Listening Session on MAC Opportunities to Enhance Provider Experience

Moderated by: Leah Nguyen
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Table of Contents

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen only mode until the feedback session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I'm Leah Nguyen from the Provider Communications Group here at CMS. And I am your moderator today. I'd like to welcome you to this Medicare Learning Network listening session on MAC performance and request for feedback on opportunities to Enhance Provider Experience and Beneficiary's Quality of Care.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.cms.gov/mln-events. Again, that URL is go.cms.gov/mln-events.

Today's event is not intended for the press. And the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the question and answer session. If you have inquiries, contact press@cms.hhs.gov.

At this time, I'd like to turn the call over to Larry Young, Director of the Medicare Contractor Management Group in the Center for Medicare.

Presentation

Larry Young: Thank you, Leah. So good afternoon, everybody. Happy to be with you all again. One clarification point, I think in our – in our advertisements for the session, we were anticipating that the Administrator would be with us to kind of kick off the overview. She is not able to meet with us today, unfortunately, to be part of the conversation.

But we're hopeful that she could meet and participate in next Wednesday's session. So unfortunately, you're stuck with me today only. So kind of similar to what we had done last week, I just wanted to run through a short presentation on Medicare Administrative Contractors, lay a foundation for what they are, the functions they do for us, before we kind of turn the mic over to you all to hear your good thoughts.

So, I'll run through this quickly. And then certainly, you have the opportunity to ask questions if I – if I confuse any of you.

So, just working off of slide 3 in the material, this is just intended to frame the conversation on what Medicare Administrative Contractors are, what they do for the Fee-For-Service program, the different functions they perform, how many Medicare Administrative Contractors we have, their jurisdictions, how they interact with other Fee-For-Service contractors, give you a sense of the number of claims they process and the number of workloads they administer for us, and last but not least how they'd been performing from our perspective, the CMS over the last few years.

What is a MAC?

So just moving ahead, what is the Medicare Administrative Contractor? They're the – they're the contractors that we contract with, CMS contracts with, to administer the Medicare Part A and B benefit, what you think of as traditional Medicare.

I want to make that clear that we had a few written comments come in. Some folks were confusing Medicare Administrative Contractors with I think some Medicare Advantage contractors. So, we'll think of Medicare Administrative Contractors as the foundation of the traditional Fee-For-Service Medicare program if you will.

There is two basic types. We have the – what we call A/B benefit administrative contractors and DME, Durable Medical Equipment contractors. That the A/Bs process roughly 95 percent of all fee-for-service claims. There is 12 A/B MAC jurisdictions. A subset of those 12, some 4, also process home health and hospice claims for the program.

The other type that we distinguish are that Durable Medical Equipment Administrative Contractors. They process claims for durable medical equipment, supplies and those products, and then roughly processing about 5 percent of the claims for the country. All the contracts are – we procure them through a competitive contract process.

What Do MACs Do?

What do MACs do? MACs by design are intended to be the front point of the Fee-For-Service program for all providers kind of being able – the thought is to try and provide a one-stop-shopping experience for providers.

Slide 6 will give you a little bit of a high-level overview of their different functionaries as far as having the provider customer service center, managing the provider enrollment process for us, processing Medicare claims, Fee-For-Service claims.

So, you know, claims payment notices, doing a number of financial management activities for us and things that are like auditing and reimbursements, cost reports, collecting debts, managing – helping to manage those Medicare secondary payors for us.

One critical point to note is the Medicare Administrative Contractors do not handle beneficiary phone calls. That's handled by the 1-800 contact center. And that's been carved out for probably over 15 years now, I believe.

Primary Functions of the MACs

Slide 7 will give you a little bit more of a precise detailed overview of their primary functions as far as process with Medicare claims, enrolling providers. They also handle first-level appeal decisions, what we call redetermination requests, perform medical review, roughly 700,000 claims I believe there under medical review, provider reimbursement services, audit and cost reports.

Another kind of large function they do is provide provider education for the provider community on how to bill Medicare Fee-For-Service. They also established local coverage decisions, determinations for the program, support a number of demonstration programs for us as well.

MAC Jurisdictions

On slide 8 through 10, I believe, you'll see a breakout of the different Medicare Administrative Contractor jurisdictions. Not going to name them all for you. You can peruse through there.

The Operational Scale of the MAC Program

On that slide 11, just to give you an idea of the scope of the work that they performed for the agency with any given year, they process a little over 1.2 billion claims year over year for about roughly two-thirds the Medicare population. So, a third of – a third of the population is enrolled in Medicare Advantage, if you will. And two-thirds are in the Medicare position with Medicare Fee-For-Service.

Service about 2.1 million healthcare providers and suppliers, pay at roughly little more than $400 billion in annual benefits. And they do all those functions for a little under $1.2 billion.

More MAC Program Metrics

Slide 12 gives you a little more detail around the number of provider enrollment application transactions that are handled for over 1.2 million.

2.8 million first-level appeals redeterminations are handled. Almost 20 million provider telephone calls are handled by the contact centers. The majority of those are, I think, handled in automated fashion; about 7-1/2, 7.6 million are answered by the customer service representatives.

That's been at – that's been one of our most successful areas, we think, over the years. And that the MACs have been able to listen to their local provider wants and desires, to provide themselves with service technology that they can handle their own transactions on their own through the portal applications. And it's really helped drag down a number of phone calls that a CSR has to answer directly necessarily.

I mentioned earlier they perform at 700,000 medical reviews for us annually and so about 44,000 hospital cost reports for us annually. If you added everything up, they – it's a little over 1.4 billion transactions or work products that the Medicare Administrative Contractors handle for us each year.

The – a little context on slide 13 as far as how they performed for us over the years. We – we've had upward trends in them – in their ability to meet our – what we call our – you would commonly call our service level agreement metrics, our performance metrics, we call them. They're part of what we call our Quality Assurance Surveillance Plan metrics. You'll see QASP score listed on the left side of that scale there.

And the graph illustrates the average QASP scores that the MACs had been attaining year over year. The last several years, we've been over 90 percent, which we're very pleased with.

That all said, while the programs – are pleased with the MAC performance, we've also been pleased with the cost savings they developed for us. We've spent about over 30 percent less than we did in 2005, if we were administering the Medicare Fee-For-Service program.

We don't – we don't believe in resting on our laurels. There's always opportunities to try and improve the – our stakeholder's experience with the Medicare Fee-For-Service program. So that the intent for this listening session was primarily in to give you all a forum with us so we can listen to you all directly and hear your thoughts on things that we can do structurally or elsewise to help us improve your experience with the Medicare Fee-For-Service program.

We were – we were particularly interested in hearing your thoughts on things we could do to improve the overall beneficiary quality of care if there is some space there to the MACs at operating them that we haven't traditionally done, perhaps explore as well as understanding whether there're things that MACs can do in any of the other essential services they perform for you that can improve your experience in overall – the overall program.

So, with that, I'll turn it over. And we'll open to listening set. Back to Leah.

Feedback Session

Leah Nguyen: Thank you, Larry. During this session, we want to hear your feedback so we can improve our processes and quality of care. Although we do not have subject matter experts on hand to respond to specific questions, you can email them to the research mailbox on slide 15.

As a reminder, this event is being recorded and transcribed. In effort to get through to hear as much of your feedback as possible, each caller will have a maximum of 3 minutes to provide input. All right, Dorothy, we are ready for our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to ensure clarity. Once your line is opened, state your name and servicing MAC or state. Please note your line will remain open during the time you are providing your feedback. So, anything you say or any background noise will be heard in the conference. Please hold while we compile the roster – please hold while we compile the roster. Your first question comes from the line of Maria Sera.

Maria Sera: No question.

Operator: Your next question – your next feedback comes from the line of Robert Siman.

Robert Siman: Yes. Hi. I have a comment regarding the LCD process. Now, it used to be prior to 21st Century Cures, the LCDs and NCDs were very clearly and distinctly different. But then I'd been a CAC representative. And currently, I'm in Novitas jurisdiction. And I also served as a med tech panel member.

And you know while everybody supports this desire to level the evidentiary playing field between LCDs and NCDs, the sort of bureaucratic maze that it's been created through creating this multijurisdictional CAC

process has really been concerning. It's really hampered communication and discussion of evidence and really sort of has lacked transparency.

It really concerns me. I think most of you who are on the call know that in this process, there is like one mega call that has multiple presenters and subject matter experts on the line from all around the country. And then a final policy gets written without necessarily sort of very specifically justifying the evidence that is used for their policy.

And when there is clearly mistakes or the evidence wasn't completely considered, the process is really very unwieldy for providers after that because you have to like to apply or appeal for reconsideration, but it has to go to each jurisdiction then.

So, it adds up to hours and hours of physician time between your original multijurisdictional call and when all of these appeal phone calls that then have to occur. And it just seems like there should be a better process because it really discourages physician involvement. They have to commit multiple - multiple hours of their time.

And so that would be my one plea. And the only other thing I would say is that we all have a zeal for evidence. But you know there has to be some common sense in the process. In the old LCD process when we'd get together locally or regionally, now, there'd be discussions about the practicalities of what's doing best for Medicare patients.

In one recent draft policy on vertebroplasty, it was suggested that the patients needed to see multiple subspecialists before they could qualify for the procedure. And when you have a patient with a vertebral fracture and pain who's often bedridden, is a Medicare beneficiary. It's really hard to get them to go to multiple subspecialists, and yet that found its way into the final policy even though there really wasn't evidence to support it. And again, it's being appealed. It's being discussed. And my particular contractor, Novitas, has been very responsive actually in that regard and has had a recent open session to discuss that.

But again, there's going to be a better way to streamline this for providers and for the – for their Medicare beneficiaries. Thank you.

Larry Young: So, I think your name is Robert. I appreciate those thoughts.

Robert Siman: Yes.

Larry Young: That one question – one question for you was on the – when you talk about the multijurisdictional aspects of it …

Robert Siman: Yes.

Larry Young: … are you talking about just that …

Robert Siman: Yes.

Larry Young: … across the different states within one MAC's jurisdiction, or are you talking about across different regional MACs?

Robert Siman: I'm – yes. Thank you for that question. Yes. Now, I'm talking about across all the MACs. There was one call across all the MACs. And you can imagine again it really sort of makes the communication difficult. You know, we had presenters and subject matter experts who were asked to speak. But again, it really filters a lot of the communication.

And there is not that same sense of having like open back and forth discussions like there were when we had all the regional MACs even when they were across states. Within one MAC, it was – it was better and more conducive, the transparency, than at – than in the current process.

Larry Young: I think I understand you. Thank you for those thoughts. We will take that back certainly with our work with our colleagues and our coverage in panel.

Robert Siman: Thank you. And thank you for giving us the opportunity to raise this kind of issue. Thank you.

Larry Young: Absolutely.

Operator: Your next comment comes from the line of Paige Cummings. Miss Cummings, your line is open. There is no response from that line. Your next comment comes from the line of Susan Herzinger.

Susan Herzinger: Hi. Good afternoon. We are – our MAC is WPS. We do cross state lines inthe -- Kansas and Missouri. So, we deal with them in a couple of different areas. My recent frustration is we have one group that has a very unique setup as far as the way PTANs and NPIs are used. We were about 3 months after filing an 855B and had not heard any response. And every time we would call WPS, the response was, well, CMS has it, like, okay, well, first, if we even got that response.

The first response is check online. We would check online. It says in process. Well, that's great. What does that mean to us? Are you waiting for something from us? Has it gone somewhere else? Was there an error that we just don't know about?

So finally, when we would get someone on the line and we ask him, the answer would be CMS has it. It's like, well, can you tell me how to contact CMS or can you contact CMS and get us an update. It took us 6 months to get an application approved.

And I finally ended up having to call the Administrator at CMS to get resolved to the issue. Do the MACs not have a contact at CMS when there is an issue so that they can call for us or give us updates if an application has indeed been sent for us at CMS?

Larry Young: So, Susan, yes. They – I mean we do have contacts here in our provider enrollment area that do interact with the MACs daily, hourly in some cases. So that that exists. But I was going to ask you what type of provider are you? Were you a facility by chance?

Susan Herzinger: This particular application, it was an 855B. It was for a provider group.

Larry Young: Okay. So, it was a Part B. Okay. So, I would give say – if it was a Part A institution, I was suspecting there may have been issues around that, a tie-in notice or something like that. That doesn't make sense for your particular situation.

If you would – if you would like to give me a little more detail by sending it into the CMS Listens mailbox, I could – I could look into it a little more thoroughly to find out exactly what happened for your current situation. That doesn't – the experience that you relayed to me does not sound consistent with what I would expect you to have.

Susan Herzinger: Okay. Thank you.

Leah Nguyen: And that's on slide 15. Thank you.

Operator: As a reminder, if you have a comment, please press star followed by the number 1 on your touch-tone phone. That is star, 1 for a comment. Our next comment comes from the line of Cathy Ball.

Cathy Ball: Thank you for listening to and then – to my comments here. What I want to broach is the NPI issue that we are running into. In order to save both our MAC and our time, we created an umbrella NPI for our practitioners. And we have in excess of probably 200 practitioners.

And the example I want to give that we're – that we're coming up against, just the newest established E&Ms. And for example, if we have a patient that visits our cardiology practice and see, so, nurse practitioner because we are trying to be – save money for the patient and ourselves, and then the patient then ultimately has to be seen by a pulmonologist, if they're seen by another nurse practitioner, with the way the system is set up, we can never get another new visit even though we have to do the appropriate work up at – when they see the pulmonologist group.

And so, it – we're kind of at a stalemate as far as trying to be efficient, trying to save time, trying to lower costs for patients. But, yet, we get penalized when we used nurse practitioners because they only have one specialty code.

So is there any thought about expanding nurse specialty codes for nurse practitioners because I think that's the way with the future. Thank you.

Larry Young: So, Cathy, appreciate those thoughts. That I was going to ask you what – what's – who's your servicing MAC.

Cathy Ball: Noridian.

Larry Young: Noridian. Okay.

Cathy Ball: That they've been really attentive to listen that we really delve into the details of the 1500. There just doesn't seem to be any different angle.

Larry Young: Okay. We'll – I don't have a simple answer for you. That …

Cathy Bill: Yes.

Larry Young: … I think this, that we actually then to take this back to our policy folks so I think – because I – I'm thinking what you're getting to is there's a limited number of codes that the nurse practitioners could actually bill for. Is that correct?

Cathy Bill: Well, specifically the new versus established E&M. So, yes, there is a …

Larry Young: Okay.

Cathy Bill: … limited number. But if delved, what it gets branches out into the edited setup. And this – it gets down to the back, that the NPI is an umbrella NPI for all of our practitioners. And then it gets down into the specialty code.

And for different positions like if the patient was seen by a cardiologist and the patient was subsequently seen by a pulmonologist, you could have two new E&M codes. But the fact that their workup is initially being done by a nurse practitioner limits us on the second if they were referred to a pulmonologist for different needs or vice versa. So, yes, it's kind of particular.

Larry Young: No. I appreciate that. I understand where you're coming from. We will – we will take that back. And I will have to talk to our policy folks about it. There, I don't know that that's a MAC issue that can be settled exactly. But we appreciate the thoughts. Thank you.

Leah Nguyen: Thank you.

Operator: As a reminder, to provide feedback, press star followed by the number 1 on your touch-tone phone. That is star, 1 to provide feedback. Your next comment comes from the line of Nando Wilts.

Nando Wilts: Yes. Good afternoon. If I heard you correctly, you said there's been a cost savings of over 30% to the program due to MACs. Can you at a very high level give us some idea of where these savings have occurred?

Larry Young: Sure. At a high level, absolutely. That most of them have – are on what we call our program management side. And it's been over a number of years. This kind of – this is kind of your priorities. Primarily I would ascribe it to a few different things.

One is that, just the consolidation of the environment. We went to an environment where we had over 50-plus fiscal intermediaries and carriers. Back in 2005, we first started the Medicare Administrative Contractor program through – by competing the contracts. And over time, we whittled that down to our current footprint, which is basically we have – we have 16 contracts. But we have roughly 7 different entities that have one or more of those contracts.

So, we've gone from that, just that mass number right there and consolidated a fewer entities. With the same token, we've actually – the MACs are actually doing more work for us. They processed more claims for us than ever before as a – as a baseline, if you will.

They've become much more efficient over time. Then through a lot of their automation of their processes internally, it helped them offset a number of actually new positions over the years as well.
So, from – as I said, from around 2005 to the present, we're – last time, like we were about 33% less than what we expended in 2005 just around the administrative – I'm sorry – the Medicare Fee-For-Service program in total.

Nando Wilts: Thank you.

Larry Young: Yes. Thank you.

Operator: Your next comment comes from the line of Paige Cummings.

Paige Cummings: Hi. Can we have some clarification on exactly who we should be contacting at Medicare when we have issues such as denial questions or questions related to, I guess any contract updates with Medicare? There is an email address that we're sending our questions to.

But it could be weeks before you receive a response back. I guess it's not possible to have a person to be directly in contact with for a monthly meeting series with our MAC to review any escalations we have submitted. But is there a definitive place where we can find a list of email addresses or avenues that we should be submitting our claims questions to?

Larry Young: So, Paige, let me ask you – thank you for that. Let me ask you with who is your servicing MAC?

Paige Cummings: JM …

Larry Young: Okay.

Paige Cummings: Palmetto. I'm sorry. Palmetto.

Larry Young: That's fine. I know that they are. The – I don't have it, an answer for you off the top of my head. But, well, we can certainly take that back and see if that's possible. I mean your servicing MAC is into the – whom you should contact through claims questions.

Paige Cummings: Yes. We often get told just to contact the 1-800 number, which is a generic customer service number. So, it's hard to do follow up calls. And I guess there's expected turnaround from our initial inquiries. Would be nice to have some things scheduled that we can …

Larry Young: Okay.

Paige Cummings: … speak with somebody regularly instead of us continuously essentially starting that process all over again by contacting the Provider Contact Center.

Larry Young: Okay. I'm writing this down. And I again invite you and everyone to send in your thoughts in writing to the CMS Listens mailbox on the slide. But I mean capturing this.

Leah Nguyen: And so, you probably want to send that question in just so you can make sure you can get response back as well.

Larry Young: Yes. I mean, if you would – if you could – if you could submit into the CMS Listens mailbox, and we will actually – we'll get you an answer on how you could possibly just get a follow up contact at Palmetto.

Paige Cummings: Okay. That would be great. Thank you.

Larry Young: Thank you.

Operator: As a reminder, to provide your feedback, press star followed by the number 1 on your touch-tone phone. That is star, 1 to provide feedback. Your next comment comes from the line of Matthew Rider.

Matthew Rider: Hi. I'm raising comments on behalf of the Healthcare Business Management Association today. And first, I'd like to just follow up to what the previous commenter said and just mention that it would be helpful if that type of contact information was made pretty – displayed pretty prominently or made available for anyone to see, because I can speak for a lot of HBMA members that they would love to have an easier access to raising issues with MACs.

And that brings me to the point that I was going to raise, which is that inconsistent implementation of various policies has been – by MACs, has been a source of administrative burden for HBMA members.

That can range from the way LCDs are implemented to the way remittance advice is issued. And so – and it can be difficult to find ways to get a consistent answer within MAC or across different MACs. So – and hard to elevate those issues to someone higher up if there is confusion about the answer they received.

So, I guess to cut – is there anything that CMS is doing to try and cut down on those inconsistencies? Is there any sort of programs or efforts to have MACs collaborate with each other to share best practices, to just try and create a more consistent way of doing things? Thank you.

Larry Young: Matt, appreciate that. We did get your written comments as well before the call. And unfortunately, I don't – I don't have the time to loop in my comrades and the coverage analysis group to talk about your concerns on the LCD process. That we'll – we will certainly take that back and take a look at it.

And so, your just specific question now, there are things that we do to encourage the MACs to collaborate around a number of different topics. We have – we have a reward-fee metrics for example, that reward them for collaborating. So, there are mechanisms that incentivize them to collaborate.

That your issue around the consistency, I understand that's – that may be a recurring theme here while gearing, trying to get consistency around the MAC in that – and their processes. Particularly, we want them to have consistent answers, certainly, when they're calling and asking questions. That's what we strive for. The agency try – attempts to provide uniform messaging around hot topics or explain developments for that, the MACs to provide to the callers as well.

They don't all have the same consistent processes; that's by design. I mean, to the extent that we practically can, we make these performance-based contracts.

So, we ask them to meet a standard and fulfill a requirement. But we try not to be too prescriptive about exactly how to get there. So, sometimes that can develop into different processes, if you will. But we do – we do – we'll – and we'll continue to encourage them to be consistent as far as having consistent answers necessarily for you.

Matthew Rider: Thank you very much.

Larry Young: Hey, thank you.

Leah Nguyen: Thank you.

Operator: As a reminder, to provide your feedback, press star followed by the number 1 on your touch-tone phone. Again, that is star, 1 to provide feedback. One moment for your next comment. That caller has withdrawn their statement.

As a reminder, if you would like to provide feedback, please press star followed by the number 1 on your touch-tone phone. One moment for your next comment. Our next comment comes from the line of Mike Shaver.

Mike Shaver: Good afternoon. This is Mike. I'm the Director of Reimbursement at a hospital. And some of the issues that I have had – have to do with audit reimbursement. Over the last few years, we – we've gotten, I guess, a little more difficult timelines for an auditor who starts working on a desk review.

For example, you know an auditor would work on a desk review in July. And then they get pulled off to do something else. And then they take it back up in October and November when we thought – when we're filing our cost reports. And so, they – you know they want to have that, an exit in a week it – rather than in the middle of following cost reports. But they started in July.

So, we have a lot of issues with that. And I had an issue this year with wage index where the auditor – we responded to the adjustments. We had asked for some corrections to be made within about 3 or 4 hours of getting the adjustments. And they told me that they didn't have time to change the adjustments because it was such a time – tight timeline.

And so, things like that just kind of frustrate me because when you're doing cost reports it's difficult enough when you've got a lot of auditors that are calling you and wanting the information. But when they're not giving you reasonable amounts of time to pull the information or they start and then they put stuff down for a few months or get called off to do something else, you know, it's just frustrating to know that this stuff spans out for 6 or 7 months. And then, you know, their emergency becomes your emergency because they have to get it done.

So that's just my feedback. I've had some issues the last 2, 3 years with really tight timelines. And you know, they should be giving you a 10-day letter that – where you can go and look at your adjustments and make comments and ask for corrections with additional documentation. But that doesn't always happen.

Larry Young: Okay. Mike, I appreciate that. I – there certainly are – we can certainly look at our internal timelines that we expect the MACs to meet. I do know that they – we let them manage their work. So there probably is some starting and stopping that's happening for you.

Well, it's – but it's good to know what that kind of bottom line impact is for you guys. So that's something we should look at. If you're out – who is your servicing MAC?

Mike Shaver: So, we're under JJ. So, Palmetto.

Larry Young: Okay.

Mike Shaver: And then I guess one other thing is there – now they're beginning to use subcontractors. And so, I'm not just dealing with Palmetto. But I'm dealing with several other subcontractors. And so, we – we've got three or four different people, auditors going at the same time. And so, it just takes up a lot of time.

I just hope that they realize that it is very time consuming on our end. And so, we can't always drop everything that we're doing at a hospital to work on these audits in their timeline without giving us some consideration as well.

Larry Young: Appreciate that. I will say in there, well, it's more of an explanation, anything that – sometimes we – what we're requiring the MACs to do requires them to go out and get subcontractors because there can be some last-minute program changes and needs around our audit work where we're asking them to perform more audits than we have perhaps historically done in one area or another. And so that really the only way to fill that gap is for them to go out and get subcontractors. So, it's – yes.

But we – it's certainly good for us to be mindful of the bottom-line impact for some of the – on you all. And we'll take that …

Male: Right.

Larry Young: … back.

Mike Shaver: And one thing that I notice that Palmetto does more than anybody that I worked with – because I worked – I actually worked for the MAC for a number of years. And so, I know the challenges that they have. But you know they send us an audit sample of like 5 claims. And they try to project it to a population. And you know I went – I went – I took statistics classes many years ago.

But you know to me, those kinds of things, those shortcuts shouldn't be extrapolated to populations and stuff. So, I disagree with a lot of the stuff. And I asked them to send me instructions as where they come up with you can extrapolate claims by just pulling 5. And they never end up sending me anything. And so, it – that's

frustrating as well when you're trying to explain – trying to understand this extrapolation process that they used because it seem – it seems to be a shortcut.

Larry Young: Okay. I appreciate that as well. We will go back in with – there are specific sampling requirements in our program instruction manuals as far – particularly around statistical extrapolation of overpayments, for example, that we …

Mike Shaver: Right.

Larry Young: … expect in the following. If they're meeting the confidence of the – confidence intervals and what not, then it shouldn't be a problem. But it sounds like when then you take a look at that. So, I appreciate that.

Mike Shaver: Okay. Well, thank you.

Larry Young: All right. Thank you.

Operator: Your next comment comes from the line of Charlie John.

Charlie John: Good afternoon. And thank you for taking the time to go over this with us. Just a quick question on the QASP score realm. Number 1, is that information publicly available? And is it – is it a more detailed breakdown of the 11 areas?

And then number 2, just want to take it, a sense of how much it incorporates sort of a provider satisfaction realm, in terms of just timeliness and things like that, and some of the concerns that folks had brought up on this call as well as a, I guess, beneficiary satisfaction realm, so access to their therapies, continuity of care, all that kind of stuff. Thank you.

Larry Young: Appreciate that, Charlie. So that your first question, just so the QASP performance metrics, those are available publicly. If you would like to – I can't remember the website link off the top of my head. If you'd like to send something to the CMS Listens box, we can turn that back out – back out to you.

But it's – it is on. It's a public facing website. You can go see the average MAC scores. We don't – we don't produce the individual MAC scores by functional area. What we'll – what we'll produce there show what their total QASP scores are. And I think we do it by functional area. So, you'll be able to see how a MAC – the MACs had been performing by different functional areas. But it wouldn't show you which specific MAC per se necessarily try to …

Torris Smith: I could certainly now ...

Larry Young: … keep that closer. Torris, you know their website?

Torris Smith: Yes. If you go on CMS.gov and just use your search button or your search field and put in Medicare Administrative Contractors, you'll come to the homepage for the MACs and who they are, what they do.

And we have 2 tabs in the left-hand side of that website that actually shows the performance of – and their compliance also with our service level agreement. So, there're 2 tabs on the QASP scores and their MAC performance. And you should be able to view that. And it will break it down in various levels on based on their functional level of achievements.

Larry Young: And as far as your other questions. The provider there – those – the QASP scores, there is not a provider satisfaction component to the QASP audit, the service level audits, if you will. There is a – we measure that through a different data source. There is a Medicare provider satisfaction index survey that all the MACs ask providers in their different jurisdictions to compile. And those survey results are part of what rolls up in each MAC's annual performance evaluation.
So, it's not part of a – the QASP review per se. It's a different – it's a different survey tool if you will. The – as far as the beneficiary satisfaction, there is not a – just over beneficiary satisfaction metric for the MACs necessarily. And I think not that there shouldn't be necessarily.

One of the challenges there is how we would differentiate that and then manage that I think as far as being able to articulate and identify of what's a specific MAC issue versus perhaps a program issue necessarily. But if – I'm willing to entertain ideas as the folks would like to share those with us certainly. Thank you.

Charlie John: Thank you.

Operator: There are no further comments at this time. I will turn the call back over to you, Leah.

Additional Information

Leah Nguyen: Thank you. An audio recording and transcript will be available in about two weeks at go.cms.gov/mln-events. Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network Listening Session on MAC Opportunities to Enhance Provider Experience. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.