546/PM AB-03-012; CR 2555/AB-03-029, CR 2576/AB-03-036, CR 2581/PM AB-03-026, CR2657/AB-03-060, CR2699/AB-03-068, CR2706/A-03-041, CR 2742, CR 2774; and

- MIM, Part 2, Section 2982, Part 3, Sections 3508-3508.6, 3601.1, .2, .3, .4, 3602.1, .2, .3, and 3600.A to the extent these manual references have not been superceded by any of the listed PMs, and the EFT requirements in MIM, Part 1, Section 1430.

This activity does not include those tasks separately captured in the “Manage EDI Bills/Claims” activity that follows. Nor does it include the following costs that are not allowable by Medicare:

- Any share of the costs of a clearinghouse or other service organization established by an umbrella organization which owns or has a contractual relationship with a Medicare intermediary;
- Any costs for activities not specifically permitted by CMS for EDI; and
- Costs that exceed Medicare’s pro-rata share of the indirect, general and administrative EDI costs related to overhead shared with any parent company of a Medicare intermediary.

See the Productivity Investment (PI) section for information on subsequent instructions planned for FY 2004 implementation. Do not include incremental costs for those PI activities in your estimates for this operational activity.

The tasks in this activity include:

- a. Provision of free billing software and PC-Print software to providers/agents on their request, and upgrading of that software once per year, if so directed by CMS;
- b. Alpha testing and validation of free billing software and PC-Print software prior to issuance to providers/agents;
- c. Resolution of problems with telecommunication protocols and lines, software and hardware to support connections to enable providers/agents to electronically send/receive data for EDI transactions in a secure manner, and with the processing of magnetic tapes containing EDI data, where supported, that have been delivered by providers/agents;
- d. Maintenance of capability for receipt and issuance of transactions via direct data entry (DDE) and via electronic transmission of transactions in batches, for DDE and batch correction of edits, and submission of adjustments in batches by electronic intermediary institutional providers/agents;
- e. Maintenance of EDI access, syntax and semantic edits at the front-end, prior to shared system processing;
- f. Routing of electronic edit and exception messages, electronic bill acknowledgements, electronic bill development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic

- mailbox for downloading by the trading partners, routing of EFT, and receipt of 997 transactions from trading partners to report errors in transactions;
- g. Verification of the validity of EDI data received from electronic providers/agents through selective audits and use of other verification tools;
 - h. Maintenance of back end edits to assure that outgoing electronic remittance advice and response transactions comply with the applicable implementation guide requirements, and that ACH EFT transactions comply with those separate requirements;
 - i. Creation and retention of a copy of each EDI bill as received and the ability to recreate each remittance advice and COB transaction as issued;
 - j. Maintenance of audit trails to document processing of EDI transactions;
 - k. Translation of transaction data between the pre-HIPAA and HIPAA standard formats and the corresponding internal flat files used in the shared system;
 - l. Updating of claim status and category codes, revenue codes, claim adjustment reason codes, remittance advice remark codes, and taxonomy codes three times per year as directed by CMS; and
 - m. Billing of third parties as directed by CMS for access to beneficiary eligibility data, maintaining receivables for those accounts, and terminating third parties if warranted due to non-payment.

Workload

The EDI bills workload (Workload 1) is reported on the CMS-1566, Page 11, Line 38, Column 8.

Bills/Claims Determination (Activity Code 11204)

After the bills are entered, and the initial edits applied, contractors must determine whether or not to pay a bill. Most of this process is fully automated with the costs included in the Run Systems Activity Code. However, technical staffs are also required to support bills pricing, adjudication, and payment in conjunction with the programming activities included in Run Systems. Specifically, contractors must create, maintain, and oversee fee schedules and other pricing determination processes (e.g., annual ICD-9 updates), including the following:

- Validity, consistency, eligibility, and duplicate detection checks on each bill.
- Re-entry of corrected/developed data for bills that suspend from the standard system.
- Payment method and payment rates are obtained for each provider file. If applicable, the PIP indicator is set. For PPS claims, the appropriate GROUPER is called and the output is forwarded to Pricer. For other PPS claims, appropriate fee schedules and pricers are used.
- Payment amounts are calculated.

Workload

The adjudicated bills workload (Workload 1) is the cumulative number of bills processed as reported on the CMS-1566, Page 1, Line 12, Column 1.

Run Systems (Activity Code 11205)

This activity includes the costs of the programmer/management staff time and procurements associated with the systems support of bills processing. This activity also includes the local systems costs related to bills processing, as well as charges from the data center to the contractor to support its processing of the standard system. Other costs include (but are not limited to) local CPU costs, depreciation costs or lease of CPU; software/hardware costs; maintaining interfaces and data exchanges with standard systems, CWF, HDC, and State Medicaid Agencies; maintaining the print mail function; on-line systems; costs associated with testing of releases; and change requests. Also included are ongoing costs for LAN/WAN support and costs of transmitting data to and from the CWF hosts.

Note: All bills processing systems costs should be charged to 11205 including the application of MIP edits. However, the personnel costs associated with installing and activating the edits, and the staff resolution of bills that fail the edits should be charged to the function with ownership of the edits. Also, other systems related items such as personal computers or computer peripherals should be directly charged to the areas that use them.

Standard systems changes are being made to create two new MSN files for future electronic (web) viewing via Change Request 2663. At the request of CMS, contractors may be asked to electronically transfer these new MSN file types via National Data Mover (NDM) to a predetermined location as of a certain date. You are not required to store or retain these new MSN files or take any other action with them unless notified by CMS.

Manage Information Systems Security Program (Activity Code 11206)

The Systems Security BPRs for FY 2004 relate to CMS' goals to promote the fiscal integrity of CMS programs and enhance program safeguards.

Principal Systems Security Officer (SSO)

Include the cost for appointing a principal SSO and staff responsible for managing a Medicare systems security program. This cost must include the cost of the Principal SSO earning 40 hours of continuing professional education credits from a recognized national information systems security organization. This cost may also include the cost of participating in CMS systems security conferences, CMS Systems Security Technical Advisory Group (if requested by CMS), or CMS systems security best practice conferences. (Refer to Section 2.2 of the CMS Business Partner Systems Security Manual.)

Systems Security Self-Assessment using the Contractor Assessment Security Tool (CAST)

Include the cost of conducting the annual assessment of the CMS Business Partner Systems Security Manual.

Risk Assessment

Include the cost of conducting an initial risk assessment or if previously developed, the cost to review the risk assessment to determine if changes have occurred and requires the current risk assessment to be updated. Business Partners are required to perform an annual risk assessment in accordance with the CMS Information Security RA Methodology and is available at the following CMS website: www.cms.hhs.gov/it/security. (Refer to Section 3.2 of the CMS Business Partner Systems Security Manual.)

Systems Security Certification

Include the cost of preparing the systems security portion of the annual internal control certification. The certification documents that the Security Self-Assessment, Risk Assessment, Business Continuity and Contingency Plan, System Security Plan, Annual Compliance Audit and Correction Action Plan are in compliance with the CMS Business Partner Systems Security Manual. (Refer to Section 3.3 of the CMS Business Partner Systems Security Manual.)

Information Technology Systems Contingency Plan

Include the cost of conducting a review of the Information Technology Systems Contingency Plan annually or whenever new systems, such as GSSs and MAs are planned, or new safeguards contemplated. Also include the annual cost of testing the plan. (Refer to Section 3.4 of the CMS Business Partner Systems Security Manual.)

Annual Compliance Audit

Include the cost of conducting an annual compliance audit of designated CMS Core Security Requirements. (Refer to Section 3.5.1 of the CMS Business Partner Systems Security Manual.)

Corrective Action Plan

Include the cost of preparing a corrective action plan to review security compliance and determine the degree of compliance to the CMS Core Security Requirements. The corrective action plan addresses risks identified as a result of the Annual Self-Assessment and Annual Compliance Audit plus CMS SAS 70 audits (if any) and OIG electronic data processing control audits (if any). (Refer to Section 3.5.2 of the CMS Business Partner Systems Security Manual.)

Incident Reporting and Response

Include the cost of analyzing and reporting systems security incidents, in the violation of security policy and procedures, to CMS and other appropriate officials. (Refer to Section 3.6 of the CMS Business Partner Systems Security Manual.)

Systems Security Profile

Include the cost of collecting and maintaining all systems security files and documentation in appropriate on-site and off-site storage. (Refer to Section 3.7 of the CMS Business Partner Systems Security Manual.)

Manage Trading Partner Agreements (TPAs) to Accomplish Coordination of Benefits with Supplemental Payers and States (Activity Code 11207)

Contractors are to continue the solicitation of the Standard Trading Partner Agreement for the purpose of crossing paid claims data to other health care insurers. Contractors are to continue to cross over Medicare paid claims data to their new and existing trading partners, and to collect the fees in accordance with the MIM, Section 1601. Tasks include the following:

- Market, execute, and maintain CMS’s Eligibility File-Based Standard Trading Partner Agreement for COB Purposes (see AB-03-066, dated May 9, 2003 and AB-02-095, dated July 5, 2002, for policy regarding appropriate “crossover” partners);
- Perform billing/collections functions for crossover activities;
- Perform internal and external systems support and testing;
- Maintain information to answer inquiries regarding crossover claims;
- Resolve problems with trading partners and impacted providers, as applicable; and,
- Resolve COB processing problems.

Workload

Workload 1 is the number of claims transferred as designated in the MIM, 1361.10 (currently only reported on the FACP).

Workload 2 is the number of TPAs executed in this FY.

Conduct Quality Assurance (Activity Code 11208)

Include costs related to routine quality control techniques used by management to measure the competency and performance of bill processing personnel; quality assurance reviews of fee schedules, HCPCS, and ICD-9 updates and maintenance; and reviews of contractor systems.

Manage Outgoing Mail (Activity Code 11209)

This activity includes the costs to manage the outgoing mail operations for the bills processing function, e.g., costs for postage, printing NOUs/MSNs/EOMBs/ remittance advice notices and checks, and paper stock. This includes the following tasks:

- a. Mail NOUs/MSNs/EOMBs, remittance advice notices and checks;
- b. Mail requests for information (other than for medical records or MSP) to complete claims adjudication;
- c. Return unprocessable claims to providers;

- d. Return misdirected claims, e.g., back to providers; and
- e. Forward misdirected mail, e.g., to another contractor where required by CMS.

The paper remittance advice notice instructions are contained in the MIM Part 3, Sections 3602.5, .7 and 3750, Program Memoranda A-00-23, A-00-36, AB-00-65, A-00-98, A-01-57/CR1522, AB-01-124/CR1802, as part of instructions issued for implementation of Outpatient, SNF and HHA PPS, and in CR 1959 currently being cleared for release in FY 2002. Remittance advice reason and remark codes are contained at www.wpc-edi.com and included by reference in a number of the listed remittance advice MIM and PM instructions. Paper check instructions are contained in the MIM Part 3, Section 3703. *Note: Do not include postage costs identified with other contractor operations (e.g., Medical Review, MSP, Inquiries, etc.). Also, the front-end mailroom costs of sorting incoming mail should be treated as overhead.*

Reopen Bills/Claims (Activity Code 11210)

Include all costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error; inaccurate coding; input error; or the misapplication of reasonable charge profiles and screens, etc. Refer to the MIM, Section 3799 for a comprehensive definition of what constitutes a reopening.

FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS PROGRAM MANAGEMENT

Provider/Supplier Enrollment (Intermediary)

Provider/Supplier Enrollment (Activity Code 31001)

Provider/Supplier Enrollment (PSE) attempts to ensure that only qualified and eligible individuals and entities are enrolled in the Medicare program and receives reimbursement for services furnished to beneficiaries.

CMS has made it a priority to establish a strong link in its budget requests between program outcomes and contractor administrative funding levels utilizing the concept of Activity Based Costing (ABC). The ABC initiative is to identify and trace all material costs incurred when providing a service, e.g., Provider Enrollment, back to the activities that produce that output. The attached Activity Dictionary (Attachment 1 to the BPRs) lists “tasks” for the provider enrollment function; however, they are not to be considered an all-inclusive list of tasks performed under the PSE function. In addition to satisfying all requirements contained in the Provider Enrollment BPRs the Activity Dictionary, fiscal intermediaries are to budget according to the Medicare Program Integrity Manual, Chapter 10; other referenced manuals; and any applicable general instructions.

Workload Reporting Requirements (Cumulative)

Workload 1 – Initial applications (CMS-855A) and Changes of Ownership (CHOW) completed in a month.

Workload 2 – Changes of information (including seller CHOWs) completed in a month.

Other issues

- Fiscal Intermediaries must justify all provider enrollment budget requests in writing.
- In general, provider enrollment-initiated educational activities will be charged to provider enrollment, e.g., phone calls, letters, and site-specific visits with suppliers, etc. Time associated in working with Provider Communications (PCOM) staff at seminars, conferences, etc. or through other PCOM initiated resources, e.g. a bulletin, is to be charged to the PCOM line item.
- Identify, by job title, the number of FTEs for the provider enrollment activity code. Intermediaries should be assigning staff corresponding with the enrollment workload to meet processing time requirements while still effectively screening applicants.

- A new activity code has been added to report the cost and workload associated with provider based entities (Activity Code 16005). Provider Enrollment should only be charged for the review of the CMS-855A application.
- Intermediaries should budget for and plan to attend a provider enrollment conference in 2004. PECOS will be discussed at the conference.

FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS PROGRAM MANAGEMENT

Appeals/Hearings (Intermediary)

The Medicare Appeals and Hearings function ensures that the due process rights of beneficiaries and providers who are dissatisfied with initial claims determinations and subsequent appeal decisions are protected under the Medicare program. These BPRs are designed to provide continued support and guidance to the Medicare contractors as they focus their efforts on efficiently and effectively administering all levels of the Part A and Part B appeals processes.

In keeping with CMS' Strategic Plan Objectives, the appeals and hearings function is focused on improving beneficiary satisfaction with programs and services, increasing the usefulness of communications, and maintaining and improving CMS' position as a prudent program administrator and an accountable steward of public funds. We must also comply with statutory requirements regarding the processing of appeal requests in a cost-effective manner that supports our goals of customer service and fiscal responsibility.

In FY 2004, contractors should continue with the following objectives:

- Ensure that all appeals decisions are processed accurately and correctly;
- Process reconsiderations, reviews, and hearing officer hearings in accordance with the statutory timeliness standards;
- Prepare customer friendly written correspondence in accordance with the guidelines established in Sections 3784, 3792 and 3794 of the Medicare Intermediary Manual (MIM);
- Maintain complete and accurate case files;
- If necessary, prioritize workload in accordance with CR 2330 or the most current program guidance;
- Conduct quality improvement and data analysis activities as part of your administration of the appeals process;
- Establish and maintain open communication with other program areas that affect appeals;
- Continue quality improvement and data analysis activities as described in your plan. Monitor and track significant changes in appeals receipts; and, identify root causes, anticipated duration, and necessary actions for countering any workload aberrancies; and
- Identify and refer providers that would benefit from education on the importance of submitting requests for appeals correctly, including applicable documentation at the earliest point in the appeals process.

In FY 2004, CMS expects that contractors will establish workload strategies within the budget provided. As a reminder, in addition to satisfying all requirements contained in the BPRs,

intermediaries are responsible for meeting the requirements of Sections 3780 through 3798 of the MIM, along with any relevant Program Memoranda, and should develop their FY 2004 budget requests accordingly. Also see the Activity Dictionary (Attachment 1 to the BPRs).

Capturing Workload

Intermediaries will continue to report appeals cost data on the CAFM II system. For each activity, Workload 1 is the number of claims processed and Workload 2 is the number of cases processed, unless otherwise noted. Workload 3 is the number of reversals at the given level of appeal, unless otherwise noted. If the workload is currently captured in CROWD, CAFM II will transfer this data into the appropriate Activity Code. Please refer to the workload chart included in this section of the BPRs for a description of workload for each Activity Code.

Changes in FY 2004

Activity Code 12113 – Incomplete Reconsideration Requests has been added.

Activity Code 12140 – Part B Dismissals/Withdrawals of Review Requests has been deleted.

Miscellaneous Activity Code 12141-01 -- Part B Dismissals/Withdrawals of Review Requests (Telephones) has been added.

Miscellaneous Activity Code 12142-01 – Part B Dismissals/Withdrawals of Review Requests (Written) has been added.

Activity Code 12143 – Incomplete Review Requests has been added.

Preparing and Submitting the Appeals and Hearings Budget Request

Intermediaries must submit narrative justifications supporting their appeals budget request. As part of the justification, include the following:

- Identify the processes that the contractor shall use to monitor spending in each appeals activity code to ensure that spending is consistent with the allocated budget. Indicate how often this is monitored. Include processes that the contractor will undertake to revise or amend the plan when spending is over or under the budget allocation;
- Identify and describe the processes that assure the accuracy and the consistency of reporting workload for each Activity Code and assess the proper allocation of FTE/hrs that are required for each activity;
- Identify by name your claims processing standard system and list any other system support you use (e.g., user interfaces) and the appeals functions it performs;
- Identify current trends, program initiatives, or other program requirements that could impact

the volume of appeal receipts. Explain how the initiative/requirement will impact your appeals function and any additional cost you believe will be incurred in the appeals area.

- Identify the cost impact of CR 2551.
- Identify the dollars associated with continuing quality improvement/data analysis (QI/DA) activities that you performed prior to the release of CR 2740 and the dollars related to the QI/DA activities that you have implemented as a result of CR 2740.

APPEALS AND HEARINGS DELIVERABLES

<i>Reports</i>	<i>Submit to</i>
1.) Any revisions to your Appeals QI/DA Plan. If there are significant and/or numerous changes, submit a revised QI/DA report in its entirety. 2.) At least 3 QI/DA Reports per year, as indicated in CR 2740. (This CR will be updated for FY 2004)	Regional Office to: RO Appeals Contact Central Office to: AppealsOperations@cms.hhs.gov

Descriptions of FY 2004 Intermediary Appeals Activities:

A general description of each activity is listed below. Please refer to Sections 3780 through 3798 of the MIM and applicable Program Memoranda for guidance in carrying out current appeals process activities.

NOTE: CR 2551 should decrease your workloads of reconsiderations, reviews, and hearings. Submit your budget request accordingly.

Parts A and B Quality Improvement/Data Analysis (Activity Code 12090) (CR 2740 or AB-03-067, which will be updated for FY 2004)

Report all costs associated with conducting a quality improvement/data analysis program focused on reducing unnecessary appeals and improving performance requirements. Include costs of continuing activities you performed prior to the release of CR 2740 as well as costs for new activities you implemented as a result of CR 2740.

Part A Reconsiderations (Activity Code 12110) (§§1869 and 1816(f)(2)(A)(i) of the Social Security Act; MIM §§ 3782, 3783, 3784)

Report all costs and workloads associated with processing reconsiderations. Seventy-five percent of reconsiderations must be processed within 60 days and 90 percent must be processed within 90 days.

Incomplete Reconsideration Requests (Activity Code 12113) (MIM §3782) (pending CR)

Report all costs and workloads associated with returning incomplete and unclear requests for reconsideration to the provider or State Medicaid Agency. Do not count these as dismissals or completed reconsiderations.

Part A Administrative Law Judge (ALJ) Hearing Requests (Activity Code 12120) (§§1869 and 1816(f)(2)(A)(ii) of the Social Security Act; MIM §§ 3785, 3786, 3787, 3797 and a pending CR)

Report all costs and workloads associated with processing Part A ALJ Hearing Requests. Report all costs associated with effectuating Part A ALJ decisions. Report all costs and workload associated with referring Part A ALJ cases to the Departmental Appeals Board (DAB) also known as the appeals council (AC); responding to DAB requests for case files and effectuating DAB decisions.

- **Part A ALJ Courier Service (Miscellaneous Code 12120-01) (AB-02-126)**

Report all costs associated with using the courier system to send ALJ case files to the appropriate Office of Hearings and Appeals.

Part B Telephone Reviews (Activity Code 12141)

Intermediaries who perform Part B telephone reviews should report the applicable costs and workload here. Telephone reviews are reviews which are requested by phone and completed by phone.

- **Part B Telephone Review Dismissals and Withdrawals (Miscellaneous Code 12141/01)**

Report costs associated with Part B Telephone Reviews that are dismissed or withdrawn.

Part B Written Reviews (Activity Code 12142) (§1842(b)(2)(B)(i) of the Social Security Act; MIM §§ 3793)

Report all costs and workload associated with processing written review requests. At least 95 percent of Part B reviews must be completed within 45 days.

- **Part B Written Review Dismissals and Withdrawals (Miscellaneous Code 12142/01)**

Report costs associated with Part B written reviews that are dismissed or withdrawn.

Part B Incomplete Review Requests (Activity Code 12143) (MIM §3793)

Report all costs and workloads associated with review requests that are incomplete and, therefore, returned to the provider or State Medicaid agency. Do not count cost or workload associated with dismissals or completed reviews here.

Part B Hearing Officer (HO) Hearings (Activity Code 12150) (MIM §3794; §1842 (b)2(B)(ii) of the Act)

Report all costs and workload associated with processing HO hearings. Include on-the-record, telephone and in-person hearings and dismissals/withdrawals. At least 90 percent of all HO hearing decisions must be completed within 120 days of receipt of the request for the hearing.

Part B ALJ Hearings (Activity Code 12160) (MIM §3797)

Report all costs and workloads associated with processing Part B ALJ Hearing Requests. Report all costs associated with effectuating Part B ALJ decisions. Report all costs and workload associated with referring Part B ALJ cases to the Departmental Appeals Board (DAB) also known as the appeals council (AC); responding to DAB requests for case files and effectuating DAB decisions.

- **Part B ALJ Courier Service (Miscellaneous Code 12160-01) (AB-02-126)**

Report all costs associated with using a courier mail system to send ALJ case files to the Office of Hearings and Appeals in Falls Church, Virginia.

**SUMMARY OF APPEALS CAFM II ACTIVITY CODE DEFINITIONS FOR INTERIM
EXPENDITURE REPORTS- Part A and Part B**

Activity Code	Activity	Workload 1	Workload 2	Workload 3
12090	Part A and B Quality Improvement/Data Analysis	NA	NA	NA
12110	Part A Reconsiderations	Reconsideration Requests Cleared (claims)	Reconsideration Requests Cleared (cases)	Reconsideration Reversals (cases)
12113	Part A Incomplete Reconsideration Requests	NA	Incomplete Reconsideration Requests (cases)	NA
12120	Part A ALJ Hearing Requests	ALJ Hearing Request Forwarded (claims)	ALJ Hearing Request Forwarded (cases)	ALJ Hearings Effectuated (cases)
12120/01	Courier Service Fee	NA	NA	NA
12141	Part B Telephone Reviews	Telephone Review Requests Cleared (claims)	Telephone Review Requests Cleared (cases)	Review Reversals
12141/01	Part B Telephone Reviews Dismissed or Withdrawn	NA	NA	NA
12142	Part B Written Reviews	Written Review Requests Cleared (claims)	Written Review Requests Cleared (cases)	Review Reversals (cases)
12142/01	Part B Written Reviews Dismissed or Withdrawn	NA	NA	NA
12143	Incomplete Review Requests	NA	Incomplete Review Requests (cases)	NA
12150	Part B Hearing Officer Hearings	HO Hearings Completed (claims)	HO Hearings Completed (cases)	HO Hearings Reversed (cases)
12160	Part B ALJ Hearing Requests	ALJ Hearing Requests Forwarded (claims)	ALJ Hearing Requests Forwarded (cases)	ALJ Hearings Effectuated (cases)
12160/01	Courier Service Fee	NA	NA	NA

FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS PROGRAM MANAGEMENT

Beneficiary Inquiries (Intermediary)

As a customer-centered organization, CMS is focusing on providing improved service to all customers, including Medicare beneficiaries. The FY 2004 Fiscal Intermediary Beneficiary Inquiry BPRs are designed to encompass CMS' Strategic Plan and facilitate continuously improving customer service. CMS requests that each Fiscal Intermediary prioritize its workload in such a manner to ensure that funding is allocated to accomplish the priority goals of the listed activities. CMS expects that each Fiscal Intermediary meet standards for inquiry workloads in the following order of precedence:

- 1) Beneficiary Telephone Inquiries (including Quality Call Monitoring and the Next Generation Desktop)
- 2) Screening of Complaints Alleging Fraud and Abuse
- 3) Written Inquiries
- 4) Walk-in Inquiries
- 5) Beneficiary Outreach to improve Medicare customer service (Customer Service Plans)

All resources should be devoted to performing only these activities.

Any contractor call center upgrades or initiatives for purchases or developmental costs of hardware, software or other telecommunications technology that equal or exceed \$10,000 must first be approved by CMS. Contractors shall submit all such requests to the servicing CMS regional office (RO) for review. The RO shall forward all recommendations for approval to the Center for Beneficiary Choices, Division of Beneficiary Customer Service (DCBS), for a final decision.

Beneficiary Telephone Inquiries (Activity Code 13005)

The instructions for beneficiary telephone inquiries are described in Medicare Intermediary Manual (MIM), Section 2958.A. Also refer to the Activity Dictionary (Attachment 1 to the BPRs) for the lists of tasks for this activity.

Please note the following additions/revisions to the current telephone manual instruction.

1. Transfer of Part A Telephone/Written Inquiries Workload

In response to the draft BPRs, numerous large Part A contractors volunteered to take on additional telephone/written workload. However, since there were no small contractor volunteers to have their inquiry workloads transferred to another contractor, CMS is determining those small contractors whose inquiry workload will be moved in FY 2004 based on performance, call volume (50,000 calls or less), and unit cost (cost per call over \$10).

Based on the progress of transferring the inquiry workloads, some contractors will have their inquiry budgets significantly modified in FY 2004. CMS will work directly with the ROs and the Medicare contractors who are losing and gaining workload in FY 2004. Contractors receiving the additional inquiry workload will be chosen based on cost, quality, performance and Next Generation Desktop (NGD) availability.

2. Quality Call Monitoring (QCM) Process

- Of all calls monitored for Customer Service Representatives (CSRs) each month, the percent of calls scoring as “Pass” for Adherence to Privacy Act must be no less than 90%.
- Of all calls monitored for CSRs each month, the percent of calls scoring as “Achieves Expectation” or higher must be no less than 90% for Customer Skills Assessment.
- Of all calls monitored for CSRs each month, the percent of calls scoring as “Achieves Expectation” or higher should be no less than 90% for Knowledge Skills Assessment.

3. Availability of Telephone Service

- Maintain the ability to respond directly (via CSR and automated service) to telephone inquiries in both English and Spanish. For Intermediaries not utilizing Interactive Voice Response Units (IVRs) or in those situations where automated service would not be cost-efficient for the number of Spanish-speaking calls received, those callers should be transferred directly to the CSR queue for service.
- Options, services or messages offered callers at one level in the network or by premise-based equipment should not be duplicated and offered to callers again. For example, if callers are offered the option of transferring to the IVR or to a bilingual queue in the network, they should not be offered this service again at the call center level.
- Premise-based equipment should not be programmed to allow for the recording of voice messages by callers at any time.

4. Call Handling Requirements

- CMS will no longer require a minimum performance requirement of 1100 calls per FTE per month for Non-Medicare Customer Service Center (MCSC) call centers and 1000 calls per FTE per month for MCSC call centers. Contractor call centers will still be required to report the necessary data points monthly in the Customer Service Assessment and Management System (CSAMS) to calculate the CSR Productivity measure. CMS will continue to use CSR Productivity as an indicator of a call center’s performance.

- The monthly Incompletion Rate (also known as the All Trunks Busy (ATB) External Rate) shall not exceed 20% for any Beneficiary call center. This includes all of the call center's voice lines as well as any "hidden" toll-free lines terminating at the call center. CMS will be monitoring call center accessibility during the fiscal year and will be working with any contractors experiencing Incompletion Rates over 20%. Any situation that disturbs the usual operation of the call center and results in extreme variances in the call center's performance level will be considered as an exceptional event by CMS and reviewed on a case-by-case basis. CMS will be monitoring accessibility during the fiscal year and will be working with any contractors experiencing Incompletion Rates over 20%.
- A number of contractor TDD/TTY lines experienced significant incompletion rates (ATB levels) in FY 2003. CMS would like to ensure that TDD/TTY service is accessible to beneficiaries with hearing impairments. Therefore, beginning in FY 2004, the monthly Incompletion Rate (also known as the ATB external rate) shall not exceed 20% for any Beneficiary call center's TDD/TTY service. CMS will be monitoring TDD accessibility during the fiscal year and will be working with any contractors experiencing Incompletion Rates over 20%.

In the event significant costs would be incurred for a contractor to immediately meet this requirement, CMS will also review and consider approval of waiver requests while CMS works with the contractor to remove obstacles that impede access for these beneficiaries.

5. Medicare Customer Service Center Next Generation Desktop (MCSC-NGD)

CMS is developing a new MCSC-NGD application to be deployed at Medicare contractor sites. The new desktop will allow Customer Service Representatives (CSRs) to answer written, telephone, and walk-in inquiries from both providers and beneficiaries. The NGD application will enable CSRs to address, at a minimum, the same general Medicare and claims inquiries currently handled, but in a more user-friendly and efficient manner. The NGD is being developed on requirements gathered from call center personnel currently handling telephone, written, and walk-in inquiries. Although NGD may be found useful by other components interacting with the telephone and written inquiries areas, specific requirements are not being identified for those areas.

The initial rollout of NGD will provide contractors with access to information from the VIPS Medicare System (VMS), Fiscal Intermediary Standard System (FISS), and Multi Carrier System (MCS) claims processing systems used today. Initially contractors will only access information to perform the functions required within their existing workload. However, the technology being built into the NGD will ultimately allow contractors to access claim information outside their service areas and to access additional CMS databases once those business processes have been defined. This increased access will enable contractors to support each other in times of heavy call volumes, disaster situations, emergency closings, and any other downtime as well as to handle more of the calls currently being blocked in the network. As NGD is rolled out, those contractors utilizing NGD will have call history information

displayed for beneficiaries and providers who have previously contacted other sites using NGD. For example, call history in Ohio will be visible to both the Carrier and the Intermediary Call Centers for Ohio after both Call Centers begin utilizing NGD. The call history information does not contain claim information, only a record of and reason for the call.

Implementation Approach and Schedule

Since the NGD will continue to be rolled out to contractors throughout FY 2004, contractors must include NGD implementation costs in the FY 2004 budget requests. These costs must be included in Activity Code 13005 and also reported using Miscellaneous Code 13005/01 so that they can be separately identified as NGD implementation costs. The MIM, Section 2958, Change Request 2079 Program Memorandum, Subject: Installation of a New MCSC Next Generation Medicare Desktop Application and Change Request 2390 Program Memorandum, Subject: Next Generation Desktop Data Center Connectivity – Security Information Clarification contain more detailed instructions describing NGD implementation functions.

Contractors utilizing the MCSC-Forte desktop application should budget for minimal support and maintenance of that application until call centers are transitioned over to MCSC-NGD.

Call centers will be notified at a minimum of six months in advance of beginning deployment discussions. Call centers will be implemented with consideration to business impact to the Medicare program as a whole. Input from contractors regarding the desired timing of implementation will be considered, as well as, other implementation activity and specific circumstances of each call center.

Centers Using Non-Standard Claims Processing Systems

Currently, plans provide for the NGD to support FISS, MCS, and VMS (Part B and DMERC) claims processing systems. Centers using other systems will not implement the NGD until they have converted to one of these standard systems.

Technical Considerations

Hardware

The hardware necessary to implement the NGD application includes Siebel Systems' eHealthcare product, centrally-located servers, and personal computers (PCs).

Siebel

The NGD is being built using Siebel Systems' eHealthcare product. This product employs a "zero footprint" Web-based client, which means that no specialized hardware or software is required on the agents' desks other than a typical Personal Computer (PC) and a Web browser. PCs that will be used to generate correspondence will also require Microsoft Word '97, or a higher version of Word, which will be the responsibility of the Medicare contractor to procure. CMS is purchasing the necessary Siebel software licenses and ongoing Siebel software

maintenance contracts.

Servers

All servers needed to run the NGD application will be centrally-located (initially at the AdminaStar Federal data center in Louisville, KY). Each call center site will access the servers via the Medicare Data Communications Network (MDCN); CMS currently uses AT&T Global Network Services (AGNS) to provide service to the MDCN. Prior to implementation, each call center's network configuration will be evaluated to ensure that sufficient network bandwidth will be available.

Firewalls

All Internet Protocol (IP) access to the MDCN/AGNS network will be firewall protected. Each call center will be responsible for the installation and configuration of a firewall solution between themselves and the MDCN/AGNS network. Call centers will access the NGD system via IP. The NGD will provide access to the mainframe processing systems at the data centers via IBM's System Network Architecture (SNA). SNA connectivity will not require firewall protection. Future plans may include access to the mainframe processing systems via IP; however, CMS will work closely with the data centers if and when this option becomes available. The contractors are only responsible for having the firewall(s) implemented at their call centers and/or data centers.

Personal Computers

NGD Personal Computer (PC) Requirements – Following are updated PC software requirements for MCSC-NGD. These requirements supercede those listed in Change Request 2079 dated 5/16/02 and the Medicare Carrier Manual. The only additional software requirements for FY2004 are the Microsoft Word and Adobe Acrobat viewers which can be downloaded free of charge. **Consideration will be required for coexisting software applications in addition to NGD. The system requirements may increase based on these additional applications. Please consult the software vendor for this information and make appropriate modifications to these requirements on the basis of that information.**

Requirements for an NGD Personal Computer	
Processor:	500MHz Pentium III or comparable AMD 800MHz Celeron or comparable AMD
Disk Space:	100MB available
Memory:	224MB for Windows 2000 288 MB for Windows XP
Operating System:	Windows 2000 Service Pack 2 OR Windows XP Service Pack 1
Browser:	Internet Explorer 5.5 Service Pack 2; Q323759

	OR Internet Explorer 6 Service Pack 1; Q810847
Monitor:	21”
Pointing Device:	Mouse with scroll
Network Interface:	Network Interface Card compatible with the call center LAN, which will ultimately allow workstation access to MDCN
Word Processor:	Microsoft Word '97 (or higher version) – Required only for generation of correspondence.
Viewers:	Microsoft Word Viewer (provided free by Microsoft) and Adobe Acrobat Reader (v4.05 or v5.0 free from Adobe) are required to view correspondence and some reference materials available in NGD.

Integration Methods

Standard Systems

Integration between the NGD and VMS, CWF, MCS, and FISS will be accomplished using Jacada’s Integrator software product. Jacada uses TN3270 sessions to work with these systems. This allows NGD to be implemented without any changes to the standard systems. Access to CWF will be through the claims systems. The NGD Integration Layer will log and time-stamp all interactions, recording the NGD user, the back-end system user, and the transaction being performed along with the transaction’s data. Integration with EDB and MBR will be done using IBM CICS Transaction Client Application Program Interface (API). Access to these systems will be via the CMS Traffic Cop application.

Computer Telephony

CTI is not currently in the scope of the NGD development for Releases One and Two. CTI may be integrated in a future release.

Impact on Contractor Resources

Although implementing the NGD will improve the overall efficiency of the call center operations, there will be some short-term impact on resources during the initial implementation. Resources potentially affected include CSRs, trainers, information services and technology staff. A reduction in CSR efficiency is expected during the learning curve of first using the new system. As CSRs become proficient with the new environment, efficiency should improve.

Early in the deployment process CMS and the NGD team will review with each site the expected staffing levels that will be in place when NGD is implemented. Performance measures available from previously deployed locations will be shared to assist in determining potential impact and needed support.

A Deployment Assistance Center (DAC) has been established to support call centers during

NGD implementation. The DAC is staffed with CSRs trained to handle Medicare inquiries from all lines of business. Certain functions may need to be transferred back to the site, however, it is expected the sites deploying NGD will utilize the services provided by the DAC prior to requesting any performance waivers. During the period of implementation, CMS will work with the contractor to determine the support needed from the DAC and relax performance standards where it is still deemed appropriate.

Call Center CSRs

It is expected that CSRs already trained to handle Medicare inquiries will need to attend three-four days of training on the new system. Contractors will continue to provide new CSRs with Medicare program training and any changes to local procedures resulting from NGD. Generally, CSRs will continue to answer the same types of inquiries they currently answer today, so the primary focus of the initial NGD training will be on how to access the same information within the new desktop. Additionally, NGD will offer some enhanced features and functionality which will deliver improved service to CMS customers. Training materials will be provided for any new functionality in NGD. Although contractors can choose to phase in the implementation of any new NGD features, it is expected that CSRs will fully utilize the functionality built within NGD.

Below is a sample of identified changes to pre-NGD procedures:

Publication Requests and General Information – If a CSR is using the MCSC-NGD then all requests for CMS beneficiary-related Medicare publications and alternative CMS products should be ordered via the desktop. If a CSR does not have the MCSC-NGD, but has Internet access, these items should be ordered on-line at www.medicare.gov.

Scripted Responses - The NGD will include standard CMS-approved scripted language for some Medicare topics to be used by CSRs when responding to inquiries. The purpose of scripted language is to ensure accuracy and consistency of the information conveyed by the call centers.

Callbacks Closed - The counting for this CSAMS metric will change for those call centers using MCSC-NGD. Currently this number is based on calls received for the calendar month and represents the number closed within five workdays even if a callback is closed within the first five workdays of the following month. For MCSC-NGD call centers, the desktop will provide a report based on seven calendar days which will be used to satisfy this requirement.

Logging Issues – NGD provides the functionality to log multiple issues on one call. Once NGD Release Two is implemented, many of the high frequency topics or activities worked on a call are automatically logged. There is a need for some manual logging by CSRs. Those conducting quality call monitoring should ensure that CSRs are making use of this additional functionality to log multiple issues. This will provide the call centers and CMS with more accurate and thorough reporting. For quality call monitoring (QCM) purposes,

all logging and coding including the logging of multiple issues is to be recorded under the Call Action portion of the Knowledge Skills Assessment section of the QCM scorecard. Correct logging of calls falls under the performance criteria of "completes call activities".

Ordering a Replacement Medicare Card – The NGD has built in the functionality to allow for a CSR to order a replacement Medicare card. NGD will perform the edit checks for the CSR which will minimize the training needed for this function.

Trainers

This project will use a “Train the Trainer” approach. This approach requires each contractor to provide trainers and training facilities to instruct CSRs, supervisors, quality assurance personnel, and other support staff on how to use the system. Training materials will be provided by CMS. The initial “Train the Trainer” classes (covering each contractor’s primary line of business) will be five days of instruction. An additional two days are required for any added line of business (Part A, Part B, DME). “Train the Trainer” classes will be held in a central location or at contractor locations, if warranted by the number of trainees.

The local call center trainers will have the responsibility to train all CSRs on the NGD. For example, the training may take a phased approach in which some CSRs are trained while others continue to take calls in the current manner. At some point in time an individual call center may have some CSRs utilizing the current methods, some in training, and others using the NGD if a phased approach is followed. Regardless of the approach followed during the period of implementation, CMS will work with each contractor to define the extent of the impact during the transition, [schedule support from the Deployment Assistance Center](#) and relax performance standards where it is deemed appropriate.

The NGD will have the ability to facilitate national web-based training. Contractors who wish to have their locally-developed web-based training accessible directly from the NGD are encouraged to comply with CMS standards. The CMS standards for both print and web-based training design can be found on the Medicare Beneficiary Telephone Customer Service home page @ <http://cms.hhs.gov/callcenters/>. In addition to the PC requirements outlined previously, in order to fully utilize the national web-based training modules, contractors will also need to have an audio player capable of playing .wma files (generally Windows Media Player); sound card and speakers (headphones are suggested); and Microsoft Word 97 or higher.

Local Site Administration

Several administrative functions will be performed at the call center level by contractor personnel. These functions include:

- Creating and Maintaining User Profiles
- Adding User Accounts (includes identifying each user's zip code, state, and time zone)
- Disabling User Accounts
- Adding and Maintaining Personal Information

- Adding, Maintaining and Resetting User Passwords
- Defining and Maintaining User Responsibilities
- Defining and Maintaining User Positions
- Defining the Local Organizational Structure
- Receive Step by Step instructions for Setting up Public Queries
- Creating and Maintaining System User Alerts and Broadcast Messages.
- Initiate Time Out Settings

Helpdesk

Each contractor will be expected to operate a local help desk (Tier One) for NGD. The Tier One Help Desk Analysts are responsible for supporting the call center personnel in resolving issues they experience within the NGD application. This may be incorporated within the contractor's existing helpdesk or defined independently. The local help desk will be expected to triage NGD-related issues to determine if resolution can occur in house and those issues that need to be documented and submitted to the NGD Help Desk (Tier Two).

Local Tier One application support will likely be comparable to existing MCSC-Forte and CustomView sites. Support levels for those locations currently using mainframe applications only will probably increase. The call centers will need to provide Tier One help desk support. Tier One help desk support will be a focal area for each call center and will begin the resolution process. They will help identify if the issue resides at the call center or if it is an issue that must be resolved outside of the call center. If the issue can be resolved locally, then the normal call center process will be followed. If the issue cannot be handled locally, the local help desk will contact the NGD Tier Two Help Desk. The NGD help desk will work to resolve the issue within forthcoming Service Level Agreement standards. If the issue cannot be resolved by the NGD help desk, the NGD helpdesk will contact the appropriate NGD resources (Tier Three), including Siebel and AT&T for MDCN/AGNS issues. Once resolved, the NGD help desk will contact the local help desk so any log entries opened there can be closed

At a minimum, the local help desk will handle:

- Password resets;
- PC and PC software configurations - Tier Two can assist Tier One or provide guidance in correcting the problem, but ultimately it is the responsibility of Tier One to resolve PC configuration/setup issues. The settings must follow NGD and CMS guidelines;
- PC or LAN related problems;
- Proper functioning of local workstations, network and network connections;
- Contacting AT&T for any AT&T Global Network Service (AGNS) issues on the contractor side; and
- Local training and business process issues.

The help desk training provided by the NGD trainers will provide more details on what is expected of the local help desk.

Information Technology

For those sites that currently have PCs on the CSRs' desktops, little, if any, change in demand for infrastructure support is expected. Connectivity between the NGD servers in Louisville, KY and contractor mainframe claims processing systems (i.e. data center) is planned to be via MDCN/AGNS using SNA. Contractor PCs at Call Centers using the NGD will access the NGD servers in Louisville using MDCN/AGNS via IP.

Existing call monitoring applications, such as e-Talk Recorder and Witness eQuality Balance, that are integrated with a call center's Automatic Call Distribution (ACD) system should continue to function with no change.

Impact on Data Center Resources

Contractors shall work with their respective data centers to ensure Data Center staff performs the following tasks in support of the NGD implementation. These tasks include, but are not limited to:

- Provide a Data Center Point of Contact (POC) to coordinate NGD testing and deployment activities;
- Assist in planning for adequate MDCN/AGNS bandwidth and routing changes;
- Create and assign standard system mainframe User IDs per CMS/NGD requirements;
- Provide TN3270, TCP/IP, or SNA connectivity information and create any required SNA LUs to establish the necessary sessions; and
- Ensure that claims systems test regions and test data are available as required for system testing.

After initial testing the following support is required:

- Test regions need to be available during normal business hours beginning when system testing starts and continuing through the deployment of the desktop at all call centers.
- Availability of test regions will also be required for subsequent quarterly releases.
- Ensure system production regions are available by contractor Go Live date(s).
- Ensure system production regions are available during Call Center hours of operation.

NGD Access for Other Departments

It may be desirable for other departments (Correspondence, Benefits Integrity, Medical Review, and so on) to have limited access to the new system. If so, some minimal training for the users from these departments will be required. Using the NGD in other departments will be considered on a case-by-case basis. Other departments will be expected to acquire the necessary NGD Siebel desktop licenses and appropriate PCs within their own budgets.

Security Issues

Call and Data Center

NGD retrieves data from systems, such as the CMS Enrollment Database (EDB) and the SSA Master Beneficiary Record (MBR). These systems are Privacy Act protected and require high levels of security. Data and Call Centers are required to follow strict security controls in their data center implementation to segregate CMS data from other business data and to safeguard the confidentiality, integrity and availability of such data.

NGD Network Traffic and Overview

For MCSC NGD implementation, connectivity must be established between Siebel NGD and SNA (System Network Architecture) servers, the Medicare Data Communications Network (MDCN) and the Medicare Call Center's servicing data center. Currently, the Siebel NGD and SNA gateway servers reside at the AdminaStar Federal Data Center in Louisville, Kentucky.

A Customer Service Representative (CSR), as a NGD user located at the Medicare Call Center, uses a browser-based, thin client with zero footprint to access the Siebel NGD servers. All communications between client and server travel via the MDCN, provided by AT&T Global Network Services (AGNS). This configuration establishes Private Virtual Connection's (PVC) from each Call Center to the NGD Data Center, and between the NGD Data Center and all Medicare Data Centers. Call Centers are directly connected to Louisville NGD via AGNS. Louisville NGD is connected to all host Medicare Data Centers. The Louisville DC queries the host for the information. After Louisville DC gets the information from the host data center, paints the screen and sends the data back to the call center's CSR desktop.

When the Siebel NGD application requests Medicare shared claims processing systems information for an NGD user, the NGD systems' Integration Server acts on behalf of the NGD user and utilizes a CICS transaction-based approach to retrieve the requested information. This SNA connection communicates directly with the Medicare shared claims processing systems (MCS, VMS, FISS) via the MDCN, to process the NGD users' information request.

NGD update requests to Medicare shared claims processing systems are limited to users within the local call center, as controlled by their specific Local System Administrator and their local NGD security profile. Therefore, updates are allowed only to native users. **Non-native call center NGD users (e.g. other Medicare Call Centers) will have read-only access to the specific data center's Medicare systems as described in the Mainframe ID's paragraph below.** Memorandums of understanding between the data center and call center contractors will be needed prior to NGD's authorization (or capability) to update Medicare shared claims processing systems that are not native to the NGD user. If this non-native update capability becomes necessary, CMS will work with call center contractors to establish these memorandums of understanding.

Mainframe IDs

The Siebel application identifies the information's requester and determines the source required to fulfill the information request. This information is passed to the Integration Server, which establishes a session between NGD Data Center and the source Data Center. The Integration Server uses an established Logical Unit (LU) connection from available LU session pools. Each Data Center will be assigned a specific number of LU session IDs, which will be assigned and controlled by AGNS.

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The session pool concept is referred to as Master ID since only a limited number of sessions are available for a larger number of users sessions. Master IDs are used by NGD Integration Servers, which acts in behalf of NGD users, to access the source Data Center's mainframe. Master IDs have been successfully implemented within other CMS applications with similar large user base and technical requirements. It is important to note that allowing NGD users read-only access to other Medicare contractors databases is not a new idea, and in theory the NGD read-only access is not too different than the shared access that all Medicare contractors have to the Common Working File (CWF).

The Data Center's System Administrators restricts and controls access to the shared claims processing systems housed at their data center, thus protecting the Government's Medicare claims information that they have been entrusted to maintain. **It is the Data and Call Centers System Administrators' responsibility to establish, add, and maintain the NGD-provided LU sessions and Master IDs on the mainframe's security software for NGD access as needed for development, validation, training, and production.** The benefit of establishing and maintaining a limited number of LU IDs and Master IDs for each Call Center, versus establishing individual accounts for each NGD user, results in reduced administrative tasks and costs.

NGD Security Responsibilities

The NGD Contractor (currently AdminaStar Federal) is responsible for the security controls within NGD. **It is National NGD Security Administrators' responsibility to establish, add maintain, and track the AGNS-provided LU sessions and Master Ids for all Medicare contractors on the applicable NGD software, (e.g., Siebel server, Jacada server, etc.).** The NGD software is developed to enable each Call Center to grant security access to its files, and will only retrieve/display data defined within the security access granted. Security tests have been developed to ensure access controls mechanisms are in place and operating as intended.

Stringent controls and monitoring processes will be in place to ensure that only assigned personnel gain access to the range of IDs assigned to their Center. Those transactions will be performed in NGD's authentication servers within a secured environment.

The NGD system generates transaction logs with information to fulfill user traceability

requirements. The Siebel server, Integration server, and CICS/SNA gateway logs will document the transactions being performed, who performed them, when they were performed, what User ID and what LU session, host, and system were used to perform the transaction. This logging supports the use of Master IDs within the NGD, providing individual accountability for NGD users. Auditing will be performed within the NGD network and will provide a trace mechanism for the Medicare shared claims processing systems to validate users.

Security Oversight

Oversight and separation of duties for NGD security will be accomplished by:

- (1) Establishing System Administrators for Call and Data Centers, when applicable, with access only to the range of IDs designated for their Center;
- (2) Establishing a National NGD Security Administrator responsible for establishing user IDs and granting security access to Call and Data Center's System Administrators; and
- (3) Designating a third-party to audit security functions and logs, including the National NGD Security Administrator.

Shared/Standard System Issues

The Next Generation Desktop relies on extensive interfaces with many standard Medicare systems, operated by CMS as well as contractors. In order to make each contractor's deployment to the NGD as problem-free as possible, it would be helpful if each contractor provided systems documentation for any changes or customizations that they have made to the standard system. By providing this documentation during the discovery period, it will allow the NGD developers to make any necessary adaptations before deployment. Once a site has implemented NGD, the NGD team will need to be made aware of any local planned changes to these shared systems well in advance. This will allow time to make sure that the interfaces with the shared systems continue to perform correctly.

NGD updates will occur quarterly and will follow the release schedule used for the shared system updates. Once the NGD is implemented, contractors are requested to inform the NGD team of any notifications of changes being planned to the standard systems currently accessed. This will serve as a backup to the current process CMS has in place for notification of systems changes. It is important that the NGD sites work closely with the NGD team to coordinate any additional testing needed specific to NGD in conjunction with testing for the shared system quarterly releases.

Implementation Planning and Support

Implementation of the NGD will represent significant change for many call centers. Managers and staff will need to be available for pre-implementation meetings (e.g., conference calls, in-house meetings, completion of surveys, etc.), to provide information about the site in general,

the technology used, and to plan for the rollout of the NGD. To minimize the impact of this change, at a minimum, the call centers will be provided with the following assistance:

- Planning for functional, technical, and business process change;
- Deployment Notebook detailing key aspects of the deployment process;
- Deployment Checklist/Project Plan and updates to the project plan;
- Regularly scheduled NGD specific conference calls;
- Training assistance as described above; and
- 24 x 7 post-implementation support (on site, if required).

Future Changes to the Next Generation Desktop

The CMS will implement an NGD Change Control Board that will include representation from the contractor community. Change requests can be submitted in a variety of ways: feedback forms within the NGD system, change requests submitted to the NGD helpdesk and participation in user acceptance testing and functional workgroup meetings. The change control procedures will be provided in the call center deployment notebook for further reference. New releases of the NGD are expected to follow the current standard mainframe system quarterly release schedule.

Retirement of Redundant Systems

After implementation of the NGD, several existing systems will become redundant. These include the current MCSC Forte application, the 1-800 GT-X application and **some of the** CustomView implementations. There may be other contractor or call center specific applications that will also become redundant. Retirement of these redundant applications may involve archival of data and disposition of any surplus hardware. The CMS and the affected contractors will determine the specific tasks required.

Beneficiary Telephone Inquiries Workload

Beneficiary Telephone Inquiries workload (Workload 1) is the cumulative inquiries as reported on the CMS-1566, Line 35, Beneficiary Column.

Beneficiary Written Inquiries (Activity Code 13002)

The instructions for beneficiary written inquiries are contained in MIM Section, 2958.B. Also refer to the Activity Dictionary (Attachment 1 to the BPRs) for the lists of tasks for this activity. Please note that in FY 2004 only beneficiary written inquiries should be reported in Activity Code 13002. Provider Written Inquiries should be reported using Activity Code 33002.

Workload

Written Inquiries workload (Workload 1) is the cumulative inquiries as reported on CMS-1566

Line 37, Beneficiary Column.

Walk-In Inquiries (Activity Code 13003)

The instructions for walk-in inquiries are contained in MIM, Section 2958.C. Also refer to the Activity Dictionary (Attachment 1 to the BPRs) for the lists of tasks for this activity. Please note that in FY 2004 only beneficiary walk-in inquiries should be reported in Activity Code 13003. Provider Walk-In inquiries should be reported using Activity Code 33003.

Workload

Walk-In Inquiries workload (Workload 1) is the cumulative inquiries as reported on the CMS-1566, Line 36, Beneficiary Column.

Customer Service Plans (Activity Code 13004)— Include Your Annual CSP and Costs for Customer Service Plan Activities in Your Budget Request.

Refer to the Activity Dictionary (Attachment 1 to the BPRs) for the lists of tasks for this activity.

FY 2004 CSP funding will be at the same level as that for FY 2003 CSP funding. Contractors who wish to continue CSP activities for FY 2004 should submit an annual CSP to their Associate Regional Administrators for Beneficiary Services. There is no national format for the CSPs and copies of the CSP should not be sent to CMS headquarters. Plans should be as innovative as possible and propose only the most effective education and outreach activities. For those contractors whose service areas cross CMS regional lines, contractors should not restrict their CSP activities to the local RO area. Within their CSP budget, these contractors should include activities that would have the greatest impact for beneficiaries in their entire geographic service area. Each regional office will decide the CSP funding level for their contractors.

Those contractors receiving funding should utilize their resources in the following beneficiary efforts including but not limited to:

- Establish partnerships and collaborate with local and national coalitions and beneficiary counseling and assistance groups;
- Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries; and
- Work with appropriate Congressional staffs to resolve beneficiary issues with Medicare.

Due to the diversity of the Medicare beneficiary population, these activities have not been prioritized. Be prepared to discuss this plan with your regional office.

Second Level Screening of Beneficiary and Provider Inquiries (Activity Code 13201) (CR 2719):

The Medicare fee-for-service contractor reports all costs associated with second level screening of inquiries for both beneficiaries and providers in Activity Code 13201. Report the number of second level screening of beneficiary inquiries in workload column 1; report the total number of medical records ordered for beneficiary inquiries in workload column 2; and report the total number of potential fraud and abuse beneficiary complaints identified and referred to the Program Safeguard Contractor (PSC) in workload column 3.

Second Level Screening of Provider Inquiries (Miscellaneous Code 13201/01):

The Medicare fee-for-service contractor must keep a record of the cost and workload associated for all provider inquiries of potential fraud and abuse that are referred to the PSC or Medicare fee-for-service contractor Benefit Integrity Unit in Miscellaneous Code 13201/01.

**FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT**

Provider Inquiries (Intermediary)

In keeping with our FY 2003 efforts, we are maintaining our pursuit of providing improved service to all Medicare Providers. The Provider Inquiries instructions in Section 2959 of the Medicare Intermediary Manual, together with these BPRs, identify the work to be performed in FY 2004. In FY 2004, the Provider Inquiries BPRs will again incorporate Activity Based Costing (ABC) in the budget process. ABC identifies the all inclusive business process for each activity so that the total costs of the activity are fully visible. Business processes are defined for each Provider Inquiries Activity Code and are included in the Activity Dictionary (Attachment 1 to the BPRs). Call Center managers should identify only those costs associated with Activity Code definition to ensure the integrity of the ABC process.

CMS expects that each Intermediary will prioritize its workload in such a manner to ensure high quality service to all providers. CMS expects that each Intermediary will continue to prioritize its provider inquiry workloads in the following sequential manner:

- 1) Provider Telephone Inquiries
 - i. Answering Provider Telephone Inquiries
 - ii. Quality Call Monitoring Performance Measures
 - iii. Staff Development and Training
- 2) Provider Written Inquiries
- 3) Provider Walk-In Inquiries

Please note the following additions/revisions to the current provider inquiries manual instruction. The MIM will be updated to reflect these changes.

Answering Provider Telephone Inquiries (Activity Code 33001)

Manual Reference: MIM §2959.C.1-4, MIM §2959.C.6, MIM §2959.C.9-12, MIM §2959.D.1-3

Additions/Revisions for FY04:

NOTE: All Equipment and Maintenance Costs should also be reported under Code 33001.

1. Provider Satisfaction Survey

Contractors must have the ability to incorporate a short CMS-created provider satisfaction survey in their Interactive Voice Response Unit (IVR) to be accessed either by a transfer from the Customer Service Representative (CSR). The survey will use touch-tones, therefore speech

recognition is not required to meet this requirement. Contractors who cannot comply with this requirement should contact CMS through the ServiceReports mailbox at servicereports@cms.hhs.gov by October 31, 2003 with a total breakdown of the costs to implement such a system.

2. IVR Quality Control

During FY 2004, CMS will begin to evaluate the quality of the contractors' IVRs. These evaluations will be based on the following:

- IVR Availability;
- Accuracy of the information provided;
- Timeliness of the information provided;
- Quality of the information provided; and
- Tone

3. Call Flow--Soft Busies

Call center customer premise equipment should not be configured/programmed to return "soft busies," i.e. at no time shall any software, gate, vector, application, IVR, and/or ACD/PBX accept a call by providing answer back supervision to the FTS network and then subsequently provide a busy signal to the caller and/or drop the call. Soft busies are currently counted as complete calls by WorldCom and inaccurately depicts the call traffic situation. Understanding there may be circumstances where the incoming call volume overwhelms the contractor call centers' resources, the contractor may initiate a "hard busy," e.g. busying out circuits at the PBX, thus returning an all trunks busy (ATB) to the FTS network.

4. Core Hours of Operation

Make live telephone service available to callers continuously during normal business hours. The minimal "normal business hours" for live telephone service are defined as 8:00 a.m. through 4:30 p.m. Monday through Friday for all time zones of the geographical area serviced. Our analysis shows the most contractors are already operating beyond these hours so we do not expect budgetary impact. Where contractors provide national coverage or where contractors serve areas outside of the continental United States, CMS will entertain waiver requests related to standard hours of operation. Contractors who received approval of their waiver requests in FY 2003 can assume approval in FY 2004. Please include a statement of your understanding of that waiver approval in your narrative justification with your budget request.

5. Interactive Voice Response Units (IVR):

With automated tools available for improving customer service while simultaneously managing cost, the contractor shall develop and implement self-service capabilities through the utilization of IVRs. For this reason, all contractors are required to utilize an IVR.

IVR Availability

The IVR should be available to providers 24 hours a day with allowances for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance. When information is not available, contractors should provide a message alerting providers.

IVR Requirements

- IVR service is intended to assist providers in obtaining answers to various Medicare questions, including those listed below. **NOTE:** IVRs (or ACDs) should be updated to address areas of provider concern as determined by contractors' inquiry analysis program and CMS best practices.
 - ✓ Contractor hours of operation for CSR service.
 - ✓ General Medicare program information. (**NOTE:** Contractors must target message duration to be under 30 seconds. Contractor should have the technical capability to either require callers to listen or to allow them to bypass the message as determined by CMS. In cases where CMS makes no determination the contractor should use their own discretion.)
 - ✓ General information about appeal rights and actions required of a provider to exercise these rights.
 - ✓ Specific information about claims in process and claims completed. (**NOTE:** Contractors must also indicate how they are authenticating the call when claim specific information is involved. A copy should be sent to both the contractor's Regional Office contact and to the Service Reports mailbox at servicereports@cms.hhs.gov by October 31, 2003.)
 - Contractors must have a readily understood IVR operating guide to distribute to providers upon request. The guide should also be posted on the contractor's website.
 - Contractors who are able to provide claims status information through their IVR should require providers to use their IVR to obtain this information.

Those contractors not currently using an IVR should provide a total breakdown of the costs associated with installing an IVR that meets the requirements outlined above and in §2959 of the MIM. This figure should be clearly identified as part of their FY 2004 budget request.

6. General Provider Toll Free Number for General Inquiries Only

The provider toll free numbers installed for Part A, Part B, DMERC, and RHHI general

provider inquiry traffic shall not be used for other applications (e.g. MSP, Reviews, EDI, Provider Enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. Complex questions (ones that might currently require an internal transfer) should be directed to the "other" units on a different toll free number than the general inquiry number. It is not necessary for each "other" function to have its own unique toll free number, although contractors can choose this option. Other acceptable options are having a single "other" toll free number to handle all the "other" (non general inquiry) functions or a few "other" toll free numbers handling more than one "other" function via each number. CSRs on the general inquiry line shall not transfer callers to the "other" functional units but rather should instruct the caller to hang up and dial the appropriate number. "Other" numbers will not be subject to CSAMS reporting or the call performance standards that govern the general inquiries line. If contractors need toll free service for other Medicare applications currently being handled on the provider claims inquiry toll free numbers, please follow the established process for adding additional toll free numbers outlined in §5105 of the MCM. We will consider all requests for additional toll free numbers.

7. Contact Person

Contractors shall appoint a primary customer service contact person to CMS; this would normally be the call center manager. The contact's name, business address, business telephone number, and e-mail should be submitted to the ServiceReports mailbox at servicereports@cms.hhs.gov and to the Regional Office by October 31, 2003. The contact should submit an organizational chart for call center's provider inquiry function to the ServiceReports mailbox by October 31, 2003. If the contact person is replaced, the contractor must submit the new contact information to the ServiceReports mailbox and to the Regional Office within two weeks of the change.

8. Contingency of Operations Plans

All contractors must have, or develop, a written contingency plan describing how the Medicare Provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The plan should cover partial loss of telecommunications capabilities due to equipment or network failures through the total loss of a call center. The plan can include arrangements with one or more other contractors to assist in telephone workload management during the time the call center is unable to receive provider phone calls. All plans must be submitted to the ServiceReports mailbox at servicereports@cms.hhs.gov, with a copy to the Regional Office by December 31, 2003. Contractors may choose to submit the portion of their contingency plan developed under Activity Code 11206 that deals with their call center. In the event that the contractor develops a different plan related only to their call center, these costs should be charged to 33001, not 11206.

9. Call Handling Measures

- For callers choosing to talk with a CSR, 85% or more telephone calls shall be answered within the first 60 seconds.
- Each month, contractors shall handle no less than 90 percent of calls to completion during the initial call -- minimizing transfers, referrals and callbacks.
- Every call center must have a call completion rate of no less than 80%.

10. Medicare Customer Service Center Next Generation Desktop (MCSC-NGD)

CMS is developing a new MCSC-NGD application to be deployed at Medicare contractor sites. The new desktop will allow Customer Service Representatives (CSRs) to answer written, telephone, and walk-in inquiries from both providers and beneficiaries. The NGD application will enable CSRs to address, at a minimum, the same general Medicare and claims inquiries currently handled, but in a more user-friendly and efficient manner. The NGD is being developed on requirements gathered from call center personnel currently handling telephone, written, and walk-in inquiries. Although NGD may be found useful by other components interacting with the telephone and written inquiries areas, specific requirements are not being identified for those areas.

The initial rollout of NGD will provide contractors with access to information from the VIPS Medicare System (VMS), Fiscal Intermediary Standard System (FISS), and Multi Carrier System (MCS) claims processing systems used today. Initially contractors will only access information to perform the functions required within their existing workload. However, the technology being built into the NGD will ultimately allow contractors to access claim information outside their service areas and to access additional CMS databases once those business processes have been defined. This increased access will enable contractors to support each other in times of heavy call volumes, disaster situations, emergency closings, and any other downtime as well as to handle more of the calls currently being blocked in the network. As NGD is rolled out, those contractors utilizing NGD will have call history information displayed for beneficiaries and providers who have previously contacted other sites using NGD. For example, call history in Ohio will be visible to both the Carrier and the Intermediary Call Centers for Ohio after both Call Centers begin utilizing NGD. The call history information does not contain claim information, only a record of and reason for the call.

To ensure ongoing operations are consistent with CMS's call center strategy, any contractor call center purchases or developmental costs for hardware, software, or other telecommunications technology that equals or exceeds \$10,000 in a fiscal year require prior approval by CMS. This includes development of existing or new desktop applications. Contractors shall submit all such requests to the servicing regional office (RO) for review. The RO shall forward all recommendations for approval to the Director, Beneficiary Information Services Group (BISG), central office (CO) for a final decision. Provider call center purchases or development costs for

hardware, software or other telecommunication technology that exceeds \$10,000 should be forwarded, for final approval, to the Division of Provider Education and Training.

Implementation Approach and Schedule

Since the NGD will continue to be rolled out to contractors throughout FY 2004, contractors must include NGD implementation costs in the FY 2004 budget requests. These costs must be included in Activity Code 33001 and also reported using Miscellaneous Code 33001/01 so that they can be separately identified as NGD implementation costs. The MIM, Section 2959, Change Request 2079 Program Memorandum, Subject: Installation of a New MCSC Next Generation Medicare Desktop Application and Change Request 2390 Program Memorandum, Subject: Next Generation Desktop Data Center Connectivity – Security Information Clarification contain more detailed instructions describing NGD implementation functions.

Contractors utilizing the MCSC-Forte desktop application should budget for minimal support and maintenance of that application until call centers are transitioned over to MCSC-NGD.

Call centers will be notified at a minimum of six months in advance of beginning deployment discussions. Call centers will be implemented with consideration to business impact to the Medicare program as a whole. Input from contractors regarding the desired timing of implementation will be considered, as well as, other implementation activity and specific circumstances of each call center.

Centers Using Non-Standard Claims Processing Systems

Currently, plans provide for the NGD to support FISS, MCS, and VMS (Part B and DMERC) claims processing systems. Centers using other systems will not implement the NGD until they have converted to one of these standard systems.

Technical Considerations

Hardware

The hardware necessary to implement the NGD application includes Siebel Systems' eHealthcare product, centrally-located servers, and personal computers (PCs).

Siebel

The NGD is being built using Siebel Systems' eHealthcare product. This product employs a "zero footprint" Web-based client, which means that no specialized hardware or software is required on the agents' desks other than a typical Personal Computer (PC) and a Web browser. PCs that will be used to generate correspondence will also require Microsoft Word '97, or a higher version of Word, which will be the responsibility of the Medicare contractor to procure. CMS is purchasing the necessary Siebel software licenses and ongoing Siebel software maintenance contracts.

Servers

All servers needed to run the NGD application will be centrally-located (initially at the AdminaStar Federal data center in Louisville, KY). Each call center site will access the servers via the Medicare Data Communications Network (MDCN); CMS currently uses AT&T Global Network Services (AGNS) to provide service to the MDCN. Prior to implementation, each call center's network configuration will be evaluated to ensure that sufficient network bandwidth will be available.

Firewalls

All Internet Protocol (IP) access to the MDCN/AGNS network will be firewall protected. Each call center will be responsible for the installation and configuration of a firewall solution between themselves and the MDCN/AGNS network. Call centers will access the NGD system via IP. The NGD will provide access to the mainframe processing systems at the data centers via IBM's System Network Architecture (SNA). SNA connectivity will not require firewall protection. Future plans may include access to the mainframe processing systems via IP; however, CMS will work closely with the data centers if and when this option becomes available. The contractors are only responsible for having the firewall(s) implemented at their call centers and/or data centers.

Personal Computers

NGD Personal Computer (PC) Requirements – Following are updated PC software requirements for MCSC-NGD. These requirements supercede those listed in Change Request 2079 dated 5/16/02 and the Medicare Carrier Manual. The only additional software requirements for FY2004 are the Microsoft Word and Adobe Acrobat viewers which can be downloaded free of charge. **Consideration will be required for coexisting software applications in addition to NGD. The system requirements may increase based on these additional applications. Please consult the software vendor for this information and make appropriate modifications to these requirements on the basis of that information.**

Requirements for an NGD Personal Computer	
Processor:	500MHz Pentium III or comparable AMD 800MHz Celeron or comparable AMD
Disk Space:	100MB available
Memory:	224MB for Windows 2000 288 MB for Windows XP
Operating System:	Windows 2000 Service Pack 2 OR Windows XP Service Pack 1
Browser:	Internet Explorer 5.5 Service Pack 2; Q323759 OR Internet Explorer 6 Service Pack 1; Q810847

Monitor:	21"
Pointing Device:	Mouse with scroll
Network Interface:	Network Interface Card compatible with the call center LAN, which will ultimately allow workstation access to MDCN
Word Processor:	Microsoft Word '97 (or higher version) – Required only for generation of correspondence.
Viewers:	Microsoft Word Viewer (provided free by Microsoft) and Adobe Acrobat Reader (v4.05 or v5.0 free from Adobe) are required.

Integration Methods

Standard Systems

Integration between the NGD and VMS, CWF, MCS, and FISS will be accomplished using Jacada's Integrator software product. Jacada uses TN3270 sessions to work with these systems. This allows NGD to be implemented without any changes to the standard systems. Access to CWF will be through the claims systems. The NGD Integration Layer will log and time-stamp all interactions, recording the NGD user, the back-end system user, and the transaction being performed along with the transaction's data. Integration with EDB and MBR will be done using IBM CICS Transaction Client Application Program Interface (API). Access to these systems will be via the CMS Traffic Cop application.

Computer Telephony

CTI is not currently in the scope of the NGD development for Releases One and Two. CTI may be integrated in a future release.

Impact on Contractor Resources

Although implementing the NGD will improve the overall efficiency of the call center operations, there will be some short-term impact on resources during the initial implementation. Resources potentially affected include CSRs, trainers, information services and technology staff. A reduction in CSR efficiency is expected during the learning curve of first using the new system. As CSRs become proficient with the new environment, efficiency should improve.

Early in the deployment process CMS and the NGD team will review with each site the expected staffing levels that will be in place when NGD is implemented. Performance measures available from previously deployed locations will be shared to assist in determining potential impact and needed support.

A Deployment Assistance Center (DAC) has been established to support call centers during NGD implementation. The DAC is staffed with CSRs trained to handle Medicare inquiries from all lines of business. Certain functions may need to be transferred back to the site, however, it is expected the sites deploying NGD will utilize the services provided by the DAC

prior to requesting any performance waivers. During the period of implementation, CMS will work with the contractor to determine the support needed from the DAC and relax performance standards where it is still deemed appropriate.

Call Center CSRs

It is expected that CSRs already trained to handle Medicare inquiries will need to attend three-four days of training on the new system. Contractors will continue to provide new CSRs with Medicare program training and any changes to local procedures resulting from NGD. Generally, CSRs will continue to answer the same types of inquiries they currently answer today, so the primary focus of the initial NGD training will be on how to access the same information within the new desktop. Additionally, NGD will offer some enhanced features and functionality which will deliver improved service to CMS customers. Training materials will be provided for any new functionality in NGD. Although contractors can choose to phase in the implementation of any new NGD features, it is expected that CSRs will fully utilize the functionality built within NGD.

Below is a sample of identified changes to pre-NGD procedures:

Publication Requests and General Information – If a CSR is using the MCSC-NGD then all requests for CMS beneficiary-related Medicare publications and alternative CMS products should be ordered via the desktop. If a CSR does not have the MCSC-NGD, but has Internet access, these items should be ordered on-line at www.medicare.gov.

Scripted Responses - The NGD will include standard CMS-approved scripted language for some Medicare topics to be used by CSRs when responding to inquiries. The purpose of scripted language is to ensure accuracy and consistency of the information conveyed by the call centers.

Callbacks Closed - The counting for this CSAMS metric will change for those call centers using MCSC-NGD. Currently this number is based on calls received for the calendar month and represents the number closed within five workdays even if a callback is closed within the first five workdays of the following month. For MCSC-NGD call centers, the desktop will provide a report based on seven calendar days which will be used to satisfy this requirement.

Logging Issues – NGD provides the functionality to log multiple issues on one call. Once NGD Release Two is implemented, many of the high frequency topics or activities worked on a call are automatically logged. There is a need for some manual logging by CSRs. Those conducting quality call monitoring should ensure that CSRs are making use of this additional functionality to log multiple issues. This will provide the call centers and CMS with more accurate and thorough reporting. For quality call monitoring (QCM) purposes, all logging and coding including the logging of multiple issues is to be recorded under the Call Action portion of the Knowledge Skills Assessment section of the QCM scorecard. Correct logging of calls falls under the performance criteria of "completes call activities".

Ordering a Replacement Medicare Card – The NGD has built in the functionality to allow for a CSR to order a replacement Medicare card. NGD will perform the edit checks for the CSR which will minimize the training needed for this function.

Trainers

This project will use a “Train the Trainer” approach. This approach requires each contractor to provide trainers and training facilities to instruct CSRs, supervisors, quality assurance personnel, and other support staff on how to use the system. Training materials will be provided by CMS. The initial “Train the Trainer” classes (covering each contractor’s primary line of business) will be five days of instruction. An additional two days are required for any added line of business (Part A, Part B, DME). “Train the Trainer” classes will be held in a central location or at contractor locations, if warranted by the number of trainees.

The local call center trainers will have the responsibility to train all CSRs on the NGD. For example, the training may take a phased approach in which some CSRs are trained while others continue to take calls in the current manner. At some point in time an individual call center may have some CSRs utilizing the current methods, some in training, and others using the NGD if a phased approach is followed. Regardless of the approach followed during the period of implementation, CMS will work with each contractor to define the extent of the impact during the transition, schedule support from the Deployment Assistance Center and relax performance standards where it is deemed appropriate.

The NGD will have the ability to facilitate national web-based training. Contractors who wish to have their locally-developed web-based training accessible directly from the NGD are encouraged to comply with CMS standards. The CMS standards for both print and web-based training design can be found on the Medicare Beneficiary Telephone Customer Service home page @ <http://cms.hhs.gov/callcenters/>. In addition to the PC requirements outlined previously, in order to fully utilize the national web-based training modules, contractors will also need to have an audio player capable of playing .wma files (generally Windows Media Player); sound card and speakers (headphones are suggested); and Microsoft Word 97 or higher.

Local Site Administration

Several administrative functions will be performed at the call center level by contractor personnel. These functions include:

- Creating and Maintaining User Profiles;
- Adding User Accounts (includes identifying each user's zip code, state, and time zone);
- Disabling User Accounts;
- Adding and Maintaining Personal Information;
- Adding, Maintaining and Resetting User Passwords;

- Defining and Maintaining User Responsibilities;
- Defining and Maintaining User Positions;
- Defining the Local Organizational Structure;
- Receive Step by Step instructions for Setting up Public Queries;
- Creating and Maintaining System User Alerts and Broadcast Messages; and
- InitiateTime Out Settings.

Helpdesk

Each contractor will be expected to operate a local help desk (Tier One) for NGD. The Tier One Help Desk Analysts are responsible for supporting the call center personnel in resolving issues they experience within the NGD application. This may be incorporated within the contractor's existing helpdesk or defined independently. The local help desk will be expected to triage NGD-related issues to determine if resolution can occur in house and those issues that need to be documented and submitted to the NGD Help Desk (Tier Two).

Local Tier One application support will likely be comparable to existing MCSC-Forte and CustomView sites. Support levels for those locations currently using mainframe applications only will probably increase. The call centers will need to provide Tier One help desk support. Tier One help desk support will be a focal area for each call center and will begin the resolution process. They will help identify if the issue resides at the call center or if it is an issue that must be resolved outside of the call center. If the issue can be resolved locally, then the normal call center process will be followed. If the issue cannot be handled locally, the local help desk will contact the NGD Tier Two Help Desk. The NGD help desk will work to resolve the issue within forthcoming Service Level Agreement standards. If the issue cannot be resolved by the NGD help desk, the NGD helpdesk will contact the appropriate NGD resources (Tier Three), including Siebel and AT&T for MDCN/AGNS issues. Once resolved, the NGD help desk will contact the local help desk so any log entries opened there can be closed

At a minimum, the local help desk will handle:

- Password resets;
- PC and PC software configurations - Tier Two can assist Tier One or provide guidance in correcting the problem, but ultimately it is the responsibility of Tier One to resolve PC configuration/setup issues. The settings must follow NGD and CMS guidelines;
- PC or LAN related problems;
- Proper functioning of local workstations, network and network connections;
- Contacting AT&T for any AT&T Global Network Service (AGNS) issues on the contractor side; and
- Local training and business process issues.

The help desk training provided by the NGD trainers will provide more details on what is expected of the local help desk.

Information Technology

For those sites that currently have PCs on the CSRs' desktops, little, if any, change in demand for infrastructure support is expected. Connectivity between the NGD servers in Louisville, KY and contractor mainframe claims processing systems (i.e.data center) is planned to be via MDCN/AGNS using SNA. Contractor PCs at Call Centers using the NGD will access the NGD servers in Louisville using MDCN/AGNS via IP.

Existing call monitoring applications, such as e-Talk Recorder and Witness eQuality Balance, that are integrated with a call center's Automatic Call Distribution (ACD) system should continue to function with no change.

Impact on Data Center Resources

Contractors shall work with their respective data centers to ensure Data Center staff performs the following tasks in support of the NGD implementation. These tasks include, but are not limited to:

- Provide a Data Center Point of Contact (POC) to coordinate NGD testing and deployment activities;
- Assist in planning for adequate MDCN/AGNS bandwidth and routing changes;
- Create and assign standard system mainframe User IDs per CMS/NGD requirements;
- Provide TN3270, TCP/IP, or SNA connectivity information and create any required SNA LUs to establish the necessary sessions; and
- Ensure that claims systems test regions and test data are available as required for system testing.

After initial testing the following support is required:

- Test regions need to be available during normal business hours beginning when system testing starts and continuing through the deployment of the desktop at all call centers. Availability of test regions will also be required for subsequent quarterly releases.
- Ensure system production regions are available by contractor Go Live date(s).
- Ensure system production regions are available during Call Center hours of operation.

NGD Access for Other Departments

It may be desirable for other departments (Correspondence, Benefits Integrity, Medical Review, and so on) to have limited access to the new system. If so, some minimal training for the users from these departments will be required. Using the NGD in other departments will be considered on a case-by-case basis. Other departments will be expected to acquire the necessary NGD Siebel desktop licenses and appropriate PCs within their own budgets.

Security Issues

Call and Data Center

NGD retrieves data from systems, such as the CMS Enrollment Database (EDB) and the SSA Master Beneficiary Record (MBR). These systems are Privacy Act protected and require high levels of security. Data and Call Centers are required to follow strict security controls in their data center implementation to segregate CMS data from other business data and to safeguard the confidentiality, integrity and availability of such data.

NGD Network Traffic and Overview

For MCSC-NGD implementation, connectivity must be established between Siebel NGD and SNA (System Network Architecture) servers, the Medicare Data Communications Network (MDCN) and the Medicare Call Center's servicing data center. Currently, the Siebel NGD and SNA gateway servers reside at the AdminaStar Federal Data Center in Louisville, Kentucky.

A Customer Service Representative (CSR), as a NGD user located at the Medicare Call Center, uses a browser-based, thin client with zero footprint to access the Siebel NGD servers. All communications between client and server travel via the MDCN, provided by AT&T Global Network Services (AGNS). This configuration establishes Private Virtual Connection's (PVC) from each Call Center to the NGD Data Center, and between the NGD Data Center and all Medicare Data Centers. Call Centers are directly connected to Louisville NGD via AGNS. Louisville NGD is connected to all host Medicare Data Centers. The Louisville DC queries the host for the information. After Louisville DC gets the information from the host data center, paints the screen and sends the data back to the call center's CSR desktop.

When the Siebel NGD application requests Medicare shared claims processing systems information for an NGD user, the NGD systems' Integration Server acts on behalf of the NGD user and utilizes a CICS transaction-based approach to retrieve the requested information. This SNA connection communicates directly with the Medicare shared claims processing systems (MCS, VMS, FISS) via the MDCN, to process the NGD users' information request.

NGD update requests to Medicare shared claims processing systems are limited to users within the local call center, as controlled by their specific Local System Administrator and their local NGD security profile. Therefore, updates are allowed only to native users. **Non-native call**

center NGD users (e.g. other Medicare Call Centers) will have read-only access to the specific data center's Medicare systems as described in the Mainframe ID's paragraph below. Memorandums of understanding between the data center and call center contractors will be needed prior to NGD's authorization (or capability) to update Medicare shared claims processing systems that are not native to the NGD user. If this non-native update capability becomes necessary, CMS will work with call center contractors to establish these memorandums of understanding.

Mainframe IDs

The Siebel application identifies the information's requester and determines the source required to fulfill the information request. This information is passed to the Integration Server, which establishes a session between NGD Data Center and the source Data Center. The Integration Server uses an established Logical Unit (LU) connection from available LU session pools. Each Data Center will be assigned a specific number of LU session IDs, which will be assigned and controlled by AGNS.

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The session pool concept is referred to as Master ID since only a limited number of sessions are available for a larger number of users sessions. Master IDs are used by NGD Integration Servers, which acts in behalf of NGD users, to access the source Data Center's mainframe. Master IDs have been successfully implemented within other CMS applications with similar large user base and technical requirements. It is important to note that allowing NGD users read-only access to other Medicare contractors databases is not a new idea, and in theory the NGD read-only access is not too different than the shared access that all Medicare contractors have to the Common Working File (CWF).

The Data Center's System Administrators restricts and controls access to the shared claims processing systems housed at their data center, thus protecting the Government's Medicare claims information that they have been entrusted to maintain. **It is the Data and Call Centers System Administrators' responsibility to establish, add, and maintain the NGD-provided LU sessions and Master IDs on the mainframe's security software for NGD access as needed for development, validation, training, and production.** The benefit of establishing and maintaining a limited number of LU IDs and Master IDs for each Call Center, versus establishing individual accounts for each NGD user, results in reduced administrative tasks and costs.

NGD Security Responsibilities

The NGD Contractor (currently AdminaStar Federal) is responsible for the security controls within NGD. **It is National NGD Security Administrators' responsibility to establish, add maintain, and track the AGNS-provided LU sessions and Master Ids for all Medicare contractors on the applicable NGD software, (e.g., Siebel server, Jacada server, etc.).** The NGD software is developed to enable each Call Center to grant security access to its files, and will only retrieve/display data defined within the security access granted. Security tests have

been developed to ensure access controls mechanisms are in place and operating as intended.

Stringent controls and monitoring processes will be in place to ensure that only assigned personnel gain access to the range of IDs assigned to their Center. Those transactions will be performed in NGD's authentication servers within a secured environment.

The NGD system generates transaction logs with information to fulfill user traceability requirements. The Siebel server, Integration server, and CICS/SNA gateway logs will document the transactions being performed, who performed them, when they were performed, what User ID and what LU session, host, and system were used to perform the transaction. This logging supports the use of Master IDs within the NGD, providing individual accountability for NGD users. Auditing will be performed within the NGD network and will provide a trace mechanism for the Medicare shared claims processing systems to validate users.

Security Oversight

Oversight and separation of duties for NGD security will be accomplished by:

- (1) Establishing System Administrators for Call and Data Centers, when applicable, with access only to the range of IDs designated for their Center;
- (2) Establishing a National NGD Security Administrator responsible for establishing user IDs and granting security access to Call and Data Center's System Administrators; and
- (3) Designating a third-party to audit security functions and logs, including the National NGD Security Administrator.

Shared/Standard System Issues

The Next Generation Desktop relies on extensive interfaces with many standard Medicare systems, operated by CMS as well as contractors. In order to make each contractor's deployment to the NGD as problem-free as possible, it would be helpful if each contractor provided systems documentation for any changes or customizations that they have made to the standard system. By providing this documentation during the discovery period, it will allow the NGD developers to make any necessary adaptations before deployment. Once a site has implemented NGD, the NGD team will need to be made aware of any local planned changes to these shared systems well in advance. This will allow time to make sure that the interfaces with the shared systems continue to perform correctly.

NGD updates will occur quarterly and will follow the release schedule used for the shared system updates. Once the NGD is implemented, contractors are requested to inform the NGD team of any notifications of changes being planned to the standard systems currently accessed. This will serve as a backup to the current process CMS has in place for notification of systems changes. It is important that the NGD sites work closely with the NGD team to coordinate any additional testing needed specific to NGD in conjunction with testing for the shared system

quarterly releases.

Implementation Planning and Support

Implementation of the NGD will represent significant change for many call centers. Managers and staff will need to be available for pre-implementation meetings (e.g., conference calls, in-house meetings, completion of surveys, etc.), to provide information about the site in general, the technology used, and to plan for the rollout of the NGD. To minimize the impact of this change, at a minimum, the call centers will be provided with the following assistance:

- Planning for functional, technical, and business process change;
- Deployment Notebook detailing key aspects of the deployment process;
- Deployment Checklist/Project Plan and updates to the project plan;
- Regularly scheduled NGD specific conference calls;
- Training assistance as described above; and
- 24 x 7 post-implementation support (on site, if required).

Future Changes to the Next Generation Desktop

The CMS will implement an NGD Change Control Board that will include representation from the contractor community. Change requests can be submitted in a variety of ways: feedback forms within the NGD system, change requests submitted to the NGD helpdesk and participation in user acceptance testing and functional workgroup meetings. The change control procedures will be provided in the call center deployment notebook for further reference. New releases of the NGD are expected to follow the current standard mainframe system quarterly release schedule.

Retirement of Redundant Systems

After implementation of the NGD, several existing systems will become redundant. These include the current MCSC Forte application, the 1-800 GT-X application and some of the CustomView implementations. There may be other contractor or call center specific applications that will also become redundant. Retirement of these redundant applications may involve archival of data and disposition of any surplus hardware. The CMS and the affected contractors will determine the specific tasks required.

Provider Telephone Inquiries Workload

Workload 1 is the cumulative inquiries as reported on the HCFA-1566, Line 35, Provider Column.

Provider Written Inquiries (Activity Code 33002)

In FY 2004, the responsibility for provider written inquiries will shift from the Center for

Beneficiary Choices to the Center for Medicare Management. The Provider Inquiries instructions in Section 2959 of the MIM, together with these BPRs, identify the work to be performed in FY 2004.

Manual Reference: MIM §2959.A.1-3, MIM §2959.B

Workload

Workload 1 is the number of Provider Written Inquiries as reported on the CMS-1566, Line 37, Provider Column.

Provider Walk-In Inquiries (Activity Code 33003)

Contractors should not actively publicize the walk-in function. However, give individuals making personal visits to you the same high level of service you would give through phone contact. The representative must have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims-related issues.

If a provider inquires about a denied or reduced claim, give him/her the opportunity to understand the decision made and an explanation of any additional information which may be submitted if the provider would like to appeal the decision.

Make the same careful recording of the facts as for a telephone response. The report of contact should include the following information: provider's name and address, telephone number, provider number, date of contact, internal inquiry control number, subject, summary of discussion, status action required (if any) and the name of the customer service representative who handled the inquiry.

Guidelines for High Quality Walk-In Service

- After contact with a receptionist, the inquirer may meet with a service representative.
- Waiting room accommodations must provide seating.
- To the extent possible, inquiries must be completed during the initial meeting.
- Upon request, current Medicare publications must be available to the provider.

Workload

Walk-In Inquiries workload (Workload 1) is the cumulative inquiries as reported on the CMS-1566, Line 36, Provider Column.

Quality Call Monitoring (QCM) Performance Measures (Activity Code 33014)

Manual Reference: MIM §2959.C.7-8

Additions/Revisions for FY04:

1. Performance Standards

Until Remote Monitoring is implemented, each contractor must meet the following performance standards:

- Using the current quality call monitoring process, monitor 3 calls per CSR per month.
- Of all calls monitored for CSRs each month, the percent of calls scoring as "Pass" for Adherence to Privacy Act must be no less than 90%.
- Of all calls monitored for CSRs each month, the percent of calls scoring as "Achieves Expectation" or higher must be no less than 90% for Customer Skills Assessment.
- Of all calls monitored for CSRs each month, the percent of calls scoring as "Achieves Expectation" or higher must be no less than 90% for Knowledge Skills Assessment.

2. Remote Call Monitoring

The contractor will provide the capability for remote quality call monitoring by CMS personnel for CSR and IVR handled calls. This will allow CMS personnel to hear calls as they occur. CMS will take reasonable measures to ensure the security of this access (i.e., passwords will be controlled by one person, no passwords will be sent via email, no one outside of CMS will have access to passwords). Contractors who do not currently have this capability should provide a total breakdown of the cost to install such a system. This figure should be clearly identified as part of their FY 2004 budget request. In FY 2004 we will be moving to CMS monitoring. When this begins we will notify contractors and give criteria for evaluation.

Staff Development and Training (Activity Code 33020)

Manual Reference: MIM §2959.C.5

Additions/Revisions for FY04:

Contractor Web-Site Training

All contractors must train their CSRs about how to find, navigate and fully use their Medicare provider education website. CSRs must be connected to and able to use the contractor's web site for providers. Those contractors who do not currently have this capability should provide a total breakdown of the costs associated with providing Internet access. This figure should be clearly identified as part of their FY 2004 budget request.

Second Level Screening of Provider Inquiries (Activity Code 13201/01) (CR-2719):

The Medicare fee-for-service contractor must keep a record of the cost and workload associated for all provider inquiries of potential fraud and abuse that are referred to the Program Safeguard Contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity Unit using Activity Code 13201 in the Beneficiary Inquiries function.

FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS PROGRAM MANAGEMENT

Provider Communications (PCOM)(Intermediary)

The aim of Program Management Provider Communications (PM-PCOM) for FY 2004 continues to be based on CMS' goal of giving those who provide service to beneficiaries the information they need to: understand the Medicare program; be informed often and early about changes; and, in the end, bill correctly.

The PM-PCOM Budget and Performance Requirements (BPRs) activities in FY 2004 will center on electronically communicating to providers information on Medicare programs, policies and procedures. The remaining provider communications work will be funded through the Medicare Integrity Program (MIP) budget.

The Provider Communications instructions in the Intermediary Manual (Part 2, Chapter XI, Section 2965) represent the current requirements for Fiscal Intermediaries. This BPR, and the companion MIP-PCOM BPR, identify the new and incremental work proposed for FY 2004.

Activity Based Costing (ABC) will again be used in the budget process for Provider Communications. The Provider Communications work components from the manual and both PCOM BPRs are grouped within and under the ABC definitions. The ABC Dictionary is attached. (Attachment 1 to the BPRs.)

The following are the new PM-PCOM BPR activities for FY 2004:

Provider/Supplier Information and Education Website (Activity Code 14101)

Reference: MIM, Part 2, Chapter XI, Section 2965,A.7.b.

Website Feature Enhancements

- Develop and implement a feedback mechanism for users of your Medicare website. Users should be able to easily reach the feedback instrument from the homepage of your provider education website. This mechanism would ask users of your site for their appraisals of the helpfulness and ease of use of the site and the information contained on it as well as their thoughts and suggestions for improvement or additions to the site. This feedback mechanism should be operational by July 1, 2004.

Easy Identification of Bulletin Information

Providers should have easy access to relevant Medicare information that pertains to their particular type of practice. It is important to identify the information in your bulletin/newsletter that appears on your Medicare provider education web site so that providers can easily and quickly find information of interest to them. As such, provide within the introductory table of contents, summary, or compilation or listing of articles/information an indicator (word(s), icon, or symbol) that denotes whether the article/information is of interest to a specific provider audience(s) or is of general interest. This requirement may be disregarded if your introductory table of contents, summary, or article/information compilation is structured by specialty or provider interest groupings.

Website Links

- Requirements and regulations issued by CMS and of interest to providers/suppliers are listed on CMS's Quarterly Provider Update (QPU) website page. Provide an explanation of the QPU on your Medicare provider website and a link to it at: www.cms.hhs.gov/providerupdate/main.asp.
- Promote the use and understanding of the remittance advice notice as an educational tool. Providers/suppliers receive remittance advice information that can contain adjustment reason codes and remark codes that explain payment modifications made and other important information related to the claim. Descriptions for both of these code sets appear at: www.wpc-edi.com/servicesreview.asp. Provide a general explanation of the reason and remark codes on your Medicare provider website and a link to the aforementioned site.
- Providers/suppliers will need to update their information about HIPAA as the implementation dates for several requirements near. Provide a general description of the information to be found on the CMS HIPAA web site and provide a link to it at: www.cms.hhs.gov/hipaa/hipaa2.

Workload

Workload 1 is the cumulative number of page views at the URL (root) level for your provider education website.

Electronic Mailing Lists (listserv) Expansion (Activity Code 14102)

Reference: MIM, Part 2, Chapter XI, Section 2965, A.7.b

Develop electronic mailing lists that allow you to target the provider specialties you serve. Use these provider electronic mailing lists to send targeted information to specific provider populations.

Contractors should determine from the following list the applicable provider audiences

appropriate to them, and if feasible, develop and use these as targeted provider listserv categories. These categories represent the minimum of provider listserv groupings and do not preclude contractors from developing or using additional, more finite categories.

Provider Listserv Categories:

Ambulatory Surgical Center, Ambulance, Clinical Diagnostic Laboratory, Community Mental Health Center, Comprehensive Outpatient Rehabilitation Facility, DMEPOS, Federally Qualified Health Center, Hospital, Hospice, Home Health Agencies, Independent Diagnostic Testing Facility, Non-Physician Practitioner, Organ Procurement, Outpatient Physical Therapy Facility, Physician, Renal Dialysis Facility, Rural Health Clinic, Religious Non-Medical Health Care Institution, Skilled Nursing Facility.

Workload

Workload 1 is the cumulative total number of contractor provider/supplier PCOM electronic mailing lists. Workload 2 is the cumulative total number of registrants on all the PCOM electronic mailing lists. Workload 3 is the cumulative total messages sent to registrants. (Number of registrants of each listserv multiplied by the number of times used.)

**FY 2004 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT**

Provider Reimbursement

Intermediaries should ensure their budgets include appropriate funding to perform all provider reimbursement activities. In accordance with Activity Based Costing initiative (refer to the Activity Dictionary, BPRs Attachment 1) your funding should be reported to the following activity codes:

Non-MSP Debt Collection/Referral (Activity Code 16002)

Report all overpayment recovery costs (except MSP recovery cost) in Activity Code 16002. This includes the following activities related to debt collection, debt referral, extended repayment plan requests, etc:

1. Promptly suspend payments to providers in accordance with 42 CFR 405.370 to help assure the proper recovery of program overpayments and to help reduce the risk of uncollectable accounts.
2. Verify Bankruptcy information for accuracy, timeliness, and coordinate with CMS/OGC to ensure proper treatment and collection of any overpayments to the Trust Funds.
3. Record overpayments determined by functional areas timely.
4. Refer all eligible delinquent debt to Treasury within 180 days of the debt becoming delinquent. (Do not include MSP debt referral on this line.)
5. Promptly review all extended repayment plan requests. Coordinate with regional and central office on Extended Repayment Plans (ERPs) that are over 12 months.
6. Overpayment Recoupment Processing.

Note: The financial accounting and reporting associated with the actual overpayment recoupments will continue to be handled as an overhead cost. Overpayment development costs should be charged in the respective budget line from which they are generated.

Workload

Report the cumulative number of ERPs processed (approved or denied) in Workload 1.

Interim Payment Control (Activity Code 16003)

Report all Interim Payments activities in activity code 16003. This includes the following:

1. Closely monitor provider compliance with interim payment requirements, especially those providers reimbursed under the periodic interim payment (PIP) method of reimbursement, and terminate providers from PIP, when necessary, in accordance with 42 CFR 413.64 (h).
2. Review Graduate Medical Education (GME), Indirect Medical Education (IME), Disproportionate Share Hospital, bad debt, and organ acquisition, etc. interim rates. Ensure its accurate computation in accordance with Medicare reimbursement principles.
3. Review documentation requests for special payment status such as sole community and Medicare dependent hospitals.

Workload

Report the cumulative number of provider interim rate reviews performed (include PIP reviews) in Workload 1.

Reimbursement Report and File Maintenance (Activity Code 16004)

Report all reimbursement report and file maintenance cost in activity code 16004. This includes the following activities:

1. Maintain accurate PPS Pricer Prov (provider specific) file.
2. Ensure an accurate System for Tracking Audit and Reimbursement (STAR) database is maintained, including ensuring that all information is properly entered and reported.
3. Maintain the Provider Statistical and Reimbursement (PS&R) system including testing all system updates and ensuring data is reliable for cost report settlements.
4. Obtain cost reports from providers including issuing cost report submission reminder letters, PS&R reports, and demand letters.
5. Update file for cost-to-charge ratios including mass updates – (Note - Calculating cost-to-charge ratios requiring audit/review activities should be charged to the provider audit.
6. HCRIS – generate and submit HCRIS files.
7. Update provider specific files for all payment factors, e.g. DSH, IME, CCR, etc.

8. Calculate and notify providers of applicable rates, limits and caps (e.g. TEFRA, ESRD, Hospice, etc).
9. Answer information requests from CMS, OIG, DOJ, FBI, and GAO including FOIA requests related to reimbursement activities.

Workload

Do not report workload this activity code.

Provider-Based Regulations (Activity Code 16005)

Carry out all functions in accordance with 42 CFR 413.65 related to making provider-based determinations. These activities include:

- processing all provider applications or attestations
- reviewing all applications or attestations for completeness and accuracy
- making any necessary on-site visits
- carrying out random sample reviews of providers that have not submitted any attestations or applications
- taking any necessary review or audit steps needed to allow to make final provider-based determinations

Intermediaries should follow the instructions in CR 2411 for implementing the provider-based rules.

Workload

Report the cumulative number of recommendations for approval made to the regional office in Workload 1. Report the cumulative number of recommendations for disapproval made to the regional office in Workload 2. Report the cumulative number of attestations received (but for which recommendation to the regional office have not been made) in Workload 3.

**FY 2003 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT**

Productivity Investments (Intermediary)

HIPAA EDI Transactions (Activity Code 17004)

Separately identify each of the funding estimates requested below using the assigned Miscellaneous Codes under Activity Code 17004.

- Complete system compatibility testing with HIPAA claims submitters that are covered by the testing requirement but were not tested in FY 2003. Report the amount you expect to need to complete this task as a Productivity Investment in your BR using Miscellaneous Code 17004/01.

Submitter testing requirements have been issued in AB-01-96/CR1704 and CR 2385/PM AB-03-026 as well as in certain other HIPAA transactions implementation instructions referenced under the "Manage EDI Claims" activity. Submitter refers to the entity actually sending any EDI transaction to you. If a clearinghouse submits claims on behalf of 1000 providers, it would be necessary to test the clearinghouse, but not to individually test the 1000 providers who use that clearinghouse for submission of all their claims. In addition, if multiple submitters use the same software to submit claims, testing of every user of that software is not required.

- As directed by an instruction expected to be issued in FY 2004, intermediaries may be required to begin using an expanded EDI agreement. Intermediaries will be required to have the new EDI agreement signed by each provider. Include an estimate in your BR as a Productivity Investment request of your anticipated costs to make that change using Miscellaneous Code 17004/03. Itemize the various costs included in your estimate.
- The UB-02/CMS-1450 revision is expected to be available for implementation in FY 2004. No UB-02 flat file will be implemented in conjunction with this implementation. The UB-02 will not contain any data elements not currently included in the 837 or the 837-version 4010.A.1 flat file. The form changes are not expected to be extensive, but could require Optical Character Recognition, data entry screen, and possibly other changes. Include an estimate in your BR as a Productivity Investment request of your anticipated incremental costs to implement the UB-02 in FY2004 using Miscellaneous Code 17004/05. Itemize the various costs included in your estimate. Do not include provider outreach costs in this estimate.
- The Administrative Simplification Compliance Act (ASCA) requires that almost all claims be submitted to Medicare electronically effective October 16, 2003. An interim final rule with comment period is to be published in the Federal Register to establish the requirements, exceptions, and enforcement rules for this requirement. Do not include a

funding request for intermediary enforcement of this requirement in your BR prior to receipt of the implementing CMS instruction. This is included in BPRs for informational purposes only and is not to be acted upon pending receipt of the implementing CMS instruction.

- Separate funding will be supplied upon release of any further instructions in FY 2004 that affect tasks under 17004 which are not included in ongoing activities as indicated under operational activities 11201, 11202, and 11203.

System Security

In FY 2003, each intermediary and carrier was required to conduct a CMS Core Security Assessment (using the CAST). The assessment identifies the core security requirements for which a policy, procedure or control must be implemented and the cost for doing so.

CMS will: 1) review each intermediary and carrier's CMS Core Security Assessment, 2) prioritize each one and, 3) fund as many payment safeguards as possible within the limit of available funds. CMS will notify each intermediary and carrier of each payment safeguard that has been approved for FY 2004 productivity investment funding. Productivity investment funds will be released automatically by CMS so that no supplemental budget requests will be required of the Medicare contractor. Policies, procedures, or controls that were not funded will be automatically considered for FY 2005 Productivity Investment funding.

No systems security activity covered under activity code 11206 may be funded under Productivity Investments.