Reform of the Medicare Provider Contracting Process

by Christian G. Downs

Over the past several years, many of you have been working with organizations such as ACCC to effect policy for your Medicare beneficiaries. Sometimes, this tremendous effort seems to pay off, and we are able to make a change at the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration).

However, other times it seems as if we have made progress with CMS and then nothing happens. The policy is changed or amended, but you do not see the effects at the physician office or hospital level. What happened?

Many experienced practice managers and cancer program administrators understand that changing the policy at the CMS level is only half the battle. The other half must be fought with the carriers and fiscal intermediaries (FIs), the organizations that implement the program for CMS.

The carriers and FIs establish local medical review policies, are responsible for provider education, and ultimately manage the dreaded information systems that calculate and generate provider reimbursement.

Unfortunately, many providers believe that the carriers and FIs have in some cases been less than efficient and even downright incompetent.

Is this new? Thomas Scully, the new administrator for CMS, testifying at a recent hearing before the House Energy and Commerce Subcommittees on Health and Oversight and Investigations, said:

"There is substantial evidence that the Medicare cost-based contracts do not contain sufficient incentives for efficient, innovative, and cost-effective operations. Since contractors are reimbursed for whatever 'reasonable costs' they incur, they have no financial motivation to be innovative in attempting to improve service to beneficiaries or in saving money. In other areas of federal procurement of this magnitude, contractors are required to compete for the business and are rarely reimbursed under the kind of no-risk, cost-based contracts, which are used in Medicare."

Scully made his point by noting that these were not his words, but those of past HCFA Deputy Administrator Earl Collier spoken in 1980 at a Ways and Means Health Subcommittee hearing on fee-for-service contractors.

So what can be done to reform the contracting process and ultimately make the FIs and carriers more responsive? Well, some reforms have already begun to take place and others are on the way.

CMS has taken several actions over the last few years, which should begin to reform the system. First, CMS has changed its contractor performance evaluation process to ensure more specific, objective, and measurable standards in its annual review of contractors. This evaluation process is used to tell contractors what is expected of them and what improvements are needed. Unfortunately, the focus of this review process has been on financial integrity, and not provider-customer service, although CMS promises this will be a future goal.

Second, CMS has restructured the oversight of contractors into the Office of the Deputy Director for Medicare Contractor Management. By centralizing this function, CMS hopes to more efficiently and consistently manage the program. A broader CMS restructuring should help strengthen this position.

The future reforms CMS is proposing are far broader and should have a much greater impact on providers. First, CMS is proposing to award contracts on a competitive basis to the best-qualified entities, using performance-based service contracts that include appropriate payment methodologies. This reform would result in contractors receiving payment when they deliver value, and only profit when they perform at or above the satisfactory level.

Second, and maybe more importantly, CMS is looking at integrated data processing, where claims processing would be consolidated and standardized across all contractors. CMS's goal is to have one system for intermediary claims, one for carrier claims, and one for durable medical equipment. CMS claims this will allow for consistency across the system and faster updates for new technologies and therapies.

One of the problems CMS faces, however, goes back to simple supply and demand. Currently, there are 28 FIs and 20 carriers processing Medicare fee-for-service claims. Twenty-six of the FIs are Blue Cross plans and two are commercial insurers. On the Part B side, 15 of the current carriers are Blue Shield plans and five are commercial insurers.

CMS bases much of its reform on the fact that it will be able to create efficiency because of competition. Unfortunately, because of the high cost of getting into claims processing, and the relatively low-profit margins, not many companies are looking to get into the business. While CMS may make this more attractive with financial incentives, this initiative will remain one of the long-term challenges of reforming the system.

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