

# Medicare Contracting Reform: Will Introducing The FAR Regulatory Framework Make The Contracting Process More Complicated?

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We are all well aware of the public controversy and political outcry surrounding the Medicare prescription drug plan that is part of the far-reaching Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"). Public Law 108-173. Equally important, notwithstanding the lack of attention currently being paid to it by the media, is the Medicare contracting reform initiative ("MCR") set forth in Section 911 of the MMA. The goal of the MCR initiative is to revamp the current Medicare carrier and intermediary contracts by transforming them into Medicare Administrative Contracts ("MAC") and, in so doing, improve and modernize the Medicare fee-for-service system. The Centers for Medicare and Medicaid Services ("CMS") estimates that the new reforms will result in savings of \$900 million between 2008 and 2010 and that future savings will exceed \$100 million annually. While certainly the improvement and modernization of the Medicare system is a laudable goal, the process for revising the carrier and intermediary contracts is not without its difficulties and complexities. The reform legislation restructures dramatically the contracting process and reconfigures drastically the administrative structure of the Medicare program.

Although CMS has not had any meaningful opportunity to evaluate the results of the program safeguard activities under the Medicare Integrity Program ("MIP"), the new contracting reforms propose yet another unproven methodology for the reorganization of various carrier and intermediary functions. Current contracts are cost reimbursement in nature; the change to a fixed price environment is one that involves substantial operational and administrative modifications of the contractors.

## The Current Medicare FFS System

Currently, there are approximately 45 Medicare Part A and Part B carriers and intermediaries that provide claims processing and customer service to more than 36 million beneficiaries under the fee for service ("FFS") component of the Medicare program. Working with more than one million health care providers, the Part A and Part B contractors process more than 930 million claims annually, paying out almost \$200 billion for beneficiary health care services. They also handle more than seven million review requests and appeals each year, all while navigating the complex maze of Medicare regulations, guidance, program memoranda, and directives. If this burden were not difficult enough, contractors generally make no profit on this work.

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## The Proposed Reforms

The new reform seeks to make the Medicare contracting system more consistent with standard federal government contracting procedures, which are typically governed by the Federal Acquisition Regulation ("FAR") and the Cost Accounting Standards ("CAS"), while at the same time providing CMS with more flexibility to "adapt its business model to meet the evolving needs of the Medicare program and bringing competitive discipline to the world of Medicare administrative contracting." See Statement by Thomas A. Scully on Medicare Regulatory and Contracting Reform before the House Ways and Means Subcommittee on Health, Feb. 13, 2003. The reform legislation also contemplates reducing the current number of carriers and intermediaries to fifteen, renaming them Medicare Administrative Contractors ("MAC").<sup>1</sup> The new MACs will process both Part A and part B claims, thereby creating a single point of contact for relevant beneficiaries. Further, CMS is to be given flexibility in its contracting authority so that it may transition from the current cost reimbursement structure to a fixed price contract environment in order that contractors might be incentivized to "excel in their performance." *Id.* According to CMS, under the current cost-reimbursement structure, contractors are too focused on profit goals and are not motivated financially to improve their performance.<sup>2</sup>

Section 911 also expands CMS contracting authority so that it will be able to avoid incurring contractor termination costs during the period of transition to the MAC contracts, *i.e.*, 2006-2011. Further, CMS is no longer restricted to entering into relevant contracts with health insuring organizations – competition for the new MAC contracts is open to all responsible, qualified offerors.

By reducing the number of contractors, by opening the sphere of competition, consolidating the processing of Part A and Part B claims, by changing the nature of the contract mechanism, and by allowing for the payment of performance incentives, CMS expects to increase efficiency, improve customer service, and, ultimately, improve the access to and quality of patient care. CMS claims that these steps are necessary to achieve its vision of "a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service." *Reforming Medicare's Contracting Process*, CMS Fact Sheet dated February 8, 2005,

[www.cms.hhs.gov/media/press/release.asp](http://www.cms.hhs.gov/media/press/release.asp).

The first MAC competition will be for the durable medical equipment ("DME") claims workloads. In this regard, a Request for Information ("RFI") was issued by CMS on February 8, 2005. By way of comparison to the carrier and intermediary claims workload, in fiscal 2004, the DMERCs processed approximately 68 million claims compared to the 930 million claims processed annually by the carriers and intermediaries. By starting the transition to the new contracting scheme with this small and discrete claims processing workload, CMS hopes to have worked out all of the kinks in the process before beginning the competition for the Part A and Part B claims processing work later this year.

## What Do The Reforms Mean For Contractors?

While CMS's stated motivation behind and goals for Medicare contracting reform are indeed laudable, they impose fairly significant contractual and regulatory obligations on the MACs, especially for those current carriers and intermediaries that choose to compete for the new contracts. Specifically, the current claims processing contracts are not subject to the FAR, nor are they CAS covered. On a going forward basis, these contractors will be required to become CAS compliant. Those contracts that are subject to "full CAS coverage" will require compliance with the following:

- CAS 406: cost accounting period,
- CAS 401, 402 and 405: previously relevant accounting requirements with new impact,
- CAS 403, 410, 418 and 420: home office and business unit allocations,
- CAS 404, 409, 414 and 417: accounting for the cost of capita,
- CAS 408, 415 and 416: fringe benefits and insurance,
- CAS 412 and 413: pension costs.

The cost impact of CAS compliance will undoubtedly be significant. In addition, substantial aspects of contract administration, including billing, the requirement to submit incurred cost proposals, accounting, and the processing of contract changes and modifications will be impacted dramatically by the overlay of the FAR regulatory framework on the MAC contracts.

Certainly, CMS can argue that, by opening the competitions to non-health insurers, contracts will be awarded to entities experienced with FAR and CAS, thereby eliminating the concerns and threats to smooth transition and uninterrupted program continuation voiced by the current carriers and intermediaries. The flaw in CMS' logic in opening up the competition to non-health insurers as well as the reasoning underlying much of the reform legislation is that CMS has failed to take into account the complexity of the Medicare FFS program and the institutional knowledge of the current contractors that is critical to effective contract administration.

There is no dispute that administration of the Medicare FFS program has become difficult, if not impossible. For starters, the Medicare rules are not codified in a single document. Instead, there are both carrier and intermediary manuals, program memoranda, guidance memoranda, CMS directives, and CMS opinions. Moreover, the

CMS regional offices are not always of one mind, nor are their positions always in line with the central office. Then, there are the auditors who conduct site visits and proffer their own directives to the carriers and intermediaries. At times, it is a challenge to know which rules are applicable to the Medicare FFS program, let alone which rules are to be implemented and enforced by CMS. This creates a minefield of sorts for the contractors, who are ever mindful of their performance requirements, as well as the obligation to eliminate fraud, waste, and abuse, and the associated potential liabilities under the civil and criminal false claims acts.

Moreover, contrary to statements made by CMS in support of the need to financially motivate contractors to increase the level of performance, most carriers and intermediaries complain of the budget cuts and restraints placed on them by CMS. In many instances, CMS will routinely increase the performance requirements, *e.g.*, number of claims processed and associated error rates, while decreasing the relevant budgets. As a result, the contractors are being asked to do more for less money. The consequence is that contractors are under enormous financial pressure to perform, which leads to compliance problems and liability as employees cut corners to try to keep up. Most carriers and intermediaries perform their contracts at a financial loss, which is why so many have sought to terminate their contracts and to get out of the program in recent years. Of financial benefit to the carriers and intermediaries is the opportunity to allocate some amount of corporate overhead to Medicare. At some point, however, the decreasing benefit derived from participation in the Medicare program may be outweighed by the various challenges and risks, especially given the complexities and uncertainties associated with the reform initiative. The suggestion that the current contractors are fat, dumb, and happy under the current cost reimbursement structure is dramatically at odds with the reality.

Most current carriers and intermediaries would laud meaningful efforts to improve the Medicare FFS program and to improve beneficiary services. Few would dispute the need to reform some aspects of the program. The problem is that, without truly examining and attempting to resolve the underlying programmatic difficulties, the MMA seeks to "fix" Medicare with one sweep of a magic wand. While it may prove that moving to a FAR/CAS contracting environment is beneficial to the Medicare program, there is no basis to believe that this cure all will achieve anything other than short-term confusion which will mask the real problems with the Medicare FFS program. Until CMS determines to face what really ails it, the Medicare FFS program, even under the MAC contracts, will continue to operate less than optimally.

<sup>1</sup> While there is slated to be a total of 23 MACs, this number includes regional home health intermediaries ("RHHS") and durable medical equipment regional carriers ("DMERCs"), as well as the Part A and Part B carriers and intermediaries, which will be reduced from their present number of forty-five to fifteen.

<sup>2</sup> Given that most carriers and intermediaries are performing the FFS contracts at a loss, it remains a mystery how CMS has reached this conclusion.

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