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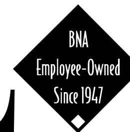

REPORT

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Health Care Contracts

The Medicare Prescription Drug, Improvement, and Modernization Act not only provides a prescription drug benefit for senior citizens but also dramatically changes the way contracts will be awarded by the Centers for Medicare and Medicaid Services to payors such as carriers and fiscal intermediaries. These changes will provide new business opportunities for prospective contractors and teaming possibilities for existing payors interested in retaining a market presence as Medicare Administrative Contractors for CMS.

Later this year, contracts will be awarded for the first time by CMS to Medicare Administrative Contractors based on full and open competition. These new contracts will be subject to the Federal Acquisition Regulation and the Cost Accounting Standards.

This analysis describes the contracting changes mandated by the Medicare Modernization Act, the solicitation process contemplated by CMS, and some of the compliance issues that will face Medicare Administrative Contractors.

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MEDICARE CONTRACTING REFORM: NEW OPPORTUNITIES, NEW RISKS

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On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. No. 108-173) (''MMA''). The MMA is designed primarily to provide seniors with a prescription drug benefit. The MMA also makes a profound change in the way the Centers for Medicare & Medicaid Services (''CMS'') will award and administer Medicare fee-for-service (''FFS'') contracts. For the first time, those contracts will be subject to full and open competition. As a result, any qualified company can vie for large contracts that until now have been for the most part the province of the Blue Cross Blue Shield plans.

Section 911 of the MMA mandates that the Secretary of Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B programs,[1] contained under Title XVIII of the Social Security Act, with the new authority. Through a series of sweeping changes, CMS will transfer administration of Medicare Parts A and B FFS benefits to new entities called Medicare Administrative Contractors (''MACs'').[2]

This reform is intended to improve Medicare's administrative services to beneficiaries and providers, while bringing Medicare in line with the standard contracting principles that have long applied to other federal programs under the Federal Acquisition Regulation (''FAR''). Using competitive procedures, Medicare will replace its current claims payment contractors — fiscal intermediaries and carriers — with MACs.

Among other significant changes, Section 911 removes the restriction, in existence since the Medicare program's inception, requiring entities considered for administration of the FFS work to be health insuring organizations. The competitions for the MAC contracts will be the first full and open competitions for the FFS workloads.[3]

The changes required by Section 911 will have a dramatic impact on how CMS does business with Medicare Parts A and B contractors. Under the new regulations, competition will be vastly expanded, existing and new Medicare contractors will need to learn procedures for operating in a performance-based contracting environment, contractors will need to learn the new FAR-based processes, and prospective offerors will need training on the Medicare contracting program to assess the new business opportunities.

This article describes some of the changes ushered in by Section 911 of the MMA by comparing the current system to the new regulations. Additionally, the article will describe how prospective MACs can begin preparing for contracts to be awarded under the FAR system.

Legislative Background: Section 911

■ The Current System

Under the current system, CMS maintains a network of contractors to process nearly one billion Medicare claims from over one million healthcare providers each year.[4] The contractors include 25 fiscal intermediaries and 18 carriers. The fiscal intermediaries process claims for Medicare Parts A and B facilities, including hospitals and skilled nursing facilities. The carriers process claims for Medicare Part B, specifically, for physician, laboratory and other services. Contractors can process claims for specific jurisdictions consisting of a single county, a single state, a block of states, or several states in different parts of the country. Some contractors serve only one state while others serve several, sometimes non-contiguous states.

Section 911 is a response to a number of restrictions and weaknesses in the current system that have hampered Medicare's ability to deliver more efficient and effective services. Among the more prominent restrictions and weaknesses under the current system are:

- lack of full and open competition
- separate processing of Parts A and B claims
- specialization restrictions
- absence of performance-based incentives
- cumbersome termination procedures and procedures that permit contractors to terminate without cause.

Additionally, under the current system, Part B carriers are limited to health insurance companies and fiscal intermediaries may not compete for Part B contracts unless nominated by provider institutions, such as hospitals. These limitations unduly restrict competition and preclude offers from other potential bidders, such as information technology providers.

[1] Medicare Part A Coverage typically includes: hospital care; nursing home care; hospice care; and home health care. Part B generally pays for outpatient services, but the amount varies depending upon the type of services. These include physicians' services, specialists' services, labs, x-rays, flu shots, mammograms, home health care, therapies, durable medical equipment, psychiatric services, and other similar kinds of services.

[2] The work of carriers and intermediaries has traditionally been performed by Blue Cross and Blue Shield Organizations, under an exclusive contract awarded to the Blue Cross Blue Shield Association.

[3] CMS Fact Sheet Report to Congress dated February 2005, available at http://www.cms.hhs.gov/medicarereform/contractingreform.rtc/rtc_fact_sheet.pdf.

[4] ''Medicare Contracting Reform: A Blue Print For A Better Medicare,'' Report to Congress submitted Feb. 7, 2005, Michael O. Leavitt, Secretary of Health and Human Services at I-2.

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■ The New System

Under the heading ''Contracting Requirements,'' Section 911 of the MMA, Congress directs CMS to enter into contracts with MACs.[5] In terms of contracting, the most dramatic change will be the introduction of standard federal government contracting principles to Medicare. The changes mandated by Section 911 include the following:

- **Competition.** CMS will conduct full and open competition for contracts related to claims payment. This includes use of competitive procedures for the award of MAC contracts.[6]
- **Application of the Federal Acquisition Regulation**. The MMA also requires application of the FAR.[7] While some FAR clauses are included in existing carrier and intermediary contracts, the MMA requires a fully compliant FAR contract.
- **Beneficiary-Centered Benefit Administration.** Contracting services for Parts A and B will be consolidated to provide beneficiaries with a unified Medicare point-of-contact and to modernize the administrative information technology platform.
- **Additional Provider Services.** MACs will serve as the providers' primary point-of-contact for enrollment, training on Medicare coverage and billing requirements, and the receipt, processing, and payment of Medicare FFS claims within their respective jurisdictions. MACs will perform all core claims processing operations for both Parts A and B.
- **Performance-Based Contracting.** The MMA also mandates the use of performance-based contracting requirements. Consistent with the CMS Quality Improvement Organizations' (QIO) use of performance metrics, the MAC contracts will have standards for measuring how well a contractor meets the requirements.[8] These performance standards will be published and available to the public. Two key mandatory performance standards for MACs will be provider and beneficiary satisfaction levels.
- **Conflict of Interest Clause and Certificate.** On June 3, 2005, CMS issued a draft request for information (''RFI'') for Part A and B MACs. Included in the RFI is an extensive conflict of interest clause. The clause requires MACs to prepare and submit a Conflict of Interest Certificate that includes a MAC's plan to mitigate conflicts. The obligation to mitigate conflicts applies equally to a MAC's subcontractors, at any tier. Additionally, there is a disclosure requirement that requires constant monitoring of conflicts and disclosure to CMS of any actual or potential conflict. With the exception of external audits, the conflict of interest clause and certificate in the RFI for Part A and B MACs looks remarkably similar to the one used by CMS for its Medicare Integrity Program (''MIP'').[9]
- **Contract Performance Incentives.** CMS will pay performance incentives, allowing contractors to earn profits when they are more efficient, innovative, and cost-effective and deliver better administrative services to beneficiaries and providers. If the QIO contracts are a precursor, it is likely CMS will use award fees to incentivize contractors. Using the same performance metrics, CMS has determined award fees and contract renewals for QIOs.
- **Re-competition/Contract Renewal.** CMS is given discretion to renew MAC contracts without competition if the MAC has met or exceeded the performance requirements applicable to the contract.[10] The renewal process for MAC contractors is similar to the non-compete provisions used by QIOs.[11] However, competition must now occur not less frequently than once every five years.[12]
- **Limitations on Liability.** The MMA provides MACs certain limitations on liability. A MAC is not liable for payment to a provider absent a showing of *reckless disregard*.[13] However, the MMA specifically states that the limitation of liability provisions do not limit a MAC's liability for a violation of the False Claims Act.[14]
- **Need for Comprehensive Compliance Programs.** The MMA mandates that MACs must establish compliance with certain requirements, such as financial responsibility, legal authority, and quality of services provided. CMS has published a compliance guide, available on its Web site, to aid MACs in this area.[15]

In their capacity as the face of Medicare to providers, practitioners, and suppliers, MACs will be responsible for performing the following functions:

- determination of payment amounts made to Medicare providers
- payment to Medicare providers, including receipt, disbursement, and accounting for funds
- provision of education and assistance to beneficiaries
- offering consultative services to enable providers to establish and maintain fiscal records

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[5] Pub. L. No. 108-173, Section 911.

[6] Pub. L. No. 108-173, Section 911(b) and (b)(1)(A).

[7] Pub. L. No. 108-173, Section 911(a)(6).

[8] The QIO program consists of a national network of 53 QIOs responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations. The program also safeguards the integrity of the Medicare trust fund by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care.

[9] The MIP is designed to promote the integrity of the Medicare program. Congress concluded that there is an inherent conflict of interest created when a carrier or intermediary pays claims and identifies fraud and performance integrity problems. Therefore, Section 202 of the Health Insurance Portability and Accountability Act of 1996 (P.L. No. 104-191) (''HIPAA'') removed from carriers and intermediaries Medicare program integrity functions. As part of the MIP, CMS has awarded Program Safeguard Contractor (''PSC'') contracts, Coordination of Benefits (COB) contracts, and Medicare Managed Care (MMC) Program Integrity Contractors contracts. As authorized by Section 202 and the implementing regulations (found at 42 CFR 421 at al), these contracts all include extensive conflict of interest protections, including submission of a certificate and use of an external auditor to assess the accuracy of the certificate.

[10] The concept of contract renewal for MACs is similar to that found for Quality Improvement Organizations. 42 U.S.C. § 1320c-2 (2005).

[11] 42 U.S.C. § 1320c-2(c)(3) (2005).

[12] Pub. L. No. 108-173, Section 911(b)(1)(B). During testimony before the House Ways and Means Subcommittee on Health in February 2003, Thomas A. Scully, Administrator, Centers for Medicare and Medicaid Services, raised concerns regarding the five-year competition. Mr. Scully said this contract period limitation may be too short in some circumstances. Testimony of Thomas A. Scully, Administrator, CMS, before the House Ways and Means Subcommittee on Health, Feb. 13, 2003, http:\\www.cms.hhs.gov/media/press/testimony.asp?Counter=73.

[13] Pub. L. No. 108-173, Section 911(d).

[14] Pub. L. No. 108-173, Section 911(d)(3)(B).

[15] Centers for Medicare & Medicaid Services, ''Guidance for Medicare Fee-For-Service Contractors,'' (March 2005), available at http://www.cms.hhs.gov/medicarereform/contractingreform/compliance.pdf.

- communication between CMS and providers
- education and technical assistance to providers
- any additional functions necessary to carry out the purposes of the statute.[16]

Excluded from the MACs' functions are activities carried out by contractors under the Medicare Integrity Program (''MIP'')[17] and those called for by QIO contractors. The duties of MIP contractors were taken away from carriers and intermediaries several years ago due to the inherent conflict between detecting fraudulent payments and timely paying claims to providers. When passing the MIP program, Congress concluded the conflict was too great.[18] Likewise, QIOs have now been assigned authority to perform quality of care and review work. Again, this avoids conflicts associated with claims payment by carriers and intermediaries.

In summary, CMS has identified the following differences between the current contracts and future contracts:

CURRENT CONTRACTS

- restrictions on who can receive contract award
- generally limited to cost reimbursement contracts
- performance standards and criteria are published in the Federal Register
- either party may terminate
- contractor must submit monthly expenditure reports, which do not have to be approved in advance in order to access funds
- contracts/agreements renewed year to year

FUTURE CONTRACTS

- full and open competition required
- several types of contracts available
- performance standards contained in the contract
- only government may terminate for convenience or default
- contractor must submit voucher to get paid, and payment is made after voucher is approved
- period of performance maximum of five years.

CMS's Procurement Strategy for the MACs

Between 2005 and 2011, CMS will conduct full and open competitions to replace current Medicare contractors performing claims processing and related functions with MACs that will perform many of the same tasks. The latest timetable calls for the MAC Parts A and B request for proposals (''RFP'') to be posted on FedBizOpps in September 2005, with proposals due in November and contracts to be awarded in June 2006. CMS issued a Request for Information addressed to potential offerors, posted on FedBizOpps on June 3, 2005.

Central to the implementation of the contracting reform is the creation of new jurisdictions to be administered by the MACs. The new jurisdictions will create competition and will balance the workloads of the providers. Under the current system, in 2001 for example, there were 28 fiscal intermediaries and 20 carriers processing Medicare FFS claims. Twenty-six of the fiscal intermediaries are Blue Cross Blue Shield plans and two were commercial insurance companies. Of the 20 carriers processing Medicare FFS claims, 15 were Blue Cross Blue Shield plans and the remaining five were commercial insurance companies.[19] This will change radically with the new jurisdictions.

Under the new MAC jurisdictions, there will be 15 primary A/B MACs servicing the majority of all types of providers (both Parts A and B), four specialty MACs servicing the home health and hospice providers, and four specialty MACs servicing durable medical equipment suppliers. The jurisdictions for the eight specialty MACs will reflect a realignment of the existing jurisdictions and will overlay the boundaries of the 15 primary A/B MAC jurisdictions.

The primary A/B MACs will operate in 15 distinct, non-overlapping geographical jurisdictions. CMS designed the new MAC jurisdictions to promote competition, balance the allocation of workloads, and account for integration of claims processing activities. The result is jurisdictions that reasonably balance the number of beneficiaries, practitioners, and claims. The new MAC jurisdictions are a vast improvement over the current system. The fiscal intermediaries and carriers under the current system are primarily Blue Cross Blue Shield organizations or other health insurance providers. These providers will be forced to expand their jurisdiction and compete among themselves and other contractors.

According to CMS, Medicare's primary A/B MAC jurisdictions are comprised of the following states and territories:

Jurisdiction 1: American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands;

Jurisdiction 2: Alaska, Idaho, Oregon, and Washington;

Jurisdiction 3: Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming;

Jurisdiction 4: Colorado, New Mexico, Oklahoma, and Texas;

Jurisdiction 5: Iowa, Kansas, Missouri, and Nebraska;

Jurisdiction 6: Illinois, Minnesota, and Wisconsin;

Jurisdiction 7: Arkansas, Louisiana, and Mississippi;

Jurisdiction 8: Indiana and Michigan;

Jurisdiction 9: Florida, Puerto Rico, and U.S. Virgin Islands;

Jurisdiction 10: Alabama, Georgia, and Tennessee;

Jurisdiction 11: North Carolina, South Carolina, Virginia, and West Virginia;

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[16] Pub. L. No. 108-173, Section 911(a)(4)(A-G).

[17] Pub. L. No. 108-173, Section 911(a)(5)(A).

[18] The Health Insurance Portability and Accountability Act (also known as the Kassebaum-Kennedy legislation) includes a provision establishing the ''Medicare Integrity Program.'' That provision gives the Centers for Medicare and Medicaid Services specific contracting authority, consistent with Federal Acquisition Regulation, to enter into contracts with entities to promote the integrity of the Medicare program. Pursuant to that MIP authority, CMS maintains 12 indefinite delivery-indefinite quantity (IDIQ) contracts for the Program Safeguard Contractor (PSC) effort. In addition, CMS awarded the Coordination of Benefits (COB) contract to GHI Medicare in November 1999, as well as eight IDIQ contracts for the Medicare Managed Care Program Integrity Contractors effort.

[19] Testimony of Thomas A. Scully, Administrator, CMS, before the House Ways and Means Subcommittee on Health, Dec. 4, 2001.

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Jurisdiction 12: Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania;

Jurisdiction 13: Connecticut and New York;

Jurisdiction 14: Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont;

Jurisdiction 15: Kentucky and Ohio.

CMS plans to begin to compete the workloads of the existing fiscal intermediaries, carriers, regional home health intermediaries, and durable medical equipment regional carriers (''DMERCs'') with a start-up acquisition and transition cycle. The start-up cycle will be the competition of the current DMERC workload and the primary A/B workload for Jurisdiction 3. This scenario was chosen due to the focused, discrete workload. The start-up cycle will be followed by MAC acquisition and transition Cycles One and Two. CMS anticipates each acquisition cycle will take approximately nine to 12 months, from solicitation to contract award.

Transitioning the workload from the existing contractors to the new MACs will take approximately six to 13 months. Under this schedule, the full FFS workload will be transitioned to MACs by October 2009.[20]

Procurement Schedule for MACs Cycle Workload Being Competed

	RFP Issuance Date	Contract Award	Start-Up
DME MAC	April 2005	Sept. 2005	December 2005-June 2006
MAC Jurisdiction 3	Sept. 2005	June 2006	
Cycle One Jurisdictions 1, 2, 4, 5, 7, 12, 13	Sept. 2006	Sept. 2007	
Cycle Two Jurisdictions 6, 8, 9, 10, 11, 14, 15 and Home Health/ Hospice MACs	Sept. 2007	Sept. 2008	

Bid Protests and the New Solicitations

On February 25, 2005, CMS issued a request for information regarding the primary A/B MAC performance measures, including the draft statement of work. A second RFI was issued on FedBizOpps April 11, 2005. On June 3, 2005, CMS issued a further RFI for the primary A/B MACs, which included information regarding the concept of operations, Sections H, L, M, a table of government-furnished property, a table of deliverables and reporting requirements, an implementation handbook, and questions for industry. Comments on the June 3 RFI are due July 5, 2005.

The RFP for the primary A/B MAC Jurisdiction 3 will be available to the public September 2005, with a projected award date of June 2006, and cutover date of July 2007.[21] The RFPs for Jurisdictions 1, 2, 4, 5, 7, 12 and 13 are expected in September 2006 and for Jurisdictions 6, 8, 9, 10, 11, 14 and 15 in September 2007.[22]

The MAC solicitations will be subject to the Competition in Contracting Act and the FAR, including full and open competition requirements and the bid protest procedures of the Government Accountability Office (''GAO''). Any protest regarding the terms of the MAC RFP must be filed by the initial proposal submission due date. To avoid solicitation challenges by offerors, agencies will sometimes issue a draft RFP seeking feedback regarding potential solicitation problems. CMS has issued some draft solicitation terms for the first A/B MAC procurement in its June 3 RFI.

Given limitations on previous CMS Medicare procurements, there have not been a significant number of protests to the GAO or the Court of Federal Claims involving the Medicare program. This likely will change under the new regime. Pre-award protests likely will focus on terms of the solicitation that offerors believe unduly restrict competition. Post-award challenges will raise many of the typical protest issues: evaluation of cost or price, past performance and technical proposals, as well as cost realism analysis and best value determinations.

Draft provisions are unclear on whether CMS intends to award MAC contracts on the basis of initial proposals or to conduct discussions with offerors in the competitive range and request final proposal revisions (''FPRs''). Given the complexity of the work to be performed by the MACs and given the many changes to the Medicare program, CMS may well conduct discussions to ensure that offerors have a full and equal understanding of the performance work requirements and basis for cost or price.

Preparing for MAC Bidding

The enabling legislation for the MMA makes the FAR applicable to covered contracts. MACs will now be required to follow the same rules and regulations that govern most U.S. government contracts. Current fiscal intermediaries and carriers that do not have other cost-reimbursable U.S. government contracts, such as contracts issued by the Center for Disease Control (''CDC''), Department of Defense (''DOD''), or Department of Veterans Affairs, need to start preparing for the financial and audit requirements immediately.

In addition to complying with the FAR, MACs may also be required to follow the Cost Accounting Standards (''CAS'') and to file a Cost Accounting Standards Board Disclosure Statement.[23] For a potential MAC contractor not familiar with FAR and CAS requirements, the list of prerequisites is formidable. Those contractors must learn to deal with government auditors, such as the Defense Contract Audit Agency (''DCAA''), as well as the cost and pricing analysts and contracts personnel within CMS.

[20] Medicare Contracting Reform, Medicare's New Administrative Contractor Jurisdictions, February 2005, available at http://www.cms.hhs.gov/medicarereform/contractingreform/maps/mac_jurisdiction_facts.pdf.

[21] Standard Questions and Answers, Answer 3, March 8, 2005, available at http://www.cms.hhs.gov/medicarereform/contractingreform.

[22] Standard Questions and Answers, Answer 3, March 8, 2005, available at http://www.cms.hhs.gov/medicarereform/contractingreform/maps/mac_jurisdiction_facts.pdf.

[23] Categories of contracts exempt from CAS standards are specified at 48 C.F.R. § 9903.201-1(b) and include the following: (1) sealed bid contracts; (2) negotiated contracts/subcontracts not in excess of $500,000; (3) contracts/subcontracts with small businesses; (4) contracts/subcontracts with foreign governments, their agents, or instrumentalities, except for CAS 401 and 402; (5) contracts/subcontracts in which price is set by law; (6) firm fixed-price contracts/subcontracts with economic price adjustment or for acquisition of commercial items; and (7) contracts/subcontracts of not less than $7.5 million, provided that at the time of award, the business unit of the contractor/subcontractor is not currently performing any CAS-covered contracts/subcontracts valued at $7.5 million or greater.

Pre-Award Surveys

CMS will require that the contractor's cognizant government auditors conduct a review of proposals as a part of the award process. Contractors that currently have DOD or other civilian agency work are familiar with the pre-award proposal review. CMS is likely to choose DCAA auditors to perform the contract audit functions on these contracts.

If a MAC proposal is an offeror's first proposal effort reviewed by DCAA, the auditors will first focus on the adequacy of the offeror's accounting system. In a pre-award survey, the auditors will determine if the accounting system is sufficient for the recording and accumulation of costs under the contract.

The accounting system survey covers numerous areas. These include: (1) whether the accounting system properly segregates direct costs incurred from indirect costs (overhead and/or general and administrative), and (2) whether the accounting system can identify and accumulate direct costs by contract. Other areas to be reviewed include: (3) whether cost allocations are employed in a consistent method for apportioning indirect costs to contracts; (4) whether costs are accumulated under general ledger control; (5) whether the timekeeping system identifies employee-time charges by final cost objectives; (6) whether labor costs are accumulated in a labor distribution system that tracks both direct and indirect charges; (7) whether costs are summarized on at least a monthly basis via posting to the books of account; and (8) for cost-type contracts, whether FAR Part 31 ''unallowable'' costs are specifically excluded from billings to the U.S. government.[24]

Item (8) above, relating to the exclusion of unallowable costs, is critical for cost-type contracts. Contractors must understand what should and should not be included in proper billings to the government — either as a direct charge, or a charge via an indirect cost pool. Unallowable charges consist of bad debts, contingencies, contributions and donations, entertainment, alcoholic beverages, and the like. Travel costs are allowable to the extent they are restricted to the Federal Travel Regulation per diem limits. There are significant penalties, including criminal charges, for failure to segregate unallowable costs from billings or cost claims and for failure to properly certify associated disclosures.

With all of these factors in mind, the auditors prepare a report and make their conclusions and recommendations to the contracting officer. The review either results in an opinion that the accounting system is adequate, or notes where changes need to be made.

Cost/Price Proposal Review

The government's audit of a MAC cost proposal will consist of an evaluation of supporting data accumulated and prepared for audit review. A ''basis for estimate'' document should be prepared and will serve as a roadmap for the auditor to follow in reviewing the cost elements.

The auditors may evaluate the proposed costs from all aspects, including a review of the calculation of labor rates, reasonableness of the salaries, proposed salary escalation rates, proposed travel costs through both the airfares and per diem rates used, support provided for subcontractors, and other internal expenses. Also, the auditors will spend significant time assessing proposed overhead and general and administrative (''G&A'') rates. The auditors will assess the proposed indirect cost pool elements for reasonableness as well as allocability and will review the composition of the cost pool base of allocation, such as total costs for G&A or direct labor dollars for overhead.

The auditors will prepare a report for the contracting officer on the results of their review. Factual matters, like errors or omissions, will be discussed with the offeror by the auditor, but otherwise, the specific recommendations made by the auditor are withheld from the contractor until after award.

CAS-Covered Contracts

Contracts resulting from the MAC program may be subject to CAS. Generally, if a contractor already has CAS-covered contract awards, additional awards will be CAS-covered if they exceed $500,000 in value. For a first-time contractor without prior CAS-awards, a $7.5 million contract value threshold must be exceeded to ''trigger'' CAS applicability. Contracts of less than $7.5 million are exempt, provided that at the time of award, the business unit is not currently performing any CAS-covered contract or subcontract valued at $7.5 million or greater. The ''value'' is determined as the total value of the award, plus all unpriced options, assuming they are all to be awarded.[25] The specifics of CAS are contained at 48 C.F.R. Chapter 99, and implemented in FAR Part 30.

CAS Disclosure Statement

If the value of the contract to be awarded is expected to exceed $50 million, the contractor will be required to submit a CAS ''Disclosure Statement'' along with the proposal. A Disclosure Statement details the contractor's accounting practices as they relate to government contracting and financial management practices. Areas covered in a disclosure statement include: direct costs, indirect costs, direct versus indirect costs, depreciation and capitalization practices, other costs and credits, deferred compensation and insurance costs, and home office expenses. A typical Disclosure Statement consists of 25-30 pages of ''checked box'' or brief narrative explanations. In addition, a number of areas require detailed, supplemental explanations. The total document can easily exceed 75-100 pages depending on the size and complexity of the company/business unit.

The auditors typically conduct a separate ''adequacy'' review of the Disclosure Statement in addition to individual compliance reviews of the applicable CAS standards. These review efforts will generally not be conducted until well after contract award.

If the contract value is less than $50 million, the requirement for the submission of a Disclosure Statement is waived and the contractor will be considered to be subject to ''modified'' CAS-coverage (CAS 401, 402, 405 and 406). Modified CAS-coverage (vs. full coverage) applies to a negotiated contract of less than $50 million, but more than $500,000, awarded to a business unit that received less than $50 million in net CAS-covered awards in the immediately preceding cost accounting period.

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[24] Available at http://www.cms.hhs.gov/medicarereform/contractingreform/cas/accounting_systems.pdf.

[25] CAS applicability standards can be found at 48 C.F.R. § 9903.201-1.

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For a contractor receiving its first CAS-covered award, there is a phase-in period before the Standards become applicable. A few Standards, however, are effective immediately, such as CAS 405 which requires the removal of unallowable costs.

Other Reviews

The auditors may conduct other reviews during contract performance if a company is awarded a MAC cost-type contract. Billing systems reviews, forward pricing rate reviews, timekeeping ''floorchecks'', and the annual incurred cost audit are among the key reviews. The incurred cost audit submission is required to be prepared within six months after the close of the fiscal year and must include the summary of costs incurred for the contractor's cost-reimbursable U.S. government work. The annual submission also includes the details of indirect cost pools and allocation bases and a number of other required schedules, such as subcontractor costs, number of employees at locations, income tax returns, board of directors minutes, reconciliation of costs booked to billed, and related areas.

Compliance Issues

A key resource available to aid a potential MAC is a CMS document, available at www.cms.gov, entitled ''Compliance Program Guidance for Medicare Fee-For-Service Contractors.'' This guide, dated March 2005, covers elements of an effective compliance program, and includes such topics as the need for written policies and procedures, an effective compliance officer, effective training and education programs, and ongoing auditing and monitoring initiatives.[26] More specifically, the compliance guide addresses the following issues:

1. WRITTEN POLICES AND PROCEDURES
   standards of conduct
   retention of records and information systems
   compliance as an element of performance plan
2. DESIGNATION OF A COMPLIANCE OFFICER AND A COMPLIANCE COMMITTEE
3. CONDUCTING EFFECTIVE TRAINING AND EDUCATION
   formal training programs
   informal on-going compliance training
4. DEVELOPING EFFECTIVE LINES OF COMMUNICATION
   hotline or other system for reporting suspected noncompliance
   routine communication and access to the compliance officer
5. AUDITING AND MONITORING
   auditing
   monitoring
   risk areas
6. ENFORCEMENT THROUGH PUBLICIZED DISCIPLINARY GUIDELINES AND POLICIES DEALING WITH INELIGIBLE PERSONS
   consistent enforcement of disciplinary policies
   employment of, and contracting with, ineligible persons
7. RESPONDING TO DETECTED OFFENSES, DEVELOPING CORRECTIVE ACTION INITIATIVES AND REPORTING TO GOVERNMENT AUTHORITIES
   Responding to Offenses and Developing Corrective Action
   Reporting to the Government.

The compliance guide is based on reviews of existing compliance programs implemented by Medicare FFS contractors, the Federal Sentencing Guidelines promulgated by the United States Sentencing Commission, similar guidance documents prepared by the HHS Office of Inspector General, other business segments of the healthcare industry, and contemporary literature in the field of compliance.[27]

Summary

Section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 will have sweeping consequences in the way CMS conducts its Medicare responsibilities. Existing contractors will be subject to competitive forces they have not encountered. FAR and CAS requirements are being imposed for the first time by the Government on the Medicare Part A/B programs. A large number of existing fiscal intermediaries and providers who have not done business in the federal environment will have a steep learning curve.

Each company desiring to become a MAC should take stock of its compliance and begin remedial measures necessary to ensure conformity with all of the CMS proposal requirements, as well as FAR and CAS requirements.

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[26] *See supra*, Note 14.

[27] *Id.*