CMS Manual System	Department of Health & Human Services (DHHS)
Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications Manual	Centers for Medicare & Medicaid Services (CMS)
Transmittal 6	**Date: MAY 21, 2004**
	CHANGE REQUEST 3179

I. **SUMMARY OF CHANGES:** Medicare contractor provider communications program changes and requirements for provider customer service include: order of manual rearranged - telephone inquiries is now the first section followed by written and walk-in inquiries, related material is separated into subsections, FY04 Budget Performance Requirements (BPRs) is manualized, to include: 1) all call centers should make live telephone service available to callers from 800 a.m. through 4:30 p.m. for all time zones of the geographical area serviced, Monday through Friday, 2) all contractors must have the ability to incorporate a short CMS-created provider satisfaction survey in their IVR to be accessed by a CSR transfer, 3) all contractors are required to provide CMS with remote access to their general provider inquiries toll free lines, 4) all contractors are required to utilize an IVR, 5) IVR systems must be available 24 hours a day with allowances for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance, 6) all contractors must develop a process to evaluate the quality of their IVR systems, 7) contractors are prohibited from configuring their premise equipment to return "soft busies", 8) contractors must only allow general provider inquiries over their provider inquiries lines, 9) all contractors must identify a primary customer service contact person, 10) all contractors must have, or develop, a written contingency plan describing how the Medicare Provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters, 11) all contractors must train their CSRs about how to find, navigate and fully use their Medicare provider education Web site. CSRs must be connected to and able to use the contractor's Web site and the CMS Web site.

Contractors are now required to meet the following performance standards: a) for callers choosing to talk with a CSR, 85% or more telephone calls shall be answered within the first 60 seconds, b) every call center must have a call completion rate of no less than 80%, c) for all provider calls monitored each month, at least 90% or higher must score a "Pass" for Adherence to Privacy Act, d) for all provider calls monitored each month, at least 90% or higher must score as Achieves Expectation for Customer Skills Assessment, e) for all provider calls monitored each month, at least 90% or higher must score as Achieves Expectation for Knowledge Skills Assessment.

All other changes are minor language modifications or clarifications to facilitate understanding.

NEW/REVISED MATERIAL - EFFECTIVE DATE: February 1, 2004
*IMPLEMENTATION DATE: June 21, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
   (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/20/Provider Services
R	3/20.1/Guidelines for Telephone Service
R	3/20.1.1/Toll Free Network Services
R	3/20.1.2/Publication of Toll Free Numbers
R	3/20.1.3/Call Handling Requirements
R	3/20.1.4/Customer Service Assessment and Management System (CSAMS) Reporting Requirements
R	3/20.1.5/CSR Qualifications
R	3/20.1.6/Staff Development and Training
R	3/20.1.7/Quality Call Monitoring (QCM)
R	3/20.1.8/Disclosure of Information (Adherence to the Privacy Act)
R	3/20.1.9/Fraud and Abuse
N	3/20.1.10/Next Generation Desktop (NGD)
R	3/20.1.11/Call Center User Group (CCUG)
R	3/20.1.12/Performance Improvements
R	3/20.2/Guidelines for Handling Written Inquiries
R	3/20.2.1/Contractor Guidelines for High Quality Written Responses to Inquiries
R	3/20.3/Walk-In-Inquiries
R	3/20.3.1/Guidelines for High Quality Walk-In-Service
N	3/20.4/Surveys

III. FUNDING:

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

*Medicare contractors only

Attachment - Business Requirements

Pub. 100-09	Transmittal: 6	Date: May 21, 2004	Change Request 3179

SUBJECT: Provider/Supplier Communications – Revisions and Additions to Existing Contractor Requirements

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services' (CMS) goal is to continuously improve Medicare customer satisfaction through the delivery of accurate, timely and consistent customer service. The CMS' vision is for customer service to be a trusted source of accurate and relevant information that is convenient, accessible, courteous and professional. Contractors are required to have a provider (or supplier) communications program.

The fundamental goal of this program is to inform and educate Medicare providers or suppliers served by the contractors about relevant and current Medicare program policies, procedures, and billing information. The CMS has issued provider communications customer service program requirements to Medicare contractors.

B. Summary of Changes: Contractors' provider communications program changes and requirements for provider customer service include: order of manual rearranged - telephone inquiries is now the first section followed by written and walk-in inquiries, related material is separated into subsections, FY 04 Budget Performance Requirements (BPRs) is manualized.

The accompanying manual update adds additional program requirements and makes minor language changes to the existing provider customer service instructions.

C. Policy: Sections 1816(a) and 1842(a)(3) of the Social Security Act require that Medicare contractors serve as a channel of communications for information to and from providers/suppliers.

D. Provider Education: None. This change request does not require providers be educated about it. Rather it articulates the methodology that contractors use for provider education.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3179.1	Medicare contractors shall implement the provider/supplier communications program requirements as stated below and contained in the revised manual instructions:	Medicare contractors

3179.2	All call centers should make live telephone service available to callers from 8:00 a.m. through 4:30 p.m. for all time zones of the geographical area serviced, Monday through Friday.	
3179.3	All contractors must have the ability to incorporate a short CMS-created provider satisfaction survey in their IVR to be accessed by a CSR transfer.	
3179.4	All contractors are required to provide CMS with remote access to their general provider inquiries toll free lines	
3179.5	All contractors are required to utilize an IVR.	
3179.6	IVR systems must be available 24 hours a day with allowances for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance.	
3179.7	All contractors must develop a process to evaluate the quality of their IVR systems.	
3179.8	Contractors are prohibited from configuring their premise equipment to return "soft busies",	
3179.9	Contractors must only allow general provider inquiries over their provider inquiries lines,	
3179.10	All contractors must identify a primary customer service contact person.	
3179.11	All contractors must have, or develop, a written contingency plan describing how the provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters.	
3179.12	All contractors must train their CSRs about how to find, navigate and fully use their Medicare provider education Web site. CSRs must be connected to and able to use the contractor's web site and the CMS Web site.	

3179.13	Contractors are now required to meet the following performance standards: a) For callers choosing to talk with a CSR, 85% or more telephone calls shall be answered within the first 60 seconds, b) For callers choosing to talk with a CSR, 85% or more telephone calls shall be answered within the first 60 seconds, c) Every call center must have a call completion rate of no less than 80%, d) For all provider calls monitored each month, at least 90% or higher must score a "Pass" for Adherence to Privacy Act, e) For all provider calls monitored each month, at least 90% or higher must score as Achieves Expectation for Customer Skills Assessment, f) For all provider calls monitored each month, at least 90% or higher must score as Achieves Expectation for Knowledge Skills Assessment.	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: This CR has no known dependencies.

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: February 1, 2004 **Implementation Date: June 21, 2004** **Pre-Implementation Contact(s): Amy Abel-Matkins, 410 786-1858** **Post-Implementation Contact(s): Amy Abel-Matkins, 410 786-1858**	**These instructions shall be implemented within your current operating budget.**

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 3 - Provider Customer Services

Table of Contents

(Rev. 6, 05-21-04)

20 - Provider Services
(Rev. 6, 05-21-04)

A2- 2959, B2-5105

The Centers for Medicare & Medicaid Services' (CMS) goal is to continuously improve Medicare customer satisfaction through the delivery of accurate, timely and consistent customer service. The CMS' vision is for customer service to be a trusted source of accurate and relevant information that is convenient, accessible, courteous and professional.

Every member of the customer service team shall be committed to providing the highest level of service to Medicare providers. This commitment shall be reflected in the manner in which you handle each provider inquiry. The following guidelines are designed to help contractors to ensure CMS' goals and visions are met.

Each contractor shall prioritize its work and meet standards for inquiry workloads in the following order of precedence:

1. *Provider telephone inquiries;*

   Including:

   - *Answering provider telephone inquiries*
   - *Quality call monitoring performance measures*
   - *Staff development and training*

2. *Provider written inquiries; and*

3. *Provider walk-in inquiries*

By October 31st of each fiscal year, call centers shall appoint a primary customer service contact person to CMS; this would normally be the call center manager. The contact's name, business address, business telephone number, and e-mail shall be submitted to the service reports mailbox at servicereports@cms.hhs.gov and to the RO. If the contact person is replaced, the contractor shall submit the new contact information to the service reports mailbox and to the RO within 2 weeks of the change.

By October 31st of each fiscal year, call centers shall submit a high-level organizational chart for call center's provider inquiry function to the service reports mailbox at servicereports@cms.hhs.gov and to the RO.

20.1 - Guidelines for Telephone Service
(Rev. 6, 05-21-04)

A2- 2959, B2-5105

The guidelines established below apply to contractors' general provider inquiry telephone numbers. The standards shall not apply to those inquiries handled by other units within the

contractor (e.g., appeals, fraud, MSP). To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) shall be separate from beneficiary inquiry numbers. Providers shall not use numbers established for beneficiary inquiries.

A - Availability of Telephone Service

1. Contractors shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks. Normal business hours for live telephone service are defined as 8:00 a.m. through 4:30 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where contractors provide national coverage or where contractors serve areas outside of the continental United States, CMS will entertain a waiver request for hours of operation.

2. On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of the fiscal year about any planned call center closures. This list shall also be sent to the appropriate RO. Changes may be made to this schedule during the fiscal year and shall be sent to CMS CO and RO prior to the holiday impacted by the change. Call centers shall notify the provider community of the planned closure.

3. Call center staffing shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained.

B - Automated Services-Interactive Voice Response (IVR)\

1. Although the provider shall have the ability to speak to a CSR during normal call center operating hours, automated "self-help" tools, such as IVRs, shall also be used by all contractors to assist with handling inquiries. IVR service is intended to assist providers in obtaining answers to various Medicare questions, including those listed below:
   - Contractor hours of operation for CSR service

   - General Medicare program information. (Contractors shall target message duration to be under 30 seconds. Contractor shall have the technical capability to either require callers to listen or to allow them to bypass the message as determined by CMS. In cases where CMS makes no determination the contractor shall use their own discretion.)

   - General information about appeal rights and actions required of a provider to exercise these rights

   - Specific information about claims in process and claims completed. (By October 31st of the fiscal year, those call centers providing claim specific information

through the IVR shall indicate how they are authenticating the caller. A copy shall be sent to both the contractor's RO contact and to the service reports mailbox at servicereports@cms.hhs.gov.)

NOTE: *IVRs shall be updated to address areas of provider confusion as determined by contractors' inquiry analysis staff and CMS best practices at least once every six months.*

2. *Call centers shall submit to CMS a call flow document that outlines their IVR scripts and call flow, clearly showing all provider inquiry transactions that they are performing through their IVR. Contractors shall also indicate how they are authenticating the call when claims specific information is involved. The contractors can deliver this document in Visio, Paintbrush, Word, or PowerPoint. A copy shall be sent to both the contractor's RO and to the central office (CO) at servicereports@cms.hhs.gov. If the contractor changes the IVR script or call flow, they shall submit the revised document to these parties within 2 weeks of implementing the changes.*

3. *The IVR shall be available to providers 24 hours a day with allowances for normal claims processing and system mainframe availability, as well as normal IVR and system maintenance. When information is not available, contractors shall put a message alerting providers. Waivers shall be granted as needed to allow for normal IVR and system maintenance.*

NOTE: *IVRs shall be programmed to provide callers with an after-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR.)*

4. *Contractors shall print and distribute a clear IVR operating guide to providers upon request. The guide shall also be posted on the contractor's Web site.*

5. *Contractors who are able to provide claims status information through their IVR shall require providers to use the IVR to obtain this information.*

6. *The CMS will evaluate the quality of the contractors' IVRs. These evaluations will be based on the following:*

   - *IVR Availability*
   - *Accuracy of the information provided*
   - *Timeliness of the information provided*
   - *Quality of the information provided*
   - *Tone*

C– Provider Satisfaction Survey

Contractors shall have the ability to incorporate a short CMS-created provider satisfaction survey in their Interactive Voice Response Unit (IVR) to be accessed by a transfer from the

Customer Service Representative (CSR). The survey will use touch-tones; therefore speech recognition is not required to meet this requirement.

20.1.1 - Toll Free Network Services

(Rev. 6, 05-21-04)

A - Inbound Services

The CMS will use the General Services Administration's FTS 2001 contract for its toll-free network. All inbound provider telephone service will be handled over the toll-free FTS network, with the designated long-distance contractor. Any new toll-free numbers and the associated network circuits used to carry these calls shall be acquired via the FTS 2001 network. Contractors shall not maintain their own local inbound lines.

B - Processes for Ordering More Lines, Changing Configurations, or Disconnecting Lines

1. *The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either contractor or CMS. All change requests associated with the FTS 2001 network (e.g., adding or removing channels or TIs, office moves, routing changes), shall be processed through the Provider Telecommunications Technical Support Contractor (TSC). Contact information for the TSC is located at http://www.cms.hhs.gov/contractors/customerserv/network.asp. Any CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of CSAMS data and traffic reports.*

2. *If a contractor is requesting changes they shall provide an analysis of their current telephone environment (including a detailed traffic report) specific to the service being requested that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information shall be gathered at the contractor site through the contractor's switch and through the MCI Customer Center reports. This information should be sent to CO and the appropriate RO. Based on technical merit and availability of funds, CO will review the recommendation and make a determination. In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance.*

C – Troubleshooting

To ensure that provider toll-free service is available and clear, CMS established the Provider Incident Reporting & Response System (PIRRS). The PIRRS establishes a standard incident response and resolution system for Medicare contractors who are troubleshooting problems. The CMS has assembled a multi-functional team, consisting of both MCI telecommunications support and personnel from the TSC to quickly and effectively resolve reported problems. To report and monitor a problem, contractors shall follow these steps:

Step 1

Isolate the problem and determine whether it is caused by internal customer premise equipment or the toll-free network service.

- Internal Problem - The contractor's local telecommunications personnel shall resolve, but report per steps below.

- Toll-Free Network Service Problem - Contractor reports the problem to MCI by calling 1-888-387-7821.

Step 2

Involve personnel from the provider TSC, if needed, to answer technical questions or to facilitate discussions with the MCI Help Desk. Contact information for the TSC is located at http://www.cms.hhs.gov/contractors/customerserv/network.asp

Step 3

File an incident report with the provider TSC for major interruptions of service. The TSC will notify the appropriate CMS staff. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service. The contractor shall send an email to service reports that summarizes the problem and the steps taken to restore full service. The contractor shall send a follow-up email to service reports when the problem has been resolved.

Step 4

Use MCI's Customer Service Center to review documentation, track trouble tickets, or to close a trouble ticket online.

Step 5

File a monthly report with CMS at servicereports@cms.hhs.gov about interruption of service - including both MCI related and in-house and send a copy to the contractor's RO.

D - Disaster Recovery

1. When a call center is faced with a situation that results in a major disruption of service, the call center shall take the necessary action to ensure that callers are made aware of the situation. This service is intended to supplement the contractor's existing disaster recovery or contingency plans. Whenever possible, the call center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the call center switch, the call center shall contact the Beneficiary Network Services Center (BNS) and request that they initiate a pre-scripted disaster recovery message based in the FTS 2001 network. Contact information for the BNS is located at http://www.cms.hhs.gov/contractors/customerserv/network.asp. Once the problem is

resolved, the call center shall also contact the BNS to de-activate the FTS 2001 network disaster messages. For provider only call centers, contractors shall contact the BNS only for the disaster situations. It will manage only these types of requests. The CMS designated the single point of contact to streamline the process for shared call centers and avoid making two calls in an emergency situation. The BNS contacts and updates the provider TSC when a provider call center disaster situation occurs. For all other FTS 2001 support requests, provider call centers shall follow their normal procedures.

2. By December 31st of each fiscal year, call centers shall update their written contingency plan describing how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The plan shall cover partial loss of telecommunications capabilities due to equipment or network failures through the total loss of a call center. The plan may include arrangements with one or more other contractors to assist in telephone workload management during the time the call center is unable to receive provider phone calls. Plans may be submitted to the service reports mailbox at servicereports@cms.hhs.gov or via postal mail, with a copy to the RO. Contractors may choose to submit the portion of their contingency plan developed under Activity Code 11206 that deals with their call center. In the event that the contractor develops a different plan related only to their call center, these costs shall be charged to 33001, not 11206.

E - Inbound Service Costs

The CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for FTS-2001 toll-free service. The costs associated with the installation and monthly fees for this toll-free service will be paid centrally by CMS and shall not be considered by contractors in their budget requests. However, contractors shall still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors shall maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and shall provide this information upon request by RO or CO.

20.1.2 - Publication of Toll Free Numbers

(Rev. 6, 05-21-04)

A - Directory Listings

Contractors shall not be responsible for the publication of their inbound 800 services in any telephone directory. However, at their discretion, contractors may choose to publish their general provider toll free number in the directory they feel is most appropriate.

B - Printing Toll Free Numbers on Provider Notices

Any toll-free Medicare provider customer service number provided and paid for by CMS shall be printed on all provider notices, (RAs, etc.) immediately upon activation. Contractors shall display this toll-free number prominently so the reader will know whom to contact regarding the notice.

C – Publicizing Toll Free Numbers on the Web

Any toll-free Medicare provider customer service number provided and paid for by CMS shall be prominently displayed on the contractor's Web site.

20.1.3 - Call Handling Requirements
(Rev. 6, 05-21-04)

A - Call Acknowledgement

Contractors shall program all systems related to inbound provider calls to the center to acknowledge each call within 20 seconds before a CSR, IVR or ACD prompt is reached. This measure shall be substantiated and/or reported upon request by CMS.

B - Providing Busy Signals

Call center customer premise equipment shall not be configured/programmed to return, "soft busies." Contractor call centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor shall optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.

C - Queue Message

Contractors shall provide a recorded message that informs callers waiting in queue to speak with a CSR of any temporary delay before a CSR is available. They shall use the message to inform the provider to have certain information readily available (e.g., health insurance claim number) before speaking with the CSR. The queue message shall also be used to indicate non-peak time frames for callers to call back when the call center is less busy.

D – General Inquiries Line

The provider toll free numbers installed for Part A, Part B, DMERC, and RHHI general provider inquiry traffic shall not be used for other applications (e.g., MSP, reviews, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. At a minimum, these general lines shall be used to handle questions related to billing, claims, eligibility, and payment. Complex questions (ones that might currently require an internal transfer) shall be directed to the "other" units on a different toll free number

than the general inquiry number. It is not necessary for each "other" function to have its own unique toll free number, although contractors can choose this option. Other acceptable options are having a single "other" toll free number to handle all the "other" (non general inquiry) functions or a few "other" toll free numbers handling more than one "other" function via each number. The CSRs on the general inquiry line shall not transfer callers to the "other" functional units but rather shall instruct the caller to hang up and dial the appropriate number. "Other" numbers shall not be subject to CSAMS reporting or the call performance standards that govern the general inquiries line. If contractors need toll free service for other Medicare applications currently being handled on the provider claims inquiry toll free numbers, please follow the established process for adding additional toll free numbers. We will consider all requests for additional toll free numbers.

E - CSR Identification to Callers

The CSRs shall identify themselves when answering a call, however the use of both first and last names in the greeting is optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR shall provide both first and last name. Where the personal safety of the CSR is an issue, call center management shall permit the CSR to use an alias. This alias shall be known for remote monitoring purposes. The CSRs shall also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

F- Sign-in Policy

Contractors shall establish and follow a standard CSR sign-in policy in order for CMS to ensure that data collected for telephone performance measurement are consistent from contractor to contractor. The sign-in policy shall include the following:

- The CSRs available to answer telephone inquiries shall sign-in to the telephone system to begin data collection;

- The CSRs shall sign-off the telephone system for breaks, lunch, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR work-state or category that accumulates this non-telephone inquiry performance data so that it can be separated and not have any impact on the measurements CMS wants to collect, this work-state or category may be utilized in lieu of CSRs signing-off the system; and

- The CSRs shall sign-off the telephone system at the end of their workday.

G - Service Level

Each month, contractors shall answer no less than 85 percent of all callers who choose to speak with a CSR within the first 60 seconds of their delivery to the queuing system.

H - Initial Call Resolution

Each month, contractors shall handle no less than 90 percent of the calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR.

I – Call Completion

Each CSR line shall have a monthly completion rate of no less than 80%.

J - Quality Call Monitoring:

- *Frequency of Monitoring: Contractors shall monitor a minimum of three calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a minimum of three calls, including at least one of each type, during the month. Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.*

- *Performance Standards for Quality:*

    1. *Of all calls monitored each month, the number of CSRs scoring as "Pass" for Adherence to Privacy Act shall be no less than 90 percent.*

    2. *Of all calls monitored each month, the percent of CSRs scoring as "Achieves Expectation" or higher shall be no less than 90 percent for Customer Skills Assessment.*

    3. *Of all calls monitored each month, the percent of CSRs scoring as "Achieves Expectation" or higher shall be no less than 90 percent for Knowledge Skills Assessment*

K - Equipment Requirements:

- *To ensure that inquiries receive accurate and timely handling, contractors shall provide the following equipment:*

    1. *Online access to a computer terminal for each CSR responsible for claims-related inquiries. Locate the computer terminal so that representatives can research data without leaving their seats.*

    2. *Access to the contractor's Web site and www.cms.hhs.gov.*

    3. *An outgoing line for callbacks.*

    4. *A supervisory console for monitoring CSRs.*

- *Any contractor call center purchases or developmental costs for hardware, software or other telecommunications technology that equal or exceed $10,000 shall first be approved by CMS. Contractors shall submit all such requests to the servicing RO for review. The RO shall forward all recommendations for approval to CO for a final decision.*

20.1.4 - Customer Service Assessment and Management System (CSAMS) Reporting Requirements

(Rev. 6, 05-21-04)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display call center telephone performance data. Each call center site shall enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To change data after the 10th of the month, users shall inform CO via CSAMS at csams@cms.hhs.gov. In those rare situations where one or more data elements are not available by the 10th of the month, the missing data shall not prevent the call center from entering all other available data into CSAMS timely. The call center shall supply the missing data to CMS within two workdays after it becomes available to the contractor. Definitions, calculations and additional information for each of the required telephone customer service data elements as well as associated standards are posted on the CMS' telephone customer service Web site at https://bizapps.cms.hhs.gov/csams. Call centers shall use CSAMS call handling data to improve call center performance.

A - Definition of Call Center for CSAMS

*All contractors **shall** ensure that monthly CSAMS data are being reported by individual call centers and that the data are not being consolidated. The CMS wants telephone performance data reported at the lowest possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs are answering similar type calls (A, B, DMERC, A&B, or some breakout or consolidation of these calls). The physical location could be in the same room, building, or complex but not in a separate geographic location, city, state, etc.*

B - Data to Be Reported Monthly

Contractors shall capture and report the following data each month:

- ***Number of Attempts -** This is the total number of calls offered to the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/*

- ***Number of Failed Attempts** - This represents the number of calls unable to access the call center via the toll-free line. This data shall also be taken from reports produced by*

FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/

- ***Call Abandonment Rate*** *- This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.*

- ***Average Speed of Answer -*** *This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.*

- ***Total Sign-in Time (TSIT)*** *- This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.*

- ***Number of Workdays*** *- This is the number of calendar days for the month that the call center is open and answering telephone inquiries. For reporting purposes, a call center is considered open for the entire day even if the call center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.*

- ***Total Talk Time*** *- This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.*

- ***Available time*** *- Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).*

- ***After Call Work Time*** *- This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.*

- ***Status of Calls Not Resolved at First Contact*** *- Report as follows:*

    1. *Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.*

    2. *Number of callbacks closed within 5 workdays. This number is based on calls received for the calendar month and represents the number closed within 5 workdays even if a callback is closed within the first 5 workdays of the following month. For call centers that have transitioned to the Next Generation Desktop, the collection of this data point will be automated and will be based on 7 calendar days rather than 5 workdays.*

- **IVR Handle Rate** - *Report data needed to calculate the IVR handle rate.*

  This includes:

  1. *The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours); and*

  2. *The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message and did not subsequently transfer to a CSR).*

- **Calls in CSR queue** - *This is the total number of calls delivered to the CSR queue.*

- **Calls Answered by CSRs** - *This represents the total number of calls answered by all CSRs for the month from the CSR queue.*

- **Calls Answered <= 60 Seconds** - *This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.*

- **Quality Call Monitoring (QCM)-Number of CSRs Available for Monitoring** - *This is the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time CSRs. This number is obtained from the QCM Database.*

- **QCM-Number of Completed Scorecards** – *This is the number of scorecards that were completed and entered into the QCM database for the month. This number is obtained from the QCM Database.*

- **QCM-Customer Skills Assessment** - *This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.*

- **QCM-Knowledge Skills Assessment -** *This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.*

- **QCM-Privacy Act** - *This is the percentage of calls that scored as pass. This number is obtained from the QCM Database.*

20.1.5 - CSR Qualifications

(Rev. 6, 05-21-04)

Contractors shall fully train CSRs to respond to provider questions, whether of a substantive nature, a procedural nature, or both. The CSRs who answer telephone calls shall be qualified to answer general questions about initial claims determinations, operation of the Medicare

program, and appeal rights and procedures. To ensure that these services are provided, CSRs shall have the following qualifications:

- *Knowledge of Medicare (prior customer service experience in positions where the above skills are utilized, e.g., claims representative or telephone operator, is desired but not necessary);*
- *Good telephone communications skills;*
- *Flexibility to handle different situations that may arise;*
- *Good keyboard computer skills.*

20.1.6 – Staff Development and Training
(Rev. 6, 05-21-04)

1. *Contractors shall provide training for all new CSR hires and refresher training updates for existing personnel. This training shall enable the CSRs to answer the full range of customer service inquiries. The training, at a minimum, shall include technical instructions on Medicare eligibility, coverage benefits, claims processing, Medicare systems and administration, customer service skills and telephone techniques, CSAMS performance requirements, the function of the IVR unit and the use of a computer terminal. Contractors shall have a training evaluation process in place to certify that the trainee is ready to independently handle inquiries.*

2. *Upon receipt of CMS developed standardized CSR training materials, including job aids, contractors shall implement these materials for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted to the following Web site: http://www.cms.hhs.gov/contractors/customerserv/train.asp. Contractors shall check this Web site monthly for updated training materials. Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.*

3. *All contractors shall train their CSRs about how to find, navigate and fully use their Medicare provider education Web site and www.cms.hhs.gov. CSRs shall be connected to and able to use the contractor's Web site and the CMS Web site for providers.*

4. *Contractors shall send training representatives to 2-4 national train-the-trainer conferences provided by CMS. Contractors shall be prepared to send at least one customer service/provider education representative to these training sessions. Contractors shall expect training sessions to run from 2-4 days. This representative shall be responsible for training additional contractor customer service staff. These staff members shall also be prepared to develop training programs for Medicare providers and suppliers on the various initiatives.*

20.1.7 - Quality Call Monitoring (QCM)
(Rev. 6, 05-21-04)

Contractors shall:

A - Process and Tools

1. *Monitor, measure and report the quality of service continuously by utilizing the CMS-developed QCM process. Contractors shall monitor all CSRs throughout the quarter, using a sampling routine. The sampling routine shall ensure that all CSRs are monitored at the beginning, middle and end of each month (ensuring that assessments are distributed throughout the week), and during morning and afternoon hours. If there is more than one auditor, contractors shall rotate the CSR monitoring assignments regularly among the auditors.*

2. *Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Copies of the scorecard and chart can be obtained at QCM database Web site at https://www.qcmscores.com. Contractors shall use only the official versions of the scorecard and chart that are posted on the Web site. The QCM database, also available on the Web site, shall be used to collect monitoring results that will be reported monthly in CSAMS.*

3. *Train every CSR and auditor on the scorecard, chart and database and ensure that each person has a copy of the chart for reference. Contractors shall analyze individual CSR data frequently to identify areas needing improvement, document and implement corrective action plans.*

4. *Analyze QCM data to develop a plan for continuous improvement and to determine where training is indicated, whether at the individual, team, or call center level and provide such training.*

B - Frequency of Monitoring

- *Experienced CSRs - Monitor a minimum of 3 calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a minimum of 3 calls, including at least one of each type, during the month. Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.*

- *New CSRs - Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle calls independently. Scores for these trainees will be excluded from CSAMS reporting on QCM performance for a period up to 30 days following the end of formal classroom training. The calculation will be done automatically when the CSRs are entered into the QCM database with the appropriate indicator of trainee.*

C – Type of Monitoring

 Monitor the calls in one or more of the following ways:

1. **LIVE** *remote;*

2. **LIVE** *side by side (shadow); or*

3. *Taped.*

D - Giving Feedback to CSRs

*Complete the scorecard in its entirety and give written feedback to the CSR within 2 working days for calls monitored **LIVE** or 7 working days for taped calls (Timeframe for giving feedback begins on the day the call occurred). Coach and assist the CSR to improve in areas detected during monitoring.*

E – Calibration

Participate in all national and regional QCM calibration sessions organized by CMS. (Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more call centers or throughout CMS.) National sessions are held on the first Wednesday of February, May, August and November at 1:30 e.s.t. Conduct regular calibration sessions within the call center or between multiple centers. Contractors with more than one reviewer shall conduct monthly calibration sessions within the call center.

F - Retention of Taped Calls

Contractors that tape calls for QCM purposes shall be required to maintain such tapes for an ongoing 90-day period during the year. All tapes shall be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review. Contractors may reuse tapes after the 90-day period. Contractors shall dispose of tapes that are no longer used in a manner that would prohibit someone from obtaining any personally identifiable information on the tapes.

G - Remote Access

The contractor shall provide remote access to CMS personnel to one of the following: agent split/group, DNIS, trunk, or application. This will allow CMS personnel to hear calls as they are occurring. The CMS will take reasonable measures to ensure the security of this access, (e.g., passwords will be controlled by one person, no one outside of CMS service will have access to the passwords).

20.1.8 - Disclosure of Information (Adherence to the Privacy Act)
(Rev. 6, 05-21-04)

Contractors shall follow the guidelines for disclosure of information that are provided in the Disclosure Desk Reference for Provider Call Centers (DDRPCC) which can be found at http://www.cms.hhs.gov/contractors/customerserv/default.asp, under Medicare Fee-for-Service Call Center Policies and Procedures. The DDRPCC is a compilation of policies and procedures gathered from existing manual instruction and program issuances. It is designed to help customer service representatives (CSRs) adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. It tells CSRs what information may be disclosed over the telephone depending on the caller and inquiry type. The DDRPCC shall be the reference used by all CSRs who service providers through telephone inquiries. It is meant to serve as a guide and in no way override any other existing or new policies and procedures regarding the release of beneficiary-specific information to providers. The DDRPCC will be periodically updated to reflect any new polices and procedures.

20.1.9 - Fraud and Abuse
(Rev. 6, 05-21-04)

When a provider inquiry or complaint of potential fraud and abuse is received, the second level screening staff shall not perform any screening, but prepare a referral package and send it immediately to the PSC or Medicare fee-for-service BIU. The referral package shall consist of the following information:

- *Provider name and address;*

- *Type of provider involved in the allegation and the perpetrator, if an employee of a provider;*

- *Type of service involved in the allegation;*

- *Relationship to the provider (e.g., employee or another provider);*

- *Place of service;*

- *Nature of the allegation(s);*

- *Timeframe of the allegation(s);*

- *Date of service, procedure code(s); and*

- *Name and telephone number of the Medicare fee-for-service contractor employee who received the complaint.*

The Medicare fee-for-service contractor shall keep a record of the cost and workload associated for all provider inquiries of potential fraud and abuse that are referred to the Program Safeguard Contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity Unit using Activity Code 13201 in the Beneficiary Inquiries function.

20.1.10 - Next Generation Desktop (NGD)

(Rev. 6, 05-21-04)

The CMS is developing a new MCSC-NGD application to be deployed at Medicare contractor sites. The new desktop will allow CSRs to answer written, telephone, and walk-in inquiries from both providers and beneficiaries. The NGD application will enable CSRs to address, at a minimum, the same general Medicare and claims inquiries currently handled, but in a more user-friendly and efficient manner. The NGD is being developed on requirements gathered from call center personnel currently handling telephone, written, and walk-in inquiries. Although NGD may be found useful by other components interacting with the telephone and written inquiries areas, specific requirements are not being identified for those areas.

The initial rollout of NGD will provide contractors with access to information from the VIPS Medicare System (VMS), Fiscal Intermediary Standard System (FISS), and Multi Carrier System (MCS) claims processing systems used today. Initially contractors will only access information to perform the functions required within their existing workload. However, the technology being built into the NGD will ultimately allow contractors to access claim information outside their service areas and to access additional CMS databases once those business processes have been defined. This increased access will enable contractors to support each other in times of heavy call volumes, disaster situations, emergency closings, and any other downtime as well as to handle more of the calls currently being blocked in the network. As NGD is rolled out, those contractors utilizing NGD will have call history information displayed for beneficiaries and providers who have previously contacted other sites using NGD. For example, call history in Ohio will be visible to both the carrier and the intermediary call centers for Ohio after both call centers begin utilizing NGD. The call history information does contain claim information, and a record of and reason for the call.

To ensure ongoing operations are consistent with CMS's call center strategy, any contractor call center purchases or developmental costs for hardware, software, or other telecommunications technology that equals or exceeds $10,000 in a fiscal year require prior approval by CMS. This includes development of existing or new desktop applications. Contractors shall submit all such requests to the servicing RO for review. The RO shall forward all recommendations for approval to the CO, Division of Contractor Provider Communications.

A - Implementation Approach and Schedule

Since the NGD will continue to be rolled out to contractors throughout FY 2004, contractors shall include NGD implementation costs in the FY 2004 budget requests. These costs shall be included in Activity Code 33001 and also reported using Miscellaneous Code 33001/01 so that they can be separately identified as NGD implementation costs. Change Request 2079 *Program Memorandum, Subject: Installation of a New MCSC Next Generation Medicare Desktop Application* and Change Request 2390 *Program Memorandum, Subject: Next Generation Desktop Data Center Connectivity – Security Information Clarification* contain more detailed instructions describing NGD implementation functions.

Contractors utilizing the MCSC-Forte desktop application shall budget for minimal support and maintenance of that application until call centers are transitioned over to MCSC-NGD.

Call centers will be notified at a minimum of 6 months in advance of beginning deployment discussions. Call centers will be implemented with consideration to business impact to the Medicare program as a whole. Input from contractors regarding the desired timing of implementation will be considered, as well as, other implementation activity and specific circumstances of each call center.

B - Centers Using Non-Standard Claims Processing Systems

Currently, plans provide for the NGD to support FISS, MCS, and VMS (Part B and DMERC) claims processing systems. Centers using other systems will not implement the NGD until they have converted to one of these standard systems.

C - Technical Considerations

1. Hardware

The hardware necessary to implement the NGD application includes Siebel Systems' eHealthcare product, centrally located servers, and personal computers (PCs).

2. Siebel

The NGD is being built using Siebel Systems' eHealthcare product. This product employs a "zero footprint" Web-based client, which means that no specialized hardware or software is required on the agents' desks other than a typical personal computer (PC) and a Web browser. PCs that will be used to generate correspondence will also require Microsoft Word '97, or a higher version of Word, which will be the responsibility of the Medicare contractor to procure. CMS is purchasing the necessary Siebel software licenses and ongoing Siebel software maintenance contracts.

3. Servers

All servers needed to run the NGD application will be centrally located (initially at the AdminaStar Federal data center in Louisville, Kentucky). Each call center site will access the servers via the Medicare Data Communications Network (MDCN); CMS currently uses AT&T Global Network Services (AGNS) to provide service to the MDCN. Prior to implementation, each call center's network configuration will be evaluated to ensure that sufficient network bandwidth will be available.

4. Firewalls

All Internet Protocol (IP) access to the MDCN/AGNS network will be firewall protected. Each call center will be responsible for the installation and configuration of a firewall solution between themselves and the MDCN/AGNS network. Call centers will access the NGD system via

IP. The NGD will provide access to the mainframe processing systems at the data centers via IBM's System Network Architecture (SNA). SNA connectivity will not require firewall protection. Future plans may include access to the mainframe processing systems via IP; however, CMS will work closely with the data centers if and when this option becomes available. The contractors are only responsible for having the firewall(s) implemented at their call centers and/or data centers.

5. Personal Computers

NGD Personal Computer (PC) Requirements – Following are updated PC software requirements for MCSC-NGD. These requirements supercede those listed in Change Request 2079 dated 5/16/02 and the Medicare Carriers Manual. The only additional software requirements for FY2004 are the Microsoft Word and Adobe Acrobat viewers which can be downloaded free of charge. Consideration will be required for coexisting software applications in addition to NGD. The system requirements may increase based on these additional applications. Consult the software vendor for this information and make appropriate modifications to these requirements on the basis of that information.

Requirements for an NGD Personal Computer	
Processor:	500MHz Pentium III or comparable AMD 800MHz Celeron or comparable AMD
Disk Space:	100MB available
Memory:	224MB for Windows 2000 288 MB for Windows XP
Operating System:	Windows 2000 Service Pack 2 OR Windows XP Service Pack 1
Browser:	Internet Explorer 5.5 Service Pack 2; Q323759 OR Internet Explorer 6 Service Pack 1; Q810847
Monitor:	21"
Pointing Device:	Mouse with scroll
Network Interface:	Network Interface Card compatible with the call center LAN, which will ultimately allow workstation access to MDCN
Word Processor:	Microsoft Word '97 (or higher version) – Required only for generation of correspondence.
Viewers:	Microsoft Word Viewer (provided free by Microsoft) and Abobe Acrobat Reader (v4.05 or v5.0 free from Adobe) are required.

D - Integration Methods

Standard Systems

Integration between the NGD and VMS, CWF, MCS, and FISS will be accomplished using Jacada's Integrator software product. Jacada uses TN3270 sessions to work with these systems. This allows NGD to be implemented without any changes to the standard systems. Access to

CWF will be through the claims systems. The NGD Integration Layer will log and time-stamp all interactions, recording the NGD user, the back-end system user, and the transaction being performed along with the transaction's data. Integration with EDB and MBR will be done using IBM CICS Transaction Client Application Program Interface. Access to these systems will be via the CMS Traffic Cop application.

E - Computer Telephony

The CTI is not currently in the scope of the NGD development for Releases One and Two. The CTI may be integrated in a future release.

F - Impact on Contractor Resources

Although implementing the NGD will improve the overall efficiency of the call center operations, there will be some short-term impact on resources during the initial implementation. Resources potentially affected include CSRs, trainers, information services and technology staff. A reduction in CSR efficiency is expected during the learning curve of first using the new system. As CSRs become proficient with the new environment, efficiency shall improve.

Early in the deployment process CMS and the NGD team will review with each site the expected staffing levels that will be in place when NGD is implemented. Performance measures available from previously deployed locations will be shared to assist in determining potential impact and needed support.

A Deployment Assistance Center (DAC) has been established to support call centers during NGD implementation. The DAC is staffed with CSRs trained to handle Medicare inquiries from all lines of business. Certain functions may need to be transferred back to the site, however, it is expected the sites deploying NGD will utilize the services provided by the DAC prior to requesting any performance waivers. During the period of implementation, CMS will work with the contractor to determine the support needed from the DAC and relax performance standards where it is still deemed appropriate.

G - Call Center CSRs

It is expected that CSRs already trained to handle Medicare inquiries will need to attend three-four days of training on the new system. Contractors will continue to provide new CSRs with Medicare program training and any changes to local procedures resulting from NGD. Generally, CSRs will continue to answer the same types of inquiries they currently answer today, so the primary focus of the initial NGD training will be on how to access the same information within the new desktop. Additionally, NGD will offer some enhanced features and functionality that will deliver improved service to CMS customers. Training materials will be provided for any new functionality in NGD. Although contractors can chose to phase in the implementation of any new NGD features, it is expected that CSRs will fully utilize the functionality built within NGD.

Below is a sample of identified changes to pre-NGD procedures:

- ***Publication Requests and General Information*** *– All provider-related requests for publications should be directed to www.cms.hhs.gov/medlearn.*

- ***Scripted Responses*** *- The NGD will include standard CMS-approved scripted language for some Medicare topics to be used by CSRs when responding to inquiries. The purpose of scripted language is to ensure accuracy and consistency of the information conveyed by the call centers.*

- ***Callbacks Closed -*** *The counting for this CSAMS metric will change for those call centers using MCSC-NGD. Currently this number is based on calls received for the calendar month and represents the number closed within five workdays even if a callback is closed within the first five workdays of the following month. For MCSC-NGD call centers, the desktop will provide a report based on seven calendar days that will be used to satisfy this requirement.*

- ***Logging Issues*** *– NGD provides the functionality to log multiple issues on one call. Once NGD Release Two is implemented, many of the high frequency topics or activities worked on a call are automatically logged. There is a need for some manual logging by CSRs. Those conducting quality call monitoring shall ensure that CSRs are making use of this additional functionality to log multiple issues. This will provide the call centers and CMS with more accurate and thorough reporting. For quality call monitoring (QCM) purposes, all logging and coding including the logging of multiple issues is to be recorded under the Call Action portion of the Knowledge Skills Assessment section of the QCM scorecard. Correct logging of calls falls under the performance criteria of "completes call activities".*

- ***Ordering a Replacement Medicare Card*** *– The NGD has built in the functionality to allow for a CSR to order a replacement Medicare card. NGD will perform the edit checks for the CSR that will minimize the training needed for this function.*

H - Trainers

This project will use a "Train the Trainer" approach. This approach requires each contractor to provide trainers and training facilities to instruct CSRs, supervisors, quality assurance personnel, and other support staff on how to use the system. Training materials will be provided by CMS. The initial "Train the Trainer" classes (covering each contractor's primary line of business) will be five days of instruction. An additional two days are required for any added line of business (Part A, Part B, DME). "Train the Trainer" classes will be held in a central location or at contractor locations, if warranted by the number of trainees.

The local call center trainers will have the responsibility to train all CSRs on the NGD. For example, the training may take a phased approach in which some CSRs are trained while others continue to take calls in the current manner. At some point in time an individual call center may have some CSRs utilizing the current methods, some in training, and others using the NGD if a phased approach is followed. Regardless of the approach followed during the period of implementation, CMS will work with each contractor to define the extent of the impact during the

transition, schedule support from the Deployment Assistance Center and relax performance standards where it is deemed appropriate.

The NGD will have the ability to facilitate national web-based training. Contractors who wish to have their locally developed web-based training accessible directly from the NGD are encouraged to comply with CMS standards. In addition to the PC requirements outlined previously, in order to fully utilize the national Web-based training modules, contractors will also need to have an audio player capable of playing .wma files (generally Windows Media Player); sound card and speakers (headphones are suggested); and Microsoft Word 97 or higher.

I - Local Site Administration

Contractor personnel will perform several administrative functions at the call center level. These functions include:

- *Creating and maintaining user profiles;*
- *Adding user accounts (includes identifying each user's zip code, state, and time zone);*
- *Disabling user accounts;*
- *Adding and maintaining personal information;*
- *Adding, maintaining and resetting user passwords;*
- *Defining and maintaining user responsibilities;*
- *Defining and maintaining user positions;*
- *Defining the local organizational structure;*
- *Receive step by step instructions for setting up public queries;*
- *Creating and maintaining system user alerts and broadcast messages; and*
- *Initiate time out settings.*

J – Helpdesk

Each contractor will be expected to operate a local help desk (Tier One) for NGD. The Tier One Help Desk Analysts are responsible for supporting the call center personnel in resolving issues they experience within the NGD application. This may be incorporated within the contractor's existing helpdesk or defined independently. The local help desk will be expected to triage NGD-related issues to determine if resolution can occur in house and those issues that need to be documented and submitted to the NGD Help Desk (Tier Two).

Local Tier One application support will likely be comparable to existing MCSC-Forte and CustomView sites. Support levels for those locations currently using mainframe applications only will probably increase. The call centers will need to provide Tier One help desk support. Tier One help desk support will be a focal area for each call center and will begin the resolution process. They will help identify if the issue resides at the call center or if it is an issue that shall be resolved outside of the call center. If the issue can be resolved locally, then the normal call center process will be followed. If the issue cannot be handled locally, the local help desk will contact the NGD Tier Two Help Desk. The NGD help desk will work to resolve the issue within forthcoming Service Level Agreement standards. If the NGD help desk cannot resolve the issue,

the NGD helpdesk will contact the appropriate NGD resources (Tier Three), including Siebel and AT&T for MDCN/AGNS issues. Once resolved, the NGD help desk will contact the local help desk so any log entries opened there can be closed

At a minimum, the local help desk will handle:

- Password resets;
- PC and PC software configurations - Tier Two can assist Tier One or provide guidance in correcting the problem, but ultimately it is the responsibility of Tier One to resolve PC configuration/setup issues. The settings shall follow NGD and CMS guidelines;
- PC or LAN related problems;
- Proper functioning of local workstations, network and network connections;
- Contacting AT&T for any AGNS issues on the contractor side; and
- Local training and business process issues.

The help desk training provided by the NGD trainers will provide more details on what is expected of the local help desk.

K - Information Technology

For those sites that currently have PCs on the CSRs' desktops, little, if any, change in demand for infrastructure support is expected. Connectivity between the NGD servers in Louisville, Kentucky and contractor mainframe claims processing systems (i.e., data center) is planned to be via MDCN/AGNS using SNA. Contractor PCs at call centers using the NGD will access the NGD servers in Louisville using MDCN/AGNS via IP.

Existing call monitoring applications, such as e-Talk Recorder and Witness eQuality Balance, that are integrated with a call center's automatic call distribution system shall continue to function with no change.

L - Impact on Data Center Resources

Contractors shall work with their respective data centers to ensure data center staff performs the following tasks in support of the NGD implementation. These tasks include, but are not limited to:

- Provide a data center point of contact to coordinate NGD testing and deployment activities;
- Assist in planning for adequate MDCN/AGNS bandwidth and routing changes;
- Create and assign standard system mainframe User IDs per CMS/NGD requirements;
- Provide TN3270, TCP/IP, or SNA connectivity information and create any required SNA LUs to establish the necessary sessions; and
- Ensure that claims systems test regions and test data are available as required for system testing.

After initial testing the following support is required:

- *Test regions need to be available during normal business hours beginning when system testing starts and continuing through the deployment of the desktop at all call centers. Availability of test regions will also be required for subsequent quarterly releases.*
- *Ensure system production regions are available by contractor Go Live date(s).*
- *Ensure system production regions are available during call center hours of operation.*

M - NGD Access for Other Departments

It may be desirable for other departments (correspondence, benefits integrity, medical review, and so on) to have limited access to the new system. If so, some minimal training for the users from these departments will be required. Using the NGD in other departments will be considered on a case-by-case basis. Other departments will be expected to acquire the necessary NGD Siebel desktop licenses and appropriate PCs within their own budgets.

N - Security Issues

The NGD retrieves data from systems, such as the CMS Enrollment Database (EDB) and the SSA Master Beneficiary Record (MBR). These systems are Privacy Act protected and require high levels of security. Data and call centers are required to follow strict security controls in their data center implementation to segregate CMS data from other business data and to safeguard the confidentiality, integrity and availability of such data.

O - NGD Network Traffic and Overview

For MCSC-NGD implementation, connectivity shall be established between Siebel NGD and SNA (System Network Architecture) servers, the Medicare Data Communications Network (MDCN) and the Medicare call center's servicing data center. Currently, the Siebel NGD and SNA gateway servers reside at the AdminaStar Federal Data Center in Louisville, Kentucky. A CSR, as a NGD user located at the Medicare call center, uses a browser-based, thin client with zero footprint to access the Siebel NGD servers. All communications between client and server travel via the MDCN, provided by AT&T global network services (AGNS). This configuration establishes private virtual connection's (PVC) from each call center to the NGD Data Center, and between the NGD Data Center and all Medicare data centers. Call Centers are directly connected to Louisville NGD via AGNS. Louisville NGD is connected to all host Medicare Data Centers. The Louisville DC queries the host for the information. After Louisville DC gets the information from the host data center, paints the screen and sends the data back to the call center's CSR desktop.

When the Siebel NGD application requests Medicare shared claims processing systems information for an NGD user, the NGD systems' integration server acts on behalf of the NGD user and utilizes a CICS transaction-based approach to retrieve the requested information. This SNA connection communicates directly with the Medicare shared claims processing systems (MCS, VMS, FISS) via the MDCN, to process the NGD users' information request.

The NGD update requests to Medicare shared claims processing systems are limited to users within the local call center, as controlled by their specific local system administrator and their local NGD security profile. Therefore, updates are allowed only to native users. ***Non-native call center NGD users (e.g., other Medicare call centers) will have read-only access to the specific data center's Medicare systems as described in the Mainframe ID's paragraph below.*** *Memorandums of understanding between the data center and call center contractors will be needed prior to NGD's authorization (or capability) to update Medicare shared claims processing systems that are not native to the NGD user. If this non-native update capability becomes necessary, CMS will work with call center contractors to establish these memorandums of understanding.*

P - Mainframe IDs

The Siebel application identifies the information's requester and determines the source required to fulfill the information request. This information is passed to the integration server, which establishes a session between NGD Data Center and the source data center. The integration server uses an established logical unit (LU) connection from available LU session pools. Each data center will be assigned a specific number of LU session IDs, which will be assigned and controlled by AGNS

The session pool concept is referred to as Master ID since only a limited number of sessions are available for a larger number of user sessions. Master IDs are used by NGD Integration Servers, which acts in behalf of NGD users, to access the source data center's mainframe. Master IDs have been successfully implemented within other CMS applications with similar large user base and technical requirements. It is important to note that allowing NGD users read-only access to other contractors databases is not a new idea, and in theory the NGD read-only access is not too different than the shared access that all contractors have to the Common Working File.

The data center's system administrators restricts and controls access to the shared claims processing systems housed at their data center, thus protecting Medicare claims information that they have been entrusted to maintain. ***It is the data and call centers system administrators' responsibility to establish, add, and maintain the NGD-provided LU sessions and Master IDs on the mainframe's security software for NGD access as needed for development, validation, training, and production.*** *The benefit of establishing and maintaining a limited number of LU IDs and Master IDs for each call center, versus establishing individual accounts for each NGD user, results in reduced administrative tasks and costs.*

Q - NGD Security Responsibilities

The NGD contractor (currently AdminaStar Federal) is responsible for the security controls within NGD. ***It is National NGD security administrators' responsibility to establish, add maintain, and track the AGNS-provided LU sessions and Master Ids for all contractors on the applicable NGD software, (e.g., Siebel server, Jacada server).*** *The NGD software is developed to enable each call center to grant security access to its files, and will only retrieve/display data*

defined within the security access granted. Security tests have been developed to ensure access controls mechanisms are in place and operating as intended.

Stringent controls and monitoring processes will be in place to ensure that only assigned personnel gain access to the range of IDs assigned to their center. Those transactions will be performed in NGD's authentication servers within a secured environment.

The NGD system generates transaction logs with information to fulfill user traceability requirements. The Siebel server, integration server, and CICS/SNA gateway logs will document the transactions being performed, who performed them, when they were performed, what User ID and what LU session, host, and system were used to perform the transaction. This logging supports the use of Master IDs within the NGD, providing individual accountability for NGD users. Auditing will be performed within the NGD network and will provide a trace mechanism for the Medicare shared claims processing systems to validate users.

R - Security Oversight

Oversight and separation of duties for NGD security will be accomplished by:
  (1) Establishing system administrators for call and data centers, when applicable, with access only to the range of IDs designated for their center;
  (2) Establishing a National NGD Security Administrator responsible for establishing user IDs and granting security access to call and data center's system administrators; and
  (3) Designating a third-party to audit security functions and logs, including the National NGD Security Administrator.

S - Shared/Standard System Issues

The Next Generation Desktop relies on extensive interfaces with many standard Medicare systems, operated by CMS as well as contractors. In order to make each contractor's deployment to the NGD as problem-free as possible, it would be helpful if each contractor provided systems documentation for any changes or customizations that they have made to the standard system. By providing this documentation during the discovery period, it will allow the NGD developers to make any necessary adaptations before deployment. Once a site has implemented NGD, the NGD team will need to be made aware of any local planned changes to these shared systems well in advance. This will allow time to make sure that the interfaces with the shared systems continue to perform correctly.

The NGD updates will occur quarterly and will follow the release schedule used for the shared system updates. Once the NGD is implemented, contractors are requested to inform the NGD team of any notifications of changes being planned to the standard systems currently accessed. This will serve as a backup to the current process CMS has in place for notification of systems changes. It is important that the NGD sites work closely with the NGD team to coordinate any additional testing needed specific to NGD in conjunction with testing for the shared system quarterly releases.

T - Implementation Planning and Support

Implementation of the NGD will represent significant change for many call centers. Managers and staff will need to be available for pre-implementation meetings (e.g., conference calls, in-house meetings, completion of surveys), to provide information about the site in general, the technology used, and to plan for the rollout of the NGD. To minimize the impact of this change, at a minimum, the call centers will be provided with the following assistance:

- *Planning for functional, technical, and business process change;*
- *Deployment notebook detailing key aspects of the deployment process;*
- *Deployment checklist/project plan and updates to the project plan;*
- *Regularly scheduled NGD specific conference calls;*
- *Training assistance as described above; and*
- *24 x 7 post-implementation support (on site, if required).*

U - Future Changes to the Next Generation Desktop

The CMS will implement an NGD Change Control Board that will include representation from the contractor community. Change requests can be submitted in a variety of ways: feedback forms within the NGD system, change requests submitted to the NGD helpdesk and participation in user acceptance testing and functional workgroup meetings. The change control procedures will be provided in the call center deployment notebook for further reference. New releases of the NGD are expected to follow the current standard mainframe system quarterly release schedule.

V -Retirement of Redundant Systems

After implementation of the NGD, several existing systems will become redundant. These include the current MCSC Forte application, the 1-800 GT-X application and some of the CustomView implementations. There may be other contractor or call center specific applications that will also become redundant. Retirement of these redundant applications may involve archival of data and disposition of any surplus hardware. The CMS and the affected contractors will determine the specific tasks required.

20.1.11 - Call Center User Group (CCUG)
(Rev. 6, 05-21-04)

Call centers shall participate in the monthly CCUG calls. The CCUG sessions provide a forum for CMS to discuss new and ongoing projects related to telephone customer service, for contractors to surface issues for CMS resolution, and call centers to share best practices in telephone customer service delivery. The CCUG is held the third Wednesday of each month at 2:00 p.m. Eastern Time. At a minimum, the call center manager or a designated representative shall participate. Call centers may submit topics for consideration in agenda planning to the CCUG mailbox at ccug@cms.hhs.gov.

20.1.12 - Performance Improvements
(Rev.)

As needed, the contractor shall develop a corrective action plan to resolve deficient performance by staff in the call center, and maintain results on file for CMS review.

20.2 - Guidelines for Handling Written Inquiries
(Rev. 6, 05-21-04)

A2- 2958.B, B2-5104.B

The contractor shall stamp all written inquiries with the date of receipt in the corporate mailroom and control them until it sends final answers. In addition, the contractor shall:

- *Answer inquiries timely;*

- *Not send handwritten responses;*

- *Include a contact's name and telephone number in the response;*

- *Keep responses in a format from which reproduction is possible;*

- *Include the CMS alpha representation on all responses, except for email responses; and*

- *Forward all appeal requests to the appeals unit for handling.*

The majority of contractors currently retain all written inquiries on site. Some contractors house files at a remote location during the year due to cost and space constraints. Those contractors housing written inquiries off site shall notify CMS within 6 weeks of the final BPR date of the exact address/location of their off site written inquiries. This information shall be sent electronically to the servicing RO Provider Branch Chief. This notification is necessary in the event an onsite CPE review is conducted. Contractors are required to allow CMS access to all written inquiries stored off site within 1 day of notification to the contractor so that cases can be retrieved timely. All written inquiries, whether maintained on site or off-site, shall be clearly identified and filed in a manner that will allow for easy selection for the CPE review. Identification data shall be kept that will allow electronic production of a sequential listing of the universe of written inquiries.

20.2.1 - Contractor Guidelines for High Quality Written Responses to Inquiries
(Rev. 6, 05-21-04)

A2-2958.A, B2-5104.B

Contractors shall maintain a correspondence quality control program (containing written policies and procedures) that is designed to improve the quality of written responses. In addition, contractors shall perform a continuous quality review of outgoing letters including computer notices. This review consists of the following elements:

1. **Accuracy** - *Content is correct with regard to Medicare policy and contractor data. Overall, the information broadened the inquirer's understanding of the issues that prompted the inquiry.*

NOTE: *Effective FY 2003, all contractors shall involve clinicians as needed in developing responses to coverage/coding inquiries from providers and use clinicians in scoring the accuracy of responses to coverage/coding inquiries in their quality appraisal program*

2. **Completeness** - *The response addresses the inquirer's concerns and states an appropriate action to be taken.*

3. **Clarity** - *Letters have good grammatical construction, sentences are of varying length, and paragraphs generally contain no more than five sentences. Use CMS-provided model language and guidelines, where appropriate. Contractors shall process all written inquiries using a 12-point font and a font style of Universal or Times New Roman, or another similar style for ease of reading.*

4. **Timeliness** - *Substantive action shall be taken and an interim or final response shall be sent to all provider correspondence within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry shall be referred to a specialized unit for response), the contractor shall send an interim response acknowledging receipt of the inquiry and the reason for any delay. When possible, inform the provider about how long it will be until a final response will be sent.*

   Contractors using Interactive Correspondence Online Reporting (ICOR) to document inquiries received from providers and others shall record the correspondence in the electronic environment in a timely manner.

   If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same time frame for response (i.e., the 45-day period starts on the same day for both responses). Therefore, the contractor ensures that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for the contractor's conditions. If a contractor responds separately, each response shall refer to the fact that the other area of inquiry will be responded to separately.

   Every contractor shall have the flexibility to respond to provider written inquiries by phone within 45 calendar days. For tracking purposes, the contractor shall develop a report of contact for each telephone response that includes the following information:

   - *Provider's name and address;*

   - *Telephone number;*

   - *Provider number;*

- *Date of contact;*

- *Internal inquiry control number;*

- *Subject;*

- *Summary of discussion;*

- *Status;*

- *Action required (if any); and*

- *The name of the customer service representative who handled the inquiry.*

Upon request, the contractor shall send the provider a copy of the report of contact that results from the phone response. The report of contact shall be retained in the same manner and time frame as the current process for written responses. The contractor shall use its discretion when identifying which written inquiries (i.e., provider correspondence that represents simple questions) can be responded to by phone. Use the correspondence that includes the provider's telephone number or use a provider's telephone number from internal records if more appropriate for telephone responses. If the contractor cannot reach the provider by phone, it shall not leave a message for the provider to return the call. It shall develop a written response within 45 calendar days from the incoming inquiry.

5. **Tone** *- Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.*

6. **E-mail Inquiries** *– In some cases, an e-mail inquiry received can be responded to by e-mail. Since e-mail represents official correspondence with the public, it is paramount that contractors use sound e-mail practices and proper etiquette when communicating electronically. Contractors shall ensure that e-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension). Exception: Responses that are personal in nature (contain financial information, HICN, etc.) cannot be sent by e-mail.*

7. **Check-off Letters** *-- Check-off letters are appropriate for routine inquiries like claims status or eligibility. Check-off letters shall not be used to address more complex inquiries.*

20.3 - Walk-In Inquiries
(Rev. 6, 05-21-04)

A2-2959, B2-5105

Contractors shall not actively publicize the walk-in function. However, they shall give individuals making personal visits the same high level of service they would give through phone contact. The interviewer shall have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims-related issues.

If a provider inquires about a denied or reduced claim, the contractor gives the provider the opportunity to understand the decision made and an explanation of any additional information that may be submitted if an appeal is sought.

The contractor makes the same careful recording of the facts as for a telephone response. The contractor shall maintain a log or record of walk-in inquiries. The log, at a minimum shall include the following:

- *Name of inquirer*

- *Time of arrival*

- *Time service was provided*

- *Statement indicating whether the inquiry is closed or still pending*

20.3.1 - Guidelines for High Quality Walk-In Service
(Rev. 6, 05-21-04)

A2-2959, B2-5105

The following are guidelines that the contractor shall use for providing high quality walk-in service:
- *After contact with a receptionist, the inquirer shall meet with a service representative;*

- *Waiting room accommodations shall provide seating;*

- *Inquiries shall be completed during the initial interview to the extent possible;*

- *Current Medicare publications shall be available to the provider (upon request); and*

- *Contractors shall maintain a log or record of walk-in inquiries during the year.*

20.4 - Surveys
(Rev. 6, 05-21-04)

A2-2959, B2-5105

The CMS requires periodic surveys of customer service operations to be completed by each contractor within the time frames and in areas indicated on the specific notice. Examples include annual call center technology surveys, staffing profiles, training needs, etc.