DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUN 1 2 2012

The Honorable Michael C. Burgess, M.D.
U.S. House of Representatives
Washington, DC 20515

Dear Representative Burgess:

Thank you for your letter regarding the transfer of the contract for Medicare fee-for-service (FFS) claims adjudication and payment from TrailBlazer Health Enterprises (TrailBlazer) to Novitas Solutions (Novitas) as the Centers for Medicare & Medicaid Services (CMS) implements the new jurisdiction H (J-H) Medicare Administrative Contractor (MAC). The J-H MAC operational area includes the States of Arkansas, Louisiana, Mississippi, Colorado, New Mexico, Oklahoma, and Texas. CMS greatly appreciates your bringing these concerns to our attention.

CMS is working with both contractors to ensure that the implementation of this contract is completed without disrupting services to health care providers who are caring for Medicare beneficiaries in Texas, and all other affected states. The actual transfer of the claims administration responsibilities to Novitas will occur in phases later this year, with claims adjudication for Oklahoma, Texas, New Mexico, and Colorado Part A providers—including hospitals and skilled nursing facilities-transferring on October 29, 2012, and claims adjudication for Part B providers—including physicians and other health care practitioners in those states—transferring on November 19, 2012. Similarly, Part A providers in Arkansas, Louisiana, and Mississippi will transfer to Novitas on August 20, 2012. Part B providers in Arkansas and Louisiana will transfer on August 13, 2012, with Part B providers in Mississippi transferring on October 22, 2012.

We greatly appreciate your concern over the transition and desire to ensure continuity of services for affected providers, physicians, and other practitioners. We are aware of the concerns among the provider community concerning the completion of new electronic funds transfer (EFT) agreements and the transition to a new banking provider. Novitas has already begun providing information to impacted providers concerning the new EFT forms that must be submitted and under which circumstances. We closely monitor contractor receipts of required EFT forms during every transition both before and for several months after each phase of a contract cutover. We will be doing the same for the J-H contract transition to ensure that there are no significant disruptions to provider payments.

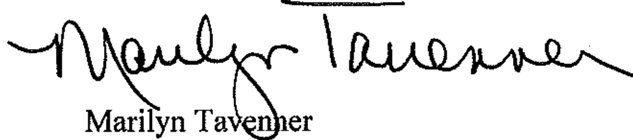
With respect to your concern over the need for providers to transition to a new "front-end" or electronic data interchange (EDI) system to submit electronic claims, Novitas is required to provide EDI information, assistance, testing, and training to providers/submitters throughout the implementation period. EDI transition is emphasized in Novitas' implementation bulletins and in seminars/workshops. Novitas will also be affording providers with an opportunity to

"early-board" or submit claims electronically to its front-end system for receipt and acceptance several weeks in advance of each workload segment's transition date. Early boarding allows current EDI submitters to have an extended period of time to update connectivity and communication processes and to become comfortable using Novitas' new EDI front-end system prior to the cutover date. Early boarding and EDI receipts and rejections is one of the more critical transition functions that we monitor closely up through and for several weeks after each transition phase, and we will be doing the same for the J-H contract transition.

Please see the attached enclosure in response to your specific questions regarding other potential issues associated with the transfer of the contract for Medicare FFS claims administration in J-H.

Thank you for your interest in this important issue as we work towards our mutual goal of strengthening the Medicare program for all beneficiaries. I will also provide this response to the co-signers of your letter.

Sincerely,



Marilyn Tavenner
Acting Administrator

Enclosure

Enclosure

1. **Can CMS outline the performance standards in claims processing – both submission and payment – that are required of Novitas and make them public?**

   All MACs must meet multiple performance requirements and standards stipulated in their contracts as well as in CMS manuals. CMS monitors contractor claim processing and payments trends on a daily basis, but timeliness of claim processing performance is measured on a monthly basis. For claims processing timeliness, all MACs are expected to process 95 percent of clean claims (i.e., claims which contain all the information needed to process) within 30 days of receipt.

   As the Medicare claims administration contractor for the states of Pennsylvania, New Jersey, Maryland, Delaware, and the District of Columbia, Novitas has experience processing claim workloads of the same approximate size as that of TrailBlazer, and has regularly exceeded CMS's performance requirements for claims payment timeliness over the course of its contract, as has TrailBlazer. In calendar year 2011, TrailBlazer processed 16.8 million Part A claims, with over 99.86 percent of clean claims processed within 30 days.

   By comparison, Novitas processed 15.7 million Part A claims, with 99.88 percent of clean claims processed within 30 days. With respect to Part B claims processed in the same timeframe, TrailBlazer processed 93.8 million claims, with 99.7 percent of clean claims processed within 30 days, and Novitas processed 103 million claims with 99.55 percent of clean claims processed within 30 days.

2. **Does CMS plan to address Novitas' failure to respond to an Office of the Inspector General request for information on Physicians Opting Out of Medicare, OEI-07-11-00340? Is it CMS's intention to require Novitas and all Medicare Administrative Contractors to maintain such information and make it publicly available – and if not, why not?**

   Medicare's contractors are required to maintain information on physicians and practitioners who opt-out of Medicare and to report that opt-out information to CMS. In November of 2011, CMS provided additional instructions to all MACs requiring that they maintain and track affidavit information for physicians that elect to opt-out of the Medicare program. These instructions were effective April 1, 2012. CMS has not determined how much information on opt-out physicians/practitioners should be released to the public. We expect to provide additional information regarding this matter shortly.

3. **How does CMS intend to intervene to resolve provider issues related to this transition?**

   Communication and information provision to the local health care provider community is a critical aspect of the implementation phase of a MAC contract. CMS requires MACs to focus early information and outreach to providers regarding EDI for claims submission, local

coverage determinations and billing and coding, and EFT authorization. Through its regional offices, CMS provides detailed information about the change in contractor to local provider associations and serves as a conduit for questions and concerns from the provider community. For this implementation, Novitas has a public website for providers in the jurisdiction where updated information is available to health care providers in all impacted states including Texas, and in early May, Novitas began to meet with individual provider associations throughout the J-H jurisdiction in preparation for the contract implementation later on this year. Individual providers may submit questions or concerns directly to Novitas via their transition website, or they may elect to attend scheduled webinars designed to address individual concerns in an interactive format. Information on the transition, frequently asked questions (FAQ's), pod-casts, and webinar sessions are available on the Novitas informational webpage at:
https://www.novitas-solutions.com/transition/jh/index.html.

4. **How does CMS plan to actively monitor whether or not the contractual standards are being met?**

   All contractual standards and processes that are in the statement of work (SOW) will be actively monitored by CMS staff for both the outgoing and incoming contractors through ongoing workgroup meetings, weekly reports, and periodic site-visits. TrailBlazer is accountable for meeting the contractual performance standards through the end of their contract with CMS. TrailBlazer will continue to be evaluated against all the performance objectives outlined in its SOW and will be audited for compliance with internal controls and systems security requirements. Similarly, Novitas' performance is monitored by the CMS Implementation Lead through a combination of daily/weekly meetings, written reports, and site visits. Once operational in the MAC jurisdiction, Novitas' performance following each segment cutover will be monitored on a daily basis to identify any operational anomalies which may need to be addressed. Monitoring of daily workload productivity, provider complaints, and claim receipts will continue for several weeks or months following each segment transition depending upon the number and gravity of transition issues which may arise.

5. **Will CMS provide information about subcontractors and the functions for which they have been delegated and CMS authority to monitor their performance?**

   As the Medicare claims administration contractor for the J-H MAC, including the State of Texas, Novitas has not subcontracted any major functions to any external entity. They do contract with small businesses for mailroom support and independent audit functions to fulfill their contractual obligation to CMS for an annual independent internal control review. There are other CMS contractors who Novitas must work with to carry out their contract. These include the recovery auditors, a Medicare Secondary Payer recovery contractor, a coordination of benefits contractor, a zone program integrity contractor, a data center, claims processing system maintainers, the comprehensive error rate testing contractor, and the 1-800 Medicare contractor. CMS performs oversight and administration of all of its contracts, including the coordination of issues among the contracts.

6. **How will CMS respond to issues related to performance issues that threaten access to care by Medicare patients and the viability of physician practices that rely on prompt Medicare payment for the services provided?**

   Over the past 5 years, CMS has managed more than a dozen MAC contract implementations, with minimal disruptions in payment or services to health care providers. CMS has developed contract implementation requirements for both outgoing and incoming claims administration contractors, and companies bidding for MAC contracts must provide detailed implementation project plans for evaluation by CMS as a part of the procurement selection process. When a MAC contract is awarded, CMS requires a finalized project plan within 30 days of contract award. Progress toward each plan milestone is monitored by CMS on a weekly basis with more intensive oversight as the actual "cutover" of contract occurs, and up to each segment transition date. Monitoring of events during transition weekends takes place on an hourly basis, by CMS and the responsible contractors. Following a transition weekend, incoming contractor claim receipts, provider complaints, and workload productivity are monitored on a daily basis against the outgoing contractor's historical experience so as to identify any anomalies. CMS also requires incoming claims administration contractors to staff their provider customer service areas to support a heightened level of phone calls during the early weeks of a new contract start.