

# Health Care Alert

*March 2008*

## **MEDICARE CONTRACTING REFORM**

### **CMS NAMED NATIONAL GOVERNMENT SERVICES AS THE MEDICARE ADMINISTRATIVE CONTRACTOR FOR CONNECTICUT AND NEW YORK**

Pursuant to the Medicare Modernization Act of 2003, the Secretary of HHS must implement “Medicare Contracting Reform” and replace all current intermediaries and carriers with Medicare Administrative Contractors (“MACs”) by 2011. Through the creation of MACs, claims processing for Medicare Parts A and B will become integrated. According to CMS, the goal of Medicare plan reform is to offer both beneficiaries and providers “one-stop shopping” for all their program inquiries and requests. In the case of providers, reform is also aimed at allowing access to a comprehensive view of a beneficiary’s care, including recent hospitalizations, physician visits, and prescription drugs.

On March 18, 2008, CMS announced that National Government Services (NGS) has been awarded the contract for the combined administration of Part A and Part B Medicare fee-for service claims in New York and Connecticut. NGS will immediately begin implementation activities and will assume full responsibility for the work no later than November 2008. Currently, NGS is serving as the fiscal intermediary in Connecticut with First Coast serving as the carrier.

NGS operations will be headquartered in Indianapolis, Indiana. Some operations will also be performed in Binghamton and Syracuse, New York and Middletown, Connecticut. NGS has subcontracted with the following entities to assist it in the performance of its duties:

- MedUS Services to provide support with appeals, medical review, provider enrollment and provider outreach and education;
- Systematic billing and credentialing services to provide support with Medicare secondary payer and hospital audits; and



- Figliozi & Co. to provide provider audit services.

Despite the efforts to centralize administration of the Medicare program, CMS will continue to maintain its relationship with the following functional contractors:

- **Beneficiary Contact Center**

Will assume the duties once held by fiscal intermediaries and carriers. Beneficiaries will have a single Medicare point-of-contact, a 1-800-MEDICARE call center operated by CMS, that will connect them to a “seamless” network of customer service entities that can answer Medicare and related questions and resolve problems.

- **Enterprise Data Center**

Will consolidate the large number of data centers that currently house claims processing software systems for Medicare claims.

- **Healthcare Integrated General Ledger and Account System**

Will replace the Contractor Administrative Budget and Finance Management system, also known as CAFM functions. Once a Medicare claim has been processed, HIGLAS, will perform the payment calculation, formatting, and accounting, enabling them to better record, track, and collect accounts receivable.

- **Medicare Secondary Payer Recovery Contractor**

Will recover overpayments where Medicare was not the primary payer. The MAC will continue to accept unsolicited refunds and will continue working any MSP debt currently in HIGLAS.

- **Program Safeguard Contractors (PSCs)**

Will interact with one PSC to handle fraud and abuse issues within their jurisdictions to insure Medicare program integrity.

- **Qualified Independent Contractors (QICs)**

Will be responsible for conducting the second level of appeals (reconsiderations of initial determinations and redeterminations of Medicare claims). The MAC is responsible for handling the first level of appeals.

- **Quality Improvement Organization (QIO)**

Will review complaints about the quality of health care services given to Medicare beneficiaries and certain appeals determinations of institutional services and home health agencies. QIOs will also review cases from acute care hospitals and long-term care hospitals to make sure the care was medically necessary, provided in the appropriate setting, and coded correctly.

- **Recovery Audit Contractors (RACs)**

Will identify improper Medicare payments that may have been made to healthcare providers and that were not detected through existing program integrity efforts.

### **SHIPMAN & GOODWIN LLP ADVICE:**

Since MACs will be responsible for properly interfacing with Medicare accounting systems and setting up adequate internal controls within their operations, CMS, for the first time in program history, will be in a position to compare the facility claims with that of the professional service claims. Up until now, institutional providers have not had a mechanism to assure that the claims for a particular service provided by a facility are consistent with that of the professional providers on their staff. This challenge will continue, but now with greater urgency.

### **QUESTIONS OR ASSISTANCE?**

If you have any questions, please don't hesitate to call Joan Feldman at (860) 251-5104, Alex Lloyd at (860) 251-5102, John Lawrence at (860) 251-5139, Maureen Anderson at (860) 251-5589, or Vincenzo Carannante at (860) 251-5096.

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