
CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

CARRIER/INTERMEDIARY

**WORKLOAD CLOSEOUT
HANDBOOK**

MEDICARE CONTRACTOR MANAGEMENT GROUP

02/22/08

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Chapter 1: INTRODUCTION

1.1 Carrier/Intermediary Workload Closeout Handbook

This handbook was prepared by CMS to assist our carriers and fiscal intermediaries in moving Medicare data, records, and operational activities to Medicare Administrative Contractors (MACs). It contains a compilation of best practices, lessons learned, and over 25 years of CMS experience in overseeing Medicare workload transitions. The handbook describes the basic responsibilities and processes required by the carrier or intermediary to close out its Medicare contract activities and to assist the incoming MAC in its efforts to assume Medicare claims administration functions. While both the carrier/intermediary and the incoming MAC are responsible for accomplishing various activities during the transition, this handbook is intended for use by the departing carrier/intermediary. A similar MAC Workload Implementation Handbook has been developed for incoming Medicare Administrative Contractors.

Every Medicare workload transition will vary depending on the unique circumstances and environment of the Medicare contractors involved. There may be activities and processes described in the handbook that will not be applicable to a specific transition. There may also be activities that will need to be performed that the handbook does not cover. The handbook cannot identify and address all of the variations that may occur during a workload transition, nor all of the tasks for which the outgoing contractor will be responsible. However, it will provide the framework for Medicare contract closeout and guidance in addressing situations as they arise.

1.1.1 Chapters

The handbook is comprised of **8** chapters and **11** exhibits as follows:

1. **Chapter 1: Introduction** provides an introduction to the Handbook and the goals for a successful workload transition.
2. **Chapter 2: CMS Organization** provides information on the duties and responsibilities of CMS's transition oversight staff.
3. **Chapter 3: Initial Closeout Activities** describes the activities that are necessary to start the contract closeout process. It discusses establishment of the closeout project team, project kickoff meetings, and the organization and function of transition workgroups. The chapter also addresses initial notification activities.
4. **Chapter 4: Project Management** discusses the various tasks necessary to manage the closeout process. This includes developing the Closeout Project Plan, the use of consultants, interaction with the incoming MAC, communications, and meeting and reporting requirements.

5. **Chapter 5: Personnel and Infrastructure** provides information on personnel issues and CMS policy on retention bonuses and severance pay. It also discusses policy on terminating subcontracts, asset inventory and disposition, and security.
6. **Chapter 6: Closeout Operations and Providing Information/Assistance** deals with the approach that a carrier/intermediary may take for its closeout operations and the type of information that should be provided to assist the MAC in its implementation. File transfer activities and assisting the MAC's communication efforts are also discussed.
7. **Chapter 7: Cutover and Post-Cutover Activities** covers the activities associated with final preparations for the operational closeout and the migration of records, files, and data. In addition, the chapter provides information on cutover plans, system dark days, lessons learned, and post-cutover reporting.
8. **Chapter 8: Financial Processes** provides information on the development of closeout costs and the financial activities required to move the Medicare workload. It discusses the development of transition and termination costs, banking activities, the accounts receivable reconciliation, audits, and 1099 responsibilities.

1.1.2 *Exhibits*

- Exhibit 1 Transition Phases and Terminology**
- Exhibit 2 MAC Contract Administrative Structure**
- Exhibit 3 Financial Memorandum to Outgoing Contactors**
- Exhibit 4 Sample Closeout Project Plan**
- Exhibit 5 Outgoing Contractor Information/Documentation**
- Exhibit 6 Files to be Transferred to a Medicare Administrative Contractor**
- Exhibit 7 Workload Closeout Meetings and Documentation**
- Exhibit 8 Sample Workload Report**
- Exhibit 9 Sample Staffing Report**
- Exhibit 10 Glossary**
- Exhibit 11 Acronyms**

1.2 Transition Phases

A Medicare workload transition involves three major participants: the incoming contractor (MAC), the outgoing contractor (carrier or intermediary) and CMS. Each transition has three major phases. For an outgoing contractor, the three major phases of a Medicare workload transition are identified as: operations (normal Medicare activities prior to the award of a MAC contract), closeout, and post-contract.

Transition activities in the **operations phase** are generally not extensive and are largely dependent upon whether or not the carrier/intermediary submitted a proposal for the jurisdiction in which it resides. If a proposal was submitted, there would not be significant transition activity and normal Medicare operations would continue until the MAC contract is announced. However, if the carrier/intermediary did not submit a proposal for its jurisdiction, then it may take some initial steps described in this handbook to prepare for the closeout phase.

The **closeout phase** begins at MAC contract award and ends at the carrier/intermediary's operational cutover to the new MAC. During this time the carrier/intermediary works with the incoming MAC to transfer Medicare data, records, and functions and to shut down its Medicare operation.

The **post-contract phase** begins at the cutover and continues for a period of time that can range up to six months. This is the period when the carrier/intermediary closes out the financial and reporting aspects of its contract.

While this handbook provides information for all three phases, its focus is on the **closeout** and **post-contract** phases of the carrier/intermediary's transition. **Exhibit 1** provides a graphic representation of terminology used for the major transition participants.

1.3 Segment Transitions

In a MAC transition, a carrier or intermediary's workload is known as a "segment". Each segment transition involves the movement of all or part of a carrier or intermediary's Medicare data, files, and functions to the MAC. The establishment of a fully operational MAC jurisdiction will involve multiple segment transitions, the number of which will depend on the number of carriers and intermediaries that currently serve the states within the jurisdiction. The length of the segment implementations and sequence of individual segment implementations will be identified in the MAC's Jurisdiction Implementation Project Plan, which will be approved by CMS. Segment implementation periods can range from 3-8 months, depending on the size of the outgoing contractor and various other factors.

The MAC will begin to perform Medicare functions after its first segment implementation has been completed. As each subsequent segment implementation of the MAC jurisdiction is completed, the MAC's Medicare administrative responsibilities will

expand over a wider area of its jurisdiction until the cutover of the last segment in the jurisdiction occurs. At that time, the MAC will be fully operational in all states within its jurisdiction.

1.4 Terminology

For purposes of this handbook, the term “**outgoing contractor**” refers to a carrier or fiscal intermediary (or simply intermediary) that is performing Medicare claims processing functions under a Part A agreement, Part A Plan subcontract agreement with the Blue Cross and Blue Shield Association (BCBSA), or a Part B contract. These contractors are also known as “**legacy contractors.**” The terms “outgoing contractor”, “carrier/ intermediary”, and “legacy contractor” are used interchangeably throughout this handbook. Legacy contractors may also be referred to as “Title XVIII contractors,” but this term should be avoided because the MAC contracts are also entered into under Title XVIII of the Social Security Act.

The Medicare Administrative Contractor (MAC) who will be assuming the Medicare functions of the outgoing carrier or intermediary is referred to as the “**incoming contractor.**” Both “MAC” and “incoming contractor” are used interchangeably.

While this handbook is written from the perspective of a carrier or intermediary transferring its Medicare functions to a MAC, it may also be used in those limited situations where a carrier or intermediary may be moving its workload to another carrier or intermediary. In those situations, “incoming carrier” or “incoming intermediary” would be used in the place of “MAC”.

The term “**provider**” is used in the broad sense of the word, meaning anyone providing a Medicare service; i.e., institutional provider, physician, non-physician practitioner, or supplier.

In this handbook, the term “**closeout**” is used for those transition activities performed by the carrier or intermediary. The term “**implementation**” is used for those transition activities performed by the MAC. The term “**transition**” is defined as the period of time that encompasses the movement of Medicare operations from a carrier/intermediary to a MAC. However, in general public usage, the term “transition” will often be applied to closeout activities performed by the carrier/intermediary, as well as implementation activities performed by the MAC.

The term “**contract**” is used in a generic sense and refers to the Title XVIII Part B carrier contract, the Title XVIII Part A agreement, or the Title XVIII Part A Plan subcontract agreement with BCBSA.

Any reference to days in this handbook refers to **business days** unless otherwise noted.

1.5 Goals of a Successful Workload Transition

All of the organizations involved in a workload transition have a responsibility to ensure that the transition is conducted properly and that their contractual obligations are met. While each participant has different roles and responsibilities during a transition, the goals remain the same:

- There is minimal disruption to beneficiaries;
- There is minimal disruption to providers, physicians and suppliers;
- There is no disruption of claims processing and Medicare operations;
- The transition is completed on schedule within the required time period;
- Actual costs represent effective and efficient use of resources; and,
- All parties with an interest in the transition (whether direct or indirect) are kept informed of the transition's status and progress.

In order to accomplish these goals, there must be proper project planning and management by the Medicare Administrative Contractor, maintenance of existing Medicare operations by the outgoing carrier or intermediary, and comprehensive oversight by CMS. All parties involved in the transition must cooperate fully and communicate constantly with all other parties at every level. This handbook will assist the carrier/intermediary in meeting its contractual obligations as it closes out its Medicare operations and help achieve the goals of a successful transition.

Chapter 2: CMS ORGANIZATION

CMS will have a number of individuals responsible for overseeing the closeout activities of the carrier/intermediary and the implementation activities of the MAC. Listed below are the individuals that the carrier/intermediary will have ongoing contact with regarding its closeout work, along with a description of their responsibilities. Also discussed are the individuals who will be responsible for monitoring the incoming MAC's implementation.

2.1 CMS Contract Administration Personnel – Carrier/Intermediary Contracts

The following are the key CMS individuals that the carrier/intermediary will have contact with for the activities related to the transfer of its Medicare operations, records, and data to the incoming MAC.

2.1.1 *Carrier/Intermediary Contracting Officer*

The carrier/intermediary Contracting Officer (CO) has the administrative responsibility for the outgoing contractor's Title XVIII Medicare contract. The CO has overall responsibility for the carrier/intermediary's closeout activities and negotiating termination and transition costs.

2.1.2 *Carrier/Intermediary Contractor Manager*

The Contractor Manager is the CMS individual responsible for monitoring the day-to-day operational activities of the outgoing carrier/intermediary. He/she will be responsible for ensuring that the carrier/intermediary continues to maintain its overall operation and performance during the closeout period. The Contractor Manager will work closely with the CMS Jurisdiction Implementation Lead (see **Chapter 2.2.3** below) to ensure that the carrier/intermediary cooperates with the incoming MAC during the transition and that all Medicare files, records, and data are successfully transferred to the MAC.

2.1.3 *CMS Segment Implementation Manager*

There may be Segment Implementation Managers (SIMs) assigned to a jurisdiction implementation. If there are, the SIMs will be responsible for monitoring, troubleshooting, problem solving, and reporting on the individual segment implementations that occur within the jurisdiction. The SIMs will work with the Jurisdiction Implementation Lead, as well as the outgoing carrier/intermediary's Contractor Manager, to manage and coordinate all of the segment transition activities of the MAC. He/she will also provide input on technical issues, schedules, and payment vouchers. Due to limited CMS resources, it is likely that there will be few, if any, Segment Implementation Managers.

2.2 CMS Contract Administration Personnel – MAC Contracts

The following individuals (along with the aforementioned CMS Segment Implementation Manager) will be responsible for monitoring the implementation and/or operational activities of the MAC. They will also interact with the carrier/intermediary in various meetings and workgroups. Except for the Segment Implementation Manager, CMS MAC contract administration personnel will not normally be involved with carrier/intermediary closeout activities during the transition. A CMS administrative organizational chart for the MAC contracts is shown in **Exhibit 2, MAC Contract Administrative Structure**.

2.2.1 MAC Contracting Officer

The MAC Contracting Officer (CO) has the overall responsibility for the incoming Medicare Administrative Contractor and is the only person authorized to enter into and bind the government by contract. He/she is the individual that negotiates and prepares the MAC contract document, modifies any terms or conditions of the contract, accepts delivered services, and approves vouchers for payment. While a single person could serve as both the carrier/intermediary CO and the MAC Contracting Officer, in the present CMS organizational structure they are two different people.

2.2.2 MAC Project Officer

The MAC Project Officer (PO) serves as the first point of contact for the MACs. He/she is the focal point for the exchange of information and the receipt of programmatic approvals on deliverables and other work under the MAC contract. The PO is the technical representative of the MAC Contracting Officer and provides technical direction to the MAC, as necessary, for all of the business functions contained in the MAC statement of work. He/she also monitors the performance of the MAC under the contract and reviews payment vouchers. The PO may designate various Business Function Leaders (BFLs) and technical monitors (TMs) to support the administration of the MAC contract.

2.2.3 MAC Jurisdiction Implementation Lead (JIL)

The MAC Jurisdiction Implementation Lead, or simply Implementation Lead, (previously known as the MAC Jurisdiction Transition Coordinator) will be the PO's representative for the overall MAC jurisdiction implementation and will serve in a specialized technical capacity to the Project Officer. The Implementation Lead will manage CMS's oversight of the jurisdiction transition and coordinate MAC implementation activities with the carrier/intermediary Contractor Managers and the functional contractor Project Officers. He/she will also resolve issues involving the various segment transitions within the jurisdiction.

The Jurisdiction Implementation Lead, as a representative of the Project Officer, will provide technical guidance and direction to the MAC and to Segment Implementation

Managers (SIMs), if any are designated for the jurisdiction. If there will not be any SIMs for the jurisdiction implementation, the JIL will work with the Medicare Implementation Support Contractor (see **Chapter 2.2.4** below) to oversee the segment implementations within the jurisdiction.

The Implementation Lead will work with business function leads (BFLs) concerning implementation issues. He/she will also coordinate implementation activities with the Project Officers of the functional contractors involved in the MAC implementation. The JIL will also conduct problem solving/trouble shooting on a jurisdiction level and be responsible for reporting to senior management. In addition, the Implementation Lead will review vouchers for jurisdiction implementation activities and provide recommendations to the Project Officer and the MISC Government Task Leader (if applicable).

2.2.4 Medicare Implementation Support Contractor (MISC)

Because of the number of implementations and the limited staff available for oversight, CMS has entered into a contract with Chickasaw Nation Industries (CNI) for a Medicare Implementation Support Contractor (MISC). The MISC will provide the project management support and the oversight services needed by CMS to monitor the implementation activities of the MACs and functional contractors. The MISC will provide oversight activities for each segment within its assigned jurisdiction and will serve in a capacity similar to that of a Segment Implementation Manager (**Chapter 2.1.3**) if one has not been designated.

There will be a MISC business analyst (BA) assigned to each jurisdiction. The business analyst's primary responsibility will be the segment implementations. The Medicare Implementation Support Contractor will have direct access and interaction with the MAC and outgoing contractor staff involved with the implementation. The BA will be a member of transition workgroups and attend all meetings associated with those workgroups. He/she will also attend general jurisdiction status meetings and teleconferences. The BA will work closely with the Jurisdiction Implementation Lead and will be the point person for segment implementation activities.

2.2.5 Business Function Lead

Business Function Leads (BFLs) will assist the Project Officer and will serve as the technical representative for their specific business function within the MAC contract. They will assist the PO with specific functional inquires and technical issues. They will also monitor and analyze activities and deliverables. In addition, they will review monthly invoices and vouchers pertaining to their area and make payment recommendations to the PO. The BFL is not authorized to direct any technical changes or make any contractual commitments or changes on CMS's behalf.

2.2.6 *Technical Monitor*

Technical Monitors are CMS Regional Office personnel who may provide information on contractor performance and help the Project Officer resolve issues, particularly those from beneficiaries and providers. The TM may assist the BFL in performing technical evaluations and inspections and may also provide input to monthly and quarterly contract administration meetings. In addition, Technical Monitors may perform on-site validations of accounts receivables and debts.

Chapter 3: INITIAL CLOSEOUT ACTIVITIES

3.1 Award Notification

The CMS Contracting Officer will contact each of the carriers and intermediaries within a MAC jurisdiction immediately after the MAC is informed of its contract award for that jurisdiction. This will begin the closeout phase of the carrier/intermediary's transition. The CO will discuss the general aspects of the incoming MAC's proposal and the transition schedule. The CO will provide the carrier/intermediary with the MAC's proposed implementation timeline and determine if there are any initial problems from the outgoing contractor's perspective. The anticipated ending date of the contract will be provided, and the CO will discuss upcoming activities, the jurisdiction and segment kickoff meetings, and CMS expectations for the transition. The CO will also provide any information regarding the MAC's proposal for utilizing any carrier/intermediary personnel should they be available for employment after contract end.

3.2 Carrier/Intermediary Contract Notification

After the MAC award has been made, the CO will provide official contract notification that CMS (or the Blue Cross and Blue Shield Association if the outgoing contractor is a Blue Cross Plan) is either terminating or non-renewing the outgoing contractor's Medicare contract or Plan agreement. There will also be an initial discussion about the financial requirements for transition and termination costs. The CO will request that the carrier/intermediary begin to prepare a budget for those costs. See **Chapter 8, Financial Processes**.

CMS will also send the outgoing contractors a letter requesting a copy of current personnel policies, including severance and related payments. The letter will include information on transition and termination costs and CMS' policy on retention bonuses and severance pay. See **Exhibit 3, Financial Information for Outgoing Contractors**.

3.3 Public Announcement

CMS will issue a press release regarding the award of the MAC jurisdiction contract. The outgoing contractor may also wish to issue a press release regarding its departure from the Medicare program. The announcement should include assurances that the outgoing contractor will work closely with the new MAC during the transition and that service to Medicare beneficiaries and providers will not be disrupted.

3.4 Initial Contact with Incoming MAC

After CMS has publicly announced the contract award and implementation schedule, the incoming MAC will be placing calls to the carriers and intermediaries within its jurisdiction. These calls will normally be made by upper management and will serve as

an introduction to the MAC. The MAC's proposal may be discussed in general terms, especially if the MAC has interest in the outgoing contractor's staff and/or facilities. Other areas of discussion may include communication, commitment of the organizations, the transition schedule, and any immediate problems or issues that need to be addressed before the kickoff meeting.

3.5 Employee Notification

After the carrier/intermediary is aware of the general provisions of the MAC's proposal, it should schedule a meeting with all of its Medicare employees. The purpose of this meeting is to provide information about the transition and to inform employees about the status of their jobs.

If the MAC has indicated that it would like to hire some or all of the outgoing contractor's staff, employees should be provided with as much information as is known about the MAC's intentions. Employees should also be informed about any jobs that may be offered in non-Medicare areas of the outgoing contractor's organization. Should jobs not be available in other areas or if employees will not have jobs offered to them by the new contractor, information on severance pay, retention bonuses, outplacement services, and other corporate benefits should be provided as soon as possible.

3.6 Closeout Project Team

The outgoing contractor will need to form a project team that will be responsible for closeout activities. The team's purpose is twofold: 1) to work directly with the MAC to accomplish the orderly transfer of Medicare data, records, and functions to the MAC; and 2) if the carrier/intermediary will not be continuing as a Medicare contractor, take the necessary steps to close out the carrier/intermediary's Medicare contract. The team should be comprised of a Closeout Project Manager and experienced personnel representing the various functional areas of the carrier/intermediary. Closeout team staff will be assigned to participate in the transition workgroups that will be formed (see **Section 3.8** below).

Once assignments have been made, an internal meeting with all team members should be held in order to plan and prepare for the closeout and upcoming kickoff meetings. An organization chart and contact list should be developed. Initial discussion should also take place regarding the development of the carrier/intermediary's Closeout Project Plan. In addition, administrative details and procedures for meetings and communications should be finalized.

3.7 Jurisdiction Kickoff

Jurisdiction kickoff is composed of 3-5 separate meetings conducted over a several day period. Jurisdiction kickoff is intended for all parties involved in any of the segment transitions that will occur within the jurisdiction, but not all parties will attend every meeting. There will be a minimum of three meetings held at kickoff: the MAC pre-

meeting, the outgoing contractor pre-meeting, and the general jurisdiction kickoff meeting. Kickoff may also include a segment kickoff meeting if a segment implementation is scheduled to begin at contract award. In addition, the post-award orientation conference conducted by the MAC Contracting Officer may be held as part of the kickoff if it has not already been held. The outgoing contractor should attend the **outgoing contractor pre-meeting** and the general **jurisdiction kickoff meeting**. It will also attend the **segment kickoff meeting** if one is scheduled and it pertains to the carrier/intermediary's segment.

Jurisdiction kickoff is generally held 10-15 days after contract award. The meetings will normally be held in the Baltimore, Maryland metropolitan area. The MAC will be responsible for providing facilities for all of the jurisdiction kickoff meetings that will take place, providing toll-free phone lines for off-site participants, developing an agenda (with input from other participants), and notifying potential attendees. In the unlikely event that the meetings are held at a CMS facility, then CMS would be responsible for the facilities and telecommunications. Meeting minutes and an attendance sheet/contact list shall be prepared by the MAC and sent to all those in attendance. Generally, each of the individual meetings that are held at kickoff can be completed in a half day (3-4 hours of concentrated meeting time) or less.

3.7.1 Outgoing Contractor Pre-Meeting

This meeting is conducted by CMS with the outgoing contractors and is normally held prior to the general jurisdiction kickoff meeting. Since these contractors will be present for the jurisdiction kickoff meeting, it provides an opportunity for CMS to discuss issues of importance solely related to contractors who are leaving the program or losing a portion of their workload. The meeting could be conducted with all outgoing contractors or there could be individual meetings with each carrier and intermediary. The meeting will be conducted by the CMS legacy contractor Contracting Officer and attended by the CMS Contractor Management Officer, Contractor Managers, and various CMS transition staff.

Topics for discussion include:

- Anticipated transition schedule and cutover dates
- Discussions regarding possible schedule modifications based on legacy contractors' circumstances/environment
- MAC hiring of carrier/intermediary employees
- Transition/termination cost policy and advanced agreements
- Incentive pay/retention bonus/severance pay policy. Contractor-specific discussions could be held if there are individual carrier/intermediary meetings.
- Staffing issues
- Operational issues
- Performance of contractual obligations; e.g., completion of audits
- Waiver policy
- Development of a Closeout Project Plan

- CMS oversight: meetings and reports
- Medicare Implementation Support Contractor (MISC)
- CMS Workload Closeout Handbook
- Workgroups and legacy contractor representation
- Accounts receivable review
- Workload reduction plans
- Upcoming jurisdiction kickoff meeting
- Pre-transition contractor readiness and documentation

3.7.2 *Jurisdiction Kickoff Meeting*

While the other kickoff meetings will have limited audiences, the jurisdiction kickoff meeting is intended for all parties involved in any of the segment transitions that will occur. This meeting is sometimes referred to as the general kickoff meeting.

3.7.2.1 Purpose

The purpose of the jurisdiction kickoff meeting is to understand, organize, and coordinate activities among all parties involved in the transition. It provides the opportunity for all parties to meet face-to-face to discuss the approach to the MAC jurisdiction transition, go over the schedule, review roles and responsibilities, and address any concerns about the upcoming segment transitions. While there may be some detailed technical discussion, the meeting is not intended to be at the level that would require all of the functional and technical project leads that the carrier/intermediary may be utilizing in its closeout efforts; those individuals would be expected to attend the segment kickoff meeting. Attendance at the jurisdiction meeting would normally include the Closeout Project Manager and a limited number of closeout project team members, such as the IT lead.

3.7.2.2 Participants

All parties directly involved in the jurisdiction transition should be in attendance: CMS, the MISC, appropriate MAC personnel, the outgoing carriers and intermediaries, the Blue Cross and Blue Shield Association (for fiscal intermediaries with Plan agreements), applicable data centers, any front end contractor, any organization(s) that will be moving Medicare workload to the MAC during the transition or will process some portion of the outgoing contractors' workload, shared system maintainers, and functional contractors such as the Program Safeguard Contractor (PSC), Qualified Independent Contractor (QIC), and the Beneficiary Call Center (BCC). Attendance may be in person or via teleconference. Toll-free teleconference lines will be available for individuals or organizations that cannot attend in person.

3.7.2.3 Topics of Discussion

The jurisdiction kickoff meeting will give a high level overview of the transition project. The MAC will be requested to make a corporate introduction and describe its Medicare organization and operation. The MAC should also discuss its implementation team/

organization, its implementation approach, and provide an overview of its Jurisdiction Implementation Project Plan. Other entities involved in the project may also be asked to provide an overview of their transition activities and interactions with the MAC. In addition, CMS will discuss its implementation expectations, review reporting and meeting requirements, and present its transition team organization.

The MAC's due diligence review will be discussed, along with deliverables that are being requested from the outgoing contractors. Proprietary issues regarding the MAC's interaction with the outgoing contractors will also be addressed. Any Deliverables List, action item list, or problem/issue log that is developed as a result of the kickoff meeting will be distributed as soon as possible after the meeting. The Deliverables List will serve as documentation for all of the information the outgoing contractors need to provide to the MAC (see **Chapter 6.4**). The coordination of communication activities will also be discussed.

Transition workgroups will be a key topic of discussion at the meeting (see **Chapter 3.8**). The MAC will work with the outgoing contractors and other attendees to establish jurisdiction-wide transition workgroups and agree on their basic responsibilities. These jurisdiction-wide workgroups and their functions should be in place for the entire jurisdiction implementation. All outgoing contractors involved in the transition will have to structure their closeout activities utilizing the workgroups. Therefore, it is critical that agreement be reached with all of the outgoing contractors as to what workgroups will be established and the major responsibilities for each.

After the jurisdiction kickoff meeting is completed, the carrier/intermediary should review its project schedule and the Closeout Project Plan and make any appropriate revisions based on the discussions that took place during the meeting.

3.7.3 Segment Kickoff Meeting

The segment kickoff meeting may or may not be a part of the jurisdiction kickoff. If it is, it will represent the formal start of the process of moving Medicare data, records, and operations from an outgoing carrier or intermediary to the MAC. It will be similar to the jurisdictional kickoff meeting in concept, but will be focused on the detailed technical and functional activities required for a specific segment transition.

3.7.3.1 Purpose

The segment kickoff meeting allows all parties involved in a segment transition to meet face-to-face to review the project expectations, discuss roles and responsibilities, and to organize and coordinate activities. The meeting will also help ensure that there is agreement among all participants regarding the tasks involved, project assumptions, and schedule. In addition, any emerging issues and/or changes that have occurred since contract award will be discussed, as will any lessons learned from prior segment transitions within the jurisdiction or other jurisdictions. Organizations that cannot attend in person may do so by teleconference.

3.7.3.2 Preparation

The MAC will be responsible for setting up the kickoff meeting for each segment implementation within its jurisdiction and shall consult with CMS regarding the time and location of such meetings. Generally, the meetings will be held at the proposed operational site or the corporate headquarters of the MAC.

The first segment kickoff meeting(s) normally will be held as part of jurisdiction kickoff, but there may be circumstances that dictate that the meeting(s) be held at a later time. The kickoff meetings for segments that will begin after the first round of segment kickoff meetings should take place within 10 days of the scheduled start date of that segment implementation. For segment kickoff meetings not occurring during jurisdiction kickoff, the MAC should meet with the CMS transition team prior to the meeting to discuss the agenda, materials to be handed out, and presentations that will be made.

All MACs will have to conduct multiple segment implementations in order to become fully operational. It is possible that there will be more than one segment implementation starting in the same month. If this occurs, the MAC will coordinate the scheduling of the kickoff meetings with CMS and the outgoing contractors of the segments. Normally, each segment implementation will require its own kickoff meeting; however, it is possible that the integration of segments in the project plan would allow for one kickoff meeting to cover multiple segment implementations.

The MAC will be responsible for setting up the facilities for the segment kickoff meeting, providing toll-free phone lines for off-site participants, developing an agenda (with CMS input), and notifying attendees. Meeting minutes and an attendance/contact list shall be prepared by the MAC and sent to all those in attendance.

3.7.3.3 Participants

All parties directly involved in the segment transition will be invited to attend: CMS (including the Medicare Implementation Support Contractor), appropriate technical and operational MAC personnel, the outgoing segment contractor, any organization other than the MAC that will be responsible for processing a portion of the outgoing contractor's Medicare workload, representatives from the applicable data center(s), shared system maintainers, the Blue Cross and Blue Shield Association (for fiscal intermediaries with Plan agreements), any front end contractor, IT services companies, and functional contractors (e.g., PSC, QIC, BCC). Attendance may be in person or via teleconference. Key members of the carrier/intermediary's closeout project team should be in attendance including anticipated workgroup heads.

Since detailed information and operational procedures may be discussed, attendance at the segment kickoff meetings should include more technical and functional experts than necessarily would be in attendance at the jurisdiction kickoff meeting. The outgoing contractor must have representatives present with the authority to establish project commitments and approvals on behalf of the organization.

3.7.3.4 Topics of Discussion

The MAC will be requested to make a corporate introduction, describe its Medicare organization, and discuss its implementation team and structure. This presentation would be similar to the one made at the jurisdiction kickoff meeting, but geared to the specific segment implementation. The Segment Implementation Project Plan (SIPP) should be distributed and an overview of the plan and the MAC's implementation approach provided. Input from attendees will be used by the MAC to prepare the "baseline" SIPP that will be submitted to CMS within 30 days of the meeting. The outgoing contractor will make a presentation regarding its organization, closeout plan, and project team. The carrier/intermediary will also discuss any unique workloads or situations where there are processing regions and files contain commingled data for states in multiple jurisdictions. Other involved parties will provide an overview of their activities and participation in the transition. CMS will discuss its transition organization and team and review reporting requirements (see **Chapter 4.10**). The meeting should also cover areas of the transition that need immediate attention, such as human resources, connectivity, and industry/provider communications.

The jurisdiction kickoff meeting will have already established the individual transition workgroups and the scope of their functions. During the segment kickoff meeting, there should be breakout sessions of the various workgroups with as many members as possible. If there are not enough workgroup members available, a date and time should be agreed upon for the group to initially meet and organize.

The breakout session will provide the opportunity for workgroup members to begin brainstorming, discuss transition strategy, and address any immediate issues. The group should also review implementation documents such as the JIPP and SIPP, deliverables that have been requested, dependencies, and any action items already identified in order to better define and develop the direction of the workgroup. Members should also discuss methods for accomplishing their workgroup tasks. The group should try to reach agreement on administrative details such as each organization's designated points of contact and workgroup meeting/teleconference dates and times, if possible.

After the meeting, the carrier/intermediary should review its Closeout Project Plan and schedule to make any appropriate revisions based on the discussions that took place during the meeting. The MAC will distribute any Deliverables List, action item list or problem/issue log that is developed. The Deliverables List will serve as documentation of the information the MAC is requesting from the outgoing contractor in order to facilitate the transfer of the Medicare workload (see **Chapter 6.4**).

3.8 Transition Workgroups

Transition workgroups are the basic organizational structure for conducting the day-to-day activities of the transition. They have proven to be the key to a successful workload transition.

3.8.1 *General*

Transition workgroups are established to facilitate the process of transferring the outgoing contractor's Medicare workload to the MAC. The MAC and all of the outgoing contractors within the jurisdiction must reach agreement on what workgroups will be established and what their specific responsibilities will be. Workgroups are generally established for infrastructure activities (facilities, hardware, human resources, telecommunications, etc.), functional program areas (MSP, audit and reimbursement, medical review, etc.), and overall project administration tasks (project management, financial, etc.).

3.8.2 *Participants*

Experienced staff from the MAC, the outgoing contractor, and other involved organizations will be assigned to the various workgroups that will be formed to oversee specific transition tasks or functional areas. Of course, the outgoing contractor will only participate in a workgroup if there is some carrier/intermediary involvement in the workgroup's function. CMS or the MISC will normally be represented on every workgroup. The MAC will be responsible for appointing the workgroup head.

If the carrier/intermediary will have more than one individual on a workgroup, it should designate a lead. The lead will be responsible for updating any tasks related to the workgroup that are listed in the Closeout Project Plan. He/she will also insure that requested carrier/intermediary information and deliverables are provided to the workgroup.

In general, there are three ways that an outgoing contractor (or other entity) may interact with the various workgroups: 1) it may be a part of a jurisdiction-wide workgroup, joining when its segment transition begins and leaving when its transition is completed; 2) it may participate in a specific segment workgroup under the aegis of the overall jurisdiction-wide workgroup; or 3) it may not need to participate at all in certain workgroups. For example, the outgoing contractor would probably not participate in a facilities workgroup that is responsible for establishing a facility to house the MAC's Medicare operation. However, if there was an agreement to utilize an outgoing contractor's existing space, then the carrier/intermediary would participate in the facilities workgroup.

3.8.3 *Scope*

The scope or area of responsibility for the individual workgroups will vary depending on a number of factors such as the MAC's organization or business structure, size of the outgoing carrier/intermediary, business processes, and workflow structure. At the Jurisdiction Kickoff Meeting, the MAC and outgoing carriers/intermediaries must reach consensus on the number and basic responsibilities of the workgroups to be established. The actual number of workgroups will vary from transition to transition, but it has been found that 8-10 workgroups generally work best. Workgroups have been established for

the areas shown below, but occasionally, more specialized workgroups have been established. Workgroups have also been combined for convenience or practicality. In addition, subgroups within a workgroup have been established to focus on specific areas or issues.

- Project Management
- Communications
- Systems/IT
- Telecommunications
- Beneficiary/Provider Relations
- Audit and Reimbursement
- EMC/EDI
- Medical Review
- MSP
- Operations/Claims Processing
- Provider Enrollment
- Hardware/Software
- Facilities
- Human Resources
- Financial
- Print/Reports
- Cutover

3.8.4 *Functions*

Each workgroup will identify the steps and action items necessary to successfully transfer the outgoing contractor's Medicare records, data, and operations that relate to that specific workgroup. They will be responsible for monitoring and updating the tasks listed in the MAC's Jurisdiction or Segment Implementation Project Plans that are applicable to their workgroup, as well as applicable tasks in the carrier/intermediary's Closeout Project Plan. Throughout the transition period, the workgroup will report their progress to the appropriate managers, resolve policy and transition issues regarding their areas of expertise, and ensure that all specific activities and deliverables have been accomplished.

Each workgroup is charged with defining the basic functions of the workgroup and establishing a work plan to address its objectives, work responsibilities, ground rules, and reporting requirements. The workgroup should maintain an issues/action item list and a deliverables log throughout the transition to insure that all items relating to the workgroup are resolved. The workgroup must have a clear understanding of the information that it must provide to other entities, as well as information and deliverables that it has requested from others. It is important that requests are precise so that time will not be lost due to misunderstanding exactly what is being asked for. The workgroups should reach an understanding of the types of issues for which they have the authority to

resolve and obtain approval from the project managers of those organizations represented in the workgroup.

While some workgroup activity may start at the jurisdiction kickoff meeting, most initial activity will begin at the segment kickoff meeting. If there are not enough participants available at that meeting, the MAC must schedule an organizational meeting for the workgroup at a later date.

Initial activities for the workgroups will include brainstorming, discussion of transition strategy, taking action on any immediate issues, identifying workgroup members, and reaching agreement on meeting dates and times. The workgroup should also discuss how they will accomplish their workgroup tasks. The group will review transition materials and meeting documentation, the Jurisdiction and Segment Implementation Project Plans, any deliverables that have been requested, dependencies, action items, etc. to better define and develop the direction of its workgroup. All of these activities will be coordinated through the MAC implementation project manager

3.8.5 Administration

Workgroups will normally meet on a weekly basis, either in person or via teleconference. It will be the responsibility of the MAC to provide toll-free teleconference capability for all participants in workgroup meetings, as well as any ad hoc teleconferences or meetings. The MAC will also develop a comprehensive workgroup meeting schedule for the segment transition. The schedule will provide a listing of all the workgroups that have been established, the workgroup leads, members, meeting days and times (normally scheduled for one hour), and the call-in numbers with corresponding pass codes. Membership of the workgroups should be finalized within a week after the segment kickoff meeting.

A workgroup agenda will normally be distributed a day before the workgroup meeting. The agenda can be in a fixed format that can be used as a minutes document after conclusion of the meeting. Workgroup meeting notes or minutes will be distributed within two business days after a meeting to allow sufficient time for required decisions to be made before the next meeting. The development and distribution of the agenda and meeting minutes/notes are the responsibility of the MAC. The notes should be reviewed at the next meeting so that all parties understand the impact of any decisions.

It is absolutely essential that there be communication between the various workgroups to ensure that each group knows what issues have been identified and the progress being made towards resolution. In some instances, the same issue will arise in several workgroups. Therefore, workgroup meeting notes need to be exchanged among the different groups, particularly for those that are handling similar or related issues. A project management workgroup could serve as a clearinghouse or forum for sharing information among the workgroups.

Chapter 4: PROJECT MANAGEMENT

4.1 Purpose

This chapter will provide general information and guidance regarding the management of carrier intermediary closeout activities. It will emphasize a number of items that the carrier/intermediary should consider and will provide the framework for completing the activities detailed in succeeding chapters so that the Medicare workload will be moved successfully into the MAC operational environment.

4.2 Project Team Modifications

Based on the discussions during the jurisdiction and/or segment kickoff meetings, the carrier/intermediary may need to refine its closeout project team. Staffing changes may need to be made and responsibilities modified. Once the team has been finalized, the organization chart and contact list should be submitted to CMS and the incoming MAC. It may be helpful for the project team to meet internally on a weekly basis to discuss issues and update the project plan, in addition to the regular biweekly segment status meetings (see **Chapter 4.11.5**).

4.3 Closeout Project Plan

The carrier/intermediary will be responsible for developing and maintaining a Closeout Project Plan (CPP). An accurate and complete project plan is necessary to properly close out the carrier/intermediary's Medicare contract. CMS does not mandate any particular method or software to be used in managing the closeout; it does, however, require that project plans, reports, and materials are readable using Microsoft Project, Excel, Word, or Adobe.

The CPP must provide an overall administrative plan and a description of all tasks and timeframes required to close down carrier/intermediary operations and transfer Medicare data, records, and operations to the MAC. The outgoing contractor must create a "baseline" CPP and submit it to CMS for approval within 15 days of the kickoff meeting. This will be the "master plan" for the closeout and will be used by the carrier/intermediary and CMS to monitor the overall progress of the project.

A sample Closeout Project Plan is shown in **Exhibit 4**. The exhibit shows a breakout of the major areas of activity that are usually required for the closeout of a Medicare contract. The tasks and the level of detail may vary depending on a number of factors associated with the transition. The CPP should show a Work Breakdown Structure (WBS) to the level commensurate with the extent of the activity, depending on the major task category and the amount of detail the carrier/intermediary (or CMS) finds necessary in order to properly track the project.

CMS understands that the CPP is a dynamic document that may change throughout the life of the project. Additional tasks may need to be added and others may need to be modified or deleted if they are no longer applicable. Timeframes may also need to be revised to correlate to any transition schedule changes. Any changes to the CPP should be communicated to CMS

It is imperative that the carrier/intermediary coordinates its CPP with the MAC's Segment Implementation Project Plan (SIPP). The interrelated project activities and dates of the two contractors must not be in conflict. A great deal of outgoing contractor information is necessary for the complete development of the MAC's SIPP. Some of this information cannot be obtained until after contract award. The MAC will need to baseline its SIPP as a result of the kickoff meeting and subsequent discussions with the carrier/intermediary and other involved organizations. CMS expects the outgoing contractor to work with the MAC to insure that any information necessary to baseline the SIPP is provided and that both organizations work together throughout the transition to refine both the IPP and the CPP.

The carrier/intermediary's CPP must be updated on a biweekly basis with an accompanying list of tasks that were completed during the reporting period and a list of tasks that are not on schedule—either they have not started or have not been completed in accordance with the dates shown on the CPP.

4.4 Consultants

As the carrier/intermediary assesses its closeout activities, it may find the need for consultant services to assist in certain transition tasks and/or to provide expertise in the financial and legal issues surrounding closeout activities. Section II of the Title XVIII Medicare contract should be reviewed for requirements regarding CMS's prior approval of consultant services. Under the Medicare contract/agreement, carriers/intermediaries must have prior written approval of the Contracting Officer if:

- Reimbursement for the services of any proposed consultant will exceed \$400 a day or \$100,000 per year, exclusive of travel costs; or
- Any employee of the company is to be reimbursed as a consultant.

If a carrier/intermediary expects to enter into a consultant service contract that requires CMS's prior approval, it **MUST** contact its Contracting Officer. It must demonstrate the need for such consultant services and document the roles and responsibilities. It must also include the estimated costs and demonstrate the reasonableness of the fees to be paid. The carrier/intermediary must allow sufficient time for CMS to approve the consultant contract prior to execution. Failure to do so may affect reimbursement.

4.5 Interaction with the Incoming Contractor

A transition is a complex undertaking involving many different organizations. It is a temporary partnership and all parties need to be working toward the common goal of a successful transition. One of the most important activities in the carrier/intermediary's closeout period is to work with the MAC to plan, organize, and control the orderly transfer of Medicare operations, workload, and documents. It is critical that the carrier/intermediary work closely with the MAC to coordinate activities, monitor workload and staffing changes, and communicate at all levels. The meeting and reporting requirements detailed in **Chapter 4.10 and 4.11** below provide a framework for that effort.

In some transitions the parties have found it helpful to have regular informal teleconferences with just the project heads of all the organizations involved (e.g., MAC, outgoing contractor, data center, CMS, PSC, etc.) to keep the lines of communication open, discuss overall progress, and ease the resolution of any issues or conflicts.

4.6 Internal Communications

It is important that the carrier/intermediary keep its employees informed about the progress of the closeout and transition to the MAC. This can be accomplished through regularly scheduled staff meetings and employee bulletins or newsletters. If the MAC has proposed to hire outgoing contractor staff, it should work with the carrier/intermediary to provide updates and information regarding the MAC's implementation efforts. The MAC may also have a human resources person and/or management staff available to answer employment questions and to provide general information on the progress of the implementation.

4.7 On-Site Presence

Depending on the circumstances of the transition, on-site presence of the MAC at the outgoing contractor's site(s) could be beneficial. Any request for on-site presence will be communicated and discussed with carrier/intermediary to determine if it is desirable or feasible. The MAC will propose how much of an on-site presence it believes is warranted and the timing of such presence. CMS recognizes that on-site access is the sole prerogative of the carrier/Intermediary and that it may limit access to its operation or not provide any working space for the MAC.

The amount of on-site presence requested will be dependent on a number of factors, but a key factor is whether or not the MAC is proposing to use any of the outgoing contractor's staff and/or maintain a presence in the area. The carrier/intermediary will need to negotiate with the MAC regarding space and equipment needed, the number of personnel, and tentative schedules. Company policy/procedures regarding site access and security measures will also need to be discussed.

4.8 Nomenclature

As the segment transition begins, the carrier/intermediary must make sure that the terminology and nomenclature used in its operation is understood by all parties involved in the project. All terms, acronyms, and files need to be well defined and clearly understood. This will help prevent project delays, duplication of effort, and unanticipated workload being transferred at cutover.

4.9 Waivers

It is possible that the demands associated with contract closeout and transferring the Medicare workload may result in the outgoing contractor identifying either administrative or workload functions and duties it believes it can no longer perform. If the carrier/intermediary finds itself in such a situation, it should discuss the issue with CMS. If it appears that a waiver would be appropriate, given the circumstances surrounding the transition, the carrier/intermediary should submit a request following the normal CMS waiver procedures. All waiver requests must be submitted in writing or through e-mail to CMS Central Office, CMM, Medicare Contractor Management Group (MCMG). The specific designee will be named for each transition.

Each waiver request submitted must identify the specific activity for which the waiver is being requested. It must also identify any related administrative cost savings, on a full and incremental basis, and provide a rationale for each savings calculation. Full cost savings could include staff costs no longer required to perform a proposed activity to be eliminated. However, those same staff costs would be excluded from the incremental cost savings if that staff were shifted to other work, including transition activities.

CMS will not review or approve any request for waiver that does not contain specific cost savings or an explanation of why no savings is anticipated. Closeout waiver requests are given priority attention in CMS; a decision will be made and notification provided as soon as possible.

CMS will also work with outgoing contractors to address telephone service issues resulting from reduced staffing levels or other transition issues. CMS may choose to relax call-handling standards, re-route calls to other call center locations, or take other actions to address the service level issue on a case-by-case basis.

The carrier/intermediary should be prepared to negotiate a reduced Notice of Budget Approval (NOBA) for any incremental cost savings which occur as a result of a waiver approval.

4.10 Documentation

CMS will closely monitor the outgoing contractor and incoming MAC during the transition to ensure that the transition occurs on schedule and that all Medicare data and operations have been properly transferred. CMS requires the carrier/intermediary to

submit the following documents during the closeout period. A comprehensive guide to all of the documentation required during a transition is found in **Exhibit 7, Workload Transition Meetings and Documentation**.

4.10.1 Closeout Approach / Inventory Reduction

The carrier/intermediary will prepare a document describing the proposed operational approach it will take for its claims processing activities and inventory reduction during the closeout period. It should include the streamlining of operations, a workload reduction plan, staffing configurations, and any proposed contingency plans. The approach should be submitted to CMS for approval no later than 15 days after the segment kickoff meeting. See **Chapter 6.1 and 6.2**.

4.10.2 Closeout Project Plan (CPP)

The Closeout Project Plan shows the tasks and schedule necessary for the transfer of Medicare files and operations to the MAC and the activities required for contract closeout. The CPP must be coordinated with the MAC's Segment Implementation Plan. A baseline CPP should be submitted for approval to CMS no later than 15 days after the segment kickoff meeting. The CPP is a dynamic document and will be modified as events occur during the transition. The carrier/intermediary must ensure that CMS is aware of any changes made to the CPP and that those changes are reflected in the biweekly CPP update. See **Chapter 4.3**.

4.10.3 Closeout Project Plan Update

The CPP will be updated on a biweekly basis. The plan should be submitted at least two days prior to the biweekly segment project status meeting (see **Chapter 4.11.5**). The updated plan should be accompanied by a list of tasks that were completed during the reporting period and a list of tasks that are not on schedule—either they have not started or have not been completed in accordance with the dates shown on the CPP. When submitting an updated CPP, many contractors highlight in red those tasks that are not on schedule. Also, the update must show any new tasks that have been added to the plan and tasks that have been deleted, along with an explanation for the action.

4.10.4 Closeout Project Status Report

This report is prepared biweekly and contains a narrative status of the segment closeout activities. The report should describe the activities that have taken place in each major task area of the project for the two week reporting period. It should also include a discussion of outstanding issues and the status of deliverables. If there are problems or potential problems, the carrier/intermediary should provide detailed information and provide any resolution measures. The report should also discuss any schedule slippage, the impact it may have on the project and the steps that are being taken to correct the situation. The Closeout Project Status Report is due two days prior to the biweekly segment project status meeting.

Because of the number of concurrent transitions taking place over the next several years, it is necessary to standardize how MACs and carriers/intermediaries will be reporting the status of their implementation or closeout activities. While the structure of each outgoing contractor's Closeout Project Plan is developed around its business needs, resources, and organizational structure, CMS requires that all status information that is reported be displayed under the following seven basic work elements. Because of the differing nature of their projects, the incoming and outgoing contractors will have varying degrees of activity in each of the elements; however, both should be able to utilize the same format. The work elements are as follows:

- **Project Management**

This element includes organizing project staff and workgroups, preparing the various plans required by CMS, conducting meetings, monitoring and reporting progress, issue/problem resolution, managing costs, and managing risk.

- **Communications**

Activities include communicating with providers, beneficiaries, medical/specialty groups, trading partners, and all other participants and stakeholders in the project.

- **Claims Processing/Operations**

This element involves activities associated with closing down the **business environment**. Tasks include preparing operational shutdown activities, due diligence assistance, asset inventory, and interaction with other organizations involved in the transition.

- **Systems/EDI**

This area involves closing down the **technical environment**, including EDI, voice and data telecommunications, base/non-base applications and services, local hardware/software, and interaction with the EDC.

- **Resources/Infrastructure**

Activities include personnel activities and closing down facilities and associated infrastructure.

- **Financial**

This element includes banking activities, accounts receivable review, and cost reporting.

- **Cutover/Workload Transfer**

This area includes file preparation, storage, and the activities associated with the actual cutover of Medicare operations and transfer of files.

4.10.5 Workload Report

As soon as the MAC award is made, CMS will begin monitoring each outgoing contractor's performance on a weekly basis. Data obtained will include:

- receipts,
- claims processed,
- claims pending,
- claims pending over 30/60/90 days,
- claims processing timeliness,
- correspondence,
- hearings,
- cost reports,
- appeals,
- telephone service, and
- compliance reviews.

The workload report with the above-mentioned items will be submitted to CMS on a weekly basis. Actual monthly workload should be cumulative on a monthly basis and displayed against the expected monthly workload goals of the inventory reduction plan that was submitted as part of the carrier/intermediary's operational closeout approach document (see **Chapter 4.10.1** above). If there are major discrepancies between the actual workload and anticipated goals, an explanation should be provided. CMS will provide carrier/intermediary workload information to the MAC on an ongoing basis, along with any operational issues that arise.

4.10.6 Issues Log/Action Items

The carrier/intermediary should maintain an issues log/action items list for those items identified during the closeout. The list should be for those issues that pertain solely to the carrier/intermediary and are not part of the implementation issues log maintained by the MAC. The list should provide an identification number, the date created, a description of the issue/action required, the responsible party, an update of the status, the date of resolution, and any pertinent comments. Some outgoing contractors have found it helpful to transfer closed items to a separate log, with the resolution date and an explanation of how the issue was resolved. The issues log/action item/closed list(s) should be updated weekly and submitted with the biweekly CPP update.

4.10.7 Staffing Report

CMS will also monitor staffing levels of the outgoing contractor by the functional areas of its Medicare operation. The outgoing contractor will provide a weekly breakout of

staffing showing staff losses by area, transfers within the Medicare operation or to other areas of the company, new hires (temporary or permanent), and staff in training. There should also be an explanation of the changes. The MAC will be provided a copy of the staffing report. Based on the workload and staffing reports, it is possible that CMS (after consultation with the carrier/intermediary and the MAC) may decide to move a particular function sooner than expected. If this occurs, the project schedule and transition/termination costs would be modified accordingly.

4.10.8 Asset Inventory

The outgoing contractor must develop a fixed asset inventory for all Medicare assets that were acquired in order to perform the functions of its Medicare contract. Any government furnished property (GFP) or equipment (GFE) should be listed separately and identified as such. The inventory will include all real property, hardware, software, supplies, equipment, furniture, etc. that was purchased for its Medicare operation and reimbursed by CMS. It should also show the residual value of the asset and its anticipated disposition. The inventory must be provided to the Contracting Officer as soon as possible after closeout activities have begun. See **Chapter 5.6**.

4.10.9 File Inventory

The outgoing contractor must develop an inventory of all files and records that will be transferred to the MAC. The inventory should give a description of the files, including contents, size, etc. If the outgoing contractor has more than one operational site, an inventory must be prepared for each site. CMS and the MAC will be provided with a copy of the inventory. The MAC will use the inventory to determine where files will be located when it assumes the workload. See **Chapter 7.6.1**

4.10.10 File Transfer Plan

When a final file inventory has been prepared, the outgoing contractor and the MAC must develop a file transfer plan. The plan should describe the files and records to be transferred by type, method of data transfer, transfer protocols, and destinations. A schedule for the transfer of the workload with shipping dates and times must be provided. It should also provide a description of the method of manifesting, packaging, and labeling all claims and correspondence. The file transfer plan must be developed and provided to CMS prior to the beginning of the cutover period. See **Chapter 7.6.2**.

4.10.11 Post-Cutover Activities and Resources

During the cutover period, the outgoing carrier/intermediary must assess what activities it will need to perform after cutover and the personnel it will need. Most of the post-cutover activity involves the final preparation and submission of the various CMS-mandated reports and the financial closeout of the contract. A document should be prepared describing the reports and functions that must be performed, an estimate of the number and availability of resources, the time commitment that will be required, and the

schedule for completing the post-cutover activities. The document should also include any additional factors that need to be considered, such as the training of staff to perform tasks that were done by employees who are no longer available. The post-cutover information should be provided to the CMS Segment Implementation Manager at the beginning of the cutover period.

4.10.12 Lessons Learned

CMS believes that each segment transition that takes place will provide valuable information and lessons learned for subsequent transitions. As such, CMS asks that the carrier/intermediary maintain a list of transition activities that could have been handled differently or areas that could be improved. It is hoped that after cutover, the outgoing contractor will be able to prepare a lessons learned document regarding its activities during the closeout. The document should be structured using the major tasks of the Closeout Project Plan or the major areas reported on the Closeout Project Status Report. The lessons learned should analyze what activities were successful and why, and discuss those activities that need improvement. The document should be submitted to CMS as soon as practicable after cutover. It will be used as part of the discussion during the post-project review meeting (see **Chapter 4.11.8**).

4.11 Meetings

The carrier/intermediary will be expected to attend a variety of meetings as part of its closeout activities. These meetings will help ensure that all parties are informed of the progress of the transition, are aware of the outstanding issues, and understand what actions need to be taken on their part for the successful outcome of the project.

The following are meetings that the outgoing contractor will need to attend. Unless otherwise noted, the MAC obtains facilities, provide toll-free teleconference lines, and prepare and distribute agendas and meeting minutes. Note that the term “biweekly” means every two weeks.

Exhibit 7, Workload Transition Meetings and Documentation, provides a useful reference of the following meeting information in chart form.

4.11.1 Outgoing Contractor Pre-Meeting

As part of the jurisdiction kickoff, the CMS will conduct a pre-meeting with the outgoing contractors prior to the general jurisdiction kickoff meeting. The meeting provides an opportunity for CMS to discuss issues of importance solely related to contractors who are leaving the program or losing a portion of their workload. The meeting may be conducted jointly with all outgoing contractors or there may be individual meetings with each carrier or intermediary. The meeting will be conducted by the CMS legacy contractor Contracting Officer and attended by the CMS Contractor Management Officer, Contractor Managers, and various CMS transition staff. See **Chapter 3.7.1**.

4.11.2 Jurisdiction Kickoff Meeting

The jurisdiction kickoff meeting is a one-time meeting that brings together all of the participants in the transition. It provides the opportunity to meet face-to-face to discuss the overall approach and organization of the project. Participants will provide an overview of their organizations and introduce their project team. The schedule will be reviewed, roles and responsibilities defined, and any concerns or issues addressed. The number and function of the transition workgroups will also be discussed and agreed upon. The kickoff meeting is usually held 10-15 days after contract award. See **Chapter 3.7.2**.

4.11.3 Segment Kickoff Meeting

The segment kickoff meeting represents the formal start of the process of moving a carrier or intermediary's workload to the MAC. It is similar to the jurisdiction kickoff meeting in concept, but is focused on the activities surrounding an individual segment transition. The first segment kickoff meeting should take place 10-15 days after award of the MAC contract and may be held in conjunction with the jurisdiction kickoff meeting. Subsequent segment kickoff meetings should take place 10-15 days prior to the scheduled start date of that segment transition. See **Chapter 3.7.3**.

4.11.4 Jurisdiction Project Status Meeting

This is a biweekly meeting intended for the project leads of the parties involved in the transition, including the overall leads for the MAC jurisdiction, MAC segments, outgoing contractors, any jurisdiction-wide workgroup leads, EDC, standard system maintainers, and functional contractors. BCBSA will also be in attendance for those segments involving a fiscal intermediary. This meeting will review the status of the overall jurisdiction transition, ensure that tasks and schedules are coordinated properly and on schedule, and resolve issues that involve multiple segments. These meetings are normally teleconferences, but some may be in person. The MAC will prepare an agenda at least one day prior to the meeting and distribute meeting documentation (list of attendees, minutes, action items, etc.) within three days following the meeting.

4.11.5 Segment Project Status Meeting

This biweekly meeting is intended for all parties involved in the segment transition to obtain an update on the progress of the project. The parties will review the major tasks of the Segment Implementation Project Plan (SIPP) and receive updates from each of the workgroups. Participants will go through the deliverables and issues logs and review workgroup items. The meeting will discuss issues that have arisen and determine appropriate action on delays in task completion, deliverables, and action items. The carrier/intermediary will also provide updates to its Contract Closeout Plan (CCP) and the relevant activities of the other parties involved in the transition will be reviewed. The segment status meetings are generally held by conference call, although there may be some face-to-face meetings. The MAC will prepare an agenda at least one day prior to

the meeting and distribute meeting documentation (list of attendees, minutes, action items, etc.) within three days after the meeting.

4.11.6 Transition Workgroup Meetings

Workgroups may be established for individual segments, multiple segments, or for the entire jurisdiction. Transition workgroups generally meet on a weekly basis. The meetings will be used to review the transition activities applicable to its function, track deliverables, and monitor action item resolution. Problems or issues will also be raised to the appropriate project lead. Workgroup meetings are normally teleconferences, although some may be in person, especially in the beginning of the project or near cutover. See **Chapter 3.8**.

4.11.7 Cutover Meeting

Beginning approximately two weeks before the segment cutover, a daily cutover teleconference will be held. The meeting will review the cutover plan and the activities scheduled for that day and resolve outstanding issues. The calls are normally held in the morning and are brief in length. See **Chapter 7.4**.

4.11.8 Post-Project Review Meeting (Lessons Learned)

After the segment transition has been completed, the MAC will conduct a post-project review meeting. This meeting will normally be via teleconference unless CMS believes that it would be beneficial to meet face-to-face. The purpose of the meeting is to review those activities that were successful during the segment transition and those that need improvement. Attendees will review the lessons learned documents that will be prepared by all parties involved in the transition (see **Chapter 4.10.12** above). The meeting will take place approximately six weeks after the segment cutover.

It is extremely important for the MAC to get input from the outgoing contractor in order to improve subsequent segment transitions. It is also important for CMS to apply lessons learned to other jurisdiction transitions. Given this importance, it is hoped that the outgoing contractor will participate in the lessons learned meeting. CMS recognizes that certain key transition personnel may no longer be employed by the company. However, if individuals are still in the employ of the outgoing contractor, CMS hopes that every effort will be made to allow them to attend the meeting.

Chapter 5: PERSONNEL AND INFRASTRUCTURE

5.1 Personnel Actions

Employee commitment to the transition is extremely critical. Carrier/intermediary employees must continue to perform their jobs throughout the transition and maintain production levels. It is incumbent on the outgoing contractor to make every effort to keep existing employees and maintain their productivity. Rumors can run rampant during a transition, especially after the announcement of the MAC award. They can affect the work environment in numerous ways and can affect efforts to retain personnel--the longer uncertainty exists, the more attractive alternate employment becomes. It is important for the outgoing contractor to provide factual and timely information throughout the closeout period.

Obviously, if employees have knowledge that they will remain with the company or that the MAC will be extending offers of employment, it will greatly facilitate the transition process and alleviate fears regarding the future. However, that will not always be the case. Even if employees are facing separation, knowledge of employee benefits and any special incentives can help keep operations running smoothly. It is important for the carrier/intermediary to provide open forums for discussion purposes and to alleviate fears regarding employees' futures. There should be an established process for written and verbal communications regarding transition issues in order to provide ongoing information to employees. A number of outgoing contractors have also found it helpful to have a transition hotline or special section on their websites dedicated to transition information.

5.1.1 *Employment Within the Company*

Carrier/intermediary management will need to ascertain corporate intentions for its employees at the end of its Medicare contract. Management will determine if jobs in other areas of the company will be offered to Medicare employees, and if so, how many and in what areas. This information should be provided to employees as soon as possible. If personnel will be offered other positions within the company, CMS expects that the carrier/intermediary will make every effort to keep Medicare employees in place until cutover or negotiate a mutually agreeable plan with the other corporate component(s) if employees will need to be transferred prior to cutover.

5.1.2 *MAC Employment*

If the MAC is proposing to offer employment to outgoing contractor employees, MAC management staff will contact the carrier/intermediary to discuss how many positions may be offered, the location(s) of jobs, and specific individuals of interest. After the details of the MAC's employment proposal have been obtained, employees should be notified. The outgoing contractor should hold a meeting with affected employees as soon

as possible to communicate the commitment of both organizations, allay fears, and provide information regarding the transition and future employment. The MAC may also wish to have a face-to-face meeting with potential employees to discuss its organization, benefits, and the types of jobs that will be available. If the MAC is proposing to hire a substantial number of carrier/intermediary employees, it may propose that a human resources representative be on site on a regular basis to address employee concerns and provide detailed information regarding benefits and employment.

The carrier/intermediary should work with the MAC to establish communication procedures for the employees it is proposing to hire. Protocols for contacting staff, obtaining approval and release of employee information, and how job postings can be displayed will need to be agreed upon. The MAC will need specific employee information such as names and addresses, dates of service, job titles, job grades, job descriptions, current salaries, review dates, and documentation of current employee benefits. Of course, obtaining certain information will require permission from the employee.

The carrier/intermediary and MAC should prepare a comparison of employee benefits showing the differences between each organization's benefits. Meetings should be scheduled with staff to discuss the differences, provide information on what employees may expect if they become MAC employees, and how the actual employment cutover will be handled. The MAC may also ask to contribute transition related articles to the carrier/intermediary's employee newsletter.

A mutually agreed upon plan or calendar for when employees will actually transfer to the MAC's employment will need to be developed. The plan must ensure that there is no degradation of service at the carrier/intermediary's site due to the hiring schedule. CMS expects that the MAC will not hire any of the outgoing contractor's staff to perform work for the MAC prior to cutover unless it has been agreed to by the outgoing contractor and CMS.

5.1.3 *Termination*

The carrier/intermediary will need to develop a strategy for: 1) retaining those employees that will not continue employment with the company or be hired by the MAC; and 2) maintaining the productivity of those employees. The strategy should be based upon CMS policy and applicable regulations, prior transitions, and internal company guidelines. Consideration may be given to items such as performance incentives, overtime, retention bonuses, compensation packages, severance pay, etc.

The carrier/intermediary will need to enter into discussions with CMS as it develops its strategy and have agreement with CMS regarding those areas that will require CMS reimbursement. Employees should be informed as soon as possible about severance pay and any other type of financial arrangement that the carrier/intermediary will offer. Carriers/intermediaries may utilize or develop an employee counseling program to provide guidance on such topics as severance pay, benefit expiration, benefit conversion

(if appropriate), vested employees retirement rights, unemployment compensation and any other entitlements. It may also make job placement services available to assist employees with employment opportunities within other areas of the company or in the local area. Carriers/intermediaries should note that CMS will not pay for job placement services.

The outgoing contractor must be cognizant of any Federal and state labor laws and requirements regarding employee notification of job loss and verify that the company policy regarding layoffs is in compliance.

5.2 Severance Payment

CMS's severance payment policy was distributed to all Medicare contractors in 2000 and can be found in **Exhibit 3**. Carriers and intermediaries should review their own corporate severance policies to insure that they conform with all of the conditions that are set forth in the memorandum. Failure to comply could put the carrier/intermediary at risk for reimbursement.

Even though the carrier/intermediary describes its current corporate severance policy in the Financial Information Survey accompanying the annual Budget Request, a copy of the most recent severance pay policy should be submitted to the Contracting Officer. CMS will closely review any recent changes to the carrier/intermediary's severance pay policy. Discussions will need to take place between the Contracting Officer and the carrier/intermediary to insure that there are no issues regarding the amount of CMS's severance payment obligation.

CMS will reimburse an outgoing contractor for severance payments made to its employees in accordance with Federal Acquisition Regulations (FAR) 31.201-4(b) and FAR 31.205.6(a),(b), and (g). As provided for in the FAR, CMS is liable, in most instances, for the severance costs stemming from the established, written policy of the carrier/intermediary. The unique circumstances surrounding the termination or non-renewal of each carrier/intermediary's contract will determine the liability and extent of liability that CMS may have.

In general, CMS will reimburse an outgoing contractor for severance payments under the following conditions:

- The carrier/intermediary shall have an established, written severance policy in place and it must be found to be reasonable by the Government; and
- Severance pay shall only be paid to employees of cost centers whose function is directly servicing the Medicare contract at the time of the non-renewal or termination notice if such cost center is eliminated or its staffing level is decreased due to the non-renewal or termination.

Severance pay normally will not be paid to carrier/intermediary employees if:

- The employee has been or will be hired by the MAC or another Government contractor associated with the MAC where continuity for prior length of service is preserved under substantially equal conditions of employment (FAR 31.205-6(g)(1)); or
- The employee has been hired by the carrier/intermediary's private lines of business or by one of the carrier/intermediary's subsidiaries or other member of a controlled group (see Internal Revenue Code, Section 1563); or
- The employee has received a written offer of employment by the MAC and has chosen to refuse that employment.

5.3 Retention Bonus

In certain transition situations, it may be necessary to provide retention bonuses in order to keep staff from departing prior to cutover. However, the end of a Medicare contract is not sufficient cause, in and of itself, to request retention bonus funds for work already funded in the Notice of Budget Approval (NOBA). The carrier/intermediary **MUST** contact the Contracting Officer if it believes that a retention bonus is warranted or necessary during the closeout period. CMS will review the retention bonus proposal and its justification. **Do not inform employees about any retention bonus prior to discussions and agreement with CMS. Failure to do so may put the carrier/intermediary at risk, since it may not be reimbursed.**

CMS's retention bonus policy was distributed to carriers/intermediaries in 2000 and is also found in **Exhibit 3, Financial Information for Outgoing Contractors**. CMS will pay retention bonuses in accordance with the FAR 31.205-6. Under the FAR, to be allowable, compensation must be reasonable for the work performed. The payments must either be paid under an agreement entered into before the services are rendered or pursuant to the carrier/intermediary's established plan or policy. The basis for the bonus payment must be supported. There may be retention (stay on) and performance-based bonuses; a bonus may include elements of both.

CMS expects the carrier/intermediary to adhere to the terms of its Title XVIII contract/agreement and FAR Part 31. It expects the outgoing contractor to perform within the funding limitations contained in the NOBA; however, it may pay for a transition retention bonus in certain situations. For a retention bonus to be reimbursable, the following conditions must be met:

- Funding has been approved by CMS in advance pursuant to a Supplemental Budget Request which adequately justifies the request.
- The cost is in compliance with the Title XVIII Medicare contract/agreement and the Intermediary and Carrier Fiscal Administration Manuals.

- The amount is reasonable and is supported by documentation from the carrier/intermediary.
- CMS determines that the bonuses are necessary for the smooth transition of the work.
- The bonuses will not be paid to the designated employees until completion of the retention period.

5.4 Terminating Subcontracts

When the outgoing contractor is notified that its Medicare contract will be terminated or non-renewed, it will need to invoke the automatic termination clause for any lease or subcontract that contains the clause. All subcontracts that are entered into by the carrier/intermediary that require prior approval by CMS should have an automatic termination clause. The clause is described in Article III of Appendix A of the carrier/intermediary's Medicare contract/agreement. If the carrier/intermediary finds that a subcontract does not include an automatic termination clause and the subcontractor will not abide by the provisions of the clause, the Contracting Officer must be contacted.

The automatic termination clause basically states that if a carrier/intermediary's Medicare contract is terminated or non-renewed, then any subcontract between the carrier/intermediary and another company shall be terminated unless otherwise agreed to by CMS and the carrier/intermediary. The notice of termination must be provided in writing to the subcontractor along with the date upon which the termination will become effective. If the outgoing contractor wishes to continue the subcontract relative to its own private non-Medicare business after the Medicare contract is terminated or non-renewed, it must provide CMS written assurance that CMS's obligations will end when the Medicare contract terminates or non-renews.

5.5 Licenses

Licensing agreements can affect a number of contractor activities including EMC software, mail, PC software, imaging equipment, and data analysis tools. The incoming MAC may wish to assume certain licenses held by the carrier/intermediary and those licenses should be evaluated on an individual basis. Licenses may be transferred if both parties agree and the language in the agreement allows for such a transfer. If the license agreement has no provisions for a transfer, or if the parties cannot agree to transfer terms, then no transfer of the lease can be made and the MAC will have to obtain a new license.

5.6 Asset Inventory

The outgoing contractor will normally discontinue the acquisition of assets during its closeout unless it is absolutely essential to the success of the transition. If there is any question about acquiring assets during the closeout period, contact the Contracting Officer.

The carrier/intermediary retains legal title and control of assets that it acquired on behalf of the Medicare program. It is responsible for disposing of those assets as quickly as possible after cutover or whenever the assets are no longer needed for Medicare. Assets not specifically furnished by CMS as government furnished property (GFP) or equipment (GFE) are the property of the outgoing contractor and may be kept, sold, or disposed of in accordance with the Federal Acquisition Regulations (FAR).

As part of its closeout activities, the carrier/intermediary must develop a fixed asset inventory for all Medicare related assets at all of its locations. It must reconcile the inventory with the fixed asset register that it maintains in order to assist CMS with the cost recovery of the assets. The inventory will include all real property, hardware, software, equipment, furniture, supplies, etc., that were purchased for its Medicare operation and reimbursed by CMS. It should show the residual value of the asset and its anticipated disposition. The inventory must be provided to the CMS Contracting Officer.

The carrier/intermediary should also provide the incoming MAC with a list of assets and other work-related items that it will not be retaining. This should be done as early in the transition as possible so that the MAC will have time to analyze, negotiate, and transfer any asset that is available from the outgoing contractor. **It is CMS's preference that assets not being retained by the carrier/intermediary will be made available for sale or transfer to the MAC.**

5.7 Security Awareness

The outgoing contractor should be cognizant of possible security breaches that may be caused by employees, once they are aware of their employment future. Unfortunately, some employees may resort to theft, system sabotage, or other types of disruption to the Medicare operation. The carrier/intermediary should review its existing security measures and, given the circumstances, determine if they are adequate or need to be improved.

Chapter 6: CLOSEOUT OPERATIONS AND PROVIDING INFORMATION/ASSISTANCE

6.1 Operational Analysis

After the award of the MAC contract, the carrier/intermediary should begin to assess its Medicare operation and develop an approach for closing out its Medicare contract.

6.1.1 *Streamlining Operations*

The carrier/intermediary should identify administrative or workload activities that it believes should be discontinued due to the demands of the transition and its contract closeout. The carrier/intermediary should look at all operational areas with the purpose of streamlining activities so that it can focus resources on claims processing and maintaining quality control safeguards. Any general activities that do not affect claims processing operation, such as meetings, travel, training, etc., should be reduced or eliminated. Activities performed solely for the purpose of Contractor Performance Evaluation (CPE), e.g., internal quality reviews, statistical compilations, document maintenance should be analyzed to see if any efforts can be reduced or eliminated. Non-essential provider/beneficiary relations activities should be reviewed to see if any can be curtailed. Any CMS special projects will need to be analyzed. Projects not past development stage should be stopped; more advanced projects will be evaluated individually by CMS to determine continuation.

After analyzing activities, the number of full time employees that will become available due to the streamlining should be determined. All qualified surplus employees gained through streamlining should be reassigned to claims processing, compiling case files, documenting internal claims processing procedures, and other workload closeout activities.

6.1.2 *Workload Assessment*

The carrier/intermediary must analyze its claims workload and develop a realistic plan for reducing the claims backlog so that a minimal number of claims are transferred to the incoming MAC. This inventory reduction plan should include an estimate of the number of claims expected to be received each month by various claims categories, processing goals for each month of the closeout period, productivity and accuracy levels, and quality control safeguards. The MAC and the outgoing contractor should anticipate the likelihood of increased workloads (especially appeals) just prior to cutover. See **Chapter 4.10.1**.

6.1.3 Contingencies

The carrier/intermediary must consider contingencies in the event that staff losses affect operations or workload backlogs during the closeout. Plans should be developed to utilize overtime, keying shops for data entry, or obtaining temporary employees. The carrier/intermediary may also consider having former Medicare employees who are currently employed in other parts of the organization reassigned to Medicare for the duration of the transition. It may also try to contact former Medicare employees to see if they may want to work part time. In addition, consideration may be given to move certain functions to the MAC earlier than originally planned.

6.2 Closeout Approach

After assessing its operations, the carrier/intermediary should prepare a document describing its proposed approach for the closeout period. The document should discuss what activities the carrier/intermediary is proposing to streamline, the workload reduction plan with productivity and accuracy levels, maintenance of personnel through severance pay and retention bonuses, staffing configurations, and contingency plans. The carrier/intermediary should consult CMS when developing its approach, as CMS will approve the final document. The Closeout Project Plan (CPP) will incorporate the carrier/intermediary's approach (see **Section 4.3**). Both the approach and the CPP should be submitted to CMS no later than 15 days after the segment kickoff meeting.

6.3 Access to Information

The MAC understands that any request for information from the outgoing contractor must be necessary and relevant to implementing the requirements of its statement of work. The MAC also understands that it may not receive all of the information and/or documents that it may request, especially those regarding internal operations or processes.

Willingness to provide information could be dependent upon a number of factors, including whether or not the carrier/intermediary will be leaving the Medicare program by choice, if it will be entering into a partnering/subcontracting relationship, or if it will be participating in future MAC procurements. Possible legal action regarding the jurisdiction award could also affect the release of information or documents.

Exhibit 5, Outgoing Contractor Information/Documentation, provides a list of some of the information and documents that incoming MACs will normally request from outgoing contractors. The exhibit shows information/documentation that is considered non-proprietary and should be released to the MAC if requested. It also shows documents that may contain proprietary or business information. Generally, CMS will not require the outgoing contractor to release those documents, but under certain circumstances, it may require that a properly redacted version be released.

The CMS Contracting Officer should be contacted if the carrier/intermediary believes that the MAC's request for information or access to operations is not warranted, or if it considers the requested documents to be proprietary in nature. However, please note that the Rights in Data clause contained in the Medicare contract gives CMS broad rights to data acquired or utilized by the carrier/intermediary in the processing of claims or in carrying out other contract functions.

6.4 Deliverables

Prior to the kickoff meeting, CMS may ask carriers and intermediaries to begin gathering documents and information that the incoming MACs will need for their implementations. This will assist the MACs in their analysis of operations and expedite the transition process. Examples would include detailed information on providers, EMC, telecommunications, the physical storage of records, and assets that may be available.

At the kickoff meeting, or shortly thereafter, the MAC should provide the outgoing contractor with a list of information that it believes is necessary for its implementation. This list is known as the Deliverables List and will be a formal record of information, documents, etc. that the MAC is requesting from the carrier/intermediary. At the minimum, the Deliverables List should contain a description of what is being requested from the carrier/intermediary, the date of the request, the requester's name, when the item will be needed in the transition process (requested due date), and the actual receipt date. The MAC should prioritize the items as to their importance and be able to provide a rationale for the request if the carrier/intermediary has an issue with providing the information. During the transition, the MAC will continue to refine and add to the Deliverables List based on its operational assessment/due diligence and workgroup activities.

It is important that the carrier/intermediary work with the MAC to ensure that everyone understands exactly what is being requested, that the information is applicable to the purpose of the request, that the carrier/intermediary has the resources available to fulfill the request, and that the timeframe for delivery is reasonable. Time will be of the essence, so it will be important for the carrier/intermediary to provide the information as quickly as possible, especially if certain information or documents are needed to assist in the MAC's initial operational assessment/due diligence. .

6.5 MAC Operational Assessment/Due Diligence

A key activity for the carrier/intermediary during the transition will be providing information about its Medicare operations to the incoming MAC. This information gathering is known by a number of different terms: operational assessment, operational analysis, due diligence, and gap analysis. All functional areas (audit and reimbursement, medical review, claims processing, provider education, Medicare Secondary Payment, financial, appeals, customer service, etc.) and all business operations and procedures will normally be analyzed. The extent of the analysis will be dependent upon the Statement of Work for the MAC contract, the nature of the MAC's jurisdiction proposal, and what,

if any, proprietary or business operation information the outgoing contractor is willing to provide.

6.5.1 General

It is important that the MAC gather as much information as possible regarding a carrier/intermediary's Medicare operations, processes, activities, unique arrangements, assets, and documentation. This will allow the MAC to determine if changes need to be made to its implementation approach, processes, or project plan. It will also facilitate the absorption of the workload into the MAC's operational environment, help ensure a smooth transition, and lessen any impact to beneficiary and providers. The operational assessment may also help the various workgroups in developing their issues log/action items list.

The assessment and documentation of the carrier/intermediary's operation could include policies and procedures, operational processes, functional work flow, files, and staff analysis. This will help in refining the MAC's resource requirements. Standard operating procedures will be reviewed, along with quality assurance processes and standards. Procedural differences and/or local variations of the claims process should be made known to the MAC.

Depending on the MAC's proposal, it may also ask for workload data and inventory statistics by functional area, as well as productivity rates and production capacity. The MAC will assess workload in progress and obtain specifics on the amount of Medicare files and records in storage, both on-site and at remote locations. The MAC may request Contractor Performance Evaluation (CPE) or Report of Contractor Performance (RCP) documents, as well as any audit findings. Any internal process improvement or CMS performance improvement plan (PIP) will be reviewed to obtain information on performance or quality problems, if pertinent. The MAC will also need to know if there are any special CMS projects, initiatives, or activities and the specific time frames for completion. As previously stated, if the carrier/intermediary believes that the MAC's request is for information or documents that it considers proprietary, the CMS Contracting Officer should be contacted. Also see **Exhibit 5**.

The MAC will make a concerted effort to complete an initial assessment within the first month of the transition so that any changes to its implementation approach or Segment Implementation Project Plan (SIPP) can be negotiated with CMS and incorporated into its "baseline" SIPP. The carrier/intermediary should continue to assist the MAC's operational assessment and information gathering throughout the transition period as part of the work effort of the various transition workgroups.

The carrier/intermediary will be contacted by the MAC to schedule any proposed site visits. Agreement will need to be reached on such items as dates, times, frequency of visits, number of staff, and availability of any on-site working space for the visiting MAC. There should be a discussion of the types of information that the MAC hopes to obtain and the operational areas it would like to review.

The carrier/intermediary's workload reduction plan and performance will be monitored throughout the transition period. Depending on the carrier/intermediary's performance and the progress of the implementation, the MAC may propose to move certain functions earlier than scheduled. For example, if the carrier/intermediary suffers a severe staff loss among auditors, or if customer service deteriorates because of staff departures, the MAC may propose to take the work prior to the established cutover date. Should such a situation arise, CMS will discuss the proposal with all parties involved and reach agreement as to how to proceed.

The following are some of the areas or activities that the MAC will normally analyze as part of its overall assessment/due diligence:

6.5.2 *Local Coverage Determinations and Edits*

The MAC will want to meet with the carrier/intermediary's Medical Director and other MR staff to obtain information on current Local Coverage Determinations (LCDs), formerly known as Local Medical Review Policies (LMRPs). The historical record for each LCD should also be provided. The MAC is required to consolidate the existing LCDs of the outgoing carriers/intermediaries within its jurisdiction so that they are the same throughout the jurisdiction. The consolidation must be completed prior to the cutover of the first segment within the jurisdiction. Therefore, the MAC will need to analyze all LCDs as soon as possible to determine their applicability jurisdiction-wide.

The MAC must also consolidate the existing FISS shared system edits (reason codes, local business rules, etc.) of the outgoing Part A contractors so that they will be the same for the entire jurisdiction. The consolidated edits for the jurisdiction will be implemented as each fiscal intermediary segment workload is cut over. While not required, some MACs may have proposed to consolidate the MCS Part B shared system edits for the jurisdiction. The carrier/intermediary must provide the MAC with information regarding its current edits so that the MAC can analyze and determine the appropriate edits for its jurisdiction.

Any proposed changes to a segment's edits must be analyzed by the MAC to determine if there will be any impact to the provider community. The MAC must also discuss and coordinate any edit consolidation with CMS. Any edit/processing changes that providers will experience must be clearly communicated. The MAC may request the outgoing contractor to assist it with communication to providers regarding any changes. See **Chapter 6.10**.

6.5.3 *Carrier/Intermediary Workload and Inventory*

As soon as the MAC award is made, CMS will begin monitoring the outgoing contractor's performance on a weekly basis. A workload report will be submitted to CMS on a weekly basis (see **Chapter 4.10.5**). It will be provided to the MAC along with any outgoing contractor operational issues that arise. If necessary, the MAC will take

appropriate action to modify its implementation activities or risk mitigation/contingency plans based on workload inventory trends and progress.

6.5.4 *Carrier/Intermediary Staffing Levels*

The MAC will be monitoring the carrier/intermediary staffing report that is provided to CMS weekly. The report should provide a weekly breakout of staffing by functional area, showing staff losses, transfers, new hires (temporary or permanent), and staff in training. The MAC will also review the explanation for any changes. Based on the workload and staffing reports, it is possible that CMS (after consultation with the carrier/intermediary and the MAC) may decide to move a particular function sooner than expected. If this occurs, the project schedule and transition/termination costs would be modified accordingly. See **Chapter 4.10.7**.

6.5.5 *Internal Controls*

The MAC will be looking at internal controls (also known as management controls) since carriers/intermediaries must annually evaluate and report on their control and financial systems for program integrity. The MAC will be looking at controls that ensure that costs comply with applicable law, assets are properly safeguarded, and revenues (e.g., overpayments) and expenditures are properly accounted for. The MAC will review the internal control indicators, particularly if it intends to hire the management and/or staff in a turnkey operation. The MAC will normally review Chief Financial Officer (CFO) audit reports, Statement on Auditing Standards No. 70 (SAS 70) audit reports, as well as the carrier/intermediary's own reports on internal controls—such as the Certification Package for Internal Controls (CPIC). If these reports are not provided to the MAC because proprietary or business information is contained within, they may be able to be obtained through CMS with the appropriate business/proprietary information deleted. See **Exhibit 5**.

6.5.6 *Contractor Performance Evaluation*

The MAC may request to look at recent Contractor Performance Evaluation (CPE) reviews. If a Performance Improvement Plan (PIP) in place as a result of a CPE, CMS must make a determination as to its continuation during the transition.

If the carrier/intermediary will have a contractual relationship with the MAC (such as a subcontractor or a partnering arrangement), or if the MAC will retain the carrier/intermediary's staff/facilities, then the following may occur: 1) the PIP may be closed because of the incoming MAC's processes or procedures; or 2) if it cannot be closed, the MAC will have to complete any outstanding parts of the PIP after cutover or develop an alternative PIP. If there is a deficiency, but no PIP has been submitted, CMS will meet with the carrier/intermediary and the MAC to determine if the deficiency can be eliminated prior to cutover, or if it will be necessary for the MAC to develop a post-cutover PIP.

If there will be no relationship with the outgoing carrier/intermediary or its staff, there should be no need for the MAC to become involved with the PIP, other than having knowledge of its existence and determining if it will affect its own operation.

6.5.7 *Functional Area Assessments*

As part of its operational analysis, the MAC will normally assess the following functional areas of the carrier/intermediary's operation:

6.5.7.1 Claims Processing

The carrier/intermediary will need to provide workload data for all claims processing areas for the current and preceding year. High volume edits, returns, and rejects should be provided, along with any contract compliance and/or service issues. Any backlogs should be identified so that the MAC can determine if it would be advantageous to move certain functions earlier than planned. Any unique processing requirements, special claims processing arrangements, or information on demonstration projects should also be provided.

The MAC will be interested in obtaining claims operations documentation so that it can review claims controls, reason codes, monitoring and reporting procedures, quality assurance processes, and the compliance edit process. This will assist the MAC in determining procedural differences between its operation and the carrier/intermediary's. The MAC may also request to review desk procedures and management reports.

6.5.7.2 Customer Service

The MAC should review provider service policies and procedures so that it can determine procedural variances. A listing of top reasons for inquires will be helpful, as will a listing of providers (including provider number) with high call volumes. Also, a list of challenging providers with consistent issues should be provided. The MAC should also review complaint analysis summaries for the past year, if applicable, and evaluate the number of unresolved pending complaints. In addition, the carrier/intermediary should provide a historical analysis and trending reports for the past two years.

The carrier/intermediary should provide current workload data (open provider written and telephone inquiries). The MAC will analyze data on call backs, email inquires, the logging and tracking of calls and written inquiries, quality call monitoring, and any walk-in activity. Copies of quality focused audits performed in past year and any CPE, OIG, or other external reviews should be provided. The MAC may also ask to examine items as automation for correspondence generation, forms, listings, and routine reports.

6.5.7.3 Medicare Secondary Payer (MSP)

The carrier/intermediary will need to provide MSP documentation so that current operations, desk procedures, and management reports may be analyzed. The MAC may

ask for copies of MSP reports relative to workloads and pending caseload. Also, a list of all open/active cases and correspondence may be requested. The MAC should review MSP prepayment claims processing, MSP post payment activities (pending subrogation liability cases, IRS/SSA/CMS data match files and outstanding cases, routine recovery), and MSP debt referral (DCIA process).

The MAC should review the status of MSP accounts receivable and will normally observe the AR review that is conducted by CMS. The MAC will need to determine the status of the MSP accounts receivable write-off and identify and reconcile MSP accounts receivable for its 750/751 reporting. See **Chapter 8.7**.

6.5.7.4 Medical Review

Medical review (MR) policies, desk procedures, edits, automated review tools, inventory, and management reports should be provided to the incoming MAC. The MAC must review policies, articles, advisories, and mailings for compatibility and retention. Medical records storage/retrieval and privacy act compliance may also be evaluated.

The carrier/intermediary should provide the MAC with MR/Local Provider Education and Training (LPET) strategy and the procedures of identifying program vulnerabilities. The MAC will also want to analyze progressive corrective action (PCA) procedures, reports, programs, data, and related activities. Data analysis methodology will need to be assessed. This includes the number and type of edits, edit effectiveness, the number and type of probes, and software for trending reports. Statistics used to determine pattern analysis and other data analysis techniques should also be reviewed by the MAC. In addition, tracking techniques for monitoring effectiveness of edits and educational activities should be analyzed.

6.5.7.5 Appeals

Information should be provided to the MAC regarding appeal procedures, including the status of any first level appeals (redeterminations) that are in progress. The carrier/intermediary should develop an estimate of the redeterminations that will be completed prior to cutover and those that will be forwarded to the MAC. Also, the carrier/intermediary will need to identify any redeterminations forwarded to the Qualified Independent Contractor (QIC), any outstanding requests from the QIC for reconsideration case files, and/or any effectuations that are in progress.

6.5.7.6 Provider Audit

The MAC will need to evaluate the intermediary's provider audit operations. This will include all activities relating to cost report acceptance through cost report settlement. It also includes all work related to reopenings and appeals. The MAC will evaluate Cost Report acceptance, Tentative Settlement, and Cost-to-Charge Ratio policies and procedures to determine if there will be changes after cutover. Audit safeguard policies such as workload rotation policy and auditor independence may also be evaluated, as well

as the settlement and finalization process. The annual master audit plan should be provided to the MAC to assist it in developing its master audit plan for the coming year. This would include all cost reports to be received, reviewed, audited and settled during the year. It would also include recurring, time-specific activities such as the wage index.

The intermediary will need to provide the location and status of desk reviews and audit reviews, as well as exception requests, reopenings, appeals and settlements, wage index reviews, hospital audits and on-site reviews. An inventory of audit data that will be finalized by cutover should also be prepared, as should an inventory of filed cost reports that will be unprocessed at cutover. In addition, the MAC will need information on provider file storage.

6.5.7.7 Provider Reimbursement

The MAC will need to ensure that it establishes accurate interim rates, provides key financial reporting, and collects overpayments timely. In order to do this it will need to obtain current interim rate policies and procedures. It should also obtain provider schedules for interim rate review. The year-to-date accuracy of interim payments will need to be reviewed, as should the tracking of settlements and interim payments. The MAC should also obtain an inventory of pending interim rate reviews.

The MAC will need to get TEFRA, Per Resident Amount (PRA), and Ambulance rates along with an inventory log of all historical rates and supporting calculations. The MAC should obtain Sole Community Hospital (SCH) information, review cumulative target amounts for multiple years. It will also want to verify provider profile data, provider rates, and address information.

The carrier/intermediary should also supply information on its debt collection and referral process. The MAC should review the demand letters/tracking process, the Provider Overpayment Report (POR)/ Physician and Supplier Overpayment Recovery (PSOR) entry and reconciliation processes, and the process for entering debts into the debt collection system. The MAC may also want to review overpayment correspondence and obtain historical settlement data. Documentation and referrals will need to be reviewed to determine the status of outstanding overpayments. Additionally, the MAC may want to review outstanding claims accounts receivables, extended repayment schedules, and outstanding accelerated payments. Internal accounting will also be evaluated by analyzing monthly reporting, payment cycles, distribution of Remittance Advices, checks, EFTs, and balancing procedures.

6.5.7.8 Provider Enrollment

The carrier/intermediary will provide the MAC with the current provider enrollment inventory in order to ensure that the process for enrolling providers and verifying provider ownership and qualification data will function properly at cutover. The MAC should assess enrollment procedures and provider application processing timeliness, as well as the provider application pending workload. The carrier/intermediary will

coordinate with the MAC to determine when the cutoff for requests will be and when applications will be forwarded to the MAC. The carrier/intermediary and the MAC will also coordinate the notification to providers regarding when and where applications should be mailed to the new MAC.

6.5.7.9 Provider Education and Training

The MAC will need to obtain training history from the outgoing contractor. This includes the locations of meetings, topics, frequency, attendee mailing information, and telephone numbers. The MAC may also wish to review training materials such as presentations, curriculum, and manuals/ handbooks. The carrier/intermediary's provider bulletins and newsletters from the past two years may be of benefit as the MAC develops its education and training plans.

6.6 EDI Assessment

The carrier/intermediary must provide the MAC with a complete listing of all vendors, suppliers, providers, and trading partners who are currently submitting electronic transactions. The listing must identify whether submitters are transmitting claims via EDI or DDE and whether the format is HIPAA compliant. The outgoing contractor should also provide Electronic Remittance Notice (ERN) and Electronic Funds Transfer (EFT) information, as well as EMC submission rates.

Since the carrier/intermediary's EMC network will not continue to forward Medicare data (except in some unusual circumstance that would require agreement by all parties) the MAC must move vendors/suppliers/providers to alternate clearinghouses or to direct billing. If the carrier/intermediary's EMC submissions come into a corporate network and are co-mingled with corporate files, those files must be separated so they can be furnished to the MAC. The MAC needs to be aware of any special carrier/intermediary claim edits and any information (other than claims) that is accepted in a paperless manner

CMS has determined that EDI submitters will not have to complete new EDI enrollment forms when the new MAC assumes the workload. Existing forms will need to be inventoried and must be transferred to the MAC at cutover.

6.7 Print/Mail Operations

The MAC may analyze mailroom workflow and functions (control, imaging, activation, etc.) to determine how mail operations will be transferred. Analysis will be largely dependent on whether or not the MAC will assume existing space or have some presence in the outgoing contractor's geographical area. A breakout of the types of mail received and the average volumes by day should be provided to the MAC, along with the volume of system generated and non-system generated mail.

Agreement will have to be reached on how existing mail will be transferred at cutover and how mail received by the carrier/intermediary after cutover will be forwarded to the

MAC. There will also need to be an agreement on how checks that are received after cutover will be handled. A decision will have to be made on the disposition of post office boxes and whether or not any of the boxes will be transferred to the MAC. The carrier/intermediary should also provide the MAC with information on any mail services contractor that the carrier/intermediary uses for pick up, delivery, presorting, metering of letters, etc.

Print job requirements, formats, and processes will be analyzed by the MAC. Information regarding usage trends for letterheads, envelopes, and internal forms should be provided. The MAC may also ask to review sample MSNs, provider remittance advices, letters, and reports.

6.8 File Inventory

The carrier/intermediary must identify all files that will need to be transferred to the MAC. The MAC should also be made aware of any carrier/intermediary files that will be split and moved to another MAC or organization during transition period.

6.8.1 *General*

An inventory of Medicare files (electronic data files, hardcopy, microfilm, microfiche, tape files, etc.) to be transferred must be developed as soon as possible after contract award. Files that are in a proprietary format will need to be converted to a standard or flat file format. The inventory should include the file content description, data set information, tape and file processing methods, and record information. The inventory shall be provided to the MAC with a copy to CMS. All required updates to files **shall** be made prior to transfer. **Exhibit 6, Files to be Transferred to a Medicare Administrative Contractor**, provides a sample list of the types of files that an outgoing contractor should be providing to an incoming MAC.

6.8.2 *Disposition*

As of the date of publication of this handbook, all Medicare contractors are under a Department of Justice decree not to destroy Medicare paper, electronic, and systems records regardless of the Medicare manual retention requirements. All Medicare files in the possession of the outgoing contractor must be transferred to the MAC. The only exceptions to this requirement are: 1) administrative financial files that the outgoing contractor must keep in order to prepare its final cost report, and 2) duplicates of original files that are being transferred to the MAC. Any files that are not transferred to the custody of the MAC must be destroyed by the outgoing contractor and certified as such.

6.8.3 *Mainframe Files*

The movement of mainframe files may be internal or external, depending on where the files are located. The structure of all the files will need to be provided to the MAC, along with a description of each directory. Support files such as print/mail, EDI, financial, and

ad-hoc interfaces must be included. The outgoing contractor must ensure that the details of all system interfaces are shared with the MAC. Passwords will also need to be removed from the files. The actual transfer method/process must be agreed upon with the MAC and responsibilities acknowledged.

6.8.4 LAN/PC-Based Files

LAN/PC-based files may need to be provided to the MAC at cutover. These files include Excel spreadsheets, access databases, and emails. The MAC will review LAN file listings and transfer protocols similar to mainframe files will be established.

6.8.5 Hardcopy Files

The MAC must be provided with a detailed inventory of the carrier/intermediary's hardcopy files and an accompanying description, including general contents, size, etc. All paper files (archived and active, on and off-site) shall be inventoried. Off-site storage site information (location, type of files stored, content, volume, security, etc.) will need to be provided.

Once the inventory has been prepared, the MAC must determine whether to keep existing storage arrangements or move the files to another location. A schedule with shipping dates should be developed for any files to be moved. A meeting should also be scheduled with the MAC and the storage facility to discuss transfer activities and access. If the parties agree, the existing storage site contract may be provided to the MAC in order to determine if it can assume the contract or will have to negotiate a new agreement.

6.9 Access to Files and Records after Cutover

There may be a need to access Medicare files and records after cutover in order to meet certain audit or reporting responsibilities or to respond to litigation that may be in process. If such is the case, the carrier/intermediary should negotiate with the incoming MAC regarding access to the Medicare files/records that were previously in its possession. A data sharing agreement should be entered into regarding the protocols and responsibilities of each party, along with the associated costs. CMS must approve the agreement that is developed and must approve any request by the former carrier/intermediary for access to Medicare files/records.

6.10 Assisting MAC Communication Efforts

The MAC must make sure that providers have a complete understanding of what will be required of them during the transition and the impact of any changes that will occur. It will also be responsible for communicating information regarding the progress of the implementation to beneficiaries and other stakeholders. In order to do this effectively, the MAC will need to partner with the outgoing contractor to ensure that information is transmitted clearly and frequently during the transition period.

6.10.1 *General*

The MAC will have a communication plan that outlines the processes and procedures that it will follow to ensure that all stakeholders are provided with appropriate information regarding the transition. This plan will have been submitted with the MAC's proposal, but after award, the MAC will work with the carrier/intermediary to refine its communication strategy and plan.

The outgoing contractor will be a valuable resource to the MAC and will have detailed practical information for communicating with the various provider groups, associations, government officials, and other stakeholders within the segment. CMS expects that the carrier/intermediary will assist in providing information to beneficiaries and providers throughout the transition period in accordance with the mutually agreed upon communication plan. Methods for communicating information include using MAC-developed language for MSNs and Remittance Advices, articles for newsletters, scripts for the ARU/IVR, and website links to the MAC's website. It would be very beneficial for the outgoing contractor to provide the subscriber list for any listservs it maintains.

6.10.2 *Provider Communication*

Provider communication will be one of the most important activities for the MAC during the transition. Providers are affected most by the change in Medicare contractors and they have a large financial stake in the project. As such, the MAC must ensure that it makes every effort to inform and properly educate providers about the transition. CMS expects that the carrier/intermediary will assist the MAC in its provider communication efforts.

6.10.2.1 Associations

It is important for the MAC to establish a relationship with the major professional organizations such as hospital associations, medical societies, and specialty groups. The carrier/intermediary should discuss its working relationship with these groups and provide the MAC with contact points. When regularly scheduled provider/association/specialty group meetings are held, the MAC should be invited to attend so that it can be introduced and make a presentation. The MAC should also attend Provider Advisory Group (PAG) and/or Provider Communication Advisory Group (PCOM) meetings.

6.10.2.2 Providers

A complete list of providers should be given the incoming MAC. The list should include such information as name, address, contact person, email address, Employer Identification Number (EIN), and EMC information. The carrier/intermediary should work with the MAC to develop articles regarding the transition for provider bulletins and other publications. Approximately two months prior to cutover, the MAC will develop language for Remittance Advices that will remind providers of the change in Medicare contractor.

6.10.2.3 Workshops

The MAC may hold provider workshops or seminars to provide a more detailed discussion of how to prepare for the upcoming change of contractor. Topics will include EMC and front end changes, claims submission and address changes, dark days, edits/LCDs, and the possibility of increased suspension/rejection of claims. Depending on the segment size, the number of workshops will normally range between four and eight and are normally scheduled six to ten weeks before cutover.

The carrier/intermediary can prove valuable assistance to the MAC in planning provider workshop/seminars/training sessions. It can provide input to the workshop schedule, content of the presentation, proposed meeting locations, hotels, and meeting facilities. If possible, a carrier/intermediary representative should be in attendance at each session to provide assistance to the MAC with its presentation.

6.10.3 *Beneficiary Communication*

As with providers, the carrier/intermediary should assist the MAC with its beneficiary communications. The following contacts should be provided to the MAC for its communication efforts:

- beneficiary associations and groups such as AARP;
- state and local government agencies dealing with the aged;
- Social Security Administration district offices;
- senior citizen centers;
- community centers/libraries/retirement centers.

The carrier/intermediary should also assist the MAC in its efforts to provide transition information to beneficiaries and related groups. Any regularly scheduled beneficiary outreach and beneficiary advisory/advocacy group meetings should be attended by the MAC. The carrier/intermediary can help the MAC assess demographic and language needs and help the MAC develop language for mail stuffers or MSN messages. These messages should begin approximately two months prior to cutover.

6.11 Contract Compliance

Carriers and intermediaries are reminded that full compliance with CMS requirements continues throughout the term of its contract. It is possible that a Carrier or Intermediary will be selected for review by the Office of Inspector General (OIG) encompassing a period of time prior to the cessation of contractor operations. These audits may be performed either directly by the OIG or through a subcontracting arrangement.

Cooperation and compliance in providing requested documentation for any audit is mandatory. In addition, carriers/intermediaries are obligated to insure that any of their subcontractors (e.g., data center services, print mail, call center, etc.) also comply with the requirement to cooperate fully and promptly respond to any request for access to data.

Failure to fully support requests for documentation may result in a limitation of audit scope. This can result in the citation of a material weakness which could impact an opinion on the adequacy of general controls entity wide.

Chapter 7: CUTOVER AND POST-CUTOVER ACTIVITIES

7.1 Definitions

Cutover

The actual point at which the carrier/intermediary ceases Medicare operations and the MAC begins to perform those functions.

Cutover Period

The period of time surrounding the actual cutover. It usually begins 10-14 days prior to the cutover and ends with the MAC's Segment Operational Start Date, which is defined as the day that the MAC begins normal Medicare operations for the segment workload that it assumed at cutover. During the cutover period the carrier/intermediary makes final preparations to shut down its operation and transfer its claims workload and administrative activities. Correspondingly, the MAC makes final preparations for the receipt and utilization of Medicare files, data, and acquired assets. The activities that occur within the cutover period and shown on the cutover plan (see **Chapter 7.2** below) are normally referred to as cutover tasks.

Post-Contract

The period of time after the actual cutover when the outgoing contractor is no longer operating as a carrier/intermediary but is performing miscellaneous wrap-up tasks and contract closeout activities.

7.2 Cutover Plan

The MAC will be required to submit a cutover plan for the segment workload that will be moved. The cutover plan will contain very detailed and specific information, showing tasks at a very low level, and it may be detailed to an hourly level at times. Many MAC and carriers/intermediaries use the plan as a checklist and to script events and deliverable dates during the cutover period.

While the cutover plan is the responsibility of the MAC, it must be developed jointly with the outgoing carrier/intermediary. The carrier/intermediary must work with the MAC to determine a complete list of cutover activities, dates, and times. There should also be input from the data center, the PSC, and any other entity that will be playing a significant role in the actual transfer of the segment workload. The consolidated plan should show the responsible organization, any related JIPP/SIPP task number, the responsible workgroup, the task description, start and finish times, status, and comments.

All entities must agree on the schedule and tasks in order to avoid confusion about time frames, specific cutover responsibilities, items to be transferred, and terminology. The MAC will submit the cutover plan to CMS for review. The plan will be distributed to all involved parties, transition team members, and workgroups. The plan will be updated daily when the cutover period begins.

7.3 Cutover Workgroup

A cutover workgroup will normally be established to manage cutover activities. It should be composed of representatives from the MAC, outgoing carrier/intermediary, and other involved parties; e.g., data center, PSC, etc. The workgroup will be responsible for cutover planning and scheduling, developing the cutover plan, and facilitating the data migration. As with all workgroups, it should be established in accordance with **Chapter 3.8**. Since the activities of the workgroup are centered on the cutover, the workgroup will not necessarily need to be established when the other workgroups are formed at the kickoff meeting. However, the MAC may find it helpful to have the workgroup lead designated at that time. The cutover workgroup will normally be formed three to four months prior to cutover.

The cutover workgroup will need to be aware of all of the other workgroups and their activities. It is important that all workgroup meeting minutes and issues/deliverables logs are forwarded to the cutover workgroup lead. The group must be informed of any decisions made by the MAC Segment Project Manager, the carrier/intermediary Closeout Project Manager, or other workgroups which will impact the manner or circumstances of the transfer of the workload. The other workgroups will provide input to the cutover plan and time schedule that is developed by the cutover workgroup. They will propose additions and/or deletions to the task list and recommend any timing changes. With the input from all of the other workgroups, the cutover workgroup will coordinate the cessation of activities (file changes, mail, etc.), determine the necessary production interruptions (EMC, OSA queries), establish dark days, and schedule and monitor the actual transfer of files and assets.

As with any other workgroup, cutover meetings will be held weekly and the agenda will follow the same format, including discussion of cutover issues, action items and accomplishments. Meetings should also discuss transition task progress, current inventories, risk evaluation, file transfer, and any facility or human resources updates. All issues that are identified by CMS, raised in the status reports or workgroup minutes, or raised in any other forum, must be placed on the issues log documenting cutover issues and discussed at each workgroup call.

7.4 Daily Cutover Meeting

Approximately 10-14 days before cutover, daily cutover teleconferences should begin. Attendees will include the outgoing carrier/intermediary, the MAC, the data center, PSC, and any other organization directly involved in the cutover. The purpose of the meeting is to go over the cutover plan and the daily events that are scheduled to occur. Calls

should be scheduled in the morning and normally will be brief in length. Participants will review the cutover plan checklist of activities scheduled for the day and determine if tasks scheduled for the prior day(s) have been accomplished. The meeting will also discuss activities for the upcoming day to ensure that everyone is in agreement as to what needs to be accomplished. In addition, the meeting should review any problem log or issues identified by any of the other workgroups that pertain to the cutover. Some incoming contractors have found it helpful to have an additional cutover meeting in the afternoon beginning several days prior to cutover in order to monitor the increasing number of activities that take place. The MAC should prepare a brief synopsis of the daily cutover meeting and highlight any issues or action items. The cutover plan should also be updated prior to the next daily meeting. Cutover meetings will continue on a daily basis through at least the first week of post-cutover operation. At that point, CMS will make a decision as to the frequency of the meetings.

The outgoing contractor should have a representative available throughout the cutover period and for the week after cutover, unless it is determined by CMS that his/her participation is not required. Key personnel involved in the cutover should have a backup means of communication so that they may be able to be reached in case of an emergency.

7.5 System Dark Days

One of the issues for discussion and resolution by the cutover workgroup will be the number of system “dark” days that will occur during cutover.

During the cutover period, the outgoing carrier/intermediary must complete all billing cycles, validate payments, cut checks, and prepare required workload and financial reports prior to the actual cutover and the end of its Medicare contract. The incoming MAC must verify that all telecommunications, hardware, software, and equipment are installed, tested, and properly functioning after each segment cutover. In addition, the MAC will also need to run cycles to check out the transferred files and claims processing functions. The EDC will also be changing contractor numbers or identifiers for reports, database tables, etc.

The time that it takes to accomplish the aforementioned activities will vary from one transition to another. Cutover normally occurs during a weekend at the end of the month; however, if the outgoing contractor is on HIGLAS, cutover will need to be in the middle of the month. Most of the time, two weekend days is insufficient to complete all of the cutover activities. If such is the case, then a “dark” day or days will be required.

A dark day is a business day (Monday-Friday) during the cutover period when the Medicare claims processing system is not available for normal business operations. There is no online access or capability, providers cannot access the system, current claim information cannot be provided, there is no direct data entry (DDE), and claims cannot be processed. System dark days may occur between the time that the outgoing

carrier/intermediary ends its final batch cycle and the MAC begins its first day of normal business operations for the segment.

The outgoing carrier/intermediary, MAC, and applicable data centers must develop a cutover schedule that provides sufficient time to accomplish all of the cutover activities. Once this is done, then the number of dark days can be determined. The number of dark days necessary at cutover will vary depending on the calendar, the size of the carrier/intermediary, the length of time required for its final cycles and closeout activities, and the various other cutover activities that have to be performed. Most cutovers will require 1-2 dark days, but some cutovers may require more. CMS must be involved in the dark day discussions and will have final approval of the number of dark days for the outgoing contractor and/or the MAC. The approval will be part of CMS's overall approval of the cutover plan. It will be based on the reasonableness of the involved parties' proposal, as well as assurances that providers were considered in the decision.

CMS expects that the outgoing contractor will post cutover information frequently on its web site and make listserv announcements to providers/suppliers regarding the cutover sequence, the number of scheduled dark days and the effect on claims submission, and the availability of IVR and CSRs for inquiries.

7.6 Release of the Payment Floor

Discussions regarding the need to release the payment floor usually begin in the Cutover workgroup. The release of the payment floor during the cutover period eliminates the need to transfer adjudicated claims waiting to be paid from the outgoing contractor to the MAC. Depending on the circumstances of each segment transition, the payment floor may or may not be released.

CMS has determined that the payment floor will be released in the following situations:

- HIGLAS involvement during any Part A or Part B segment cutover.
- Changes to the Part B MCS system during the cutover of a segment (e.g., splits, merges).

For Part A segment transitions that do not involve HIGLAS, or for Part B segment transitions that do not involve HIGLAS or any MCS changes, the floor normally will not be released.

CMS must formally approve the release the payment floor. The incoming and outgoing contractors will develop a written plan for the release of the floor and its reinstatement. The plan will provide the reason for the release and describe the process and timing of the release. It should also analyze the impact that the release will have on the carrier/intermediary's other operations (EFT, ERAs, etc). In addition, the carrier/intermediary will need to discuss how the providers will be affected and how payment information will be communicated. If the floor will not be immediately reinstated by the

MAC at cutover, there must be some description of how the payment floor will be gradually reinstated.

The MAC and legacy contractor must develop a sample communication to be distributed to the provider/supplier community. The sample communication will be distributed to the provider community by listserv and other means. It will address the change in payment schedule and the impact on the issuance of ERAs, paper checks, and EFT. It also should contain an explicit reminder that during the 14-day period following cutover, providers may experience lower, or no, payment amounts because claims submitted prior to the cutover were paid earlier than normal.

7.7 Data Migration

During the cutover period, the carrier/intermediary will prepare and transfer all Medicare files and records to the prescribed locations detailed in its file transfer plan. This plan will be developed with the MAC and any other party who will be receiving files from the carrier/intermediary.

7.7.1 *Final Inventory*

The carrier/intermediary will provide an inventory of all files and records that will be transferred to the MAC and any other organization involved in the transition (see **Chapter 6.8**). During the cutover period, the inventory will be finalized and provided to CMS and the MAC. The final inventory should give a description of each file, including contents, size, etc. The inventory list will be used by the workgroups or project managers to determine where files and records will reside after cutover. If a carrier/intermediary has more than one operational site, an inventory must be prepared for each site. Any files that will be split and moved to another MAC or organization during the transition period must be identified.

Once the records have been inventoried, both the carrier/intermediary and MAC should verify them to determine the quality of the inventory results. If records are not electronic, physical sampling should be performed to confirm the accuracy of the information recorded on the inventory form. The MAC may also want to verify, to the extent possible, that all required updates to records have been made by the outgoing contractor prior to transfer.

7.7.2 *File Transfer Plan*

The MAC and the outgoing contractor will develop a file and record transfer plan using the outgoing contractor's finalized inventory. Files may be 1) transferred to the MAC's facility (or some other Medicare contractor) for support of its operation; 2) kept at the existing operational site or existing storage facility with transfer of ownership; 3) sent to a MAC storage facility or contracted storage facility; 4) transferred to another MAC (e.g., another MAC will have responsibility for storing and accessing co-mingled carrier/intermediary records; or 5) in the case of duplicative files, destroyed. A schedule with

shipping dates will be developed for any files to be moved. A meeting should also be scheduled with the MAC and the storage facility to discuss transfer activities and access.

Certain files may be commingled with other states that are not moving to the MAC and will continue to be serviced by the carrier/intermediary. The carrier/intermediary will maintain possession of those files and the MAC and carrier/intermediary will negotiate a data access agreement.

The file transfer plan should describe the files and records to be transferred by type (suspense, EMC, audit and reimbursement, MSP, etc.) and destination. It should also establish a schedule for the transfer of the workload with shipping dates and times. In addition, it should provide the cutoff dates that the outgoing contractor will stop updating or processing particular types of claims or files. The plan should also provide a description of the method of data transfer (e.g., tapes, NDM), transfer protocols, manifesting, packaging, and labeling all claims and correspondence. Workload may be transferred in phases rather than all at one time, especially if there is serious staff attrition in certain areas of the outgoing contractor's operation. CMS must be provided a copy of the final file transfer plan at the beginning of the cutover period.

The carrier/intermediary must insure that all required updates to files are made prior to transfer. A test transfer of files should be made prior to cutover and the MAC must test transferred files as part of its system checkout at cutover.

7.7.3 *File Format*

Files scheduled to be transferred to an incoming MAC in an electronic format must not be in a proprietary format which would preclude the use of the data by the MAC. Any electronic files stored in a proprietary format **MUST** be changed to a standard or flat file format prior to transfer to the incoming MAC. The costs associated with converting files from a proprietary format will be borne by the carrier/intermediary.

7.7.4 *Packing*

The transfer plan should provide for the early packing of as many operational files as possible without any negative impact on operations. Normally, records will not be packed and moved all at one time. While the resources are available to do so, as many operational files as possible should be packed and shipped, thereby mitigating the possibility of records being packed and/or labeled improperly.

A labeling system should be used so that boxes are routed correctly to the MAC for operational use or storage. At a minimum, the label of each box of files should display the title of the record series, and the earliest and latest dates of the records in the box. CMS will be monitoring the process of packing and labeling beginning early in the transition process. CMS and incoming MAC representatives may make periodic on-site visits before files are shipped to make certain that the boxes are properly packed and labeled and that a detailed inventory has been prepared.

7.7.5 *Transfer of Hardcopy Files and Physical Assets*

The MAC will be responsible for the shipment of files and any physical assets (equipment, supplies, furniture, etc.) that it obtains from the carrier/intermediary. The cost of conveyance will be borne by the MAC. The MAC may have a representative at each of the outgoing carrier/intermediary's locations from which items will be shipped. These representatives will sample files to verify content and proper labeling and will ensure that they are loaded for the proper destination. They will also check assets against the acquisition list to verify that all are accounted for and in the proper condition. Invoices must be reviewed prior to shipping.

7.8 **Sequence of System Cutover Activities**

The sequence at cutover will involve the following system activities:

7.8.1 *System Closeout*

The carrier/intermediary will close out its system operations by performing its final batch cycle, final CWF queries, final payment cycle, and final weekly, monthly, quarterly, and yearly workload runs. A 1099 file will also be generated. Files shall be purged in accordance with applicable instructions regarding time requirements for the retention of Medicare records.

7.8.2 *Back Up*

The carrier/intermediary's data center will backup and verify the final data. The MAC and data center will determine how long the backup data will be available for inquiry after cutover, should it be necessary.

7.8.3 *Transfer and Installation*

If there is a change in data centers during cutover, files will need to be transferred. This would include preparation of programs and JCL to load the files and data bases. Regardless of any data center change, the final data would be loaded and system changes (user file changes, base system changes to MCS or FISS, release changes, non-base system changes) will be made. Changes could include: MSN and remittance advices, contractor identification number, print/mail interfaces, ARU/IVR scripts, etc.

7.8.4 *Data Conversion*

The MAC may receive files that will need to be split, merged, or converted during cutover (e.g., workload or financial files). After conversion programs have been run and the production environment has been populated with converted data, the MAC will validate the conversion output.

7.8.5 *Initial System Checkout*

An initial system verification will be performed by the MAC. It will verify on-line connectivity and that the production system can be accessed. The transfer and availability of files will be checked, as will customer interface processes. The MAC will also determine if hardware, software, and equipment is installed and operating properly.

7.8.6 *Functional Validation of System*

The MAC will run cycles over the cutover weekend to check out operational functionality. This would include on-line data entry, claims activation, file verification (files accessible, formats proper, information correct, etc.), inquiries, batch processing, and testing. The first validation cycle normally will run claims and correspondence that were pending after the carrier/intermediary's last cycle. After the cycle data is validated, another cycle may be run to process claims entered specifically for the validation, correspondence, and backdated EMC files that were received and held during the carrier/intermediary's cutover activities. The MAC will verify system output after each cycle and will then make a decision regarding the commencement of normal business operations for the segment workload.

7.8.7 *First MAC Production Cycle*

The first production cycle will be run after the MAC's first day of normal business operations and the output will be validated. The cycle will include input from all functional areas (claims processing, MR/UR, MSP, audit and reimbursement, provider enrollment, etc.) and any additional EMC held from the cutover period, as well as OCR/ICR and DDE. All aspects of the system should be verified; e.g. data entry, edits/audits, suspense, correspondence, adjustments, inquiry, etc. Interfaces and data output that will be transmitted must also be verified (EFT, EMC, CWF, etc.). All print/mail functions will be validated, including checks, remittance advices, MSNs, automated correspondence, and reports.

7.9 **Cutover Communication**

Communication with providers and submitters regarding the cutover and its impact is absolutely essential. Providers must be informed constantly and by numerous methods about the cutover and how their payments will be affected.

The MAC must coordinate its cutover communication efforts with the carrier/intermediary so that submitters are informed of the upcoming cutover and the change of Medicare contractor. While the MAC has the primary responsibility for communicating information regarding cutover activities, the carrier/intermediary should include as much cutover information as it can in any provider meetings, bulletins, MSNs, remittance advices, notices, stuffers, etc. ARU/IVR scripts may also be used.

The following list shows the kind of cutover information that providers and submitter will need to know:

- Cutoff dates for the submission of EMC and paper claims, redetermination requests, cost reports/appeals, audits, quarterly PIP data, etc., to the carrier/intermediary;
- Last day the carrier/intermediary will make bill/claim payment;
- Last date the carrier/intermediary will have telephone, lobby and contact station service for providers and beneficiaries;
- The first day the MAC will accept EMC claims;
- The first day the MAC will accept paper claims;
- The date when the MAC will begin the bill/claim payment cycle; and
- The date when the MAC will begin customer service for beneficiaries and providers and the location of these services.

7.10 Access to CMS Systems

The outgoing contractor has the responsibility to ensure that all employees that currently have access to CMS computer systems will have that access terminated if they will no longer be performing Medicare functions that require access. The outgoing contractor must identify two levels of current staff: 1) staff that will have their access to CMS computer systems end with the cutover to the MAC, and 2) staff that will need access to CMS computer systems for a limited period of time after cutover; e.g., staff needed to submit reports into CROWD, CAFM, etc. The staff that will need access in the post-operational period will have access ended for certain systems at cutover and retain access to other systems in order to perform the abovementioned activities.

CMS will provide a form that should be used by the outgoing contractor to provide a list of employees for which access must be ended. The form includes the employee's name, user identification, address, phone number, e-mail address, and each CMS system for which the employee will no longer have access. It will be reviewed by the Contractor Manager and submitted to the CMS Office of Information Services.

If outgoing contractor employees will be employed by the incoming MAC, they still must have their access to CMS systems deleted under the outgoing contractor. The incoming MAC must then request new access to CMS computer systems for those individuals previously employed by the outgoing contractor. System access cannot be transferred from one contractor to another.

7.11 Post-Cutover Activities

At cutover, the outgoing contractor will no longer be responsible for performing Medicare functions. However, it must continue wrap-up activities associated with the cutover and compile, verify, and submit a number of CMS reports. In order to do this, there must be a limited number of personnel available in the post-cutover period.

7.11.1 *Post-Cutover Approach and Resources*

The carrier/intermediary will need to assess what activities and responsibilities it will have after it ceases its Medicare operations. Generally, most activity centers around the preparation and submission of Medicare reports and the financial closeout of the contract. The number of resources, availability, and the time required in order to complete the activities must be determined. In addition, if personnel will not be available, then other staff must be trained in order to properly complete the required tasks. During the cutover period, the Closeout Project Manager should identify necessary post-cutover resources, tasks, and timeframes and submit the information to the CMS Segment Implementation Manager.

If the MAC has hired outgoing contractor staff and is located in the vicinity, the outgoing contractor may request that some of its former employees be allowed to perform post-cutover activities. Usually post-cutover assistance does not require large amounts of time and the incoming contractors have been willing to provide this help. However, a Memorandum of Understanding should be developed describing the activities to be performed, the personnel required, and the associated costs incurred by the outgoing contractor for this support.

7.11.2 *Operations Wrap-up*

After the actual cutover to the new MAC, the carrier/intermediary should review its closeout plan and the cutover plan/checklist to ensure that all tasks for which it has responsibility have been completed. It must verify that all Medicare files and documents have been transferred to the incoming MAC. It must also certify in writing that those files that were not transferred have been destroyed in accordance with CMS requirements. The carrier/intermediary will need to verify that Medicare employees are separated from corporate network systems/email and that security measures involving access to computers (internal and external) and facilities are in place, including those individuals who will need limited access to complete final reports. It should also ensure that all checks and correspondence from the final processing cycle have been released from the mailroom.

Daily cutover teleconferences will continue for at least the first week. CMS will then make a determination if the daily calls will continue, or if a weekly meeting will be sufficient. A representative should be available for the calls at least for the first week after cutover, especially if there are open issues involving the former carrier/intermediary. Open issues must continue to be worked by the responsible parties until satisfactorily resolved.

7.11.3 *Reporting Activities*

The carrier/intermediary is responsible for the completion of all monthly and quarterly reports through the end of its Medicare contract. However, a number of reports cannot be completed at cutover and must be done after Medicare operations have ceased.

Therefore, the carrier/intermediary must maintain the ability to submit the reports and have personnel available to gather data and verify its accuracy.

Normal CMS submission requirements will apply to the outgoing contractor, which means that most reports will be submitted during the first month after cutover. However, some banking reports will take longer, since the carrier/intermediary must keep its bank account open for 6 months after contract end to process outstanding checks.

All reports through the outgoing contractor's month of cutover (or through the day of cutover if it leaves mid-month) must be completed. The MAC will be responsible for completing all reports beginning with the first cycle run after cutover. Therefore, if cutover occurs before the end of a quarter, the outgoing carrier/intermediary must share data with the MAC so that it can produce a quarterly report. If the carrier/intermediary believes that completion of a specific report is not possible or unwarranted, it must contact the CMS Jurisdiction Implementation Lead.

The following is a sample of the reports that will need to be completed after cutover:

Financial

- CMS 750/751 CFO Reports
- CMS1521 Payment Voucher Draws on Letter of Credit
- CMS 1522 Monthly Contractor Financial Report
- IER Interim Expenditure Report for final month
- IBPR Intermediary Benefit Payment Report
- FACP Final Administrative Cost Proposal
- CASR Contractor Audit and Settlement Report
- CRSL Cost Report Settlement Log
- ASCR Audit Selection Criteria Report
- IRS Form 1099 Income

Other

- CMS 1565/1566 Contractor Reporting of Operational and Workload Data (CROWD) for month and quarter
- CMS 1563/1564 Monthly MSP Savings
- CMS 2591 Part B Appeals
- FOIA Freedom of Information Act Report
- CSAMS Customer Service and Management System Report
- SADBUS Small and Disadvantaged Business Report

7.11.4 Lessons Learned

CMS asks that the carrier/intermediary maintain a list of activities that went well during the transition, problems that were encountered, and suggestions for improvement. It is

hoped that the carrier/intermediary will prepare a lessons learned document regarding its activities during the transition as well as any that it might have observed from other participants in the process. Lesson learned are normally submitted 4-6 weeks after cutover. See **Chapter 4.10.12**.

7.11.5 Post-Project Review

Approximately six weeks after cutover, the MAC will hold a post-project review meeting to discuss lessons learned from the transition. The meeting may be held in person or by teleconference, depending on the circumstances of the transition. The meeting will cover each major area of the transition and focus on the actions, methods, and processes used during the transition. Activities that went well will be discussed, as well as those that need improvement. Discussion should be frank and honest, with no areas off limits. CMS understands that it may be difficult, but it hopes that every effort will be made by the former carrier/intermediary to attend the meeting. See **Chapter 4.11.8**.

Chapter 8: FINANCIAL PROCESSES

8.1 General

The carrier/intermediary should meet with CMS as soon as possible to review policy and procedures for the financial aspects associated with closing out its operations and contract. The outgoing contractor must also coordinate activities with the incoming MAC to ensure that all financial accounts are in order and documents are properly transferred. Prior to cutover, CMS send a JSM/TDL to the contractor detailing procedures for closeout financial reporting. The carrier/intermediary will also need to estimate any additional costs that it may incur in order to maintain operations and support the MAC during the transition. In addition, termination costs must be developed so that contract closeout can be completed.

8.2 Transition Costs

Transition costs are those carrier/intermediary costs that relate to the transfer of its Medicare files, records, and workload to the incoming MAC. Carrier/intermediary transition costs complement the related transition costs of the incoming MAC. They include such items as overtime, temporary staff to reduce workload, retention bonuses (see **Chapter 5.3**), the inventorying of assets, etc. Transition costs are non-recurring in nature and are funded as a productivity investment (PI).

Transition costs may be incurred at any time between the date of the carrier/intermediary's termination/non-renewal notice to CMS (or the announcement of a replacement contractor for a portion of the carrier/intermediary's workload) and the date that the incoming MAC assumes responsibility for the workload (cutover). While some transition costs may extend beyond the cutover date, most post-cutover costs are considered termination costs. Both the incoming MAC and the outgoing carrier/intermediary incur transition costs.

Carriers/intermediaries must request and obtain advance funding approval for all transition costs. Only those items and costs specifically approved and funded as transition costs may be charged to the transition PI. Should the cutover occur during the fiscal year (rather than at the end of the fiscal year on September 30), ongoing funding in the NOBA will be reduced for the period subsequent to the cutover.

To be considered a transition cost, such costs must meet all of the following criteria:

- The costs are non-recurring and would not have been incurred except for the transition;
- The costs are incremental in nature;
- The costs are "used up" in the transition;

- The costs are not already included in the contractor's ongoing budget; and
 - The costs do not represent the necessary, ongoing costs of doing business.
- It should be noted that the direct personal service costs of current employees (excluding management and “all other costs”) may be considered as transition costs; however, they must be specifically identified and justified in the transition SBR.

The following costs are **NOT** transition costs:

- General Management

Even though directly engaged in the transition, these costs would have been incurred regardless and are already included in the ongoing budget. Note: If the transition is large enough to require full time project management, the personal service costs directly related to the transition may be considered as a transition activity if fully documented as to cost and purpose.

- Overhead and G&A

These costs normally would not be considered transition costs since they are already included in the ongoing budget. However, if the transition requires additional support in overhead and G&A that can be specifically related to the transition effort, those costs may be allowable. They would be identified as Other Direct Costs.

- Furniture and Equipment (F&E)

These are necessary, ongoing costs of doing business which are "used up" over time, not during the transition. ***Only the direct costs related to incoming and "setting up" the assets, if any, may be considered as transition costs. First year depreciation costs are an ongoing cost.***

- Material and Supplies

Like F&E, these are necessary, ongoing costs of doing business.

- Facilities and Occupancy (F&O)

The costs of existing facilities should not be reallocated to transition costs, as they are already included in the ongoing budget.

- Budget shortfalls

Outgoing contractors must identify only the incremental costs related to the transition and should not include anticipated funding shortfalls unrelated to the transition.

- "All Other Costs"

As defined in Medicare cost reporting, these are all non-personal service costs related to Medicare employees. These costs should not be charged as a transition cost since they are already included in the carrier/intermediary's budget. Incremental costs associated with new employees may be considered as transition costs but must be specifically identified rather than included as part of a general allocation.

8.3 Transition Supplemental Budget Request

A Supplemental Budget Request (SBR) must be submitted to obtain funding as soon as the need for transition funding arises. The full amount of the request should be included in the SBR, even though the transition may span two fiscal years. Changes to closeout activities during the transition or unforeseen costs may necessitate the submission of additional transition SBRs.

If corporate commitments need to be made prior to a public announcement that the carrier/intermediary is leaving the Medicare program, contact the Contracting Officer immediately. CMS will make every effort to reach an early and timely agreement regarding the commitment of funds. Failure to obtain CMS's explicit, written agreement and commitment of funds could delay or jeopardize reimbursement of expenditures.

The carrier/intermediary must reference the Medicare Financial Management Manual (Pub. 100-06), Chapter 1, Section 240 for preparation and routing of SBRs. A copy of the SBR should be sent to the same address as the latest Budget Request (BR) submission.

Once funding is approved, transition costs should be included in the monthly Interim Expenditure Report (IER) and later in the Final Administrative Cost Proposal (FACP). The FACP should be submitted no later than 3 months after the contract terminates, including any negotiated extension periods.

8.4 Termination Costs

Termination costs differ from normal Medicare costs both as to nature and method of payment. Termination costs are only incurred by the outgoing contractor. Generally, termination costs will be incurred after cutover to the incoming MAC. Termination costs may include:

- Severance pay (see **Chapter 5.2**)
- Other forms of personal service compensation,
- Loss on disposition of Medicare assets,
- Direct costs for final financial and reporting activities, and
- Termination of leases.

Termination budgets and costs are **NOT** processed through the standard SBR, NOBA, IER, FACP procedure described in the Medicare Financial Management Manual (Pub. 100-6). Termination budget or cost reports should not be transmitted on the Contractor Administrative Budget and Financial Management System (CAFM II). Termination costs are not to be included in the FACP; only vouchers may be used to claim reimbursement of termination costs. Once termination costs can be reasonably estimated, a hardcopy of the termination budget should be submitted to the same address used to submit a Budget Request (BR) or Supplemental Budget Request (SBR).

To accurately estimate a termination budget, the carrier/intermediary will need to know the following information:

- The cutover date;
- The contract termination date, including any extensions;
- The number of employees that will receive severance payments considering: (1) attrition; (2) the number who transfer to the carrier/intermediary's other lines of business; and (3) offer of employment with the incoming MAC;
- Assets and leases that will be transferred to the MAC or otherwise disposed of; and
- The number of employees and time needed for post-cutover wrap-up activities.

CMS will review the termination budget and approve it in principle as to the categories of expenditures and amount. The carrier/intermediary should submit vouchers for reimbursement as costs are actually incurred and paid. All vouchers should be submitted within 7 months after cutover. These vouchers, which may include accounting extracts, must provide sufficient detail to demonstrate that the costs have been incurred and paid. CMS will review the vouchers and make payments as appropriate.

CMS expects that the carrier/intermediary will take all necessary actions to mitigate termination costs. It must discontinue the acquisition of assets that will likely result in a loss on disposition after cutover, unless it is absolutely essential to a successful transition. Any acquisition of such assets should have the approval of the CMS Contracting Officer. Since the carrier/intermediary retains legal control of assets acquired on behalf of Medicare, it must dispose of those assets as quickly as possible after cutover, or whenever the assets are no longer needed for Medicare. This will limit storage costs, loss in market value, etc. CMS's general preference is that Medicare assets be made available for sale or transfer to the incoming MAC. Other methods of disposal could include sale on the open market, transfer to private lines of business, or destruction.

8.5 Bank Accounts and Reports

The carrier/intermediary must inform its bank that it will be leaving the Medicare program and establish procedures for closing its Medicare bank account. The carrier/intermediary's Medicare bank account should be kept open for at least 6 months beyond the cutover date to allow for clearance of outstanding checks. During this 6 month period, the letter of credit issued to the bank will remain in effect to allow the bank to request funds to cover all outstanding checks as they are presented for payment.

All CMS financial reports are required to be submitted on CAFM as long as there are account balances or activity on the reports. These reports include:

- Form CMS 1521, Payment Voucher Draws on Letter of Credit;
- TAA (pages 1 through 3) Time Account Adjustment Schedules and TAA1a, TAA1b, TAA1c;
- Form CMS-1522, Monthly Contractor Financial Report;
- Form CMS-456, Intermediary Benefit Payments Report;
- Forms CMS-750A/B, Contractor Financial Statement;
- Forms CMS-751A/B and MSP, Status of Accounts Receivable.

8.6 Financial Coordination with the MAC

The MAC will need to establish the payment dates and payment frequency for its operation. The carrier/intermediary's payment schedule will need to be provided to the MAC, since it may influence its payment schedule decision. Periodic interim payments (PIP) to providers must also be coordinated when the cutover payment cutoff date occurs within a PIP payment period.

At cutover, the carrier/intermediary must provide the MAC with a voided check register and a final listing of outstanding checks. The MAC and the outgoing contractor will need to coordinate procedures for handling stop payments, voided checks, and the reissuance of old outstanding checks.

Provisions must be made for the carrier/intermediary to forward checks and other Medicare mail to the MAC after cutover. The MAC will need to determine if its bank will cash a countersigned check made out to the carrier/intermediary. If it will not, the check will be sent back to the provider for reissuance.

8.7 Accounts Receivable Reconciliation

Medicare accounts receivable are a significant balance on CMS's financial statements and require special attention during the transition. The carrier/intermediary is responsible for the reconciliation of the accounts receivable for the segment that will be transferred to the incoming MAC. After the segment transition begins, CMS (or a contracted organization) will go on site to conduct an accounts receivable review of the carrier/intermediary. The on-site reviewers are responsible for selecting a sample of items to review based on the ending balances being reported on the outgoing contractor's H751, M751, C751 and MC751 reports. From the electronic copy of the ending balance detailed reports, a sample is selected of the accounts receivable to be reviewed to justify the ending balances being reported. While the review is conducted with the carrier/intermediary, the incoming MAC may attend the review sessions to understand the process and the documentation that is prepared to support the reconciliation.

A final written report will be prepared by the auditors and provided to the outgoing contractor. Prior to cutover, the Accounting Management Group in the Office of

Financial Management will provide written instructions through a JSM/TDL on the specifics regarding the required financial reporting. The JSM/TDL will contain information on how to complete the Accounts Receivable Transmittal Document, which is the official record of the transfer and acceptance of the number and value of the accounts receivable from the closeout contractor to the MAC.

The carrier/intermediary should notify the MAC in writing of all outstanding accounts receivable at least 60 days prior to the date that they will be transferred. The written notification will include a transmittal document summarizing the number and value of the accounts receivable being transferred and an acceptance statement to be signed by the MAC. In addition to this transmittal, the carrier/intermediary will include a detailed listing showing each specific account receivable being transferred. The detailed listing must agree to the summary totals reflected on the transmittal document and will include the following data elements:

- Debtor's name, Medicare identification number, and EIN or TIN;
- Account receivable/overpayment amount being transferred that includes principal and interest;
- Account receivable types; e.g., Medicare Part A or B, MSP, or other;
- Type of account receivable; e.g., cost report overpayment - audit, medical review, duplicate payment, etc.;
- The current status of collection action; e.g., interim payments being offset, extended repayment schedule in effect, etc.; and,
- The cost report period or accounting period, if applicable.

The carrier/intermediary should also send the MAC the permanent administrative file for each provider/debtor being transferred. The file must contain all relevant information to support the accounts receivable being transferred; e.g., identity of debtor, refund requests and documentation to clearly support each accounts receivable/overpayment determination. If the workload is being distributed to more than one MAC, a transmittal document and the appropriate detail listing must be sent to each one.

The carrier/intermediary should keep a file copy of the transmittal document and the summary listing and send copies to the appropriate CMS Regional Office(s) and the CMS Office of Financial Management, Financial Services Group, Division of Accounting, Debt Collection Branch in Central Office.

The MAC will certify the receipt of the transmittal document and return the receipt to the carrier/intermediary. The MAC will review and reconcile the accounts receivable transmittal document and the detailed listing with the administrative files transferred from the outgoing contractor. The carrier/intermediary will be contacted if the MAC

identifies a discrepancy regarding a specific accounts receivable. If the discrepancy cannot be resolved, the MAC will transfer the accounts receivable to the CMS project officer for resolution. The MAC has one year to review and accept all transferred receivables from the carrier/intermediary.

8.8 Financial Reporting for Accounts Receivable

The carrier/intermediary contractor must retain copies of all documentation related to the transfer of accounts receivable, including the signed acceptance from the incoming MAC. In addition, it must report the value of receivables transferred to and accepted by the incoming MAC on the appropriate lines of the Form CMS 750 and Form CMS 751.

- Report on the Form CMS 750 under the Revenue and Expense sections (both interest and principal). Report the amount of accounts receivable on the line titled: “Transfers Out to Other Medicare Contractors (Interest/Principal).”
- Report on the Form CMS 751 under Line 5c, “Transfers Out to Other Medicare Contractors” and Section D, Transferred Receivables, Line 5c, “Transfers Out to Other Medicare Contractors.”

All contractors, including those leaving the program, are subject to audit and may be required to provide supporting documentation for the values reported on the Forms CMS 750/751.

Also, summary data should be included in the “Remarks” section of the Form CMS 750, identifying the name of the acquiring MAC and the number and value of accounts receivable transferred as a result of transition activity. In the event accounts receivable are transferred to multiple MACs, the “Remarks” section must include the above information for each specific MAC.

8.9 PSOR/POR Reconciliation

The carrier/intermediary must ensure that the principal and interest identified on the detail listing for each overpayment determination are current and reconciled with the supporting files and reported on the appropriate overpayment reporting/tracking system; i.e., the Physician and Supplier Overpayment Reporting system (PSOR) and the Provider Overpayment Reporting system (POR).

8.10 Audits and Other Issues

An administrative cost audit will be conducted prior to the closeout of the contract. Costs for all open years, including termination costs, may be audited. Once all audits are completed, a global closing agreement will be used to close all open administrative costs. Pension, post-retirement, self-insurance or other administrative costs left open in prior closing agreements will be closed in the global closing agreement.

The administrative cost audits will exclude certain pension, postretirement benefit and self-insurance/captive insurance costs from the scope of the review. Costs claimed for qualified defined-benefit pension plan(s) will always be covered in a separate review by a specialized OIG audit team. Furthermore, if accrual accounting has been used to claim costs of any nonqualified defined-benefit pension or post-retirement benefit plans, those costs will remain also be covered by separate review a specialized OIG audit team. Costs claimed for self-insurance/captive insurance may be subject to separate review unless the carrier/intermediary can demonstrate that the premium rates are competitively priced.

The Office of Inspector General Act of 1978 as amended by the Office of Inspector General Act Amendments of 1988 and OMB Circular A-73 govern the audits of governmental organizations, programs, activities and functions, and funds received by contractors.

A separate pension audit will be conducted when there is a Medicare contract closing. Because some of the information needed for the pension audit will not be available until the carrier/intermediary has received the actuarial valuation for the first period after the contract performance ends, the pension audit is normally delayed for some time. Furthermore, if a pension audit has not yet been performed by a specialized OIG audit team, the carrier/intermediary can expect the pension audit to be quite extensive. The definition of a pension segment is found in Appendix B, Paragraph XVI.B of the Medicare Contract/Agreement.

The liability for costs of post-retirement benefit plans will be closed out on the cost accounting method used to determine the cost of the contract prior to termination. The termination or non-renewal of the contract does not alter the nature of the contract cost. The carrier/intermediary is reminded that changes in cost accounting method are prospective only. The amount of any claim for liability accrued for post-retirement benefits are subject to audit besides separate review concerning entitlement.

The cost of self-insurance/captive insurance is limited to actual benefits payments plus reasonable administrative expenses unless the carrier/intermediary can demonstrate that premiums are competitively priced. When assessing the pricing of self-insurance premiums, the Office of the Actuary will review historical data on incurred losses, administrative expenses, retention rates and loss-ratios for groups that are similar in size, industry, benefit structure and geographic location.

As soon as a carrier/intermediary knows it will be leaving the Medicare program, it should contact the CMS Office of the Actuary or OIG Pension Audit staff to begin planning for the upcoming audits.

8.11 1099 Responsibilities

The carrier/intermediary shall retain responsibility for preparation and submission of the 1099's for the providers it serviced in the year that the cutover occurred (even if this period is less than one calendar year). This responsibility includes both the electronic

reporting to the Internal Revenue Service (IRS) and the hard copy reporting statement for the providers. **These items shall be released on the normal 1099 reporting cycle.** During the transition, as part of the normal communication activities, providers must be reminded that they will receive two 1099s for the year—one from the carrier/intermediary and one from the incoming MAC—unless cutover occurs at the end of the calendar year.

The outgoing carrier/intermediary should inform providers of MAC contact point for questions regarding the 1099 and any necessary restatement after the cutover date. If any provider reporting statements are returned as undeliverable mail, the former carrier/intermediary shall forward them to the MAC.

At this time, it appears that the IRS will not allow the incoming MAC to correct a 1099 issued by the outgoing contractor; therefore the former carrier/intermediary will be responsible for making any corrections to 1099s that it issued. As such, an agreement will need to be developed between the MAC and the former contractor. This agreement will detail the procedures for providing the necessary information to enable the former contractor to make the corrections.

LIST OF EXHIBITS

- Exhibit 1 Transition Phases and Terminology
- Exhibit 2 MAC Contract Administrative Structure
- Exhibit 3 Financial Information for Outgoing Contractors
- Exhibit 4 Sample Closeout Project Plan
- Exhibit 5 Outgoing Contractor Information/Documentation
- Exhibit 6 Files to be Transferred to a Medicare Administrative Contractor
- Exhibit 7 Workload Closeout Meetings and Documentat ion
- Exhibit 8 Sample Workload Report
- Exhibit 9 Sample Staffing Report
- Exhibit 10 Glossary

Exhibit 1 Transition Phases and Terminology

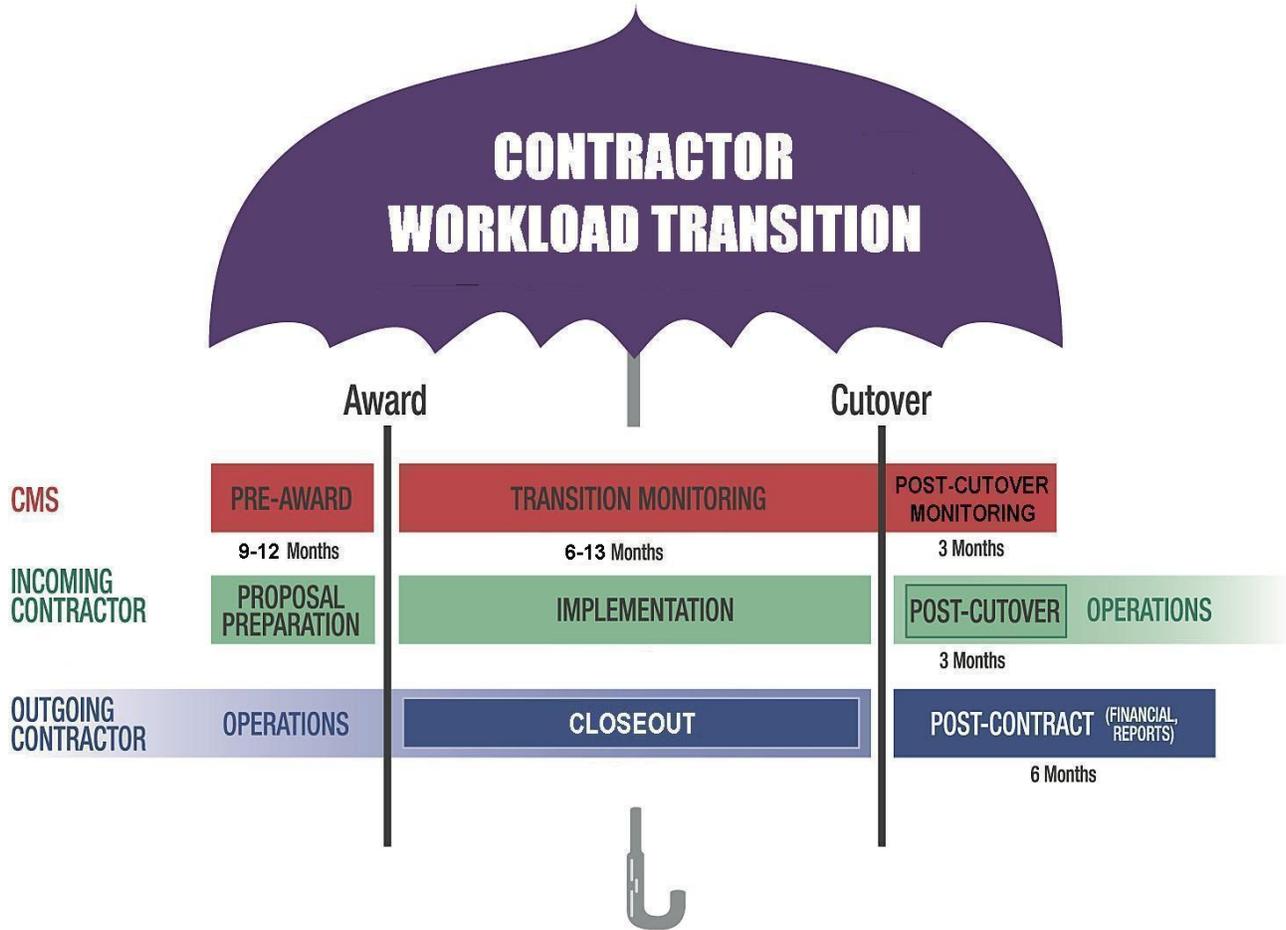


Exhibit 2 MAC Contract Administrative Structure

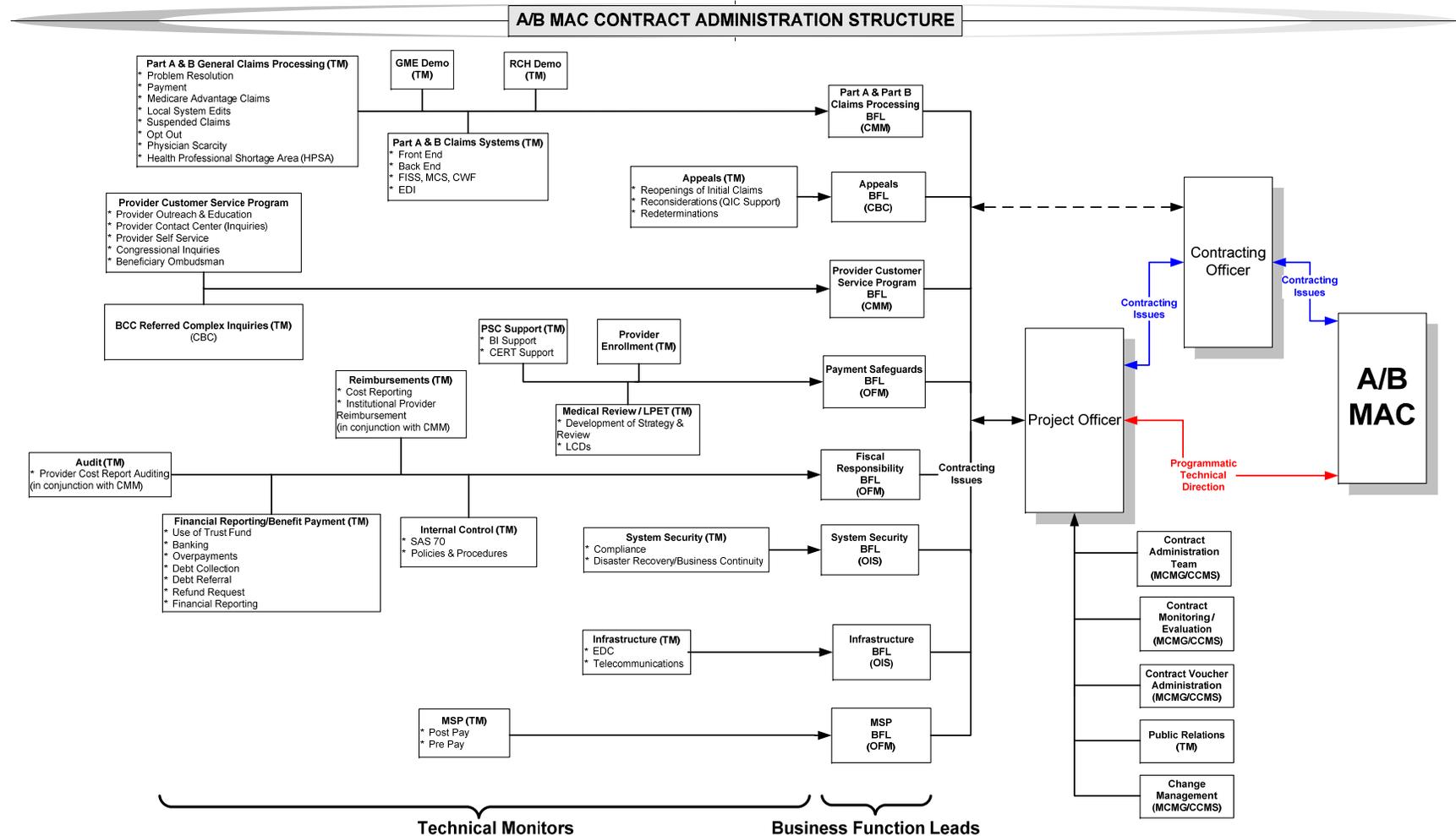


Exhibit 3

Financial Information for Outgoing Contractors

Due to the establishment of Medicare Administrative Contractors, all fiscal intermediary and carrier contracts will eventually end. While each Medicare contractor will have its own set of unique circumstances when ending its contract, each carrier/intermediary must adhere to CMS policy and procedures regarding transition and termination/non-renewal costs that may be incurred. For purposes of this document, the terms “termination” and “non-renewal” are used interchangeably. See the CMS Workload Closeout Handbook for detailed information regarding closeout activities and requirements.

1. Outgoing Contractor Transition Costs.

1.1 General

Outgoing contractor transition costs may be incurred at any time after notification of MAC contract award by the Contracting Officer or after the date of the carrier/intermediary’s written termination notice to CMS through the date that the cutover of work to the incoming contractor occurs. While some transition costs may linger beyond the cutover date, most post-cutover costs are termination costs as defined in Section II below.

Transition costs generally relate to or complement the transition efforts of the incoming Medicare contractor. They are non-recurring in nature and are funded as a Productivity Investment (PI). Only incremental costs are chargeable to the transition PI; all non-incremental costs continue to be charged to the ongoing budget. Ongoing funds contained in the annual Notice of Budget Approval (NOBA) may not be used for the transition. See Medicare Financial Management Manual (Pub. 100-06), Chapter 1, Section 100.6 for a discussion of PI and incremental costs.

Carriers and intermediaries must request and obtain advance funding approval for all transition costs. Only those items and costs specifically approved and funded as transition costs may be charged to the Transition PI. Should the cutover occur during the fiscal year (rather than on September 30), ongoing funding in the NOBA will be reduced for the period subsequent to the cutover. As discussed in Section 2 below, termination costs are not funded in the NOBA.

A Supplemental Budget Request (SBR) must be submitted to obtain funding as soon as the need for transition funding arises. Include the full amount of the request even though the transition may span two fiscal years. Submit more than one transition SBR if necessary. If commitments need to be made prior to a public announcement of termination, discuss this with responsible CMS personnel immediately. CMS will make every effort to reach an early and timely agreement regarding the commitment of funds. Failure to obtain CMS’s explicit, written agreement and commitment of funds could

Exhibit 3

Financial Information for Outgoing Contractors (Cont.)

delay or jeopardize reimbursement of expenditures. See Medicare Financial Management Manual (Pub. 100-06), Chapter 1, Section 240 for preparation and routing of SBRs. Send a copy of the SBR to the same address that you sent your latest Budget Request (BR).

Once funding is approved, include the costs in the monthly Interim Expenditure Report (IER) and later in the Final Administrative Cost Proposal (FACP). Submit the FACP no later than 3 months after the contract terminates including any negotiated extension periods.

1.2 Retention Bonuses:

CMS's requirements regarding retention bonuses are provided in the following Attachment 1. Review and conform to these requirements if it appears that bonuses may be appropriate and take into consideration at least the following circumstances in determining whether or not the bonus is reasonable and prudent for the work performed:

- The nature and timing of the transition to the incoming contractor, including whether or not employees may be retained by the outgoing contractor or employed by the incoming contractor.
- Geographic area and industry employment rates.
- Industry practices.
- Corporate severance policy and other elements of personal compensation.

Note that the bonus period shall not begin before the date on which announcement of termination is given to employees or extend beyond the cutover date. Retention bonuses are a transition expense and qualify as Compensation for Personal Services. It is the contractor's responsibility to demonstrate that this compensation is reasonable under the circumstances. See FAR 31.205-6.

It is essential that contractors obtain CMS's prior written approval of any and all potential commitments that could result in additional charges to the Medicare program. This emphatically applies to changes in compensation for personal services including the payment of retention bonuses. Contact CMS immediately with any questions regarding these requirements.

2. Termination/Non-Renewal Costs.

Termination costs are incurred by the outgoing contractor only, and generally after the cutover date. Termination costs do not pertain to the incoming contractor. Termination costs could include:

Exhibit 3

Financial Information for Outgoing Contractors (Cont.)

- Severance pay. (See Attachment 2.)
- Other forms of personal service compensation.
- Loss on disposition of Medicare assets.
- Direct costs of continuing operations
- Termination of leases.

Contact CMS as soon as possible to discuss the nature and applicability of these and possibly other termination costs to your situation. CMS expects that the carrier/intermediary will take all necessary, deliberate and diligent actions to mitigate termination costs. For example:

- The contractor retains legal control of assets acquired on behalf of the Medicare program and is responsible for disposing of the assets as quickly as possible after cutover or whenever the assets are no longer needed for Medicare. This will limit storage costs, loss in market value, etc. CMS's general preference is that these assets first be made available for sale or transfer to the incoming contractor. Other disposal actions could include sale on the open market or absorption in private lines of business.
- The contractor should discontinue the acquisition of assets, which will likely result in a loss on disposition after the cutover occurs, unless it is absolutely essential to a successful transition.
- The contractor should not enhance its established severance pay policy, once the termination is known, which may serve to increase rather than mitigate termination costs.

CMS will discuss these and other expectations with the contractor prior to cutover. Termination budgets and costs are not processed through the standard SBR, NOBA, IER, FACP procedure described in the Medicare Financial Management Manual (Pub. 100-6). Do not transmit a termination budget or cost reports on the Contractor Administrative Budget and Financial Management System (CAFMI). Once termination costs can be reasonably estimated, submit a hardcopy of the termination budget to the same address used to submit a Budget Request (BR) or Supplemental Budget Request (SBR).

To reasonably estimate a termination budget, an outgoing contractor will need to know the answers to at least some of the following:

- What will the cutover date be and when will the contract, including any extensions, terminate?

Exhibit 3

Financial Information for Outgoing Contractors (Cont.)

- How many employees may receive severance payments considering: (1) the number who transfer to the outgoing contractor's other lines of business; (2) attrition; and (3) offer of employment with the incoming contractor?
- What assets and leases may be transferred to the incoming contractor or otherwise disposed of?
- Who will be responsible for financial and miscellaneous wrap-up activities after operations end and for how long?

CMS will review the termination budget and approve it in principle as to the categories of expenditure and amount. The contractor should then submit one or more vouchers for reimbursement as costs are actually incurred and paid but all vouchers should be submitted within 7 months after cutover. These vouchers, which may include accounting extracts, must provide sufficient detail to demonstrate that the costs have been incurred and paid. CMS will review the vouchers and make payments as appropriate.

Termination costs are not to be included in the FACP; only vouchers may be used to claim reimbursement of termination costs.

3. Audits and Other Issues

3.1 Administrative Cost Audit

An administrative cost audit will be conducted prior to close out of the contract. All open years, including termination costs, may be audited. However, the closing agreement will be conditional, leaving the pension costs to be audited for the segment closing.

The Office of Inspector General Act of 1978 as amended by the Office of Inspector General Act Amendments of 1988 and OMB Circular A-73 govern the audits of governmental organizations, programs, activities and functions, and funds received by contractors.

3.2 Pension audit A separate pension audit will be conducted if there is a Medicare pension segmentation closing. Because some of the information needed for the pension audit will not be available until the contractor has received the actuarial valuation for the first period after the contract performance ends, the pension audit is normally delayed for some time. Furthermore, if a pension segmentation audit has not yet been performed, the contractor can expect the pension audit to be quite extensive. See Appendix B, Paragraph XVI.B of the Contract/Agreement for a definition of the pension segment.

Exhibit 3

Financial Information for Outgoing Contractors (Cont.)

3.3 Services of Consultants

Review Section II of the Contract/Agreement regarding the services of consultants which require CMS's prior contractual approval. Since these contracts require CMS's prior approval, allow sufficient time to submit them and to obtain CMS's approval prior to executing the contract, receiving services or otherwise incurring an obligation. Include sufficient justification in your request to demonstrate the need for all outside services.

Exhibit 3 **Financial Information for Outgoing Contractors (Cont.)**

Attachment 1

CMS Retention Bonus Policy

This attachment clarifies CMS's policy regarding reimbursement to Medicare contractors for retention bonuses paid to employees where the current Medicare contract/agreement is not renewed or is terminated. It applies to retention ("stay on") and performance-based bonuses, recognizing that a bonus may include elements of each.

HCFA will pay costs in accordance with the Federal Acquisition Regulation (FAR). Under FAR 31.205-6, to be allowable, compensation must be reasonable for the work performed. To be allowable, these payments must either be paid under an agreement entered into in good faith before the services are rendered or pursuant to an established plan or policy followed by the contractor so consistently as to imply, in effect, an agreement to make such payment and the basis for the award is supported.

CMS requires that contractors adhere to the terms of the contract/agreement, the FAR Part 31, and to perform within the funding limitations contained in the Notice of Budget Approval (NOBA). Expiration of the contract is not sufficient cause, in and of itself, to request retention bonus funds to perform work already funded in the NOBA under the terms of the contract/agreement. However, CMS may pay a retention bonus adopted for the transition of work from one contractor to another and paid by the outgoing contractor, to be reimbursable if:

- Funding has been approved by CMS in advance pursuant to a Supplemental Budget Request which adequately justifies the request. For funding to be approved, the following conditions must be met:
 - The cost is in compliance with the contract/agreement and the Intermediary and Carrier Fiscal Administration Manuals.
 - The amount is reasonable and is supported by documentation from the contractor. (See also Attachment 1, Section I above.)
 - CMS determines that the bonus is necessary for the smooth transition of the work.
- The bonus will not be paid to the designated employees until completion of the retention period.

Exhibit 3

Financial Information for Outgoing Contractors (Cont.)

Attachment 2

HCFA Severance Payment Policy

Contractors should review their own policies for conformance with ALL conditions described below. Failure to conform could put you at risk for reimbursement even if the current corporate severance policy is adequately presented in the Financial Information Survey accompanying the annual Budget Request.

The purpose of this document is to define those general conditions under which CMS will reimburse an outgoing contractor for severance payments made to that contractor's employees. It is based on authority contained in FAR 31.201-4(b) and FAR 31.205.6(a), (b), and (g) which also requires that, in most instances, CMS is liable for the severance costs stemming from the established, written policy of the contractor. The conditions surrounding the non-renewal or termination of the contract will, of course, differ and will determine the liability and extent of liability which CMS may have in that situation.

Generally, CMS will reimburse a contractor for severance payments under the following conditions:

- The contractor shall have an established, written severance policy in place and it must be found to be reasonable by the Government.
- Severance pay shall only be paid to employees of cost centers whose function is directly servicing the Medicare contract at the time of the non-renewal or termination notice if such cost center is eliminated or its staffing level is decreased due to the non-renewal or termination.

Generally, severance pay will not be paid to employees under the following conditions:

- The employee has been hired by the incoming contractor or another Government contractor associated with the replacement contract "where continuity for prior length of service is preserved under substantially equal conditions of employment." FAR 31.205-6(g)(1), or
- The employee has been hired by the outgoing contractor's private lines of business or by one of the contractor's subsidiaries or other member of a controlled group. (See Internal Revenue Code, Section 1563.), or
- The employee has received a written offer of employment by the incoming contractor and has chosen to refuse that employment.

Exhibit 4 Sample Closeout Plan

ID	% Complete	Task Name	Duration	Start	Finish	Predecessors
0		Contractor Phase-Out	158 d			
1		Contract Award	0 d			
2		Kickoff Meeting	2 d			1
3		Executive Kickoff	1 d			
4		Validate Records Access Agreement	1 d			
5		Full Kickoff Meeting	1 d			3
6		Communications	137 d			
7		Termination Protocols	25 d			
8		Notify CMS of Termination	1 d			
9		Notify Medicare Associates	1 d			
10		Formal Public Announcement	1 d			1
11		Medicare Associates/HR Meeting	1 d			
12		Bi-weekly Conference Calls with CMS	31 d			
13		Bi-weekly Conference Calls with CMS	31 d			
14		Bi-Weekly Status Update Meeting	71 d			
15		Bi-Weekly Status Update Meeting	71 d			
16		Periodic CMS Reports	120 d			
17		Weekly Staff/Attrition Reporting	98 d			
18		Establish Reporting Parameters	1 d			
19		Staffing Report	96 d			
20		Staffing Report submitted weekly	96 d			
21		Performance/Workload Reporting	98 d			
22		Establish Reporting Parameters	1 d			
23		Workload Report	96 d			
24		Workload Report submitted weekly	96 d			
25		Phase-out Plan	120 d			
26		Develop Initial Phase-out Plan	35 d			
27		Apply Incoming Contractor Tasks/Deliverables	10 d			26
28		Set Baseline/Forward to CMS	0 d			27
29		CMS Approval	5 d			28
30		Update and Report Phase-out Plan	41 d			29
31		Update and Report Phase-out Plan weekly	41 d			
32		Weekly Progress Reporting	0 d			
33		Weekly Phase-out Issues Log	0 d			39
34		Project Administration	150 d			
35		Issues Tracking	3 d			
36		Establish Tracking Protocols	2 d			
37		Organization	1 d			
38		Priorities	1 d			37
39		Construct Issues Database	1 d			36
40		Deliverables Tracking	116 d			
41		Develop Request/Tracking Form	4 d			
42		Reserve File Space	1 d			41
43		Monitor Deliverable Requests	111 d			42
44		Phase-out Project Staffing	125 d			
45		Establish Outgoing Contractor Executive Committee	1 d			
46		Establish Project Team	45 d			
47		Assign Project Manager	1 d			
48		Determine Workgroups and Assignments	1 d			
49		Transition Staffing	125 d			
50		Contract Project Team Specialists	1 d			
51		Operations Continuity Temporary Help	1 d			

Exhibit 4 Sample Closeout Plan

ID	% Complete	Task Name	Duration	Start	Finish	Predecessors
52		Budget Management	115 d			
53		Final Administrative Cost Proposal	16 d			
54		Develop FACP Data	15 d			
55		Submit FACP	1 d			54
56		Transition SBRs	61 d			
57		Review Business Unit Workplans	10 d			
58		Submit Waiver Requests	10 d			
59		Determine Sub-contracting costs	10 d			
60		Submit Initial Transition SBR	1 d			57,58,59
61		Follow-up SBR(s)	50 d			60,69
62		Identify any additional costs	40 d			
63		Submit if needed	10 d			62
64		Termination Proposals	97 d			
65		Identify Termination Costs	90 d			
66		Submit Initial Termination Proposal	1 d			65
67		Identify Additional Termination Costs	5 d			66
68		Submit Additional Termination Proposal	1 d			67
69		Request Contract Abatements/Waivers	2 d			
70		Abatements	2 d			
71		Request Abatement	1 d			
72		Receive Approval/Implement	1 d			71
73		Waivers	1 d			
74		Request Waiver	1 d			
75		Receive Approval/Implement	0 d			74
76		Notifications and Contracts Termination	87 d			
77		Data Center	1 d			
78		Data Center Services	1 d			
79		MSN Print/Mail Services	1 d			
80		EDI Trading Partners	20 d			
81		Review Contracts	15 d			
82		Notify Contract Holders	5 d			81
83		Facility(ies) Lease Termination	66 d			
84		Review Contracts	1 d			
85		Notify Contract Holders	1 d			84
86		Provide Termination Costs to CMS	1 d			
87		BCBSA Government Business Services(Part A Plan)	2 d			
88		Review Contract	1 d			
89		Notify Contract Holder	1 d			88
90		Program Safeguard Contractor	2 d			
91		Review Contract	1 d			
92		Notify Contract Holder	1 d			91
93		EDI Software Provider, PC-ACE	2 d			
94		Review Contract	1 d			
95		Notify Contract Holder	1 d			94
96		Global Network Services Provider	2 d			
97		Review Contract	1 d			
98		Notify Contract Holder	1 d			97
99		Global Network Service Frame Relay	2 d			
100		Review Contract	1 d			
101		Notify Contract Holder	1 d			100
102		Review Contract	1 d			

Exhibit 4 Sample Closeout Plan

ID	% Complete	Task Name	Duration	Start	Finish	Predecessors
103		Claims/EDI Workgroup	118 d			
104		Develop Workplan	48 d			
105		Construct Workplan	13 d			
106		Develop Plan	5 d			
107		Estimate/report transition effort	5 d			106
108		Submit Modifications that affect SBR	3 d			107
109		Revise Workplan per Kickoff Requirements	5 d			5
110		Provide Deliverables	70 d			109
111		Support Claims/Call Center Call	71 d			
112		Support Claims/Call Center Call weekly	71 d			
113		Support EDI/Connectivity Call	71 d			
114		Support EDI/Connectivity Conference Call weekly	71 d			
115		Maintain Workgroup Outgoing Contractor Issues	76 d			
116		Update Workgroup Outgoing Contractor Issues Log week	76 d			
117		Customer Service/Provider Relations Workgroup	119 d			
118		Develop Workplan	48 d			
119		Construct Workplan	13 d			
120		Develop Plan	5 d			
121		Estimate/report transition effort	5 d			120
122		Submit Modifications that affect SBR	3 d			121
123		Revise Workplan per Kickoff Requirements	5 d			
124		Provide Deliverables	30 d			123
125		Support Claims/Call Center Call	71 d			
126		Support weekly Claims/Call Center calls	71 d			
127		Support Bene/Prov Relations Call	71 d			
128		Support weekly Bene/Prov Relations calls	71 d			
129		Maintain Workgroup Outgoing Contractor Issues	71 d			
130		Update Outgoing Contractor Issues Log weekly	71 d			
131		Audit and Reimbursement Workgroup (Part A)	118 d			
132		Develop Workplan	48 d			
133		Construct Workplan	13 d			
134		Develop Plan	5 d			
135		Estimate/report transition effort	5 d			134
136		Submit Modifications that affect SBR	3 d			135
137		Revise Workplan per Kickoff Requirements	5 d			
138		Provide Deliverables	30 d			137
139		Support Audit & Reimbursement Call	71 d			
140		Support weekly Audit & Reimbursement call	71 d			
141		Maintain Workgroup Outgoing Contractor Issues	71 d			
142		Maintain Workgroup Outgoing Issues Log weekly	71 d			
143		MSP Workgroup	119 d			
144		Develop Workplan	48 d			
145		Construct Workplan	13 d			
146		Develop Plan	5 d			
147		Estimate/report transition effort	5 d			146
148		Submit Modifications that affect SBR	3 d			147
149		Revise Workplan per Kickoff Requirements	5 d			
150		Provide Deliverables	30 d			149

Exhibit 4 Sample Closeout Plan

ID	% Complete	Task Name	Duration	Start	Finish	Predecessors
151		Support MSP Call	71 d			
152		Support weekly MSP Call	71 d			
153		Maintain Workgroup Outgoing Contractor Issues Log	71 d			
154		Maintain Workgroup Outgoing Issues Log weekly	71 d			
155		MSP Inventory Reduction	71 d			
156		Review Potential Areas for Reduction	20 d			
157		Prioritize Needs	8 d			156
158		Review with CMS and Incoming Contractor	3 d			157
159		Review/Determine Implementation Methods	5 d			158
160		Implement Inventory Reduction Plan	35 d			159
161		Medical Review & Appeals Workgroup	118 d			
162		Develop Workplan	48 d			
163		Construct Workplan	13 d			
164		Develop Plan	5 d			
165		Estimate/report transition effort	5 d			164
166		Submit Modifications that affect SBR	3 d			165
167		Revise Workplan per Kickoff Requirements	5 d			
168		Provide Deliverables	30 d			167
169		Support Bene Hearings Call	71 d			
170		Support Bene Hearings Call weekly	71 d			
171		Support Med Review Call	71 d			
172		Support Med Review call weekly	71 d			
173		Maintain Workgroup Outgoing Contractor Issues Log	71 d			
174		Update Workgroup Outgoing Issues Log weekly	71 d			
175		PSC Contract/Scope Review	15 d			
176		Determine need to modify operating arrangement with PSC	15 d			
177		Conditionally Implement	0 d			176
178		Hearings Officer Phase-out	10 d			
179		Determine Run Out of Appeals	5 d			
180		Establish Cutoff	5 d			179
181		Notify Cutover Workgroup	0 d			180
182		Human Resources Workgroup	22 d			
183		Develop Workplan	1 d			
184		Revise Workplan per Kickoff Requirements	1 d			
185		Provide Deliverables	5 d			184
186		Support Recruit/Training Call	16 d			
187		Support Recruit/Training Relations Call	16 d			
188		Maintain Workgroup Outgoing Contractor Issues Log	16 d			
189		Update Workgroup Outgoing Issues Log weekly	16 d			
190		Systems Workgroup	76 d			
191		Provide Deliverables	75 d			5
192		Support Hardware/Software Acquisition Call	66 d			
193		Support Hardware/Software Acquisition Call weekly	66 d			
194		Support EDI/Connectivity Call	71 d			
195		Support EDI/Connectivity Call weekly	71 d			
196		Support Data Center/Standard System/Testing Call	71 d			
197		Support Data Center/Standard System /Testing Call weekl	71 d			
198						

Exhibit 4 Sample Closeout Plan

ID	% Complete	Task Name	Duration	Start	Finish	Predecessors
199		Project Management Workgroup	155 d			
200		Provide Deliverables	92 d			5
201		Fixed Assets Disposition	135 d			
202		Inventory Fixed Assets	5 d			
203		Notify Incoming Contractor	1 d			5
204		Notify CMS	1 d			203
205		Receive Responses	45 d			204
206		Asset Tag Inventory	50 d			
207		Review Assets List/Assess Accuracy	10 d			
208		Determine Need and Scope of Inventory	5 d			207
209		Assign Inventory Responsibilities	5 d			208
210		Conduct Inventory	30 d			209
211		Site Walk through with CMS	1 d			
212		Deliver claimed assets to Incoming Contractor	1 d			
213		Surplus any unclaimed assets	5 d			210
214		Phase Out Banking Services	0 d			
215		Determine Bank Contract End Date	0 d			
216		Coordinate Stop-payment process with incoming	0 d			215
217		Provide Voided check list to incoming	0 d			216
218		Mail and Other Receipt Forwarding	57 d			
219		Determine Items to be forwarded	1 d			
220		Develop Process for forwarding	1 d			219
221		Implement process for forwarding	1 d			
222		Accounts Receivables Review	82 d			
223		Set Date/Timeframe for Review	1 d			
224		Provide Review Protocols and Materials Request	0 d			
225		Support AR Review	3 d			
226		Notify Incoming of Outstanding AR	0 d			225
227		Obtain Signed Acceptance from Incoming Contractor	1 d			226
228		POR/PSOR Reconciliation	21 d			
229		Identify P&I Detail for Overpayments	21 d			
230		Reconcile Detail	21 d			
231		Report on Provider Overpayment Reporting System	21 d			
232		Coordinate with Incoming Contractor for entry into Stand	21 d			
233		Support Project Management Call	71 d			
234		Support Project Management Call weekly	71 d			
235		Support File Transition Call	76 d			
236		Support File Transition Call weekly	76 d			
237		Support Archived record Transfer	1 d			
238		Support Other Archived Records Transfer	1 d			
239		Final Packing of Hard Copy Files	49 d			
240		Determine Scope and Method of Packing	3 d			
241		Provide SBR Data	1 d			
242		Make Arrangements with Record Storage contractor for S	1 d			
243		Hire Packers (temporary staff)	1 d			
244		Pack and Store Files	8 d			
245		Support Record Storage Contractor Pickup of Staged Files	1 d			
246		Final Packing	1 d			245
247		Cutover Planning	61 d			
248		Initial Cutover Planning Meeting	1 d			
249		Support/Maintain Cutover Checklist	60 d			248
250		Cutover Workgroup	51 d			
251		Support Cutover Planning call weekly	51 d			

Exhibit 4 Sample Closeout Plan

ID	% Complete	Task Name	Duration	Start	Finish	Predecessors
252		Facilities Phase-out	155 d			
253		Notify landlord of Vacate Date	1 d			
254		Determine Post-Transition Facilities Needs	1 d			293
255		Workstations	1 d			
256		Phones	1 d			
257		Desktop	1 d			
258		Printers	1 d			
259		Copier	1 d			
260		Fax	1 d			
261		Supplies	1 d			
262		Notifications for Facility A Shutdown	1 d			
263		Notifications for Facility B Shutdown	1 d			
264		Security	63 d			
265		Building Security	4 d			
266		Termination Notification	1 d			
267		Collect and forward badges on exit	1 d			
268		Outgoing Contractor System Security	12 d			
269		Termination Notification	1 d			
270		LAN/RACF Terminations	1 d			
271		Data Center System Security	33 d			
272		Termination specific date Notification	1 d			
273		RACF Terminations	1 d			
274		Determine/Request TPX for Post-trans staff	1 d			
275		Termination specific date Notification	1 d			
276		RACF Terminations	1 d			
277		Standard System Operator Control	12 d			
278		CSI to delete outgoing contractor Logons	1 d			
279		Notify Incoming contractor of Post-trans Staff	1 d			
280		Delete outgoing Contractor Logons	1 d			
281		CMS System Access	61 d			
282		Determine Staff/Term Date for CMS Access	1 d			294
283		Notify CMS specific date Terminations	1 d			
284		Notify CMS specific date Terminations	1 d			
285		Notify CMS specific date Terminations	1 d			
286		Assure specific date access not shut down ea	18 d			
287		Assure specific dates not shut down early	18 d			
288		Post Transition Planning & Operations	98 d			
289		Reporting Requirements	31 d			
290		Determine Staff/Time Requirements for Reporting	5 d			
291		Develop Workplan and Contingencies	20 d			290
292		Develop Financial Reporting Plan	5 d			291
293		Submit Financial Reporting Plan to CMS	1 d			292
294		Establish Post Cutover Reporting Team	1 d			289
295		Cross Train Post Cutover Team for Reports	30 d			294
296		Post Cutover Reporting Strategy Meetings	36 d			
297		Post Cutover Reporting Strategy Meetings weekly	36 d			

Exhibit 4 Sample Closeout Plan

ID	% Complete	Task Name	Duration	Start	Finish	Predecessors
298		CROWD Workload Reporting	8 d			
299		Year end Workload Data	6 d			
300		Obtain Final Year end 308 Reports	1 d			
301		Obtain Line 40 MSN counts	1 d			
302		Compile Statistics	4 d			301
303		Input 1566 Data into CROWD	1 d			302
304		Final Quarterly Workload Data	2 d			
305		Compile Quarterly Workload Reports	1 d			299
306		Input 1566 Data into CROWD	1 d			305
307		750/751	16 d			
308		Develop Non-MSP CFO Data	15 d			
309		Develop MSP CFO Data	15 d			
310		Compile and Enter Data	1 d			309
311		CASR & Other A&R Reporting	18 d			
312		Reopening Report to CMS - RO	1 d			
313		Year End Monitoring Reports	1 d			
314		CRSL (Cost Report Settlement Log)	1 d			
315		ABC - Audit	1 d			
316		ABC - Reimbursement	1 d			
317		Audit Effort Extract	1 d			
318		ASCR (Audit Selection Criteria Report)	1 d			
319		MONSTR2004 Reports	1 d			
320		CASR - CIER	1 d			
321		Last Quarter IER	19 d			
322		Final Timesheets	1 d			
323		Compile/submit time reports	1 d			
324		Compile other IER data	5 d			
325		Submit Final IER	1 d			324
326		Other Reporting	24 d			
327		FOI Report	3 d			
328		Annual FOI Report (6 month & annual)	21 d			
329		MSP Savings (1563)	12 d			
330		Part B Appeals (2591)	7 d			
331		CSAMS Report - Beneficiary	7 d			
332		CSAMS Report - Provider	7 d			
333		RBS & Medical Rev. Activ.	24 d			
334		PIP Quarterly Report "Q"	12 d			
335		Change Request Report	24 d			
336		Medicare SADBUS Report	24 d			
337		CNC & Writeoffs	24 d			
338		CASEWORK Approvals	24 d			
339		MSP Waiver Report	24 d			
340		DCIA Recall Report	24 d			
341		Final 1099s	55 d			
342		Confirm IRS Rules for Early 1099s	1 d			
343		Test Standard System 1099s with IRS	5 d			
344		Receive Final 1099 Files from Data Center	2 d			
345		Generate Final 1099s	7 d			344
346		Distribute Output	1 d			345
347		Final Transfers to Incoming	1 d			
348		Electronic Files	1 d			
349		Hard Copy	1 d			
350		Final CPIC	33 d			
351		Develop Materials and Statistics	28 d			
352		Weekly CPIC Planning Meeting	26 d			
353		Support Weekly CPIC Planning Meeting	26 d			
354		Prepare Final CPIC	3 d			
355		Sign & Submit Final CPIC	1 d			354

Exhibit 5

Outgoing Contractor Information/Documentation

The following is a sample of Medicare information and documentation that is normally requested by the incoming contractor and must be provided in its entirety by the outgoing contractor:

- Copies of MSNs, Remittance Advices
- Copies of all notices and bulletins
- Outgoing contractor closeout plan
- Copies of fee schedules and payment schedules
- List of providers on 100% review, under investigation (including issues involved), and referrals to the Department of Justice
- Information on providers:
 - Name, telephone number, address, EIN of provider
 - List of providers on PIP/off PIP, with effective dates
 - Date of last interim rate payment review
 - EMC status
 - Current provider payment rates
 - Waiver of liability information, if applicable
 - Current program integrity information
 - Summary PS&R data
- Listing of historical provider issues and problems
- Unique procedure information
- Complete EMC information on all providers and submitters including:
 - Standard formats used
 - Vendors/billing houses/software used
 - Status of EDI agreements/contracts
 - EMC submission rates
 - Use of ERN and EFT
- A list of all special claims handling circumstances
- Beneficiary State Tape (BEST) or the Carrier Alphabetical State File (CASF).
- Inventory of all program materials and procedures that are available to the MAC, including any government owned property (equipment and supplies).
- List of assets available for purchase from the outgoing contractor.
- Key contacts: beneficiary, providers, Congress, specialty groups, associations.
- Staff attrition reports
- Storage information
- Status of key workload volumes
- Accounts receivable
- Enrollment inventory
- Status of cost Reports
- STAR databases
- Audit trails for Provider debt
- Workshop schedule

Exhibit 5

Outgoing Contractor Information/Documentation (Cont.)

The following is a sample of Medicare information/documentation that may contain certain proprietary or business information. CMS will generally not require the outgoing contractor to release this information. However, if CMS believes that the information is critical to the success of the implementation and has the authority to do so, it will direct the release of a redacted version of the information:

- Annual Internal Audit Plan
- Business Continuity Plan
- Interim Expenditure Report/Notice of Budget Authorization
- Risk Assessment
- Lease agreements
- Subcontracts
- Off-site storage contract
- Personnel information
- Medicare organizational chart
- Disaster Recovery test results
- Production standards and performance requirements by functional area
- Internal controls/process manuals
- Training manuals and materials
- Claims processing guidelines

The following are public documents that are releasable specifically by statute or under the Freedom of Information Act (FOIA). However, these documents may contain some proprietary business information and/or financial data that is not releasable. CMS expects that outgoing contractors will normally release properly redacted copies of such documents to the incoming contractor:

- List of CAPs/PIPs/CPE findings
- CMS Regional Office Memorandum/Letters
- Certification Package of Internal Controls
- SAS 70 final report
- CFO Audit final report

NOTE: This exhibit (including the categorizations and examples contained within it) does not supersede CMS's rights under the Rights in Data clause contained in the Medicare carrier contract, intermediary agreement, or Plan agreement under the Blue Cross and Blue Shield Association.

Exhibit 6

Files to be Transferred to a Medicare Administrative Contractor

This list provides a sample of the types of files that will be transferred to an incoming Medicare contractor. It is not all-inclusive. Files to be transferred will vary depending on functions currently performed by the outgoing contractor and the functions that will be performed by the MAC.

Provider File

- Data File
- Index File
- Provider Mnemonic File
- Provider Overflow File
- Reasonable Charge File
- Physician ID File

Customary File

- Current Year File
- Previous Year File

Prevailing File

- Current Year File
- Previous Year File

Profile Procedure/Pricing Files

- Current Year File
- Previous Year File

Lowest Charge Level File

Limiting Charge Monitoring File

Beneficiary File

- On-line History Data Base File
- Off-line History Data Base File
- Index File
- Soundex File

Claim History/Conversion File

- Data File
- Beneficiary Inverted File
- Provider Inverted File

Exhibit 6
Files to be Transferred to a Medicare Administrative Contractor
(Cont.)

Activity/Pended File

- Data File
- Master Pending File
- Index File
- Beneficiary Inverted File
- Provider Inverted File

Financial Files

- Accounting Master File
- Bank Reconciliation/Accounts Receivable File
- Inverted File

DME Files (DME MACs only)

Eligibility File

QA Files

Carrier Option File

Pending/ Finalized Audit and Reimbursement File

Personnel File

Correspondence Files

- On-line Correspondence History Data Base File
- Index File
- Inverted File
- Inverted Index File

Utilization (Post Payment) Review Files

Provider Development Systems (PDS) Files

- PDS Option File
- Base Year File
- Maximum Allowable Prevailing Charge File
- No Rollback File

Exhibit 6
Files to be Transferred to a Medicare Administrative Contractor
(Cont.)

MSP Files

- Savings File
- Insurer File
- Data Match File

Government File

Coordination of Benefits File

HCPCS File

Pacemaster File

Miscellaneous Files

- SCC Files
- On-line and Update Reference Files
- Rolling Transaction File
- RPTTOTAL File
- OBFNEW File
- Batch Control File
- CICS Table Files
- Miscellaneous Transaction File
- Statistics File
- Replies Restart File
- Beneficiary Restart File
- HIC Restart File
- Procedure Frequency File
- PVSELECT File
- Provider Log File
- Procedure Diagnosis File
- Activity Restart File
- Daily/Weekly Check Number Files

Exhibit 7 Workload Closeout Meetings and Documentation

Blue shaded activities indicate required Carrier/Intermediary face-to-face meetings or teleconferences.

Red shaded activities indicate required Carrier/Intermediary closeout documentation. Red is darker shading in black & white.

Non-shaded activities indicate documentation distributed to Carrier/Intermediary for information purposes.

Abbreviations:

CMS: **CO**—Contracting Officer; **PO**—Project Officer; **JIL**—Jurisdiction Implementation Lead; **SIM/MISC**—Segment Implementation Manager/Medicare Implementation Support Contractor; **CM**—Contractor Manger; **MAC:** **PM**—Project Manager; **SPM**—Segment Project Manager; **Other:** **BCBSA**—Blue Cross and Blue Shield Association; **PSC**—Program Safeguard Contractor; **EDC**—Enterprise Data Center; **BCC**—Beneficiary Contact Center; **QIC**—Qualified Independent Contractor; **SSM**—Shared System Maintainer; **HIGLAS**—Healthcare Integrated General Ledger Accounting System.

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
1.	<i>Outgoing Contractor Pre-Meeting.</i>	<i>2-3 hour meeting.</i>	<i>To discuss closeout activities, contractor-specific financial issues, CMS project expectations, and Jurisdiction Kickoff Meeting.</i>	<i>One-time meeting usually held prior to the Jurisdiction Kickoff Meeting.</i>	<i>Face-to-face meeting.</i>	<i>CMS: CO, CM, JIL; SIM/MISC; Carrier/ Intermediary.</i>	<i>CMS.</i>	<i>3.7.1</i>
2.	<i>Jurisdiction Kickoff Meeting Agenda.</i>	<i>Outline of meeting topics with dial-in teleconference number.</i>	<i>To provide participants with an outline of topics to be discussed with estimated times.</i>	<i>Due 3 days prior to meeting.</i>	<i>Memo via email.</i>	<i>CMS: COs, PO, Project Team, CM, SIM/MISC; MAC; Carrier/Intermediary; EDC; SSM; BCC; PSC; QIC; BCBSA etc.</i>	<i>MAC with CMS input.</i>	<i>3.7</i>
3.	<i>Jurisdiction Kickoff Meeting.</i>	<i>1 day meeting.</i>	<i>To review the upcoming MAC implementation activities and associated carrier/intermediary closeout activities.</i>	<i>One-time meeting scheduled 10-15 days after contract award.</i>	<i>Face-to-face meeting with teleconference capability.</i>	<i>CMS: COs, PO, JIL, SIM/MISC, CM, Project Team; MAC and Project Team; Carrier/ Intermediary Closeout Team; EDC; PSC; SSM; BCC; QIC; etc.</i>	<i>MAC.</i>	<i>3.7.2</i>

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
4.	<i>Jurisdiction Kickoff Meeting Documentation.</i>	<i>Minutes, record of discussion, issues/action items.</i>	<i>To document the issues and action items from the Jurisdiction Kickoff Meeting.</i>	<i>3 days following meeting.</i>	<i>Memo via electronic mail.</i>	<i>All attendees.</i>	<i>MAC.</i>	<i>3.7</i>
5.	<i>Transition Contact List.</i>	<i>List of Jurisdiction Kickoff meeting attendees and others involved in the project.</i>	<i>To ensure that appropriate transition personnel can be reached as needed throughout the transition.</i>	<i>Update and distribute as changes are made.</i>	<i>Spreadsheet via electronic mail.</i>	<i>All Jurisdiction Kickoff Meeting attendees and others identified to be involved in the transition.</i>	<i>MAC.</i>	<i>3.7</i>
6.	<i>Deliverables List.</i>	<i>List of items, information, files, etc. requested by MAC to be provided by the carrier/intermediary.</i>	<i>To facilitate the transition from the outgoing contractor to the incoming contractor.</i>	<i>Development begins at contract award. Maintained and updated throughout the implementation.</i>	<i>Memo via electronic mail.</i>	<i>MAC; CMS; Carrier/Intermediary.</i>	<i>MAC Project Manager.</i>	<i>6.4</i>
7.	<i>MAC Segment Kickoff Meeting Agenda.</i>	<i>List of meeting topics with estimated times and dial-in teleconference number.</i>	<i>To provide participants with a description of topics to be discussed during the Segment Kickoff Meeting.</i>	<i>One-time meeting for each segment implementation. Due 3 days prior to meeting.</i>	<i>Memo via electronic mail.</i>	<i>CMS: CO, PO, JIL, SIM/MISC; MAC: PM, Project Team leads; Outgoing Contractor; BCBSA; PSC; EDC; 1-800-MEDICARE; QIC, etc.</i>	<i>MAC Project Manager with input from CMS.</i>	<i>3.7.3.2</i>
8.	<i>MAC Segment Kickoff Meeting.</i>	<i>1 day meeting.</i>	<i>To review the upcoming segment implementation and carrier/intermediary closeout activities.</i>	<i>One-time meeting for each segment implementation.</i>	<i>Face-to-face meeting with teleconference capability.</i>	<i>CMS: CO, PO, JIL, SIM/MISC, workgroup heads; MAC: PM, workgroup leads; Outgoing Contractor; PSC; EDC; BCBSA; BCC ; QIC, etc.</i>	<i>MAC Project Manager.</i>	<i>3.7.3</i>
9.	<i>MAC Segment Kickoff Meeting Documentation.</i>	<i>Minutes, record of discussion, and issues/action items.</i>	<i>To document the discussion and issues/action items from the Segment Kickoff Meeting.</i>	<i>3 days following meeting.</i>	<i>Memo via electronic mail.</i>	<i>All attendees.</i>	<i>MAC Project Manager.</i>	<i>3.7.3.2</i>

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
10.	<i>Segment Transition Contact List.</i>	<i>Contact list of Segment Kickoff Meeting attendees and others to be involved in the project.</i>	<i>To ensure that appropriate segment transition personnel can be reached as needed throughout the transition.</i>	<i>Update and distribute as any changes are made.</i>	<i>Spreadsheet via electronic mail.</i>	<i>All attendees and workgroup members and others identified to be involved in the transition.</i>	<i>MAC Project Manager.</i>	3.7.3.2
11.	<i>Comprehensive Transition Workgroup Schedule/Calendar/Contact List.</i>	<i>Document in calendar format showing all workgroups, heads, members, meeting times, and dial-in teleconference numbers.</i>	<i>To provide a reference calendar of all workgroup meetings and information.</i>	<i>Update and distribute as any changes are made.</i>	<i>Calendar format via electronic mail.</i>	<i>CMS; MAC; Carrier/Intermediary; all workgroup members.</i>	<i>MAC Project Manager.</i>	3.8.5
12.	<i>Transition Workgroup Agenda.</i>	<i>Standardized outline of workgroup topics with dial-in teleconference number.</i>	<i>To provide participants with topics to be covered in the workgroup meeting.</i>	<i>One day prior to the meeting.</i>	<i>Memo via electronic mail.</i>	<i>CMS; MAC; Carrier/Intermediary; all workgroup members.</i>	<i>Workgroup Head.</i>	3.8.5
13.	<i>Transition Workgroup Meetings.</i>	<i>Meetings for the various functional workgroups.</i>	<i>To monitor transition tasks and issues of the functional area for which the workgroup has responsibility.</i>	<i>Weekly meetings throughout the transition.</i>	<i>Teleconference.</i>	<i>All workgroup members.</i>	<i>Workgroup Head.</i>	3.8.5
14.	<i>Transition Workgroup Meeting Documentation.</i>	<i>Concise description of the workgroup meeting, issues, and action items.</i>	<i>To provide a record and document issues and action items pertaining to the workgroup.</i>	<i>Two days after each meeting.</i>	<i>Memo via electronic mail.</i>	<i>All workgroup members; all other workgroup heads; CMS; MAC; Carrier/Intermediary.</i>	<i>Workgroup Head.</i>	3.8.5

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
15.	<i>Jurisdiction Implementation Project Status Report.</i>	<i>Narrative of MAC accomplishments by major tasks, issues/concerns, action items, upcoming activities.</i>	<i>To communicate progress and performance against the MAC implementation project schedule, highlight issues, concerns, action items, etc. regarding the implementation.</i>	<i>Biweekly at least 2 days prior to the Jurisdiction Project Status Meeting.</i>	<i>Memo via electronic mail.</i>	<i>CMS; MAC; Carrier/Intermediary; workgroup heads; all others listed on Jurisdiction Kickoff Meeting/ Contact List.</i>	<i>MAC Project Manager.</i>	
16.	<i>Closeout Project Status Report.</i>	<i>Narrative description of carrier/intermediary accomplishments, issues, action items, upcoming activities.</i>	<i>To communicate progress and performance against the closeout plan and provide workload and staffing information.</i>	<i>Biweekly at least 2 days prior to the Jurisdiction Project Status Meeting.</i>	<i>Memo via electronic mail.</i>	<i>CMS; Carrier/Intermediary; MAC; workgroup heads.</i>	<i>Carrier/Intermediary Closeout Project Manager.</i>	<i>4.10.4</i>
17.	<i>Transition Project Status Meeting Agenda.</i>	<i>Outline of meeting topics with dial-in teleconference number.</i>	<i>To provide participants with a description of topics to be discussed with estimated times.</i>	<i>Biweekly at least 1 day before meeting.</i>	<i>Memo via electronic mail.</i>	<i>CMS; MAC; Carrier-Intermediary; workgroup heads; all others listed on Kickoff Meeting/ Contact List.</i>	<i>MAC Project Manager.</i>	<i>4.11.3</i>
18.	<i>Transition Project Status Meeting.</i>	<i>1-2 hour general status meeting.</i>	<i>To keep all parties involved in the transition informed about the overall transition status, to discuss progress and issues, track action items and deliverables, and to review the Implementation Project Plan and Closeout Plan.</i>	<i>Biweekly</i>	<i>Conference call. Possible face-to-face meeting with teleconference capability.</i>	<i>CMS; MAC; Carrier/Intermediary; workgroup leads; EDC; PSC; QIC; BCBSA; etc.</i>	<i>MAC Project Manager.</i>	<i>4.11.3</i>
19.	<i>Transition Project Status Meeting Documentation.</i>	<i>List of attendees, discussion items, action items.</i>	<i>To document the issues and action items from the bi-weekly project status meeting.</i>	<i>3 days after meeting.</i>	<i>Memo via electronic mail.</i>	<i>All attendees.</i>	<i>MAC Project Manager.</i>	<i>4.11.3</i>

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
20.	<i>MAC Segment Implementation Project Plan (SIPP).</i>	<i>Project plan listing major tasks/sub-tasks required for the DME MAC implementation, along with dates, duration, dependencies, and responsible parties.</i>	<i>To document all actions required for the implementation, identify dependencies, and establish start/completion dates in order to monitor progress and to facilitate the communication process among the parties involved in the transition. Coordinated with CPP.</i>	<i>Submitted with proposal. Baseline working document developed within 30 days after kickoff meeting.</i>	<i>Electronic. Project management software in, or convertible to, MS Project, MS Excel, or PDF format.</i>	<i>CMS; MAC; Carrier/Intermediary; EDC; PSC; QIC; BCBSA, etc.</i>	<i>MAC Project Manager. Input from all involved entities necessary for baseline.</i>	
21.	<i>Segment Implementation Project Plan Update.</i>	<i>Current information on the SIPP regarding tasks, start/finish dates, dependencies, and completion percentage, including a list of tasks completed and off schedule.</i>	<i>To provide up-to-date information regarding all project tasks. This will allow the DME MAC and all involved parties to effectively monitor and manage the overall project to ensure completion as scheduled.</i>	<i>Biweekly. Submitted with the Implementation Project Status Report.</i>	<i>Electronic. Project management software in, or convertible to, MS Project, MS Excel, or PDF format.</i>	<i>CMS; MAC; Carrier/Intermediary; EDC; PSC; QIC; BCBSA, etc.</i>	<i>MAC Project Manager.</i>	
22.	<i>Closeout Approach/ Inventory Reduction Plan.</i>	<i>Document describing operational approach for carrier/intermediary claims processing during closeout with weekly workload reduction goals for various claim areas.</i>	<i>To provide a plan for streamlining operations, reducing workload, maintaining staff and productivity, and establishing contingency plans for the closeout period. Inventory reduction plan will assist MAC in planning for workload volumes at cutover.</i>	<i>Submitted within 15 days after kickoff meeting.</i>	<i>Distributed by electronic mail.</i>	<i>CMS: CO,CM,SIM; MAC.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	<i>6.1 6.2</i>

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
23.	<i>Closeout Project Plan (CPP).</i>	<i>Project Plan listing major tasks/subtasks required for contract closeout activities.</i>	<i>To document all actions required for closing out the outgoing contractor's contract with start/end dates and dependencies in order to monitor progress and ensure completion of all closeout activities. Coordinated with IPP.</i>	<i>Submitted within 15 days after kickoff meeting.</i>	<i>Electronic. Project management software in, or convertible to, MS Project, MS Excel, or PDF format.</i>	<i>CMS; Carrier/Intermediary; MAC.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	<i>4.3 4.10.2</i>
24.	<i>Closeout Project Plan Update.</i>	<i>Current information on the project plan regarding tasks, start/finish dates, dependencies, and completion percentage, including a list of tasks completed and off schedule.</i>	<i>To provide up-to-date information regarding all project tasks. This will allow CMS to effectively monitor and manage closeout activities to ensure completion as scheduled.</i>	<i>Biweekly. Submitted with the Closeout Project Status Report.</i>	<i>Electronic. Project management software in, or convertible to, MS Project, MS Excel, or PDF format.</i>	<i>CMS; Carrier/Intermediary; MAC.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	<i>4.10.3</i>
25.	<i>Master List of Issues Log/Action Items.</i>	<i>Comprehensive list that documents issues/action items for each including ID, date created, description, responsible party, status, date of resolution. Accumulated from various work-groups.</i>	<i>To track transition issues and action items related to the project. Will be reviewed during the transition project status meetings.</i>	<i>Reviewed weekly and updated as required. Submitted with the biweekly MAC Implementation Project Status Report.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/intermediary; work-group heads.</i>	<i>MAC Project Manager.</i>	

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
26.	<i>Carrier/Intermediary Issues Log/Action Items.</i>	<i>List of issues/ action items that pertain solely to Carrier/Intermediary closeout activities.</i>	<i>To track any closeout issues related solely to the Carrier/Intermediary that are not monitored through the MAC issues/action items list.</i>	<i>Reviewed weekly and updated as required. Submitted with the biweekly Closeout Project Status Report.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; Carrier/ Intermediary.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	4.10.6
27.	<i>Communication Plan.</i>	<i>A general description and detailed schedule of how the MAC will educate and keep all transition stakeholders informed of the progress of the implementation and how any changes may affect them.</i>	<i>To monitor communication activities and schedules.</i>	<i>Developed within 30 days of kickoff meeting.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/ Intermediary.</i>	<i>MAC Project Manager with input from Carrier/Intermediary.</i>	
28.	<i>Communication Plan. Update.</i>	<i>Update on communication activities and schedules.</i>	<i>To provide CMS with current information on communication activities and schedules.</i>	<i>Biweekly. Submitted with the Implementation Project Status Report.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/ Intermediary.</i>	<i>MAC Project Manager.</i>	
29.	<i>Test Plan.</i>	<i>A specific and detailed description of the resources, types of tests and schedule.</i>	<i>To monitor the testing of the MAC's claims processing system and operational environment prior to cutover.</i>	<i>Baseline test plan developed within 30 days of kickoff meeting.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/ Intermediary; appropriate workgroup heads.</i>	<i>MAC Project Manger.</i>	

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
30.	<i>Test Plan Update.</i>	<i>Update on testing activities and schedules.</i>	<i>To track schedule progress and provide current information on testing.</i>	<i>Updated on a bi-weekly basis and submitted with the Implementation Project Status Report.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/Intermediary; appropriate workgroup heads.</i>	<i>MAC Project Manager.</i>	
31.	<i>Carrier/Intermediary Workload Report.</i>	<i>Operational statistics from various functional areas. Actual monthly totals will be displayed against estimated monthly goals of the Inventory Reduction Plan.</i>	<i>To assist the CMS, Carrier/Intermediary, and MAC in assessing progress and to allocate resources or modify transition activities if necessary. Meeting workload goals.</i>	<i>Weekly with monthly totals shown against estimated monthly reduction goals.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; Carrier/Intermediary; DME MAC.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	<i>4.10.5</i>
32.	<i>Carrier/Intermediary Staffing Report.</i>	<i>A report of Carrier/Intermediary staffing levels by function with any changes and reasons for changes.</i>	<i>To allow CMS to monitor staff attrition of the Carrier/Intermediary and take any necessary actions based on staff losses.</i>	<i>Weekly.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; Carrier/Intermediary; MAC.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	<i>4.10.7</i>
33.	<i>Asset Inventory.</i>	<i>A list of Carrier/Intermediary assets acquired to perform Medicare functions.</i>	<i>To inventory assets for the purpose of determining disposition so that the financial closeout of the Medicare contract can be accomplished. Assets may be kept, offered to the MAC, sold, or destroyed.</i>	<i>As soon as possible after notice of termination.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; Carrier/Intermediary; MAC.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	<i>5.6 4.10.8</i>

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
34.	<i>Cutover Plan.</i>	<i>Day-by-day check-list of activities that need to be accomplished during the cutover period.</i>	<i>To assure that all tasks required for the transfer of Medicare files, records, equipment, etc., from the outgoing contractor are captured and tracked.</i>	<i>Submitted at least 30 days prior to the proposed cutover period start date.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/ Intermediary; EDC; PSC; QIC; BCBSA ; etc.</i>	<i>MAC Project Manager.</i>	7.2
35.	<i>Cutover Plan Update.</i>	<i>Updates to the cutover plan reflecting tasks completed.</i>	<i>To provide an up-to-date status of tasks required for cutover.</i>	<i>Daily during the cutover period.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/ Intermediary; EDC; PSC; QIC; BCBSA; etc.</i>	<i>MAC Project Manager.</i>	7.2
36.	<i>Cutover Meeting.</i>	<i>Status meeting generally one-half to one hour in length.</i>	<i>To review the Cutover Plan and progress of activities, including action items, concerns, risks, and contingencies.</i>	<i>Daily beginning 7-10 days before cutover and continuing at least one week after cutover.</i>	<i>Telecon-ference.</i>	<i>CMS; MAC; Carrier/ Intermediary; EDC; PSC; QIC; BCBSA; etc.</i>	<i>MAC Project Manager.</i>	7.4
37.	<i>Cutover Meeting Documentation.</i>	<i>Brief synopsis of attendees, discussion items, and action items.</i>	<i>To document cutover meeting conference calls.</i>	<i>Prior to next daily meeting.</i>	<i>Memo via electronic mail.</i>	<i>All attendees of the Cutover meeting.</i>	<i>MAC Project Manager.</i>	7.4
38.	<i>File Inventory.</i>	<i>An inventory of all files to be transferred to the MAC with a description and location.</i>	<i>Used for CMS review and to develop the file transfer plan.</i>	<i>Prior to the start of the Cutover period.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; Carrier/Inter- mediary; MAC.</i>	<i>Carrier/Inter- mediary Close-out Project Manager.</i>	7.6.1 4.10.9
39.	<i>File Transfer Plan.</i>	<i>Description of Medicare files and records to be transferred by type, how and where they will be moved, and schedule.</i>	<i>To provide the logistics for actual transfer of files and to assist CMS in monitoring file preparations and the relocation of files.</i>	<i>Must be sub- mitted to CMS at the start of the Cutover period.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; Carrier/Inter- mediary; MAC.</i>	<i>Joint respon- sibility: MAC Project Man- ager and Carrier/Inter- mediary Close-out Project Manager.</i>	7.6 4.10.10

Exhibits

No.	Activity	Description	Purpose	Frequency	Media	Audience	Responsibility	Ref.
40.	<i>Post-Cutover Activities and Resources.</i>	<i>A document listing the functions to be performed after contract end, resources, schedule and estimated level of effort.</i>	<i>To provide CMS with an estimate of resources to perform Carrier/Intermediary contract wrap-up activities.</i>	<i>One-time due at the beginning of the Cutover period.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; Carrier/ Intermediary.</i>	<i>Carrier/Intermediary Close-out Project Manager.</i>	<i>4.10.11</i>
41.	<i>Post Project Review (Lessons Learned).</i>	<i>A discussion of transition successes and areas that could be improved.</i>	<i>To document lessons learned and improvements to the transition process. A compilation of lessons learned from all parties involved in the transition will be used as the basis for the Post-Project Review Meeting.</i>	<i>One-time. Due 4-6 weeks after cutover. The MAC will compile lessons learned from other involved parties into a single document and distribute 1 week prior to the Post-Project Review Meeting.</i>	<i>Distributed by electronic mail.</i>	<i>CMS; MAC; Carrier/ Intermediary; EDC; PSC; QIC; BCBSA; etc.</i>	<i>MAC Project Manager with input from project leads of all parties involved in the transition.</i>	<i>7.9.4</i>
42.	<i>Post-Project Review Meeting (Lessons Learned).</i>	<i>2-3 hour meeting.</i>	<i>To discuss transition practices that worked well and areas for improvement for future transitions.</i>	<i>One-time. Approximately 4- 6 weeks following cutover.</i>	<i>Teleconference or possible face-to-face meeting.</i>	<i>CMS; DME MAC; Carrier/Intermediary; EDC; PSC; QIC; BCBSA, etc.</i>	<i>MAC Project Manager.</i>	<i>7.9.5</i>

Exhibit 8 Sample Workload Report (Cont.)

CMS Weekly Report

Week Ending (Saturday)	Claims Workload Report (1566 Workload Report 308)					
	Claims Open Pending	Claims Received	Total Processed	Pending End of Week	Pending over 30 days	Pending over 60 days
	24,310	42,700	42,834	23,384	2,722	1,614
	23,384	42,908	44,206	21,245	1,653	996
	21,245	37,804	34,163	24,423	4,130	1,553
	24,423	45,223	46,249	22,613	2,837	1,293
	22,613	45,085	45,782	21,188	2,009	1,084
	21,188	43,465	42,737	21,454	1,500	908
	21,454	42,467	41,851	21,339	8,353	1,329
	21,339	38,226	31,667	27,600	3,339	1,252
	27,600	42,846	34,675	35,310	2,292	1,092
	35,310	43,212	55,067	22,501	1,261	477
	22,501	43,401	44,407	20,762	1,013	381
	20,762	42,174	42,204	20,084	2,736	871
	20,084	45,595	45,335	19,948	1,915	807
	19,948	40,551	41,571	18,312	1,495	675
	18,312	41,639	40,447	18,812	967	498
	18,812	40,742	41,049	18,096	3,187	771

Exhibit 8 Sample Workload Report (Cont.)

CMS Weekly Report

Week Ending (Saturday)	MSP Workload			
	Total Pending Cases	Cases Received	Cases Closed	Ending Cases
	11,757	133	-163	11,727
	11,727	127	-100	11,754
	11,754	162	-217	11,699
	11,699	147	-182	11,664
	11,664	150	-235	11,579
	11,579	126	-62	11,643
	11,643	106	-160	11,589
	Report unavailable this week			
	11,589	129	-211	11,507
	11,507	76	-89	11,494
	11,494	117	-192	11,419
	11,419	85	-249	11,255
	11,255	225	-260	11,220
	11,220	319	-226	11,313
	11,313	131	-229	11,215
	11,215	88	-112	11,191

Exhibit 8 Sample Workload Report (Cont.)

CMS Weekly Report

CMS Weekly Report

Week Ending (Saturday)	Appeals Workload Report										Medical Review Report									
	Appeals Received	Appeals Completed	Appeals Reviews Pending	Appeals Over 45 Days	Part B FH Rec'd	Part B FH Completed	Part B FH Pending	Part B ALJ Rec'd	Part B ALJ Completed	Part B ALJ Pending	Part A Recon Rec'd	Part A Recon Completed	Part A Recon Pending	Part A ALJ Rec'd	Part A ALJ Completed	Part A ALJ Pending	FTE's Working Appeals	Lab Appeals Received	Regular Appeals Received	Appeals Rec'd No Records
	101	124	236	66													3	64	37	12
	4	172	71	6													3	0	4	1
	32	24	102	0	0	1	8	0	0	35	1	1	5	0	0	5	3	Note: No longer reporting these items		
	39	39	102	0	0	1	7	0	1	34	0	1	4	0	0	5	3			
	37	27	112	0	1	0	8	0	0	34	0	0	4	0	0	5	2.5			
	36	22	126	0	1	0	9	0	0	34	0	2	2	0	0	5	2.5			
	37	14	149	0	0	0	9	0	0	34	2	0	4	0	0	5	2.5			
	23	77	95	0	8	5	12	1	0	35	1	2	3	0	0	5	2.5			
	15	53	57	0	1	0	13	0	1	34	1	1	3	0	0	5	2.5			
	41	30	68	0	2	0	15	1	5	30	0	1	2	0	0	5	2.5			
	50	0	118	0	0	0	15	0	0	30	0	0	2	0	0	5	0.5			
	37	30	125	0	10	2	23	0	2	28	0	0	2	0	0	5	2.0			
	45	30	136	0	0	1	22	0	1	27	0	1	1	0	0	5	2.5			
	18	56	98	0	6	9	15	0	0	27	0	0	1	0	0	5	Note: No longer reporting these items			
	24	32	90	0	5	0	20	0	0	27	2	0	3	0	1	4				

Exhibit 9 Sample Staffing Report

Medicare Contractor Staffing Changes:
Date: Week Ending

	1st week	2nd week	3rd week	4th week
	Head Count	Head Count	Head Count	Head Count
Claims/EDI				
Staffing Level				
Permanent	15	15	15	0
Temp/Contractor				0
Customer Service				
Staffing Level				
Permanent	10	9	9	0
Temp/Contractor	0	4	5	0
Provider Communication				
Staffing Level				
Permanent	1	1	1	0
Temp/Contractor				0
Medical Review				
Staffing Level				
Permanent	8	8	8	0
Temp/Contractor				0
Medical Appeals				
Staffing Level				
Permanent	2	2	1	0
Temp/Contractor				0
MSP				
Staffing Level				
Permanent	17	17	17	0
Temp/Contractor	1	1	2	0
Audit				
Staffing Level				
Permanent	18	18	17	0
Temp/Contractor	1	1	1	0
Reimbursement				
Staffing Level				
Permanent	9	9	9	0
Temp/Contractor				0
Provider Enrollment				
Staffing Level				
Permanent	1	1	1	0
Temp/Contractor				0
Administration				
Staffing Level				
Permanent	10	10	10	0
Temp/Contractor				
TOTAL				
Staffing Level	93	96	96	0

Comments
Date Comment/Explanation

Exhibit 10 Glossary

Closeout: The period of time from the MAC's contract award to the end of the outgoing contractor's Medicare business operations during which the carrier/intermediary carries out its plan to close operations and transfer Medicare functions to the MAC.

Cutover: The actual point at which the outgoing Medicare carrier/intermediary ceases Medicare operations and the MAC begins to perform Medicare business functions.

Cutover Period: The period of time surrounding the actual cutover. The cutover period normally begins 10-14 days prior to the cutover and ends with the MAC's segment operational date; i.e., when the MAC begins normal business operations for the segment workload that it assumed at cutover. During the cutover period the outgoing contractor makes final preparations to shut down its operation and transfer its claims workload and administrative activities to the MAC. Correspondingly, the MAC makes final preparations for the receipt and utilization of Medicare files, data, and acquired assets.

Dark Day: A business day during the cutover period when the Medicare claims processing system is not available for normal business operations. System dark days may occur between the time the outgoing contractor ends its regular claims processing activities and the MAC begins its first day of normal business operations for the segment.

Deliverable: Information and documents that are requested from the outgoing contractor or other parties involved in a transition as part of the MAC's due diligence.

Implementation: The period of time beginning with the award of the MAC contract and ending with the segment operational date of the MAC. During this period, the MAC performs all of the activities specified in its implementation plan to ensure the effective transfer of Medicare functions from the outgoing carrier or intermediary.

Jurisdiction: The territory in which the Medicare Administrative Contractor will contractually perform its Medicare functions.

Legacy Contractor: A Medicare Part A fiscal intermediary or a Part B carrier.

Medicare Administrative Contractor (MAC): The incoming contractor that will assume the Medicare Part A and B functions from a carrier or fiscal intermediary.

Medicare Claims Processor: A Part A fiscal intermediary, Part B carrier, or Medicare Administrative Contractor.

Medicare Data: Any representation of information, in electronic or physical form, pertaining to Medicare beneficiaries, providers, physicians, or suppliers, or necessary for the contractual administration thereof, that is received, maintained, processed,

Exhibit 10 Glossary (Cont.)

manipulated, stored, or provided to others in the performance of functions described in a Medicare contract.

Medicare Record: A collection of related items of Medicare data treated as a unit.

Medicare File: A set or collection of related Medicare records treated as a unit.

Operational Date: The date that the MAC assumes all Medicare functions from an outgoing Medicare carrier or fiscal intermediary and is capable of processing Medicare claims.

Outgoing Contractor: The Medicare carrier or fiscal intermediary whose functions will be assumed by the MAC.

Post-Operational Period: A six month period of time beginning with the end of the outgoing carrier or intermediary's Medicare operations. During this time, the outgoing contractor maintains the Federal Health Insurance Benefits account, completes financial reporting, and performs related closeout business activities.

Provider: An organization or individual who is providing a Medicare service; i.e., an institutional provider, physician, non-physician practitioner, or supplier.

Segment: The Medicare Part A or Part B workload which a carrier or intermediary processes and which will be transferred to the MAC. There may be multiple Part A/Part B workloads in one segment.

Segment Operational Date: The date that the MAC assumes all Medicare functions from an outgoing Medicare carrier or fiscal intermediary.

Transition: The entire scope of activities associated with moving the functions of Medicare fee-for-service carriers and intermediaries to the Medicare Administrative Contractors. It includes implementation activities of the MAC, closeout activities of the outgoing contractor, and the activities of other parties involved in the transition.

Transition Monitoring: A responsibility of CMS to ensure that Medicare functions are properly transferred from each outgoing Medicare carrier or fiscal intermediary to the MAC. Transition monitoring begins with the award of the MAC contract and generally ends three months after the MAC's segment operational date.

Exhibit 11

Acronyms

ASCR	Audit Selection Criteria Report
ASPEN	Automated Survey Processing Environment
ACD	Automated Call Distributor
ACH	Automated Clearing House
AdQIC	Administrative Qualified Independent Contractor
ART	Analysis, Reporting, and Tracking System
BCBSA	Blue Cross and Blue Shield Association
BCC	Beneficiary Contact Center
BESS	Part B Extract and Summary System
BFE	Business Function Expert
BFL	Business Function Lead
CAFM	Contractor Administrative Budget and Financial Management
CAT	Contract Administration Team
CERT	Comprehensive Error Rate Testing
CICS	Customer Interface Communications System
CMIS	Contractor Management Information System
CMM	Center for Medicare Management
CMS	Centers for Medicare and Medicaid Services
CNI	Chickasaw Nation Industries
CO	Central Office
CO	Contracting Officer
COB	Coordination of Benefits
COBA	Coordination of Benefits Administrator
COBC	Coordination of Benefits Contractor
COI	Conflict of Interest
COTS	Commercial Off-the-Shelf
CPE	Contractor Performance Evaluation
CR	Change Request
CROWD	Contractor Reporting of Operational and Workload Data
CRSL	Cost Report Settlement Log
CSAMS	Customer Service Assessment and Management System
CSR	Customer Service Representative
CTA	Cooperative Transition Agreement
CWF	Common Working File
DASD	Data Access Storage Device
DCN	Document Control Number
DCS	Delinquent Debt Collection System
DDE	Direct Data Entry
DNF	Do Not Forward
DHHS	Department of Health and Human Services
DMERC	Durable Medical Equipment Regional Carrier
DNF	Do Not Forward
ECRS	Electronic Correspondence Referral System

Exhibit 11
Acronyms (Cont.)

EDC	Enterprise Data Center
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EMC	Electronic Media Claims
ERA	Electronic Remittance Advice
ERN	Electronic Remittance Notice
FACP	Final Administrative Cost Proposal
FAQ	Frequently Asked Question
FAR	Federal Acquisition Regulations
FFS	Fee-for-Service
FI	Fiscal Intermediary
FOIA	Freedom of Information Act
FISS	Fiscal Intermediary Standard System
FQHC	Federally Qualified Health Clinic
GAO	Government Accountability Office
GFE	Government Furnished Equipment
GFP	Government Furnished Property
GTL	Government Task Leader
HHH	Home Health and Hospice
HGTS	Harkin Grantee Tracking System
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act
IACS	Individuals Authorized to Access CMS Systems
IBPR	Intermediary Benefit Payment Report
ICOR	Interactive Correspondence Online Reporting
IDIQ	Indefinite Delivery/Indefinite Quantity
IER	Interim Expenditure Report
IOM	Internet Only Manual
ISO	International Organization for Standardization
IT	Information Technology
IVR	Interactive Voice Response
JIL	Jurisdiction Implementation Lead
JIPP	Jurisdiction Implementation Project Plan
JOA	Joint Operating Agreement
JOSD	Jurisdiction Operational Start Date
JSM/TDL	Joint Signature Memorandum/Technical Direction Letter
LAN	Local Area Network
LCD	Local Coverage Determination
LOLA	Limited On Line Access
MAC	Medicare Administrative Contractor
MCMG	Medicare Contractor Management Group
MCR	Medicare Contracting Reform
MCS	Multi-Carrier System

Exhibit 11 Acronyms (Cont.)

MDCN	Medicare Data Communications Network
MED	Medicare Exclusion Database
MISC	Medicare Implementation Support Contractor
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MOU	Memorandum of Understanding
MPaRTS	Mistaken Payment Recovery Tracking System
MR	Medical Review
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
NARA	National Archive and Record Administration
NGD	Next Generation Desktop
NIH	National Institutes of Health
NOBA	Notice of Budget Authorization
OAGM	Office of Acquisition and Grants Management
ODIE	Online Data Input and Edit
OFM	Office of Financial Management
OIS	Office of Information Services
OIG	Office of the Inspector General
OSCAR	Online Survey Certification and Reporting System
PECOS	Provider Enrollment, Chain and Ownership System
PI	Program Integrity
PIES	Provider Inquiry Evaluation System
PIMR	Program Integrity Medical Review
PO	Project Officer
POC	Point of Contact
POR	Provider Overpayment Reporting
PSC	Program Safeguard Contractor
PSOR	Physician and Supplier Overpayment Report
PTS	Provider Tracking System
QASP	Quality Assurance Surveillance Plan
QCM	Quality Call Monitoring
QWCM	Quality Written Correspondence Monitoring
QIO	Quality Improvement Organization
QIC	Qualified Independent Contractor
RAC	Recovery Audit Contractor
RACF	Resource Access Control Facility
RCP	Report of Contractor Performance
ReMAS	Recovery Management and Accounting System
RFC	Request for Contract
RFP	Request for Proposals
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RO	Regional Office

Exhibit 11
Acronyms (Cont.)

SADBUS	Small and Disadvantaged Business
SAS 70	Statement on Auditing Standard, Number 70
SBR	Supplemental Budget Request
SIPP	Segment Implementation Project Plan
SMART	System for MSP Automated Recovery and Tracking
SOSD	Segment Operational Start Date
SOW	Statement of Work
SSA	Social Security Administration
SSM	Shared System Maintainer
SIM	Segment Implementation Manager
STAR	System Tracking Audit and Reimbursement System
STC	Single Testing Contractor
TM	Technical Monitor
UAT	User Acceptance Testing
VMS	ViPS Medicare System
WAN	Wide Area Network
WBS	Work Breakdown Structure
WIC	Western Integrity Center
ZPIC	Zone Program Integrity Contractor (PSC)

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