9/11 HEALTH WATCH
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Dr. Mandy Cohen, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

March 20, 2024

Dear Dr. Cohen,

On behalf of the Board of Directors of *9/11 Health Watch, Inc.*, I am again writing to you regarding the Center for Disease Control (CDC) Contract Office and their administration of contracts for the World Trade Center Health Program; this time regarding the administration of the program's Third-Party Administrator Contract (TPA).

As you may know, the CDC contract office issued a solicitation for Third Party Administrator Services for the World Trade Center Health Program on December 3, 2021, and made an award under that solicitation to a firm called Cahaba Safeguard Administrators LLC (Cahaba).

Given the history of this solicitation, the resulting award, the subsequent bid protest, cancellation, and litigation resulting in the current contract holder being left in place during a bridge contract, it would be safe to say that the CDC Contract Office performance in this solicitation and award was inadequate.

While the problems with this solicitation and subsequent award were discovered before it impacted the Members of the World Trade Center Health Program, we have many of the same concerns regarding any new solicitation for a TPA for the program by the CDC contract office as we do with any solicitation for under the National Provider Network (NPN) as we detailed in our letter of February 6, 2024.

While we would have thought that a new solicitation for this contract would have been issued by the contract office by now, we want to make some specific recommendations of what should be in any future TPA solicitation:

1. Termination Provision. First and foremost, as with the Sedgwick's contract for the NPN, we would expect that any future TPA contract provides that the contract can not only be terminated for nonperformance, but that the vendor would be required to continue to perform until another vendor is obtained. As with the NPN contract, any TPA contract should have a provision that if an option to terminate is exercised, the contractor must continue to provide services until another contractor takes over.

2. Financial Penalties. Any future contract needs the means to enforce the contract short of full termination. It is our understanding that contracts issued by the Veterans Administration for similar services contain financial disincentives and incentives whereby failure to adequately perform the contract results in penalties, and conversely better-than-minimum performance merits rewards. These penalties need to be significant enough that they would impact any future TPA vendor who is not meeting contract performance requirements. Currently the CDC has few, if any tools, to hold a contractor accountable. This must change.

3. Performance Statistics. Any future contract should require the periodic public release of contract performance statistics. The current contracts drafted by the contract office preclude the public release of contract performance statistics by vendors, hiding the details of their performance or nonperformance from the public. We are told by the CDC contract office that this is to protect the contractor and is meant to ensure "fairness" to the contractor, but there is no consideration of the impact to WTC Health Program members due to this lack of transparency.

4. Management of the Provider Network: It was understood years ago that the TPA would be responsible for vetting and enrolling providers, managing their contracts, onboarding, and providing continuous education on the WTC Health Program policies and procedures and maintaining a useable codebook that could be accessed by the CCEs and providers. Meanwhile, the CCE's have worked very closely with providers and have developed referral pathways as well as contacts over the course of the years. It is important that

CCE's can inform TPA of a clinical need for specific provider due to the following (1) a geographic need, (2) expertise in specific specialty, (3) continuity of care or (4) when requested by a patient for one of the aforementioned reasons. The CCE's have never been and should not be responsible for vetting providers for good standing, with their presentation of provider to TPA being based on medical/patient need only. Clarification of the roles and responsibilities for the TPA vs the CCE's is crucial, with the TPA taking clear ownership of management of the network while effectively responding to inquiries and requests from the patients via the CCE.

5. Need for Provider Portal for Members. The Providers in the TPA network are not publicly available to the members so that WTC Health Program members can see for themselves if their providers are in network prior to choosing a provider.
   Because the list is not available to the members, they are not able to know for certain whether a provider is or is not in the network unless they call and consult the CCE. If they choose an out-of-network provider, it is not often discovered until the claim is denied. At that point, the enrollment of the new provider becomes unnecessarily urgent, and problematic, if the provider chooses not to join the network. Some CCEs with large geographic regions may experience this problem more often, because members need accessibility to where they live rather than accessing a centralized hospital system.

6. Managing the Codebook: The codebook should be proactively updated and not rely so heavily on CCEs to request standard medical codes to be added after services have been received. An example is chemotherapy drugs that are administered at infusion centers. There should be a better system for adding new drugs once they are approved or including groups of new codes rather than adding one specific code at a time. What happens is the CCE requests changes so a claim can be paid, which is at the very end of the process, and it causes unnecessary work and delays. The onus should be on the TPA to proactively update the codebook while allowing CCEs to request additions for those unforeseen services.

7. Managing the Claims Process: The existing claims processing procedure is complex and involves many moving parts. A tumultuous change in the TPA could negatively impact provider participation if the changes or transition

results in payment delays. Such a negative outcome could have a devastating impact on patient care by limiting the providers willing to accept WTC program coverage. Many of the CCEs have developed an efficient low-cost claims process which has proven efficacy in that less than 2% of claims submitted by the CCEs are denied by the TPA; therefore, it is crucial that any future TPA is able to adapt to the individual needs of the CCE's. Existing resources such as the provider portal should be customizable and expanded upon, with more tools being offered to the program to facilitate the claims review process. The TPA should accurately identify standard claim edits and check for eligibility. Opportunities for the TPA to further support the CCE through additional standardized edits or reviews should also be explored, as this would enable the CCE's to work more efficiently on performing claims reviews. An assessment of CCE needs should be included as part of the research for the new TPA solicitation. Any change should transition of the TPA vendor should have a significant transition timeline.

8. Consulting with Clinics. Before the TPA solicitation, the CDC contract office consulted with the CCEs for ways to improve the delivery of services to the members; however, due to the delay in awarding a new contract, it is not known if these above issues were addressed in the new solicitation. At this point, everything has remained static while we wait for the new contractor to be put in place. We would urge that before any new solicitation that there be another round of consultation with the clinics.

These are just some of the many issues that should be addressed in any future contract.

Given the difficulties that the CDC contract office has experienced with this contract we assume that planning is beginning for the next contract RFP. We expect that steps will be taken to learn from the extensive problems the CDC staff has had with the previous RFP and that future contracts for the TPA will be better drafted and include the provisions outlined above.

We would appreciate a reply from your office and/or the CDC Contracting Office in charge of oversight and the development of the RFP for the next TPA contract.

Thank you for your attention to this matter.

Sincerely,

Benjamin Chevat
Executive Director