AWARD/CONTRACT

1. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 350) | RATIN | PAGE OF PAGES: 1 | 72

2. CONTRACT (Proc. Inst. Ident.) NO.: HHSM-500-2007-M0001Z

3. EFFECTIVE DATE: 08/06/2007

4. REQUISITION/PURCHASE REQUEST/PROJECT NO.: 767-7-750701

5. ISSUED BY | CODE: DMC

CMS, OAGM, MCG, DMC
7500 SECURITY BLVD., MS: C2-21-15
BALTIMORE MD 21244-1850

6. ADMINISTERED BY (If other than Item 5) | CODE: AGG/BE

Barbara Erbe
Contract Specialist
(410) 786-5142

7. NAME AND ADDRESS OF CONTRACTOR (No., Street, City, Country, State and ZIP Code)

TrailBlazer Health Enterprises, LLC
Executive Center III
8330 LBJ Freeway
Dallas TX 75243

Attn: Marti Mahaffey

CODE 4693724902 | FACILITY CODE

8. DELIVERY
[ ] FOB ORIGIN [X] OTHER (See below)

9. DISCOUNT FOR PROMPT PAYMENT
Net 30

10. SUBMIT INVOICES (4 copies unless otherwise specified) TO THE ADDRESS SHOWN IN | ITEM

11. SHIP TO/MARK FOR | CODE: N/A

Not Applicable

12. PAYMENT WILL BE MADE BY | CODE: ACCT

DHHS, CMS, OFM, FSG
Div. of Financial Operations,
P.O. Box 7520
Baltimore MD 21207-0520

13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION:
[ ] 10 U.S.C. 2304 (c) ( ) [ ] 41 U.S.C. 253 (c) ( )

14. ACCOUNTING AND APPROPRIATION DATA
75998723-757/80511-252Z

15A. ITEM NO	15B. SUPPLIES/SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
	Continued				

15G. TOTAL AMOUNT OF CONTRACT: $2,453,483.00

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CONTRACTING OFFICER WILL COMPLETE ITEM 17 OR 18 AS APPLICABLE

17. [X] CONTRACTOR'S NEGOTIATED AGREEMENT (*Contractor is required to sign this document and return* 2 *copies to issuing office.*) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. *(Attachments are listed herein.)*

18. [ ] AWARD (*Contractor is not required to sign this document.*) Your offer on Solicitation Number _____, including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any condition sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.

19A. NAME AND TITLE OF SIGNER (*Type or print*)
MARTHA P. MAHAFFEY

20A. NAME OF CONTRACTING OFFICER
DARRELL BACHMAN

19B. NAME OF CONTRACTOR
BY _____
(Signature of person authorized to sign)

19C. DATE SIGNED: 8/2/07

20B. UNITED STATES OF AMERICA
BY _____
(Signature of the Contracting Officer)

20C. DATE SIGNED: 8/2/07

NSN 7540-01-152-8069
PREVIOUS EDITION IS UNUSABLE

STANDARD FORM 26 (Rev. 4-85)
Prescribed by GSA
FAR (48 CFR) 53.214(a)

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SECTION I - CONTRACT CLAUSES

SECTION J - LIST OF ATTACHMENTS

SECTION B – SUPPLIES OR SERVICES AND PRICES/COSTS

B.1 BRIEF DESCRIPTION OF SERVICES

The purpose of this contract is to obtain a Medicare Administrative Contractor (hereinafter referred to as "the contractor" or "MAC") to provide specified health insurance benefit administration services, including Medicare claims processing and payment services, in support of the Medicare program (also known as the Medicare fee-for-service, or FFS, program) for Jurisdiction 4. Jurisdiction 4 consists of the following states: Colorado, New Mexico, Oklahoma, and Texas.

B.2 TYPE OF CONTRACT

This is a Cost-Plus Award Fee (CPAF) contract.

B.3 AWARD FEE

The amount of award fee the Contractor earns, if any, will be based on an evaluation by the Government of the contractor's performance in accordance with the Performance Evaluation Award Fee Plan (see Attachment J-18). The CMS Fee Determination Official (FDO) will determine the amount of award fee earned by the contractor for the evaluation period. This determination of the award fee amount for the evaluation period is a unilateral decision made solely at the discretion of the FDO. Upon receiving written notification from the FDO of the amount of award fee earned for the evaluation period, the Contractor may submit an invoice for the earned award fee. The Government may unilaterally change the Performance Evaluation Plan at any time. However, any revisions to the evaluation criteria in the Performance Evaluation Plan shall be presented to the Contractor prior to the evaluation period in which it will be used. The award fee evaluations will be performed on a annual basis with the actual evaluation taking place in the month immediately following the evaluation period. The award fee amount available for each period shall be a portion of the total award fee pool available for the entire contract period (See Section G.23).

Period	Award	NTE	Period of Performance
CLIN 0001	(b)(4)		August 6, 2007 – August 5, 2008
CLIN 0002			February 1, 2008 – August 5, 2008
CLIN 0003			August 6, 2008 – August 5, 2009
CLIN 0004			August 6, 2009 – August 5, 2010
CLIN 0005			August 6, 2010 – August 5, 2011
CLIN 0006			August 6, 2011 – August 5, 2012
CLIN 0007			March 6, 2012 - August 5, 2012

B.4 ESTABLISHED COST AND AWARD FEE

The estimated cost of this contract is (b)(4). The base fee is (b)(4) The maximum available award fee is (b)(4) Total cost plus base fee and award fee is $2,453,483.

B.5 TASK DIRECTIVES

The Contracting Officer may use individual Task Directives with specifically defined scopes and schedules to direct the contractor to perform special projects. Task Directives may also be issued to request a special administrative or user support services project. This mechanism will be used on a project-by-project basis and will be incorporated into the contract through the Changes clause (FAR 52.243-2).

Task Directives issued under this contract may be fixed price or cost reimbursement. The contractor is required to establish separate cost accounts for each Task Directive issued and to segregate those costs on their vouchers.

B.6 SCHEDULE OF SUPPLIES/SERVICES:

CONTRACT LINE ITEM NUMBER	ESTIMATED COST	BASE FEE (3%)	AWARD FEE (2%)	TOTAL COST NTE	EST. COMP CREDITS*
CLIN 0001 IMPLEMENTATION August 6, 2007 – August 5, 2008	(b)(4)				**$0**
CLIN 0002 – A/B MAC SERVICES/BASE YEAR OPERATIONS OPTION February 1, 2008 – August 5, 2008					
0002AA Part A/Program Management	(b)(4)				$634,270
0002AB Part A/Medicare Integrity Program					$0
0002AC Part B/Program Management					$10,160,624
0002AD Part B/Medicare Integrity Program					$0
0002AE VA Medicare Project Part A					$0
0002AF VA Medicare Project Part B					$0
TOTAL CLIN 0002 – A/B MAC SERVICES/BASE YEAR OPERATIONS OPTION					**$10,794,894**

CONTRACT LINE ITEM NUMBER	ESTIMATED COST	BASE FEE (3%)	AWARD FEE (2%)	TOTAL COST NTE	EST. COMP CREDITS*
CLIN 0003 – A/B MAC SERVICES/OPTION YEAR 1 August 6, 2008 – August 5, 2009					
0003AA Part A/Program Management	(b)(4)				$1,311,663
0003AB Part A/Medicare Integrity Program					$0
0003AC Part B/Program Management					$20,991,848
0003AD Part B/Medicare Integrity Program					$0
0003AE VA Medicare Project Part A					$0
0003AF VA Medicare Project Part B					$0
TOTAL CLIN 0003 – A/B MAC SERVICES/OPTION YEAR 1					**$22,303,511**

CONTRACT LINE ITEM NUMBER	ESTIMATED COST	BASE FEE (3%)	AWARD FEE (2%)	TOTAL COST NTE	EST. COMP CREDITS*
CLIN 0004 – A/B MAC SERVICES/OPTION YEAR 2 August 6, 2009 – August 5, 2010					
0004AA Part A/Program Management	(b)(4)				$1,386,245
0004AB Part A/Medicare Integrity Program					$0
0004AC Part B/Program Management					$22,456,127
0004AD Part B/Medicare Integrity Program					$0
0004AE VA Medicare Project Part A					$0
0004AF VA Medicare Project Part B					$0
TOTAL CLIN 0004 – A/B MAC SERVICES/OPTION YEAR 2					**$23,842,372**

CONTRACT LINE ITEM NUMBER	ESTIMATED COST	BASE FEE (3%)	AWARD FEE (2%)	TOTAL COST NTE	EST. COMP CREDITS*
CLIN 0005 – A/B MAC SERVICES/OPTION YEAR 3 August 6, 2010 – August 5, 2011					
0005AA Part A/Program Management	(b)(4)				$1,476,445
0005AB Part A/Medicare Integrity Program					$0
0005AC Part B/Program Management					$24,161,981
0005AC Part B/Medicare Integrity Program					$0
0005AE VA Medicare Project Part A					$0
0005AF VA Medicare Project Part B					$0
TOTAL CLIN 0005 – A/B MAC SERVICES/OPTION YEAR 3					**$25,638,426**

CONTRACT LINE ITEM NUMBER	ESTIMATED COST	BASE FEE (3%)	AWARD FEE (2%)	TOTAL COST NTE	EST. COMP CREDITS*
CLIN 0006 – A/B MAC SERVICES/OPTION YEAR 4 August 6, 2011 – August 5, 2012					
0006AA Part A/Program Management	(b)(4)				$1,575,264
0006AB Part A/Medicare Integrity Program					$0
0006AC Part B/Program Management					$26,085,961
0006AD Part B/Medicare Integrity Program					$0
0006AE VA Medicare Project Part A					$0
0006AF VA Medicare Project Part B					$0
TOTAL CLIN 0006 – A/B MAC SERVICES/OPTION YEAR 4					**$27,661,225**

CONTRACT LINE ITEM NUMBER	ESTIMATED COST	BASE FEE (3%)	AWARD FEE (2%)	TOTAL COST NTE	EST. COMP CREDITS*
CLIN 0007 **Workload Closeout Activities March 6, 2012 – August 5, 2012**	(b)(4)				**$0**

CONTRACT LINE ITEM NUMBER	ESTIMATED COST	BASE FEE (3%)	AWARD FEE (2%)	TOTAL COST NTE	EST. COMP CREDITS*
TOTAL MAC JURISDICTION 4 August 6, 2007 – August 5, 2012	(b)(4)			**$376,525,309**	**$110,240,428**

*Refer to Section G.19, Complimentary Credits.

Note: Facilities Capital Cost of Money was not proposed, therefore, it is not considered an allowable cost in accordance with HHSAR 315.404-4(d)(4).

SECTION C – DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

C.1 STATEMENT OF WORK

The Statement of Work dated July 31, 2007, is provided under Section J as Attachment J-1 and made a part of this contract.

C.2 INCORPORATION OF CONFLICT OF INTEREST CERTIFICATE

The Contractor's Conflict of Interest Certificate, submitted in response to the solicitation's Section H.4, dated June 22, 2007, is hereby incorporated and made a part hereof of this contract (Attachment J-22).

C.3 INCORPORATION OF REPRESENTATIONS AND CERTIFICATIONS

The Contractor has completed the annual representations and certifications electronically via the Online Representations and Certifications Application (ORCA) website at http://orca.bpn.gov. After reviewing the ORCA database information, the contractor verified by submission of their proposal that the representations and certifications currently posted electronically have been entered or updated within the last 12 months, are current, accurate, complete, and applicable to this contract (including the business size standard applicable to the NAICS code referenced for this contract), as of the date of this contract and are incorporated in this contract by reference.

SECTION D – PACKAGING AND MARKING

D.1 PACKAGING AND MARKING

All deliverables required under this contract must be shipped and marked in accordance with contract Section F. Deliverables and any other requirements are set forth herein.

SECTION E - INSPECTION AND ACCEPTANCE

E.1 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 98)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address: www.arnet.gov/far/

Federal Acquisition Regulation (FAR) Clauses:

52.246-5 INSPECTION OF SERVICES – COST REIMBURSEMENT (APR 84)

E.2 APPROVALS BY THE PROJECT OFFICER

All services or supplies to be delivered to the Project Officer will be deemed to have been accepted 30 calendar days after date of delivery, except as otherwise specified in this contract, if written approval or disapproval has not been given within such period. The Project Officer's approval or revision to the services or supplies delivered shall be within the general scope of work stated in this contract.

E.3 INSPECTION OF SERVICES – COST-REIMBURSEMENT

a. All work under this contract is subject to inspection and final acceptance by the Contracting Officer or the duly authorized representative of the Government.

b. The Government's Project Officer is a duly authorized representative of the Government and is responsible for inspection and acceptance of all items to be delivered under this contract.

c. Inspection and acceptance of the Contractor's performance shall be in accordance with FAR Clause 52.246-5 "Inspection of Services-Cost Reimbursement."

SECTION F - DELIVERIES OR PERFORMANCE

F.1 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 98)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address: www.arnet.gov/far/

Federal Acquisition Regulation (FAR) Clauses:

52.242-15 STOP WORK ORDER (AUG 89) - ALTERNATE I (APR 84)

F.2 PERIOD OF PERFORMANCE

The work and services required hereunder shall be completed as follows:

The base period of performance shall be 12 months. Performance beyond the base contract period may be authorized by the Government's right to unilaterally exercise the following option periods:

CLIN	DESCRIPTION	PERIOD OF PERFORMANCE
0001	Implementation	August 6, 2007 – August 5, 2008*
0002	Base Year Operations	February 1, 2008 – August 5, 2008*
0003	Option Year 1 Operations	August 6, 2008 – August 5, 2009
0004	Option Year 2 Operations	August 6, 2009 – August 5, 2010
0005	Option Year 3 Operations	August 6, 2010 – August 5, 2011
0006	Option Year 4 Operations	August 6, 2011 – August 5, 2012
0007	Workload Closeout Activities Option	March 6, 2012 – August 5, 2012**

*CLIN 0001 and CLIN 0002 shall be completed within 12 months after date of contract award.

**CLIN 0007 shall be exercised no later than 6 months prior to the expiration of the current year of performance.

Note: The option periods delineated above are subject to the option clause in Section I of this contract.

F.3 DELIVERABLES

a. A list of deliverables is provided under Section J, Attachment J-2, attached hereto and made part of this contract.

b. All deliverables required under this contract shall be packaged, marked and shipped in accordance with U.S. Government specifications. The Contractor shall guarantee that all required materials shall be delivered in immediate usable and acceptable condition.

c. The Contractor shall submit all required deliverables and reports in accordance with the attached schedule. Reports submitted under the contract shall reference and cite the contract number and identify CMS as the sponsoring agency.

d. Satisfactory performance under the contract shall be deemed to occur upon delivery and acceptance by the Contracting Officer, or the duly authorized representative, of the following items in accordance with the attached schedule J-2 (reports submitted under the contract shall reference and cite the contract number and identify CMS as the sponsoring agency):

The following abbreviations apply to schedule J-2:

IAW	In accordance with
NLT	Not later than
COB	Close of business
E	Electronic copy (e-mail or diskette)
H	Hard copy
CP	Cover page
PO	Project Officer
CS	Contract Specialist

Note: Additional deliverables may be assigned as part of the product planning process. Individual products may be released on a flow basis, as necessary by the direction of the Project Officer.

Addressees:

PROJECT OFFICER
Centers for Medicare & Medicaid Services
Attn: Virginia Adams, CMS/MCMG
Atlanta Federal Center Room 4T20
61 Forsyth Street, SW
Atlanta, GA 30303-8909
(404) 562-7250
Email: Virginia.Adams@cms.hhs.gov

CONTRACTING OFFICER
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Division of Medicare Contracts
Attn: Darrell Bachman, Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, MD 21244-1850
(410) 786-7442
Email: Darrell.Bachman@cms.hhs.gov

CONTRACT SPECIALIST
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Division of Medicare Contracts
Attn: BJ Erbe, Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, MD 21244-1850
(410) 786-5142
Email: Barbara.Erbe@cms.hhs.gov

All electronic files shall be submitted in a format that is compatible with Microsoft Office PC-based software. As this requirement is subject to change, the contractor shall be able to adapt to any new CMS standard in order to submit deliverables. Unless specifically denoted as "workday(s)," all timeframes are in calendar weeks, calendar months, etc. after the effective date of the contract.

SECTION G - CONTRACT ADMINISTRATION DATA

G.1 ACCOUNTING AND APPROPRIATION DATA

Requisition #	CAN	Appropriation	Object Class	Amount
767-7-750701	75998723	75 7/8 0511	252Z	(b)(4)

G.2 PAYMENT, SELECTED ITEMS OF COST REIMBURSEMENT CONTRACTS

1. Travel Costs (Including Foreign Travel)

The Contractor shall be reimbursed for travel costs in accordance with FAR 31.205-46.

2. Per Diem

Expenses for subsistence and lodging shall be reimbursed to the Contractor only to the extent where overnight stay is necessary for performance under this contract. Incurred costs shall be considered to be reasonable and allowable only to the extent that they do not exceed, on a daily basis, the maximum per diem rates in effect at the time of travel as set forth in the Federal Travel Regulations. See FAR 31.205-46(2).

3. Cost of Materials

The cost of materials furnished or used under this contract shall be reimbursed in accordance with paragraph (b) of the clause entitled "Allowable Cost and Payment (FAR 52.216-7)" for cost reimbursement contracts. Expendable material costs for items such as office supplies, report paper, etc., and tools of the trade shall be priced in accordance with the Contractor's approved accounting practices or standards, as applicable. The Contractor shall be required to support all material costs claimed.

4. Relocation Costs

In accordance with FAR 31.205-35, relocation costs, either direct charged or included in the contractor's indirect cost pools, associated with an individual not completing a term of service equal to one year working under this contract shall be an unallowable cost under this contract.

G.3 DISSEMINATION, PUBLICATION & DISTRIBUTION OF INFORMATION

(a) Data and information either provided to the Contractor, or to any subcontractor or generated by activities under this contract or derived from research or studies supported by this contract, shall be used only for the purposes of the contract. It shall not be duplicated, used or disclosed for any purpose other than the fulfillment of the requirements set forth in this contract. This restriction does not limit the contractor's right to use data or information obtained from a non-restrictive source. Any questions concerning "privileged information" shall be referred to the Contracting Officer.

(b) Some data or information may require special consideration with regard to the timing of its disclosure so that preliminary findings which could create erroneous conclusions, are not stipulated. Also, some data or information, which relate to policy matters under consideration by the Government, may also require special consideration with regard to the timing of its disclosure so that the open and vigorous debate, within the government, of possible policy options is not damaged.

(c) Any questions about use or release of the data or information or handling of material under this contract, shall be referred to the Contracting Officer who must render a written determination. The Contracting Officer's determinations will reflect the results of internal coordination with appropriate program and legal officials.

(d) Written advance notice of at least forty-five (45) days shall be provided to the Contracting Officer of the Contractor's desire to release findings of studies or research or data or information described above. If the Contractor disagrees with the Contracting Officer's determination, and if this disagreement cannot be settled by the Contractor and the Contracting Officer in a mutually satisfactory manner, then the issue will be settled pursuant to the "Disputes" clause.

(e) Any presentation of any report, statistical or analytical material based on information obtained from this contract shall be subject to review by the Project Officer before dissemination, publication, or distribution. Presentation includes, but is not limited to, papers, articles, professional publications, speeches, testimony or interviews with public print or broadcast media. This does not apply to information that is requested pursuant to the Federal Freedom of Information Act.

(f) The Project Officer review shall cover accuracy, content, manner of presentation of the information, and also the protection of the privacy of individuals. If the review finds that the Privacy Act is or may be violated, the release/use of the presentation shall be denied until the offending material is removed or until the Contracting Officer makes a formal determination, in writing, that the privacy of individuals is not being violated.

(g) If the review shows that the accuracy, content, or manner of presentation is not correct or is inappropriate in the light of the purpose of the project, the Project Officer shall immediately inform the Contractor, in writing, of the nature of the problem. If the Contractor disagrees, the Project Officer may insist that the presentation contain, in a manner of equal importance, materials, which show the government's problem with the presentation.

(h) The Contractor agrees to acknowledge support by CMS whenever reports of projects funded, in whole or in part, by this contract are published in any medium. The Contractor shall include in any publication resulting from work under this contract, an acknowledgment substantially, as follows:

"The analyses upon which this publication is based were performed under Contract Number _____, entitled, _____," Sponsored by the Centers for Medicare & Medicaid Services, Department of Health & Human Services."

Any deviation from the above legend shall be approved, in writing, by the Contracting Officer.

G.4 SUBCONTRACTING REPORTING

The Contractor shall report all subcontract awards to small, small disadvantaged, women-owned, HUBZones, veteran-owned and service-disabled veteran-owned small business concerns. The reports shall be prepared using the electronic Subcontracting Reporting System (eSRS) via the internet at http://www.esrs.gov. The Individual Subcontracting Report (ISR), formerly SF 294, shall be submitted semi-annually for the periods of October 1 through March 31 and April 1 through September 30. The Summary Subcontracting Report (SSR), formerly, SF 295 shall be submitted annually for the period of October 1 through September 30.

G.5 SUBCONTRACTING PROGRAM FOR SMALL AND SMALL DISADVANTAGED BUSINESSES

The contractor hereby agrees to implement the conditions of the subcontracting plan submitted and approved by the Contracting Officer for this contract. The Small Business and Small Disadvantaged Business Subcontracting Plan is hereby incorporated and made a part hereof as Attachment J-15 of this contract.

G.6 SUBCONTRACT CONSENT

(a) To facilitate the review of a proposed subcontract by the Project Officer and the Contracting Officer, the Contractor shall submit the information required by the FAR Clause 52.244-2 entitled, "SUBCONTRACTS" to the Contracting Officer. The Contracting Officer shall review the request for subcontract approval and the Project Officer's recommendation and advise the Contractor of his/her decision to consent to or dissent from the proposed subcontract, in writing.

(b) Consent is hereby given to issue the following subcontract(s):

N/A

G.7 SERVICE OF CONSULTANTS/SUBCONTRACTORS

a. For the purposes of this contract, consultants are considered subcontractors. The Contractor shall follow the procedures established in FAR Clause 52.244-2 entitled, "SUBCONTRACTS" to the Contracting Officer. Whenever Contracting Officer approval is required, the Contractor shall furnish to the Contracting Officer information concerning the need for such consultant services and the reasonableness of the fees to be paid to any consultants. The Contracting Officer shall review the request for consultants approval and the Project Officer's recommendation and advise the Contractor of his/her decision to consent to or dissent from the proposed consultant agreement, in writing.

b. For utilization of the services of any consultants under this contract, the contractor shall be reimbursed in accordance with the rate(s) set forth below.

Name	Rate Per Hour	Number Of Hours	Total Cost Not to Exceed

N/A

G.8 GOVERNMENT REPRESENTATIVES

The following CMS personnel are points of contact for this contract:

Title	Name	Phone Number	Email Address
Contracting Officer	Darrell Bachman	(410) 786-7442	Darrell.Bachman@cms.hhs.gov
Contract Specialist	BJ Erbe	(410) 786-5142	Barbara.Erbe@cms.hhs.gov
Project Officer	Virginia Adams	(404) 562-7250	Virgina.Adams@cms.hhs.gov
Alt. Project Officer	TBD		

G.9 CONTRACTING OFFICER RESPONSIBILITY

In accordance with FAR 52.201-1 Definitions, the term 'Contracting Officer' means a person with the authority to enter into, administer, and/or terminate contracts and make related determinations and findings. The term includes certain authorized representatives of the Contracting Officer acting within the limits of their authority delegated by the Contracting Officer.

Notwithstanding any of the other provisions of this Contract, the Contracting Officer shall be the ONLY individual authorized to:

a. Enter into and commit/bind the Government by contract for supplies or services;
b. Accept nonconforming work or waive any requirement of this Contract;
c. Authorize reimbursement to the Contractor for any costs incurred during the performance of the Contract, and
d. Modify any term or condition of this Contract, i.e., make any changes in the Statement of Work; modify/extend the period of performance; change the delivery schedule.

G.10 CONTRACTOR PROJECT MANAGER

Barbara Harvey will serve as Project Manager. It will be his/her responsibility to obtain the staff necessary and to direct the work for the conduct of this project. The Project Manager shall also keep the Government Project Officer and Business Function Leads (BFLs) up to date regarding all technical, cost and schedule-related issues. The Government reserves the right to approve any necessary successor to be designated as Project Manager.

G.11 PROJECT OFFICER

(a) The following Project Officer(s) will represent the Government for the purpose of this contract:

Virginia Adams

(b) The Project Officer is responsible for: (1) monitoring the Contractor's technical progress, including the surveillance and assessment of performance and compliance with all substantive project objectives; (2) interpreting the statement of work and any other technical performance requirements; (3) performing technical evaluation as required; (4) performing technical inspections and acceptances required by this contract; (5) assisting in the resolution of technical problems encountered during performance; (6) providing technical direction in accordance with Section G.12; and (7) reviewing of invoices/vouchers.

(c) The Project Officer does not have the authority to act as an agent of the Government under this contract. Only the Contracting Officer has the authority to: (1) direct or negotiate any changes in the statement of work; (2) modify or extend the period of performance; (3) change the delivery schedule; (4) authorize reimbursement to the Contractor any costs incurred during the performance of this contract; or (5) otherwise change any terms and conditions of this contract.

(d) The Government may unilaterally change its Project Officer designation.

(e) The Project Officer may be assisted by Business Function Leads (BFLs). The BFLs will not have the authority to provide technical direction in accordance with Section G.12, however, they may be responsible for: (1) monitoring the Contractor's technical progress, including the surveillance and assessment of performance and compliance with all substantive project objectives; (2) interpreting the statement of work and any other technical performance requirements; (3) performing technical evaluation as required; (4) performing technical inspections and acceptances required by this contract; (5) assisting in the resolution of technical problems encountered during performance; and (6)reviewing of invoices/vouchers.

(f) In the event that the Project Officer is not available, the alternate Project Officer is TBD. The Alternate Project Officer duties and responsibilities shall also be performed in accordance with G.11, Technical Direction.

G.12 TECHNICAL DIRECTION

(a) Performance of the work under this contract shall be subject to the technical direction of the Project Officer. The term "technical direction" is defined to include, without limitation, the following:

(1) Directions to the Contractor which redirect the contract effort, shift work emphasis between work areas or tasks, require pursuit of certain lines of inquiry, fill in details or otherwise serve to accomplish the contractual statement of work.

(2) Provision of information to the Contractor, which assists in the interpretation of drawings, specifications, or technical portions of the work description.

(3) Review and, where required by the contract, approval of technical reports, drawings, specifications, and technical information to be delivered by the Contractor to the Government under the contract.

(b) Technical direction must be within the general Scope of Work stated in the contract. The Project Officer does not have the authority to and may not issue any technical directions which:

(1) Constitutes an assignment of additional work outside the general Scope of Work of the contract.

(2) Constitutes a change as defined in the contract clause entitled "Changes - Cost Reimbursement."

(3) In any manner causes an increase or decrease in the total estimated contract cost, fixed-fee, or the time required for contract performance.

(4) Change any of the expressed terms, conditions, or specifications of the contract.

(c) All technical direction shall be issued in writing by the Project Officer or shall be confirmed by him/her in writing within five working days after issuance.

(d) The Contractor shall proceed promptly with the performance of technical direction duly issued by the Project Officer in the manner prescribed by this article and within his/her authority under the provisions of this article.

(e) If, in the opinion of the Contractor, any instruction or direction issued by the Project Officer is within one of the categories as defined in (l) through (4) above, the Contractor shall notify the Contracting Officer in accordance with FAR 52.243-7, Notification of Changes.

G.13 DESIGNATION OF PROPERTY ADMINISTRATOR

The CMS Property Administrator, Administrative Services Group, Office of Property and Space Management at (410) 786-6462, is hereby designated the property administration function for this contract. The Contractor agrees to furnish information regarding Government Property to the Property Administrator in the manner and to the extent required by the Property Administrator, his duly designated successors, and in accordance with FAR Part 45 and Department of Health & Human Services (DHHS) Manual entitled, Contractor's Guide for Control of Government Property, (1990). This manual may be accessed at http://knownet.hhs.gov/log/AgencyPolicy/HHSLogPolicy/contractorsguide.htm

G.14 GOVERNMENT FURNISHED PROPERTY

Pursuant to FAR Part 45 – Government Property and FAR clause 52.245-5, of this contract, the Government will furnish for performance of the work required herein a list of property, which is provided under Section J, Attachment J-16 and is hereby made part of this contract.

G.15 CONTRACTOR FURNISHED PROPERTY

A list of Contractor Furnished Property is incorporated as Attachment J-17.

G.16 INVOICING AND PAYMENT (See Attachment J-20 for Billing Instructions)

A. Submission of invoices for payment:

Once each month following the effective date of this contract, the Contractor may submit to the Government an invoice for payment, in accordance with FAR clause 52.216-7 "Allowable Cost & Payment." The Government shall make provisional payments on all invoices pending the completion of a final audit of the Contractor's cost records. A Standard Form (SF) 1034, Public Voucher for Purchases and Services Other than Personal, shall be used.

To expedite payment, invoices shall be submitted as follows:

(a) Original and four (4) copies shall be submitted to the following address:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OFM/Division of Accounting Operations
P.O. Box 7520
7500 Security Boulevard
Baltimore, MD 21207-0520

--For overnight delivery:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OFM/Division of Accounting Operations
7500 Security Boulevard/Mailstop: C3-11-03
Baltimore, MD 21244-1850

(b) One (1) copy shall be sent to the Project Officer and the Contract Specialist.

(i) Content of Invoice (If Applicable):

a. Contractor's name and address.
b. Invoice date and number
c. Purchase Order Number and GSA Schedule Contract Number or other authorization for delivery of property and/or services.
d. Individually identify the names of all personnel with appropriate/applicable labor categories and their hours, rates and a breakdown of Other Direct Costs.
e. Travel costs shall be broken down to include number of trips, number and name of individuals per trip, mode of transportation, mileage charge, and length of stay.

f. Shipping and payment terms.
g. Other substantiating documentation or information as required by the task order.
h. Name, title, phone number of person to notify in event of defective invoice.

B. Invoice Payment

Payments will only be made by electronic funds transfer (EFT) using the Contractor's EFT information from the Central Contractor Registration (CCR) database. In the event that during the performance of this contract, the Contractor elects to designate a different financial institution for receipt of payment using the electronic funds transfer procedures, the contractor shall notify CMS's Division of Accounting Operations of all EFT and address changes made in CCR via the following email address: CCRChanges@cms.hhs.gov. The contractor's email notification must contain the contractor's name, DUNS or DUNS+4 number, contract and/or order number, and the name, title, and telephone number of the Contractor's official representative authorized to provide their information.

C. Prompt Payment

Invoices will be handled in accordance with the Prompt Payment Act (31 U.S.C. 3903) and Office of Management and Budget (OMB) prompt payment regulations at 5 CFR part 1315.

G.17 SEPARATION OF MIP AND PM FUNDING BY PART A AND PART B

Funding for Medicare Integrity Program activities under section 1893 of the Social Security Act is derived from a different source than funding for the other functions (called "Program Management functions") which the Contractor performs pursuant to the authority of section 1874A of the Social Security Act. Therefore, separate accounts shall be designated for Medicare Integrity Program activities by Part A and Part B and for the Program Management functions by Part A and Part B which the Contractor performs pursuant to the authority of section 1874A. The Contractor shall separately account for costs incurred to perform Medicare Integrity Program activities and its Program Management functions under this contract. In no event shall the Contractor apply funding which is designated for Medicare Integrity Program activities to costs incurred in performing its Program Management functions authorized by section 1874A; similarly, the Contractor shall not apply funding designated for costs incurred in performing its Program Management functions under section 1874A to Medicare Integrity Program activities.

G.18 SEPARATION OF TRUST FUND EXPENDITURES/ACCOUNTING FROM ADMINISTRATIVE EXPENDITURES/ACCOUNTING

Any costs which are properly chargeable by a provider of services, physician, or supplier as benefit costs in accordance with Title XVIII of the Social Security Act, its implementing regulations and this contract, shall not be chargeable to this contract as administrative costs (i.e., either Medicare Integrity Program or Program Management costs). The Contractor shall separately account for benefit payments made by it from costs incurred to perform its Medicare Integrity Program activities and its Program Management functions under this contract.

G.19 COMPLEMENTARY CREDITS

The contractor shall separately account for complementary credits and reflect the current and cumulative totals on their monthly invoice. The estimated amounts for complementary credits shall be shown as a reduction to the total costs amount (i.e.: After application of any fees) within each applicable CLIN.

G.20 METHOD OF PAYMENT

In accordance with FAR 52.232-33, the Centers for Medicare & Medicaid Services (CMS) shall only make an electronic reimbursement/payment.

In accordance with FAR 52.204-7, the contractor must register in the Central Contractor Registration (CCR) database.

The contractor shall notify CMS' Division of Accounting Operations of all EFT and address changes in CCR via the following email address: CCRChanges@cms.hhs.gov

G.21 CORRESPONDENCE PROCEDURES

To promote timely and effective administration, correspondence (except for invoices), submitted under this contact shall be subject to the following procedures:

(a) Technical Correspondence - Technical correspondence (as used herein, this term excludes correspondence which proposes or otherwise involves waivers, deviations or modifications to the requirements, terms or conditions of this contract) shall be addressed to the Project Officer/Government Task Lead (GTL) with an informational copy of the basic correspondence to the Contracting Officer.

(b) Other Correspondence - All other correspondence shall be addressed to the Contracting Officer, in duplicate, with an informational copy of the basic correspondence to the Project Officer//GTL.

(c) Subject Lines - All correspondence shall contain a subject line, commencing with the contract number and assigning consecutive numbers (serial numbers to permit accountability), as illustrated below:

EXAMPLE: Contract No.- HHSM-500-200X-XXXXXX
Sequence # - XX(YEAR) - XXXX
Subject - Request for Subcontract Consent

G.22 DATA TO BE DELIVERED

Any working papers, interim reports, data given by the Government or first produced by the Contractor under the contract or collected or otherwise obtained by the Contractor under the contract, or results obtained or developed by the Contractor (subcontractor or consultants) pursuant to the fulfillment of this contract are to be delivered, documented, and formatted as directed by the Contracting Officer.

In addition, information and/or data, which are held by the Contractor related to the operation of their business and/or institution and which are obtained without the use of Federal funds, shall be considered "PROPRIETARY DATA" and are not "subject data" to be delivered under this contract.

G.23 AWARD FEE PLAN

The Award Fee Performance Evaluation Plan, upon which the determination of award fee is based, is identified herein as Attachment J-18. The plan contains details on how the Contractor will be evaluated periodically for its performance. The general criteria upon which the Contractor will be evaluated substandard, expected, or superior in performing each function includes such elements as efficiency, ingenuity, responsiveness, perceptiveness, thoroughness, timeliness, and resourcefulness.

G.24 WORKING PAPERS

The Contractor shall provide, at the request of the Contracting Officer, all the working papers used by the participating officials and employees of the Contractor in connection with all work undertaken pursuant to the contract.

G.25 INDIRECT COST FINAL RATES

In accordance with Federal Acquisition Regulation (FAR) (48 CFR Chapter 1) Clause 52.216-7(d)(2), Allowable Cost and Payment incorporated by reference in this contract in Part II, Section I, the cognizant Contracting Officer representative responsible for negotiating provisional and/or final indirect cost rates is identified below:

Director, Division of Financial Advisory Services
Office of Acquisition Management and Policy
National Institutes of Health
6100 Building, Room 6B05
6100 Executive Blvd. MSC-7540
Bethesda, MD. 20892-7540

G.26 PROVISIONAL RATES/CEILINGS

a. Pursuant to the provisions of FAR 52.216-7 entitled "Allowable Cost & Payment," in Section I of this contract, the allowable Indirect Costs under this contract shall be obtained by applying the final rates or rates negotiated to the appropriate bases. The period or periods for which such rates will be established shall correspond to the Contractor's fiscal year(s). The final rate proposal is to be submitted to the Contracting Officer.

In the event that the final rate proposal is submitted to the cognizant audit agency, the Contractor shall advise the Contracting Officer in writing when and to whom it was submitted.

b. Pending establishment of final rates for any period, provisional reimbursement will be made on the basis of the provisional rates shown below. To prevent substantial over or under payment, and to apply either retroactively or prospectively, provisional rates may, at the request of either party, be revised by mutual agreement. The Government shall execute a contract modification upon receipt of DCAA's or the audit agency's indirect rate audit to incorporate the negotiated indirect rates. In the event the final indirect cost rates are less than the provisional rates, retroactive adjustments to both the applicable costs and award fee shall be made at the time of contract modification. The Government will not be obligated to pay any additional amount should the final indirect cost rates exceed the negotiated ceiling rates by 3% per individual rates, i.e. G&A, Overhead, and Fringe. In the event the audit determined final indirect cost rates are less than the original negotiated ceiling rates, the negotiated rates will be reduced to conform with the lower rates.

Type	Cost Center	Provisional Rate Ceiling	Rate Ceiling Period	Base
Provisional	Audit, Debt Mgmt And PI (AD&I)	(b)(4)	08/06/2007-08/05/2008	(a)
Provisional	Claims & Customer Service (C&CS)		08/06/2007-08/05/2008	(b)
Provisional	Other Contracts – Non MAC (OCNM)		08/06/2007-08/05/2008	(c)
Provisional	G&A		08/06/2007-08/05/2008	(d)

(a) applies to total AD&I Direct Labo
(b) applies to total C&CS Direct Labor;
(c) applies to total OCNM Direct Labor;
(d) applies to total Direct Labor, Fringe, Overhead, and ODCs;

G.27 USE OF GOVERNMENT DATA (REPORTS/FILES/COMPUTER TAPES OR DISCS)

Any data given to the contractor by the Government shall be used only for the performance of the contract unless the Contracting Officer specifically permits another use, in writing. Should the Contracting Officer permit the contractor the use of Government-supplied data for a purpose other than solely for performance of this contract and if such use could result in a commercially viable product, the Contracting Officer and the contractor must negotiate a financial benefit to the Government. This benefit should most often be in the form of a reduction in the price of the contract; however, the Contracting Officer may negotiate any other benefits he/she determines are adequate compensation for the use of these data.

Upon the request of the Contracting Officer or the expiration date of this contract, whichever shall come first, the contractor shall, upon instructions from the Contracting Officer, return or destroy all data given to the contractor by the Government. However, the Contracting Officer may direct that the data be retained by the contractor for a specific period of time, which period shall be subject to agreement by the contractor. Whether the data are returned, retained, or destroyed shall be the decision of the Contracting Officer with the exception that the contractor may refuse to retain the data. The contractor shall retain no data, copies of data, or parts thereof, in any form, when the Contracting Officer directs that the data be returned or destroyed. If the data are to be destroyed, the contractor shall directly furnish evidence of such destruction in a form the Contracting Officer shall determine is adequate.

SECTION H - SPECIAL CONTRACT REQUIREMENTS

H.1 HHSAR 352.270-5 KEY PERSONNEL (JAN 06)

The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the Contracting Officer and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the Government of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The Government may modify the contract to add or delete key personnel at the request of the contractor or Government.

All proposed substitutions must be submitted, in writing, to CMS at least thirty (30) days prior to the proposed substitution or as soon as reasonably known. Each request shall provide a detailed explanation of the circumstances necessitating the proposed substitution, a complete resume and any other information required by CMS. All proposed substitutions must have qualifications equal to or greater than the person(s) being replaced.

When key personnel positions are vacated due to unforeseen circumstances, a proposed replacement shall be submitted in writing for approval no later than 30 calendar days from the date the position was vacated. Interim replacements should be identified when a permanent replacement cannot be identified within this time frame. The Centers for Medicare & Medicaid Services (CMS) may consider a 60-day interim replacement until a permanent replacement is secured.

The following individuals are considered "key" under this contract:

LABOR CATEGORY	NAME
Project Manager	(b)(4)
Chief Information Officer	
Claims Processing Manager	
Compliance Officer	
Contract Administrator	
Implementation Project Director	
Chief Financial Officer	
Provider Customer Service Manager	
Systems Security Officer	
Program Safeguard Contractor Liaison	
Contractor Medical Director	
Audit and Reimbursement Manager	

H.2 CONDITIONS OF PERFORMANCE

In addition to the performance requirements of this contract set forth under Section C, Description/Specifications, Work Statement, the Contractor may be required to comply with the requirements of any revisions in legislation or regulations, which may be enacted or implemented during the period of performance of this contract, and are directly applicable to the performance requirements of this contract. In the event that revisions in legislation or regulations are enacted and do impact the performance requirements of this contract, the Contractor will have an opportunity to assess the cost and schedule impacts of such revisions and will, when applicable, be provided an equitable adjustment.

H.3 CONFLICT OF INTEREST

a. General: It is essential that the Contractor and the services provided to Medicare beneficiaries under this contract be free, to the greatest extent possible, of all conflicts of interest. Except as provided below, the Contracting Officer shall not enter into a contract with an offeror or maintain a contract with a Contractor that the Contracting Officer determines has, or has the potential for, an unresolved conflict of interest.

b. Disclosure: Contractors must disclose all actual, apparent and potential conflicts of interest to the Contracting Officer during the term of the contract in accordance with paragraph H.3.d. below. The Contractor shall have programs in place to identify, evaluate and mitigate all actual, apparent and potential conflicts of interest that preclude, or would appear to preclude, the Contractor from rendering impartial assistance or advice on work performed for this contract. The Contractor's Conflict of Interest Certificate, that includes the Contractor's plan to mitigate all actual, apparent and potential conflicts of interest (d.1.(c)) identified during the term of the contract and certification that all work to be performed under this contract is free of unresolved conflicts of interest is incorporated at Attachment J-22.

c. Conflict of interest identification:

1. Definitions: As used in this subpart, the following definitions apply:

(a) Financial relationship means--

(1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity that exists through equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or

(2) A compensation arrangement with an entity.

(b) Conflict of interest--

Conflict of interest means that because of other activities or relationships with other persons, a person is unable or potentially unable to render impartial assistance or advice to the Government, or the person's objectivity in performing the contract work is or might be otherwise impaired, or a person has an unfair competitive advantage.

For purposes of the AB-MAC, the activities and relationships described include those of the offeror or Contractor itself and other business related to it and those of officers, directors (including medical directors), managers, and subcontractors.

2. Identification of conflict:

(a) The Contracting Officer determines that an offeror or Contractor has a conflict of interest, or the potential for the conflict exists, if-

(1) The offeror or Contractor is an entity described in paragraph H.3.c.2.(c) of this section; or

(2) The offeror or Contractor has a present, or establishes a future, direct or indirect financial relationship with an entity described in paragraph H.3.c.2.(c) of this section.

(b) A financial relationship may exist either--

(1) Through an offeror's or Contractor's parent company, subsidiaries, affiliates, subcontractors, or current clients; or

(2) From the activities and relationships of the officers, directors (including medical directors), or managers of the offeror or Contractor and may be either direct or indirect. An officer, director, or manager has an indirect financial relationship if an ownership or investment interest is held in the name of another but provides benefits to the officer, director, or manager.

Examples of indirect financial relationships are, but are not limited to, holdings in the name of a spouse or dependent child of the officer, director, or manager and holdings of other relatives who reside with the officer, director, or manager.

(c) For the purpose of identifying entities with conflicts of interest above, the entity is one that-

(1) Would review or does review, under the contract, Medicare services furnished by a provider or supplier that is a direct competitor of the offeror or Contractor;

(2) Prepared work or is under contract to prepare work that would be reviewed under the AB-MAC contract;

(3) Is affiliated, as that term is explained in FAR 19.101, with a provider or supplier to be reviewed under the contract.

(d) The Contracting Officer may determine that an offeror or Contractor has a conflict of interest, or the potential for a conflict exists, based on the following:

(1) Apparent conflicts of interest. An Apparent conflict of interest exists if a person believes that the offeror or Contractor would have a conflict of interest in performing the requirements of a contract under this subpart. No inappropriate action by the offeror or Contractor is necessary for an apparent conflict of interest to exist.

(2) Other contracts and grants with the Federal Government.

3. Exception. The Contracting Officer may contract with an offeror or Contractor that has an unresolved conflict of interest if the Contracting Officer determines that it is in the best interest of the Government to do so.

4. Offeror's or Contractor's responsibility with regard to subcontractors. An offeror or Contractor is responsible for determining whether a conflict of interest exists in any of its proposed or actual subcontractors at any tier and is responsible for ensuring that the subcontractors have mitigated any conflict of interest or potential conflict of interest. The contracting officer shall be notified of such identifications for a determination in accordance with H.3.b.

A Contractor shall maintain documentation necessary to support its determination that its subcontractors have mitigated any conflict or potential conflict. A Contractor may require its subcontractors to follow the procedures for identifying, evaluating and disclosing conflicts of interest and potential conflicts of interest as contained herein.

5. Post-award conflicts of interest.

a. In addition to the conflicts identified in this section regardless of when such conflict may arise, the Contracting Officer considers that a conflict of interest has occurred if during the term of the contract--

(1) The Contractor receives any fee, compensation, gift, payment of expenses, or any other thing of value from any entity that is reviewed or contacted during the normal course of performing activities under the AB-MAC contract; or

(2) The Contracting Officer determines that the Contractor's activities are creating a conflict of interest.

b. In the event the Contracting Officer determines that a conflict of interest exists during the term of the contract, the Contracting Officer may take action including, but not limited to,

(1) Not renewing the contract for an additional term;

(2) Modifying the contract; or

(3) Terminating the contract.

d. Conflict of interest evaluation:

1. Disclosure. Offerors that wish to be eligible for the award of an AB-MAC contract under this subpart and AB-MAC contractors, must submit, at times specified in paragraph H.3.d.2. of this section, a Conflicts of Interest Certificate. The Certificate must contain the information specified in paragraphs H.3.d.1.(a) through (h) of this section as follows:

(a) A description of all business or contractual relationships or activities that the contractor’s compliance officer has determined that such relationship could be viewed as a conflict of interest.

(b) A description of the methods the offeror or Contractor will apply to mitigate any situations listed in the Certificate that could be identified as a conflict of interest.

(c) A description of the offeror's or Contractor's program to monitor its compliance and the compliance of its proposed and actual subcontractors with the conflict of interest requirements as identified in the relevant solicitation.

(d) A description of the offeror's or Contractor's plans to contract with an independent auditor to conduct an annual conflict of interest audit.

(e) A description of all other Medicare contracts held by the Contractor or its parent, subsidiaries, or other affiliated entities.

(f) An affirmation, using language provided below, signed and dated by an official authorized to bind the Contractor:

I, (Name and Title), certify that to the best of my knowledge and belief: 1) I am an official authorized to bind the entity; 2) the information contained in the Conflict of Interest Certificate is true and accurate as of (Date); and 3) I understand that the Contracting Officer may consider any deception or omission in this Certificate to be grounds for nonconsideration for contract award, modification or nonrenewal or termination of the current contract, and/or other contract or legal action.

An offeror shall submit an affirmation certifying the information to be true and accurate as of the date the proposal is submitted. Upon award, the Contractor shall submit an updated affirmation, if necessary, certifying the information to be accurate as of the date of contract award.

(g) Corporate and organizational structure.

(h) Financial interests in other entities, including the following:

(1) Percentage of ownership in any other entity.

(2) Income generated from other sources.

(3) A list of current or known future contracts or arrangements, regardless of size, with any--

(i) Insurance organization or subcontractor of an insurance organization; or

(ii) Providers or suppliers furnishing health services for which payment may be made under the Medicare program.

(4) In the case of contracts or arrangements identified in accordance with paragraph H.3.d.1.(g)(3) of this section, the dollar amount of the contracts or arrangements, the type of work performed, and the period of performance.

(i) The following information for all of the offeror's or Contractor's officers, directors (including medical directors), and managers who would be, or are involved with, the performance of this AB-MAC contract:

(1) The information required under paragraphs H.3.d.1.(a), H.3.d.1.(g)(3) and (4) of this section.

(2) The information specified in paragraphs H.3.d.1.(g)(1) and (2) of this section.

2. When disclosure is made. The Conflicts of Interest Certificate is submitted--

(a) With the offeror's proposal;

(b) When the Contracting Officer requests a revision in the Certificate;

(c) Within 45 days of any change in the information submitted in accordance with paragraph H.3.d.1. of this section; and,

(d) As part of the annual conflict of interest certification by an independent auditor. The first annual certification shall be submitted on the anniversary date that the contract became fully operational, and annually thereafter.

3. Evaluation. The Contracting Officer evaluates conflicts of interest and potential conflicts, using the information provided in the Conflicts of Interest Certificate, and information from other sources in order to promote the effective and efficient administration of the Medicare program.

For each conflict identified, the Contracting Officer will evaluate the plan proposed to mitigate the conflict to determine if the mitigation plan will allow the Contractor to render impartial assistance or advice to the Government.

4. Protection of proprietary information disclosed.

(a) CMS protects disclosed proprietary information as allowed under the Freedom of Information Act (5 U.S.C. 552).

(b) The Contracting Officer requires signed statements from CMS personnel with access to proprietary information that prohibits personal use during the procurement process and term of the contract.

e. Conflict of Interest Resolution: Resolution of a conflict of interest is a determination that--

(1) The conflict has been mitigated;

(2) The conflict precludes award of a contract to the offeror;

(3) The conflict requires that the Contracting Officer modify an existing contract;

(4) The conflict requires that the Contracting Officer terminate an existing contract; or

(5) It is in the best interest of the Government to contract with the offeror or Contractor even though the conflict exists.

H.4 APPROVAL OF CONTRACT ACQUIRED INFORMATION TECHNOLOGY (IT)

A. The Contractor must obtain the Contracting Officer's written approval prior to the acquisition of any IT investments (see FAR Part 2.101, for definition of IT) to ensure compatibility and successful integration with CMS's infrastructure/architecture.

B. In the performance of a system life cycle development project, the Contractor must submit to the Project Officer the technical specifications for each of the following incremental phase of the projected life cycle prior to the commencement of work:

1. Design and Engineering
2. Development, and
3. Testing

C. Upon written approval from the Contracting Officer, the Contractor shall commence work under the approved technical specification for the authorized incremental phase.

D. In either instance of an approved IT investment acquisition, or an incremental phase of a system life cycle development project, the contract shall be modified accordingly and the Contractor shall proceed.

E. CMS may disallow any contractor incurred cost that would not be allocated to the approved IT investment acquisition.

H.5 HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA) BUSINESS ASSOCIATE PROVISION II

HIPAA Business Associate Provision II

Definitions:

All terms used herein and not otherwise defined shall have the same meaning as in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA," 42 U.S.C. sec. 1320d) and the corresponding implementing regulations. Provisions governing the Contractor's duties and obligations under the Privacy Act (including data use agreements) are covered elsewhere in the contract.
"Business Associate" shall mean the Contractor.
"Covered Entity" shall mean CMS' Medicare Fee for Service program and/or Medicare's Prescription Drug Discount Care and Transitional Assistance Programs.
"Secretary" shall mean the Secretary of the Department of Health and Human Services or the Secretary's designee.

Obligations and Activities of Business Associate

(a) Business Associate agrees to not use or disclose Protected Health Information ("PHI"), as defined in 45 C.F.R. § 160.103, created or received by Business Associate from or on behalf of Covered Entity other than as permitted or required by this Contract or as required by law.
(b) Business Associate agrees to use safeguards to prevent use or disclosure of PHI created or received by Business Associate from or on behalf of Covered Entity other than as provided for by this Contract. Furthermore, Business Associate agrees to use appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information ("EPHI"), as defined in 45 C.F.R. 160.103, it creates, receives, maintains or transmits on behalf of the Covered Entity to prevent use or disclosure of such EPHI.
(c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Contract.
(d) Business Associate agrees to report to Covered Entity any use or disclosure involving PHI it receives/maintains from/on behalf of the Covered Entity that is not provided for by this Contract of which it becomes aware. Furthermore, Business Associate agrees to report to Covered Entity any security incident involving EPHI of which it becomes aware.
(e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Contract to Business Associate with respect to such information. Furthermore, Business Associate agrees to ensure that its agents and subcontractors implement reasonable and appropriate safeguards for the PHI received from or on behalf of the Business Associate.

(f) Business Associate agrees to provide access, at the request of Covered Entity, to PHI received by Business Associate in the course of contract performance, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
(g) Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 upon request of Covered Entity.
(h) Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity, available to Covered Entity, or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the various rules implementing the HIPAA.
(i) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
(j) Business Associate agrees to provide to Covered Entity, or an individual identified by the Covered Entity, information collected under this Contract, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Contract, Business Associate may use or disclose PHI on behalf of, or to provide services to, Covered Entity for purposes of the performance of this Contract, if such use or disclosure of PHI would not violate the HIPAA Privacy or Security Rules if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity.

Obligations of Covered Entity

(a) Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
(b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
(c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy or Security Rules.

Term of Provision

(a) The term of this Provision shall be effective as of contract award**,** and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.
(b) Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

(1) Provide an opportunity for Business Associate to cure the breach or end the violation consistent with the termination terms of this Contract. Covered Entity may terminate this Contract for default if the Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
(2) Consistent with the terms of this Contract, terminate this Contract for default if Business Associate has breached a material term of this Contract and cure is not possible; or
(3) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) Effect of Termination.
(1) Except as provided in paragraph (2) of this section, upon termination of this Contract, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
(2) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon such notice that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Contract to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

Miscellaneous

(a) A reference in this Contract to a section in the Rules issued under HIPAA means the section as in effect or as amended.
(b) The Parties agree to take such action as is necessary to amend this Contract from time to time as is necessary for Covered Entity to comply with the requirements of the Rules issued under HIPAA.
(c) The respective rights and obligations of Business Associate under paragraph (c) of the section entitled "term of Provision" shall survive the termination of this Contract.
(d) Any ambiguity in this Contract shall be resolved to permit Covered Entity to comply with the Rules implemented under HIPAA.

H.6 SECTION 508 – ACCESSIBILITY OF ELECTRONIC AND INFORMATION TECHNOLOGY

A. This contract is subject to Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) as amended by the workforce Investment Act of 1998 (P.L. 105-220). Specifically, subsection 508(a)(1) requires that when the Federal Government procures Electronic and Information Technology (EIT), the EIT must allow Federal employees and individuals of the public with disabilities comparable access to and use of information and data that is provided to Federal employees and individuals of the public without disabilities.

B. The EIT accessibility standards at 36 CFR Part 1194 were developed by the Architectural and Transportation Barriers Compliance Board ("Access Board") and apply to contracts and task/delivery orders, awarded under indefinite quantity contracts on or after June 25, 2001.

C. Each Electronic and Information Technology (EIT) product or service furnished under this contract shall comply with the Electronic and Information Technology Accessibility Standards (36 CFR 1194), as specified in the contract, as a minimum. If the Contracting Officer determines any furnished product or service is not in compliance with the contract, the Contracting Officer will promptly inform the Contractor in writing. The Contractor shall, without charge to the Government, repair or replace the non-compliant products or services within the period of time to be specified by the Government in writing. If such repair or replacement is not completed within the time specified, the Government shall have the following recourses:

    1. Cancellation of the contract, delivery or task order, purchase or line item without termination liabilities; or

    2. In the case of custom Electronic and Information Technology (EIT) being developed by a contractor for the Government, the Government shall have the right to have any necessary changes made or repairs performed by itself or by another firm for the noncompliant EIT, with the contractor liable for reimbursement to the Government for any expenses incurred thereby.

D. The contractor must ensure that all EIT products that are less than fully compliant with the accessibility standards are provided pursuant to extensive market research and are the most current compliant products or services available to satisfy the contract requirements.

E. For every EIT product or service accepted under this contact by the Government that does not comply with 36 CFR 1194, the contractor shall, at the discretion of the Government, make every effort to replace or upgrade it with a compliant equivalent product or service, if commercially available and cost neutral, on either a contract specified refresh cycle for the product or service, or on a contract effective option/renewal date; whichever shall occur first.

H.7 WAGE DETERMINATION

WD 2005-2509, Revision No. 1, Dated 09/01/2006 (Dallas, Texas) is incorporated as Attachment J-21)

H.8 INDEMNIFICATION

A. In the event the Contractor or any of its directors, officers, employees, or other persons who are engaged or retained by the Contractor to participate directly in the claims administration process are made parties to any judicial or administrative proceeding arising, in whole or in part, out of any functions under this contract in connection with any claims for benefits under Title XVIII of the Social Security Act by any individual entitled to such benefits or his assignee or provider of services, then the Secretary shall, to the extent permitted by law and this contract, indemnify the Contractor for all judgments, settlements, awards, and costs, in favor of such individual or his assignee or provider of services, incurred by the Contractor (or any of its directors, officers, or employees, or other persons who are engaged or retained by the Contractor to participate directly in the claims administration process) in connection therewith to the extent that such judgments, settlements, awards and costs relate to the Contractor's performance of its functions under the contract. Further, any reasonable administrative expenses directly or indirectly incurred by the Contractor (or any of its directors, officers, or employees, or by other persons who are engaged or retained by the Contractor to participate directly in the claims administration process) in connection with proceedings described in the preceding sentence, shall be reimbursable, to the extent permitted by law and this contract. Nothing in this paragraph shall be construed to permit the payment of costs not otherwise allowable, reasonable, or allocable under Part 31 of the Federal Acquisition Regulations.

B. The Secretary shall not provide indemnification for judgments, settlements, awards, or costs under paragraph A, and the Secretary shall not reimburse expenses as provided for in paragraph A, insofar as the liability for such judgment, settlement, award, or costs arises directly from conduct on the part of the Contractor determined by judicial proceedings or the agency making the award to be criminal in nature, fraudulent, or grossly negligent. In the event that a judicial or administrative proceeding described in paragraph results in a judgment, settlement, award or claim for costs against the Contractor, but makes no explicit finding regarding the degree of culpability of the Contractor, the Secretary shall not provide indemnification under paragraph A if the CMS contracting officer makes a written determination that the Contractor's conduct was criminal in nature, fraudulent, or grossly negligent.

C. If indemnification is provided by the Secretary with respect to the Contractor under paragraph A before a determination is made under paragraph B that the Contractor's conduct was criminal in nature, fraudulent, or grossly negligent, the Contractor shall reimburse the United States within thirty days of such determination (or earlier if another date is ordered by a judicial or administrative proceeding described in paragraph A) for the

amount of any indemnification paid by the United States in the discharge of the Secretary's obligations under paragraph A; provided, however, the Contractor shall not be required to reimburse the United States that portion of an award or judgment directly attributable to an allowable program benefit under Title XVIII of the Social Security Act.

D. In the event the Contractor (or any of its directors, officers, employees or other persons who are engaged or retained by the Contractor to participate directly in the claims administration process) is a party to any judicial or administrative proceeding described in paragraph A above, and proposes to negotiate a settlement or compromise of such proceeding prior to final judicial or administrative determination, the Contractor must first obtain the prior written approval of the CMS contracting officer.

E. Any indemnification under paragraph A above with respect to amounts paid under a settlement or compromise of a proceeding described in such paragraph are conditioned upon prior written approval by the CMS contracting officer of the final settlement or compromise. Administrative expenses (including expenses for outside counsel) which are incurred in connection with any settlement or compromise of any proceeding described in paragraph A shall only be reimbursable if such settlement was entered into with the prior written approval of the CMS contracting officer.

F. The availability of indemnification under paragraph A does not extend to judgments, settlements, awards, or costs relating to judicial or administrative proceedings against the Contractor (or any of its directors, officers, employees, or other persons who are engaged or retained by the Contractor to participate directly in the claims administration process) that do not arise from or relate to the functions of the Contractor under this contract (and which have no connection with claims for benefits under Title XVIII of the Social Security Act by any individual entitled to such benefits or his assignee or provider of services) or that arise from or relate to a violation of federal, state or local laws (except for that portion of any such judgment, settlement, award, or cost directly attributable to an allowable program benefit under Title XVIII of the Social Security Act).

G. If any judicial or administrative proceeding described in paragraph A is initiated against the Contractor (or any of its directors, officers, employees, or other persons engaged or retained by the Contractor to participate directly in the claims administration process), the Contractor shall promptly notify the CMS contracting officer and the Office of General Counsel, Department of Health & Human Services as to the nature and venue of the proceeding. The Contractor shall cooperate fully and promptly with all requests for documents and assistance from CMS, such Office of General Counsel, the Department of Justice and any other agency operating within its lawful authority in connection with the investigation or defense of such proceeding.

H. If the Contractor wishes to engage outside counsel in connection with the defense of a proceeding described in this provision, the Contractor shall notify the CMS contracting officer. The Contractor shall obtain the prior written approval of the CMS contracting officer for all expenses related to such outside counsel.

I. The United States, at its sole discretion, may intervene as the party of interest and undertake the defense of any proceeding described in paragraph A. Notwithstanding any such action by the United States, the Contractor shall be reimbursed for outside counsel expenses if reasonable and allowable in accordance with FAR Part 31, and approved in accordance with paragraph H.

J. The full extent of indemnification and reimbursement under this provision for any judgments, settlements, awards, and costs shall be limited to five million dollars ($5,000,000) per proceeding, unless and until this contract is modified; provided, however, this limitation shall not apply to that portion of any judgment, settlement, award or cost directly attributable to an allowable program benefit under Title XVIII of the Social Security Act.

H.9 DISCLOSURE OF INFORMATION

The Contractor shall establish and maintain procedures and controls for the purpose of assuring that information contained in its records and obtained from CMS or from others in carrying out functions under this contract will be used by it and disclosed solely as provided in section 1106 of the Social Security Act and its implementing regulations (42 CFR Part 401, subpart B).

H.10 PARTICIPATION IN DEMONSTRATIONS

The Contractor shall, at the written request and approval of the Contracting Officer, engage or participate in statistical and research studies pertinent to the program under Parts A and B of Title XVIII of the Social Security Act as the Contracting Officer deems necessary. The Changes – Cost Reimbursement clause of this contract (FAR 52.243-2) shall apply to such activities.

H.11 SEPARATION OF CERTIFICATION AND DISBURSEMENT RESPONSIBILITIES

As a critical element of the system of internal controls required pursuant to this Contract (see C.5.3.8), the Contractor shall establish and maintain adequate procedures and controls to insure that any Medicare benefit payments pursuant to Title XVIII of the Social Security Act and this contract are made only upon proper certification (or authorization). In establishing and maintaining such procedures, the Contractor shall provide for separation of the functions of certification and disbursement. As one element of fulfilling the requirements of the preceding two sentences, the Contractor shall designate one or more individuals to be accountable for the authorizing of Medicare benefit payments (and the certification as to their accuracy). The

Contractor shall also designate one or more individuals (who shall not authorize or certify payments) to be accountable for the proper disbursement of such payments. The Contractor shall provide the Contracting Officer with a list of such designated certifying and disbursing officers prior to making any Medicare benefit payments, and should any such officers be unable to continue performing their responsibilities during the term of this contract (including all option periods), the Contractor shall promptly designate a replacement officer (or officers) and notify the Contracting Officer as to the identity of such replacement(s).

H.12 FIDELITY BONDS

Upon the written request of the Contracting Officer, the Contractor shall give a fidelity bond to the United States in such manner and in such amount as the Contracting Officer may deem appropriate. The expense of such bond (if required) shall be allowable, to the extent reasonable and allocable in accordance with Part 31 of the Federal Acquisition Regulation.

H.13 LIABILITY FOR MEDICARE BENEFIT PAYMENTS – CERTIFYING OFFICER

No individual designated pursuant to this contract as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payment certified by the individual pursuant to this contract. Nothing in the preceding sentence shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of Title 31, United States Code.

H.14 LIABILITY FOR MEDICARE BENEFIT PAYMENTS – DISBURSING OFFICER

No disbursing officer designated pursuant to this contract shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payments made by such officer under this contract if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General of the United States) of a certifying officer designated pursuant to this contract. Nothing in the preceding sentence shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of Title 31, United States Code.

H.15 LIABILITY FOR MEDICARE BENEFIT PAYMENTS – MEDICARE ADMINISTRATIVE CONTRACTOR

The Contractor shall not be liable to the United States for a payment by a certifying and disbursing officer unless, in connection with such payment, the Contractor acted with reckless disregard of its obligations under this contract or with intent to defraud the United States. Nothing in the preceding sentence shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of Title 31, United States Code.

H.16 LIABILITY FOR UNCOLLECTED OVERPAYMENTS

No certifying officer or disbursing officer shall be held liable for any amount certified or paid by such officer under this contract to any provider of services or other person where adjustment or recovery of such amount (as authorized by section 1870 of the Social Security Act, 42 United States Code 1395gg and this contract) is waived pursuant to such section 1870(c) or where adjustment authorized under section 1870(b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

H.17 RECORD RETENTION

The Contractor is responsible for records retention as defined in IOM Pub. 100-01, Chapter 7, Section 30.

CMS is not implementing a document destruction program authorizing the destruction of Medicare documents. However, in an effort to reduce associated costs for storing Medicare documents (which includes returned/undeliverable Medicare Summary Notices), the DOJ has agreed that electronic imaging is an acceptable method of storage. This provides contractors the opportunity to destroy the paper documents, as long as the following conditions are met:

1. Contractors must certify the image is absolutely an identical replication of the paper document in every way;
2. The scanned image becomes the record keeping copy and is verified and documented as an identical replication of the paper document; and
3. Contractors must maintain accessibility and the ability to read the document in accordance with changes in technology.

Under no circumstances are contractors to destroy the only copy of any information, data, or files that CMS, DOJ, DHHS' Office of General Counsel or the OIG have identified as relating to a current investigation or litigation/negotiation, ongoing Workers' Compensation set aside arrangements, or documents which prompt suspicions of fraud or abuse of over utilization of services. Contractors can either retain the image copy or the hardcopy. This will satisfy evidentiary needs and discovery obligations critical to the agency's litigation interest.

H.18 REPORTABLE EVENTS

The Contractor shall report to the CMS Contracting Officer and the CMS Project Officer whenever a known, probable or suspected reportable event, as defined below, is discovered. Reports to CMS shall be in accordance with the procedures set forth below.

A. Definition of "Reportable Event." A "Reportable Event" means anything that involves the following: (1) a matter that a reasonable person would consider a violation of criminal, civil or administrative laws applicable to any Medicare contract or Federal health care program; or (2) integrity violations, including any known, probable or suspected violation of any

Medicare contract term or provision. A reportable event may be the result of an isolated event or a series of occurrences. Reportable events that are subject to reporting under these procedures include reportable events that occur at the Contractor or any of its subcontractors, consultants, vendors or agents.

B. If the Contractor discovers, through any means, a known, probable or suspected reportable event, the Contractor shall provide to CMS an initial written report within 30 calendar days of discovering the reportable event. Within 45 calendar days of the date of the initial report, the Contractor shall provide to CMS a written final investigative report on the reportable event. If the Contractor is unable to complete its investigation within this 45-day period, the Contractor shall provide to CMS a written request for an extension of time to complete its investigation and submit its final written investigative report. The request for an extension of time must specify the reasons for the request and a proposed new due date for the final written investigative report. The Contractor shall submit its written final investigative report by this new due date, unless the CMS contracting officer specifies another due date in writing.

C. The Contractor's initial written report shall include the following information:

(1) If the reportable event is the result of a known, probable or suspected violation of criminal, civil or administrative law or a violation of a Medicare contract term or provision, the report shall describe the reportable event with as much specificity as possible, including the following:

(i) The law, regulation or contract term implicated.
(ii) The persons involved and the department(s) within the Contractor's operation that are affected.
(iii) The time period of the reportable event.
(iv) A determination as to the extent that the reportable event has affected, or is affecting performance under the contract.
(v) Any corrective action taken, or intended to be taken, by the Contractor.

(2) If the reportable event results in a significant overpayment, relating to either the Medicare Trust Funds or contractual administrative costs, the report must describe the overpayment with as much specificity as possible as of the time of the due date for the submission of the report, including the following:

(i) The amount of the overpayment. If the overpayment has not been quantified, the contractor must provide its best estimate of the amount of the overpayment.
(ii) The nature of the overpayment and the reason for the overpayment.
(iii) The time period of the overpayment.
(iv) Any corrective action taken, or intended to be taken, by the Contractor.

(v) The Contractor's plan to recover or repay the overpayment in accordance with the requirements of law, regulation, and this contract relating to Medicare Trust Fund payments and contractual administrative costs (whichever may apply in the particular case).

D. The final written report shall include the following information:

(1) The report shall address all the required information for the initial written report, as described above.
(2) A statement as to whether the Contractor considered changing any policies and procedures or retraining its employees to prevent the recurrence of this or other similar reportable events. If policies and procedures were changed, or retraining occurred, or will occur, the Contractor shall describe the changes and/or the training that has been done or will be done in the future.
(3) A corrective action plan prepared in accordance with CMS policies and procedures.
(4) A statement that the Contractor's internal investigative file on the reportable event is available to CMS for audit, inspection or reproduction.
(5) The name(s) of the person(s) who conducted the investigation.

E. The Contractor shall submit its initial and final written reports, as well as any request for extension of due dates for such reports under this provision, to the Contracting Officer, the Project Officer, the Contractor Compliance Officer, and/or their designees.

H.19 WORK PERFORMED OUTSIDE THE UNITED STATES AND ITS TERRITORIES

The contractor, and its subcontractors, shall not perform any activities under this contract at a location outside the United States without the prior written approval of the Contracting Officer. In making a decision to authorize the performance of work outside the United States, the Contracting Officer will consider the following factors, including but not limited to:

1. All contract terms regarding system security
2. All contract terms regarding the confidentiality and privacy requirements for information and data protection
3. All contract terms that are otherwise relevant, including the provisions of the statement of work
4. Corporate compliance
5. All laws and regulations applicable to the performance of work outside the United States
6. The best interests of the United States

In order to secure the Contracting Officer's authorization to perform work outside the United States, the contractor must demonstrate that the performance of work outside the United States satisfies all of the above factors. If, in the Contracting Officer's judgment, the above factors are not fully satisfied, the performance of work outside the United States will not be authorized.

Particular attention should be given to:

C.5.4.3	System Security
C.5.4.11	Compliance Program
H.2	Confidentiality of Information
H.6	HIPAA

H.20 SYSTEMS OF RECORDS

The Privacy Act of 1974, Public Law 93-579, and the Regulations and General Instructions issued by the Secretary pursuant thereto, are applicable to this contract, and to all subcontractors there under to the extent that the design, development, operation or maintenance of a system of records as defined in the Privacy Act is involved. The following system of records will be applicable to this contract and made available to the Contractor:

Carrier Medicare Claims Record (CMC)
System Record Number: 09-70-0501 (PDF, 69KB)

Intermediary Medicare Claims Record
System Record Number: 09-70-0503 (PDF, 64KB)

Common Working File (CWF)
System Record Number: 09-70-0526 (PDF, 69KB)

Intern and Resident Information System (IRIS)
System Record Number: 09-70-0524 (PDF, 55KB)

Provider Enrollment Chain and Ownership System (PECOS)
System Record Number: 09-70-0532 (PDF, 55KB)

H.21 SECURITY CLAUSE -BACKGROUND - INVESTIGATIONS FOR CONTRACTOR PERSONNEL

If applicable, Contractor personnel performing services for CMS under this contract, task order or delivery order shall be required to undergo a background investigation. CMS will initiate and pay for any required background investigation(s).

After contract award, the CMS Project Officer (PO) and the Security and Emergency Management Group (SEMG), with the assistance of the Contractor, shall perform a position-sensitivity analysis based on the duties contractor personnel shall perform on the contract, task order or delivery order. The results of the position-sensitivity analysis will determine first, whether the provisions of this clause are applicable to the contract and second, if applicable, determine each position's sensitivity level (i.e., high risk, moderate risk or low risk) and dictate the appropriate level of background investigation to be processed. Investigative packages may contain the following forms:

1. SF-85, Questionnaire for Non-Sensitive Positions, 09/1995
2. SF-85P, Questionnaire for Public Trust Positions, 09/1995
3. OF-612, Optional Application for Federal Employment, 12/2002
4. OF-306, Declaration for Federal Employment, 01/2001
5. Credit Report Release Form
6. FD-258, Fingerprint Card, 5/99, and
7. CMS-730A, Request for Physical Access to CMS Facilities (NON-CMS ONLY), 11/2003.

The Contractor personnel shall be required to undergo a background investigation commensurate with one of these position-sensitivity levels:

1) High Risk (Level 6)

Public Trust positions that would have a potential for exceptionally serious impact on the integrity and efficiency of the service. This would include computer security of a major automated information system (AIS). This includes positions in which the incumbent's actions or inaction could diminish public confidence in the integrity, efficiency, or effectiveness of assigned government activities, whether or not actual damage occurs, particularly if duties are especially critical to the agency or program mission with a broad scope of responsibility and authority.

Major responsibilities that would require this level include:

a. development and administration of CMS computer security programs, including direction and control of risk analysis and/or threat assessment;
b. significant involvement in mission-critical systems;
c. preparation or approval of data for input into a system which does not necessarily involve personal access to the system but with relatively high risk of causing grave damage or realizing significant personal gain;

d. other responsibilities that involve relatively high risk of causing damage or realizing personal gain;
e. policy implementation;
f. higher level management duties/assignments or major program responsibility; or
g. independent spokespersons or non-management position with authority for independent action.

2) Moderate Risk (Level 5)

Level 5 Public Trust positions include those involving policymaking, major program responsibility, and law enforcement duties that are associated with a "Moderate Risk." Also included are those positions involving access to or control of unclassified sensitive, proprietary information, or financial records, and those with similar duties through which the incumbent can realize a significant personal gain or cause serious damage to the program or Department. Responsibilities that would require this level include:

a. the direction, planning, design, operation, or maintenance of a computer system and whose work is technically reviewed by a higher authority at the High Risk level to ensure the integrity of the system;
b. systems design, operation, testing, maintenance, and/or monitoring that are carried out under the technical review of a higher authority at the High Risk level;
c. access to and/or processing of information requiring protection under the Privacy Act of 1974;
d. assists in policy development and implementation;
e. mid-level management duties/assignments;
f. any position with responsibility for independent or semi-independent action; or
g. delivery of service positions that demand public confidence or trust.

3) Low Risk (Level 1)

Positions having the potential for limited interaction with the agency or program mission, so the potential for impact on the integrity and efficiency of the service is small. This includes computer security impact on AIS.

The Contractor shall submit the investigative package(s) to SEMG within three (3) days after being advised by the SEMG of the need to submit packages. Investigative packages shall be submitted to the following address:

Centers for Medicare & Medicaid Services
Office of Operations Management
Security and Emergency Management Group
Mail Stop SL-13-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

The Contractor shall submit a copy of the transmittal letter to the Contracting Officer (CO).

Contractor personnel shall submit a CMS-730A (Request for Badge) to the SEMG (see attachment in Section J). The Contractor and the PO shall obtain all necessary signatures on the CMS-730A prior to any Contractor employee arriving for fingerprinting and badge processing.

The Contractor must appoint a Security Investigation Liaison as a point of contact to resolve any issues of inaccurate or incomplete form(s). Where personal information is involved, SEMG may need to contact the contractor employee directly. The Security Investigation Liaison may be required to facilitate such contact.

SEMG will fingerprint contractor personnel and send their completed investigative package to the Office of Personnel Management (OPM). OPM will conduct the background investigation. Badges will not be provided by SEMG until acceptable finger print results are received; until then the contractor employee will be considered an escorted visitor. The Contractor remains fully responsible for ensuring contract, task order or delivery order performance pending completion of background investigations of contractor personnel.

SEMG shall provide written notification to the CO with a copy to the PO of all suitability decisions. The PO shall then notify the Contractor in writing of the approval of the Contractor's employee(s), at that time the Contractor's employee(s) will receive a permanent identification badge. Contractor personnel who the SEMG determines to be ineligible may be required to cease working on the contract immediately.

The Contractor shall report immediately in writing to SEMG with copies to the CO and the PO, any adverse information regarding any of its employees that may impact their ability to perform under this contract, task order or delivery order. Reports should be based on reliable and substantiated information, not on rumor or innuendo. The report shall include the contractor employee's name and social security number, along with the adverse information being reported.

Contractor personnel shall be provided an opportunity to explain or refute unfavorable information found in an investigation to SEMG before an adverse adjudication is made. Contractor personnel may request, in writing, a copy of their own investigative results by contacting:

Office of Personnel Management
Freedom of Information
Federal Investigations Processing Center
PO Box 618
Boyers, PA 16018-0618

The Contractor must immediately provide written notification to SEMG (with copies to the CO and the PO) of all terminations or resignations of Contractor personnel working on this contract, task order or delivery order. The Contractor must also notify SEMG (with copies to the CO and the PO) when a Contractor's employee is no longer working on this contract, task order or delivery order.

At the conclusion of the contract, task order or delivery order and at the time when a contractor employee is no longer working on the contract, task order or delivery order due to termination or resignation, all CMS-issued parking permits, identification badges, access cards, and/or keys must be promptly returned to SEMG. Contractor personnel who do not return their government-issued parking permits, identification badges, access cards, and/or keys within 48 hours of the last day of authorized access shall be permanently barred from the CMS complex and subject to fines and penalties authorized by applicable federal and State laws.

Work Performed Outside the United States and its Territories

The contractor, and its subcontractors, shall not perform any activities under this contract at a location outside of the United States, including the transmission of data or other information outside the United States, without the prior written approval of the Contracting Officer. The factors that the Contracting Officer will consider in making a decision to authorize the performance of work outside the United States include, but are not limited to the following:

1. All contract terms regarding system security
2. All contract terms regarding the confidentiality and privacy requirements for information and data protection
3. All contract terms that are otherwise relevant, including the provisions of the statement of work
4. Corporate compliance
5. All laws and regulations applicable to the performance of work outside the United States
6. The best interest of the United States

In requesting the Contracting Officer's authorization to perform work outside the United States, the contractor must demonstrate that the performance of the work outside the United States satisfies all of the above factors. If, in the Contracting Officer's judgment, the above factors are not fully satisfied, the performance of work outside the United States will not be authorized. Any approval to employ or outsource work outside of the United States must have the concurrence of the CMS SEMG Director or designee.

H.22 CODE OF CONDUCT

A. SMOKING

Effective June 9, 2004, smoking is not permitted anywhere on the CMS single site campus. This includes all areas outside the building, such as off-site facility, entranceways, sidewalks and parking areas. Smoking will not be permitted anywhere in Regional Offices or Washington, D.C. Office locations unless permitted by GSA guidelines or local landlord requirements. Contractor employees are subject to the same restrictions as government personnel. Fines up to $50 per occurrence will be issued and enforced by the Federal Protective Service.

B. DRESS

The preferred dress codes at CMS facilities are professional attire, business attire or business casual attire.

H.23 POST AWARD EVALUATION OF CONTRACTOR PERFORMANCE

In accordance with the past performance requirements of the FAR, CMS shall require the contractor to register with the National Institutes of Health (NIH) Contractor Performance System (CPS). The database allows for the electronic collection, maintenance and dissemination of contractor performance information.

a. Contractor Performance Evaluations

Interim annual, and final evaluations of contractor performance will be prepared on this contract in accordance with FAR 42.15. The final performance evaluation will be prepared at the time of completion of work. At the discretion of the Contracting Officer, interim evaluations should be considered. Annual evaluations shall be prepared to coincide with the anniversary date of the contract.

A copy of all evaluations should be provided to the Contractor as soon as practicable after completion of the annual and final evaluation. The Contractor will be permitted thirty (30) days to review the document and to submit additional information or a rebutting statement. Any disagreement between the parties regarding an evaluation will be referred to the Deputy Director, Acquisition and Grants Group, whose decision will be final.

Copies of the evaluation, contractor responses, and review comments, if any, will be retained as part of the contract file, and will be used to support future award decisions.

b. Electronic Access to Contractor Performance Evaluations

Contractors that have Internet capability may access evaluations through a secure Web site for review and comment by completing the registration form that can be obtained at the following address: https://cpscontractor.nih.gov.

To register, simply logon and click on the "Register Here" link. This site provides instructions on how to register and offers computer-based training for contractors through the "CPS Contractor On-Line Training" hyperlink. There is no fee for registration or use of this system. Electronic evaluations are available to registered contractors for review 30 days from the date the evaluation is sent.

The registration process requires the contractor to identify an individual that will serve as a primary contact and who will be authorized access to the evaluation for review and comment. In addition, the contractor will be required to identify an alternate contact who will be responsible for notifying the cognizant contracting official in the event the primary contact is unavailable to process the evaluation within the required 30-day time frame.

H.24 PRIVACY ACT 'SYSTEMS NOTICE'

The contractor will be required to sign a Privacy Act notice when they apply for a CMS user ID for CMS Data Center access.

H.25 PUBLICITY

Any news release, public announcement, advertisement, or publicity proposed to be released by the Contractor or subcontractor will be subject to the written approval of CMS prior to release.

H.26 LIMITATION OF FUNDS (INCREMENTAL FUNDING)

a. The estimated cost to the Government for the performance of all work under this contract is $_____. The fixed-free amount is $_____. The award-fee amount is $_____. The total estimated cost plus award-fee is $_____.

b. Pursuant to FAR Clause 52.232-22, entitled "Limitation of Funds", total funds in the amount of $_____ have been allocated and are available for payment for the contractor's performance from the effective date of award through _____. $_____ represents the amount available for reimbursement of costs incurred by the contractor, $_____ represents the amount available for payment of fixed-fee, and $_____ represents the amount available for payment of award-fee.

c. The Government may increase the incremental funded amount of this contract by a unilateral contract modification

d. The provisions of the "Limitation of Funds" clause shall become inapplicable when funding equal to the total estimated cost and fixed-fee set forth in paragraph **a** above is obligated to this contract. At such time the "Limitation of Cost" clause shall become applicable.

SECTION I - CONTRACT CLAUSES

I.1 52.252-2 CLAUSES INCORPORATED BY REFERENCE. (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this/these address(es):

http://www.arnet.gov/far/

a) The following general clauses are applicable:

52.202-1 DEFINITIONS (JUL 04)

52.203-3 GRATUITIES (APR 84)

52.203-5 COVENANT AGAINST CONTINGENT FEES (APR 84)

52.203-6 RESTRICTIONS ON SUBCONTRACTOR SALES TO THE GOVERNMENT (SEP 06) – ALTERNATE I (OCT 95)

52.203-7 ANTI-KICKBACK PROCEDURES (JUL 95)

52.203-8 CANCELLATION, RESCISSION, AND RECOVERY OF FUNDS FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 97)

52.203-10 PRICE OR FEE ADJUSTMENT FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 97)

52.203-12 LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (SEPT 05)

52.204-4 PRINTING/COPYING DOUBLE-SIDED ON RECYCLED PAPER (AUG 00)

52.204-7 CENTRAL CONTRACTOR REGISTRATION (JUL 06)

52.209-6 PROTECTING THE GOVERNMENTS INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT (SEP 06)

52.215-2 AUDIT AND RECORDS--NEGOTIATION (JUN 99)

52.215-8 ORDER OF PRECEDENCE - UNIFORM CONTRACT FORMAT (OCT 97)

52.215-10 PRICE REDUCTION FOR DEFECTIVE COST OR PRICING DATA (OCT 97)

52.215-11 PRICE REDUCTION FOR DEFECTIVE COST OR PRICING DATA -- MODIFICATIONS (OCT 97)

52.215-12 SUBCONTRACTOR COST OR PRICING DATA (OCT 97)

52.215-13 SUBCONTRACTOR COST OR PRICING DATA -- MODIFICATIONS (OCT 97)

52.215-15 PENSION ADJUSTMENTS AND ASSET REVERSIONS (OCT 04)

52.215-17 WAIVER OF FACILITIES CAPITAL COST OF MONEY (OCT 97)

52.215-18 REVERSION OR ADJUSTMENT OF PLANS FOR POSTRETIREMENT BENEFITS (PRB) OTHER THAN PENSIONS (JUL 05)

52.215-21 REQUIREMENTS FOR COST OR PRICING DATA OR INFORMATION OTHER THAN COST OR PRICING DATA -- MODIFICATIONS (OCT 97) – ALTERNATE IV (OCT 97)

52.217-8 OPTION TO EXTEND SERVICES (NOV 99)

52.219-8 UTILIZATION OF SMALL BUSINESS CONCERNS (MAY 04)

52.219-9 SMALL BUSINESS SUBCONTRACTING PLAN (SEP 06), ALTERNATE II (OCT 01)

52.219-16 LIQUIDATED DAMAGES-SUBCONTRACTING PLAN (JAN 99)

52.222-3 CONVICT LABOR (JUN 03)

52.222-21 PROHIBITION OF SEGREGATED FACILITIES (FEB 99)

52.222-26 EQUAL OPPORTUNITY (MAR 07)

52.222-35 EQUAL OPPORTUNITY FOR SPECIAL DISABLED VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (SEP 06)

52.222-36 AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES. (JUN 98)

52.222-37 EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (SEP 06)

52.222-41 SERVICE CONTRACT ACT OF 1965, AS AMENDED (JUL 05)

52.222-49 SERVICE CONTRACT ACT – PLACE OF PERFORMANCE UNKNOWN (MAY 89)

52.223-6 DRUG-FREE WORKPLACE (MAY 01)

52.223-14 TOXIC CHEMICAL RELEASE REPORTING (AUG 03)

52.224-1 PRIVACY ACT NOTIFICATION (APR 84)

52.224-2 PRIVACY ACT (APR 84)

52.225-13 RESTRICTIONS ON CERTAIN FOREIGN PURCHASES (FEB 06)

52.227-3 PATENT INDEMNITY (APR 84)

52.227-14 RIGHTS IN DATA – GENERAL (JUN 87)

52.227-17 RIGHTS IN DATA – SPECIAL WORKS (JUN 87)

52.227-23 RIGHTS TO PROPOSAL DATA (TECHNICAL) (JUN 87)

52.230-2 COST ACCOUNTING STANDARDS (APR 98)

52.230-3 DISCLOSURE AND CONSISTENCY OF COST ACCOUNTING PRACTICES (APR 98)

52.230-6 ADMINISTRATION OF COST ACCOUNTING STANDARDS (APR 2005)

52.232-9 LIMITATION ON WITHHOLDING OF PAYMENTS (APR 1984)

52.232-17 INTEREST (JUN 96)

52.232-23 ASSIGNMENT OF CLAIMS (JAN 86)

52.232-25 PROMPT PAYMENT (OCT 03) – ALTERNATE 1 (FEB 02)

52.232-33 PAYMENT BY ELECTRONIC FUNDS TRANSFER – CENTRAL CONTRACTOR REGISTRATION (OCT 03)

52.233-1 DISPUTES (JUL 02) - ALTERNATE I (DEC 1991)

52.233-3 PROTEST AFTER AWARD (AUG 96) - ALTERNATE I (JUNE 1985)

52.233-4 APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 04)

52.237-3 CONTINUITY OF SERVICES (JAN 91)

52.237-10 IDENTIFICATION OF UNCOMPENSATED OVERTIME (OCT 97)

52.239-1 PRIVACY OR SECURITY SAFEGUARDS (AUG 96)

52.242-2 PRODUCTION PROGRESS REPORTS (APR 1991)

52.242-13 BANKRUPTCY (JUL 95)

52.244-2 SUBCONTRACTS (AUG 98 - ALTERNATE I (JAN 06)

52.244-5 COMPETITON IN SUBCONTRACTING (DEC 96)

52.244-6 SUBCONTRACTS FOR COMMERCIAL ITEMS (MAR 07)

52.245-1 PROPERTY RECORDS (APR 84)

52.251-1 GOVERNMENT SUPPLY SOURCES (APR 84)

52.252-4 ALTERATIONS IN CONTRACT (APR 84)

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52.216-8 FIXED FEE (MAR 97)

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52.242-1 NOTICE OF INTENT TO DISALLOW COSTS (APR 84)

52.242-3 PENALTIES FOR UNALLOWABLE COSTS (MAY 01)

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52.249-6 TERMINATION (COST-REIMBURSEMENT) (MAY 04)

52.249-14 EXCUSABLE DELAYS (APR 84)

I.2 DEPARTMENT OF HEALTH & HUMAN SERVICES ACQUISITION REGULATIONS (HHSAR)

352.202-1 DEFINITIONS (JAN 06)

352.216-72 ADDITIONAL COST PRINCIPLES (JAN 06)

352.228-7 INSURANCE – LIABILITY TO THIRD PERSONS (DEC 91)

352.233-70 LITIGATION AND CLAIMS (JAN 06)

352.242-71 FINAL DECISIONS ON AUDIT FINDINGS (APR 84)

352.270-1 ACCESSIBILITY OF MEETINGS, CONFERENCES, AND SEMINARS TO PERSONS WITH DISABILITIES (JAN 2001)

352.270-4 PRICING OF ADJUSTMENTS (JAN 01)

352.270-6 PUBLICATION AND PUBLICITY (JAN 06)

I.3 52.215-19 NOTIFICATION OF OWNERSHIP CHANGES (OCT 97)

(a) The Contractor shall make the following notifications in writing:

(1) When the Contractor becomes aware that a change in its ownership has occurred, or is certain to occur, that could result in changes in the valuation of its capitalized assets in the accounting records, the Contractor shall notify the Administrative Contracting Officer (ACO) within 30 days.

(2) The Contractor shall also notify the ACO within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership.

(b) The Contractor shall--

(1) Maintain current, accurate, and complete inventory records of assets and their costs;

(2) Provide the ACO or designated representative ready access to the records upon request;

(3) Ensure that all individual and grouped assets, their capitalized values, accumulated depreciation or amortization, and remaining useful lives are identified accurately before and after each of the Contractor's ownership changes; and

(4) Retain and continue to maintain depreciation and amortization schedules based on the asset records maintained before each Contractor ownership change.

(c) The Contractor shall include the substance of this clause in all subcontracts under this contract that meet the applicability requirement of FAR 15.408(k).

I.4 52.217-9 OPTION TO EXTEND THE TERM OF THE CONTRACT (MAR 00)

(a) The Government may extend the term of this contract by written notice to the Contractor within 60 days*;* provided, that the Government gives the Contractor a preliminary written notice of its intent to extend at least 60 days before the contract expires. The preliminary notice does not commit the Government to an extension.

(b) If the Government exercises this option, the extended contract shall be considered to include this option clause.

(c) The total duration of this contract, including the exercise of any options under this clause, shall not exceed 60 months.

I.5 52.222-2 PAYMENT FOR OVERTIME PREMIUMS (JUL 90)

(a) The use of overtime is authorized under this contract if the overtime premium does not **exceed $15,598** or the overtime premium is paid for work—

(1) Necessary to cope with emergencies such as those resulting from accidents, natural disasters, breakdowns of production equipment, or occasional production bottlenecks of a sporadic nature;

(2) By indirect-labor employees such as those performing duties in connection with administration, protection, transportation, maintenance, standby plant protection, operation of utilities, or accounting;

(3) To perform tests, industrial processes, laboratory procedures, loading or unloading of transportation conveyances, and operations in flight or afloat that are continuous in nature and cannot reasonably be interrupted or completed otherwise; or

(4) That will result in lower overall costs to the Government.

(b) Any request for estimated overtime premiums that exceeds the amount specified above shall include all estimated overtime for contract completion and shall—

(1) Identify the work unit; *e.g.,* department or section in which the requested overtime will be used, together with present workload, staffing, and other data of the affected unit sufficient to permit the Contracting Officer to evaluate the necessity for the overtime;

(2) Demonstrate the effect that denial of the request will have on the contract delivery or performance schedule;

(3) Identify the extent to which approval of overtime would affect the performance or payments in connection with other Government contracts, together with identification of each affected contract; and

(4) Provide reasons why the required work cannot be performed by using multishift operations or by employing additional personnel.

I.6 52.222-39 NOTIFICATION OF EMPLOYEE RIGHTS CONCERNING PAYMENT OF UNION DUES OR FEES (DEC 04)

(a) *Definition*. As used in this clause—
"United States" means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b) Except as provided in paragraph (e) of this clause, during the term of this contract, the Contractor shall post a notice, in the form of a poster, informing employees of their rights concerning union membership and payment of union dues and fees, in conspicuous places in and about all its plants and offices, including all places where notices to employees are customarily posted. The notice shall include the following information (except that the information pertaining to National Labor Relations Board shall not be included in notices posted in the plants or offices of carriers subject to the Railway Labor Act, as amended (45 U.S.C. 151-188)).

Notice to Employees

Under Federal law, employees cannot be required to join a union or maintain membership in a union in order to retain their jobs. Under certain conditions, the law permits a union and an employer to enter into a union-security agreement requiring employees to pay uniform periodic dues and initiation fees. However, employees who are not union members can object to the use of their payments for certain purposes and can only be required to pay their share of union costs relating to collective bargaining, contract administration, and grievance adjustment.

If you do not want to pay that portion of dues or fees used to support activities not related to collective bargaining, contract administration, or grievance adjustment, you are entitled to an appropriate reduction in your payment. If you believe that you have been required to pay dues or fees used in part to support activities not related to collective bargaining, contract administration, or grievance adjustment, you may be entitled to a refund and to an appropriate reduction in future payments.

For further information concerning your rights, you may wish to contact the National Labor Relations Board (NLRB) either at one of its Regional offices or at the following address or toll free number:

National Labor Relations Board
Division of Information
1099 14th Street, N.W.
Washington, DC 20570
1-866-667-6572
1-866-316-6572 (TTY)

To locate the nearest NLRB office, see NLRB's website at http://www.nlrb.gov.

(c) The Contractor shall comply with all provisions of Executive Order 13201 of February 17, 2001, and related implementing regulations at 29 CFR Part 470, and orders of the Secretary of Labor.

(d) In the event that the Contractor does not comply with any of the requirements set forth in paragraphs (b), (c), or (g), the Secretary may direct that this contract be cancelled, terminated, or suspended in whole or in part, and declare the Contractor ineligible for further Government contracts in accordance with procedures at 29 CFR Part 470, Subpart B—Compliance Evaluations, Complaint Investigations and Enforcement Procedures. Such other sanctions or remedies may be imposed as are provided by 29 CFR Part 470, which implements Executive Order 13201, or as are otherwise provided by law.

(e) The requirement to post the employee notice in paragraph (b) does not apply to—

(1) Contractors and subcontractors that employ fewer than 15 persons;

(2) Contractor establishments or construction work sites where no union has been formally recognized by the Contractor or certified as the exclusive bargaining representative of the Contractor's employees;

(3) Contractor establishments or construction work sites located in a jurisdiction named in the definition of the United States in which the law of that jurisdiction forbids enforcement of union-security agreements;

(4) Contractor facilities where upon the written request of the Contractor, the Department of Labor Deputy Assistant Secretary for Labor-Management Programs has waived the posting requirements with respect to any of the Contractor's facilities if the Deputy Assistant Secretary finds that the Contractor has demonstrated that—

(i) The facility is in all respects separate and distinct from activities of the Contractor related to the performance of a contract; and

(ii) Such a waiver will not interfere with or impede the effectuation of the Executive order; or

(5) Work outside the United States that does not involve the recruitment or employment of workers within the United States.

(f) The Department of Labor publishes the official employee notice in two variations; one for contractors covered by the Railway Labor Act and a second for all other contractors. The Contractor shall—

(1) Obtain the required employee notice poster from the Division of Interpretations and Standards, Office of Labor-Management Standards, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-5605, Washington, DC 20210, or from any field office of the Department's Office of Labor-Management Standards or Office of Federal Contract Compliance Programs;

(2) Download a copy of the poster from the Office of Labor-Management Standards website at http://www.olms.dol.gov; or

(3) Reproduce and use exact duplicate copies of the Department of Labor's official poster.

(g) The Contractor shall include the substance of this clause in every subcontract or purchase order that exceeds the simplified acquisition threshold, entered into in connection with this contract, unless exempted by the Department of Labor Deputy Assistant Secretary for Labor-Management Programs on account of special circumstances in the national interest under authority of 29 CFR 470.3(c). For indefinite quantity subcontracts, the Contractor shall include the substance of this clause if the value of orders in any calendar year of the subcontract is expected to exceed the simplified acquisition threshold. Pursuant to 29 CFR Part 470, Subpart B—Compliance Evaluations, Complaint Investigations and Enforcement Procedures, the Secretary of Labor may direct the Contractor to take such action in the enforcement of these regulations, including the imposition of sanctions for noncompliance with respect to any such subcontract or purchase order. If the Contractor becomes involved in litigation with a subcontractor or vendor, or is threatened with such involvement, as a result of such direction, the Contractor may request the United States, through the Secretary of Labor, to enter into such litigation to protect the interests of the United States.

I.7 HHSAR 352.224-70 CONFIDENTIALITY OF INFORMATION (JAN 06)

(a) Confidential information, as used in this clause, means information or data of a personal nature about an individual, or proprietary information or data submitted by or pertaining to an institution or organization.

(b) The Contracting Officer and the Contractor may, by mutual consent, identify elsewhere in this contract specific information and/or categories of information which the Government will furnish to the Contractor or that the Contractor is expected to generate which is confidential. Similarly, the Contracting Officer and the Contractor may, by mutual consent, identify such confidential information from time to time during the performance of the contract. Failure to agree will be settled pursuant to the "Disputes" clause.

(c) If it is established elsewhere in this contract that information to be utilized under this contract, or a portion thereof, is subject to the Privacy Act, the Contractor will follow the rules and procedures of disclosure set forth in the Privacy Act of 1974, 5 U.S.C. 552a, and implementing regulations and policies, with respect to systems of records determined to be subject to the Privacy Act.

(d) Confidential information, as defined in paragraph (a) of this clause, shall not be disclosed without the prior written consent of the individual, institution, or organization.

(e) Whenever the Contractor is uncertain with regard to the proper handling of material under the contract, or if the material in question is subject to the Privacy Act or is confidential information subject to the provisions of this clause, the Contractor should obtain a written determination from the Contracting Officer prior to any release, disclosure, dissemination, or publication.

(f) Contracting Officer determinations will reflect the result of internal coordination with appropriate program and legal officials.

(g) The provisions of paragraph (d) of this clause shall not apply to conflicting or overlapping provisions in other Federal, State, or local laws.

I.8 HHSAR 352.232-9 WITHHOLDING OF CONTRACT PAYMENTS (JAN 06)

Notwithstanding any other payment provisions of this contract, failure of the Contractor to submit required reports when due or failure to perform or deliver required work, supplies, or services, may result in the withholding of payments under this contract unless such failure arises out of causes beyond the control, and without the fault or negligence of the Contractor as defined by the clause entitled "Excusable Delays" or "Default", as applicable. The Government shall immediately notify the Contractor of its intention to withhold payment of any invoice or voucher submitted.

I.9 HHSAR 352.249-14 EXCUSABLE DELAYS (JAN 06)

(a) Except with respect to failures of subcontractors, the Contractor shall not be considered to have failed in performance of this contract if such failure arises out of causes beyond the control and without the fault or negligence of the Contractor.

(b) Such causes may include, but are not restricted to, acts of God or of the public enemy, acts of the Government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather, but in every case the failure to perform must be beyond the control and without the fault or

negligence of the Contractor. If the failure to perform is caused by the failure of a subcontractor to perform, and if such failure arises out of causes beyond the control of both the Contractor and subcontractor, and without the fault or negligence of either of them, the Contractor shall not be deemed to have failed in performance of the contract, unless:

(1) the supplies or services to be furnished by the subcontractor were obtainable from other sources,
(2) the Contracting Officer ordered the Contractor in writing to procure such supplies or services from such other sources, and
(3) the Contractor failed to comply with such order.

Upon request of the Contractor, the Contracting Officer shall ascertain the facts and extent of such failure and if the Contracting Officer determines that any failure to perform was caused by circumstances beyond the control and without the fault or negligence of the Contractor, the delivery schedule shall be revised accordingly, subject to the rights of the Government under the termination clause contained in this contract. (As used in this clause, the terms "subcontractor" and "subcontractors" mean subcontractor(s) at any tier.)

I.10 HHSAR 352.270-7 PAPERWORK REDUCTION ACT (JAN 06)

(a) This contract involves a requirement to collect or record information calling either for answers to identical questions from 10 or more persons other than Federal employees, or information from Federal employees which is outside the scope of their employment, for use by the Federal government or disclosure to third parties; therefore, the Paperwork Reduction Act of 1995 (Pub. L. 104–13) shall apply to this contract. No plan, questionnaire, interview guide or other similar device for collecting information (whether repetitive or singletime) may be used without first obtaining clearance from the Office of Management and Budget (OMB). Contractors and Project Officers should be guided by the provisions of 5 CFR Part 1320, Controlling Paperwork Burdens on the Public, and seek the advice of the HHS operating division or Office of the Secretary Reports Clearance Officer to determine the procedures for acquiring OMB clearance.

(b) The Contractor shall not expend any funds or begin any data collection until OMB Clearance is received. Once OMB Clearance is received from the Project Officer, the Contracting Officer shall provide the Contractor with written notification authorizing the expenditure of funds and the collection of data. The Contractor must allow at least 120 days for OMB clearance. Excessive delays caused by the Government which arise out of causes beyond the control and without the fault or negligence of the Contractor will be considered in accordance with the Excusable Delays or Default clause of this contract.

I.11 HHSAR 352.270–10 ANTI-LOBBYING (JAN 06)

Pursuant to the current HHS annual appropriations act, except for normal and recognized executive-legislative relationships, the Contractor shall not use any HHS contract funds for (i) publicity or propaganda purposes; (ii) the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any State legislature itself; or (iii) payment of salary or expenses of the Contractor, or any agent acting for the Contractor, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

I.12 HHSAR 352.270–11 Privacy Act (JAN 06)

This contract requires the Contractor to perform one or more of the following: (a) Design; (b) develop; or (c) operate a Federal agency system of records to accomplish an agency function in accordance with the Privacy Act of 1974 (Act) (5 U.S.C. 552a(m)(1)) and applicable agency regulations. The term "system of records" means a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual. Violations of the Act by the Contractor and/or its employees may result in the imposition of criminal penalties (5 U.S.C. 552a(i)). The Contractor shall ensure that each of its employees knows the prescribed rules of conduct and that each employee is aware that he/she is subject to criminal penalties for violation of the Act to the same extent as HHS employees. These provisions also apply to all subcontracts awarded under this contract which require the design, development or operation of the designated system(s) of records (5 U.S.C. 552a(m)(1)). The contract work statement: (a) identifies the system(s) of records and the design, development, or operation work to be performed by the Contractor; and (b) specifies the disposition to be made of such records upon completion of contract performance.

I.13 HHSAR 352.270-19 ELECTRONIC INFORMATION AND TECHNOLOGY ACCESSSIBILITY (JAN 06)

Pursuant to Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) as amended by Public Law 105–220 under Title IV (Rehabilitation Act Amendments of 1998), all Electronic and Information Technology (EIT) developed, procured, maintained, and/or used under this contract shall be in compliance with the "Electronic and Information Technology Accessibility Standards" set forth by the Architectural and Transportation Barriers Compliance Board (also referred to as the "Access Board") in 36 CFR part 1194. The complete text of Section 508 Final Standards can be accessed at *http://www.access-board.gov/sec508/standards.htm.*

The standards applicable to this requirement can be accessed at: http://www.access-board.gov/sec508/guide/index.htm, and http://cmsnet.cms.hhs.gov/hpages/cmm/dmsd/508Ref_Guide.doc

Vendors may document conformance using Voluntary Product Accessibility Template at *http://www.itic.org/archives/articles/20040506/faq_voluntary_product_accessibility_template_vpat.php*].

Vendors should provide detailed information necessary for determining compliance, including defined contractor-incidental exceptions.

SECTION J - LIST OF ATTACHMENTS

J-1 STATEMENT OF WORK (SOW)

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J-22 CONTRACTOR'S CONFLICT OF INTEREST CERTIFICATE (Incorporated by reference)

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Statement of Work Jurisdiction 4

ATTACHMENT J-1

JULY 31, 2007

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C.1 SCOPE

The Contractor, as an independent Contractor and not as an agent of the government, shall furnish all the necessary services, qualified personnel, material, equipment, and facilities, not otherwise provided by the government, as needed to perform the work described in this Statement of Work (SOW).

The Contractor shall perform all Medicare Administrative Contractor (MAC) functions specified in this SOW and outlined in both the Internet-Only-Manuals (IOMs, http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage) and Paper-Based Manuals. For purposes of this contract, when differences or conflicts occur, **this SOW shall take precedence over the IOMs** unless otherwise specified. The Contractor shall contact the Contracting Officer and the Project Officer if budgetary concerns occur because of this conflict. The Contractor is advised that any and all references in the SOW (including manuals, IOMs, etc.) to "RO-Regional Office" shall be replaced with "CO-Contracting Officer." Attachment J-5 contains definitions of all abbreviations used in this SOW.

C.1.1 Purpose of Contract

The purpose of this contract is to obtain a Medicare Administrative Contractor (hereinafter, referred to as "the Contractor" or "MAC") to provide specified health insurance benefit administration services, including Medicare claims processing and payment services, in support of the Medicare fee-for-service (FFS) program. The Contractor will perform its responsibilities under the direction of the Centers for Medicare & Medicaid Services (CMS).

Under this contract, the Contractor will perform numerous functions to support health care services for Medicare beneficiaries, which include performing claims-related activities and establishing relationships with providers of health care services, both institutional and professional, for a defined geographic area or "jurisdiction." The Contractor will perform the requirements of this contract in accordance with applicable laws, regulations, Medicare manuals, and CMS requirements to ensure the financial integrity of the Medicare program. The Medicare program's legal, policy, and operating environment is complex, and the Contractor will utilize or interact with certain CMS-required payment schedules, systems, equipment, and operational capabilities in the performance of its functions. Further, the Contractor will coordinate its activities not only with the CMS, but also with a broad range of agencies (at the federal, state, and local levels of government), other CMS partners and Contractors, and a diverse range of stakeholders within the health care system of the United States.

The Contractor will receive and control Medicare claims from institutional and professional providers, suppliers, and beneficiaries within its jurisdiction and will perform standard or required editing on these claims to determine whether the claims are complete and should be paid. In addition, the Contractor will calculate Medicare payment amounts and arrange for remittance of these payments to the appropriate

party. The Contractor also will enroll new providers; conduct redeterminations on appeals of claims; operate a Provider Customer Service Program that educates providers about the Medicare program and responds to provider telephone and written inquiries; respond to complex inquiries from Beneficiary Contact Centers (BCCs); and make coverage decisions for new procedures and devices in local areas. The Contractor also will conduct a variety of different provider services, such as enrolling new providers in the program, answering written inquiries, and educating providers on Medicare's rules, regulations, and billing procedures.

The mission of CMS is to ensure health care security for beneficiaries. This contract specifically applies to that mission by fostering excellence in the design and administration of CMS' programs.

C.1.2 Background

The Medicare program is an integral component of the federal government's commitment to the health and welfare of the American people, which includes the Social Security system, the Medicaid program (which is primarily administered by the states), and other programs. The Medicare program provides affordable health insurance to (1) eligible individuals aged 65 and over; (2) certain individuals eligible for disability benefits under the Social Security system; and (3) individuals with acute kidney failure (end-stage renal disease, or ESRD). Approximately 42 million people were enrolled for Medicare coverage in FY2004.

Nearly all Medicare beneficiaries may access their insurance benefits through one of two health care delivery systems:

- First, in all areas of the country, a beneficiary may enroll in the traditional Medicare program (the Medicare FFS program) under which benefits are largely provided in keeping with an indemnity insurance model. That is, the beneficiary chooses his/her health care providers, the providers bill the appropriate Medicare claims administrator for their services, and the claims administrator pays the provider based on the eligibility, coverage, and payment rules of the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs. The federal government bears all financial (underwriting) risk for the cost of program benefits and develops detailed administrative requirements and processes to support the claim administration process. This national entitlement program has a strong imperative to provide a common level of benefits and service in all areas of the country, while maintaining adequate flexibility to account for local and regional medical practices. More than 87% of all Medicare beneficiaries—or about 36 million—participate in the traditional Medicare program.

- Second, in many areas of the country, beneficiaries have the option to enroll in one or more privately sponsored Medicare plans under the Medicare Advantage (formerly Medicare+ Choice) program. These private Medicare plans may

organize themselves in keeping with one of several health care delivery and payment models (health maintenance organizations, preferred provider organizations, etc.). These private Medicare plans are required to cover the same basic benefits that the traditional Medicare program offers, but they are given fairly broad responsibility and latitude to set up their internal requirements and processes as they see fit. About 13% of Medicare beneficiaries are enrolled in Medicare Advantage.

The recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) includes significant incentives to increase the participation in Medicare Advantage. However, for the next decade at least, a significant majority of all Medicare beneficiaries will likely remain enrolled in the traditional FFS Medicare program. FFS coverage in the Medicare program consists of two distinct parts: (1) HI, which also provides coverage for Medicare institutional benefits, and (2) SMI, which provides coverage for the professional medical services of physicians and certain other licensed practitioners, as well as coverage for a variety of other services and items (ambulance, durable medical equipment, etc.). In common usage, the HI program is known as "Medicare Part A," although both the Part A and B trust funds are used to reimburse institutional claims. The SMI program is known as "Medicare Part B"; only the Medicare Part B trust fund is used to reimburse Part B claims.

Nearly all Medicare beneficiaries are entitled to receive their Medicare Part A (HI) without payment of any insurance premium. Beneficiaries must elect to enroll in Medicare Part B (SMI), for which they must pay a monthly premium, and nearly all do so. In Fiscal Year (FY) 2004, about 41.2 million individuals were enrolled in both Medicare Part A and Part B. A relatively small number of beneficiaries were enrolled in Part A only (2.5 million) or Part B only (0.4 million).

Under Medicare law, the Medicare HI (Part A) benefit is funded through the HI trust fund. The primary revenue source for the HI trust fund is a wage tax administered through the Social Security system. The HI trust fund accumulates a significant balance in excess of the amount needed for ongoing satisfaction of claims. The trustees of the HI trust fund include the Secretaries of the Treasury, Labor, and Health and Human Services. The Social Security Administration (SSA) Commissioner and two members of the public also serve as trustees of the HI trust fund.

The Medicare SMI (Part B) benefit is administered through the SMI trust fund. Unlike the HI fund, however, the SMI trust fund does not accumulate a significant balance in excess of the amount needed for ongoing satisfaction of claims. In addition to receipts from beneficiary premiums, the primary revenue source for the SMI trust fund is an annual congressional appropriation from the Treasury's general revenues. The trustees for the SMI trust fund are the same as those for the HI trust fund.

Medicare spending – both HI and SMI – is a substantial portion of the federal government's annual budget and the health care economy of the United States. In

FY2004, total HI spending equated to $170.6 billion (offset by $1.9 billion in premiums), and total SMI spending equated to $138.3 billion (offset by premiums of $31.4 billion).

The CMS relies on a network of contractors to process Medicare claims; enroll health care providers in the Medicare program and educate them on Medicare billing requirements; handle claims appeals; and answer beneficiary and provider inquiries. Fiscal intermediaries (FIs) handle claims processing and benefit payment functions for institutional providers under Part A and Part B of the Medicare program; carriers perform the same functions for professional providers under Part B of the program.

C.1.3 Contracting Reform

On December 8, 2003, the President signed into law the MMA (Public Law 108-173). Section 911 of MMA directed implementation of Medicare FFS Contracting Reform. Medicare Contracting Reform requires that the CMS use competitive procedures to replace its current FIs and carriers with a uniform type of administrative entity, referred to as a MAC.

C.1.4 Roles and Responsibilities

The roles and responsibilities of the parties are outlined below.

C.1.4.1 The Centers for Medicare & Medicaid Services

The Medicare program's authorizing statutes charge the Secretary of the Department of Health and Human Services (DHHS) with administrative responsibility for the Medicare program. The Secretary has delegated the program authority for Medicare (both the traditional FFS program and Medicare Advantage) to the CMS Administrator.

The CMS administers the Medicare program, including formulation and promulgation of Medicare program policy and guidance, contract execution, operation and management, maintenance and review of utilization records, and general Medicare financing. The CMS is the largest purchaser of health care in the United States and provides health care coverage to nearly one in four Americans. The CMS' annual budget places it among the largest businesses in the world; its programs channel one out of every three dollars in the health care market, and its policies influence the other two dollars. In FY 2004, CMS Contractors processed approximately 1.13 billion Medicare claims.

As part of its responsibility to administer the Medicare program, the CMS manages the work of the Contractors engaged in its day-to-day operation. This management is accomplished through a variety of avenues such as periodic conferences on topics of general interest; targeted sessions with selected subsets of the Contractors; issuance of manual updates describing changes in coverage, pricing, and eligibility; and evaluation of the performance of those Contractors within the description of the work the CMS engages them to do.

C.1.4.1.1 Business Function Leads and Technical Monitors

Within the CMS, specialists on various Medicare topics shall serve as Business Function Leads (BFLs) and Technical Monitors (TMs) to assist the Project Officer and the Contracting Officer in administering the contract. These BFLs/TMs shall provide technical guidance to the Contractor on matters within each BFL's/TM's area of responsibility. The BFL/TM shall consult with the Project Officer on Technical Direction as necessary. The BFL/TM is not authorized to direct changes to contract work.

C.1.4.2 MEDICARE ADMINISTRATIVE CONTRACTOR ("THE CONTRACTOR")

Section 1861 of the Social Security Act defines the items and services for which Medicare may pay. It also defines the provider types recognized by the Medicare program. Attachment J-3, Categories of Benefits and Provider/Supplier Types for the MAC Contract, briefly lists each category and provider type. The Contractor is responsible for handling all the claims identified in Attachment J-3, and related requirements identified in section C.5 of this SOW, that are within its jurisdiction, except for the distinct types of claims that are identified as additional services in section C.7 of this SOW. The MAC is also responsible for processing Part A claims for Railroad Retirement Board Beneficiaries. The types of claims identified as additional services in section C.7 are also mandatory requirements under the contract.

The complexity of Medicare payment systems and policies and the numbers of Contractors, providers, and insurers involved in the Medicare FFS program create vulnerabilities for error. To minimize these vulnerabilities and reduce the Medicare claims payment error rate, CMS has made paying claims right, the first time, one of its primary goals. This means paying the right amount, to legitimate providers, for Medicare-covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

In the interest of consistency across the Medicare program, during the performance of this contract, the Contractor is expected to seek and follow advice from CMS on questions of law and policy as they arise.

Information relating to A/B MAC claims processing, information flows, interfaces and other supporting processes with "functional Contractors" can be found in the Concept of Operations document located in Attachment J-12.

C.1.4.3 UNIQUE REQUIREMENTS FOR THE MAC

Under Title XVIII of the Social Security Act ("the Act"), the CMS contracted with individual fiscal intermediaries (FIs) and carriers to perform unique work and tasks beyond the base scope of the FI and Carrier contracts. These special contract

arrangements were for work that may have affected beneficiaries and/or providers in every state and/or region.

C.1.4.3.1 Unique Core Requirements

Under Medicare Contracting Reform, the CMS has decided to include some of these unique contract tasks within the core work requirements for each A/B MAC jurisdiction. Table 1 lists the activities that are incorporated into the core requirements for each A/B MAC jurisdiction.

Table 1: Unique Core Requirements

SOW Section	Requirement
C.5.16	Coordinated Care Benefits Demo (Notice of Enrollment)
C.5.17	ESRD Clinical Trial
C.5.18	Rural Health Clinics
C.5.19	Federally Qualified Health Centers
C.5.20	Foreign Claims
C.5.21	Laboratory Competitive Bidding Demonstration
C.5.22	Shipboard / Foreign Travel Services

The Contractor should ensure they understand the impact to the functional requirements of these workloads.

C.1.4.3.2 Jurisdiction-Specific Requirements

In addition to the requirements described in section C.1.4.2.1, the CMS has identified requirements for the MACs that are specific to a jurisdiction. Table 2 lists the requirements that will be incorporated into select A/B MAC jurisdictions.

Table 2: Jurisdiction-Specific Requirements

SOW Section	Requirement	Jurisdiction
C.7.1	Centralized Billing for Mass Immunizers	4
C.7.2	Indian Health Services	4
C.7.4	Rural Community Hospital Demonstration	4
C.7.5	Veterans Affairs Medicare Equivalent Remittance Advice	4

SOW Section	Requirement	Jurisdiction
	Project	
C.7.6	Chiropractic Services Demonstration	4

C.2 APPLICABLE DOCUMENTS

The following statutes, regulations, manuals, and documents apply to this contract.

C.2.1 Statutes

The Contractor must comply with all applicable laws. The major statute governing the Medicare program is Title XVIII of the Social Security Act ("the Act"), as amended. The Act and major amendments to the Act are outlined below. The identified amendments include legislation that significantly changed the Medicare program, are being implemented, or significantly affect the scope of work. Congress may pass new legislation at any time, and the Centers for Medicare & Medicaid Services (CMS) must act to implement such legislation as timely and accurately as possible.

C.2.1.1 SOCIAL SECURITY ACT (PUBLIC LAW 74-271)

The Act was enacted on August 14, 1935, with subsequent amendments. The Act consists of 20 titles, four of which have been repealed. The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs are authorized by Title XVIII of the Act. The vast bulk of the traditional Medicare program's authorizing law is codified in Parts A, B and E of Title XVIII. (Part C is primarily devoted to private Medicare plans, and Part D governs the new Medicare prescription drug benefit.) Other Medicare-related authorizing statutes are in Titles II and XI of the Act; other governing provisions are in the Internal Revenue Code and other statutes.

To the extent that there is no conflicting Medicare requirement, the administration of the traditional Medicare program is also governed by numerous statutes pertaining to the general administration of federal programs. The following are among the general statutory authorities with broad implications for the traditional Medicare program and the Medicare Administrative Contractor (MAC) contract:

a. Acquisition (Competition in Contracting Act, etc.)

b. Federal Information Security Management Act of 2002 (FISMA)

c. Government Performance and Results Act (GPRA)

d. Personnel and civil rights law (Drug-Free Workplace Act, Americans with Disability Act)

e. Privacy and information technology requirements (Privacy Act of 1974, Information Technology Management Reform Act of 1996).

f. Rehabilitation Act of 1998 (section 508, Accessibility Standards)

C.2.1.2 MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT (PUBLIC LAW 108-173)

On December 8, 2003, the President signed the Medicare Prescription Drug, Improvement and Modernization Act (MMA) into law. This statute makes the most sweeping changes in the structure of the Medicare program since its inception in 1966. The significant changes made by this statute include the following:

a. Establishment of a temporary Medicare prescription drug discount card program.

b. Establishment of a permanent Medicare prescription drug program.

c. Renaming of the Medicare+ Choice to Medicare Advantage and provision of significant new incentives to facilitate the participation of private plans in Medicare.

d. Provision of certain preventive benefits under both traditional Medicare and Medicare Advantage.

e. Implementation of many changes in coverage and payment policy within traditional Medicare.

f. Implementation of many administrative and regulatory reforms within traditional Medicare.

g. Under section 911 of the MMA, restructuring of the acquisition statutes that govern traditional Medicare, commonly known as Medicare contracting reform.

h. Under section 912 of the MMA, requirements for information security program and independent evaluations.

i. Under section 921 of the MMA, provision requiring toll-free lines for provider inquiries and an expansion of provider education.

The work under this contract will be affected by many of these provisions; however, the primary authority governing the terms and conditions of this contract is section 911.

C.2.1.3 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (PUBLIC LAW 104-191)

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996. Title II, Subtitle F, of HIPAA gives the Department of Health and Human Services (DHHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or

sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

C.2.1.4 Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248)

The Tax Equity and Fiscal Responsibility Act (TEFRA) made Medicare the secondary payer for certain employees and dependents.

C.2.1.5 Benefit Improvement and Protection Act of 2000 (Public Law 106-554)

Section 521 of the Benefit Improvement and Protection Act (BIPA) changed the Medicare appeals process to create a uniform procedure for handling all Medicare appeals (Parts A and B) and specified time frames for filing appeals and rendering decisions.

C.2.2 Regulations

Generally, Medicare regulations are located at Title 42 of the Code of Federal Regulations (CFR).

C.2.3 Medicare Manuals

Medicare manuals (e.g., Internet-only manuals—IOMs) are CMS program instructions, day-to-day operating instructions, policies, and procedures that are based on statutes and regulations, guidelines, models, and directives. CMS program components, providers, Contractors, and state survey agencies use Medicare manuals to administer CMS programs. As CMS paper-based manuals are updated, the updated materials are published in the IOMs and eliminated from the paper-based manuals. The IOMs have precedence over paper-based manuals. The CMS will continue this phase-out/phase-in process until all manual instructions are in the IOMs. IOMs and paper-based manuals can be found at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage. Attachment J-11 offers an index of Manual Citations sorted by requirement number, and a summary of CFR Citations, sorted by requirement number.

Citations in this Statement of Work (SOW) are generally to an IOM Publication (IOM Pub.). Paper-based manual citations are used only where necessary (indicated as CMS Pub. XX).

C.3 KEY DEFINITIONS

Several Statement of Work (SOW) appendices contain definitions critical to understanding this SOW. Attachment J-7 is an alphabetical listing of key definitions and Attachment J-8 describes the different terms used to describe the function of reevaluating a decision. These attachments are not intended to be an all-inclusive list of definitions for terms used throughout the SOW. Additional definitions are available on http://www.cms.hhs.gov.

C.4 OBJECTIVES

This acquisition supports the mission of the Centers for Medicare & Medicaid Services (CMS) to ensure health care security for beneficiaries. The CMS' strategic goals and objectives, developed in conjunction with the Department of Health and Human Services' strategic plan, emphasize the themes of accountability, stewardship, and a renewed focus on the customer. For the CMS, this has resulted in a commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. To ensure that the CMS remains a responsive, dynamic, and relevant government agency that serves its citizens, the CMS is committed to monitoring and evaluating the effectiveness of its programs. The CMS will communicate, collaborate, and cooperate with key customers, both public and private, to help achieve the desired outcomes.

Consistent with Government Performance and Results Act principles, the CMS has used a balanced-scorecard approach to develop objectives for the Contractor in the following four categories: customer service, operational excellence, innovation and technology, and financial management. In this Statement of Work (SOW), the CMS has identified meaningful, outcome-oriented performance standards and measures that speak to fundamental program purposes and to CMS' role as a steward of taxpayer dollars.

C.4.1 Customer Service

Customer service addresses the ability to provide quality services effectively and to increase the overall level of customer service and satisfaction. In support of customer service, the Contractor shall do the following:

a. Provide an overall environment where providers understand the fee-for-service (FFS) Medicare program.

b. Respond to provider telephone and written inquires promptly, clearly, and accurately.

c. Maintain effective provider education that achieves accurate billing with prompt and correct provider payment.

d. Maintain a high level of provider service and satisfaction by good communication and relationships with providers.

e. Maintain a high level of beneficiary service and satisfaction related to the complex inquires referred to the MAC by the Beneficiary Contact Center.

C.4.2 Operational Excellence

Operational excellence addresses the ability of employees, the quality of information systems, and the effects of organizational alignment in supporting the accomplishment of organizational goals. In support of achieving operational excellence, the Contractor shall do the following:

a. Effectively manage the combined administration of Medicare Parts A and B.

b. Promote corporate integrity and establish internal controls and an effective compliance program to achieve contractual goals and objectives.

c. Work collaboratively with CMS, providers, and other CMS contractors to foster integration of Medicare operations.

C.4.3 Innovation and Technology

Innovation and technology addresses internal business results that lead to financial success and satisfied customers. In support of innovation and technology, the Contractor shall do the following:

a. Develop and continually refine business processes to foster excellence and quality in the administration of the Medicare program.

b. Foster efficiencies in the administration of the Medicare FFS program to promote best value for the government.

c. Use innovative and creative solutions to improve program operations.

C.4.4 Financial Management

Improving financial management is a key initiative in the President's Management Agenda and has been a long-term focus in achieving CMS' mission. Under the Medicare Integrity Program, the CMS is focused on paying the right amount to legitimate providers for covered, reasonable and necessary services. Financial management also addresses efforts to promote cost efficiency and the ability to deliver maximum value to the customer. In support of financial management, the Contractor shall do the following:

a. Promote the fiscal integrity of the Medicare FFS program and be an accountable steward of public funds.

b. Pay claims timely, accurately, and reliably.

C.5 FUNCTIONAL REQUIREMENTS

The following sections list the Centers for Medicare & Medicaid Services' (CMS') requirements, which are grouped by functional area. Table 1 lists the requirements sections.

Table 3. Requirements Sections

Number	Name
1	Workload Implementation Requirements
2	Contractor Responsibilities during the Closeout Period and at Contract End
3	Infrastructure Requirements
4	Administrative Requirements
5	Provider Enrollment
6	Local Coverage Determinations
7	Provider Customer Service Program
8	Claims Processing
9	Reopening of Medicare Initial Claims Determinations
10	Appeals of Medicare Initial Claims Determinations
11	Financial Management of Trust Fund Dollars
12	Medical Review
13	Coordination with Program Safeguard Contractor
14	Medicare Secondary Payer
15	Provider Oversight
16	Coordinated Care Benefits Demonstration
17	End Stage Renal Disease Clinical Trial

Number	Name
18	Freestanding Rural Health Clinics
19	Federally Qualified Health Centers
20	Foreign Claims
21	Laboratory Competitive Bidding Demonstration
22	Shipboard/Foreign Travel Services
23	Program Management Office

Each requirement section presents the following information:

a. Requirement number—unique number identifying the requirement

b. Requirement name and description—descriptive title and words conveying the requirement (a few sections contain only a requirement name, relying on subsections to describe requirements)

c. Background—information providing the context for a requirement (background information is provided as needed).

d. Standards—defined levels of performance against which the quality of services can be determined.

C.5.1 Workload Implementation Requirements

The Contractor shall carry out the orderly transfer of all Medicare data, records, and operations from all outgoing carriers and intermediaries (segments) within its jurisdiction in accordance with the Jurisdiction Implementation Project Plan.

The Contractor shall establish and maintain through the course of the implementation an experienced implementation management team.

Background	Guidelines for conducting a successful implementation are found in Attachment J-19, Medicare Administrative Contractor (MAC) Implementation Handbook.
Standard 1	A workload implementation is successful when the implementation is completed within the required time period, as stated in the Jurisdiction

	Implementation Project Plan.
Standard 2	A workload implementation is successful when there is no disruption of claims processing and Medicare operations; and
Standard 3	A workload implementation is successful when there is minimal disruption of payment, customer service, and other benefits/services.
Standard 4	The segment implementation is successful when all Medicare functions specified in the SOW are performed by the Contractor beginning on the Segment Operational Start Date (SOSD).
Standard 5	The jurisdictional operational cutover is successful when the Contractor performs all Medicare functions under the SOW for the entire jurisdiction on the Jurisdiction Operational Start Date (JOSD).

C.5.1.1 JURISDICTION IMPLEMENTATION PROJECT PLAN

The Contractor shall develop, execute, and maintain a Jurisdiction Implementation Project Plan consistent with the Contractor's proposed Jurisdiction Implementation Project Plan that was submitted in response to the Request for Proposal (RFP) and report its status. The Jurisdiction Implementation Project Plan shall include a detailed description of all activities required to transfer all Medicare operations from each carrier and intermediary in the Contractor's jurisdiction.

C.5.1.2 SEGMENT IMPLEMENTATION PROJECT PLANS

The Contractor shall develop, update, and follow a detailed Segment Implementation Project Plan for the transfer of each Part A and/or Part B Medicare FFS workload (segments) and report its status for each segment in its jurisdiction.

Background	The Segment Implementation Project Plan is an expanded part of the Jurisdiction Implementation Project Plan containing more specific details for a particular segment.

C.5.1.3 RISK MANAGEMENT PLAN

The Contractor shall develop, execute, and maintain a Risk Management Plan consistent with the Contractor's proposed Risk Management Plan submitted in response to the RFP.

The Contractor shall deliver a Risk Management Plan to the Project Officer and identified CMS business owners prior to each Segment Kick-off Meeting. The Risk Management Plan shall include jurisdiction-wide as well as segment-specific risks and a periodic assessment, conducted monthly at a minimum, of new risks and mitigation and contingency planning where appropriate.

Standard	The Contractor's Risk Management Plan is successful when it is delivered within 30 calendar days of the of the Segment Kick-off Meeting.

C.5.1.4 SEGMENT CUTOVER PLAN

The Contractor shall develop, maintain, and follow a Segment Cutover Plan for each segment implementation identifying the daily processes and procedures, some of which may be hour specific, that the Contractor will follow during the cutover period to ensure a successful cutover.

Background	The Segment Cutover Plan is an expanded part of the Segment Implementation Project Plan containing more specific details for the segment cutover period.

C.5.1.5 SEGMENT TEST PLAN

The Contractor shall develop, maintain, and follow a comprehensive test plan for each segment. The test plan shall identify:

a. The approach to testing,

b. Types of tests,

c. The schedule,

d. Resources, and

e. Documentation of progress.

C.5.1.6 LESSONS LEARNED DOCUMENTATION

The Contractor shall identify the lessons learned during the implementation of each segment in a Lessons Learned document.

Standard	The Contractor's Lessons Learned document is successful when it is delivered within 40 days after the segment cutover date.

C.5.1.7 ACCOUNTS RECEIVABLE RECONCILIATION

The Contractor shall work with the outgoing Contractors in its jurisdiction to achieve successful transfer and reconciliation of accounts receivables from each in accordance with the Segment Implementation Project Plans.

C.5.1.8 CONSOLIDATION OF PART A AND PART B EDITS

Background	The consolidation of shared system edits includes Local Coverage Determinations (LCDs) and Fiscal Intermediary Shared System (FISS) reason

	codes as well as any other FISS edits that implement local business rules. The consolidation of LCDs shall be done for both the FISS and the Multi-Carrier System (MCS) shared systems. The consolidation of reason codes will be required for the FISS shared system but will not be required for the MCS shared system; however, a Contractor may propose to consolidate carrier business rules (MCS shared system edits) during the transition period or later in the operational period. The criteria the Contractor uses to determine final edits should include operational efficiency, minimization of disruption to the provider community, or other factors that the Contractor believes are pertinent. The single set of reason codes will include a unique, defined action for each code. The consolidation of FISS edits includes the implicit condition that Part A workload for each Jurisdiction will be processed in one data processing cycle (one CICS region) -- absent any other data processing, operational, or FISS constraints that might dictate the need for more than one cycle. The MAC shall consolidate existing shared system edits of the outgoing contractors so that they are the same for the entire jurisdiction. This activity shall be completed by the cutover date of the first segment; however, if circumstances arise wherein an unanticipated early departure of a contractor(s) occurs, the MAC shall keep existing edits (LCDs and reason codes) in place at the outgoing contractor, after cutover, until the first planned contractor cutover date. At the time of the first planned cutover date, the contractor shall implement the consolidated edits at the first site(s). This is necessary in order to provide adequate time for possible provider billing changes. CMS will provide edit documentation from all Part A segments in J4 at the time of contract award.
Standard 1	The consolidation of shared system edits is successful when the edits are completed during the transition period by the first segment cutover date.

C.5.1.8.1 Consolidation of Reason Codes

The Contractor shall consolidate the existing shared system edits of the outgoing Contractors so that they are the same for the entire jurisdiction.

The Contractor shall analyze existing edits and determine the final edits based on criteria that it proposes when implementing consolidated reason codes.

The Contractor shall assure that the final edits have been tested and significant changes have been communicated to the provider community.

C.5.1.8.2 Consolidation of Local Coverage Determinations

Except as described in this section, MACs shall follow instructions in IOM Pub. 100-08, Chapter 13.

The MAC shall consolidate the existing shared system edits of the outgoing contractors so that they are the same for the entire jurisdiction.

The MAC shall select the least restrictive Local Coverage Determination (LCD) from the existing LCDs on a single topic when consolidating LCDs (see background for exception). The MAC shall not revise the LCDs until the consolidation process is final.

Each draft LCD must be accompanied by a narrative justification describing how least restrictive was applied for that particular policy. This narrative must be submitted along with the proposed policy 30 days before notification of the provider community, to the CMS Business Function Lead or Technical Monitor, and is subject to their approval. The narrative must also be sent to providers along with the final policy as part of the consolidation process.

The MAC shall notify the provider community within its jurisdiction which LCDs it has consolidated and adopted no less than 45 days prior to those policies cutting over to the incoming MAC.

The Contractor shall educate the affected provider community and other CMS-contracting entities, including Medicare Advantage (MA) organizations, Prescription Drug Plans, and others, of any changes in LCDs during the implementation period and prior to the cutover of any workload from an outgoing Contractor to the incoming Contractor.

Background	The outgoing Contractor will provide the MAC with any LCDs. The MAC is required to consolidate the existing LCDs of the outgoing FIs and/or Carriers within its jurisdiction so that they are the same throughout the jurisdiction. In situations where there is no policy in one or more states in a jurisdiction, the Contractor is permitted to have no LCD on that topic only with the prior approval of the CMS Central Office or Regional Office Business Owner. The Contractor shall use the least restrictive policy of policies currently in place unless the CMS Business Owner approves use of a more restrictive policy upon request on an exception basis. The request must be sent with sufficient justification to explain why a more restrictive policy should be adopted. The Contractor must determine whether the least restrictive policy means no policy or the least restrictive of the policies that are existing. In many cases it is more burdensome to have no policies, or a policy touching on an issue only briefly, than a robust policy since there is limited national guidance in some areas. Least restrictive can be no policy, but that is a judgment the MAC must make in the context of a MAC jurisdiction. In making that judgment, the MAC should consider potential vulnerabilities of having no policy. The contractor must submit the narrative justification for their determination to CMS for approval. This activity shall be completed by the cutover date of the first segment; however, if circumstances arise wherein an unanticipated early departure of a

	contractor(s) occurs, the MAC shall keep existing edits (LCDs and reason codes) in place at the outgoing contractor, after cutover, until the first planned contractor cutover date (as defined in Section L of this Request for Proposal). At the time of the first planned cutover date, the Contractor shall implement the consolidated edits at the first site(s). This is necessary in order to provide adequate time for possible provider billing changes. The Contractor is not required to utilize the formal notice and comment revision process specified in Chapter 13 of the Program Integrity Manual (PIM) until the consolidation process is final. The Contractor has the discretion to involve the provider community in the selection of least restrictive policies. However, due to the short timeframes involved they are not required to go through a formal Contractor Advisory Committee as defined in the PIM. To allow for adequate notice, the contractor may allow current policies and edits at existing contractors to remain in place until all contractors cut over. A CAC is required for a new or revised policy developed after the cutover of existing workload to an incoming Contractor. For more information regarding LCDs, see section C.5.5 of this SOW.
Standard 1	Initial consolidation of inherited LCDs by subject area is successful when all LCDs are completed and the policies posted on the web 45 days (or more) prior to the first segment cutover date.
Standard 2	Notification of the provider community is successful when the Contractor provides the notice 45 days (or more) prior to the policy cutover date.

C.5.1.9 Implementation Stakeholder Communication

The Contractor shall develop, execute, and maintain a Communication Project Plan for each segment consistent with the Contractor's proposed Communication Project Plan submitted in response to the RFP. The Communication Plan shall identify the processes and procedures the Contractor will follow to ensure that all implementation stakeholders (i.e., hospital associations) are informed of the implementation, its status, and progress and how changes may affect them.

Background	Implementation stakeholders are those parties directly involved in the implementation such as providers, the outgoing Contractor(s), beneficiaries, etc., as well as those with an interest in the implementation, such as governmental entities, medical societies, medical specialty groups, and law enforcement.

C.5.1.10 Implementation Meetings

The Contractor shall organize, host, and provide toll-free telecommunication lines and facilities for implementation meetings. The meetings shall follow a prepared agenda and discuss the status of the major tasks, issues, deliverables, schedule, delays, problem resolution, and risk mitigation and contingencies.

The Contractor shall document the minutes of each implementation meeting conducted.

The Contractor shall also maintain an issue log.

Background	Implementation meetings include: ▪ A jurisdiction kickoff meeting; the date will be determined by the Project Officer, but will be no later than 30 days after contract award. ▪ Individual segment kickoff meetings, which are held within ten (10) days after the scheduled implementation start date of the segment, unless otherwise directed by the Project Officer. ▪ Jurisdiction status teleconferences or meetings, which are held every two (2) weeks. ▪ Segment implementation workgroup teleconferences or meetings which are held weekly. ▪ Segment implementation status teleconferences or meetings, which are held every two (2) weeks. ▪ After each segment implementation, a teleconference (unless a face-to-face meeting is directed by CMS), which is held to discuss the overall implementation and the lessons- learned document prepared by the Contractor. ▪ Ad hoc meetings, as necessary.

C.5.2 Contractor Responsibilities during the Workload Closeout Period and at Contract End (Option that may be exercised at the End of the Contract)

The outgoing Contractor shall cooperate fully, and shall transfer all Medicare data and records to the replacement Contractor during the workload closeout period at the end of the contract.

Background	At contract end, Medicare Fee-for-Service (FFS) activities will be transferred to a replacement Contractor.
Standard 1	At the end of the contract, the outgoing Contractor successfully meets this standard when Medicare data is delivered to the new Contractor in accordance with the new MAC's implementation project plan and by the contract end date.
Standard 2	At the end of the contract, the outgoing Contractor successfully meets this standard when duplicate files or data not required by the incoming Contractor are destroyed in accordance with CMS data security requirements.

Standard 3	At the end of the contract, the outgoing Contractor successfully meets this standard when the Contractor maintains an experienced workload closeout management team.

C.5.2.1 Workload Closeout Project Plan (Option that may be exercised at the End of the Contract)

The outgoing Contractor shall develop, maintain, update, and follow a Workload Closeout Project Plan to provide for the transfer of Medicare functions and operations at contract end and report its status.

The outgoing Contractor's plan shall provide detailed tasks reflecting the activities necessary for the outgoing Contractor to provide Medicare data to the incoming Contractor, and to maintain operational standards during the workload closeout period, and shall include all the tasks required for the transition of benefits payments financial reporting.

The outgoing Contractor shall also provide the incoming MAC with its Workload Closeout Project Plan and shall coordinate the plan with the incoming Contractor's implementation plan.

C.5.2.2 Workload Closeout Meetings (Option that may be exercised at the End of the Contract)

The Contractor shall attend meetings and provide appropriate staff to participate in the various functional workgroups that may be established during the workload closeout period, including:

a. Kickoff meeting organized by the incoming Contractor;

b. Weekly transition workgroup teleconferences or meetings;

c. Biweekly transition status teleconferences or meetings with the incoming Contractor;

d. Lessons-learned conference that will be held by the new Contractor; and

e. Ad hoc meetings as necessary.

C.5.2.3 Workload Closeout Risk Management Plan (Option that may be exercised at the End of the Contract)

The outgoing Contractor shall develop, execute, and maintain a Workload Closeout Risk Management Plan. The Workload Closeout Risk Management Plan shall include a

monthly assessment of new risks and mitigation and contingency planning where appropriate for the transition of its operations and the transfer of Medicare data.

C.5.2.4 Accounts Receivable Reconciliation (Option that may be exercised at the End of the Contract)

The outgoing Contractor shall accomplish Accounts Receivable Reconciliation in accordance with C.5.11, provide detailed supporting documentation, and cooperate fully with the incoming Contractor to ensure the accuracy of any accounts receivable balances to be transferred.

C.5.2.5 Cost Accounting/Audit (Option that may be exercised at the End of the Contract)

The outgoing Contractor shall perform CMS-required post-cutover financial and administrative activities and participate in a cost accounting audit at the end of the contract.

C.5.2.6 Provider Cost Reports and Appeals (Option that may be exercised at the End of the Contract)

The outgoing Contractor shall cooperate fully with the incoming Contractor to identify all open provider cost reports and appeals.

The outgoing Contractor shall transfer all open and closed cost reports, appeals, and audit documentation and any other pertinent files/records.

C.5.3 Infrastructure Requirements

The Contractor shall provide/use infrastructure to fulfill the requirements of this contract.

Background	For information related to the Centers for Medicare & Medicaid Services (CMS) required hours of operation, see the relevant Internet-only Manual (IOM) for the functional area.
Standard 1	The infrastructure is successful when it is available during all required hours of operation.

C.5.3.1 ENTERPRISE DATA CENTER

The Contractor shall provide infrastructure required, to integrate and interact with the assigned CMS Enterprise Data Center (EDC) and to accomplish services not provided by the EDC, to fulfill the requirements of this contract.

The Contractor shall coordinate their transition schedule to the EDC transition schedule in order to comply with the movement of the Medicare FFS workloads

Background	The CMS EDC is managed by a Program Management Office (PMO) that is responsible for oversight of the EDCs. The EDC PMO will serve as the customer-facing organization responsible for: ▪ Monitoring the EDCs' relationships with all customers and assisting them in using the EDCs and other CMS data center capabilities ▪ Coordination of the transition of new applications and the migration of Medicare FFS workloads to the EDCs ▪ Providing "one-stop shopping" for EDC services and the focal point for resolution of EDC-related issues ▪ Oversight and program management of the deployment of new application and/or functionality to the EDCs ▪ Ensuring the quality of EDC service delivery. The EDC will provide the necessary infrastructure and environments required for hosting the Medicare FFS shared systems (e.g., MCS, FISS, and CWF). The EDC operational environment will provide CMS and Medicare stakeholders with the flexibility to grow in size and capabilities to meet future Medicare FFS claims processing needs. CMS will use a 3-Zone enterprise architecture for its EDC. The EDC enterprise architecture for new applications is designed to facilitate robust security in three zones. The 3-Zone architecture will be implemented incrementally. As an A/B Medicare Administrative Contractor (MAC) requires services, it will work through the CMS EDC-PMO to ensure that adequate capacity and connectivity exist. Any requirements for Fiscal Year (FY) 2006 will be accomplished through the CMS Data Center with transition planned into the new EDC facilities FY 2007. Several software programs and entities outside the Shared System are distributed by CMS or its agents that are also critical to the overall processing of Medicare claims. The EDC Contractor will also provide interfaces to the MAC front-end and back-end process. The EDC Contractor will be responsible for obtaining (connectivity or other) and operating these. This would include any future changes in standardizing processes such as a Standard Front-End or re-defining the network entry/exit point for any contractor changes or moves (such as MACs, CWF Host moves). The Shared System processing includes the responsibility to integrate with

	several processing nodes that provide input to or are given output by the Shared System. The EDC Contractor will be responsible for providing this full range of computer and human resource support to ensure that the various datasets are either received from or sent to these points of processing. This support will include not only the routine steps associated with successfully completing these transmissions, but also any special steps associated with a failure or problem, even if the failure or problem is due to another party. Appendix A provides a list of base and non-base functions. The MAC shall work with all such entities, including the EDC, to interface and/or facilitate the receipt or transmission of files, programs or other such products. Base functions are defined on the spreadsheet as being functions provided either by the shared system or the EDC, in other words, government furnished property. Base functions also include interfaces that are part of the base system processing such as CWF, CERT, CCI, COBC, PECOS, PIMR, Pricer, PULSE etc. Non-base/Non-core refers to any applications or interfaces that are not part of the base system processing or are not provided or maintained as a part of the Medicare Shared Systems (FISS or MCS). These non-base/non-core applications or interfaces may involve an outside vendor, another Medicare Data Center, or any entity with or share information through a software application in processing your Medicare claims. This does not include commercial word processing or spreadsheet programs (Microsoft Word, Excel, PowerPoint, etc.), which you routinely use. Examples of non-base/non-core processes include but are not limited to the following: ▪ Print Mail, ▪ ANSI Translation, ▪ Workload Management reports, ▪ Scanning Administration, ▪ ICR/OCR Imaging, ▪ Fraud and Abuse reporting, ▪ Data Analysis (Easytrieve, SAS extracts, etc.), and ▪ Data files you routinely receive from your current FISS/MCS data center. In the future, some non-base functions may become base if CMS deems that is in its best interest. In this situation, a change request would be prepared to incorporate the function in the shared system, and MACs would be notified of the change through the quarterly release process. The Data Use Agreement (DUA) can be found at the following website: http://www.cms.hhs.gov/cmsforms/downloads/cms-r-0235.pdf.
Standard 1	The Contractor's use of EDC is successful when it uses the operational processes and procedures the EDC establishes with its users.

C.5.3.1.1 Local Hardware and Software Requirements

The Contractor shall provide hardware and utility software identified in Attachment J-17, Contractor Furnished Property, as necessary to accomplish the requirements of this contract and to communicate with and utilize the CMS EDC.

The Contractor shall distribute the free or low cost Medicare billing software compliant with the HIPAA 837, Medicare Remit Easy Print (MREP), and 835 print software to requesting providers in accordance with IOM Pub. 100-04, Chapters 22 and 24.

The Contractor shall support and distribute all current, free billing software being used by the EDI submitters during the initial transition of EDI submitters to the Contractor. The Contractor shall ensure plans are in place to migrate the EDI submitters to one free billing software package.

C.5.3.1.1.1 COTS

The Contractor shall provide a single COTS translation software package for inbound (i.e., 837 claims, 276 claim status inquiries, 275 claim attachment) and outbound (835 remittance advice, 277 claim status response, TA1 interchange acknowledgement, 999 syntax acknowledgement, 277 health care claim acknowledgement , and 824 non-claim application acknowledgement) transactions. The software must be capable of supporting multiple versions (current HIPAA version and future 5010 version). There shall be no limitations to file size, segment and loop repeats.

Background	The translation/validation software package shall provide: ▪ Translation of the inbound HIPAA transactions into a CMS-provided flat file format. ▪ Editing of the data to ensure HIPAA compliance (see IOM Pub. 100-04, Chapters 22, 24 and 31, published implementation guides, and CMS companion guides for the EDI transactions). ▪ The submission of a 997 functional acknowledgement file, or TA1 (X12N transactions only). ▪ The submission of error reports back to the submitter. ▪ Translation and editing of the outbound flat files for the X12N 277 claim status and X12N 835 remittance advice received from the shared system into the HIPAA-compliant X12N transactions. The ASC X12N Implementation guides are available at www.wpc-edi.com in the HIPAA section.

C.5.3.1.1.2 Electronic Claims Retention

The Contractor shall provide software and procedures to ensure that all electronic claim transactions are copied as received and retained to fully comply with the CMS data

retention requirements for electronic claims as received in accordance with IOM Pub. 100-04, Chapter 24, section 80.2.

Background	This data shall be used to reconcile claim transactions, indicate the number of claims received and the number of claims transferred to each shared system, ensuring that claims have not been dropped during processing.

C.5.3.2 TELECOMMUNICATIONS

The Contractor shall use only the CMS-supplied telecommunications network to transmit Medicare data to ensure the privacy and security of this protected information for:

a. Medicare communications between the Contractor and subcontractors, if any;

b. Communication between the Contractor and other Medicare Contractors; and

c. Communications between the Contractor and CMS.

Background	The CMS provides a telecommunications service – The Medicare Data Communications Network (MDCN) – which is used to transmit Medicare data between various Medicare processing sites. This service is provided through AT&T, with local access to the Contractor for linkage to: ▪ The EDC; ▪ The Common Working File (CWF); ▪ The CMS Data Center (HDC); and ▪ Other specialty Contractors such as the print mail Contractor, when applicable. The Contractor may not utilize CMS-provided and MDCN telecommunications for health care providers to submit information and/or inquiries to development requests, or for any other communication with providers. Section C.5.7.2 of this Statement of Work describes the toll-free line requirement for providers.

C.5.3.2.1 Telecommunications for Electronic Data Interchange

The Contractor shall interact with the Individuals Authorized Access to the CMS Computer Services (IACs) to ensure that the EDI submitter/receiver is an authorized EDI submitter for each transaction.

The Contractor shall adhere to the EDI front-end requirements for both incoming and outgoing EDI transactions as defined in IOM Pub. 100-04, Chapters 22, 24 and 31; and in the EDI standard format implementation guides published at http://www.wpc-

edi.com/hipaa/HIPAA_40.asp, which the CMS directs its contractors to implement in accordance with HIPAA.

Background	**NOTE: The MAC is only responsible for telecommunications to the MDCN. The MDCN to EDC interface is the responsibility of the EDC.** IACS provides a single identity and associated authentication for each user. IACS is a set of common security services that will be deployed throughout CMS IT systems to control both the issuance of electronic identities and access to CMS applications. IACS employs state-of-the-art technology to support: ▪ Delegated Administration ▪ Self-Registration ▪ Self-Management (of user data) ▪ Approval workflows to manage access requests ▪ Single Sign-on A user who needs access to CMS applications or services will "self-register" via IACS. The user is responsible for entering all required personal, professional and official "role" information via online forms. The request is managed via workflows defined for the type of access request. Approval is granted by the local administrator at the user's place of work, and (in some cases) a CMS approver. Upon approval, the user is granted a "role". That role will provide access to the full suite of applications which support that role. The user's access is restricted to only those data resources the role requires. Access to increasingly higher levels of data will be controlled by multiple levels of authorization and multiple factors of authentication.

C.5.3.2.1.1 Electronic Data Interchange Enrollment Form

The Contractor shall obtain an EDI Enrollment form from each provider prior to electronic transfer of data and issuance of system passwords/billing numbers to protect the security of transferred data. The EDI enrollment process shall take 1 week or less and submitters shall be able to begin testing within 2 weeks after enrollment.

The Contractor shall be responsible for the verification/validation of the trading partners that will be exchanging EDI with the Contractor.

The Contractor shall gather the information from the EDI enrollment form and validate the entity and security official information contained in the form. The entity will be validated against the Provider, Enrollment, Claims, and Ownership System (PECOS). Once validated, the Contractor shall generate a secret, unique entity number and provide it to the organization's security official. The security official will provide that entity number to submitters (i.e., from the hospital's billing department). The Contractor shall set up trading partner profiles in the EDI COTS translator. The Contractor shall authenticate that each trading partner is an agent of the provider for whom they wish to

send Medicare transactions (e.g., clearinghouse submitting claims for multiple providers).

The Contractor shall utilize the CMS Web-based EDI Enrollment application when that application becomes available.

Background	User verification is one of the lynch pins in IT security. Access to Medicare beneficiary claims data cannot be penetrated by unverified or unauthorized users. Similar to the "no error" directives in medication administration, CMS will guide the implementation of this system under a "no error" principle. CMS places the protection of the Medicare beneficiary and protected health information above all else. Identity management, external user verification/authorization, intrusion detection, safety protocols, and security protocols will all support the no-mistake directive, but ultimately, the system design must integrate all of these standards, as well as, safeguards in the event data is compromised. The EDI Enrollment and Network Service Vendor Forms are contained in IOM Pub. 100-04, Chapter 24.

C.5.3.2.1.2 TRANSACTION ERROR REPORTING

The Contractor shall produce a negative interchange acknowledge (TA1) if the inbound X12N Interchange Envelope is invalid and a positive TA1 if the inbound X12N Interchange Envelope is valid.

The Contractor shall produce a negative Implementation Acknowledgement (999) if the inbound X12N transaction set contains X12 and implementation guide syntax errors in the Functional Group (GS-GE) and Transaction Set (ST-SE) and a positive 999 if the Functional Group and Transaction Set are valid.

The Contractor shall produce a negative 277 acknowledgement to indicate the inbound transaction (X12N 837 claim and X12N 276 claim status inquiry) failed pre-shared system edits (companion guide and Medicare pre-screen requirements (return as unprocessable)) and indicate the status of those units of data that failed the edits. For those transactions that are accepted, the Contractor shall produce a 277 acknowledgement to indicate that the inbound transaction passed the edits and was accepted.

The Contractor shall produce a negative 824 application acknowledgement to indicate the inbound 275 attachment transaction failed HL7 conformance, implementation guide edits, and Medicare specific pre-shared system edits. For those 275 attachment transactions that are accepted, the Contractor shall produce a positive 824 to indicate that the transaction passed the edits and was accepted.

Background	Refer to the WEDI recommendations found in Attachment J-32, WEDI Acknowledgement Recommendations For ASC X12N Implementation Guides.

C.5.3.2.1.3 Receipt of Electronic Data Interchange Transactions

The Contractor shall direct X12N-based flat files received from EDI for the 837 health care claims and the 276 claim status inquiry to the shared system.

The Contractor shall edit each HIPAA transaction to ensure HIPAA-compliant syntax.

The Contractor shall edit each HIPAA transaction to ensure it meets the HIPAA implementation guide and companion guide requirements.

The Contractor shall edit each claim transaction against Medicare “pre-screen” edits (e.g., Medicare return unprocessable edits) in accordance with IOM Pub. 100-04, Chapter 1, section 80.3.1.

The Contractor shall edit medical and non-medical code sets for HIPAA compliance.

The Contractor shall use the CMS flat files as output from the translation software and input to the shared system.

The Contractor shall implement date stamping processes and procedures to ensure that all claims are provided with correct receipt dates.

C.5.3.2.1.4 Sending Electronic Data Interchange Transactions

The Contractor shall use the CMS flat files received from the shared system as input to the translation process to build the outbound HIPAA transactions.

The Contractor shall receive the X12N-based flat file for the 277 claim status response and the 835 remittance advice from the shared system maintainer. The Contractor shall translate those flat files to the appropriate HIPAA 835 and 277 formats. The Contractor shall subject the data to HIPAA syntax and implementation guide edits.

The Contractor shall load outbound files directly to the receiver’s (provider, clearinghouse, etc.,) electronic mailbox or queuing mechanism for subsequent retrieval by the trading partner. The Contractor shall retain file submissions on the “mailbox” retrieval system for a period of five (5) days.

C.5.3.2.1.5 Automated Clearing House transactions

The Contractor shall monitor, track, and provide direction in response to Automated Clearing House (ACH) transactions for initiation of electronic funds transfers (EFT) to providers if elected or required by CMS.

C.5.3.2.1.6 Direct Data Entry Capability

Background	The shared system and EDC will continue to support direct data entry capability (DDE) where it previously existed. The data elements in those screens must be compliant with the data requirements of the corresponding

	HIPAA transaction implementation guides as specified in the HIPAA transaction implementation instructions in IOM Pub. 100-04, Chapter 24.

C.5.3.2.2 Testing

The Contractor shall test inbound transaction receipt, translation, front-end editing, and transfer exchange.

The Contractor shall test receipt of outbound flat files from the shared system, translation, and routing to appropriate receiver (i.e., provider, clearinghouse, etc.) mailboxes or other queuing/retrieval mechanism.

The Contractor shall test new EDI claim submitters (837) on the HIPAA claim versions.

The Contractor shall test EDI claim submitters on new HIPAA versions. The Contractor shall also test existing EDI claim submitters who plan to begin to use new billing software not previously tested by the Contractor.

The Contractor shall support a test environment for partners, EDI transitions, and new software releases.

Background	The Contractor is not required to individually test submitters using software that is new to it, but which has been successfully used by other submitters to submit HIPAA-compliant claims to Medicare in the past. The Contractor shall only test submitters on non-claim EDI transactions if specifically requested by a provider who is concerned about its ability to use the software successfully, or when the Contractor has a reason to believe the submitter will incur usage difficulties. IOM Pub. 100-04, Chapter 24 contains further information on the Medicare requirements for provider and provider agent testing.

C.5.3.2.2.1 Initial Edits

The Contractor shall provide initial (pre-shared system) editing of electronically submitted transactions to ensure the completeness and correctness of transactions entering the system.

The Contractor shall establish a technique to detect duplicate transmissions; have the capability to reject, or return as unprocessable, at a file, batch or business transaction level, based upon the edit(s) failed; and determine when all initial edits have been passed.

The Contractor shall implement either the X12N 824 Application Advice transaction set or other standard error report to report application-level errors. The Contractor shall provide informational warning messages to notify providers of new claim edits prior to implementing new edits.

Background	Initial editing will include format and data editing: ▪ Format edits validate the integrity of the incoming transactions based upon the HIPAA adopted standards and implementation guides which includes file layout, information sequencing, balancing, alpha-numeric/numeric/date file conventions, data content values, and relational edits; and ▪ Data editing validates business-specific transaction data required for processing, e.g., procedure/diagnosis codes, modifiers. Syntax compliance edits include edits of the standard such as alpha-numeric or numeric data formats, field lengths, valid qualifiers, mandatory loops and segments, appropriate segments within a given loop. Implementation guide edits vary depending on the implementation guide being used.

C.5.3.2.3 Electronic Data Interchange Help Desk

The Contractor shall provide a centralized EDI Help Desk, which is integrated and interactive with the EDC help desk.

The EDI Help Desk staff shall respond to telephone inquiries in accordance with IOM Pub. 100-09, Chapter 3.

The Contractor shall triage incoming calls and will route appropriate EDI calls to the Contractor's EDI Help Desk and EDC-related issues to the EDC help desk.

Background	All EDI Help Desk staff shall have experience with the X12N 837, 276/277, and 835 version 4010A1 transactions. All EDI Help Desk staff shall have experience with error reports. The EDI Help Desk staff shall have access to trading partner electronic mailboxes or other queuing mechanisms to track or re-queue reports and have access to transactional data. Help Desk services shall include a centralized problem database where all problems shall be documented. This database shall record and track all problems, related changes, and status. Further, the problem database shall contain sufficient information to both operationally manage individual problems and provide the ability to analyze problems for trends. The problem database content shall include, at a minimum: ▪ Name, company, security/sign-on ID, and the phone number of the individual reporting the problem; ▪ A detailed description of the problem; ▪ The effect of the problem on the customer/user; ▪ The relationship to other problem or change tickets (i.e., AGNS, parent/child relationship); ▪ The date and time the problem was reported; ▪ Person/group that the problem was assigned to and when it was assigned;

	▪ Problem status that is updated every 60 minutes for severe problems; ▪ The resolution of the problem; ▪ Date and time of the resolution; and ▪ Total time taken from time of report to time of resolution (time is tracked during help desk hours). In addition to this content, the Contractor should include any other information it deems appropriate.

C.5.3.2.3.1 Electronic Data Interchange Outreach Activities

The Contractor shall:

a. Feature information on EDI during trade shows, vendor fairs, educational forums, and vendor association meetings that they sponsor or in which they participate;

b. Provide educational information on EDI to providers as well as to the software vendors and clearinghouses that serve or market services to Medicare providers; and

c. Make themselves available whenever possible, and invited to participate as an EDI speaker on the agenda of organized provider group meetings, such as EDI user groups, state and local medical societies, and other provider and related vendor trade groups.

The Contractor shall maintain a directory of electronic billing software vendors and clearinghouses that have successfully completed software and/or submission testing for the X12 837 version 4010A1 and 5010 claim transactions adopted as national claim standards for HIPAA. Once the 275 claim attachment is adopted, the Contractor shall add those vendors who tested successfully to this list as well. The Contractor shall make this directory available to their providers via a Web page or electronic bulletin board. The Contractor shall update the directory whenever software from additional software vendors and additional clearinghouses is moved into production. At a minimum, the directory must include the vendor/clearinghouse name, phone number, address, software product name, and production version. The Contractor shall also note any additional transactions for which the tested software can be used for submission or receipt of HIPAA transactions other than the claim.

Background	IOM Pub. 100-04, Chapter 24 contains further information on the Medicare requirements for EDI education and outreach.

C.5.3.2.4 Electronic Funds Transfer EFT Forms

The Contractor shall obtain an Electronic Funds Transfer (EFT) form, as applicable, from each provider prior to electronic transfer of funds.

C.5.3.2.4.1 NETWORK SERVICE AGREEMENTS

The Contractor shall obtain Network Service Agreements (NSA) from provider agents, business associates, and subcontractors who transfer provider EDI transactions, EFT data, and Coordination of Benefits (COB) data electronically, as required in IOM Pub. 100-04, Chapter 24.

C.5.3.2.5 HIPAA Code Set Updates

The Contractor shall make system changes as needed to update claim adjustment reason and remittance advice remark codes, claim status category codes, and claim status codes up to four times per year as directed by CMS.

C.5.3.3 TELEPHONE SERVICE

The Contractor shall provide telephone systems to meet minimum design guidelines, make telephone service available, and connect with CMS-provided toll-free lines.

Background	The CMS provides toll-free service for provider inquiries handled by provider contact centers. The Contractor provides all other telephone services needed to fulfill the requirements of the contract.

C.5.3.4 CMS AUDITS AND REVIEWS

The Contractor shall allow CMS the use of provided software and software documentation, tools, and equipment to conduct audit reviews, tests, and assessments of the Contractor at its facility and its data center.

C.5.4 Administrative Requirements

C.5.4.1 KEY PERSONNEL

Unless noted in the specific requirement, key personnel are neither fully dedicated nor restricted only to Medicare lines of business. Unless otherwise approved by the Contracting Officer, the key personnel noted below shall possess the following minimum work experience and educational requirements:

C.5.4.1.1 Project Manager

The Project Manager shall be **fully dedicated** to the A/B MAC.

The Project Manager shall possess:

Experience

Ten or more years of professional experience with at least three (3) years as a manager responsible for managing complex systems and work flow.

Education

A bachelor's degree from an accredited institution, plus a master's degree from an accredited institution or substitution of four (4) additional years of related work experience in lieu of the master's degree.

C.5.4.1.2 Claims Processing Manager

The Claims Processing Manager shall be **fully dedicated** to the A/B MAC contract.

The Claims Processing Manager shall possess:

Experience

A minimum of three years prior work experience with Medicare or Medicare-equivalent Fee-for-Service claims processing operations. Prior experience with both Medicare Part A (intermediary) and Part B (intermediary and carrier) claims processing operations is highly desirable.

C.5.4.1.3 Chief Financial Officer

The Chief Financial Officer (CFO) shall not be responsible for other external third party or corporate activities. However, the CFO may oversee other Medicare contracts (**must be dedicated to the Medicare line(s) of business**) and is not required to be fully dedicated to the A/B MAC contract.

To eliminate any conflict of interest and ensure separation of duties, the CFO shall not serve as the Compliance Officer, but is responsible for meeting all the compliance requirements of the Medicare financial operations.

The CFO shall possess:

Experience

Knowledge of and extensive practical experience in financial management practices in large organizations and significant managerial or other practical involvement relating to financial management.

Education

An accounting degree from an accredited four-year college or university, and possess an active Certified Public Accountant (CPA) license.

C.5.4.1.4 Compliance Officer

The Compliance Officer must be **dedicated to the Medicare line(s) of business** and is not required to be fully dedicated to the A/B MAC contract (i.e. the Compliance Officer may be responsible for the Medicare Title XVIII and MAC lines of business, but not responsible for other private business lines).

The Compliance Officer shall possess:

Experience

A minimum of three years experience in compliance or related activities.

Education

A bachelors or more advanced degree.

C.5.4.1.5 Program Safeguard Contractor Liaison

The Program Safeguard Contractor (PSC) Liaison must be **dedicated to the Medicare line(s) of business** and is not required to be fully dedicated to the A/B MAC contract.

The Contractor shall designate an individual to serve as a PSC Liaison to support the PSC in all benefit integrity and medical review related activities, and to assist the PSC in all revisions to the Joint Operating Agreement (JOA). This individual shall refer to IOM Pub. 100-8 for guidance on supporting the PSC in all activities, including the JOA and shall be able to report that all PSC activities are being executed in accordance with the JOA and IOM Pub. 100-8.

The PSC Liaison shall perform the following duties:

a. Coordinate and fulfill all PSC requests for information.

b. Coordinate with the PSC to fulfill the Comprehensive Error Rate Testing Support functions.

c. Ensure that the terms of the JOA are met and coordinate all updates to the JOA with the PSC on a timely basis.

d. Schedule meetings with the PSC as appropriate.

The PSC Liaison shall possess:

Experience

A minimum of 3 years experience with Medicare that demonstrates extensive knowledge of the Medicare program.

Education

Bachelor's degree.

C.5.4.1.6 Chief Information Officer

The Chief Information Officer (CIO) may oversee other Medicare Contracts, not just the A/B MAC. The CIO must be **dedicated to Medicare business line(s) of work**.

The CIO shall possess:

Experience

Knowledge of and extensive practical experience in information technology (IT) practices, including security controls, in large organizations and significant managerial or other practical involvement relating to IT management.

Education

An information technology degree from an accredited four-year college or graduate program or equivalent experience, preferably as a CIO.

C.5.4.1.7 Systems Security Officer

The Contractor's Systems Security Officer (SSO) may oversee other Medicare Contracts, provided he has the necessary supporting staff, not just the AB MAC contract. The SSO must be full time and **dedicated to Medicare business line(s) of work**. The SSO will perform duties in accordance with IOM Pub. 100-17, the CMS Business Partner System Security Manual (BPSSM).

The SSO shall possess:

Experience

Knowledge of and extensive practical experience in information technology (IT) systems security policies, procedures and practices to manage security administrative duties in large organizations.

Education

An information technology (IT) degree from an accredited four-year college or equivalent experience. Security accreditations such as the Certified Information Systems Security Professional (CISSP) are highly desirable.

C.5.4.1.8 Implementation Project Director

The Implementation Project Director must be **fully dedicated** to the A/B MAC contract.

The Implementation Project Director's activities will commence with contract award and continue through the Jurisdiction Operational Start Date until all implementation activities are completed. This position must be fully dedicated until implementation activities are complete.

The Implementation Project Director shall possess:

Experience

A minimum of three (3) years experience as a Project Manager, with recent past experience managing Medicare Fee-for-Service workload transitions, systems conversions or a similar type of activity.

C.5.4.1.9 Provider Customer Service Program Manager

The Provider Customer Service Program Manager must be **dedicated to the Medicare line(s) of business** and is not required to be fully dedicated to the A/B MAC contract.

The Provider Customer Service Program Manager shall possess:

Experience

A minimum of two (2) years experience as manager of a customer service unit. Preferably the experience will have a focus on the handling of Medicare provider customer inquiries/questions and the education of those customers.

Education

The PCSM manager shall have a Bachelor's degree from an accredited college/university and related training in the area of customer service. Work experience may be substituted for the Bachelor's degree with a minimum of four years of work experience required.

C.5.4.1.10 Contract Administrator

The Contract Administrator must be **dedicated to the Medicare line(s) of business** and is not required to be fully dedicated to the A/B MAC contract.

The Contract Administrator is responsible for all contract administration issues and shall act as the central point of contact with the Government for all such issues.

The Contract Administrator shall possess:

Experience

Federal Acquisition Regulation (FAR) knowledge and the experience of applying such knowledge on a daily basis. This knowledge includes, but is not limited to, contract types, negotiating, contract changes/modifications, cost/price analysis, exercising options, conducting subcontract surveillance, managing contract close-out, roles, responsibilities, and authorities of Contractor and CMS personnel, Cost Accounting Standards, contract administration policies and procedures to sufficiently monitor and maintain uniform management controls over performance.

Education

A bachelors degree from an accredited educational institution authorized to grant baccalaureate degrees, with at least 24 semester hours in any combination of the following fields: Accounting, business, finance law, contracts, purchasing,

economics, industrial management, marketing, quantitative methods or organization and management. In addition, the Contract Administrator shall have direct experience in administering contracts in accordance with the FAR.

C.5.4.1.11 Contractor Medical Director

The Contractor Medical Director (CMD) must be **dedicated to the Medicare line(s) of business** and is not required to be fully dedicated to the A/B MAC contract.

The Contractor shall maintain as key personnel a Contractor Medical Director (CMD) in accordance with IOM Pub. 100-8, Chapter 1, section 1.5.

The CMD shall possess:

Experience

Prior work experience in the health insurance industry, a utilization review firm, or another health care claims processing organization in a role that involved developing coverage or medical necessity policies and guidelines.

Extensive knowledge of the Medicare program, particularly the coverage and payment rules.

Public relations experience such as working with physician groups, beneficiary organizations, and/or congressional offices is preferred.

CMD candidates must also meet a requirement of never having been sanctioned or excluded from the Medicare Program.

Education

Experience practicing medicine for at least three (3) years as a board-certified doctor of medicine or doctor who is currently licensed.

C.5.4.1.12 Audit and Reimbursement Manager/Director

The Audit and Reimbursement Manager/Director shall be **fully dedicated** to the A/B MAC.

The Audit and Reimbursement Manager/Director shall possess:

Experience

Five (5) or more years of Medicare Cost Report Audit and Reimbursement experience with a minimum of three (3) years as a manager of Medicare Cost Report Audit or Reimbursement.

Education

A bachelor's degree from an accredited institution with a minimum of 24 credit hours in accounting, or a Certified Public Accountant (CPA), and knowledge of Medicare laws, regulations and Government Auditing Standards (GAS). In lieu of education, fifteen (15) or more years of significant management experience in Medicare Audit and Reimbursement.

C.5.4.2 RESERVED

C.5.4.2.1 Reserved

C.5.4.3 SECURITY

C.5.4.3.1 Certification by Chief Information Officer for Compliance with CMS Systems Security Requirements

The Contractor's designated Chief Information Officer (CIO) shall certify compliance with CMS' systems security requirements.

C.5.4.3.2 Administer Security Program

The Contractor shall conduct all security administration activities for all parts of the Medicare claims process within its jurisdiction in accordance with IOM Pub. 100-17, BPSSM, the Core Security Requirements and its operational appendices (A, B, C, D, and E), found at www.cms.hhs.gov/informationsecurity.

The Contractor shall adhere to all deadlines and formats outlined in official CMS communications (e.g., Technical Direction Letter, or TDLs).

The Contractor shall comply with the CMS Information Security "Virtual Handbook," found at http://www.cms.hhs.gov/InformationSecurity/Downloads/Handbook.pdf, and all CMS methodologies, policies, standards, and procedures contained within the handbook.

The Contractor shall comply with the Federal Information Security Management Act of 2002 (FISMA) requirements set forth in section 912 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

The Contractor shall comply with and utilize standards and guidelines promulgated by the National Institute of Standards and Technology (NIST) in its entity-wide information security program.

The Contractor shall comply with the applicable standards, implementation specifications, and requirements of the Health Insurance Portability and Accountability Act (HIPAA) security rule, found at http://www.cms.hhs.gov/SecurityStandard/Downloads/securityfinalrule.pdf, covering electronically protected health information.

The Contractor shall fully cooperate with (including the timely installation of CMS test software on the Contractor's systems) CMS audits, reviews, evaluations, tests, and assessments of Contractor systems, processes, and facilities.

The Contractor shall visit the CMS security website (www.cms.hhs.gov/informationsecurity) at least monthly for updates to the CMS IOM Pub. 100-17, BPSSM and related program materials and conference information.

The Contractor shall participate in the CMS Security Best Practices conferences and audio conferences. (Details are found at www.cms.hhs.gov/informationsecurity).

The Contractor shall document its compliance with CMS security requirements and maintain such documentation in the Systems Security Profile as required by IOM Pub. 100-17, BPSSM.

C.5.4.3.3 Access to Systems

C.5.4.3.3.1 Data Use Agreements

The Contractor shall enter into a Data Use Agreement (DUA) with the CMS.

The Contractor shall complete the CMS DUA form located at http://www.cms.hhs.gov/cmsforms/downloads/cms-r-0235.pdf and submit it to the Project Officer and/or designees for review.

Background	The DUA must delineate confidentiality requirements of the Privacy Act, implement security safeguards, and explain CMS' data use policies and procedures. The DUA serves as both a means of informing the Contractor of these requirements and a means of obtaining their agreement to abide by these requirements. The Project Officer and/or designees will then coordinate with the CMS Director of the Division of Privacy Compliance for authorization and assigning of a DUA number. If additional data not identified in the DUA is required, a second DUA may also be required to obtain access to that information.
Standard 1	The Contractor's DUA is successful when it is delivered to the Project Officer and/or designees no later than 30 days prior to the cutover date.

C.5.4.3.3.2 OTHER SYSTEMS ACCESS REQUIREMENTS

The Contractor shall have all employees requiring access to CMS systems complete an Application for Access to CMS Computer Systems to obtain a user ID. This form is available at: http://www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf. The Contractor shall submit all completed forms to the Project Officer and/or designees for routing to the CMS Access Administrator (formerly the Resource Access Control Facility Administrator).

C.5.4.3.4 Correct Deficiencies

The Contractor shall correct any security deficiencies, conditions, weaknesses, findings, or gaps identified by all audits, reviews, evaluations, tests, and assessments in a timely manner, which include, but are not limited to:

a. Statement on Auditing Standards (SAS) 70 audits

b. MMA section 912 evaluations and tests,

c. Office of the Inspector General (OIG) audits,

d. Self-assessments, and

e. Vulnerability assessments

The Contractor shall develop Corrective Action Plans (CAPs) for all identified weaknesses, findings, gaps, or other deficiencies in accordance with IOM Pub. 100-17, BPSSM or as otherwise directed by CMS.

The Contractor shall validate and document that corrective actions are implemented, tested, and effective.

The Contractor shall provide CAPs and monthly progress reports to CMS in accordance with IOM Pub. 100-17, BPSSM or as otherwise directed by CMS.

Background	Time is of the essence in correcting the deficiencies or remediating the findings of an audit.
Standard 1	The Contractor's corrective action procedures are successful when its weaknesses, findings, gaps, or other deficiencies are corrected within 90 calendar days of receipt of the final audit or evaluation report unless authorized by CMS otherwise.

C.5.4.3.4.1 CORRECTIVE ACTION ATTESTATION

The Contractor shall provide attestation and documentation of corrective actions to CMS upon request.

C.5.4.3.5 Security Review and Verification

The Contractor shall comply with the CMS certification and accreditation (C&A) methodology, policies, standards, procedures, and guidelines for Contractor facilities and systems.

The Contractor shall conduct or undergo an independent evaluation and test of its systems security program in accordance with section 1874A, as added by MMA section 912. The Contractor's first independent evaluation and test of its systems security program shall be completed prior to the Contractor commencing claims payment under the contract.

The Contractor shall conduct, at a minimum, annual vulnerability assessments of its systems, programs, and facility.

The Contractor shall support CMS validation and accreditation of Contractor systems and facilities in accordance with CMS C&A methodology.

The Contractor shall provide annual certification, in accordance with C&A methodology, that certifies it has examined the management, operational, and technical controls for its systems supporting the Medicare Administrative Contractor (MAC) function and considers these controls adequate to meet CMS security standards and requirements.

Background	The CMS C&A methodology can be found on the CMS web site at www.cms.hhs.gov/informationsecurity

C.5.4.4 QUALITY ASSURANCE REQUIREMENTS

Background	The Contractor is responsible for establishing a quality control program and implementing quality control actions necessary to meet the requirements and standards set forth by the contract. The Government will monitor the Contractor's performance under this contract using systematic quality assurance methods as defined in the Quality Assurance Surveillance Plan (QASP).

C.5.4.4.1 Quality Control Program

The Contractor shall provide and maintain a comprehensive quality program for the control of quality that is acceptable to the Government and ensures the requirements of the contract are provided.

The Contractor shall submit a quality control plan specifying procedures and resources applied to ensure services meet contract performance requirements to the Project Officer no later than 45 days after contract award.

The Contractor shall submit an updated copy of the quality control plan to the Project Officer on the jurisdiction operational start date and then quarterly as changes occur.

Background	The Contractor's comprehensive quality program will include, but not be limited to, the following: ▪ Documented procedures and processes for services to ensure that services of this Statement of Work (SOW) meet contract performance requirements. ▪ Documented change management program to ensure that correct procedures and processes are followed. ▪ Provide and maintain an inspection and audit system to ensure that services meet contract performance requirements. ▪ Provide a method of identifying nonconformance or deficiency in the quality of services performed. ▪ Provide a formal system to implement corrective action. ▪ Provide a file of all quality records relating to inspections and audits conducted by the Contractor and the corrective action implemented. This documentation shall be made available to the Government during the term of the contract. ▪ Provide for Government inspections and audits while work is in process or complete.

C.5.4.4.2 Reserved

C.5.4.4.3 Reserved

C.5.4.4.4 Contractor's Internal Education

The Contractor shall conduct internal education for its employees and periodically assess the continuing education needs of its staff to continuously improve the quality and efficiency of operations.

Standard 1	The Contractor's internal education is successful when the Contractor maintains satisfactory performance levels, as measured by CMS, in regards to satisfaction surveys.
Standard 2	The Contractor's internal education is successful when claims adjudication by all clinical staff for all functional lines of business result in accurate and consistent determinations.

C.5.4.5 PUBLIC RELATIONS

The Contractor shall develop, execute, and manage a public relations plan to utilize its resources to serve CMS stakeholders' Medicare needs and concerns.

The Contractor shall, as a representative of CMS, be courteous and responsive to all stakeholders at all times.

Background	Public relations involves the Contractor representing Medicare to stakeholders such as beneficiaries and their advocacy groups, industry associations, data users, standards setting organizations, and taxpayers, for information about the Medicare programs and operations. Providers are specifically excluded from the public relations plan, because they are separately addressed in Provider Customer Service. Public relations do not involve the release of personally identifiable information or information about specific claims.
Standard 1	The Contractor's public relations plan is successful when its processes and procedures are used to address problem areas as they are identified.
Standard 2	The Contractor's public relations plan is successful when general information developed by the Contractor concerning Medicare and its policies is approved by CMS before being distributed to stakeholders.

C.5.4.5.1 Medicare Beneficiary Ombudsman

The Contractor shall provide a direct point of contact to CMS (Center for Beneficiary Choices, or CBC) for the purposes of assisting the Medicare Beneficiary Ombudsman with resolving beneficiary areas of complaints, grievances, and inquires about any aspect of the Medicare program.

The Contractor point of contact shall coordinate resolution of the problem and involve appropriate functional areas within the MAC as necessary to resolve the problem.

The Contractor shall contact the beneficiary directly with the resolution, if requested by the Medicare Beneficiary Ombudsman. In most instances, the Medicare Beneficiary Ombudsman will relay the resolution directly to the beneficiary.

Background	The Medicare Beneficiary Ombudsman was created by Section 923 of the MMA to provide assistance to beneficiaries in the areas of complaints, grievances, and inquires about any aspect of the Medicare program, including collecting information necessary to file appeals and resolve Medicare Advantage (MA) disenrollment problems and Medicare premium adjustments.

C.5.4.6 Responses to Congressional Inquiries

The Contractor shall furnish responses to congressional inquiries in accordance with IOM Pub. 100-09, Chapter 2, section 20.2.2.

Background	The BCC will be responsible for addressing Congressional inquiries that are specifically related to the BCC (i.e. a CSR is rude to a beneficiary, or why does it take so long for someone to answer the phone when a beneficiary calls). Any congressional inquiries received by the MAC that are the responsibility of the BCC should be forwarded to the BCC for response. All other congressional inquiries are the responsibility of the MAC. If the BCC receives any misdirected congressional inquiries, they will be forwarded to the MAC.

Standard 1	The standard is met when the Contractor seeks advice from CMS, as necessary, on questions of law and policy in advance of developing a draft for review, and when congressional inquiries receive review and approval by CMS before submitting to Congress.

C.5.4.7 Participation in Conferences, Meetings, and Work Groups

C.5.4.7.1 Participation in Conferences

The Contractor shall participate in, and ensure that appropriate Contractor personnel attend a variety of conferences as directed by CMS, including, but not limited to, the following:

a. Best practices conferences

b. Any CMS-sponsored provider enrollment conference(s), regularly scheduled conference calls and CMS-sponsored provider enrollment workgroups

c. Annual CMS Medical Review (MR) Manager's conference

d. Contractor Medical Director (CMD) conference

e. Security best practices conferences

f. Security Technical Advisory Group (TAG), as identified on the CMS Information Security homepage (www.cms.hhs.gov/informationsecurity)

g. Provider Customer Service Program conferences

h. National Audit Conference, Provider Statistical and Reimbursement Reporting (PS&R) work group, and others as necessary

i. Conferences related to electronic data interchange (EDI) and HIPAA requirements.

j. Qualified Independent Contractor (QIC) and Administrative Qualified Independent Contractor (AdQIC) meetings.

k. Medicare Secondary Payer (MSP) National Conferences.

C.5.4.7.1.1 CHIEF FINANCIAL OFFICER FINANCIAL REPORTING CONFERENCE

The Contractor's Chief Financial Officer (CFO) shall attend the annual CMS CFO Financial Reporting Conference.

C.5.4.7.2 Participation in Meetings and Work Groups

The Contractor shall ensure that appropriate personnel attend a variety of meetings and work groups as directed by CMS groups to present and discuss operational requirements and propose changes to the Medicare program, including, but not limited to, the following:

a. Cost report audit, PS&R, reimbursement related work groups

b. Audit and reimbursement meetings

c. Workgroups and Joint Application Development sessions on proposed changes to the Medicare program

d. Weekly operations TAG and Functional Work Group calls

e. Teleconferences with the Office of Information Services and CMS program staff

f. Ad hoc work groups

g. Quarterly Change Control Board Meetings

Standard 1	The participation requirement is successful when the Contractor is represented at every meeting and workgroup for which attendance is mandatory or requested.

C.5.4.7.3 Support Income Tax Reporting

The Contractor shall issue to every provider paid under this contract [a] 1099 and/or any other forms required for income tax and reporting purposes.

C.5.4.8 PARTICIPATION IN CHANGE MANAGEMENT PROCESS

The Contractor shall actively participate in and support the CMS change management process in accordance with IOM Pub. 100-01, Chapter 7. **NOTE: The Contractor's participation in the CMS change management process begins upon the award of the contract.**

Background	The current CMS Medicare change management process was formally implemented in October 1997 to manage and coordinate changes across the Medicare FFS program. These changes typically arise from legislation, litigation, and policy and result in CMS change requests (CRs). The CMS change management process allows CMS to control, plan, assess,

communicate, and implement Medicare FFS changes timely and effectively.

CMS' Fee-for-Service Operations Board (FFSOB) prioritizes, plans, schedules, and controls the implementation of CMS changes to the computer software, functionality, or operations. The FFSOB is comprised of CMS senior management representatives. The FFSOB develops and finalizes a model release schedule approximately five (5) months prior to the start of a quarter (January, April, July and October). The model release consists of the CMS CRs scheduled for implementation by the Shared System Maintainers (SSMs), the Healthcare Integrated General Ledger Accounting System (HIGLAS) Maintenance Contractor, and Common Working File (CWF) Maintenance Contractor.

A User Change Control Board (CCB) is comprised of the SSM, the Contractor users, and CMS personnel from both Central and Regional Offices. The CCB is responsible for controlling and managing Contractor-initiated (or user-initiated) changes, otherwise known as "user changes." However, all changes to the shared systems will be approved by CMS. User changes are implemented on a quarterly basis along with the CMS CRs. They usually involve corrections to processing problems or system-generated reports or enhancements to the shared system.

The Contractor shall review and comment on all draft CRs issued by CMS and shall comply with all final CRs, including all revisions to the Internet-only manuals (IOMs). The Contractor shall provide a level of effort up to 46,200 hours per contract year to (1) Participate in the Point of Contact (POC) Review process that is described in detail in Section C.5.3.8.1 of the SOW; (2) Implement CRs that require shared system changes; and (3) Implement CRs that do not require changes to the shared systems. There will be an estimated ten (10) percent increase in hours for each contract year.

The process of controlling changes helps to ensure that the shared systems, HIGLAS, and the Common Working File (CWF) operate as required and that only CMS-approved changes are made. Change requests that require changes to the shared systems, HIGLAS, and CWF are implemented in one of four quarterly software releases. Large changes may span over multiple releases. The production date is generally the first Monday of the calendar year quarters (January, April, July, and October). In conjunction with the four quarterly software releases, "off-releases" and/or emergency releases occur as needed. The Shared System Maintainer will provide a release schedule of planned releases. Emergency releases are not scheduled and will occur as needed. These releases usually contain system fixes or priority code changes.

As mentioned above, the FFSOB develops and finalizes a quarterly model release schedule approximately five months prior to the start of a quarter. This model release consists of the CMS change requests (CRs) scheduled for implementation by the SSM, HIGLAS Maintenance Contractor, and CWF Maintenance Contractor. Almost all CRs scheduled on the quarterly release have the same implementation date, which is the implementation date of the release, but they may have different effective dates. CRs are either recurring or non-recurring. Recurring CRs are quarterly or annual changes, updates to CMS-supplied software and software documentation, fee schedules, and the

	federal interest rate percentage. Non-recurring CRs are new instructions or updates or clarifications to existing instructions. CRs and formal instructions from CMS to the Contractors, SSMs, HIGLAS Maintenance Contractor, and CWF Maintenance Contractor are issued as one of the following documents: ▪ Business Requirements Notification/Transmittal. This document form is used to communicate Medicare Fee-for-Service policy changes, new, updates or clarifications to existing instructions, and can be accompanied by Internet Only Manual (IOM) updates. ▪ One-Time Notification. This document is used to communicate one-time instructions to Contractors, SSMs, HIGLAS Maintenance Contractor and the CWF Maintenance Contractor. ▪ Confidential Notification. This document is used to request system or non-system changes that are not to be shared with the Medicare provider and beneficiary community. ▪ Recurring Update Notification. This document is used to communicate quarterly or annual instructions, changes and updates to CMS-supplied software and software documentation, fee schedules, and the federal interest rate percentage. ▪ Joint Signature Memorandum (JSM). A JSM is a formal CMS communication vehicle used for administrative announcements, emergency alerts, and one-time informational requests that do not involve shared system changes. ▪ Contractor participation in the CMS change management process helps ensure that Medicare program changes produce the expected results.

C.5.4.8.1 Review and Comment on Draft Change Requests

The Contractor shall review draft CRs for operational impacts and provide timely comments to CMS.

Background	As part of the change management process, CMS sends the draft CR via an e-mail notification to all Contractors, SSMs, HIGLAS Maintenance Contractor, and the CWF Maintenance Contractor to review before final issuance. This is referred to as the "Point of Contact (POC) Review process" or "POC Review." During the POC Review period, the Contractor is required to assess the impact and provide comments to CMS, specifically addressing how the draft CR affects the following: ▪ Claims or other workloads ▪ Level of effort- Contractor will provide an estimate in terms of staffing hours ▪ Appeals volume ▪ Provider inquiry volumes

	▪ Provider education needs ▪ Provider reaction due to impact on business operations ▪ Shared systems from a user perspective ▪ Any systems impact local or cycle run time. ▪ Conflict in current process or CMS direction. Contractors will provide comments by the closing date and time of the POC Review comment period, which is specified at the beginning of the POC Review cover letter. No response is required if the Contractor concurs with the CR. The POC Review comment period generally ranges from 4 to 15 business days, depending on the length and urgency of the CR. Sometimes, it is necessary for the POC Review comment period for emergency CRs to be less than four days. CMS determines the length of the POC Review periods based on the following: ▪ Is it an emergency? This is usually driven by a legislative mandate or quarterly release implementation deadline. ▪ Length of the CR. CRs over 25 pages usually have a longer review period. ▪ Frequency of time the CR has been in the POC Review process. CRs that are being re-reviewed may have a shorter review timeframe. CMS issues almost all draft CRs electronically via the Electronic Change Information Management Portal (eChimp) or its equivalent via eChimp. Contractors receive an e-mail from eChimp@cms.hhs.gov that alerts them that a CR is currently in POC review. Contractors will access eChimp via a link that is provided in the e-mail notification to review the CR and submit their comments through the POC Review Forum within eChimp.
Standard 1	Timely CR review is successful when the Contractor provides comments by the closing date and time of the POC Review comment period, which is specified at the beginning of the POC Review cover letter.

C.5.4.8.2 Early Involvement

The Contractor shall participate in early involvement in the change management process.

The Contractor shall participate in an ‘early involvement’ call with the SSMs and CMS personnel when invited to attend. The Contractor shall review the business requirements of the subject CR and submit questions before an early involvement call.

Background	During the early stages of a draft CR and occasionally before it has formally entered the change management process, CMS analysts may solicit input/feedback from the Contractors, SSMs, HIGLAS Maintenance Contractor, and the CWF Maintenance Contractor. This exchange usually occurs as part of weekly communication teleconference calls or subject-specific workgroup calls.

	An “early involvement” call is a conference call between the Contractor, the SSMs, and CMS during which the parties review a CR’s business requirements. These teleconferences almost always occur before a CR is issued in final, where discussions are held to improve understanding and clarify requirements. Early involvement calls assist the SSMs in estimating the level of effort required to implement the CR. CMS has early involvement calls for CRs that are viewed as risky due to their size or complexity or simply need to be clarified. The SSM will notify CMS as to which CRs they would like to have early involvement calls. Generally, the SSMs select five to ten CRs that are targeted for an upcoming quarterly release. Occasionally, a CR may require more than one early involvement call if it is particularly complex or large. CMS invites the SSMs, the HIGLAS Maintenance Contractor, the CWF Maintenance Contractor, the CR’s sponsoring Contractor, and Single Testing Contractor (STC) to participate in the early involvement call. All Contractors may or may not be invited to all of early involvement calls. The length of the call is usually one to one-and-a-half hours. Each call is dedicated to one CR.
Standard 1	Participation in Early Involvement Calls is successful when (1) the Contractor attends all Calls when invited by CMS and/or its SSM, (2) the Contractor has reviewed all documentation prior to the Call, and submitted their questions (3) the Contractor is represented by at least one subject matter expert (SME).

C.5.4.8.3 Successful Implementation of Change Requests

The Contractor shall implement CRs in accordance with the requirements IOM Pub. 100-01, Chapter 7.

Background	Once the POC Review period has ended, the CMS analyst addresses comments and resolves any issues or problems with the CR that arose during that time. The CMS analyst incorporates changes into the final version of the CR and obtains the necessary CMS approvals for its issuance prior to presenting it to senior management. If the changes made due to comments made during POC have a serious impact on shared systems, contractors or providers, the CR may be subject to another POC review. The approved/final CR is then issued via e-mail to the Contractors, SSMs, HIGLAS Maintenance Contractor, and the CWF Maintenance Contractor for implementation based on the effective and implementation dates specified. Contractors SSMs, HIGLAS Maintenance Contractor, and the CWF Maintenance Contractor should begin work on CRs that are in final upon its receipt. CMS' strives to meet the following goals when issuing final CRs in order to provide Contractors, SSMs, HIGLAS Maintenance Contractor, and the CWF Maintenance Contractor with adequate lead-time for implementation: ▪ Non-recurring system changes are usually issued five months in advance of the implementation date. ▪ Recurring system changes are usually issued 60-90 days in advance of the implementation date.

	▪ Non-system changes are usually issued 30 days before the implementation date if there is no provider impact. ▪ Non-system changes with provider impact are usually issued 90 days before the implementation date. Exceptions include CRs that are recurring, corrections to finals, Contractor-specific, National Coverage Determinations (NCDs), and cleared by the CMS Administrator. Shared systems and software changes are gathered into quarterly releases so that the claims processing systems follow a System Development Life Cycle (SDLC) discipline. The software changes are made to all the systems at the same time and installed at all processing sites during the same quarterly release timeframes. Off-quarter releases are necessary in order to meet emergency legislative deadlines or correct serious problems. They are much smaller in scale than the quarterly releases and may be implemented at any time throughout the quarter. Due to these emergency off-cycle releases, the Contractors may need to mass-adjust claims. The shared systems usually have software to assist with the mass adjustment process. The Contractor is part of this SDLC discipline because its perspective is a necessary adjunct to the work of the CMS subject matter specialists, the SSMs, HIGLAS Maintenance Contractor, the CWF Maintenance Contractor, and the STC. Successful implementation of the software releases demands that CMS be sure, before the "Go Live" date, that changes will produce the expected results and can be implemented into production without adverse or unintended effects on existing operations. CRs are not implemented based on the draft instructions; Contractor implementation occurs when CMS issues the final CR. On rare occasions, CMS will instruct SSMs to begin work on a CR prior to CMS issuing it in final. This is known as Draft Treat as Final. Its purpose is to allow SSMs sufficient time to complete software development tasks for the CR by the quarterly release implementation date. For Draft Treat as Final CRs, Contractors participate in conference calls, early involvement calls, and walkthroughs upon the request of the SSM and CMS. Contractors participate in testing and implementation of the shared system changes, although it is very unlikely that the CR will progress to this point of the SDLC while it is in the Draft Treat as Final stage.

C.5.4.8.3.1 WALKTHROUGHS

The Contractor shall review the functional specifications of the subject CR before the walkthroughs and ensure that their SMEs shall participate in the walkthrough with the SSMs and CMS personnel.

Background	After final release of a CR, the SSMs analyze the CR and develop the functional specifications. These specifications explain how the CR will be implemented in the shared system in non-technical, business function terminology. Before the CR is coded in the system, the SSM invites the Contractors (user group) and CMS to participate in a walkthrough of the functional specifications.

	Walkthroughs occur for all non-recurring CRs in scheduled in a quarterly release. Walkthroughs are usually held over a four-week period and occur 90-120 days prior to a CR's implementation. Walkthroughs provide the Contractor and CMS with an opportunity to obtain clarification from the maintainer to suggest an alternate approach. All CRs with systems changes shall have a walk-through unless time does not allow because the CR is being fast-tracked. This means the CR is being implemented prior to the quarterly release production date. One (1) to three (3) CRs may have a walk-through during the same teleconference. The length of the call is usually one to one-and-a-half hours.
Standard 1	Participation in walkthroughs is successful when (1) the Contractor attends all walkthroughs when invited by CMS and/or its SSM, (2) the Contractor has reviewed all documentation prior to the walkthrough, and (3) the Contractor is represented by at least one SME.

C.5.4.8.4 Participation in Testing Changes to Systems

The Contractor shall perform testing in accordance with the standards and requirements specified for Contractors (Users) in IOM Pub. 100-01, Chapter 7 Section 40.3. The Contractor shall ensure that the required testing is complete within the Medicare Contractor (User) testing period.

Background	Testing changes to the Medicare claims processing environment and systems involves four entities: the SSM, the Single Testing Contractor (STC), the Enterprise Data Center (EDC) Contractor, and the Contractor (MAC) who is a user of the shared system. SSMs and the STC have full responsibility for testing the shared systems' base functionality, whereas the Contractor, in cooperation with the EDC that provides data center support services to the Contractor, has full responsibility to test ancillary software components, test non-base system unique programming/coding, and complete an end-to-end operational test. The EDC supports the Contractor's testing activities by scheduling jobs, executing jobs, resubmitting jobs as needed, and resolving issues created by the EDC data center. The Contractor's scope of testing includes all claims processing related components and coding, and an end-to-end operational test. The test must ensure that processing is contiguous from claims entry, to claims adjudication, and ultimately remittance and Medicare Summary Notice generation. As part of the Contractor's end-to-end operational test, the MAC is required to test the interfaces between all key claims processing components (excluding banking system interfaces). The Contractor is not required to test the specific functionality implemented in the base shared system (i.e. Fiscal Intermediary Shared System, or FISS; Multi-Carrier System, or MCS) or CWF.
Standard 1	The Contractor completes test plans, test executions, and test analysis in a

	timely manner.
Standard 2	The Contractor promptly reports any issues or problems involving poor support from the EDC to their CMS Project Officer. Issues that may adversely affect Contractor testing performance shall be reported within 24 hours.
Standard 3	Errors or production problems that should have been identified through Contractor testing and are within the scope of Contractor testing do not occur in production.
Standard 4	All interfaces and data exchanges between the Shared System and ancillary claims processing components operate in production without problems.

C.5.4.8.5 Successful Post-Implementation Operation

The Contractor shall report problems related to systems to both CMS and the appropriate system maintainer as needed, indicating the correct priority as defined in IOM Pub. 100-01, Chapter 7, Section 40.2.

C.5.4.9 Business Continuity Planning and Disaster Recovery

The Contractor shall assess existing vulnerabilities; implement disaster avoidance and prevention procedures; and develop a comprehensive continuity of operations plan (COOP) that shall enable it to react appropriately and in a timely manner if disaster strikes.

The Contractor's disaster recovery plan shall address identified risks and vulnerabilities.

The disaster recovery plan shall be continually updated to reflect changes resulting from the CMS change management process.

The Contractor shall follow CMS guidelines in accordance with IOM Pub 100-17.

The Contractor's COOP shall meet the requirements of Federal Preparedness Circular 65, Federal Executive Branch Continuity of Operations (see Attachment J-14).

The Contractor shall participate in Business Continuity Planning and Disaster Recovery activities for the Enterprise Data Center as needed.

Background	Policies and procedures developed by the Contractor to ensure essential business functions continue during a disaster. The COOP plan elements include protection of physical infrastructure, IT disaster recovery, business continuity (with or without system availability), and other topics.

C.5.4.10 INTERNAL CONTROL

The Contractor shall establish and maintain efficient and effective internal controls to perform the requirements of this contract in accordance with IOM Pub. 100-06, Chapter 7.

Background	Internal controls should not be looked upon as separate, specialized systems within an organization. Rather, they should be recognized as an integral part of each system that the Contractor's management uses to regulate and guide its operations. Internal controls facilitate the achievement of management objectives by serving as checks and balances. Internal controls and the correction of internal control material weaknesses are essential to the certification of CMS' financial statements by the Office of the Inspector General (OIG) and to provide CMS with knowledge and assurance that Contractor operations are complying with CMS instructions and directions. The Contractor's management must take responsibility for implementing internal controls that accomplish these various operational goals.
Standard 1	Internal controls are successful when no findings are identified by the Statement on Auditing Standards (SAS) 70 auditors during the audit's period of performance.

C.5.4.10.1 Written Policies and Procedures

The Contractor shall have written policies and procedures for internal controls in place and operating effectively in accordance with IOM Pub. 100-06, Chapter 7, sections 10–20.

C.5.4.10.2 Attestation

The Contractor shall attest to the adequacy of the internal controls under its authority in accordance with IOM Pub. 100-06, Chapter 7, section 30.

C.5.4.10.3 Correcting Internal Control Deficiencies

The Contractor shall report and correct any internal control findings, exceptions, or material weaknesses identified during audits and reviews in accordance with IOM Pub. 100-06, Chapter 7, section 40–40.6.

Standard 1	The Contractor's corrective action procedures are successful when its deficiencies have been corrected within one year of being identified.

C.5.4.10.4 Statement on Auditing Standards No. 70 Audit

The Contractor shall contract with an independent certified public accounting firm to perform an annual SAS 70 Type II audit in accordance with Attachment J-6, Requirements for Performing a Statement on Auditing Standards No. 70 (SAS 70) Audits.

C.5.4.11 COMPLIANCE PROGRAM

The Contractor shall maintain a corporate compliance program consisting of at least the following elements:

a. A written code of conduct and written compliance policies and procedures;

b. A Medicare compliance officer and Medicare compliance committee;

c. An annual employee training and education program on compliance issues;

d. A process to receive compliance-related complaints that permits anonymous reporting;

e. An internal monitoring and auditing function to help ensure compliance with the requirements of the Medicare contracts;

f. An enforcement and disciplinary process for violations of the contract, code and/or federal statutes and regulations; and

g. A process to conduct investigations of compliance-related complaints and concerns, and act to prevent compliance-related problems from developing; policies and procedures consistent with applicable laws and regulations to address persons who are suspended, debarred, or excluded from participation in any federal program.

Background	CMS has determined that all Medicare Contractors awarded contracts pursuant to the MMA shall have in place an effective compliance program. The compliance program may be tailored to the size and scope of the work to be performed under the MMA contract. CMS has published its own "Compliance Guidance for Fee-for-Service Contractors" (CMS Compliance Guidance) that may be found on the CMS web page (http://www.cms.hhs.gov/MedicareContractingReform/Downloads/compliance.pdf) that is based on the seven elements specified in the United States Sentencing Commission's Sentencing Guidelines for Organizational Defendants, as amended. Contractors that are designing, implementing or evaluating their compliance programs may find it useful to refer to the CMS Compliance Guidance. However, it is not to be read as the sole pronouncement of desired substantive or procedural elements of an effective compliance program. Most importantly, an effective program is not static, but is constantly evolving towards the ultimate goal of being proactive rather than reactive.

C.5.4.12 CHAIN PROVIDER ORGANIZATIONS

The Contractor shall be responsible for performing all required and appropriate A/B MAC SOW functions for the chain home office and chain members, regardless of the geographic locality of their members, if the chain in question both enjoys CMS approved

single MAC status and the home office of that chain is located within the boundaries of the MAC jurisdiction.

Similarly, the Contractor shall be responsible for servicing future chain organizations meeting the above geographic criteria who are subsequently approved for single MAC status by CMS.

Background	In cases where the providers are part of a chain but do not bill the chain home office, they shall bill their local MAC in their jurisdiction; however, they shall not bill a MAC outside of their jurisdiction. Proposed section 42 CFR 421.404 [see page 49703] sets forth the criteria CMS proposes to use when evaluating a request for an exception to the general rule that providers shall be assigned to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the provider is physically located.

C.5.5 Provider Enrollment

The Contractor shall manage the CMS provider enrollment process to ensure that only qualified individuals and organizations are enrolled in the Medicare Program via the processing of OMB approved CMS-855 applications (either electronic/web-based or paper) and by using the government-furnished Provider Enrollment, Chain and Ownership System (PECOS); both in accordance with IOM Pub. 100-08, Chapter 10.

Background	Using the government-furnished PECOS and a third party validation Contractor selected by CMS, the Contractor will input provider enrollment information into PECOS and verify the enrollment data through a third-party Contractor, unless otherwise prescribed in IOM Pub. 100-08, Chapter 10. Such provider enrollment information includes all data on initial enrollment applications, change requests, revalidation applications, changes of ownership (which, for purposes of C.5.5 through C.5.5.6 of this SOW, include acquisitions/mergers and consolidations), reactivation applications, reassignments, voluntary terminations, and other information. For providers with records already entered into PECOS, the Contractor will change or update that information. For providers who do not have an established record in PECOS, the Contractor may be required to ask the providers to complete and submit enrollment data to establish such a record. The MAC will maintain a consistent and uniform policy for issuing and maintaining Medicare identification numbers for all providers/suppliers. This may require a change to the numbering sequence previously used by Contractors within the assigned jurisdictions.

C.5.5.1 Process Initial Enrollment Applications

The Contractor shall accurately and timely process initial enrollment applications for providers enrolling in the Medicare program for the first time or enrolling in another Contractor's jurisdiction.

Background	The applications in this category include initial enrollment applications, reassignments and CMS-588 forms (electronic funds transfer, or EFT) submitted with initial applications; change of ownership (CHOW) applications submitted by the new owner; revalidation applications; reactivation applications; and opt-out affidavits.
Standard 1	The applications described in C.5.5.1 of this SOW will be considered timely processed when 80% of applications are processed within 60 calendar days of receipt or sooner, 90% in 120 calendar days of receipt or sooner and 99% of applications are processed within 180 calendar days of receipt.
Standard 2	The applications described in C.5.5.1 of this SOW will be considered accurately processed when 98% of applications are processed in accordance with all of the instructions in IOM Pub. 100-08, Chapter 10, with the exception of the timeliness standards identified in Standard 1 of C.5.5.1.

C.5.5.2 Process Changes, Updates, Reassignments or Corrections

The contactor shall timely and accurately process changes of information; updates (i.e., changes not resulting in a submission of a CMS-855, such as changes in participation status and date of death reports); reassignments and CMS-588 forms that are not associated with initial applications; CHOW applications submitted by the old owner; voluntary terminations; or corrections to provider enrollment information.

Standard 1	The applications described in C.5.5.2 of this SOW will be considered timely processed when 80% of applications are processed within 45 calendar days of receipt or sooner, 90% in 60 calendar days of receipt or sooner, and 99% of applications within 90 calendar days of receipt.
Standard 2	The applications described in C.5.5.2 of this SOW will be considered accurately processed when 98% of applications are processed in accordance with all of the instructions in IOM Pub. 100-08, Chapter 10, with the exception of the timeliness standards identified in Standard 1 of C.5.5.2.

C.5.5.3 Revocations

The Contractor shall revoke a billing number (or recommend a number to be revoked) if CMS or the MAC determines through investigation that a revocation is appropriate based on the reasons listed in IOM Pub. 100-08, Chapter 10.

Standard 1	The Contractor shall process 100% of all revocation actions – regardless of whether notification was received through investigation by CMS or by a

	Contractor – in full accordance with all revocation instructions in IOM Pub. 100-08, Chapter 10.

C.5.5.4 PROVIDER ENROLLMENT APPEALS

The Contractor shall interface with CMS, as requested, to handle appeals of initial provider enrollment determinations that can be appealed to a Contractor hearing officer.

Background	This appeal procedure ensures that a physician, non-physician practitioner, or entity that is entitled to appeal rights under 42 CFR Part 498 receives a fair opportunity to be heard. The Contractor will need to: ▪ Conduct appeals of initial provider enrollment denials; ▪ Participate, to the extent necessary, in provider enrollment appeals conducted by an Administrative Law Judge at the Department Appeals Board; and ▪ Participate, to the extent necessary, in appeals heard by a Federal District Court.

C.5.5.5 MAINTAIN STATE-SPECIFIC LICENSURE/CERTIFICATION INFORMATION

The Contractor shall collect and maintain information regarding state licensure/certification requirements for all provider types, and notify CMS of any changes to State laws pertaining to State licensure/certification for enrollment.

Background	Note that this requirement does not apply with respect to (1) provider and supplier types that are enrolled via the CMS 855A, (2) ambulatory surgical centers, and (3) portable X-ray suppliers.

C.5.5.6 PARTICIPATING PHYSICIAN PROGRAM MANAGEMENT

The Contractor shall perform physician participation enrollment, limiting charge monitoring activities and dissemination of participation information in accordance with IOM Pub. 100-04, Chapter 1 and IOM Pub. 100-06, Chapter 6.

Background	Participating physician enrollment, monitoring and information dissemination are vital functions to the operating efficiency of CMS. Some of the functions the Contractor will engage in are as follows: produce and mail enrollment packages, process enrollment and withdraws, furnish data to CMS and RRB Contractor (IOM Pub. 100-04, Chapter 1), investigate beneficiary-initiated limiting charge violation complaints, respond to limiting charge inquiries from non-participating physicians, produce and store limiting charge reports (LCERs/LCMRs), respond to and produce requests for customized participation information and populating your internet website with MEDPARD information and informing physicians, practitioners, suppliers, hospitals, Social Security Offices, Congressional Offices, QIOs, senior citizen groups and State agencies

	of the Administration on Aging how to access the website information.

C.5.6 Local Coverage Determinations

The Contractor shall develop and enter into the Medicare Coverage Database (MCD) Local Coverage Determinations (LCDs) in accordance with IOM Pub. 100-08, Chapter 13.

The Contractor shall ensure that all LCDs are consistent with all statutes, rulings, regulations, and national coverage, payment, and coding policies.

Background	Section 522 of the Benefits Improvement and Protection Act created the term "local coverage determinations" (LCDs). An LCD is a decision by a Contractor whether to cover a particular service on a Part A-wide and/or Part B-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). LCDs specify under what clinical circumstances a service is considered to be reasonable and necessary. Contractors publish LCDs to provide guidance to the public and medical community within their jurisdictions. Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community. LCDs are entered into the CMS provided MCD system. The MCD acts as a central point of dissemination for both National and Local Medicare Coverage policies. On the national side, the MCD houses National Coverage Analyses (NCAs), Coding Analyses for Laboratories (CALs), and National Coverage Decisions (NCDs). On the local side, the MCD houses LCDs, Local Medical Review Policies and Contractor articles. Besides these policies, the MCD contains downloadable indexes and reports. The MCD will notify Contractors of each LCD that is affected by an update to a HCPCS or ICD-9-CM code. A Contractor with LCD jurisdiction for two or more States is strongly encouraged to develop uniform LCDs across all its jurisdictions.

C.5.6.1 Contractor Advisory Committee

The Contractor shall establish a Contractor Advisory Committee (CAC) in accordance with IOM Pub. 100-08, Chapter 13 (NOTE: The Contractor shall reference the requirements for the Carrier Advisory Committee outlined in this Manual).

Background	The purpose of the CAC is to provide: ▪ A formal mechanism for physicians in the State to be informed of and participate in the development of an LCD in an advisory capacity; ▪ A mechanism to discuss and improve administrative policies that are within the Contractor's discretion; and

	▪ A forum for information exchange between Contractors and physicians. After the initial consolidation period, the CAC will be tasked with advising the Contractor on the revision of consolidated LCDs, if appropriate, and the creation of new LCDs, as needed.

C.5.7 Provider Customer Service Program

The Contractor shall conduct a Provider Customer Service Program (PCSP) in accordance with IOM Pub. 100-09, Chapter 6, section 20.

Background	The PCSP is a comprehensive, coordinated and integrated program. The PCSP provides high-quality and timely information, education, and training and increases the overall level of provider satisfaction with Contractor interaction related to the Medicare program. Medicare providers need to receive clear, accurate, timely, and consistent information about the Medicare program in multiple ways. To meet provider information, education, and training goals, the Centers for Medicare & Medicaid Services (CMS) PCSP includes three major components: ▪ Provider outreach and education (POE) for educating providers and their staff. ▪ Provider Contact Center (PCC) for handling provider inquiries. ▪ Provider self-service (PSS), including web and interactive voice response (IVR) technology allowing access to Medicare information any time of the day.

C.5.7.1 Provider Outreach and Education

The Contractor shall conduct provider outreach and education (POE) activities in accordance with IOM Pub. 100-09, Chapter 6.

Background	The fundamental goal of the POE program is to reduce the provider compliance error rate and the claims payment error rate by giving Medicare providers the information they need to understand the Medicare program, be informed timely about changes, and bill correctly. POE is driven by educating providers and their staffs about the fundamentals of the Medicare national and local program, polices, and procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through analyses of such things as provider inquiries, claim submission errors, medical review data, and Comprehensive Error Rate Testing (CERT) data. These efforts are aimed at reducing the number of provider inquiries and claim submission errors. The Contractor shall educate and train providers about the Medicare program and billing issues in accordance with IOM Pub. 100-09, Chapter 6 §20.3. POE education may be delivered to groups, to individuals, and through various in-person and media channels at the complete discretion of the contractor, with the goal of effectively and efficiently using the POE funding to reduce the error rate.

	Provider outreach and education by the Contractor shall include new provider training, training tailored for small providers, and education on preventive benefits, local coverage determinations, education resulting from medical review referrals, electronic claim submissions, and remittance advice. The Contractor shall communicate information from CMS program instructions (Change Requests, or CRs; and Joint Signature Memorandums, or JSMs) to providers in the manner specified in the instruction. Measurement tools will be provided to the contractors by CMS. See Attachment J-16 for more information.
Standard 1	The Contractor's POE activities are successful when the Contractor maintains satisfactory performance levels, as measured by CMS, in regards to website satisfaction, as measured using American Customer Satisfaction Index survey methodology, and provider education as measured by the Medicare Contractor Provider Satisfaction Survey.
Standard 2	The Contractor's POE activities are successful when there is a decrease in the contractor-specific provider compliance error rate of 10% as compared to the contractor's baseline determined during the base year of the contract (The decrease will be measured on an annual basis; the provider compliance error rate is the gross rate before any adjustments has been made, including errors based on the non-response rate).
Standard 3	The Contractor's POE activities are successful when there is a decrease in the state-specific Hospital Performance Monitoring Program error rate of 5% as compared to the contractor's baseline determined during the base year of the contract by the Quality Improvement Organization (The decrease will be measured on an annual basis).

C.5.7.1.1 Data Analysis

The Contractor shall analyze the data available in order to identify outreach and educational needs of the providers in its jurisdiction in accordance with IOM Pub. 100-09, Chapter 6, §20.2.

Background	At a minimum, the Contractor shall perform inquiry analyses, claims submission error analyses, and review of the error rate data. The Contractor shall also use a consideration of referrals from medical review in setting education priorities.

C.5.7.1.2 Provider Outreach and Education Advisory Group

The Contractor shall establish and maintain a POE Advisory Group in accordance with IOM Pub. 100-09, Chapter 6, §20.4.

C.5.7.1.3 "Ask-the-Contractor" Teleconferences

The Contractor shall organize toll-free "Ask-the-Contractor" teleconferences (ACTs) in accordance with IOM Pub. 100-09, Chapter 6, §20.3.4.6. ACTs serve as a method to

share information with the Contractor's provider community and shall be offered at least quarterly.

C.5.7.1.4 Provider Organization Partnerships

The Contractor shall establish partnerships with provider organizations to disseminate Medicare provider information in accordance with IOM Pub. 100-09, Chapter 6, §20.1.2.

C.5.7.1.5 Promotion of Internal Communication and Development of Provider Education Needs

The Contractor shall coordinate with appropriate staff within the contractor's other business areas (medical review, provider inquiries; Medicare Secondary Payer, or MSP; enrollment; appeals, systems; etc.) to promote internal communication and development of provider education needs in accordance with IOM Pub. 100-09, Chapter 6, §20.1.1.

C.5.7.1.6 Bulletin/Newsletter Publication

The Contractor shall publish and distribute paper bulletins/newsletters in accordance with IOM Pub. 100-09, Chapter 6, §20.3.1.

Background	The Contractor may use alternative approaches to printing and mailing paper bulletins, in accordance with IOM Pub. 100-09, Chapter 6. Contractors interested in using alternative approaches shall have their plan approved by CMS. The alternative approaches shall ensure that the same information that would have appeared in the paper bulletins is available to providers electronically, include a mechanism for providers who have technical barriers to continue to receive paper copies, and include a process that providers will use to return to receiving paper copies. The alternative approach shall be sent to CMS for approval prior to ceasing the publication of paper bulletins and at any time the Contractor wants to modify its CMS-approved approach.

C.5.7.1.7 Provider Service Plan

The Contractor shall develop and submit an annual Provider Service Plan (PSP) for the outreach and education activities the Contractor will accomplish throughout the year in accordance with IOM Pub. 100-09, Chapter 6, §20.5.1. The PSP will include a self-evaluation of the Contractor's POE activities during the previous contract year.

C.5.7.1.8 Education Activity Report

The Contractor shall develop and submit a semiannual Education Activity Report that summarizes and recounts the completed POE activities in accordance with IOM Pub. 100-09, Chapter 6, §20.5.2.

C.5.7.2 PROVIDER CONTACT CENTER

The Contractor shall establish and maintain a PCC in accordance with IOM Pub. 100-09, Chapter 6, §30.

Background	The Contractor will choose and implement contact center technology that demonstrates innovation and efficiency in providing excellent customer service. Because of the various communication channels available to providers today, it is important that all communication be coordinated to ensure consistency. The initial provider contact is normally made to a PCC. The PCC serves as the coordinating centerpiece for developing and managing the relationship with the Medicare providers. Measurement tools will be provided to the Contractors by CMS. See Attachment J-16 for more information.
Standard 1	The Contractor's PCC activities are successful when the Contractor maintains satisfactory performance levels, as measured by CMS, in regards to call center satisfaction, as measured using American Customer Satisfaction Index survey methodology, and provider inquiries as measured by the Medicare Contractor Provider Satisfaction Survey.

C.5.7.2.1 Telephone Inquiries

The Contractor shall respond to provider telephone inquiries in a timely, accurate, and consistent manner in accordance with IOM Pub. 100-09, Chapter 6, §30.2.

Provider contact centers shall monitor a minimum of 5 calls per CSR per month per jurisdiction.

Background	The Contractor must divide provider telephone inquiry staff into at least two levels of Customer Service Representatives (CSRs). First level CSRs shall answer a wide range of basic questions that cannot be answered by the interactive voice response (IVR). Second level CSRs will answer more complex questions. Inquiries that require additional time or yet higher degree of expertise and/or research shall be referred to the Provider Relations Research Specialists (PRRS) (see requirement C.5.7.2.3). Triage approaches must be consistent with the guidance provided in IOM Pub. 100-09, Chapter 6, §30.1. If a Contractor chooses to have multiple call centers, the call centers shall be networked in such a way as to enable them to balance the call volume load, and assist with contingency planning and disaster recovery, with a goal of meeting performance metrics at a Contractor level. Fraud and Abuse Complaints – When a provider inquiry or complaint of potential fraud and abuse in received by the first level screening staff, it shall be referred to the second level screening staff. The second level screening staff shall not performance any screening, but prepare a referral package and send it immediately to the PSC in accordance with IOM Pub. 100-09, Chapter 6, §30.8.
Standard 1	Telephone inquiries are successful when, for calls monitored for the quarter, the

	number of CSRs scoring as “Achieves Expectations” or higher for Knowledge Skills and Customer Skills and scoring as “Pass” for Adherence to Privacy Act using the Quality Call Monitoring tool shall be no less than 93% (cumulative for the quarter).
Standard 2	Telephone inquiries are successful when the corporate quarterly call completion rate is 95% for IVRs and 80% for CSRs.
Standard 3	Telephone inquiries are timely when the corporate quarterly average speed of answer is 60 seconds.

C.5.7.2.2 Written Inquiries

The Contractor shall respond to provider written inquiries in a timely, accurate, and consistent manner in accordance with IOM Pub. 100-09, Chapter 6.

Provider contact centers shall monitor a minimum of 5 pieces of correspondence (or the universe, whichever is smaller) per written respondent per month per MAC jurisdiction.

Background	Contractors have the discretion to develop a tiered approach to answering general written inquiries. Written inquiries shall include letters, faxes, and e-mails. Inquiries made through electronic transmission are considered written inquiries. Contractors shall handle the rare occurrence of a walk-in inquiry. Such inquiries are counted in the written inquiry workload.
Standard 1	Written inquiries are successful when, of the written responses monitored for the quarter, the number of written inquiry respondents scoring as “Achieves Expectations” or higher for Knowledge Skills and Customer Skills and scoring as “Pass” for Adherence to Privacy Act using the Quality Written Correspondence Monitoring tool shall be no less than 93% (cumulative for the quarter).
Standard 2	Written inquiries are timely when at least 95% are answered with final responses within 45 business days of receipt and no more than 5% are answered with interim responses (this 5% includes all PRRS interim responses – see requirement C.5.7.2.3) within 45 business days of receipt.

C.5.7.2.3 Provider Relations Research Specialists

The Contractor PRRS shall handle complex provider inquiries from the contact center that require significant research and complex beneficiary inquiries that cannot be resolved by the Beneficiary Contact Center (BCC), in accordance with IOM Pub. 100-09, Chapter 6, §30.5 and §60.4.

Provider contact centers shall monitor a minimum of 5 pieces of correspondence (or the universe, whichever is smaller) per PRRS per month per MAC jurisdiction.

Background	The PRRS is primarily responsible for resolving complex provider written and telephone inquiries. Referral of complex inquiries from the BCC will also be resolved by the PRRS. Responses to provider inquiries are in writing unless the

	inquiring party has requested a call back or the inquiry is best handled with a callback. The PRRS is also responsible for developing job aids for CSRs, assisting in the development of training materials for the general inquiries staff, and serving as the point of contact for Medicare Advantage plans about Medicare program coordination issues.
Standard 1	PRRS responses are successful when, of all provider and beneficiary responses monitored for the quarter, the number of PRRS respondents scoring as "Achieves Expectations" or higher for Knowledge Skills and Customer Skills and scoring as "Pass" for Adherence to Privacy Act using the Quality Written Correspondence Monitoring tool shall be no less than 93% (cumulative for the quarter).
Standard 2	PRRS responses are timely when 75% of complex inquiries referred by provider telephone CSRs or from the BCC are answered within 25 business days from receipt.
Standard 3	PRRS responses are timely when at least 95% of complex inquiries referred by provider telephone CSRs or from the BCC are answered within 45 business days from receipt and no more than 5% are answered with interim responses (this 5% includes all general inquiry interim responses – see requirement C.5.7.2.2) within 45 business days of receipt.

C.5.7.2.3.1 Responding to Complex Beneficiary Inquiries

The Contractor shall respond timely to complex beneficiary telephone and written inquiries referred by the BCC in accordance with IOM Pub. 100-09, Chapter 6. The Contractor shall respond directly to the beneficiary via telephone, written mail or e-mail and document the response in the Next-Generation Desktop (NGD).

Potential fraud and abuse complaints from beneficiaries shall also be referred to the PRRS. If contractor staff other than the PRRS performs second level screening, the PRRS shall refer these complaints to the second level screening staff within the MAC that shall process them in accordance with IOM Pub. 100-08, Chapter 4 Section 4.6.2.

Background	Once an inquiry is referred from the BCC, the PRRS researches and resolves the complex inquiry. The nature of the inquiries may be expected to range from Benefit Integrity Unit (BIU) complaints, Claim Adjustments, claims processing difficulties, Medicare Secondary Payer (MSP) adjustments, Check Reissue, Congressional Inquiries that are MAC related, and Freedom of Information Act (FOIA) requests. These are examples of types of complex inquiries and not a complete list. The inquiries will not come directly into the PRRS, but will instead be referrals transferred from BCCs to the PRRS electronically via the NGD. The MAC will take the appropriate necessary action and update the NGD record accordingly. Although the PRRS are accountable for the responses to these complex beneficiary inquiries, the work may be delegated to other staff, as appropriate. NGD is a CMS-furnished desktop application and the Contractor is required to

	use NGD only for complex beneficiary inquiry referrals. CMS will provide as many NGD licenses as needed to process the complex beneficiary inquiries. The NGD technical specifications can be found in IOM Pub. 100-09, Chapter 2. CMS provides Siebel Systems' eHealthcare product and centrally located servers that the Contractor accesses via the Medicare Data Communications Network (MDCN). No special operating or Service-Level Agreements (SLAs) are required between the Contractor and the NGD developer/maintainer.

C.5.7.2.3.1.1 Acceptance and Tracking of Complex Beneficiary Inquiry Referrals

The Contractor shall use the NGD to accept referrals of complex telephone and written inquiries from the BCC and to track the PRRS caseload from referral receipt to response.

C.5.7.2.3.1.2 English, Spanish, and Text Telephone Capabilities

The Contractor shall have adequate language capabilities (English; Spanish; and Text Telephone, or TTY) to handle telephone communications with all beneficiaries within their jurisdiction. For other beneficiary language groups in its jurisdiction, the Contractor shall obtain foreign language support service by contract.

C.5.7.2.3.1.3 Review Written Responses for Reading Level (Fogging) Accuracy and Timeliness

The Contractor shall fog written responses for reading level (8th grade or less), in accordance with IOM Pub. 100-09, Chapter 2, section 20.2.1(3), and review for accuracy, clarity, tone, and formatting.

C.5.7.2.3.1.4 Feedback

The Contractor shall provide feedback via the NGD to the BCC identifying inappropriate referrals (routine inquiries that should have been handled by the BCC) to the PRRS.

C.5.7.2.4 Inquiry Tracking System

The contractor shall maintain a tracking and reporting system for all provider inquiries and submit a quarterly contractor inquiry tracking report in accordance with IOM Pub. 100-09, Chapter 6, §30.6.

Background	Data from the tracking system is used to analyze the number and types of inquiries in order to generate frequently asked questions (FAQs) to be posted on the website, identify areas for telephone Customer Service Representative (CSR) training, and identify areas for broader provider education. The tracking system will also be used to generate quarterly reports for CMS use.

C.5.7.3 PROVIDER SELF-SERVICE TECHNOLOGY

The Contractor shall facilitate and encourage providers' use of self-service technology, through marketing materials, educational seminars, listserv messages, and instructions on websites and IVRs in accordance with IOM Pub. 100-09, Chapter 6, §50.

C.5.7.3.1 Interactive Voice Response

The Contractor shall use IVR technology to provide self-service options for providers to perform beneficiary eligibility inquiries, claims status inquiries, and access remittance advice code and definitions as well as information to help providers resolve issues identified by these code sets, 24 hours a day seven (7) days a week, with allowances for normal system availability, updates, and maintenance provided in accordance with IOM Pub. 100-09, Chapter 6, §50.1.

Background	Medicare providers are required to use the IVR to access this information (unless Internet-based transactions are available, as approved by CMS). The Contractor shall identify providers who repeatedly call CSRs for information that is available on the IVR and contact them to teach them to effectively use the IVR.

C.5.7.3.2 Web Technology

The Contractor shall maintain web self-service technology to furnish providers with timely, accessible, and understandable Medicare program information in accordance with IOM Pub. 100-09, Chapter 6, §50.2

C.5.7.3.3 Provider Listserv

The Contractor shall offer electronic listservs for providers and promote the availability of and benefits of registration to the listservs in accordance with IOM Pub. 100-09, Chapter 6, §50.3.

Standard 1	The Contractor's listserv activities are successful when the Contractor maintains at least 25% of its active provider count as unique registrants to its provider listserv by the end of the first year of the contract (active providers are all individual providers who have had billing activity during the previous twelve (12) months).

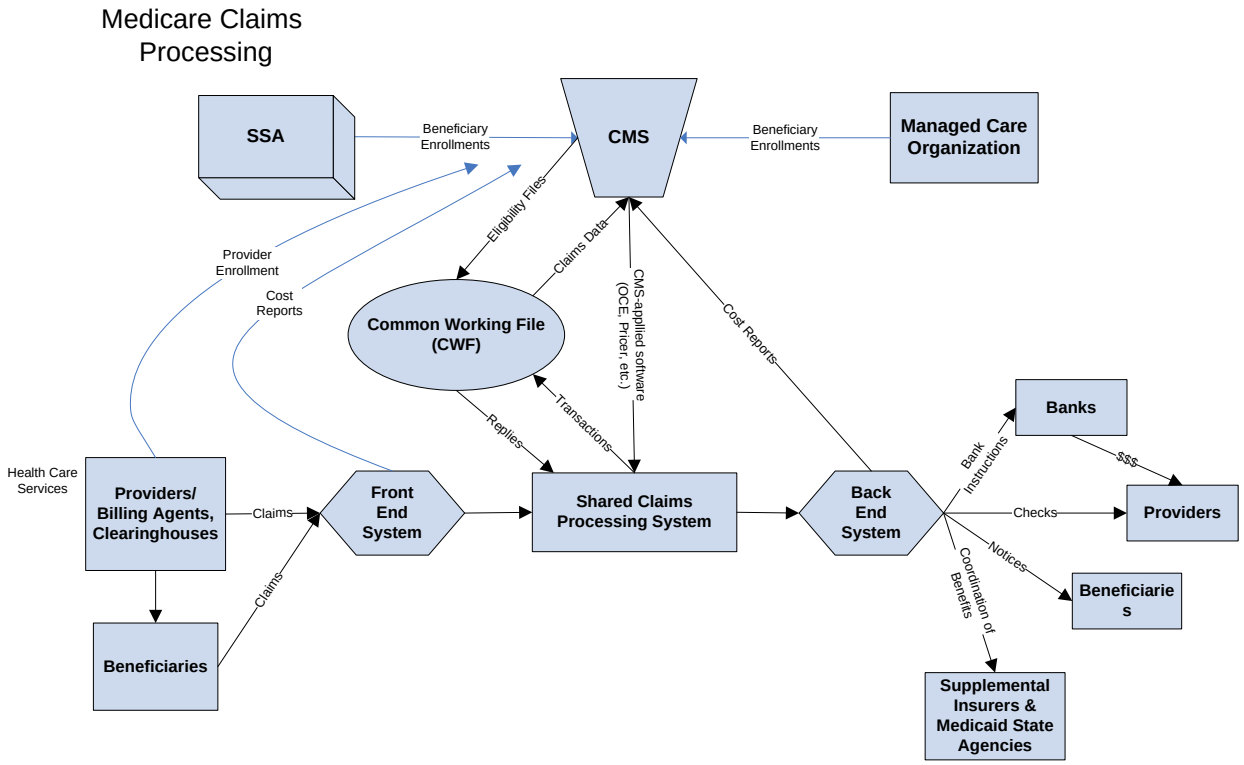
C.5.7.3.4 Provider Customer Service Program Staff Training

The Contractor shall ensure that its staff is adequately trained to provide a high level of customer service through both POE and its PCC. At a minimum, the Contractor shall follow the training requirements in IOM Pub. 100-09, Chapter 6, §40.

C.5.8 Claims Processing

The following graphic is an overview of Medicare claims processing.

[----------Area 1----------]



Medicare Environment

[----------Area 2----------][-----Area 3-----][---------Areas 4, 5, 6---------][----------Areas 7, 8----------]

The diagram above is a graphical illustration of claims processing showing flows of information. It is not intended to depict a time sequence. In area 1 (at the top of the diagram), the Social Security Administration (SSA) provides beneficiary enrollment data to the Centers for Medicare & Medicaid Services (CMS). Medicare Advantage (MA) organizations and other managed care plans (e.g., cost plans, demonstrations, PACE organizations), and Prescription Drug sponsors provide information on beneficiaries who have enrolled in Medicare delivery systems other than the traditional Medicare Fee-for-Service (FFS) program and then the information is used to adjudicate claims

In area 2 (the left side of the diagram), providers (or billing agents and clearinghouses on their behalf) or, in specialized circumstances, beneficiaries, send claims and other transactions (e.g., provider data, beneficiary demographic data, claims attachments) to a collection point that houses preprocessing functionality before entry into the shared systems.

Area 3 is the front-end system that validates format and conformance with Health Insurance Portability and Accountability Act (HIPAA) syntax, translates HIPAA electronic transactions to a file that the shared claims processing systems can receive as input; converts paper claims to electronic to join input data stream of HIPAA-compliant electronic data interchange (EDI) claims. Cost reports are also collected by CMS.

Areas 4, 5, and 6 are the claims processing core activities. In area 4, the shared system (Fiscal Intermediary Standard System—FISS; or Multi-Carrier System—MCS) begins processing: edits for consistency, utilization, covered service, eligible beneficiary and provider, and pricing algorithms. In area 5, the claim is sent to the Common Working File (CWF) for eligibility and other checks such as lifetime service limits, or cross-Contractor utilization editing. The CWF responds in one of the following ways:

a. OK to pay claim as submitted,

b. Reject claim as submitted, or

c. Claim needs additional information before it can be paid.

If CWF rejects or flags claim as needing further review, the reply will contain information to assist in resolution. In area 6, the shared system determines final claim action (pay, suspend, deny).

In area 7, back-end processing closes out the claim by sending notices to beneficiaries and providers, checks and electronic funds transfer (EFT), bank notices, and financial data. The Healthcare Integrated General Ledger System (HIGLAS) is included in this area, for those workloads using HIGLAS. In area 8, claims data and cost reports are collected by CMS from providers, and beneficiary and provider files are updated with new utilization information, tax and payment data.

C.5.8.1 Standard Paper Remittance Advice Transactions

The Contractor shall maintain the capability to issue Standard Paper Remittance Advices (SPRs) to those providers that are unable to receive 835 remittance advice transactions from Medicare in accordance with IOM Pub. 100-04, Chapter 24, 25, and 26.

C.5.8.1.1 Direct Data Entry Support

The Contractor shall provide connectivity for the remote providers to access Direct Data Entry (DDE), security clearance for such access, training for the providers on how to use DDE, and answers to providers' questions on maneuvering through the screens to institutional claims submitters for DDE access to the shared systems for the purpose of submitting and correcting claims in accordance with IOM Pub. 100-04, Chapter 24 and 25.

Background	DDE is a mode of transmitting claims using secure, dedicated hardware and communications lines. The standard front-end contractor shall support direct data entry capability (DDE), where it previously existed. The shared system maintainer shall make the data elements in those screens compliant with the data requirements of the corresponding HIPAA transaction implementation guides as specified in the HIPAA transaction implementation instructions in IOM Pub. 100-04, Chapter 24.

C.5.8.2 General Claims Processing

The Contractor shall process to the point of payment, denial, or other adjudicative action in a timely and accurate manner, usually by operating shared system software, claims and claims-related transactions for which it has processing jurisdiction. Jurisdiction of a claim is determined based on the criteria listed in IOM Pub. 100-04, Chapter 1, section 10. The Contractor shall adhere to claims processing instructions contained in IOM Pub. 100-04.

The Contractor shall recommend that CMS accept or deny a request to process untimely claims in accordance with the requirements specified in IOM Pub. 100-04, Chapter 1, section 70.

Background	Most claims are processed automatically through the CMS-provided shared systems and CWF and are usually resolved without requiring manual intervention on the part of the Contractor. CMS supplies the shared claims processing systems, including transmission to CWF, installed at the data center that the Contractor must use. FISS will process claims and transactions from institutional providers. MCS will process claims and transactions from professional providers (physicians, practitioners, and suppliers). The Contractor must have the expertise to interact with both systems. With the exception of special circumstances, CWF must approve each claim before it is paid. CWF returns information to the Contractor regarding the entitlement status of the beneficiary, information on actual or potential duplicate billing (although some duplicate editing is performed in the shared systems), conflicts between the submitted claim and previously-approved claims for which the Contractor may need to resolve issues with other agencies, individuals, or entities, as appropriate, including, but not limited to, SSA, other Medicare Contractors, the Medicare beneficiary, or the individual/ entity that furnished the service for which payment was requested. There will, however, be instances where a claim that is submitted requires manual intervention on the part of the Contractor. Many of the standards in the following sections relate to resolution of such claims. Attachment J-4, Guide to Internet Only Manuals (IOM) Claims Processing Rules for CMS MAC SOW, to this SOW contains a guide to particularly relevant

	IOM claims processing rules. However, Attachment J-4 shall not be considered to be an all inclusive list of rules or requirements for which the Contractor shall be held responsible. The MAC is responsible for adhering to all rules relevant to claims processing contained in IOM Pub. 100-04 and other CMS IOM Publications for claims in its jurisdiction. Interest is paid on clean claims that were not paid within the applicable payment ceiling in accordance with IOM Pub. 100-04, Chapter 1, section 80.2.2.
Standard 1	Claims processing is successful when claims are paid with acceptable accuracy as evidenced by a contractor-specific Comprehensive Error Rate Testing (CERT) error rate not to exceed the Government Performance Results Act (GPRA) national paid claims error rate goal for the year (The goal for each year is published in the Report on Improper Medicare Fee-for-Service Payments. www.cms.hhs.gov/cert).
Standard 2	Clean claims are processed timely when 95% of the claims are processed within the claims payment floor and ceiling specified in IOM Pub. 100-04, Chapter 1, sections 80.2.1.1 and 80.2.1.2.

C.5.8.2.1 Communication of Claims Processing Problems

The Contractor shall communicate to the shared system maintainers or to CMS, as appropriate, in a timely manner on all claims processing problems that significantly disrupt the processing of claims or that require CMS intervention. The Contractor shall provide clear, non-technical communication of problems and impacts to appropriate CMS personnel or their designated agents (e.g., Shared System Maintainers, or SSMs). The communication shall occur through regular conference calls with CMS (e.g., weekly Technical Advisory Group, or TAG, calls), e-mail, or phone calls to appropriate personnel, or in accordance with the user agreement established with the SSMs.

Standard 1	Communication is timely when CMS receives notification within five (5) business days of (Contractor) discovering systematic and/or operational claims processing problems that do not cause disruption of claims processing payments.
Standard 2	Communication is timely when CMS receives notification within 24 hours or within the same business day of identification, if the problem may cause disruption of benefit payments beyond a single provider.

C.5.8.2.2 Resolution of Common Working File Rejected Claims Involving another Medicare Administrative Contractor

The Contractor shall resolve problems that prevent a claim from processing correctly because another MAC processed and posted a prior bill to CWF. The Contractor shall resolve these problems in accordance with the instructions in IOM Pub. 100-04, Chapter 27, sections 50–50.3, and the CWF system documentation for resolving problems that

prevent a claim from processing because of a conflict with a prior claim submitted by another Contractor.

Background	When a Contractor cannot process a bill because another MAC processed and posted a prior bill to CWF (e.g., due to consolidated billing edits), the two Contractors must work together to resolve the error. The CWF reject trailer identifies the Contractor that should process the bill. It is possible that the same MAC will have processed both the professional and institutional claims causing the conflict. In these cases, the MAC shall resolve the problem internally.

C.5.8.2.3 Resolution of Claims Transaction Replies from Common Working File

The Contractor shall act on replies from CWF prior to payment or denial to ensure correct entitlement and to record utilization of benefits in accordance with CMS documentation on the CWF maintenance Contractor website.

C.5.8.2.4 Resolution of Unsolicited Responses from Common Working File

The Contractor shall process unsolicited responses from CWF by taking action on pended, previously paid, or denied claims to ensure correct entitlement, record utilization of benefits, and adjust payment as necessary in accordance with CMS published instructions.

Background	Applicable CMS published instructions include IOMs, Joint Signature Memoranda (JSMs), and approved change requests (CRs).

C.5.8.2.4.1 Medicare Secondary Payer Claim with Complete Primary Payer Notification of Benefits Paid: Explanation of Benefit, Remittance Advice, or Such Other Acceptable Notice: Update Common Working File

The Contractor shall identify an MSP claim with a complete explanation of benefit (EOB) and update the Common Working File (CWF) in accordance with IOM Pub. 100-05, Chapter 5, section 20.

Background	CWF can only be updated with a primary payer's notice of primary payment (e.g., EOB, Remittance Advice—RA).

C.5.8.2.4.2 Identification of Potential MSP Existence

The Contractor shall determine if the claim and/or the attachment is complete in accordance with IOM Pub. 100-04, Chapter 1, sections 70.2.3.1 and 70.2.3.2, and IOM Pub. 100-05, Chapter 3.

The Contractor, after identifying a complete attachment (EOB or primary payer RA), a possible MSP claim, possible MSP situation, or CWF exclusion, shall forward the information to the Coordination of Benefits Contractor (COBC) in accordance with IOM Pub. 100-05, Chapter 4, section 10.3, and Chapter 5, sections 10.1, 10.2, and 10.7.

Background	The COBC consolidates activities that support the collection, management, and reporting of all other health insurance coverage of Medicare beneficiaries, as well as all insurance coverage obligated to pay primary to Medicare. The COBC is charged with ensuring the accuracy and timeliness of updates to the CWF MSP auxiliary file. The COBC does not process any claims, nor does it handle any mistaken payment recoveries or claims-specific inquiries (telephone or written). The COB Contractor handles all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries.

C.5.8.2.5 Payment of Claims outside Common Working File

The Contractor shall pay claims without prior CWF approval only in accordance with CMS procedures found in IOM Pub. 100-04, Chapter 27, sections 60–60.2.

Background	CWF must approve most claims before payment; however, there may be special circumstances when it is necessary to pay claims outside of the CWF system. CMS will instruct the Contractors to pay without CWF approval. One example of special circumstances is enactment of new coverage policies with effective dates that preclude making the necessary changes to CWF timely. There also may be circumstances unique to individual Contractors that justify paying claims outside CWF approval. For such situations, the Contractor must obtain CMS approval to pay the claims outside CWF.

C.5.8.2.6 Handling of Medicare Advantage Claims

The Contractor shall pay, deny, return, or forward Medicare Advantage (managed care) claims in accordance with CMS published instructions.

Background	CMS instructions include IOMs, JSMs, and approved CRs. Generally, the MACs do not pay claims for beneficiaries enrolled in MA Plans. In certain situations (e.g., hospice election, newly covered services, clinical trials), the MAC is required to pay claims for MA beneficiaries. CMS will instruct the MACs as these situations occur. To ensure that Medicare is not paying twice for covered services, the Contractor is required to report, to the MA Organizations, on payments to FFS providers for beneficiaries enrolled in the MA Plan. Medicare Advantage beneficiary elects the hospice benefit, they retain services under the MCO for conditions unrelated to the terminal or related conditions. The payment made to the MCO is adjusted to reflect the services under hospice which are paid for under fee-for-service.

C.5.8.2.6.1 MEDICARE ADVANTAGE CLAIMS FOR HOSPICE CARE

The Contractor shall pay, deny, return, or forward Medicare Advantage (managed care) claims for hospice care in accordance with 42 Code of Federal Regulations (CFR) 422.320, Special Rules for Hospice Care.

C.5.8.2.6.2 MEDICARE ADVANTAGE CLAIMS FOR NATIONAL COVERAGE DECISION OR LEGISLATIVE CHANGE IN BENEFITS

The Contractor shall pay, deny, return to providers or notify MA organizations (where appropriate) for National Coverage Decision (NCD) or legislative change in benefits in accordance with 42 CFR 422.109.

Background	When the patient is an enrollee in a MA Plan, the Contractor may be responsible for obtained services if: ▪ CMS determines that an NCD or legislative change in benefits meets the significant cost criteria, and ▪ MA organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments (to MA organizations) are adjusted.

C.5.8.2.7 Local System Edits

The Contractor shall apply local system edits in accordance with CMS mandates. The processes and procedures specified in the CMS notification is applicable to each shared system and Contractor. Full compliance of these mandates is required to ensure that the claims are processed accurately.

Background	The Contractor applies local edits as necessary to the shared systems via Contractor-driven type tables (e.g., entity action records, SuperOpEvents {add to Key Definitions}, System Control Facility (SCF) rules, or procedure/diagnosis code tables). The Contractor cannot alter or add edit logic to the shared systems, because the source code is unavailable to the Contractor.

C.5.8.3 DEVELOPMENT OF SUSPENDED CLAIMS

The Contractor shall investigate and resolve suspended claims in accordance with 42 CFR 424.32 and IOM Pub. 100-04, including but not limited to the references in Attachment J-4, Guide to IOM Claims Processing Rules for CMS MAC SOW, to this Statement of Work (SOW).

Background	Developing claims involves problem resolution for claims that require human intervention before they can be completely processed through the shared system. Some examples why a claim suspends for manual intervention would be: ▪ If they involve medical review,

	▪ If they have incomplete information when Medicare is the secondary payer, or ▪ If they entail non-automated edit resolution. The issues arising under “non-automated edit resolution” are varied, complex, and require experts to resolve.

C.5.8.4 BACK-END PROCESSING

The Contractor shall perform back-end processing of Medicare claims and shall update claims history files to include CWF claims resolution.

Background	A fully adjudicated claim is a claim that has gone through all core processes in the shared system. Claims processing actions that occur after the claim has been accepted by CWF are commonly referred to as back-end processes. The back end combines processes from both the claims and financial parts of the system.

C.5.8.4.1 Remittance Advice and Medicare Summary Notices

The Contractor shall timely and accurately generate payment and deliver Remittance Advices (RAs) to providers and Medicare Summary Notices (MSNs) to beneficiaries.

The Contractor shall generate MSNs in accordance with IOM Pub. 100-04, Chapter 21.

The Contractor shall generate RAs in accordance with IOM Pub. 100-04, Chapter 22.

Background	EFT payments are generated and delivered electronically for providers who request EFT. Hard copy checks are generated and mailed to beneficiaries and providers who have not requested payment by EFT. Electronic RAs are generated and delivered electronically to providers who request electronic RAs. Hard-copy RAs are generated and mailed to providers who do not request electronic RAs. Hard-copy MSNs are generated and mailed to beneficiaries.

C.5.8.4.2 Coordination of Benefits Flat Files

The Contractor shall deliver the Coordination of Benefits (COB) flat file received from the shared system to the Coordination of Benefits Contractor (COBC) and perform Coordination of Benefits Agreement claims crossover functions in accordance with IOM Pub. 100-04, Chapter 28 and IOM Pub 100-20.

Background	As discussed in the IOM Pub. 100-04, Chapter 28, section 70.6, Contractors will receive a Common Working File (CWF) Beneficiary Other Insurance (BOI) reply trailer (29) as part of their claims adjudication process when a crossover trading partner has signed a national Coordination of Benefits Agreement (COBA) with the Coordination of Benefits Contractor (COBC) and CWF has

	selected the claim for transference to the COBC. Upon receipt of a BOI reply trailer (29), the contractor is to send processed Medicare claims to the COBC via an 837 flat file. Contractors will send two files to the COBC; one file for its Institutional claims, and one file for its Professional claims.

C.5.8.4.3 Generate and Mail Claims Processing Documents

The Contractor shall generate and mail all claims processing documents that are not transmitted electronically in accordance with IOM Pub. 100-04, Chapters 21 and 22.

Background	Claims processing documents include but are not limited to Notices of Utilization, MSNs, RAs, checks, and redeterminations
Standard 1	MSN management is successful when the Contractor accurately generates and mails 98% of MSNs in accordance with IOM Pub. 100-04, Chapter 21.
Standard 2	Document management is successful when the Contractor mails all required documents that are not being transmitted electronically.

C.5.8.4.4 The Do Not Forward Initiative

The Contractor shall implement the Do Not Forward (DNF) initiative on professional claims in accordance with IOM Pub. 100-04, Chapter 1, section 80.5.

Background	The DNF initiative entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks to locations other than those recorded on the Medicare provider files. The use of these envelopes permits the U.S. Postal Service to return Medicare checks to the Contractor free of charge. Note that this initiative has been implemented for professional claims only. For full details of the DNF initiative, see IOM Pub. 100-4, Chapter 1, section 80.5.

C.5.8.5 Opt-Out Payment Provisions

The Contractor shall follow beneficiary payment requirements for physicians and practitioners who opt out of Medicare in accordance with IOM Pub. 100-2, Chapter 15, sections 40–40.15 and report data in accordance with IOM Pub. 100-2, Chapter 15, section 40.40. Physicians who opt out of the program are monitored through PECOS in accordance with IOM Pub. 100-08, Chapter 10.

C.5.8.6 Physician Incentive Payments for Services in Health Professional Shortage Area and Physician Scarcity Area

The Contractor shall make physician incentive (or bonus) payments for primary care and mental health care services furnished in geographic Health Professional Shortage Areas (HPSAs) and for primary or specialty physician care furnished in Physician Scarcity Areas (PSAs) in accordance with IOM Pub. 100-04, Chapter 12, sections 90.4

and all subsections (HPSA) and 90.5 and all subsections (PSA) and IOM Pub. 100-04, Chapter 4, section 250 and all subsections.

C.5.8.7 Participating Competitive Acquisition Program Physician Claims for Administering Part B Drugs

C.5.8.7.1 Listing of Competitive Acquisition Program Participating Physicians and Practitioners

The Contractor shall forward to the Contractor designated to process approved Competitive Acquisition Program (CAP) vendor claims a list of all the physicians and practitioners who have elected to participate in CAP.

Standard 1	The Contractor's performance of the CAP physician election process is successful when it conforms with the activities and timeframes required in CRs 4044, 4064, 4306, and 4309.

C.5.8.7.2 Monitoring Competitive Acquisition Program Physicians and Practitioner Claims for Administering Part B Drugs

The Contractor shall monitor claims for administering drugs by participating CAP physicians and practitioners to ensure that the participating CAP physicians and practitioners are complying with Medicare payment rules in accordance with IOM Pub. 100-04 Chapters 17 and 21 (CRs 4044, 4064, 4306, and 4309).

Standard 1	The Contractors monitoring of CAP physicians and practitioners claims for administering drugs is successful when the Contractor adjudicates CAP claims in accordance with IOM Pub. 100-4 Chapters 17 and 21 (CR 4044, 4064, 4306, and 4309).

C.5.9 Reopening of Medicare Initial Claims Determinations

C.5.9.1 Reopening

Where appropriate, the Contractor shall reopen an initial determination or a redetermination to review a decision in accordance with 42 Code of Federal Regulations (CFR) 405.980 and Internet-only manual IOM Pub. 100-04, Chapter 29 (disregard references to hearing officers and administrative law judge, or ALJ hearings).

Background	The reopening process is separate and distinct from the Medicare fee-for-service (FFS) claim appeals process. Generally, a reopening of an initial claim determination or a redetermination is a

	remedial action taken by the Contractor to correct a claim, where appeal rights have been exhausted. A Contractor may choose to reopen a claim on its own motion or at the request of a party to the initial determination or redetermination. However, the regulations governing reopenings do not permit unrestricted reopenings of determinations and decisions.

C.5.9.1.1 Reopenings on the Contractor's Own Motion

The Contractor shall conduct reopenings on the Contractor's own motion in accordance with 42 CFR 405.980 (b).

C.5.9.1.2 Reopenings on the Request of Party

The Contractor shall conduct reopenings on the request of party to the initial determination or redetermination in accordance with 42 CFR 405.980 (c).

C.5.9.1.2.1 Redetermination Resolutions for Clerical Errors

The Contractor shall resolve redetermination requests where the reason for the denial involves only a clerical error or omission (for both Contractor and provider errors) outside of the Medicare claim appeals process in accordance with Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) 937 and 42 CFR 405.980(a)(3).

Background	A Contractor must use the reopening process instead of the appeals process when an appeal has been requested to resolve claims denials where the reason for the denial involves a clerical error or omission. (Examples of clerical errors include but are not limited to human and mechanical errors on the part of the party or the Contractor such as mathematical or computational mistakes or inaccurate data entry).

C.5.9.1.2.2 Documentation Requests

The Contractor shall process redetermination requests, where the Contractor issued a denial because requested documentation was not received during medical review, as reopening in accordance with 42 CFR 405.980(a)(2).

Background	If a Contractor issues a denial of a claim because it did not receive requested documentation during medical review, and the party subsequently requests a redetermination, the Contractor must process the redetermination request as a reopening and not as a redetermination. This re-opening shall be conducted by the MR staff.

C.5.9.1.3 Reopening Appeal Cases

The Contractor shall reopen appeals cases remanded by the Qualified Independent Contractor (QIC) to the Contractor

Background	If a QIC remands a case to the Contractor for a redetermination under the limited circumstance described by 42 CFR 405.974(b)(2), the Contractor must reopen the redetermination and issue a revised redetermination. If a party has filed a valid request for a redetermination and subsequently requests a reopening, the Contractor must conduct the appeal redetermination and cannot conduct the reopening.

C.5.9.2 Establishing Good Cause for Reopening Initial Determinations and Redeterminations

The Contractor shall establish good cause for reopening a determination or decision in accordance with 42 CFR 405.986.

The Contractor shall deny reopening requests based only on a change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to a judicial decision or otherwise, or based on a third party payer's error in making a primary payment determination.

Background	The Contractor establishes good cause to reopen a decision, either on its own motion or at the request of a party, when there is new or material evidence that may result in a different decision, or when the evidence considered in making the decision clearly shows that an obvious error existed at the time the decision was made. The requirements of this section do not preclude Contractors from conducting reopenings to effectuate coverage decisions issued under the authority of 1869(f) of the Act.

C.5.9.3 Reopening Decisions

The Contractor shall issue its revised determination or decision to the parties to the initial determination or redetermination in accordance with 42 CFR 405.982.

Standard 1	The revised determination or decision is timely when it is issued within 60 calendar days from the date of receipt of request or the date of QIC remand.

C.5.10 Appeals of Medicare Initial Claims Determinations

C.5.10.1 Redetermination Requests

The Contractor shall process requests for redetermination of Medicare initial claims determinations in accordance with 42 Code of Federal Regulations (CFR) 405.940-958 and IOM Pub. 100-04, Chapter 29, section 310.

Background	The Medicare fee-for-service (FFS) appeals function ensures that due process rights—of beneficiaries, providers, participating physicians, and other providers who are dissatisfied with initial claims determinations and subsequent appeal

	decisions—are protected under the Medicare program. Previously, the Medicare program included different procedures for claim appeals. The first level of appeals consisted of reconsiderations under Part A of the program and reviews under Part B of the program. Section 1869 of the Social Security Act now requires that the Medicare program provide for a redetermination of a claim for a Medicare benefit that is denied in whole or in part. A person or entity that is a party (hereinafter called the appellant or the party) to an initial determination made on a Medicare claim by a Contractor may request a redetermination of the claim. In certain instances, a representative or a state agency may also request a redetermination of a claim. A provider may appeal any determination if the beneficiary to whom the service was rendered subsequently died and there is no other party available to appeal. The redetermination is the first level of the Medicare appeals process. The Contractor is responsible for processing redeterminations. The second level of the appeals process is called a reconsideration (not to be confused with the previous first level of appeals for Part A claims). Reconsiderations are processed by a separate appeals entity called a QIC. The rules governing redeterminations are in 42 CFR 405.940-958. Medicare Secondary Payer (MSP) postpay appeals are also processed in accordance with this section of the Statement of Work (SOW). For the purposes of MSP postpay appeals, “Initial Determinations” are as defined in 42 CFR 405.924 and 926.

C.5.10.1.1 Controlling Receipt of Correspondence

The Contractor shall control and track redetermination requests upon receipt in the mailroom.

Standard 1	Controlling receipt of correspondence is successful if all redetermination requests are date-controlled on the same business day they are received in the Contractor’s mailroom.

C.5.10.1.2 Document Imaging and Indexing

The Contractor shall electronically image and index all redetermination correspondence upon receipt in the corporate mailroom.

C.5.10.1.3 Acceptance of Valid Redetermination Requests

The Contractor shall accept valid written redetermination requests filed by a party to an initial determination in the form and manner prescribed in regulation and at 42 CFR 405.944.

Background	The party must submit the redetermination request in writing to the Contractor indicated on the initial determination. The requests must be filed within 120 calendar days of the party receiving the notice of initial determination. The initial determination receipt date shall be

	presumed to be five (5) calendar days after the date of the notice of the initial determination, unless there is evidence to the contrary. A provider or state agency must submit the request on a standard CMS form or in a written format that contains the following required elements: ▪ Beneficiary's name. ▪ Medicare health insurance claim number. ▪ Specific service and/or item for which the redetermination is being requested and the specific date(s) of the service. ▪ Name and signature of the party or the appointed representative of the party. Requests filed by a beneficiary do not have to contain the required elements stated above. Any written beneficiary communication that indicates disagreement with the initial determination should be treated as a request for redetermination. For example, a written inquiry asking "Why did you only pay $10.00?" or stating, "My neighbor got paid for the same kind of claim. My claim should be paid too" should be considered a request for a redetermination. Also, the beneficiary may circle an item or service he or she disagrees with on the MSN and return it to the Contractor. This action on the part of the beneficiary also constitutes a request for a redetermination. Any request or communication regarding the status of a claim is considered an inquiry and not a redetermination request. In addition, if the Contractor is in the process of recouping an identified overpayment and an appeal request is received regarding the overpayment recoupment action, the overpayment area must be notified to stop recoupment efforts pending a decision on the appeal.

C.5.10.1.4 Misdirected Redetermination Requests

The Contractor shall timely forward misdirected redetermination requests to the appropriate MAC or other Adjudicator (Qualified Independent Contractors, or QICs; administrative law judges, or ALJs; Fiscal Intermediaries, or FIs; Carriers; etc.).

Standard 1	Misdirected redetermination requests are timely when they are forwarded to the appropriate Medicare Administrative Contractor (MAC) or other Adjudicator within five (5) calendar days of receipt.

C.5.10.1.5 Granting of Extensions for Late Redetermination Requests and Determination of Good Cause

In accordance with 42 CFR 405.942, the Contractor shall accept late filed redetermination requests if the party demonstrates good cause for missing the deadline to request a redetermination.

Background	If the 120-calendar-day period for filing a redetermination request has expired, a

	party to the initial determination may request an extension for filing the redetermination request. The request for extension (Reference: 42 CFR 405.942(b)(1)) must be filed with the redetermination request and must: ▪ Be in writing, ▪ State why the request for redetermination was not filed within the required time frame, ▪ Demonstrate good cause, ▪ Be filed with the Contractor listed on the initial determination notice, and ▪ Contain the requirements of a valid redetermination request (Reference: 42 CFR 405.944(b)). Good cause (Reference: 42 CFR 405.942(b)(2)) is determined after considering the following: ▪ The circumstances that kept the party from making the request on time. ▪ Whether the Contractor's actions misled the party. ▪ Whether the party had physical, mental, educational, or linguistic limitations, including lack of facility with the English language, which prevented the party from filing a timely request or from understanding or knowing about the need to file a timely request for redetermination.

C.5.10.1.6 Consolidation of Multiple Requests for Same Claim

The Contractor shall consolidate separate requests for redetermination of the same claim into one redetermination proceeding when multiple parties submit requests for redetermination of the same claim, and the additional requests are received before a decision is made on the first request.

Background	More than one party may file a timely request for redetermination of the same claim. If multiple requests for the same claim are received before a decision is issued, the Contractor must issue its decision within 60 days of the latest filed request (Reference: 42 CFR 405.944 (c)).

C.5.10.1.7 Withdrawals and Eligibility-Based Dismissals

When dismissal is appropriate, the Contractor shall dismiss a request for redetermination and provide a written notice of the dismissal in a timely manner.

Background	The Contractor must provide a written notice of the dismissal of the redetermination request, clearly stating the reasons for the dismissal either in its entirety or as to any stated issue, transmitted to the parties at their last known address under any of the following circumstances:

	▪ When the person or entity requesting a redetermination is not a proper party under 42 CFR 405.906(b) or does not otherwise have a right to a redetermination under section 1869 (a) of the Social Security Act (the Act). ▪ When the Contractor determines that the party submitted a request for redetermination that did not contain all of the required elements listed in section C.5.9.1.3. ▪ When the party fails to file the redetermination request within the proper time frames. ▪ When the beneficiary or the beneficiary's representative files a request for redetermination, but the beneficiary dies while the request is pending, and the beneficiary's surviving spouse or estate has no remaining financial interest in the case; no other individual or entity with a financial interest in the case wishes to pursue the appeal; and no other party filed a valid and timely redetermination request. ▪ When the party filing for redetermination submits a timely written request of withdrawal to the Contractor before a redetermination decision has been issued. A party that files a request for redetermination may withdraw his or her request by filing a written and signed request for withdrawal. The request for withdrawal must contain a clear statement that the appellant is withdrawing the request for redetermination and does not intend to proceed further with the appeal. The request must be received in the Contractor's mail room before a redetermination has been issued (Reference: 42 CFR 405.952 (a)). ▪ When the Contractor has not issued an initial determination on the claim for which a redetermination is sought.

C.5.10.1.8 Assistance to Beneficiary

The Contractor shall assist the beneficiary in obtaining from the provider any additional information needed to process and complete the redetermination.

The Contractor shall clearly annotate the redetermination case file with any requests for additional information made on behalf of the beneficiary.

C.5.10.1.9 Conduct and Issue of the Redetermination

The Contractor shall make a timely, independent, accurate, supportable decision on each claim or issue in dispute; and issue a decision to dismiss, fully affirm, partially reverse, or fully reverse the initial determination in question, based on the evidence of record including applicable laws, regulations, and policies.

The Contractor shall mail to all parties to the redetermination at their last known addresses a written notice of the redetermination decision that is accurate, clear, and concise. The written notice shall be in printed form and written in a manner that is

understandable to the individual entitled to notice in accordance with 1869(a) of the Act and Chapter 29, Section 310."

Background	A redetermination is an independent review of an initial determination. Redeterminations are conducted in accordance with section 1869 of the Act, 42 CFR 405.948–405.958, and IOM Pub. 100-04, Chapter 29, section 310.
Standard 1	Redeterminations are successful when all redeterminations are processed and mailed within 60 calendar days of receipt of the request in the corporate mailroom, or within 60 calendar days of the latest filed request for consolidated redetermination requests for the same claim. **NOTE: The 60 calendar day decision-making time frame may be extended by 14 calendar days in accordance with 42 CFR 405.946(b)."**
Standard 2	Redetermination notices are accurate when all elements contained within 42 CFR 405.956(b) are included and fully addressed, and the notice is responsive to all substantive issues raised by the appellant. Where the redetermination involves an overpayment determined based on extrapolation of a statistical sample to a universe of paid claims, the redetermination notice will include, but not be limited, to: coverage of the individual claims within the sample; analysis of limitation on liability and waiver of recovery; and an analysis of the validity of the sampling methodology and extrapolation calculations."

C.5.10.1.10 Documenting the Redetermination Case Files

The Contractor shall document the redetermination case files with all relevant information, evidence, and supporting documentation and identify the individuals involved in making the initial claims determination and the redetermination.

C.5.10.1.11 Notice of Redetermination

Standard 1	Redetermination notices are successful when they are processed and mailed within 60 calendar days of the date the Contractor receives the valid and timely filed request. If the appellant submits additional evidence after filing the request for redetermination, the Contractor's timeframe for making the decision is extended by 14 calendar days. **Note: The 60 calendar day decision-making time frame may be extended by 14 calendar days in accordance with 42 CFR 405.946.**

C.5.10.2 Appeal Decision Effectuation

The Contractor shall effectuate all levels of appeal decisions (redeterminations, reconsiderations, ALJ, Medicare Appeals Council, and federal court) received from the QIC or Administrative Qualified Independent Contractor (AdQIC).

Background	See Key Definitions for definition of the term "effectuate."
Standard 1	Effectuation of Contractor redetermination is successful when all decisions are

	effectuated by the Contractor: ▪ Within 30 calendar days of the date of the decision, if a specific amount to be paid is stated, or ▪ Within 30 calendar days after it computes the amount to be paid, which must be done no later than 30 calendar days of the receipt of the decision.

C.5.10.3 Monthly Statistical Report on Appeals Activity (CMS – 2592)

The Contractor shall prepare and submit to CMS a report summarizing monthly appeals activity in accordance with IOM Pub. 100-06, Chapter 6, Section 460.

C.5.11 Financial Management of Trust Fund Dollars

Background	The Chief Financial Officer (CFO) Act of 1990 (Public Law 101-576) requires the Centers for Medicare & Medicaid Services (CMS) to prepare annual, audited financial statements reporting its financial position and results of operations. The Contractor financial reports provide a method of reporting financial activities for benefit payment by Medicare Contractor according to the CFO Act of 1990. The Contractor is required to maintain accounting records according to government accounting principles and applicable government laws and regulations. This requirement complies with Office of Management and Budget (OMB) bulletins about the Federal Accounting Standards Advisory Board (FASAB). The accounting principles and the auditing standards required are not substantially different from Generally Accepted Accounting Principles (GAAP) and Generally Accepted Auditing Standards (GAAS) as formulated by the accounting profession. However, government accounting principles, which are developed by FASAB, require maintaining records not only for preparing financial statements, but also to enforce applicable laws and regulations. Medicare accounts receivable is a significant balance on CMS' financial statements that will require the Contractor's special attention. Accounts receivable consists primarily of the financial data provided by Contractors. The majority of the Medicare accounts receivable balances reported by CMS in its financial statements comprises overpayments made to providers, physicians, beneficiaries, insurers, employers, and other entities. Other receivables arise from situations in which Medicare paid claims as the primary payer and it is subsequently determined that Medicare should have been the secondary payer. Medicare accounts payable consists of amounts due for services received. The accounts payable is due to unprocessed claims received that have not yet started processing and to claims that have completed processing checks, but the checks have not yet been issued or offsets applied. This includes, but is not

	limited to, underpayments resulting from cost report settlements, estimated Periodic Interim Payments (PIPs), PIP rate reviews, interim rate reviews, and adjustment bills. The Contractor is required to report financial activity into CMS via the CMS Contractor Administrative, Budget, and Financial Management (CAFM) system, the Healthcare Integrated General Ledger System (HIGLAS), or both. When these two systems have different financial reporting requirements, the SOW will separately identify the system unique requirements.

C.5.11.1 USE OF TRUST FUND

The Contractor shall ensure effective and efficient use of those trust fund dollars under its authority and adhere to its financial management responsibilities in accordance with IOM Pub. 100-06.

Standard 1	The Contractor's use of trust fund dollars is successful when it will not cause CMS to be cited for financial management related deficiencies on the CMS annual CFO audit.

C.5.11.1.1 Certification of Chief Financial Officer for Medicare Operations

The Contractor’s designated CFO shall be able to certify that all Medicare financial reporting by the Contractor is accurate and complete and that an effective internal control structure over Medicare financial management operations is in place and operating effectively by the Contractor.

The Contractor’s designated alternative CFO shall be able to perform the duties and responsibilities of the CFO in the absence of the CFO.

C.5.11.1.2 Validation of Financial Data

The Contractor shall check the validity, accuracy, completeness, and reconciliation of all financial data before submission to CMS.

The Contractor’s designated CFO shall certify all Medicare financial data stating that it conforms to IOM Pub. 100-06, GAAP, GAAS, and Federal Accounting Standards Advisory Board (FASAB).

C.5.11.1.3 Resolution of Financial Deficiencies

The Contractor shall ensure prompt resolution of financial deficiencies identified in audits or reviews that affect operations and administration under this contract.

The Contractor shall timely submit an initial Corrective Action Plan (CAP) report, which addresses all of the reported audit or review findings and is certified by the CFO for Medicare operations in accordance with IOM Pub. 100-06, Chapter 7, section 40–40.6.

Standard 1	Initial CAP reports are timely when they are provided within 45 days of receiving a final audit report.
Standard 2	The Contractor's corrective action procedures are successful when its deficiencies have been corrected within one year of being identified.

C.5.11.2 BANKING RELATIONS

The Contractor shall establish banking relations, including bank accounts, with a CMS-approved bank.

A Tripartite agreement shall be established among CMS, bank, and the Contractor in accordance with IOM Pub. 100-06, Chapter 5 section 10-60.

Background	The Contractor, CMS, and a bank establish a tripartite agreement covering two types of accounts: benefits account and time account. The earnings from the time account are used to compensate the bank for services rendered. CMS issues a letter of credit to fund the Contractor's estimated annual claims amounts, which flow through a benefits account. The letter of credit covers claims paid by the Contractor, either by check or electronic funds transfer (EFT), drawn from the benefits account. The letter of credit authorizes a Federal Reserve Bank or Branch to advance funds to a designated commercial bank on behalf of CMS. Under the Checks Paid Method of financing, a letter of credit is issued to authorize the designated commercial bank to withdraw funds for deposit only to the Contractor's benefits account when a bank issues a 1031 drawdown request. This method provides cash availability to meet Medicare program requirements, while controlling the timing of cash withdrawals to minimize the impact of the withdrawals on the public debt level and related financing costs.

C.5.11.2.1 Time Account Balance

The Contractor shall establish and maintain a time account balance in accordance with IOM Pub. 100-06, Chapter 5, sections 110 – 110.2.

Background	A time account balance is used to compensate the bank for its service fees. Part of maintaining a time account balance involves monitoring and adjusting quarterly the target balance to ensure that the target balance is sufficient to compensate the bank for services rendered.
Standard 1	The time account is maintained successfully when it is timely reconciled with the bank statement in accordance with IOM Pub. 100-06, Chapter 5, sections 70-90.7, 500-500.6 and 510-510.9.

C.5.11.2.2 Benefits Account

The Contractor shall establish and maintain a benefits account in accordance with IOM Pub. 100-06, Chapter 5, section 120 – 180.

Standard 1	The benefits account is maintained successfully when it is timely reconciled with the bank statement in accordance with IOM Pub 100-6, Chapter 5, sections 70-90.7, 500-500.6 and 510-510.9.

C.5.11.2.3 Account Reconciliation

The Contractor shall reconcile the Medicare program benefits account and time account activity as follows:

a. For non-HIGLAS transactions, the Contractor shall submit the monthly bank reconciliation (CMS Form 1521/1522) through the CAFM system in accordance with IOM Pub. 100-06, Chapter 5, sections 70 – 90.7. The reports accompanying the reconciliation between the Intermediary Benefit Payment Report (IBPR) and the CMS-1522 are input into the CAFM system 20 days following the report month.

b. For HIGLAS transactions, the Contractor shall submit a monthly bank reconciliation utilizing the HIGLAS Accounts Payable (AP), Cash Management (CM), and General Ledger (GL) modules in accordance with HIGLAS process flow documents related to Bank Reconciliation procedures.

Background	When a workload segment is reported using CAFM (non-HIGLAS transactions), Form CMS-1522 is designed to provide a reconciliation of Medicare benefit dollars between CMS, the contractor, and the bank. HIGLAS will use CM, AP, and GL reports to perform necessary bank reconciliation. When a segment is reported using CAFM (non-HIGLAS transactions), the IBPR is a report of current monthly information that covers the categories of benefits the contractor paid and selected statistical data relating to those payments. When a segment is reported using HIGLAS, the monthly bank reconciliation utilizes the HIGLAS Accounts Receivable (AR), AP, CM, and GL modules and the HIGLAS Contractor Draws on Letter of Credit report.

C.5.11.2.4 Letter-of-Credit Limitation

The Contractor shall make requests for changes, when necessary, to the monthly letter-of-credit limitation to CMS in accordance with IOM Pub. 100-06, Chapter 5, section 100–100.3.

C.5.11.3 Cost Reporting and Reimbursement Payment Policy

Background	Sections 1815 (a) and 1833 (e) of the Act provide that no payments will be made to a provider unless it has furnished the information requested by the Secretary as needed to determine the amount of payments due the provider under the Medicare program. On an annual basis, providers are required to submit this information through the Medicare Cost Report (MCR). Contractors

	determine payment amounts due the provider under the Medicare law and interpretative guidelines published by CMS. The instructions and policies the provider must adhere to in completing the MCR are found in the Provider Reimbursement Manuals (PRM) Parts I and II. The Contractor must ensure that providers follow the cost reporting principles and policies that are contained within this manual. These provisions are implemented by 42 CFR 413.20 and 413.24. All providers participating in the Medicare program, whether they are paid on a reasonable cost basis or a system of prospective payment are required under 42 CFR 413.20 (a) to maintain sufficient financial records and statistical data for proper determination of costs. In addition providers must use standardized definitions to follow accounting, statistical and reporting practices that are widely accepted in the health care industry and related fields. The proper reporting and submission of the MCR is critical because data from the MCR is used for payment reimbursement and various rate setting and payment refinement activities.

C.5.11.3.1 The Medicare Cost Report

The Contractor shall obtain and maintain CMS approved Automated Data Reporting (ADR) cost reporting software necessary to receive, process, and recreate institutional provider MCRs in accordance with the Provider Reimbursement Manual CMS Pub. 15-2, Chapter 1.

The Contractor shall install updates to the ADR software in a timely manner.

The Contractor shall attempt to resolve all compatibility issues arising from discrepancies between the ADR software and the provider MCR software communicating such discrepancies to CMS for final resolution.

The Contractor shall implement all CMS final resolutions.

The Contractor shall implement all corrective actions as directed by CMS to facilitate and expedite MCR submissions (this includes resolution of all level I edits to achieve an acceptable cost report).

The Contractor shall monitor all transmittals released by CMS to insure consistency between the Contractors' cost reporting software and the cost reporting instructions.

Background	The CMS uses an informal process to expeditiously communicate to Contractors, software vendors, and ROs revisions to the MCR. This informal process entails issuance of a Flash Report. The Flash Report is an interim step prior to the formal release of the CMS official instructions.

C.5.11.3.1.1 CMS Cost Report and Reimbursement Inquiries

The Contractor shall research cost report inquiries forwarded from CMS.

The Contractor shall collect and review all relevant information to facilitate discussion of issue (s) with CMS.

The Contractor shall assist in developing a reply to inquiries, and propose resolutions.

C.5.11.3.2 Audit of Institutional Provider Cost Reports

The Contractor shall perform cost report acceptance, desk review, audit, settlement, reopening, and cost report appeals activities for institutional providers and related home offices in accordance with IOM Pub. 100-06, Chapters 8 and 9, including any backlog inherited from the outgoing Contractor.

C.5.11.3.2.1 Cost Report Reminder Letter

The Contractor shall issue cost report reminder letters in accordance with IOM Pub. 100-06, Chapter 8, section 10.

C.5.11.3.2.2 Cost Report Acceptance

The Contractor shall verify that the submitted cost report is acceptable in accordance with IOM Pub. 100-06, Chapter 8, section 10.3 and cost report filing instructions in accordance with CMS Pub. 15-2 Section 140.

Standard 1	Cost report acceptance is timely if it is completed within 30 days from the receipt date of the provider's cost report.
Standard 2	Cost report acceptance is accurate when a CMS review indicates that they are performed in accordance with IOM Pub. 100-06, Chapter 8, section 10.3.

C.5.11.3.2.3 Late Cost Reports

The Contractor shall issue a letter and suspend payments in accordance with IOM Pub. 100-06, Chapter 8, section 10.2, if a provider's cost report is not filed timely.

C.5.11.3.2.4 Rejected Cost Reports

The Contractor shall issue a letter and suspend payments in accordance with IOM Pub. 100-06, Chapter 8, section 10.2, if a provider's cost report is rejected after the due date.

C.5.11.3.2.5 Tentative Settlements

The Contractor shall calculate and issue tentative settlements and update cost to charge ratios in accordance with IOM Pub. 100-06, Chapter 8, section 10.5.

Background	A tentative settlement is an initial retroactive settlement made by the Contractor within 60 days of the acceptance of the cost report. The Contractor will estimate the amount the provider is owed or owes Medicare at tentative settlement and make payment to or take back money from the provider where

	necessary.
Standard 1	Tentative settlements are timely when they are completed within 60 days of the acceptance of the provider's cost report.
Standard 2	Tentative settlements are accurate when a CMS review indicates that they are performed in accordance with IOM Pub. 100-06, Chapter 8, section 10.5
Standard 3	Cost to Charge Ratios are calculated accurately when a CMS review indicates that they are in compliance with IOM Pub. 100-04, Chapter 3, section 20.1.2 and IOM Pub. 100-06, Chapter 8, section 10.5.

C.5.11.3.2.6 DESK REVIEWS OF PROVIDERS' COST REPORTS

The Contractor shall perform desk reviews of institutional providers filing Medicare cost reports (except Hospice and low/no Medicare utilization cost reports) to determine the adequacy, completeness, and reasonableness of the data in the reports utilizing the most current Uniform Desk Review (UDR) program.

Background	The objective of the desk review is to determine whether the provider's cost report can be settled without audit or whether an audit is necessary (see IOM Pub. 100-06, Chapter 8, section 20 for specific guidelines in performing desk reviews).

C.5.11.3.2.7 WAGE INDEX

The Contractor shall perform wage index reviews annually on all cost reports for short-term acute Inpatient Prospective Payment System (IPPS) hospitals and hospitals that would otherwise be subject to IPPS if they did not have a waiver in accordance with the latest wage index review program released by CMS before the due date of the yearly wage index reviews (see IOM Pub. 100-06, Chapter 8, section 20.4 and IOM Pub. 100-04, Chapter 4, section 10.8.1).

Background	Section 1886 (d)(3)(E) of the Social Security Act, "Adjusting for Different Area Wage Levels," requires the Secretary to adjust the proportion of hospital costs attributable to wages and wage-related costs for area differences in hospital wage levels. This adjustment factor, the wage index, reflects the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

C.5.11.3.2.8 COST REPORT AUDITS

The Contractor shall conduct Medicare cost report audits using Medicare audit programs and the Medicare reimbursement principles in accordance with the guidelines outlined in IOM Pub. 100-06, Chapters 8 and 9, the Provider Reimbursement Manual CMS Pub. 15-1, and applicable regulations.

Background	Medicare cost report audits are conducted to provide reasonable assurance that program payments are based on Medicare reimbursement principles.

C.5.11.3.2.9 AUDIT PLAN

The Contractor shall develop an audit plan to identify cost reports to be audited and resources to be expended based on results of the desk review and/or the Contractor's knowledge of the provider in accordance with IOM Pub. 100-06, Chapter 8, sections 40 and 50.

C.5.11.3.2.10 FINAL SETTLEMENT

The Contractor shall perform outlier reconciliation, when needed, prior to final settlement of the cost report, in accordance with IOM Pub. 100-04, Chapter 3, section 20.1.2.5.

The Contractor shall final settle cost reports by issuing the NPR for cost reports that do not require an audit within 12 months of the acceptance of a cost report in accordance with IOM Pub. 100-06, Chapter 8, section 90.

The Contractor shall issue the NPR and issue a final adjustment report for cost reports that are audited in accordance with CMS IOM Pub. 100-06, Chapter 8, section 90.

Background	Upon completion of all audit activities related to a provider's cost report, the Contractor will issue an NPR, which is the final settlement of the cost report. The NPR signifies the settlement of the cost report and summarizes the reimbursable costs and determines the amount due to or due from the provider. The final settlement process is described in IOM Pub. 100-06, Chapter 8, section 90.
Standard 1	Cost reports that do not require an audit are settled timely when the NPR is issued within 12 months of the acceptance of a cost report
Standard 2	Cost reports are settled accurately when CMS review determines compliance with Medicare payment policy as defined in the Medicare Provider Reimbursement Manuals.
Standard 3	Cost reports that are audited shall have an NPR and final adjustment report issued within 60 days of the exit conference or 60 days after the adjustments are finalized if the exit conference is waived.
Standard 4	Outlier reconciliations are considered accurate when a CMS review indicates that they are in compliance with IOM Pub. 100-04, Chapter 3, section 20.1.2.5.

C.5.11.3.2.11 COST REPORT REOPENINGS

The Contractor shall reopen cost reports when appropriate in accordance with IOM Pub. 100-06, Chapter 8, section 100.

Background	In accordance with 42 CFR 405.1885 and the Provider Reimbursement Manual CMS Pub. 15-1, Part I, sections 2931–2932, a cost report may be reopened if a written request is received from a provider within three (3) years of the date that

	the NPR was issued. A Contractor may also reopen on its own or at the request of CMS within the same three (3)-year reopening period.
Standard 1	Revised NPRs are timely when they are issued within 180 days of receipt of all information and documentation necessary to resolve the reopening issue.
Standard 2	Revised NPRs are accurate when a CMS review determines compliance with IOM Pub. 100-06, Chapter 8, section 100.

C.5.11.3.2.12 Reopening Notices or Denials

The Contractor shall issue reopening notices or a letter denying the reopening in accordance with the procedures in IOM Pub. 100-06, Chapter 8, section 100.

C.5.11.3.2.13 Provider Change in Contractors

The Contractor shall be responsible for timely auditing and settling of cost reports when a provider leaves the program, transfers ownership, or transfers to a different MAC in accordance with IOM Pub. 100-06, Chapter 8, section 110.

C.5.11.3.2.14 Audits of Home Office Cost Statements

The Contractor shall perform audits of home office cost statements in accordance with IOM Pub. 100-06, Chapter 8, section 120.

Background	When a provider is related to a chain organization (within the meaning of 42 CFR 413.17) and services are furnished to the provider by the home office or other organizational entity of the chain, the reasonable costs of the services furnished are includable in the provider's costs. The reasonable costs of home office services are determined under guidelines in the Provider Reimbursement Manual CMS Pub. 15-1, Part I, section 2150, and other sections relating to specific costs, and are subject to audit by the Contractor.

C.5.11.3.2.15 Provider Permanent Files

The Contractor shall maintain a permanent reference file on each provider in accordance with IOM Pub. 100-06, Chapter 8, section 130 that includes items for use during interim rate reviews, desk reviews, and cost report audits and settlements.

C.5.11.3.2.16 Cost Report Hearings

The Contractor shall complete provider cost report hearing activities for amounts in controversy of at least $1,000 but less than $10,000, including designating a hearing officer and conducting the hearing, in accordance with procedures outlined in the Provider Reimbursement Manual CMS Pub. 15-1, Part I, sections 2913, 2914, 2915, and 2916.

Background	Per 42 CFR 405.1807, the Contractor's cost report determination is final and binding unless one of the following occur:

	▪ A Contractor hearing is requested in accordance with 42 CFR 405.1811 and a hearing decision is rendered in accordance with 42 CFR 405.1831, or ▪ The Contractor determination is revised (reopened) in accordance with 42 CFR 405.1885, or ▪ A Provider Reimbursement Review Board (PRRB) hearing is requested in accordance with 42 CFR 405.1835 and a hearing decision is rendered.

C.5.11.3.2.17 Cost Report Appeals: Provider Reimbursement Review Board

The Contractor shall complete all activities related to provider cost report appeals for amounts in controversy of $10,000 or more in accordance with PRRB instructions, and, when necessary, coordinate these activities with the CMS Appeals Support Contractor (The Appeals Support Contractor will continue with the Blue Cross and Blue Shield Association under the Title XVIII contract). This may include Administrative Resolutions of appeals prior to the hearing.

If the Contactor disagrees with the PRRB decision, the Contractor shall provide comments to the CMS Attorney Advisor for potential CMS Administrator review under 42 CFR 405.1875.

Background	A provider has the right to appeal a final determination made by the Contractor. If the amount in controversy is $10,000 or more, the provider appeals to the PRRB. When the PRRB acknowledges a case, it distributes a list of required documents along with due dates for both the provider and Contractor. It is the Contractor's responsibility to adhere to the dates set forth by the PRRB. The Contractor is responsible for all appeal activities, as explained in the regulations at 42 CFR 405.1835–1873 and the PRRB instructions, found at http://new.cms.hhs.gov/PRRBReview/02_PRRB_Instructions.asp. Cases are resolved by mediation or administrative resolution, when appropriate, consistent with Medicare reimbursement principles. Some of the more significant activities related to provider cost report appeals for amounts in controversy of $10,000 or more include maintaining a hearing file, preparing jurisdictional briefs, preparing position papers, conducting pre-hearing activities, discussing the issues with the provider, and if the case proceeds to a PRRB hearing, defending its position, including arranging for and preparing witnesses and submitting post-hearing briefs.

C.5.11.3.2.18 Cost Report Appeals: Court Hearing / Settlements

The Contractor shall assist CMS, the Office of the General Counsel (OGC), the Department of Justice or other governmental counsel/staff in defending or supporting the agency's position by providing documentation, consultation in Medicare cost reporting and reimbursement policy, ad hoc analysis and support staff.

C.5.11.3.2.19 COST REPORT APPEALS: FINAL DECISIONS

The Contractor shall implement decisions rendered by the PRRB, the Administrator of CMS, or by a court (including completing any necessary cost report reopenings) when the decision is determined to be final in accordance with IOM Pub. 100-06, Chapter 8, section 100 and case-specific instructions.

C.5.11.3.2.20 REQUESTS FOR COST REPORT, AUDIT AND REIMBURSEMENT INFORMATION

The Contractor shall assist CMS or other government staff in replying to requests pertaining to cost report audit and reimbursement issues. This may include researching or performing analytical analysis of the issue.

C.5.11.3.3 Institutional Provider Reimbursement

The Contractor shall compute/review PIP and other interim rates for institutional providers in accordance with 42 CFR 412.105, 412.106, 412.113, 412.115, 412.116, and 413.64.

The Contractor shall monitor PIP providers to determine eligibility and terminate PIP to providers when necessary.

Background	Section 1815(a) of the Social Security Act (the Act) requires each provider participating in the Medicare program to submit information, as requested by the Secretary, in order to determine the amount of payment due to the provider for services furnished under the Medicare program. Implementing regulations at 42 CFR 413.24(f) requires participating providers to submit cost reports that generally cover a consecutive twelve (12)-month period of the provider's operations. A provider may select any annual period for Medicare cost reporting purposes. Once a provider informs CMS of its selection, the provider is required to report annually for periods ending the same date unless that provider's Contractor approves a change. The Contractor may make interim payments to the provider during the provider's cost reporting year. Based on the annual cost report, a retroactive adjustment is made after the end of the provider's cost reporting year to bring the interim payments made during the period into agreement with the reimbursable amount payable to the provider.

C.5.11.3.3.1 PROVIDER-SPECIFIC FILE CORRECTNESS

The Contractor shall ensure that all provider-specific data is correctly entered in the PSF in accordance with instructions in IOM Pub. 100-04, Chapter 3, section 20.2.3.1. The file layout is contained in Addendum A of IOM Pub. 100-04, Chapter 3.

Standard 1	Data in the PSF is considered accurate when a CMS review indicates that it is in compliance with IOM Pub. 100-04, Chapter 3, section 20.2.3.1 and the file layout in Addendum A of IOM Pub. 100-04, Chapter 3.

C.5.11.3.3.2 PROVIDER STATISTICAL AND REIMBURSEMENT REPORT

The Contractor shall operate the Provider Statistical and Reimbursement Reporting (PS&R) system in accordance with the PS&R users guide, implement any changes to the system within the required time frames, and issue PS&R reports in accordance with IOM Pub. 100-06, Chapter 9 and Chapter 8, section 10.1.

Background	The PS&R accumulates statistical and reimbursement data related to Medicare claims processed. It is used by the Contractor and institutional providers to accumulate key elements of the Medicare cost report.

C.5.11.3.3.3 SYSTEM FOR TRACKING AUDIT AND REIMBURSEMENT SYSTEM

The Contractor shall enter all required data in the System for Tracking Audit and Reimbursement (STAR) system accurately and timely in accordance with the STAR manual.

Background	The STAR system is a CMS-owned and maintained system used by Contractors to track the receipt and other subsequent actions taken on all providers' costs reports. Each Contractor is responsible for maintaining its individual STAR database. In addition, STAR enables CMS to monitor audit savings.
Standard 1	STAR database is maintained accurately and timely when a CMS review indicates that it is in compliance with the STAR manual.

C.5.11.3.3.4 HOSPICE CAP

The Contractor shall compute Hospice reimbursement caps and ensure payments made in excess of the caps are refunded by the Hospice, in accordance with 42 CFR 418.308, 42 CFR 418.309 and CMS Pub. 21 Section 407 and IOM Pub. 100-04, Chapter 11, section 80.

Background	Overall aggregate payments made to a Hospice are subject to a "cap amount", calculated by the Contractor at the end of the Hospice cap period. The Contractor is responsible for the calculation of the initial cap amount and any subsequent adjustment to the cap.

C.5.11.3.3.5 TARGET LIMITS: TAX EQUITY AND FISCAL RESPONSIBILITY ACT

The Contractor shall compute Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) target limits accurately and timely in accordance with the Provider Reimbursement Manual CMS Pub. 15-1, Part I, sections 3000-3004.

Background	Providers excluded from inpatient Prospective Payment System (PPS), and not covered by a special PPS, are subject to the payment limitations and incentives established in TEFRA. Each provider is paid on a reasonable cost basis subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge, as established from a base period increased by applicable update factors.

C.5.11.3.3.6 Exception Requests: End-Stage Renal Disease

The Contractor shall process exception requests for end-stage renal disease (ESRD) facilities in accordance with 42 CFR 413.180 and IOM Pub. 100-04, Chapter 8, section 40.

C.5.11.3.3.7 Exception Requests: Tax Equity and Fiscal Responsibility Act

The Contractor shall process exception requests for TEFRA limits in accordance with program instructions within 75 days of receipt or return them to the provider within 60 days if the application was incomplete in accordance with the Provider Reimbursement Manual CMS Pub. 15-1, Part I, section 3004.

Background	A hospital may request an adjustment to the payment allowed under the rate of increase ceiling (TEFRA target) if its costs exceed the ceiling and there are differences in inpatient costs incurred during the cost reporting period in question that make comparison to the base period inappropriate. Distortions in inpatient operating costs resulting in non-comparability of the cost reporting periods are generally the result of extraordinary circumstances or one or both of the following two factors: ▪ Increases in the average length of stay of Medicare patients. ▪ Changes in the volume or intensity of direct patient care services.
Standard 1	Target Limits are timely when applications are processed to completion within 75 days after receipt by the Contractor or returned to the hospital as incomplete within 60 days of receipt.
Standard 2	Target Limits are accurate when they comply with TEFRA payment policy.

C.5.11.3.3.8 Health Care Provider Cost Report Information System

The Contractor shall transmit an extract of the provider's Medicare cost report to the Health Care Provider Cost Report Information System (HCRIS) within 210 days of the cost report period end date or 60 days after the receipt of the provider's Medicare cost report, whichever is later, in accordance with IOM Pub. 100-06, Chapter 8, section 10.4 and HCRIS specifications.

The Contractor shall transmit an extract of the provider's Medicare cost report to HCRIS within 30 days of the issuance of any Notice of Program Reimbursement (NPR) or revised NPR (RNPR) in accordance with IOM Pub. 100-06, Chapter 8, section 90.1 and HCRIS specifications.

Background	HCRIS is a cost report database developed and maintained by CMS. Contractors are required to transmit cost report data to the database. The database is available to all authorized CMS users, the public, and researchers and the cost report data files are available on the CMS website.

C.5.11.3.3.9 PROVIDER-BASED DETERMINATIONS

The Contractor shall process Provider-based determinations in accordance with 42 CFR 413.65, the Provider Reimbursement Manual CMS Pub. 15-1, Section 2446, and Program Memorandum A-03-030 (April 18, 2003).

Background	CMS, with the assistance of the Contractor, will make determinations regarding provider-based and freestanding designation. These designation decisions pertain to any provider of services under the Medicare program, and also includes physicians' practices or clinics or other entities that are not themselves providers, but who state they are part of a provider. These decisions are needed to ensure that providers are paid appropriately, since Medicare payment for services provided in a provider-based (i.e., hospital) setting is often higher than Medicare payment for a similar service in a freestanding (non-hospital) setting.

C.5.11.3.3.10 SPECIAL PAYMENT STATUS

The Contractor shall review provider requests for special payment status, and if the provider's documentation is complete, forward recommendations for special payment status to CMS in accordance with IOM Pub. 100-04, Chapter 3. If additional documentation is required, the Contractor shall return requests that identify missing information to providers.

Background	A provider—such as an Sole Community Hospital (SCH), Medicare Dependent Hospital (MDH), Rural Referral Center (RRC), and Critical Access Hospital (CAH)—may request to be paid using a specialized methodology. It is the Contractor's responsibility to review the provider's request to determine if the provider is entitled to receive payments using the requested method.

C.5.11.3.3.11 INTERNS AND RESIDENTS INFORMATION SYSTEM

The Contractor shall implement and notify providers that train residents in approved graduate medical education (GME) programs of all Interns and Residents Information System (IRIS) updates in accordance with CMS instructions provided in periodic change requests (CRs).

Background	IRIS is a database developed and maintained by CMS. It contains information pertaining to a provider's interns and residents. It is used to detect duplicate interns and resident counts in instances where the interns and residents train at more than one provider during the cost reporting year; and is used for direct graduate medical education (GME) and indirect medical education (IME) payments. The information is submitted with the provider's cost report and the Contractor submits the data to CMS.

C.5.11.3.3.12 INSTITUTIONAL PROVIDER REIMBURSEMENT - REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

The Contractor shall compute/review interim rates for Federally Qualified Health Centers and Rural Health Clinics at least twice per year using the prior-year's cost reports, the applicable prior-year's adjustments, other reliable information, and empirical knowledge of the provider with adjustments made as necessary in accordance with the Provider Reimbursement Manual CMS Pub. 15-1, Chapter 29, 42 CFR 405 Subchapter X, and Medicare Benefits Policy Manual, IOM Pub. 100-02, Chapter 13.

C.5.11.3.3.13 MEDICARE SUPPLEMENTAL PAYMENTS FOR FQHCS UNDER CONTRACT WITH MEDICARE ADVANTAGE PLANS

The Contractor shall ensure that providers properly receive supplemental (wrap-around) payments in accordance with IOM Pub. 100-04, Chapter 9, section 110.3.

C.5.11.4 NON-MEDICARE SECONDARY PAYER OVERPAYMENT

The Contractor shall determine the amount of overpayments made to institutional providers, professional providers, and beneficiaries and demand repayment and timely issue a notification letter to the provider, in accordance with 45 CFR Part 30 and IOM Pub. 100-06, Chapter 3.

Background	The majority of the Medicare accounts receivable balances reported by CMS in its financial statements are overpayments made to providers, physicians, beneficiaries, insurers, employers, and other entities. The primary responsibility for identifying, recording, recovering, and reporting overpayments lies with CMS' Medicare Contractors. The CMS defines an "overpayment" as Medicare funds that a provider, physician, beneficiary, or other entity has received in excess of amounts due and payable under the Medicare statute and regulations. Once an overpayment is discovered, the Medicare Contractors are required to notify the provider of the existence and amount of the overpayment and to request repayment. When a potential overpayment has been identified, the Contractor must take actions under this section to determine whether an overpayment has been made and establish the amount of debt owed to the U.S. Government. Once an overpayment has been determined, the Contractor is responsible for recovery of any cumulative debt in accordance with IOM Pub. 100-06, Chapters 3 and 4.
Standard 1	Overpayment notification letters are timely when they are sent to the provider within seven (7) calendar days of overpayment determination.

C.5.11.4.1 Identification of Overpayment Cause

The Contractor shall identify the nature and cause of the overpayment in accordance with IOM Pub. 100-06, Chapter 3.

C.5.11.4.2 Applications for Extended Repayment Plan

The Contractor shall process requests for an Extended Repayment Plan (ERP) for provider overpayments in accordance with IIOM Pub. 100-06, Chapter 4. The Contractor shall process requests for an ERP for beneficiary overpayments in accordance with IOM Pub. 100-06, Chapter 3.

Background	Providers may request an ERP for overpayments that will take more than 30 days to repay. Any provider that requests an ERP may be required to complete a package of required financial data. The Contractor will review the submission and may approve up to a 12-month repayment schedule. Any request for more than a year must be forwarded to CMS, with a recommendation for a specific period greater than 12 months.

C.5.11.5 Non-Medicare Secondary Payer Debt Collection

The Contractor shall collect all debts in accordance with the Federal Claims Collection Act and IOM Pub. 100-06, Chapters 3 and 4.

Background	The Medicare Contractors have primary responsibility for collection of all debts and are expected to pursue recovery to the fullest extent possible, regardless of the identity of the debtor. The Debt Collection Improvement Act of 1996 (DCIA) requires federal agencies to refer eligible delinquent debt to a Treasury-designated Debt Collection Center (DCC) for cross-servicing and offset through the Treasury Offset Program (TOP). Demand letters for overpayments resulting from payments for services provided to beneficiaries enrolled in Medicare Advantage (MA) must include the MA organization number (normally, H#####) for the MA so the provider can recover from the plan.

C.5.11.6 Non-Medicare Secondary Payer Debt Referral

The Contractor shall develop, maintain, and implement debt referral procedures in accordance with IOM Pub. 100-06, Chapter 4.

Background	This section covers non-Medicare Secondary Payer (MSP) debt referral. For all MSP requirements, including debt referral, see C.5.14.
Standard 1	The Contractor's debt referral procedures are successful when its eligible delinquent debt has been referred by the 180th day of delinquency

C.5.11.6.1 Non-Medicare Secondary Payer Debt Collection Improvement Act Intent to Refer Letter

The Contractor shall send DCIA Intent-to-Refer Letters (IRLs) in accordance with IOM Pub. 100-06, Chapter 4.

C.5.11.6.2 Non-Medicare Secondary Payer Debt Referral Inquiries

The Contractor shall handle non-MSP debt referral inquiries and actions resulting from the DCIA IRLs in accordance with IOM Pub. 100-06, Chapter 4.

C.5.11.6.3 Debt Collection System Database

The Contractor shall enter all debt eligible for referral into the Debt Collection System (DCS) database and continually verify that debts transmitted remain valid and amounts are accurate in accordance with IOM Pub. 100-06, Chapter 4, section 70, Exhibit 4/DCS User Guide.

C.5.11.6.4 Posting of Debts Collected by Treasury

The Contractor shall post collections received as a result of DCIA collection activity in accordance with IOM Pub. 100-06, Chapter 4.

C.5.11.7 Refund Request

The Contractor shall process and return refund request forms in accordance IOM Pub. 100-06, Chapter 4.

Background	When CMS identifies an excess collection for debt that was referred for cross-servicing, the Contractor will receive a refund request form. An excess collection is the result of receiving a collection and recoupment for the same debt.

C.5.11.7.1 Unsolicited/Voluntary Refunds

The Contractor system shall respond to and perform all necessary transactions related to unsolicited/voluntary refunds not related to an existing debt (both MSP and non-MSP) in accordance with IOM Pub. 100-06, Chapter 5 sections 410 and 411.

Background	The Contractors receive unsolicited/voluntary refunds from providers, physicians, suppliers, and third-party payers. An unsolicited/voluntary refund is money received with no established debt. When the monies are received, the Contractor must identify, process, track, and report the unsolicited/voluntary refund.

C.5.11.8 Overpayment Related to Bankruptcy

The Contractor shall immediately notify CMS regional counsel of any contact or information provided to the Contractor related to a provider bankruptcy or the potential bankruptcy (within 24 hours after any contact or information is received) in accordance with IOM Pub. 100-06, Chapter 3, section 140 (see also Attachment J-10).

Background	The Medicare Contractors must take certain actions to safeguard the Medicare trust funds when a provider files for bankruptcy. Bankruptcy is litigation. Bankruptcy law and the bankruptcy court may affect any actions CMS and its Contractors take concerning a bankrupt Medicare provider. The Contractor should not send any correspondence to a bankrupt provider until the OGC or Contracting Officer reviews and approves it. An individual or company declares bankruptcy by filing a petition for bankruptcy in a United States Bankruptcy Court. The Bankruptcy Court then opens a bankruptcy case. The Bankruptcy Court closely monitors the affairs of the individual or company (the debtor) including the creditors' treatment of the debtor. Title 11 of the United States Code (the Bankruptcy Code) identifies four types of bankruptcies that may involve Medicare providers: Chapters 7, 9, 11, and 13. The petition date (i.e., the date the debtor files its petition in bankruptcy with the Bankruptcy Court) draws a line between pre-petition and post petition actions. Events that occur on or before the petition date are pre-petition. Recoupment and offset are two of Medicare's strongest tools for recovering overpayments to debtor providers. The Contractor should not take, omit, continue, or discontinue any recovery action without approval from the RO and Regional Counsel. Jurisdictions vary in their decisions about how Medicare can use these tools. Once it is discovered that a provider is in bankruptcy, Medicare may enact a temporary administrative freeze of post-petition payments for pre-petition services. An administrative freeze will allow time for Medicare to determine if there are any overpayments and to ask the bankruptcy court to allow set-off. An RO counsel has jurisdiction over a bankruptcy case when it has jurisdiction over the State in which the debtor files for bankruptcy (bankruptcy is filed in federal court). Each Contractor staff member who may come in contact with a debtor is effectively a part of the Medicare "bankruptcy team" for that case, and must, through the Contractor point of contact for the bankruptcy, keep the Contracting Officer and regional counsel advised of all planned or completed actions concerning the bankrupt provider. Bankruptcy law permits a debtor to affirm ("assume") or reject each of its executory contracts, including the Health Insurance Benefit Agreement (commonly referred to as the Medicare provider agreement). The Contractor shall have certain responsibilities regarding the bankrupt provider's assumption or rejection of the agreement (see regulations found at 42 CFR 489.55, Exceptions to effective date of termination. Payment is available for up to 30 days after the effective date of termination for ▪ Inpatient hospital services, including inpatient psychiatric hospital services, and post hospital extended care services furnished to a beneficiary who was admitted before the effective date of termination; and ▪ Home health services and hospice care furnished under a plan established before the effective date of termination). For example, the Contractor shall not reimburse the provider for services it performs after the date it rejects/terminates the agreement. The Contractor shall

	calculate net overpayments or underpayments due to the bankrupt provider.

C.5.11.8.1 Administrative Freeze Payments

The Contractor shall produce accurate and detailed underpayment and overpayment data to the Contracting Officer and regional counsel as soon as it learns of a provider bankruptcy and update that information whenever there is a change in accordance with IOM Pub. 100-06, Chapter 3, section 140.6.5.

As directed by CMS, the Contractor shall effectuate administrative freezes for all categories of affected claims.

C.5.11.8.2 Closed Bankruptcy Case

The Contractor shall modify its financial records after the bankruptcy closes with guidance from the Contracting Officer/regional counsel in accordance with IOM Pub. 100-06, Chapter 3, section 140.8.

Background	After a bankruptcy case is fully administered and the bankruptcy court has discharged the trustee (if there was one), the bankruptcy court closes the case.

C.5.11.9 Financial Reporting and Accounting

The Contractor shall report financial activity into CMS via the CMS Contractor Administrative, Budget, and Financial Management (CAFM) system, Healthcare Integrated General Ledger Accounting System (HIGLAS), or both.

For HIGLAS and non-HIGLAS workloads, the Contractor shall maintain transaction-level documentation that supports all trust fund activity under the control of the Contractor.

Background	Financial reporting for the existing Medicare contractor workloads is performed using HIGLAS or CAFM. Eventually, HIGLAS will be used by all Medicare contractors. HIGLAS is a new dual-entry accounting system that replaces and modernizes Medicare Contractor accounting systems with a single standardized system. In addition to processing Medicare claims, HIGLAS will replace the legacy Financial Accounting and Control System (FACS), which accumulates CMS' financial activities, both programmatic and administrative, in its general ledger. HIGLAS is a component of the Department of Health and Human Services (DHHS) Unified Financial Management System (UFMS). ▪ HIGLAS will not change the basic role of Medicare contractors. Contractors will continue to be responsible for the Medicare claims processing activities they currently perform. ▪ Accounting functions that are now executed in Medicare contractor selected shared claims processing systems will be incorporated into HIGLAS. For example, once a Medicare claim has been approved for payment, HIGLAS,

	not the selected shared system, will perform the payment calculations, formatting, and accounting. ▪ The General Ledger feature in HIGLAS will give CMS enhanced oversight of contractor accounting systems and provide high quality, timely data for decision-making and performance measurement. ▪ Eventually, all Contractors will use HIGLAS to perform these functions on a daily basis. ▪ HIGLAS will communicate with Medicare Contractors' shared systems to process claim billing information, provider profile information, beneficiary profile information, check reconciliation, payment information, and other claim related data. These Medicare Contractor shared systems are the Federal Intermediary Standard System (FISS) and the Multi-Carrier System (MCS).
Standard 1	For non-HIGLAS workloads, the Contractor shall produce all financial reports necessary to document the trust fund activity in accordance with IOM Pub. 100-06, Chapter 4, sections 70.14 and 70.15, and Chapter 5, section 200–510.9.
Standard 2	For HIGLAS workloads, the Contractor shall produce all financial reports necessary to document the trust fund activity in accordance with IOM Pub. 100-06, Chapter 4, sections 70.14 and 70.15, and Chapter 5, section 200–510.9 along with the additional instructions identified in Attachment J-30.

C.5.11.9.1 Accounts Receivable Trend Analyses

The Contractor shall perform and report accounts receivable trend analyses in accordance with IOM Pub. 100-06, Chapter 5, section 400.22.

Background	The primary emphasis for performing trend analysis is on changes in the Contractor's financial data. To ensure that the financial data reported are accurate, the Contractor is required to perform trending procedures. Trending procedures can be used as an important tool to identify potential errors, system weaknesses, or inappropriate patterns of financial data. Trending procedures involve comparisons of recorded amounts to expectations developed by the Contractor. For HIGLAS workloads, HIGLAS will generate automated supporting reports on accounts receivable trend analysis.

C.5.11.9.2 Financial Reporting Audits/Reviews

The Contractor shall participate in financial audits/reviews such as Agreed Upon Procedures (AUP), CFO, CAPs, 1522 Reviews and Certification Package for Internal Controls (CPIC).

The Contractor shall develop available financial reports and their supporting documentation to CMS, Government Accountability Office (GAO), Office of the Inspector General (OIG), and other parties designated by CMS.

The Contractor shall make CAPs resulting from audit findings available to attest to the implementation of procedures to correct deficiencies identified during the current-year and prior-period audits/reviews in accordance with IOM Pub. 100-06, Chapter 7, sections 40-40.6.

Standard 1	The Contractor's corrective action procedures are successful when its deficiencies have been corrected within one year of being identified.

C.5.12 Medical Review

The Contractor shall decrease the paid claims error rate and address Medical Review (MR) -related coverage, coding, and billing errors in accordance with IOM Pub. 100-08.

Background	The MR program is designed to promote a structured approach in the interpretation and implementation of Medicare policy, most often requiring the evaluation of medical records to determine the medical necessity of Medicare claims. The goal of the Contractor's MR program is to reduce the claims payment error rate by identifying, through analysis of data and evaluation of other information, program vulnerabilities concerning coverage and coding made by individual providers and by taking the necessary action to prevent or address the identified vulnerabilities.
Standard 1	Claims processing is successful when claims are paid with acceptable accuracy as evidenced by a contractor-specific Comprehensive Error Rate Testing (CERT) error rate not to exceed the Government Performance Results Act (GPRA) national paid claims error rate goal for the year (The goal for each year is published in the Report on Improper Medicare Fee-for-Service Payments. www.cms.hhs.gov/cert).

C.5.12.1 Development of Medical Review Strategy

The Contractor shall develop a problem-focused, outcome-based MR strategy and Quarterly Strategy Analysis (QSA) that defines what risks to the Medicare trust fund the Contractor's MR programs will address and the interventions that will be used during the fiscal year in accordance with IOM Pub. 100-08 (see especially Chapters 1 and 3).

Standard 1	The Contractor's MR strategy is successful when problems targeted in the strategy are addressed during the fiscal year using the progressive corrective action (PCA) process and the Contractor can demonstrate a change in billing behavior.

C.5.12.1.1 Medical Review Data: Data Analysis

The Contractor shall analyze data to identify patterns of provider or service billing aberrancies that may pose a risk to the Medicare trust fund.

The Contractor's medical review data analysis shall include a prioritized problem list in the MR strategy that is data driven in accordance with IOM Pub. 100-08 (see especially Chapter 1, 2, and 3).

Background	The Contractor uses CERT findings, internal data sources, review of claims, and information from other operational areas to identify patterns of erroneous billing submissions and areas of over utilization to target provider-specific review.

C.5.12.1.2 Medical Review Data: Edit Effectiveness

The Contractor shall implement policies and concentrate their efforts on automating edits for an efficient and effective means to safeguard the program.

The Contractor shall focus medical review edits that suspend claims to suspend only those claims with a high probability of being denied on medical review in accordance with IOM Pub. 100-08, Chapter 3.

C.5.12.1.3 Medical Review Data: Probe Reviews

The Contractor shall validate data analysis findings by conducting probe reviews and implementing the necessary PCAs in accordance with IOM Pub. 100-08, Chapter 3.

Background	The Contractor must determine whether the problem is widespread or provider specific. If the identified problem is widespread and evenly distributed among a wide universe of providers, contractors should validate the concern by a review of generally up to 100 "potential" problem claims from a representative sample of providers. The review is performed on either a prepayment or postpayment basis. If the identified problem is specific to a limited number of providers, contractors should validate the concern by a review of generally 20-40 "potential" problem claims from each of the identified providers. Again, the review is performed on either a prepayment or postpayment basis. Once a problem has been verified, the Contractor implements the necessary PCA. This includes providing the initial notification informing the provider of the results of the probe review, and collaborating with Provider Outreach and Education (POE) to share potential educational needs, and making referrals to POE and Program Safeguard Contractors Benefit Integrity (BI) units, as appropriate.

C.5.12.1.4 Provider Tracking

The Contractor shall track all contacts made by their MR unit with providers during the course of medical review.

The Contractor shall take progressive corrective actions based on the follow-up data analysis to improve provider error rates in accordance with IOM Pub. 100-08, Chapters 1, 2 and 3.

Background	Part of the Contractor's tracking activity consists of tracking notifications and referrals made to POE. The Contractor is responsible for tracking probe notification letters to providers and referrals made to POE. The Contractor should follow the instructions in IOM Pub. 100-08 for collaborating with POE for tracking potential educational interventions.

C.5.12.1.5 Medical Review of Claims

The Contractor shall conduct medical review of claims submitted by providers or services in accordance with IOM Pub. 100-08 and the Contractor's MR strategy.

C.5.13 Coordination with Program Safeguard Contractors

Background	In all its functions, the Contractor is responsible for deterring and detecting fraud and abuse. The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996. Section 202 of Public Law 104-191 added Section, 1893, to the Social Security Act establishing the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen CMS' ability to deter fraud and abuse in the Medicare program. It provides a separate and stable long-term funding mechanism for MIP activities. As part of this program, CMS created Program Safeguard Contractors (PSCs). PSCs can perform any or all of the following MIP activities: Benefit Integrity (BI), Medical Review (MR), Cost Report Audit, and Data Analysis. Additionally, PSCs perform specialty functions such as the Comprehensive Error Rate Testing (CERT). The Contractor is responsible for referring all suspected fraud and abuse to the PSC regardless of the source, such as provider inquiries, medical review, and complex inquiries referred from the Beneficiary Contact Center (BCC). The roles and responsibilities of the Contractor as they relate to supporting the PSCs and BI functions are clearly delineated in IOM Pub. 100-08, Program Integrity Manual (PIM).

C.5.13.1 Support of Benefit Integrity

The Contractor shall handle and refer complaints of potential fraud and abuse in accordance with IOM Pub. 100-08.

Background	Any PIM language mentioning "affiliated Contractor" or "AC" must be construed to read "MAC."

C.5.13.2 Support of Comprehensive Error Rate Testing

The Contractor shall support the CERT program in accordance with IOM Pub. 100-08, Chapter 12.

Background	CMS has developed the CERT program to produce national, Contractor-specific,

	and service-specific paid claim error rates. The program has independent reviewers who identify random samples of Medicare claims when they enter the claims processing system. The independent reviewers review the selected claims after they are paid or denied to ensure that the decision was appropriate. The outcome of the review is a provider compliance error rate and paid claims error rate. The CERT Contractors are responsible for operating the CERT operations center and for gathering information from the Contractor.

C.5.14 Medicare Secondary Payer

Background	The Medicare Secondary Payer (MSP) provisions of the Medicare program are intended to ensure that plans with primary insurer liability pay before Medicare makes payment Medicare may make (in some cases) conditional payment for services where payment cannot be expected to be made promptly by the responsible payer. The applicable statutory MSP provisions are found in section 1862(b) of the Social Security Act (42 United States Code 1395y (b)). The applicable regulations are found in 42 Code of Federal Regulations (CFR) 411. Medicare is the secondary payer of health care benefits in the following Group Health Plan (GHP) situations: ▪ Medicare is the secondary payer for beneficiaries aged 65 or over who have GHP coverage because of their current employment status or that of their spouse. This includes multi-employer plans with at least one employer with 20 employees (see 42 CFR 411.101 and 411.170 for more information related to this provision). ▪ Medicare is the secondary payer for individuals who have GHP and Medicare entitlement or eligibility because of permanent kidney failure, during the first 30 months (coordination period) of that eligibility of entitlement. The GHP is primary to Medicare during the coordination period regardless of current employment status or the number of employees (see 42 CFR, 411.101 and 411.161 for more information related to this provision). ▪ Medicare is the secondary payer for disabled beneficiaries under age 65 who are covered under a Large Group Health Plan (LGHP) by virtue of their current employment status or through the current employment status of a family member. LGHPs by definition employ at least 100 or more employees. This includes multi-employer plans with at least one employer with 100 employees (see 42 CFR, 411.101 and 411.201 for more information related to this provision). Medicare is the secondary payer of health care benefits in the following non-GHP situations: ▪ Medicare is the secondary payer where there is no-fault insurance coverage that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident (see 42 CFR 411.50 for more information related to this provision).

	▪ Medicare is the secondary payer where there is liability insurance coverage (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property (see 42 CFR 411.50 for more information related to this provision). ▪ Medicare is the secondary payer to federal and state workers compensation benefits and other government insurance programs (e.g., Federal Black Lung Program), as well as the systems provided under the Federal Employee' Compensation Act and Harbor Workers' Compensation Act (see 42 CFR 411.40 for more information related to this provision). MSP postpay appeals are processed in accordance with Statement of Work (SOW) C.5.10.1. For MSP postpay appeals, "initial determinations" are as defined in 42 CFR 405.900 et seq.

C.5.14.1 Implementation of Medicare Secondary Payer Operations

The Contractor shall implement a comprehensive MSP operations program in accordance with IOM Pub. 100-05, Chapter 2.

C.5.14.2 Electronic Correspondence Referral System Status Inquiries

The Contractor shall perform Electronic Correspondence Referral System (ECRS) status inquiries to determine next actions (e.g., claims adjustments/recovery) in accordance with IOM Pub. 100-05, Chapter 5, section 10.2.

Background	ECRS is a communication tool used by the Contractor to transmit information to the COBC and perform status inquiries of previously submitted requests.

C.5.14.3 Identification and Adjudication of Medicare Secondary Payer Claims and Application of Benefits and Processing Formula

C.5.14.3.1 Medicare Secondary Payer Claims Payment Determinations

The Contractor shall make accurate MSP claims payment determinations to ensure that Medicare pays only for those services for which it is responsible in accordance with IOM Pub. 100-05, Chapter 1, sections 40, 50, 60, and 70.

The Contractor shall adhere to the Working Aged, end-stage renal disease (ESRD), Disability, Liability, Workers' Compensation (WC), and No-Fault provisions in accordance with IOM Pub. 100-05, Chapter 2, sections 10, 20, 30, 40, 50, and 60, respectively.

C.5.14.3.2 Medicare Secondary Payer Claims Adjudication and Validation

The Contractor shall adjudicate and validate MSP claims to ensure that Medicare pays only for those services for which it is responsible in accordance with IOM Pub. 100-05, Chapter 1, section 30, and Chapter 5, sections 30, 40, and 50.

C.5.14.3.3 Medicare Secondary Payer Claims Inquiries

The Contractor shall respond to inquiries from insurers and other interested parties (e.g., attorneys) on MSP billing requirements to assist with resolving claims inquiries accurately, timely, and responsively in accordance with IOM Pub. 100-05, Chapter 5, section 20 and IOM Pub. 100-09, Chapter 3, section 20.2.

C.5.14.4 Transfer of Documentation and Phone Calls to the Coordination of Benefits Contractor

The Contractor shall transfer to the COBC documentation in accordance with IOM Pub. 100-05, Chapter 5, sections 10.2 and 10.3 and telephone calls in accordance with IOM Pub. 100-05, Chapter 5, sections 10.6, 10.7, and 10.8.

C.5.14.5 Medicare Secondary Payer Hospital Audits

The Contractor shall perform hospital audits and reviews in accordance with IOM Pub. 100-05, Chapter 3, sections 20 and 30, and Chapter 5, section 70 (including associated exhibits, 70.5.1–70.5.4).

Each year the Contractor shall conduct a review of 10% of the hospitals up to a maximum of 20 per state in its jurisdiction.

Background	Hospitals must maintain documentation and maintain MSP information for Medicare beneficiaries in accordance with Title 42 CFR 482.20 (f). This regulation states that the provider agrees to maintain a system that, during the admission process, identifies payers that are primary to Medicare, so that Medicare is not incorrectly billed and Medicare overpayments are prevented. Intermediaries use this information to perform audits, and CMS recommends that providers maintain this information on file for ten (10) years.

C.5.14.6 Medicare Secondary Payer Post Payment Recovery

The Contractor shall recover and report MSP debts in accordance with IOM Pub. 100-05, Chapters 7 and 8, and IOM Pub. 100-06, Chapters 4 and 5.

Background	Post payment Recovery – All activities for which mistaken primary Medicare payments or conditional payments have been made and later identified as having another entity responsible for payment. For purposes of this contract, the MAC is responsible for all activities included in the identification, communication, recovery, adjudication and reporting of MSP debts pertaining to providers, physicians or other suppliers. Some of the tasks to be completed in this process are: the identification of claims to be recovered, the request for repayment, posting checks received in response to the demand for repayment, sending a second demand called an Intent to Refer (ITR) to Treasury letter, referring all unresolved debts meeting the eligibility requirements to Treasury via the Debt Collection System (DCS) system and the tracking of all actions taken on a debt. The MSP Recovery Contractor (MSPRC) will be responsible for MSP recoveries and related activities associated with the Group Health Plan (GHP) and non-GHP debts.

C.5.14.6.1 Duplicate Primary Payments

The Contractor shall pursue recoveries of provider, physician or other supplier Duplicate Primary Payments (DPP) when notified of a DPP through the receipt of either a voluntary/unsolicited refund or upon notice from another Contractor having responsibility for GHP debts for which the debtor responds “payment was made directly to the provider, physician and other supplier” in accordance with IOM Pub. 100-06, Chapter 5 and IOM Pub. 100-05, Chapter 7.

Background	REMINDER: All checks shall be deposited within 24 hours of receipt.
Standard 1	Voluntary/unsolicited refund adjudication is successful when all checks that have an associated debt are posted to established debts within 20 calendar days from receipt in the Contractor’s mailroom.
Standard 2	Voluntary/unsolicited refunds are successful when checks that do not have an associated debt, thus requiring further development, are referred to the COBC via ECRS within 20 calendar days of receipt.
Standard 3	DPPs are successfully addressed when demands for repayment are made and collection efforts initiated within 45 calendar days of receiving notice of a DPP situation.

C.5.14.6.2 Inquiries Specific to Debt Collection Efforts for Providers, Physicians and other Suppliers

The Contractor shall acknowledge and respond to inquiries in accordance with IOM Pub. 100-06, Chapter 5 and IOM Pub. 100-05, Chapter 7.

Background	The Contractor will receive inquiries from many sources. Sources may be the debtors themselves, the Treasury PCAs, the national MSP Recovery Contractor, providers/suppliers, and beneficiaries.

Standard 1	Inquiries specific to debt collection efforts are successful when 95% of provider, physician and other supplier MSP inquiries shall be acknowledged or responded to within 45 calendar days of receipt, absent IOM instructions to the contrary.

C.5.14.6.3 Debt Collection Referral Activities for Providers, Physicians and other Suppliers

The Contractor shall comply with all instructions within the IOM Pub. 100-05 and IOM Pub. 100-06 Chapters 4 and 5 specific to the acknowledgement, response and required activities necessary in adjudicating a debt.

The Contractor shall comply with all debt referral requirements.

The Contractor shall take appropriate actions with providers, physicians or other suppliers are identified as bankrupt.

The Contractor shall post all collections from Treasury interventions as described in accordance with IOM Pub. 100-06, Chapter 4, section 70.

Standard 1	All checks are adjudicated and posted to established or newly identified debts within 20 calendar days from receipt.
Standard 2	All eligible delinquent debts are referred to Treasury for cross-servicing prior to or by the time the debt is 180 days delinquent.
Standard 3	Bankrupt debts are identified and, if at Treasury, recalled and reported properly prior to the end of the current financial reporting period.

C.5.14.6.4 Financial Reporting

The Contractor shall implement and be compliant with all financial reporting requirements in accordance with IOM Pub. 100-06. Chapter 5.

The Contractor shall comply with the reporting of MSP savings associated with the recovery of provider, physician, or supplier debts in accordance with IOM Pub. 100-05.

Standard 1	Financial reports are submitted and certified within the required timeframes in IOM Pub. 100-06.
Standard 2	MSP Savings reports are submitted within the CROWD system in the required timeframes in IOM Pub. 100-05.

C.5.14.6.5 Misrouted Medicare Secondary Payer Recovery Checks

The Contractor shall deposit all checks within 24 hours of receipt while investigating the type and reason associated with the receipt of the check.

The Contractor shall 1) copy the check, 2) deposit the check, 3) reissue a check made out to Medicare to the MSPRC, and 4) send the reissued check along with all documentation to the MSPRC.

Background	Important Notice: The CMS has awarded and implemented a contract which consolidates all MSP GHP and non-GHP workloads. This section describes / allows for residual workloads that may remain at the MAC. These workloads, which are not anticipated to be large, should dissipate as the debtor community becomes more aware of the consolidation changes.
Standard 1	The Contractor shall issue a new check and forward all check copies and correspondence to the MSPRC within five (5) business days of the original check deposit.

C.5.14.6.6 Misrouted Medicare Secondary Payer Recovery Correspondence

The Contractor shall transfer all MSP GHP or non-GHP recovery correspondence to the MSPRC.

The Contractor shall isolate, refer, and provide an inventory with volumes of all correspondence transferred to the MSPRC (misrouted correspondence may include faxes, emails, and hardcopy mail).

The Contractor shall provide callers with the MSPRC call center number, if receiving calls specific to recoveries outside of their scope, to the MSPRC.

Background	Important Notice: The CMS has awarded and implemented a contract which consolidates all MSP GHP and non-GHP workloads. This section describes / allows for residual workloads that may remain at the MAC. These workloads, which are not anticipated to be large, should dissipate as the debtor community becomes more aware of the consolidation changes.
Standard 1	The Contractor shall transfer all misrouted MSP recovery correspondence to the MSPRC within five (5) business days of receipt.

C.5.15 Provider Oversight

The Contractor shall establish and maintain an oversight program to ensure compliance with Medicare regulations for providers currently enrolled in the Medicare program.

Background	MACs may be requested by CMS to conduct site visits for the purpose of ensuring that providers continue to maintain facilities that conform to their enrollment agreement. If aberrant billing practices are noted, the CMS may request the MACs to conduct a site visit.

C.5.15.1 Review of Provider Billing Records

The Contractor shall review provider billing records annually after enrollment is approved to determine any aberrant billing patterns, and shall advise the Centers for Medicare & Medicaid Services (CMS) immediately of aberrant billing.

Background	Annual reviews occur during one month per year on a rotational basis so that the audit is not performed in the same month each year.

C.5.15.2 Review of Comprehensive Outpatient Rehabilitation Facility Billing Records

The Contractor shall review Comprehensive Outpatient Rehabilitation Facility (CORF) billing records annually after enrollment is approved to determine if the CORFs are billing for mandatory CORF services, and the Contractor shall immediately advise CMS of aberrant billing.

The Contractor shall work with CMS to develop the method of communication for the notification of aberrant billing practices.

Background	Annual reviews occur during one month per year on a rotational basis so that the audit is not performed in the same month each year.

C.5.15.3 Review of Inpatient Rehabilitation Facilities and Critical Access Hospitals' Rehabilitation Distinct Part Units

The Contractor shall review Inpatient Rehabilitation Facilities' (IRFs') and distinct part units (DPUs) annually to ensure that the IRFs and DPUs meet the 75% rule, and the Contractor shall advise CMS of aberrant billing, in accordance with IOM Pub. 100-04, Chapter 3, sections 140.1.1–140.1.8.

The Contractor shall notify CMS of IRFs that are not meeting the current compliance threshold of the "75%" rule.

The Contractor shall work with CMS to develop adequate notification time frames to allow time for CMS to send the IRF letters terminating their IRF classification status prior to the IRF's next cost report period.

C.5.15.4 Conduct of Site Visits

The Contractor shall conduct site visits routinely, as directed by CMS, and as needed for problematic providers as identified by complaints or investigations in accordance with IOM Pub. 100-08, Chapter 10, section 18.

C.5.16 Coordinated Care Benefits Demonstration (Notice of Enrollment)

The Contractor shall process election notices for all Coordinated Care Benefits Demonstration "Coordinated Care Entities" in accordance with IOM Pub 100-19. http://www.cms.hhs.gov/Transmittals/Downloads/AB0130.pdf .

Background	As required by §4016 of the Balanced Budget Act (BBA) of 1997, CMS is conducting this demo to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Parts A and B. The coordinated care services will be provided by entities whose approach follows either a case management model or a disease management model. Fifteen Coordinated Care Entities have been selected for the demonstration through a national solicitation.

C.5.17 End Stage Renal Disease Clinical Trial

The Contractor shall process claims and perform the requirements for Frequent Hemodialysis Network Payment for Approved Clinical Trial Costs in accordance with IOM Pub 100-20, http://www.cms.hhs.gov/Transmittals/Downloads/R206OTN.pdf.

Background	The purpose of the two (2) End Stage Renal Disease (ESRD) Clinical Trials is to evaluate the effectiveness of more frequent hemodialysis sessions compared with conventional thrice-weekly hemodialysis. One of these trials compares daily in-center hemodialysis (6 times per week) with conventional in-center hemodialysis (three (3) times per week). The other compares nocturnal hemodialysis (six (6) times per week in the home) with conventional in-center hemodialysis. For additional information on the ESRD Clinical Trail: http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=ascending&itemID=CMS042120.

C.5.18 Rural Health Clinics

The Contractor shall process claims and perform the requirements for Rural Health Clinics (RHCs) in accordance with IOM Pub. 100-02, Chapter 13 and IOM Pub. 100-04, Chapter 9 and 42 CFR Part 405, Subpart X.

Background	The purpose of FRHCs is to increase the availability and accessibility of primary and emergency health care to people with Medicare, Medicaid, SCHIP and the uninsured in underserved of rural and urban communities (as well as tribal Indian outpatient health programs) where there is a shortage of health care service professionals.

C.5.18.1 Education Materials

The Contractor shall submit education material designed for use to train FRHCs to CMS for approval prior to use.

Background	The Contractor is encouraged to use CMS-created national education materials when training RHCs.
Standard 1	The Contractor is successful when educational materials are submitted to the Project Officer at least six (6) weeks before their intended use.

C.5.19 Federally Qualified Health Centers

The Contractor shall process claims and perform the requirements for Federally Qualified Health Centers (FQHCs), which include free-standing FQHCs and any satellite locations of the free-standing FQHC, in accordance with IOM Pub. 100-02, Chapter 13, IOM Pub. 100-04, Chapter 9 and 42 CFR Part 405, Subpart X.

NOTE: This will exclude FQHCs that are a facility of Indian Health Services (IHS). For more information, see the requirements for IHS in section C.7.2 of this SOW.

Background	The purpose of FQHCs is to provide primary care services to people with Medicare, Medicaid, SCHIP and the uninsured in underserved rural and urban communities, as well as tribal Indian outpatient health programs.

C.5.19.1 Education Materials

The Contractor shall submit education material it creates for use in training FQHCs to CMS for approval prior to use.

Background	The Contractor is encouraged to use CMS-created national education materials when training FQHCs.
Standard 1	The Contractor is successful when educational materials are submitted to the Project Officer at least six (6) weeks before their intended use.

C.5.20 Foreign Claims

The Contractor shall process claims and perform the requirements for Foreign Claims in accordance with IOM Pub. 100-04, Chapter 1, Section 10.1.4; IOM Pub. 100-04, Chapter 3, Section 110; and IOM Pub. 100-02, Chapter 16, Section 60.

Background	The purpose of Foreign Claims is to provide services for certain inpatient hospitals, inpatient physician's services, emergency room services, and ambulance services related to an inpatient stay (certain services rendered on board a ship) in Canada and Mexico.

C.5.21 Laboratory Competitive Bidding Demonstration

The Contractor shall process claims and perform the requirements for the Laboratory Competitive Bidding Demonstration in accordance with IOM Pub. 100-19.

Background	Section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule. Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments as mandated in section 353 of the Public Health Service Act are applicable. The payment basis determined for each competitive bidding area (CBA) will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

C.5.22 Shipboard/Foreign Travel Services

The Contractor shall process claims and perform the requirements for Foreign Claims in accordance with IOM Pub. 100-04, Chapter 1, Section 10.1.4.

Background	The purpose of Shipboard / Foreign Travel Services is to provide coverage for emergency services rendered on board a ship and in a foreign country when certain criteria are met.

C.5.23 Program Management Office

The Contractor shall establish and maintain a Program Management Office (PMO) with clearly defined project management processes, organizational/responsibilities, and approaches to manage the successful execution of the program.

Background	The successful execution of Medicare activities contained in this SOW is based on a strong collaboration effort both within the MAC and between the CMS. To achieve a strong collaborative approach, the Contractor's program management approach should be structured to satisfy the following aspects of effective program management: ▪ Centrally manage the overall contract to promote responsiveness and minimize costs. ▪ Provide a single point-of-contact for each functional area of the SOW services. ▪ Establish direct, simple lines of communication between the Contractor management staff and their CMS counterparts.

	▪ Empower each level of the project organization with appropriate authorities and responsibilities; specifically, to put decision-making at the lowest possible level of the organization, for effective, operationally sound solutions. ▪ Apply best practices for managing large-scale programs. These include both project management and Medicare management processes, supplemented by appropriate tools to streamline procedures and provide visibility on progress and risk. ▪ Respond efficiently to fluctuating workloads to provide timely and appropriate supply of critical resources.

C.5.23.1 POST-AWARD MEETING

The Contractor shall meet with CMS program staff at CMS Central Office in Baltimore Maryland within ten (10) government business days of the contract award.

The Contractor shall provide a written report of the discussion and decisions reached within five (5) government business days of this meeting.

Background	The purpose of this meeting will be introductions between the CMS and Contractor program staff, detailed review and discussion of the contract requirements, and for CMS to provide the Contractor with background material.

C.5.23.2 PROJECT MANAGEMENT PLAN

The Contractor shall develop and maintain a Project Management Plan (PMP) to support the management of the program. The report format and content shall be agreed upon by the Project Officer and Contractor post award.

Background	The purpose of the PMP is to define the project, the scope of work to be performed; the project activities; deliverables; staffing requirements; and organization of program team and interfaces between the Contractor and CMS. It represents a level of detail sufficient to establish and maintain control of all program functions for successful execution of the program.

C.5.23.3 COST MANAGEMENT

The Contractor shall produce on a monthly basis program Cost Management Reports describing budget versus actual cost data by cost account.

Background	Budgets and actuals should be described on a monthly basis by program total, cost account total, hours by labor category program totals, hours by labor category cost account totals. Cost reports should include easy to read formats such as graphs, tables, etc.

C.5.23.4 MONTHLY STATUS REPORT AND MEETING

The Contractor shall develop a monthly status report and conduct a monthly status meeting. The report format and content shall be agreed upon by the Project Officer and Contractor post award.

Background	Throughout the period of the contract, the Contractor shall provide a not-to-exceed 75-page description of the project status on a monthly basis. The information shall be delivered to the Project Officer by the 15th of the following month and shall provide, at a minimum, the following: ▪ Executive summary, which highlights the important events that took place during the covered period; ▪ Contract information and issues, to include, but not be limited to, budgeted cost to date, actual cost to date, estimated cost to complete, award fee issues, performance against the Award Fee Plan and any outstanding procurement issues/actions; ▪ A detailed narrative summary on the achievement of milestones and deliverables; ▪ Changes in staffing assignments or responsibilities; ▪ A summary of facility status and changes; ▪ Personnel turnover rate; ▪ The length of time of each staffing vacancy in excess of the month being reported; ▪ Problems and risks encountered during the period; ▪ Corrective action initiated on problems encountered during the period; ▪ Previously reported problems that were resolved during the period; ▪ The number of CRs remaining in the backlog; ▪ The number of overall CRs reduced/increased; and ▪ A breakout of proposed costs for travel expenses one month in advance which includes the following: Number, types and purpose of trips, number of travelers along with their labor categories and hourly rate, duration of trip for each destination, mileage, per diem, air fare, miscellaneous expense, etc. Project Officer approval must be received prior to traveling. ▪ Current and cumulative complementary credits ▪ Any recommendations for improvements in functional operations.

C.5.23.5 AD HOC REPORTING

The Contractor shall submit monthly HIPAA testing reports for current and future versions of the HIPAA transactions via DDIS Data Website: www.ddisdata.info.

The Contractor shall also submit a variety of other ad hoc reports via the DDIS Data Website or other mechanism, as directed by CMS, throughout the term of the contract.

The CMS may require additional reporting requirements on an as needed basis. In these instances, the Project Officer and Contractor will agree on format, content and due date.

C.5.23.6 CMS ART

The Contractor shall report data to the CMS Analysis, Reporting and Tracking System (CMS ART) in accordance with the format described in the cost proposal instructions.

Background	The CMS will use the CMS Analysis, Reporting and Tracking System (CMS ART) to track and analyze MAC costs, hours, certain workload, performance, production, and other information as reported by the MACs. This system is currently being modified for the MAC reporting and will be available to the MAC after contract award and upon completion of training.

C.5.23.7 CAFM

The Contractor shall report data to the Contractor Administrative Budget and Financial Management (CAFM) System in accordance with IOM Pub. 100-06, Chapter 5.

Background	CAFM is the mechanism used to report the results of program expenditures. The CMS will use the CAFM System to administer and monitor Medicare program payments.

C.5.23.8 CROWD

The Contractor shall report data to the Contractor Reporting of Operational and Workload Data (CROWD) System in accordance with IOM Pub. 100-06, Chapter 5.

Background	CROWD collects and reports on operational and Contractor workload data and types of claims processed for current Part A and B contractors. Summary data from each Contractor dealing with types of claims, overall number of claims, processing cost per claim, and similar information is provided to the CROWD system.

C.5.23.9 ASCA Enforcement and Reporting

The Contractor shall track the number and results of ASCA enforcement reviews being conducted using the ASCA online reporting screen found at: www.ddisdata.info/.

The Contractor shall submit the reports on a monthly basis until otherwise notified.

Background	Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105, and the implementing regulation at 42 CFR 424.32 require that all

	initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions. Refer to IOM pub. 100-04, Chapter 24, section 90 for additional ASCA enforcement and reporting requirements.

C.6 INTERFACE REQUIREMENTS

This section of the Statement of Work (SOW) describes ongoing activities that the Contractor must conduct, as well as entities with which it must interact, to ensure consistency of Medicare program operations. The activities in C.6.1 require a mechanism (such as a Joint Operating Agreement – JOA – or Service-Level Agreement – SLA – to ensure that all parties understand their respective responsibilities. The activities in C.6.2 do not require such mechanisms.

C.6.1 Successful Collaboration with Entities Requiring Joint Operating Agreements

The Contractor shall execute, update, and perform associated duties in accordance with a JOA that defines roles and responsibilities and creating mutually agreed upon and cost-effective methods to work with and support the Centers for Medicare & Medicaid Services' (CMS') mission with each of the following parties:

a. Program Safeguard Contractors (PSCs) with Benefit Integrity (BI) task orders, in accordance with IOM Pub. 100-08, Chapter 4, section 4.28.

b. Qualified Independent Contractor (QIC), in accordance with IOM Pub. 100-04, Chapter 29, sections 320.1, 320.3 and 320.4.

c. Administrative QIC (AdQIC), in accordance with IOM Pub. 100-04, Chapter 29, sections 320.3, 330.4 and 330.5.

d. Quality Improvement Organization (QIO), in accordance with IOM Pub. 100-10, Chapter 3, section 3110.

e. Beneficiary Contact Center (BCC), guidance on BCC JOA will be available in the BCC SOW.

f. Enterprise Data Center, in accordance with Attachment J-9, Joint Operating Agreement for Enterprise Data Center and Medicare Administrative Contractor Testing Requirements.

g. Medicare Secondary Payer Recovery Contractor (MSPRC), guidance on the MSPRC will be available in the MSPRC SOW.

h. Coordination of Benefits Contractor (COBC), in accordance with IOM Pub. 100-05, Chapter 5.

i. Appeals Support Contractor, guidance on the Appeals Support Contractor will be available in the following SOW Sections: Cost Report Appeals: Provider Reimbursement Review Board (C.5.11.3.2.17), Cost Report Appeals: Court

Hearing/Settlement (C.5.11.3.2.18) and Cost Report Appeals: Final Decisions (C.5.11.3.2.19).

Background	A JOA describes the work that needs to be accomplished, and the roles and responsibilities of each signatory to the success of the task or project. It includes specifics about who will do what, when, and for whom. The JOA also spells out the process the parties will follow if either believes that the other is not following the agreement, including any alternative dispute resolution procedures. Each JOA should include, but not be limited to, the following topics: ▪ Confidentiality ▪ Definitions ▪ Workload ▪ Contract Roles and Responsibilities ▪ Dispute Resolution ▪ Connectivity ▪ Communication The Contractor is responsible for identifying and negotiating any changes required to appropriately address the roles and responsibilities of the parties to the JOA.
Standard 1	The execution of a JOA is successful when all parties to the JOA have signed the written agreement.
Standard 2	The update of a PSC JOA is successful when, for the first year, the JOA is updated quarterly, by January 15th, April 15th, July 15th, and October 15th. After the first year, updates should occur semi-annually, by January 15th and July 15th.

C.6.1.1 Joint Operating Agreement: Quality Improvement Organization

C.6.1.1.1 Referrals to Quality Improvement Organization

The Contractor shall make appropriate referrals to the QIO for medical necessity determinations in accordance with IOM Pub. 100-04, Chapter 29, section 3600; IOM Pub. 100-10, Chapter 4, sections 4070 C and E; and 42 CFR 476.80(b).

Background	The QIO is an organization of a group of practicing doctors and other health care experts that are paid by the federal government to review and improve the care given to Medicare patients. QIOs review complaints about the quality of health care services given to Medicare beneficiaries and certain appeals determinations of services in acute care hospitals, skilled nursing facilities,

	Comprehensive Outpatient Rehabilitation Facilities, and home health agencies. QIOs also review cases from acute care hospitals and long-term care hospitals to make sure the care was medically necessary, provided in the appropriate setting, and coded correctly. In addition, QIOs provide assistance to hospitals, nursing homes, physician offices, and home health agencies in measuring and improving quality.

C.6.1.1.2 Referrals from Quality Improvement Organization

The Contractor shall accept appropriate referrals from the QIO in accordance with IOM Pub. 100-10, Chapter 4, section 4070 D, and 42 Code of Federal Regulations (CFR) 480.136.

C.6.1.1.2.1 Payment Adjustments

The Contractor shall process payment adjustments submitted by the QIOs based on medical necessity determinations and diagnosis-related group validations, including corrections to the disposition code, in accordance with IOM Pub. 100-04, Chapter 29, section 40.3.1.

C.6.1.1.2.2 Billing Errors

The Contractor shall receive all notifications of billing errors from the QIO and work with the provider in submitting a claim to resolve the error.

Background	When conducting required review of medical records, certain errors on a claim may preclude the QIO from completing the required review. Such errors result in a type of technical denial referred to as a billing error.

C.6.1.2 Joint Operating Agreement: Qualified Independent Contractor

C.6.1.2.1 Supply of Appeals Case Files

The Contractor shall supply to the QIC all appeals case file information, within five (5) calendar days of request.

The Contractor shall ensure that case files can be tracked in transit.

Background	The QIC is a contractor that conducts the second level of appeal (reconsiderations of initial determinations and redeterminations of Medicare claims.) All reconsideration requests are handled by the servicing QIC identified on the redetermination notice. The Contractor shall establish JOAs with the Part A and Part B QICs responsible for processing reconsiderations in the Contractor's jurisdiction. In addition, the Contractor shall establish a JOA with the Administrative QIC (AdQIC).

	The AdQIC is responsible for receiving case files and decisions from the OMHA field offices and the Departmental Appeals Board. The AdQIC will fax or mail decision information to the MAC in accordance with IOM Pub. 100-04, Chapter 29, section 330.4 and/or as otherwise agreed to in the MAC/AdQIC JOA.

C.6.1.2.2 Misrouted Requests for Reconsideration

The Contractor shall forward all misrouted requests for reconsideration to the servicing QIC within three (3) calendar days.

If the Contractor is the servicing MAC, the Contractor shall forward the reconsideration request along with the appropriate redetermination case file documentation to the servicing QIC within five (5) calendar days.

Background	Occasionally, the Contractor may erroneously receive a request for reconsideration, which is the next level of appeals after the redetermination.

C.6.1.2.3 Preparation of Case Files

The Contractor shall organize and prepare the case files.

C.6.1.3 Joint Operating Agreement: Medicare Secondary Payer Recovery Contractor

The Contractor shall receive and respond to all referred provider, physician, or other supplier notices of duplicate primary payments; misrouted provider, physician, or other supplier checks; and general non-MSP recovery inquiries.

The Contractor shall transfer all MSP GHP or non-GHP recovery correspondence to the MSPRC.

Background	The MSPRC contract is expected to be awarded and implemented prior to the contract for this MAC jurisdiction. Requirements for the Contractor interaction with the MSPRC are located in sections C.5.14.6.5 and C.5.14.6.6 of this SOW.

C.6.1.4 Joint Operating Agreement: Beneficiary Contact Center

Background	However, the JOA is meant to only serve as an outline of the principles, approaches, and processes that will be used to create, implement, and maintain effective working relationships, communications and information flows between the BCC and the MAC. **It does not create any affirmative duties, rights or legal obligations between the parties nor does it create any rights in any third party**. All time frames set in the JOA are merely suggestive unless otherwise provided by law of the parties' respective contracts with CMS.

	The objectives of the BCC/MAC JOA are to: ▪ Familiarize BCC/MAC management and staff with BCC and MAC activities that require mutual support, define areas where joint cooperation is critical, define information sharing strategies and opportunities and share final operating plan. ▪ Define processes/opportunities to promote the strategic benefits of customer service activities that promote both the BCC Contractor and the MAC. ▪ Build mutually agreeable strategies to gain acceptance for this major change in CMS's approach to beneficiary customer service activities and the upcoming changes associated with its implementation. ▪ Provide a clear map of the responsibilities of each party and respective responsibilities to the other party; such as defining complex inquiries and complaint screening, define processes needed to be followed to transfer issues between the BCC and MAC, process for the notification of all parties as to key personnel changes, etc. ▪ Establish methods and processes that actively encourage communications and information flows that improve the contract performance of both the BCC Contractor and the MAC. This would include defining recurring meetings, establishing the ground rules of what should be discussed, who should be required participant, and who will have the responsibility to lead each meeting. ▪ Provide processes to jointly resolve issues such as disputes between the BCC and MAC and addressing the root causes of misdirected communications.

C.6.1.5 JOINT OPERATING AGREEMENT: COORDINATION OF BENEFITS CONTRACTOR

To ensure that Medicare makes a proper payment, the contractor shall coordinate MSP activities with the Coordination of Benefits Contractor (COBC) in accordance with IOM Pub. 100-05, Chapter 5.

Background	The COBC consolidates activities that support the collection, management, and reporting of all other health insurance coverage of Medicare beneficiaries, as well as all insurance coverage obligated to pay primary to Medicare. In April 2000, the COBC implemented the first two phases of the contract, which included the Initial Enrollment Questionnaire and the IRS/SSA/CMS Data Match. Effective January 1, 2001, the COBC assumed responsibility for virtually all initial MSP development activities formerly performed by contractors. The COBC is charged with ensuring the accuracy and timeliness of updates to the Common Working File (CWF) MSP auxiliary file. The COBC does not process claims, nor handle any mistaken payment recoveries or claims specific inquiries (telephone or written). The COBC is responsible for developing to determine the existence or validity of MSP for Medicare beneficiaries. The COBC handles all MSP related inquiries, including those

	seeking general MSP information, but not those related to specific claims or recoveries. These inquiries (verbal and written) can come from any source, including but not limited to beneficiaries, attorneys/beneficiary representatives, employers, insurers, providers, suppliers and contractors. The COBC is primarily an information gathering entity. The COBC is dependent upon various sources to collect this information. With limited exceptions (e.g., claim clarification with provider to avoid returning the claim to the provider (RTP), contractors are no longer responsible for initiating MSP development and making MSP determinations. It is imperative that all information contractors receive that might have MSP implications be forwarded to the COBC in a timely and accurate fashion. Only with this timely and accurate information can the COBC evaluate all relevant information to make the correct MSP determination and appropriately update CWF for proper claims adjudication. There must be a very close working relationship between the COBC and the contractors.

C.6.1.6 Joint Operating Agreement: Appeals Support Contractor

The Contractor will develop a JOA that delineates the roles and responsibilities of the MAC and the Appeals Support Contractor in regards to all aspects of PRRB hearings, Administrative Resolutions, and, as necessary, court hearings/settlements and implementation of final appeals decisions.

The JOA will comply with all CMS instructions and PRRB procedures found at http://new.cms.hhs.gov/PRRBReview.

Background	While the MAC is responsible for all appeals activities, the Appeals Support Contractor will assist the contractor in maintaining a hearing file, preparing jurisdictional briefs, reviewing and authorizing position papers; and will provide legal assistance for all PRRB cases (including but not limited to the following, conducting pre-hearing activities, discussing the issues in the case, defending the contractor's position, arranging and preparing witnesses to give testimony, cross-examining witnesses and submitting post-hearing briefs, etc). In addition, the Appeals Support Contractor will authorize any administrative resolutions for cases resolved prior to the PRRB hearing.

C.6.2 Successful Collaboration and Coordination with Other Internal and External Entities

The CMS depends on a close and coordinated working relationship between its internal components and external organizations. The Contractor shall work with and coordinate with, as necessary, external entities including, but not limited to, those described in the following sections.

C.6.2.1 State Agencies Responsible for Licensing Institutional Providers (e.g., Survey and Certification, Licensing Authorities)

The Contractor shall exchange information with appropriate state agencies for providers who require a health insurance benefits agreement (provider agreement) or a provider-based determination, or at the direction of CMS, in accordance with IOM Pub. 100-08 Chapter 10, and CMS Pub. 7, State Operations Manual.

Background	State agencies (SAs) survey providers for various purposes (e.g., conditions of Medicare participation, conditions for coverage, and other CMS requirements). During those surveys, the SA may ascertain compliance with CMS conditions on Medicare participation.

C.6.2.2 Investigative Agencies

The Contractor shall interface with the Office of the Inspector General (OIG), Government Accountability Office (GAO), Federal Bureau of Investigation, and other investigative agencies as necessary.

If the Contractor is contacted by an investigative agency concerning Medicare fraud cases, with the exception of cost report fraud cases, the Contractor shall advise the investigative agency to contact the PSC and furnish the necessary PSC contact information.

Background	The Contractor may be contacted by investigative agencies pursuing fraud information. If the Contractor is contacted by an investigative agency pursuing fraud information, with the exception of cost report information, the Contractor shall advise the investigative agency to contact the appropriate PSC and provide contact information for the PSC. If the Contractor is served with a search warrant, the Contractor must contact the CMS Central Office compliance officer for Contractors. If the Contractor is requested to provide information from GAO, Office of Evaluation and Inspections, or Office of Audit Services for evaluation and report purposes, the Contractor shall furnish the necessary information to the requestor.

C.6.2.2.1 Access to Files, Records, Data, and Personnel

The Contractor shall provide timely access, as needed, to its files, records, data, and personnel to OIG, GAO auditors, and other investigative agencies for evaluation and report purposes and promptly address findings.

C.6.2.2.2 Search Warrants

The Contractor shall contact the CMS compliance officer for Contractors when served with a search warrant.

C.6.2.3 CMS Field Offices

The MACs shall support the CMS field offices in their efforts combat fraud and abuse and protect the Medicare Trust Fund.

C.6.2.4 Medicare Advantage Plans, Prescription Drug Plans, and Nontraditional Fee-for-Service Entities

To the extent permitted by statute, CMS, and other government regulations, the Contractor shall share information that Medicare Advantage (MA) organizations (including private fee-for-service (FFS) plans), Prescription Drug Plan (PDP) sponsors, and nontraditional FFS entities need to administer their plans. The Contractor shall maintain an ongoing dialogue with these entities.

Background	CMS will advise the Contractor on the nature and extent of information sharing and coordination it may have with MA organizations (including private FFS plans), PDP sponsors, and nontraditional FFS entities.

C.6.2.5 Other Medicare Administrative Contractors

The Contractor shall work with MACs outside its jurisdiction to share ideas and coordinate its efforts as necessary (e.g., attend national and Contractor Medical Director conferences, participate in national conference calls, coordinate cost report appeals activities).

C.6.2.6 Professional Associations

The Contractor shall meet as necessary with members of professional associations in order to gain input from the society, particularly with respect to the development of new/revised Contractor policies.

C.6.2.7 Infrastructure Service Providers

The Contractor shall interface with infrastructure service providers in accordance with the requirements at C.5.3.

C.6.2.8 Bank Interface

The Contractor shall interface with its servicing bank in accordance with the requirements at C.5.11.2.

C.6.2.9 RESERVED

C.7 JURISDICTION-SPECIFIC REQUIREMENTS

This section of the Statement of Work (SOW) contains the services requirements that are unique to a specific Medicare Administrative Contractor (MAC) jurisdiction. The Contractor shall perform the C.7 requirements in conjunction with all the remaining requirements and standards of sections C.5 and C.6.

C.7.1 Centralized Billing for Mass Immunizers

The Contractor shall process claims for Centralized Billing for Mass Immunizers in accordance with IOM Pub. 100-04, Chapter 18 Section 10.

Background	In order to encourage providers to supply flu and pneumococcal (PPV) vaccinations to Medicare beneficiaries, the CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunizer," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically. To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims. Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered and the carrier must make payment based on the payment locality where the service was provided. IOM Pub. 100-04, Chapter 18, Sections 10.3 and 10.3.1 provide more specific information related to this activity.

C.7.2 Indian Health Services

Background	The Indian Health Service (IHS) is the primary health care provider to Medicare beneficiaries who are members of federally recognized tribes living on or near reservations. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of hospitals (including CAHs), freestanding clinics, FQHCs, RHCs and other entities. While §§1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any Federal agency, passage of the Indian Health Care Improvement Act (IHCIA) in 1976 provided for an exception, amending §1880 of the Act, for facilities of the IHS whether operated by such Service or by an Indian tribe or tribal organization (as defined in section 4 of the IHCIA). The exception under § 1880 limited

	payment to Medicare services provided in hospitals and skilled nursing facilities. Effective July 1, 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), §432 extended payment on a fee-for-service (FFS) basis to services of physician and non-physician practitioners furnished in IHS hospitals and freestanding clinics. This means that clinics associated with hospitals and freestanding clinics that are owned and/or operated by IHS are authorized to bill only the Jurisdiction 4 MAC. Additionally, Tribal health facilities operated under Indian Self Determination Education and Assistance Act (ISDEAA) authorities are an extension of the IHS and considered facilities of the IHS. By virtue of this, they are authorized to bill the Jurisdiction 4 MAC. ISDEAA authorities provide flexibilities to tribes in the administration of their programs that are not provided to general public providers. The annual claims volume is estimated at about 1.2 million per year.

C.7.2.1 CLAIMS PROCESSING

The Contractor shall perform the requirements for IHS in accordance with IOM Pub. 100-04, Chapter 19.

Specifically, the Contractor shall process claims for:

a. Services delivered at Indian Health Service (IHS) and tribal organization facilities; and

b. Services performed by IHS and tribal organization physicians and non-physicians.

The Contractor shall provide additional reports on a periodic basis not identified in section 40 of the manual referenced above.

C.7.2.2 PROVIDER RELATIONS

The Contractor shall respond to inquiries from IHS and tribal organization institutional and professional providers and educate these providers and their staffs about the fundamentals of:

a. The process and contact information for the implementation and management of the new MAC contracts;

b. The Medicare national and local program, polices, and procedures;

c. New Medicare initiatives;

d. Changes to the Medicare program; and

e. Indian-specific issues identified through analyses of such things as provider inquiries and claim submission errors.

Background	Education to this population may be delivered to groups, to individuals, and through various in-person and media channels.

C.7.2.2.1 Provider Inquiries

The Contractor shall offer, and publicize, toll-free service for IHS and each Indian Health tribal organization facility.

The Contractor shall have dedicated individuals, Provider Assistance Liaisons (PALs), to provide timely and accurate responses to provider telephone and written inquiries from IHS and tribal organization providers.

Background	PALs serve as the single point of contact for IHS and tribal organization providers to pose their inquiries related to: ▪ Medicare FFS, ▪ FQHC, ▪ Diagnostic Related Group (DRG), and ▪ The Office of Management and Budget (OMB) rate. The PALs should have knowledge of the Medicare FFS, FQHC, DRG, and OMB rate programs and knowledge of unique claims processing issues surrounding services delivered at different types of IHS and tribal organization facilities.

C.7.2.2.2 Websites and Listserv

The Contractor shall maintain a website dedicated to the IHS and Indian Health tribal organization facilities' Medicare information, issues, and opportunities.

The Contractor shall maintain a dedicated and Indian Health tribal organization facilities listserv for timely dissemination of Medicare information to IHS and each tribal organization facility and provider.

C.7.2.2.3 Bulletins / Newsletters

The Contractor shall regularly publish and distribute Medicare provider bulletins / newsletters in accordance with IOM Pub. 100-09, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, Section 20.3.1 to the IHS and each tribal organization facility.

C.7.2.2.4 Indian Health Services and Tribal Organizations Education

The Contractor shall conduct and attend education events, both face-to-face and web based outreach and education, to discuss and train IHS and tribal organization providers about the Medicare program and billing issues.

The Contractor shall attend a minimum of eight (8) of the following meetings with at least one for the following:

a. CMS Regional Tribal Consultation Meetings

b. CMS Tribal Technical Advisory Committee

c. IHS Annual Meeting and Business Office Coordinators (BOC) conferences

d. IHS Medicare Part A / Part B workshops

e. National Indian Health Board Conference

The Contractor shall provide technical assistance for tribal providers in provider enrollment, claims processing, electronic claims interface, FQHC cost reporting and other activities related to accommodating new MACs.

Background	Specific Training Requests (STRs) from IHS and tribal organization providers shall be honored by the Contractors on a case-by-case basis as funding permits.

C.7.3 Reserved

C.7.4 Rural Community Hospital Demonstration

The Contractor shall process claims and perform the requirements for the Rural Community Hospital (RCH) Demonstration in accordance with IOM Pub. 100-19.

a. The MAC shall conduct these audits according to the principles expressed in IOM Pub. 100-06, Chapter 8.

b. The MAC shall reimburse the hospitals for the reasonable cost of services to beneficiaries according to the principles stated in 42 CFR 413 of Part I of the Provider Reimbursement Manual CMS Pub. 15-2, Chapter 21.

Background	The RCH Demonstration Program was mandated by section 410A of the Medicare Prescription, Drug, Improvement, and Modernization Act of 2003. The Secretary is required to conduct the RCH Demonstration, lasting five (5)

	years, to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. This Demonstration will allow selected rural hospitals to benefit from cost-based reimbursement for inpatient services. The Secretary is required to select not more than fifteen (15) hospitals to participate in the demonstration in States with low population densities. Currently, nine (9) hospitals participate in the program, serviced by seven different Fiscal Intermediaries (FIs). The CMS expects that audits will be on-site, field audits. However, the CMS will allow the MAC to assess the financial viability of an on-site audit.

C.7.5 Veterans Affairs Medicare Equivalent Remittance Advice Project

The Contractor shall process claims for Department of Veterans Affairs (VA) Medicare Eligible Claims in accordance with the IOM Pub 100-20.

Background	Current law permits the Department of VA to collect appropriate Medicare coinsurance and deductible amounts from supplemental insurers for claims for supplies and services ordinarily covered by Medicare but furnished: ▪ At VA facilities; and ▪ For veterans eligible to receive both VA health and Medicare benefits and also having Medicare supplemental insurance. To facilitate this process, the Centers for Medicare & Medicaid Services (CMS) entered into an interagency agreement with the VA whereby the CMS will help the VA work with a CMS contractor to adjudicate these claims to produce a remittance advice equivalent to that ordinarily produced for Medicare claims. The remittance advice, sent to the supplemental insurers, will help the insurers determine payment amounts they owe to the VA. The CMS will not pay these claims. Trailblazer was the contractor selected to perform the work. Part of this process involves the calculation of the deductible applicable to the Medicare-equivalent VA claims. The Common Working File (CWF) calculates the deductible based on true Medicare claims (i.e., for Medicare services rendered by Medicare providers to Medicare beneficiaries) and sends this information back to the contractors for this project. The Multi-Carrier System (MCS) and the Fiscal Intermediary Standard System (FISS) further adjust the deductible information received from the CWF with the deductible amounts that apply to the Medicare-equivalent VA claims. This arrangement results in an accurate calculation of the deductible for VA's equivalent of Part A claims. However, because the MCS and FISS calculations are separate, they cannot consider each other's Part B claims. Currently, if a veteran-beneficiary receives both outpatient hospital services and professional services, billed respectively to an FI and a Carrier, the deductible calculated will be incorrect beyond the first claim adjudicated. This

	problem does not occur for Medicare claims, for which the CWF calculates a deductible that considers Part B claims processed by both MCS and FISS.

C.7.6 Chiropractic Services Demonstration

The Contractor shall process claims and perform the requirements for Chiropractic Services Demonstration with IOM Pub 100-20.

Background	Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct the Expansion of Coverage for Chiropractic Services Demonstration. The purpose of the demonstration is to evaluate the feasibility and advisability of expanding coverage of chiropractic services under Medicare. The legislation requires CMS to expand coverage for chiropractic services to include "care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided." Any beneficiary enrolled under Part B, including one enrolled in an M+C (or MA) program, would be eligible to participate. No other physician approval is required for the receipt of chiropractic services under the demonstration. The demonstration is for two years and must be conducted in four geographic areas—two rural and two urban. One rural and one urban geographic area must be located in an area designated as a health professional shortage area (HPSA). A Report to Congress must be submitted not later than one year after the demonstration ends, which includes an evaluation of the costs of the demonstration, beneficiary satisfaction, and other matters as the Secretary deems appropriate.

C.7.7 Reserved

C.7.8 Reserved

C.7.9 Frontier Extended Stay Clinic Demonstration

The Contractor shall process claims for Frontier Extended Stay Clinics in accordance with IOM Pub. 100-19.

Background	The Frontier Extended Stay Clinic (FESC) demonstration is mandated by section 434 of the Medicare Modernization Act. The FESC demonstration addresses the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care referral centers, or patients who need monitoring and observation for a limited period of time. The statute grants a waiver to Medicare rules in order to

	conduct this demonstration. The FESC must be located in a community which is at least 75 miles away from the nearest acute care hospital or critical access hospital, or which is inaccessible by public road. The FESC demonstration will last for three years. Unless reauthorized, at the end of this period, the FESCs will lose their certification as Medicare FESC providers.

C.7.9.1 MEDICAL REVIEW

The Contractor shall conduct a medical necessity screening of each Medicare patient whose stay in the clinic equals or exceeds four (4) hours from the time he/she is originally seen by the clinic staff.

The Contractor shall make a Medicare payment under the demonstration only if the patient meets the following medical necessity requirements:

a. The patient's stay equals or exceeds four (4) hours; and
b. The Contractor determines under its medical review that the patient's condition has been evaluated by a physician, physician assistant, or nurse practitioner and is of sufficient risk to warrant continued observation in the clinic.

C.7.9.2 PAYMENT

The Contractor shall make payment according to the G-code, which will indicate the length of stay for each Medicare patient from the point of time that he/she is seen by the clinic. This code will measure four (4) hour units of time.

Background	The clinic will be paid for extended stays in four (4) hour increments. Subject to a screening for medical necessity, Medicare payment will only occur for stays that last at least 4 hours. For those stays that equal or exceed 4 hours, demonstration payment will also apply to the first four hours of stay. If the G-code indicates less than one (1) time unit, i.e., less than four (4) hours, the clinic will not receive any additional payment for an extended stay (i.e., the allowable payment will be $0.00). However, the clinic will be eligible to bill and receive the customary encounter-based payment for a clinic visit. All potential sites are Rural Health Clinics, Federally Qualified Health Centers or tribal facilities, so payment can be made on the basis of standard fiscal intermediary methods for these providers. CMS will identify a payment for a four (4) hour period of stay. The allowable payment will vary by provider.

C.7.10 Pay for Performance Check-Writing

Background	There are three (3) demonstrations that will initially be involved in this project: ▪ The Premier Hospital Quality Incentive (Premier) Demonstration, ▪ The Physician Group Practice (PGP) Demonstration, and

	▪ The Medicare Care Management Performance (MCMP) Demonstration. Premier Hospital Quality Incentive Demonstration - The Premier Demonstration is being carried out under CMS' demonstration waiver authority, section 402(a)(1) of Public Law 90-248 (42 U.S.C. 1395b-1), which allows the Secretary to waive requirements in Title XVIII that relate to reimbursement and payment. This demonstration involves approximately 200 hospitals across the country that will be rewarded for meeting specific thresholds and/or improvement goals on inpatient quality of care measures. The demonstration began in October, 2003, and was originally projected to last for three years. The demonstration has now been extended one year (October 2006 – September 2007). Incentive payments for the first year of the demonstration were issued in 2006. Payments for the second through fourth years are projected to be made in 2007, 2008, and 2009. Approximately 200 checks per year will be issued. Physician Group Practice Demonstration - The PGP Demonstration was authorized under section 412 of the Benefits Improvement and Protection Act of 2000 (BIPA). This demonstration involves 10 large group practices across the country that will be rewarded for achieving financial savings for the Medicare program as well as meeting specific quality goals. This is a three-year demonstration that began on April 1, 2005. The first incentive payments (up to 10 separate checks) are projected to be processed in fiscal year 2007). Checks for the second and third year will follow in subsequent years. Medicare Care Management Performance Demonstration - The MCMP Demonstration is a congressionally mandated demonstration authorized by § 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This three-year demonstration will be implemented starting in 2007 in Arkansas, California, Massachusetts, and Utah. Approximately 800 small to medium-sized physician group practices will participate across all four states. Practices will be eligible to receive an initial incentive payment for reporting clinical quality measures in the first year of the demonstration followed by incentive payments for meeting clinical quality performance standards in each of the three years of the demonstration. The clinical quality performance incentive payments will be issued approximately nine months after the end of the reporting year. In each of these demonstrations, CMS needs to be able to issue checks to providers participating in the demonstration that are separate from any claims they may submit to Medicare contractors for services rendered to beneficiaries, monitor payment levels against budget allocations, and produce tax and other required financial reporting forms. For more information, go to the CMS website at: http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage.

C.7.10.1 PAYMENT FILE

The Contractor shall create a file for incentive payments using the CMS-588 form.

Background	The CMS Project Officer and/or designee will provide the Contractor with the

	Authorization Agreements for Electronic Funds Transfer (EFT), or the CMS-588 form. This form is completed by all demonstration sites.

C.7.10.2 BANKING

The Contractor shall establish a bank account for incentive payments.

The Contractor shall perform the necessary Electronic Funds Transfer tests connecting the file and bank.

C.7.10.3 ISSUE CHECKS

The Contractor shall issue individual checks to specific Medicare providers (hospitals, physicians, and potentially other categories of providers) that reflect incentive or bonus payments under various demonstrations.

The Contractor shall release checks to providers within 5 business days of receiving payment from CMS.

Background	On a periodic basis, the CMS Project Officer and/or designee will provide to the Contractor a list ("list bill") of providers to be paid. The list will include: ▪ The applicable demonstration, ▪ Provider name, ▪ Medicare provider number, ▪ City, ▪ State, ▪ Total payment due, and ▪ Period for which the payment is applicable. In addition, the CMS Project Officer and/or designee will provide the Contractor with a Letter of Congratulations and Notification of Payment Amount (including a list of names, titles, and mailing addresses) to be sent to the participating hospital's Chief Executive Officer, Chief Financial Officer, or whoever CMS designates to receive the letter. The Contractor shall not be responsible for calculating or verifying payment amounts, but only for preparing and issuing checks to each provider in the amounts specified. However, the Contractor shall be responsible for verifying that the payments issued match the amount requested by the CMS Project Officer and that the checks were transmitted to the correct banking facility. Checks shall be processed and deposited electronically to provider's bank. It will be the responsibility of the Contractor to collect and maintain any information required to issue and track payments (e.g. bank routing information, mailing addresses, tax identification numbers, etc.)

C.7.10.4 INVOICING

For each group of checks issued, the Contractor shall submit one invoice to the CMS Project Officer or designee representing the total value of checks to be issued within 10 business days of receiving the list bill.

The Contractor shall submit a separate invoice for each demonstration for which checks are issued.

Background	CMS will pay the Contractor the amount of the invoice. Upon receipt of payment, the Contractor shall release the check to the providers under the demonstration(s).
Deliverable	Original Payment Voucher

C.7.10.5 TAX REPORTING

The Contractor shall issue to every provider paid under this contract a “1099” and/or any other forms required for income tax and reporting purposes.

C.8 APPENDICES

C.8.1 Appendix A: Fee-for-Service Shared System Base Functions

Function	Shared System Provided	EDC Provided …
Security	Application password security via a personnel file containing user authorization flags to control access to specific functions	Creation and maintenance of network/environment security rules, via ACF2 Data Center security ID and password that controls access into the data center, access into the CICS regions, access to CICS transactions, and read/write access to files. Data Center security Machine-ID and non-expiring password that controls access into the data center for functions such as IVR and NGD.
Tele-communications		Works with CMS-approved contractors as necessary to establish batch and interactive connectivity between the data centers.
File Transfers		The EDC creates and maintains the jobs necessary to transmit CMS-approved files from the EDC to any other location. The EDC receives files transmitted from CMS approved contractors.
Electronic Data Interchange (EDI)	MCS and FISS accepts CMS' X12 flat file HIPAA EDI transactions created from the translation of ANSI 4010 format, or subsequently adopted HIPAA claim standard inbound EDI transactions. At present, MCS and FISS support a single version of the HIPAA EDI standards. When a subsequent version is adopted as a national standard under HIPAA,	

Function	Shared System Provided	EDC Provided …
	it will be necessary for the Contractor to support both the new and the old versions until all users are required to use the new version exclusively. Perform pre-pass editing and reporting.	
	MCS furnishes the Professional Provider Telecommunication Network (PPTN) application for provider inquiry of claims status information via a DDE-type screen.	
	Creation of electronic remittance advices in the HIPAA mandated Format	Execution of the jobs to translate the remittance data to ANSI (optional) Creation and execution of the jobs to transmit the data to the contractor data center
	Creation of crossover data for the COBC	Support of telecommunications with trading partners/COBC Creation and execution of the jobs to transmit the crossover data to the COBC
	FISS furnishes the Direct Data Entry (DDE) application for provider on-line claim entry and correction of claim status and beneficiary eligibility information.	
	Creation of electronic remittance advices in the HIPAA mandated Format	Creation and execution of the jobs to transmit the data to the contractor data center
	Creation of crossover data for the COBC	Support of telecommunications with trading partners/COBC Creation and execution of the jobs to transmit the crossover data to the COBC
Claims Entry	Activations and Claims Inquiry System (ACIS)	

Function	Shared System Provided	EDC Provided …
	Automated Development System (ADS), including a base letter file selected from an existing user Generation of standard IBM AFP mixed mode or Xerox JDL/JDE print file containing development letters (English or Spanish) that support use of contractor-maintained OMR marks or 3 of 9 barcodes	Creation and execution of the jobs to transmit the base print output to the contractor local data center
	A base set of reference files and tables selected from an existing shared system user	Creation and execution of the jobs to retrieve the CCI data from the CMS data center and transmit it to the EDC
	On-line work scheduler	
	Suspense document print file	
	Weekly EOLQA sampling	
	Comprehensive Error Rate Testing (CERT) processing	Creation and execution of the jobs to transmit the base output to CMS' CERT contractor
	Existing CMS Standard ARU interface in the form of an on-line transaction	Ability to connect to the FFS application at the EDC
	Correspondence application that provides ability to track telephone and written correspondence	
Correspondence and Customer Service	GUI-based MCS Desktop Tool (MCSDT), if desired	Ability to connect to the FFS application at the EDC
	Letter-writing application, including a base letter file selected from an existing shared system user	
	Generation of standard IBM AFP mixed mode or Xerox JDL/JDE print file for correspondence response letters (English or Spanish) that support use of contractor-maintained OMR marks or 3 of 9 barcodes	Creation and execution of the jobs to transmit the base print output to the contractor's print site (if routing is not done via the JCL)

Function	Shared System Provided	EDC Provided …
Pricing/ Profiles	Maintenance capability for the MPFSDB, customary, prevailing, ambulance fee schedule and zip code file and other relative pricing files	Creation and execution of the jobs to retrieve the fee schedule data from the CMS data center and transmit it to the EDC Creation and execution of the jobs to extract the contractor-specific fee schedule data
	Standard provider profile build logic	
	Automated pricing of claims	
	Automated “mass” adjustments capability	
	Express Adjustments	
	Limiting Charge processing	Creation and execution of the jobs to transmit the base print output to the contractor’s print site (if routing is not done via the JCL)
Medicare Secondary Payer (MSP)	Medicare Secondary Payer (MSP) validation through a base set of audits	
	MSP automated payment calculation	
	Identification of MSP recovery claims via IRS/SSA Data Match and retroactive recovery with automated history searching	
	Systematic MSP Automated Recovery Tracking (SMART) system	Creation and execution of the jobs to retrieve the Data Match files and transmit them to the EDC
	Demand packages in a basic AFP mixed mode or Xerox DJDE print file, along with mailing label print files for certified and non-certified mail Associated folder label print file	Creation and execution of the jobs to transmit the base print output to the contractor’s print site (if routing is not done via the JCL)
		Receipt and installation of ECRS software.

Function	Shared System Provided	EDC Provided …
Reporting	Provide data used to complete the required CMS reports such as the: ▪ Workload and Performance/PULSE file; ▪ Appeals; ▪ Medical Review Workload; ▪ Medical Review Savings; ▪ PIMR; ▪ MSP Savings; ▪ CFO; ▪ PSOR ▪ PS&R	Creation and execution of the jobs to transmit the PIMR data to CMS' PIMR contractor Creation and execution of the jobs to transmit the CCI report to CMS' CCI contractor Creation and execution of the jobs to transmit the data to CMS' PULSE contractor
	Numerous reports to track and control inventory and production. Refer to report documentation for specifics	Creation and execution of the jobs to transmit the base print output to the contractor's print site (if routing is not done via the JCL)
	Provide the base data files for use in contractor-specific Ad-Hoc Reporting and Data Extracts	Execution of the jobs to create ad-hoc reports or data extracts (with CMS approval)
Provider	Processes claims using provider enrollment data from the Provider Enrollment Chain Ownership System (PECOS) Accepts the PECOS Daily Export Extract file of provider information, used to merge PECOS data with provider data for claims processing	Telecommunications mechanism between the EDC and the PECOS Retrieval of the Daily Export Extract file from the PECOS (one per Contractor number)
	Creation of yearly participating (PAR) provider counts	
	Creation of a weekly mammography report Validation of certification numbers for mammography facilities	Creation and execution of the jobs to retrieve the Mammography Quality Standard Act (MQSA) File from the CMS data center
	MCS creates weekly tapes for the RRB containing provider extract data	
	Interface to Finalist zip code	Receipt and installation of Finalist

Function	Shared System Provided	EDC Provided …
	cleansing software to cleanse provider addresses	software and database updates
	Provider file accessor	Execution of the jobs to create ad-hoc reports or data extracts (with CMS approval)
	Provide access to the data required to produce the MEDPARD	Execution of the jobs to extract provider data (with CMS approval) Creation and execution of the jobs to transmit the extracted data to contractor data center
	Desktop Label and Reporting database application (PIN Support (PSUP) Query appl.)	Creation and execution of the jobs to transmit the extracted data to contractor data center
CWF Interaction	Creation of CWF transmits files for claims, MSP, and eligibility data	Creation and execution of the jobs to transmit the data to the CWF host
	Accepts CWF response files for claims, MSP and eligibility data	Receipt of CWF response files from CWF Host
	Interaction with HIMR Eligibility and Claim Data on a subset of MCS screens.	Receipt and installation of HIMR software
	Accept national standard format for beneficiary Part B eligibility requests by providers and produce standard format responses	Creation and execution of the jobs to transmit the translated records to the EDC Creation and execution of the jobs to transmit the response records, returned from the CWF, to the contractor data center
	Bridge between the Professional Provider Telecommunication Network (PPTN) and the CWF ELGB screen for eligibility inquiries by providers	Receipt and installation of CWF ELGB software

Function	Shared System Provided	EDC Provided …
Accounting/ Financial	Standard interface for bank issues/clears	Support of telecommunications with bank or contractor data center Creation and execution of bank-specific interfaces for Issues file (optional, with CMS approval) Creation and execution of the jobs to transmit the issues file to the bank or contractor data center Receipt of the Clears file from the bank (optional) Creation and execution of bank-specific interfaces for Clears file (optional, with CMS approval)
	Stale date processing	
	Mailroom-ready output document files, suitable for printing on IBM equipment, that have: ▪ Basic AFP mixed mode print file; ▪ Parameters to control additional mail finishing marks; ▪ OMR coding or 3 of 9 barcodes for outgoing financial documents; ▪ Separate checks, MSNs, and remittance with AFP mixed mode formatted print streams; ▪ English language printed output for all documents, and Spanish language for the beneficiary Medicare Summary Notice (MSN); ▪ Base Presort processing	Creation and execution of the jobs to transmit the base print output to the contractor's print site (if routing is not done via the JCL)
	— OR —	
	Mailroom-ready output document files, suitable for printing on Xerox equipment that have: ▪ Xerox print file; ▪ Parameters to control additional mail finishing marks; ▪ OMR coding or 3 of 9 barcodes for outgoing financial documents; ▪ MSNs and remittance with Xerox JDL/JDE formatted print streams; ▪ English language printed output for all documents, and Spanish language	Creation and execution of the jobs to transmit the base print output to the contractor's print site (if routing is not done via the JCL)

Function	Shared System Provided	EDC Provided …
	for the beneficiary MSN; ▪ Base Presort processing	
	Interface to Finalist zip code cleansing software	Receipt and installation of Finalist software and database updates
	Cash receipts processing	
	Accounts receivable processing	
	Accounts payable processing	
	Creation of ACH EFT records, pre-notification records, and X12 835 records	Support of telecommunications with bank Creation and execution of the jobs to transmit the ACH records to the bank or the contractor data center.
	Accumulation of monthly, quarterly, and yearly financial data to create a 1099 database reflecting annual provider and beneficiary earnings	Creation and execution of the jobs to transmit the 1099 records to the contractor data center
	HPSA processing which includes: ▪ Incentive checks in the same format as other special checks; ▪ Incentive payment reports; ▪ HPSA guideline monitoring reports; ▪ Suppression of HPSA checks for violators ▪ Notification of providers of those claims for which the HPAA bonus is being paid	
National Change of Address (NCOA)	Creation of a standard format file for NCOA processing Accept standard format NCOA file used to update beneficiary address data	Support of telecommunications with vendor Creation and execution of vendor-specific interfaces for NCOA file (with CMS approval) Creation and execution of the jobs to transmit the NCOA records to the NCOA vendor or the contractor data center.
	Interface to Finalist zip code cleansing software to cleanse	Receipt and installation of Finalist software and database updates for

Function	Shared System Provided	EDC Provided …
	NCOA address data	all contractors
	File layouts to support the extract of data.	Creation and execution of the jobs to extract the data and transmit the data to the data storage location (with CMS approval)
Payment Safeguards	File layouts to support the extract of data.	Creation and execution of the jobs to extract the data and transmit the data to the data storage location (with CMS approval)
	Automated history search capability to interface with ARGUS	
	Sampling capability in support of focused medical review (online history plus 4 years of purged history)	
	Standard interface to Program Integrity Sampling Module for Part B and DME contractors (PIMB)	Receipt and installation of PIMB software
File Purges	Standard purge logic	
	Capability to retrieve information by beneficiary from purged history	
Other Add-on Software	Image request transaction files (RQ screen)	
National Provider Identifier Crosswalk	Access to NPI Crosswalk during claims processing as well as a claim by claim basis by contractor staff.	