

Statement of Work

Business Program Operations Contractor



Revision 12/5/11

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BUSINESS PROGRAM OPERATIONS CONTRACTOR
Procurement Sensitive

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1 Background

1.1. Medicare Overview

Medicare is a nationwide, Federal health insurance program enacted in 1965 as Title XVIII of the Social Security Act (~~the Act~~¹; 42 U.S.C. § 301 *et seq.*) for persons 65 years of age or older, certain younger disabled persons, and persons with End-Stage Renal Disease (ESRD)¹. The Medicare program serves an estimated 46 million beneficiaries and processes over 1.2 billion claims per year. Fee-for-service (FFS), or ~~traditional~~, Medicare consists of two primary parts: Hospital Insurance otherwise known as Part A, and Supplemental Medical Insurance also known as Part B. A third part of Medicare, known as ~~Part C~~ or the ~~Medicare Advantage~~ (MA) program, was established by the Balanced Budget Act of 1997 (Public Law 105-33) and allows beneficiaries to receive Medicare benefits through private managed care plans. Finally, Medicare prescription drug coverage called ~~Part D~~ was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Medicare provides equal access to all contract services to all Medicare beneficiaries in compliance with all applicable civil rights laws, including title VI of the Civil Rights Act, as amended; sections 503 and 504 of the Rehabilitation Act, as amended; the Age Discrimination Act of 1975, as amended; the Americans with Disabilities Act of 1990, as amended; and title IX of the Education Amendments of 1972.

Medicare Part A covers some of the costs of providing medically necessary inpatient hospital care, skilled nursing facility care following hospital care, home health agency and hospice care. Individuals entitled to Social Security or Railroad Retirement benefits are automatically eligible to receive premium-free Part A benefits beginning with the first day of the month in which the individual attains the age of 65; those not entitled to such benefits may enroll and purchase Part A once they attain age 65. Also automatically eligible for Part A are: 1) people younger than age 65 who receive Social Security disability benefits (after a defined waiting period) and meet certain qualifications; 2) persons with ESRD who meet certain criteria; and 3) individuals who worked in particular Medicare-qualified Federal, state, or local government positions, provided certain conditions are met.

Medicare Part B helps pay for certain physician services (in hospital and non-hospital settings), outpatient hospital services, home health services and other medical services,

¹ The Glossary attached to this document contains the key terms and definitions critical to understanding the performance requirements contained in this SOW.

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equipment and supplies not covered under Part A. Part B benefits are available to almost anyone age 65 or older regardless of entitlement to Part A and to all beneficiaries entitled to premium-free Part A. Part B carries a premium and is an optional program, meaning that eligible individuals may elect or decline to enroll.

MA plans are an alternative to traditional FFS Medicare whereby individuals entitled to Part A and enrolled in Part B, except for those entitled based on ESRD, may elect to receive Medicare benefits by enrolling in a private Medicare managed care plan. The Centers for Medicare & Medicaid Services (CMS) contracts directly with qualified plans. These plans must offer the full range of Medicare benefits. In turn, Medicare pays a fixed monthly amount for each enrolled beneficiary. MA plans may, but are not required to, offer Part D prescription drug benefits (see below for more information).

The Part D program works in a similar manner to the MA program in that benefits are offered through private plans. To be eligible to enroll in Part D, a Medicare beneficiary must be either entitled to Part A or enrolled in Part B (whether they receive benefits through FFS Medicare or through the MA program). A beneficiary with FFS Medicare may enroll in a Prescription Drug Plan (PDP) for standalone Part D benefits. A beneficiary in the MA program must receive all Medicare benefits through the same MA plan; those that provide Part D benefits are identified as MA-PD plans.

The Medicare program's authorizing statutes charge the Secretary of the Department of Health and Human Services (DHHS) with the administrative responsibility for the Medicare program. In turn, the Secretary has delegated the program authority for Medicare to the Administrator of CMS. Additionally, the Social Security Administration (SSA) is responsible for initially determining an individual's Medicare entitlement and for maintaining the Medicare master beneficiary record.

The CMS administers the Medicare program through activities such as: 1) program policy and guidance formulation and promulgation; 2) contract execution, operation and management; 3) utilization record maintenance and review; and 4) general Medicare financing. The CMS performs such administration through a complex set of relationships involving the private insurance industry, state and local governments, and thousands of independent hospitals, physicians, providers, and suppliers. Sections 1816(a) and 1842(a) of the Act provide that public or private entities and agencies may participate in the administration of the Medicare program under contracts or agreements entered into with CMS. These contractors are known as ~~F~~iscal Intermediaries" (FIs) and ~~e~~arriers." With certain exceptions, FIs perform bill processing and benefit payment functions for Part A of the program; carriers perform similar functions for Part B. However, the MMA requires that CMS phase out these contractors under Medicare Contracting Reform.

Section 911 of the MMA requires CMS to replace all FIs and carriers with competitively-procured Medicare Administrative Contractors (MACs) that will operate under Federal Acquisition Regulation (FAR) contracting standards. The CMS has successfully

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competed and awarded all 19 MAC contracts.

These acquisition activities resulted in 4 Durable Medical Equipment MACs (DME MACs) and 15 combined Part A & Part B MACs, (AB MACs), which will service the majority of all Medicare providers and will replace the current fiscal intermediaries and carriers that administer the Part A and Part B programs, in specific geographic regions known as jurisdictions.

For clarity, this document uses the following rules when referring to contractors:

- Where only one contractor or contracting type is relevant, it will be specifically identified;
- The phrase “Medicare claims processing contractors” refers collectively to FIs, carriers, and MACs; and
- The phrase “Medicare contractor” encompasses any entity that contracts with CMS to perform Medicare functions.

1.2. The Medicare Integrity Program (MIP)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA; Public Law 104-191), added § 1893 to the Act, establishing the Medicare Integrity Program (MIP; 42 U.S.C. § 1395ddd). This program is funded from Medicare’s Federal Health Insurance Trust Fund for activities related to both Medicare Parts A and B. Specifically, § 1893 enables CMS to contract with an expanded pool of eligible entities to carry out certain Medicare integrity program activities that were being performed under contracts with FIs and carriers. On March 20, 1998, CMS published a notice of proposed rulemaking in the *Federal Register* (63 FR 13590); however, § 1893 authorizes CMS to enter into MIP contracts without publication of a final rule (see Appendix A, *MSP Governing Statute and Implementing Regulations*; and Appendix B, *MIP Regulation* for more information).

The MIP activities identified in § 1893 include: 1) conducting medical reviews of claims to determine whether the services rendered were medically necessary and met an appropriate level of care; 2) detecting and deterring Medicare fraud, waste and abuse; 3) auditing provider cost reports; 4) developing/updating the list of durable medical equipment subject to prior authorization; and most important for purposes of this Statement of Work (SOW), 5) ensuring that Medicare pays appropriately when a beneficiary has other insurance. This last activity is known as “Medicare Secondary Payer” (MSP) and involves those situations in which Medicare does not have primary legal responsibility for paying a beneficiary’s health care expenses (see Section 1.3, *The MSP Program*, below).

1.3. The Medicare Secondary Payer (MSP) Program

MSP involves those functions performed to identify when another payer has payment

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responsibility before Medicare in order to pay claims in the proper order and to recover Medicare primary payments made when another payer held primary responsibility. Under § 1862(a) of the Act (42 U.S.C. § 1395y(a)), items and services furnished by Federal providers, a Federal agency, or under a Federal law or contract, have been excluded from Medicare coverage (*e.g.*, U.S. Military Hospitals, U.S. Department of Veterans Affairs, research grants). Furthermore, § 1862(b)(2)(A)(ii) of the Act (42 U.S.C. § 1395y(b)(2)) and the implementing regulations in 42 CFR Part 411 preclude Medicare from making primary payment where the beneficiary is:

- Age 65 or older and covered under an employer's Group Health Plan (GHP) based on the current employment status of the individual or of his/her spouse (of any age), and
 - the employer has at least (20) employees, or
 - the GHP is part of a multi-employer plan where at least one employer has at least (20) employees and the GHP has not requested a formal exception under 42 CFR 411.172(b) for any employee 65 or older employed at a company with less than (20) employees;
- Under age 65, entitled to Medicare on the basis of disability, and covered under an employer's Large Group Health Plan (LGHP) based on his/her own current employment status or the current employment status of a family member. A LGHP is a plan where
 - the employer has 100+ employees, or
 - the GHP is part of a multi-employer plan where at least one employer has 100+ employees;
- Within the first 30 months of eligibility/entitlement to Medicare based on having ESRD and is covered under any GHP (regardless of size or employment status) that covers individuals who have ESRD;

Additionally, Medicare may not make payment where payment has been made or can reasonably be expected to be made under a workers' compensation (WC) law or plan, under no-fault insurance, or under liability insurance (including self- insurance). An entity that engages in a business, trade, or profession is deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance or otherwise) in whole or in part. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

1.4. Coordination of Benefits & MSP Recovery (COB&R)

The CMS is seeking to establish a centralized Coordination of Benefits (COB) and Medicare Secondary Payer Recovery (MSPR) operation by consolidating these activities,

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the performance of all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries, and the collection of conditional payments or mistaken primary payments. These activities have been performed under two separate contracts. The CMS intends to establish a centralized COB and MSPRC operation that provides quality customer service and a single source to Medicare providers, suppliers, beneficiaries, insurers and other stakeholders by streamlining the MSP data and debt collection processes while ensuring the integrity of the Medicare Trust Funds. As with any consolidation of efforts for similar functions, savings of time and costs can be realized.

Consolidation of these two programs with an award to a single prime contractor would create a substantially large program and continue to impose restrictions on CMS related to its ability to monitor and react to a contractor's performance. To alleviate this situation, CMS will establish a matrix organization of independent contracts to manage the major functions. Under the matrix organization, the combined COB&R activities will be performed by:

- Business Program Operations Contractor (BPOC);
- MSP Systems Contractor (MSPSC);
- MSP Integration Contractor (MSPIC); and
- MSP Recovery Audit Contractor (RAC) Group Health Plans (GHP) and Non-Group Help Plans (NGHP) Ongoing Responsibility for Medical (ORM).

These contractors will work in concert to encompass all of the activities necessary to ensure that the primary payer -- whether it is Medicare, employer insurance or other insurance -- pays first, then identify claims that were paid conditionally or mistakenly paid as Medicare primary, and pursue recovery in the most cost effective and efficient manner.

The following provides additional background on the activities of the MSPIC, MSPSC, and MSP RAC. The BPOC activities and scope are provided in the following section:

1.4.1. Medicare Secondary Payer Integration Contractor (MSPIC)

The role of the MSPIC is to make certain that all components supporting the COB&R contract function in concert. The MSPIC would ensure all new and ongoing activities are properly communicated, handled, and managed by all COB&R supporting matrix contractors. The MSPIC would not be held responsible for the program deliverables, but would be expected to make sure all impacted components were aware and working toward the same goals.

The following is a synopsis of the activities that would be performed by the MSPIC:

- Program Release Management

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- Change Control Board (CCB) oversight.
- Problem/Change request database support.
- Program-wide implementation plans.
- Project help desk.
- Business Analysis
 - Business Requirement development.
 - Testing and testing support.
 - Documentation development.
- Program-wide Document Management
 - Document management system.
 - Document management administration.
- Security Oversight.
- Quality Assurance Oversight.
- Outreach and Education.

1.4.2. Medicare Secondary Payer Systems Contractor (MSPSC)

The role of the MSPSC is to provide development and support for all information systems for the COB&R contract. This support would include all systems operations and software support. The current contractor and MSPRC contractors maintain separate information systems that utilize similar infrastructures, operating systems, and software development environments. Consequently consolidation of these functions into a centralized environment would help eliminate redundancy, reduce infrastructure costs, and centralize network management and security functions.

The MSPSC would be comprised of the following groups and/or functions:

- Data Center Operations.
- Network Support.
- Systems Security.
- Communication Support.
- Data Management.
- Software Development and Support.

1.4.3. Medicare Secondary Payer Recovery Audit Contractors (MSP RACs)

The MSP RAC functions would include the identification and development of Group Health Plan (GHP) MSP Recovery and Non-GHP recovery cases where ongoing responsibility for medical care exists, and all associated recovery activities, which include, but are not limited to:

- Identifying and developing debts;
- Responding to incoming inquiries;

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- Reviewing and responding to demand defenses and rebuttals;
- Providing litigation and negotiation support;
- Performing all related Debt Collection Improvement Act of 1996 (DCIA) activities;
- Complying with all required financial activities.

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2 Statement of Work (SOW) Overview

2.1. Scope of the COB&R Business Program Operations Center

The scope of the COB&R Business Program Operations Center (–contractor”) is to perform the following high-level functions:

- Call Center operations;
- Mail Room/Imaging operations;
- MSP Assessment and Debt Determination;
- Waivers and Appeals;
- Finance Administration;
- Outreach & Education Activities;
- Debt Collections;
- Data Collection Activities (*i.e.* IEQ, Data Match, COBA, Section 111, etc.);
- Electronic Data Interchange (EDI) Support; and
- Special Projects.

The following lists some of the benefits of the consolidated COB&R:

- **Improved Customer Service:** Under the current COB and MSPRC contractors, customers are often passed to and from the contractors in an attempt to terminate an MSP occurrence or resolve an improper claim denial, for example. The contractor would rectify this situation so that a customer only has to make one phone call to terminate their MSP occurrence and/or correct the improper claim denial. The contractor would generate improved customer services by decreasing the amount of time a customer spends on the phone, ensuring the customer is not provided with conflicting information, and providing such information in a timelier manner.
- **Expanded Flexibility:** The contractor would provide greater flexibility to redirect resources to areas of greatest need. Redistributing Customer Service Representatives (CSRs) in a larger pool of available, capable resources decreases the impact on areas where those CSRs have been removed.
- **Reduction of Misdirected Correspondence:** Medicare beneficiaries view CMS as one entity and may not recognize the nuances of different contractor addresses for these separate programs. Consequently correspondence can be sent to the wrong address and must be resent to the correct address or possibly not be handled

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properly. A combined mail center would improve timeliness by eliminating this issue.

The CMS is employing Federal Acquisition Regulation (FAR) contracting for this solicitation as provided under the MIP. The selected contractor will, under CMS' discretion, perform the COB and recovery functions currently performed by the incumbent contractors; it will not duplicate work performed by other Medicare contractors.

Detailed specifications for carrying out COB and Recovery activities appear in the remainder of this SOW.

2.2. Approach

In this SOW, 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. The contractor's approach shall encompass the following:

2.2.1. COB and MSP Recovery Approach

The primary purpose of this contract is to identify the health benefits available to a Medicare beneficiary, coordinate the payment process to prevent mistaken payment of Medicare benefits, and recover MSP debts owed to the Government. The COB and Recovery approach shall address the soundness of the contractor's methodology for successfully coordinating Medicare benefits and pursuing recoveries. In support of the objective, CMS requires the contractor to maintain data collection activities, and identify and recover MSP debts timely, efficiently, accurately, and reliably, all within the scope and standards of the contract.

2.2.1.1. Customer Service

The contractor shall interact with a wide array of business partners and customers, including beneficiaries, employers, insurers, Third Party Administrators (TPAs), Workers' Compensation (WC) carriers, attorneys and providers, among others. Customer service addresses the ability to provide quality services effectively and efficiently to increase the overall level of customer service and satisfaction. The contractor shall employ a customer service approach that aims to resolve inquiries at the first occurrence, and resolve any issues that might be related to the case in its entirety, and do this with a single point of contact, where feasible. In support of this objective, CMS requires the contractor to:

- Effectively manage relationships with beneficiaries, employers, insurers, attorney and providers, etc. to identify and obtain accurate health benefit data available to a Medicare beneficiary, and coordinate the payment process to

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- prevent mistaken payment of Medicare benefits;
- Effectively manage a relationship with debtors to resolve MSP accounts receivable (AR) related issues timely;
- Maintain a relationship with Treasury to enable CMS to effectively discharge its MSP responsibilities with regard to the Debt Collection Improvement Act (DCIA);
- Promote beneficiary satisfaction with the Medicare MSP program through operational excellence;
- Effectively support CMS in its MSP litigation and negotiation efforts as necessary throughout the course of the contract; and
- Effectively manage a relationship with other CMS-contracted entities that may affect the COB&R's recovery roles and responsibilities in its recovery pursuits (*i.e.*, Qualified Independent Contractors (QICs), Administrative QIC (AdQIC), 1-800-MEDICARE, Medicare claims processing contractors, Regional Offices (ROs), Workers' Compensation Review Contractor (WCRC) and RACs).

2.2.2. Operational Excellence

Operational excellence addresses the quality of information systems, the effects of organizational alignment and the ability of employees to support the accomplishment of organizational goals. The contractor shall:

- Promote corporate integrity and establish internal controls and an effective quality program to achieve contractual goals and objectives; and
- Work collaboratively with CMS, its contractors, and the MSP community to foster the consolidation and the enhancement of Medicare COB& R operations.

2.2.3. Innovation and Technology

Innovation and technology addresses internal business results that lead to financial success and satisfied customers. The contractor shall:

- Promote efficiencies in the administration of the MSP COB&R program to promote the best value for the Government;
- Develop and continually refine business processes to foster excellence and quality in the administration of the Medicare MSP COB&R program;
- Use innovation and creative technological solutions to improve MSP COB&R program operations;
- Make proposals for system enhancements to improve MSP COB&R operations;

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- Make suggestions for MSP COB&R process enhancements with interface components; and
- Enhance the paperless environment and use automation to the maximum extent possible throughout the course of the contract while maintaining financial integrity and sufficient audit trail.

2.2.4. 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. The focus of MIP is on paying the correct amount to legitimate providers for covered services, including the appropriate recovery of mistaken primary payments and conditional payments. Financial management also addresses efforts to promote cost efficiency and the ability to deliver maximum value to the Medicare Trust Funds. The contractor shall promote the fiscal integrity of the Medicare MSP COB&R program and be an accountable steward of public funds.

2.2.5. Risk Mitigation

Risk mitigation involves avoiding situations that would prevent the successful performance of this contract's ongoing operational functions.

2.2.6. Security

Security involves the contractor's ability to comply with CMS data security requirements. In support of this objective, CMS requires the contractor to have a security plan that addresses:

- Physical site and operational security processes in accordance with the Business Partners System Security Manual (BPSSM) (IOM Pub. 100-17) <http://www.cms.gov/transmittals/downloads/R10SS.pdf>, the Program Integrity Manual (IOM Pub. 100-08), and Information Security Acceptable Risks Safeguard Manual (appendices A, B, C and D), found at <http://www.cms.gov/Manuals/IOM/list.asp>
- Hiring practices in compliance with the security measures required in a government contract; and
- Staff trained on security procedures as well as relevant aspects of the Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), and the Freedom of Information Act.

2.2.7. Subcontracting Approach

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Subcontracting addresses the soundness of any outside entities with which the contractor may choose to contract with to perform some of this contract's functions. Note that subcontracting is not required by this SOW; however, should the contractor use one or more sub-contractors, CMS requires the contractor to:

- Obtain consent to subcontract with contractors it proposes to use and the functions each sub-contractor shall perform.
- Demonstrate each sub-contractor's experience related to the functions that it would be performing under the sub-contract.
- The Subcontract Checklist included in Section J will be used to obtain consent to subcontract.

2.2.8. Quality Assurance

Quality assurance addresses the internal controls the contractor shall use as its first line of defense in managing the contract. The contractor shall maintain sufficient internal controls to assure effective and efficient operations, assure the reliability of its financial reporting, and comply with applicable laws and regulations.

2.3. References

The following statutes, regulations, manuals, and documents are applicable to this contract:

- The Social Security Act, as Amended.
- Omnibus Budget Reconciliation Act of 1980.
- OBRA 1981.
- The Tax Equity and Fiscal Responsibility Act of 1982.
- Deficit Reduction Act (DEFRA) of 1984.
- Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.
- COBRA 1986.
- COBRA 1987.
- COBRA 1989.
- COBRA 1990.
- COBRA 1993.
- 1994 Amendments to the Act.
- Balanced Budget Act of 1997.
- Section 301 of the MMA.
- Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).
- The Health Insurance Portability and Accountability Act of 1996.

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- The Benefits Improvements and Protection Act of 2000.

2.3.1. Other Key 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. General statutory authorities with broad implications for the traditional Medicare program and the contract include, but are not limited to:

- Acquisition (*e.g.*, the Federal Acquisition Regulation);
- Financial management and internal controls (*e.g.*, the Federal Management Financial Integrity Act of 1982 [Pub. L. 97-255], the Chief Financial Officers' Act of 1990 [Pub. L. 101-576]);
- Federal Information Security Management Act of 2002 (Public Law 107-347);
- GPRA;
- Personnel and civil rights law (*e.g.*, the Drug-Free Workplace Act [Pub. L. 100-690], the Americans with Disability Act [42 U.S.C. 12101 *et seq.*], etc.);
- The Clinger-Cohen Act of 1996 (formerly known as the Information Technology Management Reform Act; 40 U.S.C. § 1401 *et seq.*);
- The Rehabilitation Act Amendments of 1998, Section 508 Accessibility Standards (29 U.S.C. § 794d);
- The Federal Claims Collection Act of 1966 (Pub. L. 89-508) as amended;
- The Debt Collection Improvement Act of 1996 (DCIA); and
- The Privacy Act of 1974 (Pub. L. 93-579), as amended (–Privacy Act”).

2.3.2. Regulations

The following regulations are of particular relevance:

- 42 CFR Part 411, Exclusions from Medicare and Limitations on Medicare Payment, Subparts B-H;
- 42 CFR 405.900 *et seq.*: See particularly the sections on what is an initial determination, what is not an initial determination, reopening/good cause; and
- 42 CFR Part 405, Subpart C, for regulations relating to § 1870 waiver of recovery.
- 42 USC 1395y(b)(7)&(8), Separate mandatory reporting requirements for group health plans (GHPs) and non-group health plans (NGHPs).
- 42 USC 1395y(b)(5)(D).
- 42 USC 1395w-102(b)(4)(D)(ii).
- 42 CFR 489.20(f)&(g).

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2.3.3. Medicare Manual

The Medicare Internet Only Manual (IOM) is comprised of CMS program instructions, day-to-day operating instructions, policies, and procedures that are based on statutes and regulations, guidelines, models, and directives. The CMS program components, providers, claims processing contractors, and State survey agencies use Medicare manuals to administer CMS programs. The IOMs can be found at www.cms.gov/Manuals/IOM/list.asp. The contractor shall adhere to those sections of the IOM relevant to its roles and responsibilities as cited herein.

2.3.4. Other References

The contractor shall use the following references or mutually agreed to references in its performance of various requirements:

- Medicare Integrity Program (MIP)
<http://www.federalregister.gov/articles/2007/08/24/E7-16606/medicare-program-medicare-integrity-program-fiscal-intermediary-and-carrier-functions-and-conflict>.
- Medicare Administrative Contractor (MAC) Directory
http://cms.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf.
- MSP CWF Process <http://www.cms.gov/manuals/downloads/msp105c06.pdf>.
- X12 Implementation Guides www.x12.org.
- COB website www.cms.gov/COBGeneralInformation/;
- 1-800-MEDICARE www.cms.gov/1800medicare/;
- CMS Investment Life Cycle <http://www.cms.gov/ILCPhases/>.
- ReMAS email address ReMAS@cms.hhs.gov.
- Freedom of Information Act (FOIA) www.cms.gov/FOIA/.
- MMSEA Section 111 Mandatory Insurer Reporting
www.cms.gov/MandatoryInsRep.
- Management of Federal Information Resources
http://www.whitehouse.gov/omb/circulars_a130_a130trans4/#main-content.
- Management Accountability and Control
http://www.whitehouse.gov/omb/circulars_a123/.
- Disposal of Records and Records Management
<http://uscode.house.gov/download/pls/44C33.txt>.
- WCMSA Sample Submission/Checklist
<http://www.cms.gov/WorkersCompAgencyServices/downloads/samplesubmission.pdf>.

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3 Functional Requirements

Each requirement section presents the following information:

- Requirement number—unique number identifying the requirement;
- Requirement name and description—descriptive title and text conveying the requirement (a few sections contain only a requirement name, relying on subsections to describe requirements); and
- Background—information providing the context for a requirement (background information is provided as needed) and its standards.

3.1. Infrastructure Requirements

The contractor shall operate from 8:00 a.m. through 8:00 p.m. Eastern Time, Monday through Friday. The contractor is not required to operate on the 10 Federal holidays: New Year's Day, Martin Luther King, Jr.'s Birthday, Presidents' Day, Memorial Day, Independence Day, Labor Day, Veteran's Day, Columbus Day, Thanksgiving Day, and Christmas Day. The contractor shall submit their planned schedule to CMS 20 days after award of the contract or exercise of an option year. After approval, the contractor shall post their hours of operations to customers. Deviations to the hours of operation shall be approved by the Contracting Officer (CO) and Contracting Officer Representative (COR).

All contractor systems shall be up and running and may not be scheduled for periodic maintenance during this time period. The contractor shall not schedule any internal system maintenance during operational hours unless otherwise specified or authorized by the COR. The contractor shall allow CMS access to designated MSP specific business applications at any time during the operating hours. The contractor's infrastructure shall be available 98 percent of the time during all required hours of operation. This percentage excludes time related to issues with CMS MDCN enterprise, MSPSC, and CMS hosted or controlled applications

The contractor shall proactively notify CMS of any developing situation that may impact operations, service to customers, or any other contractual issue. The contractor shall advise CMS, in advance whenever possible, of any indication that a potential problem may be developing. In the case of a known impending problem, the contractor shall be forthcoming with CMS to address the risks and to identify mitigation strategies.

3.1.1. Local Hardware and Software Requirements

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The contractor shall provide hardware, software, and any materials necessary to accomplish the requirements within the contract. This requirement does not refer to systems and applications supported by the MSPSC (refer to Appendix 1 – Available CMS/COB&R Systems List).

The contractor shall report each incidence of non-scheduled MSP system downtime to the CMS COR within 30 minutes of each such occurrence, as well as reporting the resumption of normal service within 30 minutes of that event. Notifications shall be provided by phone and email during normal business hours and email outside of normal business hours.

The contractor shall assume responsibility for the maintenance of its internal systems (not supported by the MSPSC), including regularly scheduled quarterly and ad-hoc enhancements. The contractor shall document all of the effects/impact of the system changes using a change management process and take an active role in the change control process by:

- Scheduling meetings;
- Soliciting topics;
- Tracking recommended changes;
- Providing cost analysis of the proposed changes or enhancements;
- Obtaining approval of change requests from CMS;
- Coding the changes/enhancements into its internal systems; and
- Creating a test plan for, testing, and implementing.

3.1.2. Medicare Data Communications Network (MDCN)

The CMS currently uses the Medicare Data Communications Network (MDCN) as its data communications network (more information is available online, currently at <http://www.cms.hhs.gov/AccessstoDataApplication>).

MDCN telecommunications services are frame-based T-1 services. The contractor shall provide a gateway to its internal LANs in order to effectively interface with T-1, frame-based telecommunications technology, unless otherwise negotiated. The contractor shall also support the upgrade of the frame-based technology to the Multiprotocol Label Switching (MPLS) target architectures.

The contractor shall designate a program point-of-contact (POC) and a technical POC to initiate, focus, and facilitate MDCN connectivity. These POCs shall have the authority to represent/bind the contractor within the scope of data communications operations and supporting environments. The Office of Information Services (OIS) in

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CMS is responsible for the MDCN contract and serves as the collection and liaison point for all new/revised data communications needs.

The contractor shall submit connectivity requests as needed to OIS at MDCN@cms.hhs.gov and complete the technical information exchange necessary with the OIS MDCN POC technical representatives. At the time of the request, CMS shall supply the contractor with names of authorized MDCN POCs.

The OIS MDCN POC, the contractor, and the CMS segment transition manager shall establish regular teleconferences to accurately and timely communicate all data communications needs and to obtain a prompt installation. When all specifications and requirements are complete, the MDCN POC is contractually required to provide data communications within 60 calendar days.

The contractor shall have all facility leases signed and arrangements made for the local telephone company and/or MDCN POC to have access to buildings to install lines and/or equipment.

The contractor shall grant the MDCN POC access to equipment on its premises for installation, troubleshooting, and maintenance activities.

The contractor shall identify any modifications to its data communications network requirements, throughout the tenure of the contract, as a result of changes to its workload and shall timely communicate those needs to OIS through established protocols.

Notes:

- The MDCN POC is dependent upon the local telephone company to install lines. The local telephone companies maintain their own schedules and may not be able to meet a customer's particular need for expedited installation and service.
- Requirements-gathering shall include an interactive review process among the contractor, OIS, and its MDCN POC.

3.1.3. Telecommunications

The contractor shall establish a Toll-Free Telephone Service (TFTS) using a Verizon NETWORKX toll-free number that will be provided by CMS not later than 40 business days after the effective date of the contract.

All systems related to inbound calls shall be appropriately programmed to acknowledge each call within (20) seconds before an agent, Interactive Voice Response (IVR) Unit or Automated Call Distributor (ACD) prompt is reached.

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The contractor shall also provide the following TFTS data monitoring and reporting capabilities:

- Total calls offered (from all sources), daily, weekly, monthly, quarterly and annually.
- Total calls answered (from all sources, including Spanish callers), daily, weekly, monthly, quarterly and annually.
- All Trunks Busy (ATB) rate, daily, weekly, monthly, quarterly, and annually
- Average speed of answer, calculated every 30 minutes.
- Abandonment rate, calculated every 30 minutes.
- Average length of call, calculated every 30 minutes.
- Total number TDD calls answered (record and report separately), daily, weekly, monthly, quarterly and annually.
- Other call and operational statistics (as requested by CMS).

3.1.3.1. Telecommunication System Requirements

The contractor shall use the following telephone functions to efficiently and effectively manage and handle incoming calls:

- Interactive Voice Response (IVR) - Allows customers to interact with a company's database via a telephone keypad, after which they can service their own inquiries by following the IVR dialogue. IVR systems can respond with prerecorded or dynamically generated audio to further direct users on how to proceed. IVR applications can be used to control almost any function where the interface can be broken down into a series of simple interactions.
- Speech Recognition - A solution that refers to technology that can recognize speech without being targeted at single speaker. This technology can be used in conjunction with IVR.
- Computer Telephony Integration - technology that allows interactions on a telephone and computer to be integrated or coordinated. Functions should include:
 - Screen popping.
 - Automatic dialing.
 - Phone control (answer, hold, hang-up, conference, etc.).
 - Transfers.
 - Automatic call routing.
 - Voice recording.
 - Call Reporting functions.

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3.1.3.2. CMS Offsite Monitoring Capability

The contractor shall provide CMS with the capability to access the call system directly at its discretion in order to monitor telephone calls.

3.1.3.3. Local Telephone Service Connections

The contractor shall be responsible for voice communication services; the MDCN only supports data communication. The contractor shall ascertain that the local telephone company is aware of its implementation schedule and that voice and data communication installations are coordinated. It should be noted that the lead time for local phone system installation could vary widely; the contractor shall allow sufficient time for system setup.

3.1.4. Federal Telecommunications System 2001 Network

The CMS will provide and pay directly for the network services necessary to use and maintain the TFTS. The Government currently uses the Verizon NETWORKX network through a General Services Administration blanket contract. The CMS, as a designated user of NETWORKX, will order the necessary network services.

The contractor shall meet all NETWORKX interface requirements as defined in the most recent General Service Administration (GSA) contract. The contractor's telephone system should be designed to avoid service outages. The contractor shall interface its system with lines and trunks at both user and network levels. User-level interfaces include basic station lines, local area networks, and digital connections on a station-to-station basis; network-level interfaces include both analog and digital trunks into NETWORKX

The contractor shall use telecommunications equipment that is compatible with the NETWORKX network, including equipment that can interface with T1 facilities.

In addition to the transmission facility, NETWORKX will provide all end-to-end switching, network termination equipment, and the Channel Service Unit (CSU) demarcation point. NETWORKX provides end-to-end facility maintenance and testing. The contractor will have 24 hour access to the NETWORKX help desk. The contractor is responsible for all inside connectivity from the point of demarcation and shall perform all necessary set-up activities related to these items.

The contractor's TFTS shall provide TDD. The contractor shall also provide security to prevent unauthorized intrusions into the TFTS.

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In case of commercial power failure, the contractor shall provide a backup power system design with a minimum capacity of 120 percent based on the maximum main station and service requirements forecast for the projected life of the system. For commercial failure, there must be an uninterruptible power supply for a minimum of 8 consecutive hours for the call distribution system.

The contractor shall secure local service for its facility (-ies). The contractor shall also, based on applicable tariffs and in coordination with the Local Exchange Service (LEC), establish the demarcation point between contractor provided equipment and equipment which LEC and other carriers provide. The contractor shall interface the on-premise equipment with all circuits and facilities provided by the LEC to meet the connectivity requirements of this contract. The contractor shall conform its line and trunk terminations associated to United States Telephone Association and Bellcore standards.

The contractor shall provide and maintain equipment and telecommunications support necessary to communicate with beneficiaries and other parties and CMS representatives using modems, fax machines, internet, and any other telecommunications devices CMS deems necessary.

The contractor shall timely communicate to CMS any network or other communications outages, as they occur, and maintaining the necessary means of communication with telecommunications vendors to remedy problem situations. The contractor shall, whenever necessary, escalate remedial procedures within vendor organizations.

The contractor shall accommodate, to the best of its ability, any new equipment and/or network requirements, resulting from a change in telecommunications vendors, standards, or CMS needs.

The contractor shall promptly communicate to CMS any concerns, issues, or problems it is experiencing with NETWORKX Network services. If the contractor TFTS becomes inoperative during working hours for more than 10 minutes, the contractor shall immediately notify the COR and provide regular updates until the problem is corrected.

3.1.5. Secure Email Application

The contractor shall use the CMS provided or a CMS approved secure email application for transmissions with CMS and with Medicare contractors that have application access, including email attachments. The contractor shall use a secured email service when transmitting emails that include Protected Health Information (PHI) such as beneficiary Social Security Numbers (refer to HIPAA to learn about PHI) and/or other similarly sensitive or confidential information (e.g., information

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covered by the Privacy Act).

For additional guidance, please refer to the:

The *CMS Information Security (IS) Acceptable Risk Safeguards (ARS)* which establishes the minimum IS thresholds for CMS to be in compliance with the National Institute of Standards & Technology (NIST) Special Publication (SP) 800-53, *Recommended Security Controls for Federal Information Systems*.

<http://csrc.nist.gov/publications/nistpubs/800-53-Rev3/sp800-53-rev3-final.pdf>

3.2. Records Requirements

3.2.1. Definition of Records/Files

–Records or Files” are papers, or folders of papers, photographic copies, magnetic tapes, or other recorded information regardless of physical form or characteristics (including imaged information), accumulated or maintained in filing equipment, boxes, or shelves, and occupying office or storage/warehouse space (including electronic storage) accumulated by the contractor during the duration of the contract.

For the purposes of this section, there are four categories of records:

- A. GHP and NGHP files containing all electronic and written communications (incoming and outgoing) specific to the COB activities, and recovery and resolution of an MSP debt;
- B. Administrative and fiscal records;
- C. Litigation and negotiation support records; and
- D. Miscellaneous.

3.2.2. Disposition of Records

The contractor shall return and/or dispose of Categories A, B, C and D records per CMS instructions at the end of the contract.

3.2.3. Records Management Program

Subject to the provisions of CFR Title 41, CMS is responsible for the development and implementation of standards and programs for the economical management of records under the health insurance program. Specifically, CMS is required to provide for effective controls over the creation of records, including the making of records containing adequate and proper documentation of the contractor’s administration and operations. The contractor shall establish and maintain a continuing program for the

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economical and efficient management of COB records and MSP recovery records.

The files the contractor establishes, the records and procedures documenting the contractor's record creation, maintenance, use, selective retention, and disposal programs are subject to CMS' periodic review. "Files" are electronic documents, emails, CDs and DVDs, papers, folders of papers, fiscal and administrative records, photographic copies, magnetic tapes, imaged records, or other recorded information (not including stocks of publication), which, regardless of physical form or characteristics, are accumulated or maintained in databases, computer hard drives, CDs and DVDs, filing equipment, boxes, or shelves, and occupying office or storage space.

The incumbent contractor has retained extensive image files developed from information gathered as a result of the various MSP data collection and recovery activities. These image files will be transitioned and stored in a central COB&R system, and access will be provided by the MSPSC.

3.2.3.1. Implementing a Records Management Program

To fulfill these objectives, the contractor's records management program shall provide for:

- Effective controls over the creation, organization, maintenance, use, and disposition of all CMS documentation and related materials;
- Adequately recording important policies and decisions, keeping routine operational paperwork to a minimum, and preventing the accumulation of unnecessary files (effective techniques in this area include applying systems for the control of case files and correspondence, minimizing duplicate files and disposing of materials that have no value for record purposes);
- Developing and applying standards, procedures, and techniques designed to assure the maintenance and security of records of continuing value, and facilitating the segregation and disposal of all records of temporary value;
- Continually analyzing and improving record classification and indexing systems, using filing equipment and supplies, and reproducing and transporting records and maintaining records economically and efficiently for maximum usefulness;
- Physically safeguarding identifiable personal information (see the Privacy Act) and PHI (see HIPAA); and
- Storing and servicing records in a safe and secure environment which meets the requirements outlined in 36 CFR 1228.222.

The CMS has found the following features characterize a sound records management program:

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- Standardizing classification and filing plans to achieve maximum uniformity and ease in maintaining and using program records, and facilitating the disposal of records in accordance with applicable record retention schedules issued by CMS;
- Formally selecting official file locations and prohibit the access of files by other than authorized personnel;
- Standardizing reference service procedures to facilitate the finding, charge-out, and re-filing of records;
- Establishing and implementing standards and procedures issued by CMS for:
 - Classifying, indexing and filing records,
 - Providing reference services to filed records,
 - Locating active files to facilitate use of the records; and
 - Reviewing the program periodically to determine the adequacy of the system;
- Making the standards, guides, and instructions developed for the records management program readily available to all employees concerned with the files operations. In addition, pertinent information for users of files and reference services should be given the widest possible dissemination;
- Filing documents on a daily basis; and
- Periodically auditing a representative sample of files for duplicates or misclassifications.

The contractor shall develop a Record Retention Plan (RRP) within 40 business days of contract award and annually thereafter.

3.2.4. Documentation

The contractor shall furnish a set of documentation for any system supported by this contract. The contractor shall include at least a User Manual, a System Administrator Manual, and a System Manual in each set. Each manual shall be a complete guide to the performance of all activities associated with a discrete task. The manuals shall progressively describe, in narrative fashion, each step involved in performing their tasks' activities. The contractor shall organize each manual by discrete activity and shall include a comprehensive table of contents and index so as to direct readers to proper procedures for each activity and to permit the incorporation of new instructions and revisions without having to rewrite or reorder the entire manual. The contractor shall divide each manual into logical sections or chapters organized around discrete tasks. The contractor shall use each manual in conjunction with its training and shall provide each system user being trained with a copy of the manual(s) or section(s) that address his or her task(s).

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3.2.5. Document Library

The contractor shall maintain a library of all administrative and system related documents and shall make it accessible to CMS staff designated by the COR. The contractor shall coordinate and provide the MSPIC with a copy of all administrative and system related documents to be controlled and maintained in the MSPIC document management system.

3.2.6. Imaging

The contractor shall scan all paper documents and maintain the capability to generate electronic versions of all correspondence it issues related to the work activities it performs under this contract. The electronic version/copy image shall become the ~~official~~ recordkeeping copy.” The contractor shall verify and document that the scanned images are identical replications of the scanned paper documents. Electronic images or generated electronic copies shall be used to satisfy any investigation, litigation, and/or negotiation support request. Images of scanned documents must be readable whether using an online display or a paper copy printed from that display. The MSPSC shall be responsible for the accessibility and ability for the associated COB&R contractors to read the document.

The contractor may utilize the most up to date imaging systems available to scan and store all correspondence, including the envelope when a check is enclosed, specific to recoveries or potential recoveries. It is also important that any imaging device used must not allow for any deterioration of the images and that all images can easily be transmitted to the backend central image repository. The contractor shall make imaged documents accessible and readable until confirmation of receipt by the central image repository. Any documents that are received electronically must be stored in a secure, non-deteriorating, and retrievable environment.

The contractor shall use a quality assurance process to verify that scanned documents are exact duplicates of the originals and, once verified, shall destroy original source documents according to prescribed document destruction protocol. The accumulation period may be daily, weekly, or monthly, depending on volume. The contractor shall coordinate document destruction with the COR.

Upon request, the contractor shall accommodate document requests from entities for hardcopy cases.

The CMS will provide for the transfer of the incumbents image files to the successful offeror within 130 business days of the effective date of the contract. The contractor shall provide the capability to access and use these files when necessary.

The contractor shall image any documents transitioned from the incumbent contractor

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upon receipt.

3.2.7. Document Destruction Processes

In 1992, the Department of Justice (DOJ) requested CMS to indefinitely preserve all current and future Medicare claims payment records and supporting documentation for MSP cases. However, because of the rising costs to store these Medicare documents, and the FRC directive, the DOJ has agreed that ***an electronic image of the document is an acceptable method of storage***. The directive affects all records/documents associated with Medicare Secondary Payer (e.g., Initial Enrollment Questionnaires (IEQ), Data Match, MSP Investigations, associated correspondence, etc). The contractor shall adhere to this directive and, therefore, shall not destroy any electronic documents.

3.2.7.1. Paper Documents

The contractor shall establish and implement a quality assurance (QA) process, which ensures the image copy of the document is an identical replication of the paper document and can be read and retrieved. The CMS shall receive, review, and approve the QA process prior to the destruction of documents.

The contractor shall control these image copies for easy accessibility (e.g., control by date of correspondence, work activity, beneficiary's health insurance claim number, etc.) and shall maintain these scanned images as the official "recordkeeping copy."

The contractor shall perform quarterly reviews, due on a date to be determined and provided to CMS, of randomly selected scanned documents from **each** work activity to ensure that the scanned documents are still retrievable and can be read **prior to the destruction** of, CDs, DVDS, correspondence/documents, questionnaires, etc.

The contractor shall provide CMS with a Retrievability and Readability Image Report, which shall be included in the contractor Monthly Status Report. The contractor shall inform CMS immediately of any failure to retrieve and/or read images and provide CMS with daily updates, as necessary, until the relative problem is suitably resolved.

The contractor shall be responsible for the destruction of these CDs, DVDs, correspondence/documents, questionnaires, etc. To provide further clarification, documents related to establishing a Workers' Compensation (WC) MSP record, other than a Workers' Compensation Medicare Set Aside (WCMSA), shall be destroyed after the above parameters have been met; however, **WCMSA and**

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related documents maintained on the WC Case Control System (WCCCS) shall not be destroyed.

IEQs received electronically from the MyMedicare.gov Web portal in a file format are the official record keeping copy since no hard copy of the IEQ exists.

The contractor is instructed to commence shredding all MSP related documents four (4) months and older, providing the parameters as stated above and any other requirement listed in this SOW have been met.

Prior to destroying documents the contractor shall submit a document destruction plan to the COR, at least 20 business days prior to the planned destruction. The plan shall delineate the name of the company hired to destroy the documents, where the documents will be destroyed, the method of destruction, and the proposed date of destruction. A document destruction schedule should be sent to the COR at the beginning of each calendar year identifying the dates of destruction. Once the request and schedule is approved, CMS may make arrangements to have staff present to witness the initial destruction. The contractor shall notify CMS when the next retention period has expired. In the event that CMS cannot witness the document destruction, it will provide the contractor with written authorization of a representative. The regulations at 36 CFR Section 1228.58 state that ~~the~~ wastepaper contractor must be required to pulp, macerate, shred, or otherwise definitively destroy the information contained in these records, and their destruction must be witnessed either by a Federal employee, or if authorized by the agency that created the records, by a contractor employee.”

The CMS reserves the right to conduct periodic on-site visits to the facility to check for compliance with the above requirements.

The contractor must follow all requirements of the Internal Revenue Service (IRS) in regard to the handling and destruction of any Federal Tax Information (FTI). These requirements can be found in Publication 1075 (<http://www.irs.gov/pub/irs-pdf/p1075.pdf>) (destruction processes are detailed in Section 8 of this document).

3.2.8. Record Retrieval

The contractor shall retrieve MSP documentation (e.g., IEQ questionnaires, Data Match questionnaires, etc.) and/or retrieve and/or recreate case files. The volume of this kind of activity is expected to be low and the scope generally narrow.

Within 7 calendar days of the request or a mutually agreeable due date, the contractor shall supply 95 percent of requested case files to the COR.

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3.2.9. Correspondence and Mailroom Requirements

The contractor shall establish a scan, print, and mail sites to be used for all incoming and outgoing correspondence or documentation used in the course of this contract. The contractor shall comply with all operational requirements specific to the classification of the correspondence or request received.

The contractor shall resolve and/or respond to a variety of correspondence, including general inquiries regarding a beneficiary MSP claim or record, responses to correspondence issued by CMS, recovery case-specific inquiries, rebuttals to recovery demand letters for individuals/entities which lack formal administrative appeal rights, appeal correspondence, requests for waiver of recovery pursuant to § 1870 of the Act, unsolicited/voluntary refund checks, and checks in response to a recovery demand letter. The contractor shall resolve and/or appropriately respond to all correspondence in the required timeframes below.

The contractor shall resolve 95 percent of all correspondence, except checks, within 45 calendar days (unless directed otherwise, depending on the type of correspondence). This includes misrouted correspondence, based upon the contractor receipt date, that the contractor shall transfer to the Medicare claims processing contractors including MACs and DME/MACS.

For incoming correspondence and documentation, the contractor shall develop procedures to scan, triage, and forward images to the MSPSC. The contractor shall also develop procedures to support the images received from the MSPSC, and produce those images for distribution (i.e. - printing, mailing, etc.).

The contractor shall not issue an interim reply when information responsive to the inquiry is available. An ~~interim reply~~ refers to requesting, via paper correspondence, further clarification or correction to existing correspondence. The contractor shall document attempts to resolve the issue via phone in the contractor's recovery systems. Failed attempts may result in additional correspondence.

3.2.9.1. System Generated Letters and Mailings

The contractor shall implement quality control measures to assure that letters requested from the contractor are printed in an accurate and timely manner (e.g. language, pages or letter attachments are formatted correctly and/or not omitted). The contractor shall notify the COR, immediately upon discovery, of any issues/problems detected with all aspects of system generated letters.

3.2.9.2. Disposition of Misdirected Inquiries and Mail

The contractor will receive correspondence that has been misdirected (i.e., items

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having no relation to the COB&R program or tasks set forth in this SOW). The contractor and its subcontractors shall immediately forward these items to the appropriate entity using CMS-supplied referral lists. The CMS will provide these lists to the contractor at the time of contract award.

3.2.9.3. Postage

The CMS will pay the U.S. Postal Service directly for postage. The contractor shall keep abreast of any changes in U.S. Postal Service regulations and procedures or in technology requirements that might offer more economical mailing rates, and take advantage of any such changes.

3.2.10. Information Resources

The contractor shall return all Government-furnished products to CMS at the contract end. All data, methods, processes, and systems that are developed by the contractor or received from the Government as a result of this contract are the property of the Government (see FAR 52.227-14, *Rights in Data—General* and 36 CFR 1222.48 – *Data Created or Received and Maintained for the Government by Contractors*). This also includes systems documentation and software for systems developed to perform the functions under this contract. Systems documentation includes, but is not limited to, user guides/manuals, operating and other manuals, or technical documentation needed to understand the systems (system, user, and release documentation), source code, data language, architectural changes, updates and specifications, whether in print or machine readable media, in effect, and supplied to customers under this contract for use with any software or component, including all additions, updates, or modifications.

At the end of this contract, the contractor shall turn over to CMS, in their entirety: 1) all information resources as described above and Government-furnished products that CMS provided, 2) all products created, maintained and updated by the contractor, and 3) all information resources developed in support of this contract. The contractor shall *not* keep any information resources or copies of information (including images) without the expressed written consent of CMS.

3.3. Program Management Requirements

3.3.1. Program Management Reporting

The contractor shall provide a monthly status report. The monthly status report shall be provided to CMS by 15th day of each month. The monthly status report shall include a summary of activities transpiring during the reporting month. Issue, and

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concerns with the performance of the project shall also be include. Refer to Appendix 7 – BPOC Monthly Status Report Components for a list of reporting items that shall be included in the monthly status report. Information provided in these report (except call center activities) can be attained from reports produced by existing systems.

The contractor shall participate in a bi-weekly status meeting with CMS. At the digression of CMS, a one-on-one meeting between the COR and Program Director shall be established on a regular basis.

The contractor shall participate in a COB&R program status meeting with all COB&R component contractors and CMS. The COB&R Program Status Meeting will be held on at least a monthly basis.

3.3.2. Quality Assurance and Continuous Improvement Program

The CMS is committed to ensuring that all interactions with internal and external parties are timely, accurate, complete, and consistent.

The contractor shall:

1. Design a comprehensive quality control program;
2. Submit the program to the COR for approval; and
3. After approval, use and maintain the program in order to meet the requirements of this contract.

The contractor's comprehensive quality program shall include, but is not limited to:

1. Documenting procedures and processes to meet contract performance requirements;
2. Providing and maintaining an inspection and audit system to meet contract performance requirements;
3. Providing a method of identifying nonconformance or deficiency in the quality of services performed;
4. Providing a formal system to implement and track progress of corrective actions to completion;
5. Making improvements in its business process in accordance with the quality improvement plan and detailing the effectiveness of those changes;
6. Providing a file of all quality records relating to inspections and audits conducted by the contractor, CMS, or any investigative agency, and the corrective action implemented; and
7. Providing for Government inspections and audits while work is in process or complete.

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3.3.2.1. Quality Improvement Plan

The contractor shall develop and implement a quality improvement plan that encompasses the requirements in this SOW, and submit the plan to the COR no later than 40 business days after award of the contract. The CMS will respond to the draft plan within 20 business days of its receipt. The contractor shall submit a final plan to the COR no later than 10 business days after receiving CMS' comments.

If CMS exercises an option for a subsequent year, the contractor shall submit draft updated plans to the COR no later than 40 business days after the effective date of the exercise of an option year. The CMS will respond to the draft within 20 business days of its receipt. The contractor shall submit final plans to the COR 10 business days after receiving CMS' comments.

3.3.2.2. Continuous Quality Improvement

The contractor shall continuously improve the quality and efficiency of its MSP Data Collection and Recovery functional operations under the contract. The contractor shall provide a quarterly Process Improvement Report to the COR. The contractor shall also review all of its processes and procedures at least once a year.

3.3.2.3. Future Enhancements Report

The contractor shall provide an annual Future Enhancements Report that covers any recommended changes or improvements. The contractor shall submit its recommendations for future enhancements to the COR, by the last business day of the seventh month after the effective date of the contract. At a minimum, the report shall include complete, objective answers to the following questions:

- What is the cost of making the recommended changes?
- What are the benefits to be derived from making the changes?
- What is a reasonable time frame for completing the enhancements?
- How will outcome(s) be measured?

The contractor shall evaluate frequently asked questions it receives to identify opportunities to improve the MSP identification and recovery processes. The contractor shall also address ways to improve its internal customer support services. If a contract option year is exercised, the contractor shall submit the Future Enhancement Report by the seventh month after the effective date of the exercise of the option. CMS will respond to the recommendations within 30 business days of receipt of the report.

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3.3.3. Capability Maturity Model Integration (CMMI) Registration

CMMI is a process improvement approach with the goal to help organizations improve performance. CMMI defines practices that businesses have implemented on their way to success. Practices cover topics that include eliciting and managing requirements, decision making, measuring performance, planning work, handling risks, and more.

If the contractor is not compliant with CMMI-SVC (CMMI for Services) level-3 at the time of the contract award, the Contractor shall:

1. Develop a draft project plan within 60 business days after award of the contract, to achieve CMMI-SVC level-3.
2. Share their project plan with the MSPIC and adhere to overall COB&R plan to achieve CMMI level-3 compliance.
3. Attain CMMI-SVC level-3 within 18 calendar months after the award of the contract.

Upon attainment of CMMI-SVC level-3 compliancy, the contractor shall perform the necessary activities to continue level-3 compliancy.

3.3.4. Internal Training and Education

The contractor shall provide trained, knowledgeable staff and shall continuously monitor, manage, and control the work such staff perform. The contractor shall make its best efforts to retain staff members with valuable contract experience and to minimize staff turnover.

The contractor shall train its staff to satisfactorily perform their duties (*e.g.*, customer service procedures). This may require staff training in specific CMS-related subjects. The contractor shall also train its staff regarding system upgrades (not supported by the MSPSC) and changes in Medicare law or CMS policy. Training related to systems supported by the MSPSC shall be provided by the MSPIC and/or MSPSC.

A training plan shall be developed 40 business days after award of the contract and provided to CMS. An updated training plan shall be required annually thereafter.

The contractor shall, in 10 business days after requested, furnish the COR with formal documentation of the training provided to each labor category under the Contract, including testing tools for determining if individual employees have achieved competence in their labor categories.

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The contractor shall be responsible for the training and development of all staff. The CMS may provide national training materials, and the contractor shall utilize the materials, for training Customer Service Representatives (CSRs) on the Medicare program, policies, use of CMS web tools (e.g. Prescription Drug Benefit tool), orientation to CMS websites and publications, CMS next generation desktop content and functionality, privacy, quality customer service and other relevant topics. The contractor may be required to develop additional training materials to meet the requirements of the task order.

The contractor shall provide experienced instructors to deliver training to CSRs. Train-the-trainer programs to address CMS-provided materials will be provided by a CMS-designated contractor; however the contractor shall ensure that instructors have a baseline knowledge of contact center operations and Medicare knowledge prior to participating in train-the-trainer classes.

All customer service staff shall successfully complete training based on criteria defined in individual task orders. The contractor shall be responsible for their own internal training. The contractor shall use proven processes and tools to provide tracking and analysis of assessment results and CSR performance to insure continuous improvement of training and training materials. The contractor shall work closely with the CMS national training contractor to provide feedback for continuous improvement of the training materials.

In addition to job-specific or professional training, the contractor shall train employees on ~~contract-specific~~ issues such as DHHS ethics, standards of conduct, individual conflicts of interest, organization conflicts of interest, confidentiality requirements, CMS security requirements and sexual harassment prohibitions, the CMS-specific processes and terminology used under this contract, the tasks performed under this contract, and the importance of quality control, QA, and Continuous Quality Improvement (QCI). In addition, the contractor shall educate its managers as to the terms and conditions of the contract. The contractor shall conduct ongoing training, including refresher or remedial training, to maintain a high level of customer service and operational performance.

3.3.5. Workforce Management

The contractor shall schedule CSR work times and shifts to maximize operational efficiencies. In a multi-contractor environment, the contractor shall collaborate with other contact center contractors as required to ensure staffing levels are sufficient to meet the entire CMS beneficiary forecasted call volume.

The contractor shall adjust staffing and scheduling as necessary to meet fluctuating contact volumes while maintaining performance metrics during constant and peak states. Unforeseen events, such as new Medicare legislation, media coverage of

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issues or activities by interest groups, may spike call volumes unexpectedly with little warning.

3.3.6. Freedom of Information Act Requests (FOIA Requests)

The contractor shall analyze all requests from members of the public for records/information within its files in accordance with FOIA and all CMS laws, regulations, instructions, and directives. Written requests for records from members of the public are treated as FOIA requests. In addition, legal requests in the form of non-Federal Court Subpoena Duces Tecum (*i.e.*, Subpoenas for records) also are treated as FOIA requests. The following kind of requests and non-Federal Court Subpoenas directly received by the contractor as the result of MSP activity, shall be processed by the contractor such as written requests and subpoena's from a beneficiary's attorney or other representative, both of whom must submit a beneficiary's written and signed authorization to release records.

If the contractor receives any other kind of a subpoena or a written request for records, it shall immediately refer the request and all associated documentation to the COR. The COR will make a determination as to how to handle the subpoena and/or the FOIA request. When the contractor receives a verbal request for records from an individual or entity other than the beneficiary's representative, it shall advise the caller that his/her request must be made in writing and submitted to the COR at CMS. The contractor shall address all beneficiary specific FOIA requests and Subpoenas from a third party as a possible MSP lead and take appropriate action.

A FOIA Request Log shall be submitted on the 5th business day each month for activity occurring during the previous month.

3.3.7. ICD-10 Diagnosis Conversion

CMS has determined that it will convert from ICD-9 diagnosis codes to ICD-10 diagnosis codes by October 1, 2013 using a phased implementation approach. The contractor shall implement any procedural changes necessary to support this migration to ICD-10 and provide training for procedural changes. The MSPSC will be responsible for converting all systems changes. The MSPIC will be responsible for providing training on system modifications. System changes must be finalized to allow end-to-end testing with the Medicare shared systems by April 1, 2013. The contractor shall provide status updates on all activity related to this migration to CMS on a monthly basis.

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3.4. Customer Service Requirements

3.4.1. Call Center Overview

The contractor shall provide an efficient call center operations to handle all types of MSP inquiries from a wide array of business partners and customer, including beneficiaries, employers, insurers, TPAs, WC carriers, attorneys and providers, among others. The primary contact channels used by beneficiaries and other MSP stakeholders are telephone and written correspondence. However, the call center may be required to handle inquiries by fax, email, or text chat and other channels.

Inquiries will generally involve questions regarding:

- MSP data collection functions (e.g. IEQ; IRS/SSA/CMS Data Match, Voluntary Report, Self-Reporting; 411.25 Notifications; Secondary Claims Development, COB Agreement (COBA) program; and MMSEA Section 111 Reporting.)
- Identification and collection of Non-Group Health Plan (NGHP) MSP recovery claims, as well as all related associated activities including Conditional Payment Amount development (authorization review, case filtering, and letter issuance);
- Demand development, including claims dispute resolution, settlement data entry, pro rata reduction application, where appropriate, and demand letter issuance;
- Re-openings, appeals, waiver of recovery requests, valid documented defenses;
- Recovery claim (debt) collections and reconciliations;
- General litigation support;
- Freedom of Information Act Requests;
- Other Medicare related inquiries or concerns

3.4.2. Call Center Operations

The contractor shall have adequate language capabilities (English; Spanish; and TDD) to handle telephone communications with all stakeholders. The contractor shall utilize an approach that focuses on first call resolution and minimize the number of repeat or follow up calls.

The contractor shall schedule Customer Service Representative (CSR) shifts to maximize operational efficiencies to meet call volumes throughout the day. The contractor shall quickly adjust staffing and scheduling as necessary to meet fluctuating call volumes and maintain performance metrics during steady and peak volumes. Unforeseen events, such as new Medicare legislation, media coverage of

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issues or activities by special interest groups, may spike inquiry volumes unexpectedly with little warning. The contractor shall work with CMS to accommodate these spikes.

The contractor shall adhere to the following service level agreements:

1. Monthly All Trunks Busy (ATB) Rate shall not exceed 20 percent of all calls.
2. The Average Speed of Answer (ASA) shall be maintained at an average of 5 minutes.
3. Monthly call completion rate of no less than 95 percent of calls received; abandonment rate of no more than 5 percent.

If a caller will face a temporary delay before a CSR becomes available, the contractor shall inform the caller of the delay and tell the caller what information to have readily available for the CSR. During peak volume periods, the contractor shall also employ a message indicating a preferred time to call. During peak volume periods, the contractor shall employ a virtual hold messaging capability to provide the caller an option to virtually hold the caller's wait with a call back time to the caller. The caller will be automatically called back for assistance in place of holding on the line.

NOTE: The above standards are subject to change at CMS' discretion.

3.4.2.1. General Inquiries

The contractor shall provide high-quality customer service. The contractor shall supply enough trained CSRs to appropriately handle its call volume. The contractor shall train its call center staff to respond to inquiries from both internal and external customers. Internal customers include CMS Central Office, Consortia, Regional Offices (ROs), and Medicare contractors; external customers include beneficiaries, providers, suppliers, insurers, attorneys, employers, and others with MSP questions. Face-to-face encounters are extremely rare and no separate facility to accommodate them is required.

Inquiries received by the contractor may be presented in writing, by email (including CMS' RightNow program) or by telephone. The cover letters that accompany MSP development questionnaires shall contain the contractor's toll-free number (and its TTY/TDD service number, if different) and shall instruct readers to call if they have questions.

CSRs shall be trained in customer service principles and telephone etiquette. The contractor shall determine whether a select number of CSRs will receive specialized training to handle more complex or technical inquiries (e.g., ESRD, crossover claims; MSP case development; debt recovery). Additionally, a Medicare

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contractor may call or write to request clarification concerning the information that the contractor used to establish a period of coverage on the Common Working file (CWF) or to collect a debt.

3.4.2.2. Customer Escalation

The contractor may be required to respond to inquiries requiring technical expertise that cannot be provided by its first-line CSRs. To address these inquiries an escalation component shall be adopted. The escalation component or process shall provide essential research and information regarding inquiries when the desktop scripting and content cannot provide a thorough response to the inquiry.

The contractor shall staff the escalation component with bilingual (English/Spanish) agents who have reference/research expertise in the areas of Medicare eligibility, enrollment, appeals, claims, and the managed care processes to handle these more complex issues. This staff shall have access to the desktop application, internet, telephone, and TDD/TTY capabilities. The escalation component shall operate during the general Call Center operational hour.

The contractor shall integrate and coordinate the escalation function with other beneficiary functions, including content management, learning and development, and quality assurance. The contractor shall identify referral trends to update desktop scripting that will better address beneficiary concerns. The contractor shall also utilize information on beneficiary concerns gathered by the escalation component in developing new or improved CSR training programs. The contractor's quality assurance function shall ensure the consistency and quality of the Reference Center.

3.4.2.3. Disclosure of Information

Calls received cover all the major tasks under the scope of this contract. To help the contractor comply with CMS' standards regarding protected health information (PHI), CMS will provide the contractor's staff with the most current version of the Desk Disclosure Reference (DDR) Guide. The contractor's CSRs shall use the DDR to:

- Authenticate the caller;
- Re-route the caller to another office for assistance (e.g., Social Security Office);
- Determine whether the CSR may disclose information to the caller.

3.4.2.4. Written Inquiries

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The contractor shall have adequate staff to respond to external customer requests which it receives via written correspondence. Written correspondence received covers all the major tasks under the scope of this contract.

The contractor shall respond to all written correspondence no later than 20 business days after receipt, including those inquiries in CMS' RightNow program. The contractor shall incorporate a quality control step to check for grammatical correctness, proper reading level (seventh grade for beneficiaries), timeliness, consistency, and accuracy for all written correspondence. The contractor shall employ quality assurance measures to minimize the risk of generating correspondence with incorrect or incomplete addresses.

3.4.3. Education Requirements

Education of employers, insurers, attorneys, providers, suppliers and beneficiaries is an integral part of the MIP because, among other things, it serves to help deter fraud, waste and abuse in the Medicare Program. The contractor shall coordinate its educational activities with the MSPIC and other CMS contractors, as necessary, to disseminate information about COB on a continuous and proactive basis.

The educational activities that the contractor shall assist the MSPIC with may include, but are not limited to, the following:

- Prepare and conduct seminars, workshops, presentations and conferences for employers and insurers on coordinating benefits with Medicare, to include Computer Based Training (CBT);
- Prepare and submit to CMS bulletin language on COB and Recovery issues that can be used at CMS' discretion to keep providers, suppliers and beneficiaries informed about relevant CMS policy;
- Prepare and submit to CMS standard or "boilerplate" educational language on COB and Recovery issues that can be used at CMS' discretion to keep employers and insurers informed of relevant CMS policy;
- Inform individual beneficiaries, providers, suppliers, employers and insurers of their potential liability for not complying with the statutes, regulations and rules that govern MSP.

3.4.4. Call Center Quality Assurance

The contractor shall establish an internal quality management process to verify that Medicare customers are receiving complete, accurate responses in a courteous and timely manner. The contractor shall establish a customer service monitoring program in accordance with applicable, federal, state, and local laws and regulations. The internal quality management process shall include a corrective action plan to be

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implemented within 5 business days of occurrence of any identified weakness or performance problem.

The contractor's quality assurance process shall focus attention on critical functions including, but not limited to, CSR performance, content development, training, Reference Center, and desktop activities. The contractor shall provide quality assurance capabilities to include, at a minimum, sampling and evaluating the quality, accuracy and consistency of voice and non-voice (email, written, fax, web chat, TDD/TTY) beneficiary interactions.

3.4.5. CMS Call Monitoring

The contractor shall provide CMS with a minimum of 10 randomly selected recorded calls per month via secure email. The CMS maintains the option to access call system directly at its discretion.

3.4.6. Inquiry/Response System

The contractor shall maintain an inquiry/response system that becomes operational no later than 120 business days after the effective date of the contract. The contractor shall include in this system standard language appropriate for use in responding to telephone, written and email inquiries from beneficiaries and their representatives, providers, suppliers, insurers, employers and others. The language used in beneficiary correspondence shall conform to CMS standards for reading comprehension levels (seventh grade for beneficiaries).

All CSRs shall utilize standard, scripted responses based upon approved program content to ensure that consistent, accurate, and easy to understand information is provided to beneficiaries.

The contractor shall use the CMS-approved desktop application, as well as other resources such as medicare.gov tools (e.g. Prescription Drug Benefit tool) to provide beneficiaries with accurate, consistent, and understandable information in response to inquiries.

3.4.7. Forecasting

The contractor shall have an established forecasting process. Forecasting shall include, but not be limited to, projecting call volumes, average handle time (AHT), service level (SL), and corresponding staffing requirements. the CMS reserves the right to define forecasting components (e.g. SL, AHT) based on industry accepted best practices as opposed to specific forecasting tool parameters or contractor specified parameters.

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Forecasting should include seasonal factors, historical trends, legislation, and marketing activities generated by the government or other entities that the government agency has no control over (e.g. broadcast media, news agency, print, newspaper, magazines, etc).

3.4.8. Electronic Data Interchange (EDI) Support

EDI assistance shall be made available for beneficiaries, attorneys, insurers and employers who have questions when registering online for Secure Website services and when attempting to provide data through direct entry or electronic transmission methods or when there are other technical problems, like, but not limited to, slowness, with the secure website. EDI representatives are important in fulfilling the stakeholder's obligation to register and submit electronic COB data. The EDI support center shall operate during the general Call Center operational hours unless otherwise stated by the COR.

3.4.9. Internal Customer Support Center

The contractor shall provide a Internal Customer Support Center that provides efficient customer service to CMS internal customers and congressional staff on high priority MSP matters. Internal customers include the CMS Central Office, Consortia, Regional Offices (ROs), Medicare Administrative Contractors, Managed Care and Drug Plans. The internal customer support center shall operate during the general Call Center operational hours unless otherwise stated by the COR.

3.5. Data Collection Activities and Requirements

The COB data collection activities are comprised of the following major processes:

- Initial Enrollment Questionnaire (IEQ);
- IRS/SSA/CMS Data Match (hereafter ~~–Data Match~~)
- Voluntary Employer Reporting;
- MSP Claims Process Investigations, comprised of 42 CFR 411.25 Notice Development (hereafter ~~–411.25 Notices~~) and Secondary Claims Development (the receipt of claims containing other insurers' explanations of benefits);
- MMSEA Section 111 Reporting Requirements.

These processes are supported with existing systems applications available to the contractor. Refer to Appendix 1 – Available CMS/COB&R Systems List

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The contractor may receive information from a variety of sources, such as beneficiaries, insurers, attorneys, employers, providers, suppliers, Medicare and affiliated contractors that may require further investigation and/or development to make a determination of MSP. Receiving such varying information will require the contractor to review returned electronic data, questionnaires and letters for completeness and consistency, analyze completed questionnaires and letters for the existence of another liable party, and resolve all conflicting MSP data. The contractor shall communicate with beneficiaries, beneficiary representatives, insurers, attorneys, providers, suppliers, and other designated entities to determine the presence or absence of MSP.

Once an occurrence of MSP is identified, the contractor shall take the necessary action to establish the appropriate MSP auxiliary record on the Medicare Common Working File (CWF). A percentage of the records that the contractor creates and that are ultimately transmitted to CWF will fail to be posted and/or require further investigations. The contractor shall review and make necessary corrections to ensure a proper MSP occurrence is applied to CWF. Additionally, the contractor may learn about inaccurate information on the CWF via notices from employers, beneficiaries or their representatives, and through Electronic Correspondence Referral System (ECRS) Web Portal from Medicare contractors. The contractor shall assign staff to correct these records on CWF where sufficient information is available, or notify the requestor that the established information is correct as it stands and the contractor will take no further action.

If the contractor requires additional information to make an MSP determination, it shall contact the employer, or beneficiary, as necessary. The contractor may not modify CWF records unless it resolves the discrepancy. The contractor shall notify the requestor of the disposition of the request. The contractor shall notify the beneficiary or interested parties of the outcome of the investigation.

3.5.1. Initial Enrollment Questionnaire (IEQ)

The purpose of the IEQ is to gather information about other insurance that a new beneficiary will have at the time of his/her Medicare entitlement. The CMS conducts MSP development through the IEQ for all new beneficiaries approximately 3 months before they become entitled to Medicare, thus providing Medicare with MSP information before it receives any claims. Timely collection of MSP information means that claims are processed properly, thus decreasing the costs associated with identifying and recovering mistaken and conditional primary payments. Correct program payment not only produces enhanced beneficiary service, it also supports the program integrity activities mandated by the statutes and regulations applicable to MSP and the broader MIP.

Before a beneficiary becomes entitled to Medicare, MyMedicare.gov mails each beneficiary an introductory letter. The purpose of this letter is to provide them with

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their initial password, username and instructions for completing the Medicare Initial Enrollment Questionnaire (IEQ). The letter also explains that if the beneficiary doesn't have access to the Internet, they can contact the contractor and complete their IEQ via the phone. All five versions of the IEQ shown below are available to be completed in both English and Spanish on the MyMedicare.gov website:

- Medicare Questionnaire for Beneficiaries 65 or Over;
- Medicare Questionnaire for Disabled Beneficiaries;
- Medicare Questionnaire for Beneficiaries with End-Stage Renal Disease;
- Medicare Questionnaire for Beneficiaries with Childhood Disabilities; and
- Medicare Questionnaire for Disabled Widow or Widower.

The contractor shall answer any calls from beneficiaries or their representatives regarding the completion of the IEQ or the records created based on processed IEQs.

The CSR shall accept telephone calls from beneficiaries who request the contractor to take their IEQ information over the phone in lieu of completing the IEQ online. The contractor shall have the capability for the CSR to take this information over the telephone and record the IEQ information.

3.5.2. Data Match

In support of Medicare Secondary Payer (MSP) COB requirements, Federal law requires the Internal Revenue Services (IRS), Social Security Administration (SSA) and CMS to share certain information that each agency has about working Medicare beneficiaries and their spouses or other dependents.

Data Match information is used to help establish MSP periods by identifying insurance coverage where Medicare is or was a secondary payer. Data Match information is also used to help prevent Medicare from making mistaken payments, and to identify Medicare payments that have been made in error. The contractor shall review and analyze Data Match information for use, when necessary, in contacting employers concerning possible periods of Group Health Plan (GHP) insurance coverage that is primary to Medicare.

To collect Data Match information, the contractor will:

- Mail Data Match Questionnaires to employers.
- Work with the MSPSC to eliminate employers that are exempt from reporting.
- Respond to incoming telephone queries from employers.
- Provide Electronic Data Interchange (EDI) support to employers.
- Respond appropriately when notified of non-completed or partially completed Data Match notices.

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3.5.2.1. Data Match Notification

The contractor shall initiate the mailing of Data Match reporting notices, consisting of the Data Match Notification and PINs, to employers. Mailings may occur over a 9 month period, with at least one weekly mailing cycle. The CMS will approve the size and schedule for these mailings. The contractor shall identify employers with ~~industry codes~~ to assist in the prioritization and routing of the mailings to employers. Refer to <http://www.osha.gov/oshstats/sicser.html> for a list of Standard Industrial Classifications.

3.5.2.2. Data Match Questionnaire Entry

Using either the Direct Data Entry (DDE) option through the Coordination of Benefits Secure Website (COBSW) or the Electronic Media Questionnaire (EMQ) data submission method, the employer will provide insurance information for each working Medicare beneficiary, and for each Medicare beneficiary that is a dependent of a covered worker. The Data Match system will use these responses in identifying periods of MSP. The contractor shall also assure that all reported coverage dates are accurate.

3.5.2.3. Data Match Questionnaire Processing

Submitted questionnaires are deemed as acceptable or unacceptable. Acceptable questionnaires are responses that do not require additional data development. The contractor shall have the resources necessary to develop for information required to complete unacceptable questionnaires internally, or with additional employer cooperation. No later than 30 business days after receipt, the contractor shall return questionnaires needing corrections to employers, with appropriate instructions.

Acceptable Data Match input information from employers will be processed by the Data Match system, during the next scheduled daily processing cycle. Processing shall take place on each business day.

3.5.2.4. Non-Completed or Partially Completed Questionnaires

At the discretion of CMS, the contractor will send notices to employers that have returned partially completed questionnaires, or that have not submitted any response. Notifications may be made by regular mail or by email. The CMS will provide the contractor with appropriate guidance and model language for these notices. The contractor shall provide an annual report of any Data Match Non-Response report. The report shall be provided 20 business days before the end of the each contract year.

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3.5.2.5. Data Match Undeliverable Mail

The contractor shall manage procedures for processing undeliverable mail in accordance with requirements provided by CMS. Accounting of undeliverable mail will be provided to CMS on an established schedule. The contractor shall retain the undeliverable mail in accordance with the guidelines set forth with record retention and document destruction.

3.5.2.6. Data Match EDI Support

Electronic Data Interchange (EDI) assistance shall be made available by the contractor for employers and others who have questions about the Data Match process or file transfers. Contractor EDI Representatives shall have a thorough understanding of MSP requirements and the Data Match process. EDI representatives shall be able to facilitate all necessary technical Data Match support functions, including the coordination of employer requests for extensions of reporting deadlines

3.5.3. Voluntary Employer Reporting

The CMS has entered into voluntary agreements with employers to exchange Medicare and GHP eligibility information for the purpose of coordinating health benefit payments. The CMS views these voluntary agreements as a preferred method to use to secure GHP insurance information needed to comply with requirements of the MSP governing statute and implementing regulations. (Refer to the following link for additional information regarding Voluntary Data Sharing Agreements: http://www.cms.gov/EmployerServices/03_employervdsa.asp).

At the direction of the CMS, the contractor shall enter into voluntary reporting agreements with additional employers. The CMS will provide the contractor with the standard terms that must be included in any final agreement. The CMS will also define the parameters of permissible contractor negotiations, for example, determining the frequency of employer reporting. The contractor may not add to, subtract from or otherwise modify the substantive provisions of the model agreement. The contractor may, however, make recommendations for such changes to CMS for its consideration. The contractor shall consult immediately with designated CMS officials if it encounters any issues that are impeding its ability to manage the terms of a voluntary reporting agreement CMS has with an employer.

Key deliverables shall include, but are not limited to:

- Meeting (via teleconference or in person) with and establishing the data transfer protocols that will be used with entities that have signed agreements;

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- Assisting in the development of marketing and information campaigns to solicit additional participants; and
- Assisting CMS in securing agreement modifications and renewals, as necessary.

The contractor shall administer the ongoing data exchanges specified in the agreements. The contractor shall receive and analyze this data in accordance with the applicable provisions of the MSP governing statute and implementing regulations.

3.5.3.1. Voluntary Reporting of Prescription Drug Information

The MMA expanded CMS' provision of benefits to include prescription drug coverage. The Part D benefit is structured so that a beneficiary will receive catastrophic coverage only after paying a certain amount of "true out-of-pocket" (TrOOP) expenses. A limited number of parties are statutorily permitted to make payments that count towards a beneficiary's TrOOP balance. In order for CMS' Part D plans to accurately administer the benefit; they must be able to track the beneficiaries' TrOOP costs. To perform such tracking, they must know 1) what other parties are making prescription drug payments for each beneficiary, and 2) whether those parties' payments are allowed to count towards the beneficiary's TrOOP balance. Due to these increased responsibilities, both CMS' and the incumbent contractor's scope of COB work was expanded to include collecting enrollment information regarding Part D beneficiaries' other prescription drug coverage. A unique aspect of this Part D COB collection is that CMS needs information on both primary and supplemental payers in order to properly enforce the provisions of the MMA; for FFS Medicare, CMS only needs information on primary payers.

The CMS and the incumbent contractor thus expanded the voluntary reporting mechanisms under this contract to include necessary prescription drug information collections. The expansion included both adding new files and data elements to existing data exchanges and creating instruments to exchange information with a new market of partners (*e.g.*, SPAPs, PBMs, and ADAPs).

The contractor shall maintain the existing agreements and continue to market and execute new agreements for the exchange of Part D beneficiaries' prescription drug enrollment information. The contractor shall use the CMS-provided instrument specific to the type of entity signing the agreement (*e.g.*, the SPAP Agreement for SPAPs) and shall tailor its prescription drug agreement marketing to the pharmaceutical benefit management audience. (See the following link for additional information regarding the coordination of prescription drug coverage: <https://www.cms.gov/PrescriptionDrugCovGenIn/>)

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3.5.3.2. Voluntary Reporting for the MMA's Retiree Drug Subsidy

In addition to creating Part D, the MMA also included a provision to subsidize employers that provide prescription drug benefits to retirees. Employers must claim this Retiree Drug Subsidy (RDS) on a per-individual basis; to qualify, individuals must be retirees who are eligible to enroll in Part D but who have not done so. While CMS procured an RDS Contractor (RDSC) to administer the RDS, it also leveraged its existing relationships and connections by allowing Employer VDSA partners to use that process to submit RDS applications. The Employer VDSA partner submits a file of all retirees to determine which individuals are RDS-qualified, and then submits additions, changes, or deletes as the coverage information for their retirees changes. (See the following link for additional information regarding the RDS program:

https://www.cms.gov/EmployerRetireeDrugSubsid/01_overview.asp)

3.5.4. MMSEA Section 111 Data Exchange (Mandatory Insurer Reporting)

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) adds new mandatory reporting requirements for group health plan (GHP) arrangements and for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation. See 42 U.S.C. 1395y(b)(7) & (8).

The 2007 amendments to the MSP provisions require certain enterprises, referred to as Responsible Reporting Entities (RREs) to report specified information regarding GHP arrangements and non-GHP (NGHP) arrangements (liability insurance [including self-insurance], no-fault insurance, and workers' compensation) to CMS, beginning in 2009.

The purpose of the Section 111 reporting process is to enable CMS to pay appropriately for Medicare covered items and services furnished to Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 requires RREs to submit information specified by the Secretary in a form and manner (including frequency) specified by the Secretary.

The actual data exchange process takes place between the RREs and the MSPSC. The MSPSC will manage the technical aspects of the Section 111 data exchange process for all Section 111 RREs.

3.5.4.1. Section 111 Group Health Plan (GHP) RREs

Section 111 authorizes CMS and Group Health Plan (GHP) RREs to electronically exchange health insurance information. On a quarterly basis, a RRE must submit GHP information about employees and dependents to the contractor. Submitted

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information is interrogated systematically and if determined appropriately, a MSP occurrence will be created and posted at CWF.

In exchange, the RRE is provided with Medicare entitlement information for those individuals in a GHP who can be identified as Medicare beneficiaries. This mutual data exchange helps to assure that claims will be paid by the appropriate organization at first billing. Entitlement information is available to the RREs via file exchanges and website access; however RREs may contact the contractor for this information.

The Section 111 GHP reporting process includes an option to exchange prescription drug coverage information to coordinate benefits related to Medicare Part D. The CMS is also allowing RREs, that are also participating in the Retiree Drug Subsidy (RDS) program or are reporting to RDS on behalf of a plan sponsor, to use the Section 111 GHP reporting process to submit subsidy enrollment (retiree) files to the RDS Center using the Section 111 GHP reporting process.

3.5.4.2. Section 111 Non-Group Health Plan (NGHP)

The Secretary requires data for both Medicare claims processing and for MSP recovery actions, where applicable. RREs will submit information electronically on liability insurance (including self-insurance), no-fault insurance, and workers compensation claims (collectively referred to as non-group health plan or NGHP) where the injured party is a Medicare beneficiary. The MSPSC will manage the technical aspects of the Section 111 data submission process for all Section 111 RREs.

For purposes of RRE submissions, the term “claim” is used to refer to the overall claim for NGHPs rather than a single claim for a particular medical item or service. Claim information is to be submitted where the injured party is a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals.

NGHP claim submissions are systemically interrogated and may result in the generation of a MSP occurrence to be posted at CWF or the generation of a Total Payment Obligation to the Claimant (TPOC) record. TPOC records are not posted to CWF, but are processed as an MSP recovery activity.

3.5.4.3. General Section 111 Requirements

All RREs are required to register and test (DDE RREs are exempt from testing) with contractor prior to submission of the above production files. Registration and

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account setup functionality is performed via the Section 111 Mandatory Reporting COBSW.

Instructions for participation and notifications related to Section 111 Mandatory Reporting are posted on the www.cms.gov/MandatoryInsRep website. The contractor shall work with the MSPIC to maintain and update the GHP and NGHP user guides and instructions available on this website.

The contractor shall assist the MSPIC with the development and submission of appropriate notifications for technical and policy changes related to Section 111 Mandatory Reporting to be posted on this website.

The contractor shall monitor file submissions from RREs to ensure file submissions are submitted timely and accurately.

The contractor shall monitor file responses to RREs to ensure file responses are provided timely and accurately. Inaccurate responses or delayed responses shall be reported to the MSPIC for corrections.

The contractor shall designate at least 1 EDI Representative to each RRE to provide any necessary support. The EDI Representative support shall consist of, but is not limited to:

- User access to the Section 111 Mandatory Reporting COBSW;
- RRE Account setup;
- RRE Account status;
- File submission and response setup;
- Assistance with file processing issues;
- Assistance with error correction; and
- Assistance with policy questions.

The contractor shall maintain an escalation process for the resolution of RRE questions and issues. Items that cannot be resolved within 2 business day shall be escalated to an EDI Supervisor. Items that cannot be resolved by the EDI Supervisor within 1 business day shall be escalated to the EDI Manager. Items not resolved by the EDI Manager within 1 business day shall be escalated to the contractor Project Director.

The contractor shall have the capability of issuing communications electronically to the Section 111 users via e-mail within 60 minutes of receipt of drafted language from CMS.

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Records submitted to CWF, as a result of a Section 111 submission, to be posted as an MSP occurrence may fail and result in a Secondary Payer (SP) error. The contractor shall be responsible for resolving and correcting all SP errors resulting from Section 111 submissions.

The client/server based application; MIRA (Mandatory Insurer Reporting Application) is available to the EDI Representatives to monitor processing related to RREs. This monitoring includes the maintenance of account information, file processing and reporting functions.

3.5.5. Self-Reporting MSP Development

The contractor will receive telephone calls and/or letters from beneficiaries or attorneys and third party insurers reporting that another entity has primary responsibility for medical items and services. The contractor shall request from the reporting party all the information necessary to establish MSP records on CWF and Medicare Beneficiary Database (MBD), and to perform the necessary recovery activities.

3.5.6. 411.25 Notice Development

The Medicare statute and implementing regulations (42 CFR 411.25) require insurers to notify CMS if they become aware that Medicare paid a claim for which another insurer had primary payment responsibility. The contractor may receive such notification directly from the primary insurer, or through another source; Medicare contractors, their affiliated subcontractors, and ROs currently communicate information via ECRS. When it receives this type of notice, the contractor shall initiate investigations to develop the appropriate MSP dates with the insurer or other appropriate entities (*e.g.*, employer, provider, and beneficiary) and track development by means of a case control system. The contractor shall initiate this development within 10 business days of receiving the notice. No later than 10 business days after receiving a response, the contractor shall transmit a CWF MSP maintenance transaction to reflect the proper MSP period and resolve any returned SP error codes and shall take action to update MBD with information pertaining to primary prescription drug coverage.

3.5.7. Secondary Claims Development

If a Medicare claim processing contractor receives a claim for secondary benefits or conditional benefits and the claim contains enough information to generate an MSP occurrence, the contractor will create an I validity record. I validity records are sent to CWF and posted.

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For each new posted I record, the COB system will initiate a secondary claim development letter and questionnaire. Upon receipt of the secondary claim development, the response shall be scanned and stored as an image. The information should be interrogated and the MSP should be updated accordingly setting the validity to Y if valid or N if invalid. Processing of the questionnaires is automated, however manual intervention is required to correct or review improperly completed questionnaires.

3.5.8. MSP “08” Development

If a Medicare claim processing contractor receives information that a beneficiary refused to provide health benefit information at the time of service, a condition code –8” alert will be generated. For each new alert, the COB system will initiate a MSP claims development letter and questionnaire. Upon receipt of the MSP claims development questionnaire, the information should be interrogated and the MSP data should be updated accordingly in the CWF. The contractor shall ensure the necessary development within 10 business days of receiving the –08” notice. The number of 08 alerts received per month, the number of 08 alerts processed each month, the number of beneficiary responses to the development questionnaire sent each month, including the number of Yes MSP responses and No MSP responses, and the number of questionnaires that were closed due to no response, shall be reported to CMS each month. Any extraordinary 08 issues that arise for the contractor shall be reported to CMS.

3.5.9. Notification of MSP Record Terminations

Medicare beneficiaries may notify the contractor about the termination of MSP occurrences. In these situations, the contractor shall determine the appropriateness of this data and apply the required change to CWF. The contractor shall ensure MSP record terminations are applied timely and appropriately.

3.5.10. Medicare Contractor MSP Inquiries and Assistance Requests

Medicare claim processing contractors attain information about existing or potential MSP occurrences. Consequently, this information must be passed to the contractor for processing. The ECRS application is used as the vehicle for these contractors to report this information to the contractor. The contractors may submit Inquiries (MSP or Prescription Drug) or Assistance Requests. Inquiries indicate that the contractor has some level of information that the beneficiary may have MSP, whereas Assistance Requests indicate that the contractor would like to alter an existing MSP occurrence. Refer to http://www.cms.gov/manuals/downloads/msp105c05_att1.pdf for more information related to ECRS.

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3.5.10.1. ECRS MSP Inquiries

Based on the information provided by the submitting contractor, an MSP occurrence can be generated and/or a secondary claim development effort is initiated. These development efforts indicate that letters and questionnaires are mailed to entities that could provide additional information. These entities may be the beneficiary, representative, employer or insurer depending on the information that has been provided by the contractor on the ECRS transaction.

Currently, the contractor averages 45,000 Inquiries monthly from approximately 1,000 claim processing contractors (MACs, DME MACs, MAPD plans). Processing of the questionnaires is automated, however manual intervention is required to review and correct improperly completed questionnaires.

3.5.10.2. ECRS Assistance Requests

Claim processing contractors submit requested MSP updates based on information received during the processing of claims. Depending on the type of update or available information, the MSP occurrence can be immediately updated systemically or additional development may need to be performed. Due to the nature of Assistance Requests additional development cannot be performed as with Inquiries by sending questionnaires. A variety of letters will be needed to perform this development. An existing COB letter generation application maybe used or the contractor may develop or utilize a similar application. The application shall have the ability to create generic letters and to include standardized paragraphs. Generated letters should also utilize a mechanism to track responses and ensure development efforts are closed appropriately when responses are received.

The contractor shall initiate processing of all Assistance Requests within 15 calendar days of receipt. Items not processed in this timeframe are considered backlog. If the contractor cannot adhere to the 15 day processing limitation, the contractor shall notify CMS of the issue as soon as it has been recognized and provide an action plan to restore the 15 day processing timeframe. All Assistance Requests shall be processed and brought to a closed status within 100 calendar days of receipt of the Assistance Request.

3.5.11. Hierarchy

To improve the integrity of MSP records and prevent the “flip flopping” of fields in MSP occurrences posted to the CWF, the contractor shall utilize a hierarchy process to handle conflicting MSP information.

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- The contractor shall rank all sources of information into tiers to determine which updates and deletes can be accepted for MSP occurrences.
 - The first tier and the highest source shall be the Contractor's Analyst. The Analyst shall have the ability to lock MSP occurrences from subsequent changes, when appropriate.
 - The second tier shall consist of the Contractor's Call Center's CSRs the Recovery Contractor(s), and the Beneficiary Call Center (1-800-Medicare).
 - The third tier shall consist of Section 111 reporters and Medicare Advantage (MA) or Part C Plans.
 - The fourth tier shall consist of the Employer Voluntary Data Sharing Agreements (VDSAs) and employer responses to Data Match.
 - The fifth and lowest tier shall be all other Medicare Contractors, Beneficiary responses to the IEQ, and all other sources of information.
- Updates and deletes shall be allowed according to the rank associated with the source of the incoming update or delete and what source last added or updated the MSP occurrence.

The COB application will not allow information received from a lower ranking tier to update or delete an MSP occurrence last added or changed by a higher ranking source. These requested update or delete transactions are be rejected or ignored. When an update or delete is rejected, an error code shall be returned to inform the submitter that the MSP occurrence was either last updated by a higher ranking source or has been locked by the contractor.

3.5.12. Coordination of Benefits Agreement (COBA)

In September 2006, CMS consolidated all Medicare claims crossover processes formerly fulfilled by our Medicare claims processing contractors under the national COBA program. In addition to the primary function of claims crossover, the COBA program is also a vehicle for collecting prescription drug enrollment data necessary for appropriate coordination of benefit activities tied to the Medicare Part D provision of the Medicare Modernization Act (MMA). Accordingly, CMS requires trading partners that provide prescription drug coverage to their members to submit such enrollment data through a CMS-proprietary format within the COBA-program or through a proprietary format within the Section 111 initiative. Prescription drug enrollment data are maintained within CMS's MBD rather than within CWF.

3.5.12.1. COBA Requirements

The CMS has designated the contractor to execute and maintain COBAs between CMS and trading partners that adjudicate claims after Medicare. **(NOTE:** The

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CMS does **not** consider health care clearinghouses, billing vendors, value-added networks, and other entities that merely route files to be appropriate signatories to the COBA. Therefore, the Contractor shall not allow such entities to sign the COBA). The contractor shall use the CMS-provided model instrument as the standard crossover agreement to be used under the COBA.

For crossover agreement oversight, the contractor shall monitor file exchanges and crossover invoice payments by the COBA trading partners. In addition to contacting COBA trading partner that are not fulfilling the file exchange protocols prescribed in the signed COBA, the Contractor shall alert the COR via email within 10 business days following its detection that COBA trading partners are not complying with file exchange or invoice payment requirements. The notification shall include details concerning contact attempts made and information gathered concerning why eligibility files have not been exchanged with the contractor and/or why invoice payments remain outstanding.

The contractor shall employ enough EDI staff to service between 800 and 1,000 individual insurer lines of business within the COBA program effectively on a daily basis.

3.5.12.2. COBA Modification Requests and Other Administrative Tasks

The contractor shall process requests from COBA trading partners for changing the optional operational specifications in their COBA (*e.g.*, frequency of transaction; types of claims to cross over; or connectivity preference) or for terminating an Agreement as necessary. The contractor shall process such requests within no more than 15 business days of receipt and ideally within 10 business days of receipt.

The contractor shall also perform other tasks, as may be designated by CMS, towards realizing effective administration and maintenance of the COBA Base Agreement and COBA Attachment, both of which comprise the Coordination of Benefits Agreement. Refer to <http://www.cms.gov/COBAgreement/> for further information related to COBA processing.

3.5.12.3. Market and Execute COBAs

The contractor shall market and execute COBAs to/with all prospective trading partners, including those entities that have not yet executed a national COBA and/or moved into COBA production with the contractor. The contractor shall only execute COBAs with appropriate entities that have signatory authority, as termed by CMS. The contractor shall develop an annual Marketing Plan, which should be targeted towards contacting untapped insurance entities, such as self-insured plans. The COBA Marketing Plan shall be delivered 120 business days after the award of the contract, and an updated plan shall be delivered annually thereafter.

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The contractor shall note that CMS' standard timeframe for the new COBA trading partner execution of the COBA is no greater than 30 business days. In addition, the contractor shall support CMS in all periodic COBA Base Agreement and COBA Attachment re-execution activities and in the development of COBA Addenda as needed. Unless CMS indicates otherwise, all re-execution activities should be accomplished within 45 business days.

3.5.12.4. Testing Timeframes for New Trading Partners

As the contractor brings on new COBA trading partners following marketing efforts, the contractor shall apprise these entities that, following COBA Base Agreement and Attachment execution, the standard timeframe for testing of the COBA eligibility files and outbound crossover claims is between 60 and 90 business days. If entities require an additional period of time for testing, the contractor shall send the CMS BFL an email from the COBA trading partner that documents the rationale for an extension in testing timeframes. The Contractor must obtain CMS' written approval before granting the trading partner an additional bank of time (e.g., 20-30 business days) for testing.

The contractor and CMS shall mutually notify each other when either becomes aware that a trading partner is ready to move into COBA production. Unless otherwise directed, the contractor shall always ensure that COBA trading partners will be set to a production status on a Monday. This will require that the contractor apply COBA Other Insurance File (COIF) update actions with CWF beginning with the Wednesday immediately prior to the COBA trading partner's identified production date. When instructed by CMS, or in collaboration with CMS, the Contractor shall remove a trading partner's COIF at least 2 weeks prior to its production implementation date.

3.5.12.5. COB Eligibility and the Beneficiary Other Insurance (BOI) Auxiliary Record

The contractor shall monitor the testing and processing of COBA eligibility from each COBA trading partner at the frequency established in the COBA.

The COBA batch processing will perform the following actions:

- The prescription drug eligibility file shall, at a minimum, capture the trading partner's unique Rx BIN (Prescription Drug Beneficiary Identification Number), PCN (Prescription Drug Processor Control Number), Rx GRP (Prescription Drug Group Number), and Rx ID (Prescription Drug Identification Number) values and routers.

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- Upon receiving a COB eligibility file, the COBA batch system will populate the BOI auxiliary file via the Health Utilization Beneficiary Other Insurance (HUBO) maintenance transaction.
- They system will update the MBD with the trading partner's submitted prescription drug enrollment information. COBA trading partners will use "add, change, and delete" update indicators within their incoming E-01 (crossover) and E-02 (prescription drug enrollment data) COB eligibility records.
- For claims recovery and other purposes, the system will capture and maintain all add, change, and delete actions, so that at any given time a trading partner's cumulative added, changed, or deleted members can be easily generated in a report.

The Contractor shall maintain the capability to add multiple COBA occurrences (maximum of 40) to the CWF BOI auxiliary record via the HUBO maintenance transaction.

3.5.12.6. Agreement Issues

The contractor shall consult with the CMS COBA BFL or COR, to address any irresolvable operational, legal, or otherwise sensitive issues about an Agreement, as they arise. The Contractor shall not alter the COBA but may recommend changes to CMS.

3.5.12.7. Ability to Assign Update COBA Identification Numbers

The contractor shall assign (a) unique COBA ID to each trading partner that has signed a COBA. The assigned COBA IDs shall correspond to the CMS-established ranges as made available in Appendix 5, COBA ID List.

The contractor shall assist CMS in developing and maintaining a comprehensive trading partner COBA ID listing on CMS's Coordination of Benefits Agreement web site.

3.5.12.8. Outreach and Communications to Trading Partners

As necessary, the Contractor shall assist CMS with the development of outreach materials that will be tailored to Medicare providers/suppliers and COBA trading partners. Examples of possible outreach materials include fact sheets or brochures focused on providing an overview of the COBA process, including benefits/advantages of the program.

The Contractor shall maintain an electronic notification process to send broadcast

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messages to alert all COBA trading partners (commercial insurers and Medicaid agencies and their fiscal agents) or to a subset group. The communications include important CMS alerts as well as administrative changes in formats, fees, laws, and/or procedures. The Contractor shall have the capability of issuing such communications electronically to the intended audience(s) via email within 60 minutes of receipt of drafted language from CMS.

3.5.12.9. Crossover Fees and Administrative Costs

The Contractor shall maintain a system to accurately track and properly invoice claims on a monthly basis for all trading partners in COBA production. The Contractor's accounting system shall allow for built-in flexibility to accommodate the changing of the per claim crossover rate at either fiscal year or calendar year intervals as directed by CMS. The Contractor shall **not** charge State Medicaid Agencies (SMAs), including those receiving crossover and Medicaid Quality/coordinated care claims, and in the future health, as directed by CMS, health care pre-payment plans (HCPPs) and health maintenance organization (HMO) cost plans, unless directed to do so by CMS for special projects. The Contractor shall additionally **not** charge COBA trading partners for claims whose Beginning Hierarchical Transaction (BHT03) 23rd position indicator is "P," unless CMS directs otherwise.

The contractor shall also develop a methodology for distributing crossover fees, twice monthly, to those Medicare claims processing contractors that transmitted processed claims to be crossed over. The contractor shall report to CMS the disbursement amounts to the Medicare claims processing contractors, as soon as the disbursements occur. The contractor shall staff its COBA operation sufficiently to reconcile disputed invoices from trading partners and to participate in (and reconcile, as necessary) the fee distribution to the Medicare claims processing contractors.

The Contractor shall comply with all requirements regarding establishment and maintenance of a COBA financial accounting system and related processes.

3.5.12.10. COBA Crossover Disputes

The contractor shall, pursuant to the terms of the COBA Base Agreement, honor disputes lodged by COBA trading partners if: 1) the dispute(s) is/are determined to hold merit based upon sampling performed; 2) the dispute(s) is/are filed in advance of the invoice and the contractor agrees with the dispute; or 3) the dispute(s) is/are filed within 30 business days of the invoice billing date. **IMPORTANT:** The Contractor shall make no exception to this dispute timeframes indicated unless authorized by CMS to do so. The contractor should consider using the Dispute

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Tracking System (DTS) for processing and monitoring disputes.

3.5.12.11. Monitoring of COBA Activities

The contractor shall, pursuant to the terms of the COBA Base Agreement, honor disputes lodged by COBA trading partners if: 1) the dispute(s) is/are determined to hold merit based upon sampling performed; 2) the dispute(s) is/are filed in advance of the invoice and the contractor agrees with the dispute; or 3) the dispute(s) is/are filed within 30 business days of the invoice billing date. **IMPORTANT:** The Contractor shall make no exception to this dispute timeframes indicated unless authorized by CMS to do so. The contractor should consider using the Dispute Tracking System (DTS) for processing and monitoring disputes.

3.5.12.12. COBA Reports

As part of the monthly COB workload reporting to CMS, the contractor shall provide a roll-up of all daily and weekly COBA workload reports sent to CMS. In the monthly status report the contractor shall also provide a listing of COBA trading partners with associated number of E-02 eligibility records. Additionally, a Self Service Reporting Tool is currently available for use by contractor, the Medicare Contractors, and CMS to review COBA reporting data.

The contractor shall produce a monthly report wherein it illustrates 1) the monthly interest generated within the COBA disbursement sweeps account versus monthly bank fees owed and 2) the monthly spending of COBA funds needed to cover the bank fees owed. This report shall be delivered to CMS on a monthly basis.

The contractor shall input daily and weekly COBA workload data, including the number of E-01 eligibility records processed and volumes of test and production COBA claims crossed over within the electronic reconciliation tool.

The contractor shall input the dollar amounts disbursed twice monthly to the Medicare contractors, with contractor name and number indicated within the electronic reconciliation tool.

The contractor shall input the status of monthly crossover invoices, by trading partner, at various frequencies (1-30, 31-60, 61-90+) within the electronic reconciliation tool.

If not captured within the electronic reconciliation tool, the contractor shall report into the CAFM II or replacement system, a workload report consisting of the number of crossover claims transmitted by each contractor (tracked by contractor

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roll-up number); number of these claims adjusted through ~~“+11,” “+22,” or “+33”~~ errors; amount of expected complementary credits per contractor roll-up number, net adjustments; and the amount of complementary credits disbursed to the Medicare contractors.

The contractor shall produce a listing of active COBA trading partners, inclusive of line of business (Medigap, supplemental, TRICARE, Medicaid, Other, HCPP), COBA ID, and test or production status at the frequency specified in the Deliverables section.

On a monthly basis, the contract shall report the following production workload data: number of claims received by contractor site (i.e., by CMS assigned contractor ID by site), by trading partner type (i.e., COBA ID ranges), and by rate charged. In addition, the contractor shall report to CMS on the number of crossover claims sent by COBA ID. These production workload statistics shall be included as part of the monthly COB Workload Report.

Concurrently with the Monthly Status Report, the contractor shall submit a Monthly COBA Activity Report. At a minimum, this report shall include a section that compares accomplishments to goals in all tasks identified in the approved work plan. In addition, the report shall also include a section that discusses changes to marketing strategy, as applicable, as well as the number of new COBAs signed, number of renewals, number of terminated COBAs, and the approximate number of affected enrollees. Finally, the COB contractor shall develop and include in the monthly COBA Activity Report graphics that pictorially demonstrate the progress being realized under the COBA initiative.

From time to time CMS will require COBA Ad-Hoc reports to satisfy inquiries from upper management or even legislators. The time in which CMS will expect these reports will depend on the exigency of the circumstances.

3.6. Medicare Secondary Payer (MSP) Recovery Activities and Requirements

The CMS is entitled to recover conditional payments it made where a beneficiary received workers' compensation, liability insurance (including self-insurance), and no-fault insurance settlement, judgment, award, or other payment. The contractor shall perform all activities related to recovering NGHP conditional payments with the exception of:

- provider, physician or other supplier duplicate primary payments;
- provider, physician or other supplier voluntary/unsolicited refunds.

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Several of the data collection activities described in Section 3.5 are designed to collect data that promotes MSP recoveries of conditional payments. The recovery process begins once a case is created in the Recovery Management and Accounting System (ReMAS) system. This is generally a systematic process, although cases may be created manually in very specific circumstances. Activities related to recovering NGHP conditional payments include:

1. Identifying claims that Medicare has paid conditionally that are related to the beneficiary's case;
 - a. Medicare may recover for items and/or services associated with what was claimed or released with respect to the accident, illness, incident, or injury.
2. Informing beneficiaries of their rights and responsibilities once they have notified Medicare that they have or may obtain a NGHP settlement, judgment, award, or other payment;
3. Ensuring that beneficiary representation and privacy rules are adhered to, as set forth by CMS;
4. Developing and disseminating conditional payment amount information;
5. Addressing Notices of Settlement, Judgment, Award, or Other Payment;
6. Terminating associated MSP Records, once the contractor receives Notice of Settlement, Judgment, Award, or Other Payment;
7. Requesting claim/pleading documents when appropriate;
8. Requesting procurement cost certifications when appropriate;
9. Issuing demand letters;
10. Collecting and depositing payments; and
11. Complying with the Debt Collection Improvement Act (DCIA) processes.

The contractor shall follow applicable statutes, regulations, and CMS' MSP policy interpretations and definitions. The contractor is bound by CMS' policy and shall not substitute its own interpretation of the applicable statutes and regulations. The contractor shall raise any differences in interpretation with the COR.

3.6.1. Identification of NGHP Claims Related to the Case

The contractor shall use ReMAS to identify those claims potentially subject to recovery. The contractor shall review what has been claimed and/or released in order to determine which conditional payments for Medicare-reimbursed items and/or services furnished during the relevant time period are related to the beneficiary's case. The contractor shall associate claims to the beneficiary's case that are determined to be related. Note: 50-60percent of the time claims will be systemically associated the case.

Note: The MSP statute does not require that Medicare establish causation; i.e., Medicare does not have to prove that the accident/injury/illness/incident actually

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caused what is being claimed or released by the beneficiary. When a beneficiary obtains one of the following, primary payment responsibility has been demonstrated:

- A judgment; or
- A payment conditioned upon a recipient's compromise, waiver, or release (regardless of whether there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or its insured.

Where there is a dispute regarding whether certain Medicare-reimbursed items or services are related, claim/pleading documents may be needed to determine what has been claimed or released. It is important to note that, in most cases, it is clear which items or services are related, however, these documents are routinely needed for product liability situations to determine exactly what is being claimed or released.

The contractor shall identify those cases where claim/pleading and settlement, judgment, award or other payment documents are necessary and obtain such documents in the identified cases.

With respect to MMSEA Section 111 data, the contractor shall recover from Section 111 records reporting Total Payment Obligations to the Claimant (TPOCs). The contractor shall recover from Section 111 records reporting Ongoing Responsibility for Medical Payments (ORM) that have a termination date with a TPOC and TPOC date on or after the ORM termination date (Scenario 5 below). The contractor shall forward all records identified as ORM Scenarios 1 through 4 to the requisite recovery contractor responsible for those ORM recoveries, unless otherwise specified by the COR.

The five identified scenarios of ORM reporting through Section 111 are described below, along with the recovery rules the contractor shall follow in each particular situation. At any point in time a recovery case cannot fit into more than one of the following scenarios.

Scenario 1. ORM is reported **without** a termination date and no TPOC is reported; the ORM entity's responsibility to pay medicals bills related to the case is ongoing.

Rule: In this situation, recovery should be continuous (as defined by CMS) for all related claims paid by Medicare from the date of incident up until the ORM is termed, against the ORM entity as the debtor.

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Scenario 2. ORM is reported **without** a termination date and has one or more associated TPOCs; the ORM entity's responsibility to pay medicals bills related to the case is ongoing.

Rule: Interim TPOCs reported while ORM is ongoing should not be associated with MSP recovery unless otherwise specified. In this situation, recovery should be continuous (as defined by CMS) for all related claims paid by Medicare from the date of incident up until the ORM is termed, against the ORM entity as the debtor.

Scenario 3. ORM is reported **with** a termination date and no TPOC is reported; the ORM entity had the responsibility to pay medicals bills related to the case from the date of incident up to the termination date.

Rule: The contractor shall recover against the ORM entity as the debtor for all related claims paid by Medicare between the date of incident and the termination date.

Scenario 4. ORM is reported **with** a termination date and has one or more associated TPOCs; the ORM entity had the responsibility to pay medicals bills related to the case from the date of incident up to the termination date.

Rule: Interim TPOCs reported while ORM is ongoing should not be associated with MSP recovery unless otherwise specified. The contractor shall recover against the ORM entity as the debtor for all related claims paid by Medicare between the date of incident and the termination date.

Scenario 5. ORM is reported **with** a termination date and has one or more associated TPOCs **and** at least one of the TPOC dates reported are on or after the termination date. Settlements, judgments, awards, or other payments that are reported on or after the ORM termination are assumed to have ended the ORM; this will be stipulated in the settlement documents.

The contractor shall recover against the beneficiary/claimant as the debtor for all related claims paid by Medicare between the date of incident and the termination date.

Note: The rules above describe how the contractor shall proceed initially upon identification of the scenario. If proper documentation is received from the assumed debtor verifying it is not the correct debtor, then the contractor shall change the debtor to the appropriate party to seek recovery. ("Proper documentation" refers to any documents providing proof of release of

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responsibility for the identified time period, including but not limited to settlement documents.)

3.6.2. Informing Beneficiaries of their Rights and Responsibilities

The current process requires that the contractor issue a Rights and Responsibilities (RAR) letter within 15 calendar days of a case being created. The RAR is designed to act as confirmation that a beneficiary's recovery case has been established. It also provides details on the beneficiary's rights, the recovery process and timeframes to guide the beneficiary's expectations. The contractor shall provide a mechanism by which the beneficiary and his attorney or representative are informed of the beneficiary's rights and responsibilities in accordance with CMS policy within 15 calendar days of the case being reported to the contractor.

3.6.3. Beneficiary Privacy and Proof of Representation/Proper Releases

The contractor shall follow CMS policy with respect to representation and privacy issues

The contractor shall not discuss or disclose case specific information, either verbally or in writing, with individuals other than the beneficiary without the beneficiary's express consent. The contractor shall require authorization documentation (proof of representation documentation or consents to release) in accordance with CMS policy. Authorization documents shall be appropriately linked or attached to the corresponding beneficiary record/electronic case file. The contractor shall have this documentation and appropriate authorization on file prior to beneficiary data being released to individuals other than the beneficiary.

Verbal authorization from the beneficiary is acceptable to discuss and disclose case information. Receipt of the verbal authorization shall be tracked. Verbal authorizations are only applicable for 14 calendar days. The beneficiary should be advised that authorization beyond that timeframe will require written authorization.

All COMPLETE authorization documentation shall be associated with its related recovery case within 45 calendar days of receipt. 98 percent of INCOMPLETE authorization documentation shall be resolved within 45 calendar days of receipt.

Authorization documentation includes both Proof of Representation documents, as well as Consent to Release documents. The contractor shall not issue correspondence containing beneficiary specific information to unauthorized parties. The contractor shall issue copies of all correspondence to all authorized parties. Where documentation is requested and no authorization documentation is on file, the contractor shall issue the requested correspondence to the beneficiary only.

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3.6.4. Developing and Disseminating NGHP Conditional Payment Amounts

The current process for disseminating NGHP conditional payment amounts relies heavily on the issuance of Conditional Payment Letters (CPLs) to provide conditional payment information to beneficiaries and their representatives. The CMS is seeking innovation in the way NGHP conditional payment amounts are communicated. At a minimum, the contractor shall comply with the following, but may determine the method for which they are accomplished and shall obtain approval from the COR:

- Document conditional payments determined to be associated with what is being claimed and/or released;
- Update the beneficiary's case once notification has been received that there has been a settlement, judgment, award or other payment (including cases related to Section 111 and ORM situations) when a case has been established in the MSP Recovery System;
- Issue Conditional Payment Notices (CPNs), when appropriate;
- Address scenarios in which the contractor has identified claims as related, but are disputed by the beneficiary or their representative.
- Ensure that all complete Authorization Documentation (Proof of Representation and/or Consent to Release documentation) is applied to the appropriate MSP Recovery System cases. (–Applied” indicates that representative information is added to the case and the system will release documentation to the authorized parties with valid addresses on file.)
- Resolve all incomplete Proof of Representation and/or Consent to Release documentation (i.e.- the contractor has proactively performed/documented its due diligence to obtain or has obtained appropriate and complete documentation for a case) and apply it to the appropriate MSP Recovery System case; and

Where the contractor does not receive approval from the COR for proposed innovation, the contractor shall use the process outlined below.

- The contractor shall encourage beneficiaries and their representatives to acquire conditional payment information via www.mymedicare.gov.
- A Conditional Payment Letter (CPL) shall be issued upon request only. The requested CPL shall be issued within 45 calendar days of that request. Where the case is still running through system based auto processes (such as claims pulls or auto-filtering), the contractor shall issue the requested CPL within 15 calendar days of the case entering an active status (meaning a status in which

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auto-processes have been completed). The contractor shall provide an option to request CPLs through the IVR system.

- A CPN shall be issued when the contractor receives notification of a settlement, judgment, award or other payment (including cases related to Section 111 and ORM situations) and no case has been established in the MSP Recovery System or the initial CPL has not been issued. The CPN notifies the responsible party of claims Medicare has paid conditionally and requires the recipient to respond within a specified timeframe verifying the conditional payments amount.

3.6.5. NGHP Notices of Settlement, Judgment, Award, or Other Payment and Issuing Demand Letters

The contractor shall use the required CMS recovery demand letters. If the standard recovery demand letter is not applicable to a particular situation, the contractor shall submit suggested modifications to the COR for approval prior to its use.

Generally, in calculating Medicare's recovery claim prior to issuing a recovery demand letter, a pro rata reduction is applied to Medicare's conditional payment amount where the beneficiary incurred attorney fees and/or costs to obtain his settlement, judgment, award, or other payment. (See 42 CFR 411.37). However, in some instances, particularly for WC, attorney fees and/or costs may be awarded in addition to the settlement, judgment, award or other payment amount so that there would be no pro rata reduction. In other situations, there may be inconsistent information about fees and costs. Depending on the circumstances, additional documentation may be required to substantiate a pro rata reduction for procurement costs. The contractor shall identify those cases where procurement costs certification and/or additional documents are necessary and obtain such documents in the identified cases.

Where and when CMS institutes thresholds, the contractor shall comply with threshold requirements. The contractors shall not issue recovery demand letters in cases that fall within CMS' threshold requirements.

The contractor shall mail 100 percent of all recovery demand letters on the date printed on the demand letters. **Note:** The AR-established date shall equal the date of the demand.

3.6.5.1. Notice of Settlement, Judgment, Award, or Other Payment Submitted by Beneficiary.

Where the contractor receives a Notice of Settlement, Judgment, Award or Other Payment (NOS) submitted by the beneficiary or his representative and a recovery

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case is already established in the MSP Recovery System, the contractor shall update the conditional payment amount with the most up to date claim information, enter the NOS data and issue the recovery demand letter within 20 calendar days from the date of receipt of the NOS.

Where the contractor receives a NOS submitted by the beneficiary or his representative and the recovery case is NOT in the MSP Recovery System, the contractor shall post a MSP occurrence to CWF within 5 calendar days of the initial review of the documentation. The contractor shall work the case, so that it issues a CPN within 55 calendar days of the date the MSP occurrence was posted to CWF.

3.6.5.2. Total Payment Obligation to Claimant (TPOC) Submitted via Section 111

Where the contractor receives NOS/TPOC reported through Section 111 reporting and the case is already in the MSP Recovery System, the contractor shall update the conditional payment amount via the expedite function, enter the TPOC data and issue the recovery demand letter within 20 calendar days from the date of receipt of the TPOC.

Where the contractor receives a TPOC reported through Section 111 reporting and the case is NOT already in the MSP Recovery System, the contractor shall generate a CPN. The CPN will allow 30 days for the recipient to respond. A response due date will be printed in the body of the CPN. In order to account for incoming correspondence processing time, the contractor shall wait a maximum of 5 calendar days from the response due date printed in the CPN to receive a response to the CPN. Where a timely and complete response is received, the contractor shall work the response appropriately and issue the demand letter within 45 calendar days. Where a response is not received timely or is otherwise incomplete, the contractor shall issue the recovery demand letter within 20 calendar days of the maximum allowed wait time (5 calendar days from the response due date printed in the CPN).

The contractor shall meet timeliness requirements for 98 percent of letters issued.

3.6.5.3. NOS Submitted by the Beneficiary and TPOC Submitted via Section 111

Where the contractor receives a NOS submitted by the beneficiary, as well as a TPOC submitted through Section 111, the contractor shall follow the requirements listed above in section 3.6.5.2.

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3.6.6. NGHP MSP Record Termination with Settlement, Judgment, Award or Other Payment

The CWF contains open records of a beneficiary's MSP occurrences. The contractor is responsible for closing all non-ongoing responsibility for medicals (non-ORM) records reported pursuant to Section 111, upon settlement, judgment, award, or other payment at issuance of the demand. To do this, the contractor shall add a termination date on the relevant CWF record noting the date of the settlement, judgment, award, or other payment. The contract shall only update the MSP termination date for non-disputed NGHP cases where ORM is assumed and reported for emergency situations. All updates for NGHP ORM MSP occurrences should be performed by the MSP RAC.

The contractor shall enter the termination date on CWF for NGHP cases for all non-ORM. The contractor shall close 100percent of NGHP records upon settlement, judgment, award, or other payment at issuance of the demand, except for ORM reported pursuant to Section 111.

3.6.7. NGHP Pre-demand No-Fault Insurer Letter

The MSPRAC shall issue a "No-Fault Insurance" letter for no-fault cases not known to be in dispute between the insurer and the claimant.

Many accident situations involve both no-fault insurance and liability insurance. If all associated claims are permanently attached (from a systems/mechanical perspective) to the no-fault case, and the no-fault insurance limit is insufficient to allow for repayment of such claims, then: 1) the demand amount is incorrect; and 2) the claims inappropriately attached to the no-fault insurance MSP Recovery System case can only be used in connection with the liability insurance MSP Recovery System case through a highly manual process. The issuance of a "No Fault Insurance" letter to the no-fault insurer can eliminate or reduce the frequency of this problem.

3.6.8. Debt Collection Improvement Act (DCIA) Processes

The DCIA requires the referral of eligible delinquent MSP debt to Treasury for cross-servicing activities, including the Treasury Offset Program (TOP), if the debt is not resolved within 240 calendar days from the date of initial demand (*i.e.*, 180 calendar days' delinquent).

The contractor shall attempt to collect and resolve all debts prior to being 180 calendar days' delinquent.

Debts with an Outstanding Balance of \$25 or Less:

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Where a debtor submits payment and/or a valid documented defense that resolves a debt to the extent that there is a balance of \$25.00 or less of outstanding principal and/or interest, the contractor shall consider the debt resolved and recommend any such outstanding principal and interest for ~~write-off~~ "closed" on its next quarterly recommendation.

In these instances, the contractor shall issue the standard response letter that includes language that the contractor considers this matter resolved. The response letter shall be sent timely and without prior approval from CMS of the write off closed.

The contractor shall follow IOM instructions regarding timely and accurate response to Treasury/CMS for Treasury cross servicing activities including disputes, collections, refunds, and debts returned to agency. The contractor shall use accurate Debt Collection System (DCS) status codes when updating debts in DCS.

The contractor shall resolve 90 percent of NGHP debts prior to the debts becoming 180 calendar days delinquent. The contractor shall refer 100 percent of eligible delinquent NGHP debts to Treasury before the 181st calendar day of delinquency (241 calendar days after the date of the demand).

3.7. Post Demand Activities and Requirements

3.7.1. Reopenings

Reopening actions are relatively rare, as the reopening rules at 42 CFR 411.900 *et seq.* apply only to beneficiary recovery claims in the contractor context, and beneficiaries have administrative appeal rights if they disagree with the existence or amount of an MSP overpayment.

The contractor shall follow CMS policies and procedures for reopenings on eligible debts (beneficiary debtor involved in a settlement, judgment, award or other payment). The contractor shall transfer any reopening or appeal requests from a debtor outside of the scope of its contract (i.e., provider, physician or other supplier) to the appropriate Medicare claims processing contractor.

3.7.2. Initial Determinations for § 1870 Waiver of Recovery Requests

Section 1870 of the Act provides for a waiver of recovery if certain criteria are met. Waiver of recovery rights are set forth in the required demand letters issued to beneficiaries. The letters also inform beneficiaries that they may request § 1870 waivers of recovery if they believe they meet the applicable criteria

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If a beneficiary requests a § 1870 waiver of recovery, the contractor shall request appropriate documentation to support why the beneficiary believes that he/she meets the specified statutory and regulatory criteria.

When a beneficiary requests a § 1870 waiver of recovery, the contractor shall make an ~~initial~~ determination.” The contractor shall not process a § 1870 waiver of recovery until a recovery demand letter has been issued (there is no debt, therefore there is no recovery claim to waive until this point). The contractor’s determination may result in a full waiver, a partial waiver or a denial of waiver. The waiver determination is subject to appeal. The contractor shall complete a waiver determination within 120 calendar days from the date a waiver request is received.

3.7.3. Appeals

A beneficiary challenge to the existence or amount of an overpayment once the recovery demand letter has been issued is considered a request for appeal. A beneficiary challenge to the decision made on a § 1870 waiver of recovery request is also considered an appeal. Beneficiary MSP recovery demand letters and beneficiary § 1870 waiver of recovery decisions are ~~initial determinations~~” pursuant to 42 CFR 405.900 *et seq.* Demands to debtors under the scope of this contract other than beneficiaries (or their estates) are not ~~initial determinations~~” under these regulations and do not have formal administrative appeal rights.

The contractor shall make first-level appeal determinations (called ~~redeterminations~~”) and issue dismissals, as appropriate. The contractor shall refer second-level appeal requests to its designated QIC within 5 calendar days. This includes providing the necessary file and any related documents. The contractor shall electronically image and index all redetermination correspondence upon receipt.

The contractor shall effectuate MSP post-pay appeals determinations made at any level of administrative appeal or in court in accordance with established policy. The AdQIC shall relay notices of administrative appeal decisions via secured fax; the contractor shall set up and maintain a secured fax for these purposes. The contractor shall obtain COR concurrence/guidance before effectuating any court decision. Such ~~effectuations~~” may involve downward adjustments to the demanded amount (which may include COR notification for any refunds) or continued collection attempts such as referral to Treasury.

3.7.4. Bankruptcies and Liquidation Notices

Action must be taken to safeguard the Medicare Trust Funds when:

- A MSP debtor files a Federal bankruptcy petition (voluntary);
- Creditors of an MSP debtor petition the bankruptcy court to order the MSP

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- debtor bankrupt (involuntary); or
- A MSP debtor is ordered liquidated by a State government.

For background information on bankruptcies and liquidations, see Appendix 8 – MSP Recovery Policy.

The contractor shall receive notice of a bankruptcy during its recovery process. If the contractor identifies additional debts, cases, or ARs for a debtor/entity from a pending or adjudged bankruptcy, it shall notify the COR of the corrected or updated information. In such cases, the contractor shall recall debts it has referred to Treasury and report appropriately.

The contractor shall, upon request from the COR or CMS' Office of General Counsel (OGC) as instructed under Section 3.9.1.6, Coordinating with Investigative Agencies, gather information regarding debts where: 1) demand letters have been sent; and 2) the entity in bankruptcy/liquidation is involved (e.g., as the WC or liability insurer), but demands have not yet been sent. The contractor shall, when it discovers that a debtor/entity has filed for bankruptcy or is ordered to liquidate, act in time for the Government to meet filing deadlines established by the relevant court.

The contractor shall supply a report documenting debt-specific detail regarding the bankrupt entity and provide updates upon request; it shall also track the debts of bankrupt entities until the case is resolved.

The contractor shall maintain a subscription to Public Access to Court Electronic Records (PACER) in order to monitor previously and currently identified MSP debtor bankruptcy notices and discharges.

PACER is an electronic public access service of the United States Judiciary that allows users to obtain case and docket information from Federal Appellate, District and Bankruptcy courts, and from the U.S. Party/Case Index. It offers electronic access to case dockets to retrieve information such as:

- A listing of all parties and participants including judges, attorneys, and trustees;
- A compilation of case related information such as cause of action, nature of suit, and dollar demand;
- A chronology of dates of case events entered in the case record;
- A claims registry;
- A listing of new cases each day;
- Appellate court opinions;
- Judgments or case status;
- Types of documents filed for certain cases; and

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- In some cases, imaged copies of documents.

The PACER Service Center is run by the Administrative Office of the United States Courts. There is more information, including how to register, on the PACER website currently available at <http://pacer.psc.uscourts.gov/>.

The contractor shall track the progress, status, and resolution of all previously and currently identified MSP bankrupt/liquidated debtors. CMS will alter this tracking as needed to minimize inquiries to the contractor. .

Note: When CMS receives a Treasury Action Form bankruptcy notification from Treasury, the contractor shall update the CMS Debt Collection to reflect the bankruptcy status. The contractor shall update its AR case tracking system with the appropriate code identifying a bankruptcy for financial reporting.

When the bankrupt/liquidated entity is the debtor, itself, and the contractor receives a defense to a recovery demand, the contractor shall check the initial list provided by the COR and its own bankruptcy database to determine whether CMS is already aware of the situation. If so, the contractor shall follow prior instructions or guidance. If not, the contractor shall request a copy of the petition for bankruptcy/liquidation from the debtor. When it receives such a copy, the contractor shall update all debt tracking systems, the DCS, and financial reports. If it does not receive such a copy, the contractor shall notify the debtor that the ~~defense~~ is not valid without the proper documentation.

Note: The above reference to ~~defense~~ merely means a defense to Treasury referral and the contractor's active pursuit of recovery through venues other than the bankruptcy court. It is not a defense that would invalidate the debt or alleviate the debtor of its repayment responsibilities.

The contractor shall not send any new MSP debts to the debtor once the bankruptcy has been discovered. The contractor shall identify all existing open debts/ARs for the debtor, recall any such debts that had previously been referred to Treasury, and shall not refer any other relevant debts to Treasury.

CMS will coordinate with the contractor when bankruptcy/liquidation debts are discharged by the relevant court including the recommendation for ~~write-off closed~~. The contractor shall adhere to any date-specific discharge criteria regarding continued pursuit of claims (whole or partial) in a demand.

Occasionally, the United States Bankruptcy Court dismisses a bankruptcy action; in such cases, the COR or OGC will notify the contractor and the contractor shall treat the case as though the bankruptcy action never occurred.

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3.7.5. Recovery Litigation/Negotiation Support Requests

The CMS engages in various litigation and negotiation efforts related to MSP recoveries. The Secretary may sue or be sued, or there may be negotiated agreements/settlements without litigation.

The contractor shall designate a Special Projects group to handle CMS recovery litigation/negotiation support requests. The contractor shall respond to and act on all MSP litigation and negotiation support requests in the timeframe requested by CMS.

NGHP litigation or negotiation support activities generally involve the same types of activities typically involved in NGHP recoveries, including claims data compilation and evaluation. However, the negotiation support activities in particular, frequently involve efforts aimed at reaching a global settlement for a particular group of cases. A global settlement is designed to resolve MSP recovery claims for large groups of beneficiaries with similar alleged injuries. Globals are negotiated by CMS Central Office (CO) and are resolved outside of the traditional ReMAS recovery system and processes. These usually involve underlying product liability claims.

The contractor shall be equipped to perform the following activities upon CMS' request: tracking actions taken on a specified group of cases; sampling and evaluation of cases or claims in a specified group of cases; medical modeling (including pricing) the expected care related to the liability claims at issue or related to a particular settlement or judgment; identification and verification of Medicare beneficiary status; offering a telephone hotline for a specified group of cases; issuing specific non-standard letters; and establishing ~~dummy~~ "dummy cases" in the ReMAS system. Dummy cases are cases that are created and intentionally closed. These cases primarily act as placeholders for cases that are being resolved by CO. Each dummy case includes basic information on the global resolution in which the beneficiary is involved, so that the contractor is better able to handle and/or redirect inquiries related to beneficiaries involved in global resolutions. Dummy cases also prevent the contractor from duplicating work already being performed by CO.

The contractor shall be responsible for all financial management and Chief Financial Officer (CFO) activities and the reporting of MSP savings associated with any litigation or negotiation efforts regardless of whether there are individual recovery claims developed in conjunction with the effort.

3.8. Systems Requirements

Refer to Appendix 1 – Available CMS/COB&R Systems List, for a list of applications available to the BPOC. The contractor shall establish connectivity with each system and shall add, update, and delete MSP, COB, and Recovery records in each system, as

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appropriate.

All contractor correspondence with CMS shall be in hard copy or electronic format depending on the COR specifications. Electronic documents must be 508 compliant, and compatible with CMS hardware and software (the current CMS operating environment is Microsoft Office 2007 or earlier).

3.9. Communications Requirements

There are certain ongoing activities that the contractor shall conduct, as well as entities with which it will interact in order to maintain consistency of Medicare program operations. As a result, CMS depends on a close and well-coordinated working relationship among its internal components and external organizations. The contractor shall work and coordinate with, as necessary, external entities including but not limited to those listed in the following sections. The contractor shall establish liaison procedures for working relationships with other Medicare contractors. The contractor shall put these procedures in writing and send a copy to the COR 40 business days after the effective date of this contract.

3.9.1. Joint Operating Agreements (JOA)

A Joint Operating Agreement (JOA) describes work that needs to be accomplished and the roles and responsibilities of each signatory, for the success of the task or project. It includes details about who will do what, when, and for whom, and spells out the process the parties will follow if either believes that the other is not following the agreement. The CMS requires the execution of JOAs between all FAR-based contractors that interact with one another. The contractor shall execute JOAs that define each contractor's roles and responsibilities and create mutually agreed-upon and cost-effective methods to work with and support CMS' mission. The contractor shall execute JOAs with:

- MSPIC.
- MSPSC.
- MSP RACs.
- MACs;
- QICs/the AdQIC that address, at a minimum, those situations where coordination between the entities is necessary for work to be completed;
- Beneficiary Contact Centers (BCCs)/1-800-MEDICARE;
- Any other FAR-based Medicare contractor, as necessary or as required by CMS.
- Workers' Compensation Review Contractor (WCRC).

The contractor shall include at least the following topics in the JOAs:

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- Connectivity;
- Communication;
- Definitions;
- Party Roles and Responsibilities;
- Confidentiality; and
- Dispute Resolution.

All initially required JOAs shall be developed within 120 business days after the award of the contract. The contractor shall annually review its JOAs, identify and negotiate any changes required to appropriately address the parties' roles and responsibilities, execute necessary updates on an annual basis.

3.9.1.1. Communicating with the COB&R Contractors

The contractor shall cooperate and coordinate with the COB&R contractors (MSPSC, MSPIC, and MSP RACs) as appropriate. The contractor's performance will be evaluated using measures including, but not limited to;

- Demonstration of ongoing dialogue or meetings with the COB&R contractors;
- Feedback from the COB&R contractors; and
- Number and type of issues that arise and indicate communication, or lack of communication, between the COB&R contractors and the contractor.

3.9.1.2. Communicating with Beneficiary Contact Centers (BCCs)/1-800-MEDICARE

1-800-MEDICARE is a toll-free line for Medicare beneficiaries. The CMS consolidated all 1-800-MEDICARE operations into BCCs that will handle all beneficiary questions. Some beneficiaries who call 1-800-MEDICARE will have questions that will pertain to COB; BCC staff will directly transfer such calls to the contractor; some calls will require a direct (warm) transfer.

The contractor shall develop a secure method with 1-800-MEDICARE staff to receive written inquiries that 1-800-MEDICARE receives about MSP recoveries. The contractor shall respond to these inquiries within 45 business days of its fax receipt date.

Prior to its scheduled implementation date, the contractor shall supply to the COR with two phone numbers for 1-800-MEDICARE: one for the warm transfers mentioned above, and one for regular contact between the two entities. The contractor shall accept and handle these transferred calls.

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The contractor shall securely transmit written inquiries from beneficiaries to a designated/supplied 1-800-MEDICARE fax number. The contractor shall transfer misrouted beneficiary calls to 1-800-MEDICARE.

3.9.1.3. Interfacing with the QICs

The contractor shall forward all second-level appeal requests and all supporting hard copy documentation including the case file to the designated QIC in response to the QIC's request for case file. The contractor forwards all second-level appeal requests and all supporting documentation, including the case file, to the designated QIC within 5 calendar days. The contractor shall organize and prepare case files to be mailed hard copy, with tracking capabilities, to the designated QIC. The contractor shall reference the QIC jurisdictional maps to determine where to make referrals.

3.9.1.4. Communicating with the Medicare Claims Processing Contractors

The contractor shall forward all notices of refunds (voluntary/unsolicited provider/supplier checks, where the debtor alleges payment to the provider/supplier) for provider/supplier Duplicate Primary Payment (DPP) to the appropriate Medicare claims processing contractor. For all DDP, the contractor shall provide the claims processing contractor with a claims summary, which includes pertinent information related to payments that the provider/supplier alleged paying. For DDP related to NGHP cases, a copy of the payment ledger and Personal Injury Protection (PIP) log should be provided.

The contractor shall forward all claims information identified by the GHP debtor for which provider/supplier DPP was identified as a valid documented defense to the appropriate Medicare claims processing contractor.

The contractor shall deposit voluntary/unsolicited checks within 24 hours of receipt from a provider, physician or other supplier into its Treasury General Account (TGA; see Banking Relations section). The MSPRAC shall reissue the deposited amount and all related correspondence to the appropriate Medicare claims processing contractor via first class mail no later than 7 calendar days after receiving the requested funds from the COR.

The contractor shall transfer all misrouted general provider inquiries about benefit coordination to the contractor and about claims to the appropriate MAC. Beneficiary calls as indicated above would be transferred to 1-800 Medicare. Note that MACs are FAR-based contractors, and the contractor is obligated to execute a JOA with them.

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3.9.1.5. Communicating with the Workers' Compensation Review Contractor (WCRC)

The contractor shall identify and report any issues with data or documents input or scanned into the WCCCS. Examples of the types of issues that would be reported to the WCRC are commingled documents, duplicate cases, incorrect social security and/or Health Information Claim Numbers (HICN), mutilated documents, and cases established in the WCCCS without documents.

The WCRC may also submit a WCRC Problem Report that is used to report a problem experienced with the WCCCS. The contractor shall, upon receiving this report, complete the required action(s) and return the log via email to the WCRC within 10 business days of receipt, with a carbon copy to the Central Office WCRC COR as well as the MSPIC and MSPSC CORs. If the WCCCS report contains Protected Health Information (PHI) it must be sent via facsimile.

The contractor shall, upon receiving the WCRC Problem Report correct the problem(s) identified as quickly as possible. If the problem(s) are too complex they may be included on the WCCCS Scanning Issues Log, where the contractor shall complete the required action(s) and return via email the log to the WCRC within 10 business days of receipt, with a carbon copy to the Central Office WCRC COR and BFL. If the WC Problem Report contains PHI it must be sent via facsimile.

If the contractor is unable to resolve the WCCCS scanning issue(s), or the issue(s) on the WCRC Problem Report, the contractor shall notify the Central Office WCRC COR and open a change request

3.9.1.6. Coordinating with Investigative Agencies

The contractor shall, as directed by the COR, interface with investigative governmental agencies, which include but are not limited to CMS' OGC, DHHS' Office of the Inspector General (OIG) and the Government Accountability Office (GAO). These interfaces are not expected to be of a great volume or frequency.

The contractor shall, when and as directed by the COR, provide OGC, OIG, GAO auditors, and other investigative agencies with access to its files, records, data, and personnel and shall address findings.

If another governmental division or entity contacts the contractor directly, it shall notify the COR within one 1 day.

3.9.2. CMS Contacts

Centers for Medicare & Medicaid Services

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Office of Acquisition and Grants Management
Acquisition Support Group
Division of Program Integrity and Financial Management Contracts
Attn: Joanne Day
Contract Specialist
7500 Security Blvd
Mails Stop B3-30-03
Baltimore, Maryland 21244

Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Acquisition Support Group
Division of Program Integrity and Financial Management Contracts
Attn: Edward M. Rutherford
Contracting Officer
7500 Security Blvd
Mails Stop B3-30-03
Baltimore, Maryland 21244

3.10. Financial Management Requirements

3.10.1. Banking Relations

The contractor shall deposit all funds received into its Treasury General Account (TGA). The contractor shall implement internal controls over all bank activities to ensure timely and accurate recording, reporting and reconciliations.

The TGA will allow for deposit through the U.S. Treasury into the Medicare Trust Funds. These deposits will be categorized in CMS' cash link. The COR will reconcile the Trust Fund allocation with the cash link system. The contractor shall deposit funds into its TGA within 24 hours of receipt, and ensure recording and reconciliations are accurate and timely. The TGA will allow for deposit through the U.S. Treasury into the Medicare Trust Funds. These deposits will be categorized in CMS' CASHLINK.

The contractor shall deposit all funds received into its CMS administered account within twenty-four (24) hours of receipt.

The contractor shall submit the validated Monthly Schedule of Itemized Bank Services Provided Report to Banking2009@cms.hhs.gov and the COTR fifteen (15) calendar days after the end of the month.

The contractor shall reconcile the Funding Account and Disbursement account activity.

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The contractor shall submit a monthly bank reconciliation (CAFM, Form CMS-1521/1522) through the CAFM system in accordance with IOM Pub 100-6, Chapter 5 §70-90.7. This report is designed to provide a reconciliation of Medicare dollars between CMS, the MSPRC, and the bank.

3.10.2. Issuance of Refunds

The contractor shall request refunds within 15 calendar days of the identification of the situation requiring a refund. The contractor shall issue refunds (e.g., excess payments, duplicate collections, overpayments related to third party checks) through the contractor's corporate account and update all appropriate systems.

The contractor shall adhere to the following instructions to determine the amount of each refund based on:

- Excess collections;
- Excess Treasury collections.
- Waivers.
- Appeal effectuations.

The contractor shall follow instructions below once the need for a refund is determined:

The contractor shall enter into its disbursement system the approved refund payment request. The contractor will pay the requested funds within 30 calendar days from the date of entry into the contractor system.

The contractor shall issue a weekly report notifying the COR of all new refund checks issued since the preceding report. The COR will review the refunds for appropriateness. If a refund is found to be inappropriate, the COR will notify the contractor and the contractor shall immediately take appropriate actions to prevent payment of the inappropriate refund.

The contractor shall issue the corresponding checks via first class mail no later than 2 business days after producing the individual payments. The contractor shall maintain records and appropriate audit documentation for all checks refunded/issued. The contractor shall notify the COR monthly of all checks drawn by the contractor that are returned and/or reported as outstanding. Per CFR 1364; contractor is expected to continuously review all outstanding checks, take the appropriate action to stale dated checks in conformance with Federal and/or State/local banking regulations, and adjust financial reporting for these actions.

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The contractor shall notify the COR of all new refund checks issued within 7 calendar days of the date of issuance. Notification shall be delivered to the COR as a weekly report including the check number, the check amount and sufficient identifying information that the COR or their representative can research refunds as needed.

The contractor shall issue 100% of refunds within 30 calendar days of the identification of the situation requiring a refund. (This standard excludes Treasury refunds.)

3.10.3. Letter of Credit to Issue Refunds

The contractor shall establish banking relations, including a bank account, with a CMS-approved bank.

CMS will issue a letter of credit to fund the account used by the contractor for the estimated amounts of the vouchers that are submitted to the COR. The letter of credit covers the total amount of refunds paid by the contractor to beneficiaries, attorneys, employers, insurers, and Medicare claims processing contractors with checks drawn from the refund 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 when a bank issues a 1031 ~~draw down~~ request. This method provides cash availability to meet Medicare program requirements, controlling the timing of cash withdrawals to minimize the impact of the withdrawals on the public debt level and related financial costs.

A Tripartite agreement shall be established between CMS, the bank, and the contractor in accordance with IOM Pub 100-6, Chapter 5 §10-60.

When necessary, the contractor shall request changes to the monthly letter-of-credit limitation from CMS. Requests for changes to the limitation shall be submitted timely in accordance with IOM Pub 100-6, Chapter 5 §1

3.10.4. Unsolicited Refund Development

Providers, suppliers, and insurers sometimes send unsolicited refunds to Medicare contractors under the belief that Medicare should have been secondary for items or services for which it paid primary (it is common for such refunds to accompany 411.25 Notices). When a Medicare contractor receives such a refund check, or group

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of checks, it shall submit any information it receives to the contractor (this is currently accomplished via ECRS). If the information provided is complete and Medicare should have been properly secondary, the contractor shall add the appropriate MSP record to CWF and, if applicable, MBD. However, the information provided may not be adequate either to make an MSP determination or to create an MSP record. In such cases, the contractor shall develop for additional information resulting from these checks through the secondary claims development process, to the refunding entity (*i.e.*, the provider, supplier, or insurer) for additional MSP information to assist in creating and MSP record on CWF. In some cases, the refund is not MSP related and a new MSP record will not be added to CWF.

In those situations where checks are received in the mail and the envelope containing the check or multiple checks has enough information for processing, the contractor must do the following:

The contractor shall accurately post 100 percent) of all checks received with correspondence to a known debt within 20 calendar days (this does not affect the requirement that the contractor shall deposit all checks within 24 hours of receipt; see Banking Relations section).

The contractor shall deposit voluntary/unsolicited checks within 24 hours of receipt from a provider, physician or other supplier into its Treasury General Account (TGA; see Banking Relations section). The contractor shall reissue the deposited *amount* and all related correspondence to the appropriate Medicare claims processing contractor via first class mail no later than 7 calendar days after receiving the requested funds from the COR.

3.10.5. Financial Management of Trust Fund Dollars

The Chief Financial Officer Act of 1990 (see Section 2.3.1.17, *Other Key Statutes*) requires 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 contractors. The contractor shall maintain accounting records according to government accounting principles, such as those developed by the Federal Accounting Standards Advisory Board (FASAB), and applicable government laws and regulations. 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, the FASAB requires the maintenance of records not only for preparing financial statements, but also to enforce applicable laws and regulations. Medicare's account receivable (AR) has a significant balance on CMS' financial statements. The contractor shall manage MSP AR for NGHP (non-ORM) based debt where Medicare paid before an entity that had primary payment responsibility. Generally, the debtor

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will be the beneficiary, employer, insurer, TPA, plan, other plan sponsor, or WC carrier. The contractor's accounts payable will include refunds to debtors that have made excess payments. MSP-based recovery claims where the debtor is a provider, physician, or other supplier shall be referred to the Medicare claims processing contractor for development and recovery and shall not appear on the contractor's financial reports. The CMS will send the contractor the applicable interest rates as they change.

3.10.5.1. Use of Trust Fund Dollars

The contractor shall adhere to IOM Pub. 100-6 in conducting its financial management responsibilities. The contractor shall report only those categories within the CFO 750 for which it has responsibility.

3.10.5.2. CFO Certification for Medicare Operations

The designated CFO shall certify the accuracy and effectiveness of the contractor's financial reporting and the existence of effective internal controls over its financial management operations.

The CFO shall designate an alternate who shall, in the CFO's absence, perform his/her duties and responsibilities.

3.10.5.3. Validation of Financial Data

The contractor shall establish internal controls and maintain sufficient audit trail to ensure the validity, accuracy, and completeness, including reconciliation, of all financial data before it submits the data to CMS. The contractor's designated CFO shall certify all Medicare financial data, stating that they conform to IOM Pub. 100-6, GAAP, GAAS, and FASAB requirements.

3.10.5.4. Resolution of Financial Deficiencies

The contractor shall promptly resolve financial deficiencies identified in audits and/or reviews that affect operations and administration under this contract. The contractor shall timely submit an initial Corrective Action Plan (CAP) report that addresses all of the reported audit or review findings and is certified by the CFO in accordance with IOM Pub. 100-6, Chapter 7, Sections 40–40.6. Initial CAP reports are timely when they are provided within 45 calendar days of receiving a final audit report. The contractor's corrective action procedures are successful when its deficiencies have been corrected within one year of being identified.

3.10.5.5. Financial Reporting and Accounting

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The contractor shall produce and maintain all financial reports necessary to document Medicare Trust Fund activity in accordance with IOM Pub. 100-6, Chapter 4, sections 70.14 and 70.15, and Chapter 5, Sections 200–510.9. The contractor shall maintain transaction-level documentation that supports all Medicare Trust Fund activity under the control of the contractor (see Banking Relations, specific to daily reporting of collections).

The contractor shall identify MSP savings resulting from the recovery of debts, including transitioned debts. The contractor shall maintain tracking systems - i.e., the AR tracking system - to support its reported MSP savings (see IOM Pub. 100-5, Chapter 5, Section 60).

The contractor shall report any dollars recovered specific to the scope of the contract to CMS using established protocol. The contractor shall report additional savings as directed by CMS and in the timeframe required.

3.10.5.6. Accounts Receivable Trend Analyses

The contractor shall perform and report AR trend analyses in accordance with IOM Pub. 100-6, Chapter 5, Section 400.22 and shall, with COR approval, remedy errors or problems uncovered by the analyses.

Trend analyses are performed primarily to identify changes in, and verify the accuracy of the financial data being reported. Trending procedures involve comparing recorded AR amounts to developed expectations; they are important tools for the identification of potential errors, system weaknesses, and inappropriate patterns of financial data. Trend analyses shall be reported to CMS on a monthly basis.

3.10.5.7. Financial Reporting Audits/Reviews

The contractor shall participate in financial audits/reviews such as Agreed Upon Procedures, CFO, CAPs, and Certification Packages for Internal Controls.

The contractor shall make financial reports and their supporting documentation available to CMS, the GAO, DHHS' 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. The contractor's deficiencies must be corrected within 1 year of being identified.

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3.11. Administrative Requirements

3.11.1. Staffing

The contractor shall actively recruit and retain qualified staff for the requirements of this SOW, including subcontractor operations where necessary.

The contractor shall employ only personnel who are fully qualified and competent to perform their assigned work and who possess the minimum background/experience for each labor category as delineated below. Personnel shall have specific expertise required to perform the contract tasks to which they are assigned.

The CMS reserves the right to review the qualifications of all Key Personnel who are proposed to work on the contract before assignment and of any replacements for these individuals, and to reject individuals who do not meet the qualifications set forth in this SOW.

The contractor shall prepare and update a staff roster. The staff roster shall be in a CMS defined format. The staff roster shall include at minimum staff name, position, phone number and email address. The staff roster shall be updated and provided to CMS whenever there is a change to the contractor personnel.

3.11.1.1. Key Personnel

Note that the Key Personnel labor categories are not intended to cover all of the contractor's management positions and categories. The contractor shall provide competent overall contract management and performance. The contractor shall, on the first business day upon learning that a vacancy has occurred or will occur, notify the COR and Contracting Officer (CO) of any vacancy in a Key Personnel position identified below and shall provide its plans for: 1) task coverage while such position is vacant; and 2) timely re-filling the position. The contractor shall also provide the COR and CO with 2 weeks' advanced notice of the temporary absences exceeding 5 business days of the Project Director, Task Manager, or System Administrator, and the name of the individual acting in that capacity while the incumbent is absent.

3.11.1.1.1. Project Director

The Project Director is a senior manager responsible for coordinating the management of all work performed under this contract, including overseeing the work of subcontractors, team members and vendors. The Project Director shall act as the central point of contact with CMS and shall have the full authority to act for the contractor in the performance of the required work and services under the contract. The Project Director is responsible for all phases of performance,

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including contract management, contract cost control, project management, coordination of resource needs, coordination with corporate resources and management, and has direct accountability for the technical accuracy, timeliness and quality of all deliverables. The Project Director is also responsible for the management of all subcontractors, consultants, vendors and similar parties, if any, engaged in performing work under the contract. The Project Director provides expert leadership in all contract tasks and, as appropriate, in specialized technical areas. The Project Director will have the authority to commit the contractor without prior corporate approval. The Project Director shall report in writing and orally to contractor management and CMS officials, including the CMS Contracting Officer (CO) and COR. The Project Director shall have: 1) experience as a senior-level manager of a large (more than 100 persons), multi-shift operation similar to that described in this SOW; and 2) a working knowledge of Medicare, the insurance industry as it relates to Medicare, MSP, COB, and Recovery activities.

The Project Director shall meet with the COR and the CO or their designee(s) on a monthly basis to review scheduling, priorities, funding, performance issues, and similar matters.

The Project Director shall have broad and deep knowledge of business administration, human resource management, customer service and mass-mailing management and processing, and have excellent oral and written communications skills.

The Project Director shall have a bachelor's degree and have at least 12 years in project/program management related experience.

3.11.1.1.2. Deputy Project Director

The Deputy Project Director is a senior manager responsible for assisting the project director in coordinating the management of all work performed under this contract. In the event of the absence of the Project Director, the Deputy Project Director shall act as the central point of contact with CMS and shall have the full authority to act for the contractor in the performance of the required work and services under the contract. The Deputy Project Director may have separate areas of responsibility from the Project Director; however the Project Director still retains responsibility for all phases and areas of performance and deliverables.

The Deputy Project Director shall meet with the Project Director, COR and CO on a monthly basis to review scheduling, priorities, funding, performance issues, and similar matters.

The Deputy Project Director shall have broad and deep knowledge of business administration, human resource management, customer service and mass-mailing management and processing, and have excellent oral and written communications

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skills.

The Deputy Project Director shall have a bachelor's degree and have at least 10 years in project/program management related experience.

3.11.1.1.3. Certified Financial Officer (CFO)

The CFO shall not be responsible for other external third party or corporate activities. The CFO may oversee other Medicare contracts. To eliminate potential conflict of interest and keep duties separate, the CFO shall not serve as the Compliance Officer, but is responsible for meeting all the compliance requirements of the Medicare MSP financial operations.

The designated CFO shall certify the accuracy and effectiveness of the contractor's financial reporting and the existence of effective internal controls over its financial management operations.

The CFO shall have a bachelor's degree in accounting or finance and be a Certified Public Accountant (CPA).

The CFO shall designate an alternate who shall, in the CFO's absence, perform his/her duties and responsibilities.

3.11.1.1.4. Task Managers

Task Managers are assigned to oversee specific Data Collection and Recovery Activities, and are responsible for the production, quality control and monitoring of all routine and ad hoc reports produced for such tasks. Each Task Manager shall: 1) be familiar with the task(s) to which s/he is assigned; 2) monitor his/her assigned task(s) and keep the Project Director abreast of all problems and accomplishments; 3) anticipate problems and work to mitigate them; 4) provide technical and operational direction on the assigned task(s); and 5) complete assignments within estimated time frames and budget constraints. Task Managers may also: 1) serve as technical authorities for specific design areas; 2) schedule work and assign duties to subordinates; and 3) interact with CMS personnel.

Task Managers shall have bachelor's degree (or equivalent work experience) and at least 4 years experience working in a management related position.

Task Managers shall be identified for the following areas:

- Call Center
- Correspondence Processing
- Electronic Data Interchange (EDI)

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3.11.1.1.5. Compliance Officer

The Compliance Officer shall monitor the contractor's adherence to this SOW and CMS' MSP statutory and regulatory provisions, policy and instructions. They shall also oversee all internal control measures developed and implemented in support of this contract.

The Compliance Officer shall have a bachelor's degree (or equivalent work experience) and at least 5 years experience working with medical/legal/ethical issues in healthcare.

3.11.1.1.6. Security Officer (SO)

The contractor shall designate a Security Officer qualified to manage the Medicare program and assure the implementation of necessary safeguards.

The SO shall be organizationally independent of IT operations. The SO can be within the Chief Information Office organizational domain, but may not have responsibility for operation, maintenance, or development. The contractor may have additional SOs at various organizational levels, but they must coordinate security actions through the principal SSO for the COB&R program, which will be headed by the MSPIC.

The SO assures compliance with CMS Core Security Requirements by performing the activities listed in the BPSSM.

The SO shall be accredited as a Certified Information Systems Security Professional (CFACTSP), but this is only a recommendation, not a requirement.

3.11.1.1.7. Telecommunications Engineer

The Telecommunications Engineer provides technical support for telecommunications activities, including the planning, design, installation, and maintenance of large telecommunications networks. The Telecommunications Engineer's duties include: 1) developing (as necessary), operating, and maintaining audio, video, and data communications systems; 2) applying telecommunications engineering principles and theory to propose design and configuration alternatives; 3) evaluating existing communications systems to identify deficiencies and network performance improvements; 4) consulting with appropriate CMS staff to properly identify problems and to propose solutions that meet all requirements; 5) routinely analyzing network performance, usage and traffic flows, accesses and interfaces, transmission techniques, and protocols; 6) performing network analyses and feasibility studies concerning communications and communication networks; 7) preparing studies and giving presentations on communications concepts; 8) providing technical guidance to others concerning data communications

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requirements; and 9) preparing or helping to prepare functional specifications to acquire commercially-available data communications networks.

The Telecommunication Engineer shall have a bachelor's degree (or equivalent work experience) and at least 5 years experience with telecom and network management.

3.11.1.1.8. Medical Director

The Medical Director shall provide assistance to contractor staff in conducting evaluations, making recommendations and writing medical opinions to state Medicare's position for a case and for recovery of the conditional payment. This action shall include but not be limited to requesting medical records, reviewing medical records, and writing a medical opinion for the case file. In addition, the Medical Director shall provide assistance in various aspects of any requested MSP litigation or negotiation support (e.g., modeling and/or pricing efforts). The Medical Director shall provide ready access to medical experts, as necessary to support functions of this contract. The Medical Director shall provide knowledge concerning the applicable statutes, regulations, and CMS policy in determining which Medicare-reimbursed items or services are related to a particular recovery claim.

The Medical Director position may be a part-time position.

3.11.1.1.9. System Administrator

The Systems Administrator is responsible for all contractor systems and databases (not supported by the MSPSC) through the life of the contract. The Systems Administrator shall: 1) provide highly technical expertise and guidance in system administration and in database implementation, operation and maintenance; 2) be an authority on database design and the use of database management systems; 3) determine security procedures for all systems/databases; 4) control and monitor access to and use of systems/databases; 5) oversee the safekeeping of systems/databases from accidental or intentional damage or loss; 6) design, install, modify, maintain, and troubleshoot Local Area Networks (LANs); and 7) make any necessary adjustments in network operating system, software and hardware. The System Administrator also works with other staff to install, test, debug, modify, and maintain the LAN and related computer hardware.

The Systems Administrator shall have a bachelor's degree in a related field and 10 years experience with systems and contractors. The experience and background of the system administrator should be reflected of the systems and networks supported by the Systems Administrator.

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3.11.1.2. Non-key Personnel

The CMS believes that the following positions should be included in the contractor's staffing plan; however, the contractor is not required to obtain prior CMS approval of the persons selected to fill them.

3.11.1.2.1. Quality Assurance Officer (QA Officer)

The Quality Assurance Officer 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 met. The QA Officer is responsible for coordination and communication with Trainers, Compliance Officer, etc., when a deficiency in guidelines, processes, procedures, and/or policies is uncovered during the contractor's established quality review program. The QA Officer is responsible for the improvement of overall quality and efficiency in order to maintain the integrity of the contract.

The QA Officer shall have a bachelor's degree (or equivalent work experience) in a related field of study and at least 4 years experience in quality control or quality assurance activities.

3.11.1.2.2. Training Specialist

The Training Specialist is responsible for all training performed, both through courses and instructional materials, to educate technical and non-technical personnel. The Training Specialist: 1) gathers and assimilates information on a subject matter, organizes and condenses material, and prepares course outline, handouts, and visual aid materials; 2) coordinates with CMS subject matter experts (SMEs) to prepare courses that meet stated objectives; and 3) may be required to instruct or to prepare/arrange for the preparation of automated training materials (*e.g.*, video-recorded training, computer aided tutorials).

The Training Specialist shall work with the Policy Specialist to address training needs specific to the changing regulations that may have an effect on operations. The Training Specialist shall work with other operations management to identify specific training needs and to implement training programs to address those needs.

The Training specialist shall have a bachelor's degree (or equivalent work experience) and at least 5 years experience developing and implementing training programs.

3.11.1.2.3. Medicare Secondary Payer (MSP) Policy Specialist

The MSP Policy Specialist shall provide technical expertise and guidance to comply with all applicable statutes, regulations and CMS policy. The MSP Policy Specialist shall remain updated on applicable MSP statutes, regulations and policy and implement all updates into the contractor's operational environment. The MSP

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Policy Specialist shall communicate with the Medical Personnel, the Training Specialist, and the Compliance Officer, as appropriate.

The MSP Policy Specialist shall have a bachelor's degree (or equivalent work experience) and at least 10 years experience working with and interpreting MSP policies.

3.11.1.2.4. Customer Service Supervisor

The Customer Service Supervisor oversees operators, tasks, and processes employed in the customer service area, including all operational aspects of the contractor's Call Center (*i.e.*, providing on-line customer service, operation of TFTS, TDD and Advanced 800 services).

The Customer Service Supervisor shall have a bachelor's degree (or equivalent work experience) and at least 10 years experience managing a customer service center.

3.11.2. Work Performed Outside the United States and its Territories

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

1. Contract terms regarding system security;
2. Contract terms regarding the confidentiality and privacy of information and data protection;
3. Other relevant contract terms, including this SOW;
4. Corporate compliance;
5. All laws and regulations applicable to performing work outside the United States; and
6. The best interests of the United States.

In requesting the CO'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 CO's judgment, the above factors are not fully satisfied, the performance of work outside the United States will not be authorized. Furthermore, any approval to employ or outsource work outside of the United States must have the concurrence of the Security and Emergency Management Group (SEMG) Director or a designee.

3.11.3. Internal Controls

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The contractor shall establish and maintain efficient and effective internal controls to perform the requirements of this contract.

Internal controls are not separate, specialized systems within an organization. Rather, they are 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 facilitate the achievement of management objectives by serving as checks and balances; they are essential to assure CMS that the contractor is complying with CMS instructions and directions and for DHHS' OIG to certify CMS' financial statements.

The contractor shall ensure it has no major nonconformance and no more than 10 minor non-conformances identified by any internal or the A123 audit.

The contractor's management shall continually monitor and update internal controls to accomplish the aforementioned operational goals.

3.11.3.1. Written Policies and Procedures

The contractor shall have written policies and procedures for internal controls in place and operating effectively in accordance with the IOM

3.11.3.2. Attestation and Certification Statement

The contractor shall attest and certify to the adequacy of the internal controls under its authority annually in accordance with the IOM.

3.11.3.3. 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 the IOM. The contractor shall send a report of findings and proposed CAPs to the COR for CAP approval prior to implementing any proposed CAPs. The contractor shall supply a report quarterly, or more frequently, if requested, for a specific CAP on the status and resolution of all CAPS to the COR. All contractor A123 findings under the direct control of the contractor shall be corrected within one (1) year (or less based on CMS' determination of criticality).

3.11.3.4. Compliance Program

The contractor shall maintain a compliance program consisting of at least the following elements:

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- A written code of conduct and written compliance policies and procedures;
- A compliance officer;
- An annual employee training and education program on compliance issues;
- A process to receive compliance-related complaints that permits anonymous reporting;
- An internal monitoring and auditing function to help comply with the requirements in this contract;
- An enforcement and disciplinary process for violations of the contract, code and/or Federal statutes and regulations; and
- 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.

3.11.3.5. Contingency Planning

The Contractor shall submit its Contingency Plan (CP) no later than 60 business days after contract award. The document should follow the CMS CP template found at

http://www.cms.hhs.gov/manuals/downloads/117_systems_security.pdf. As with all deliverables, the contractor should coordinate with CMS to establish a suitable review period, allowing time for document modifications, and prior to the deliverable's due date.

3.12. Security Requirements

Information Security and reusability, modified to include reference to IRS 1075, section 11.7).

The central tenet of the CMS Information Security (IS) Program is that all CMS information and information systems shall be protected from unauthorized access, disclosure, duplication, modification, diversion, destruction, loss, misuse, or theft—whether accidental or intentional. The security safeguards to provide this protection shall be risk-based and business-driven with implementation achieved through a multi-layered security structure. All information access shall be limited based on a least-privilege approach and a need-to-know basis, i.e., authorized user access is only to information necessary in the performance of required tasks. Most of CMS' information relates to the health care provided to the nation's Medicare and Medicaid beneficiaries, and as such, has access restrictions as required under legislative and regulatory mandates.

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The CMS IS Program has a two-fold purpose:

- (1) To enable CMS' business processes to function in an environment with commensurate security protections, and
- (2) To meet the security requirements of federal laws, regulations, and directives.

The principal legislation for the CMS IS Program is Public Law (P.L.) 107-347, Title III, *Federal Information Security Management Act of 2002 (FISMA)*, <http://csrc.nist.gov/drivers/documents/FISMA-final.pdf>. FISMA places responsibility and accountability for IS at all levels within federal agencies as well as those entities acting on their behalf. FISMA directs Office of Management and Budget (OMB) through the Department of Commerce, National Institute of Standards and Technology (NIST), to establish the standards and guidelines for federal agencies in implementing FISMA and managing cost-effective programs to protect their information and information systems. As a contractor acting on behalf of CMS, this legislation requires that the Contractor shall:

- Establish senior management level responsibility for IS,
- Define key IS roles and responsibilities within their organization,
- Comply with a minimum set of controls established for protecting all Federal information, and
- Act in accordance with CMS reporting rules and procedures for IS.

Additionally, the following laws, regulations and directives **and any revisions or replacements of same** have IS implications and are applicable to all CMS contractors:

- P.L. 93-579, *The Privacy Act of 1974*, <http://www.usdoj.gov/oip/privstat.htm> , (as amended);
- P.L. 99-474, *Computer Fraud & Abuse Act of 1986*, www.usdoj.gov/criminal/cybercrime/ccmanual/01ccma.pdf P.L. 104-13, *Paperwork Reduction Act of 1978*, as amended in 1995, U.S. Code 44 Chapter 35, www.archives.gov/federal-register/laws/paperwork-reduction;
- P.L. 104-208, *Clinger-Cohen Act of 1996* (formerly known as the Information Technology Management Reform Act), http://www.cio.gov/Documents/it_management_reform_act_Feb_1996.html;
- P.L. 104-191, *Health Insurance Portability and Accountability Act of 1996* (formerly known as the Kennedy-Kassenbaum Act) <http://aspe.hhs.gov/admsimp/pl104191.htm>;
- OMB Circular No. A-123, *Management's Responsibility for Internal Control*, December 21, 2004, http://www.whitehouse.gov/omb/circulars/a123/a123_rev.html;

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- OMB Circular A-130, *Management of Federal Information Resources*, Transmittal 4, November 30, 2000, <http://www.whitehouse.gov/omb/circulars/a130/a130trans4.html>;
- OMB directives, <http://www.whitehouse.gov/omb/inforeg/infopoltech.html>;
- Department of Homeland Security (DHS) directives, , (e.g., Homeland Security Presidential Directive HSPD-7 and HSPD-12), http://www.dhs.gov/xabout/laws/editorial_0607.shtm;
- NIST standards and guidance, <http://csrc.nist.gov/>;
- Department of Health and Human Services (DHHS) regulations, policies, standards and guidance <http://www.hhs.gov/policies/index.html>; and
- GAO/AIMD-12.19.6, Federal Information System Controls Audit Manual (FISCAM), January 1999, <http://www.gao.gov/special.pubs/ai12.19.6.pdf>.

Furthermore, these laws and regulations provide an infrastructure to assist CMS in implementing and managing a cost-effective IS program to protect its information and information systems. Therefore, **the Contractor shall** adhere to all IT policies, standards, procedures, templates, and guidelines that govern the CMS IS Program, <http://www.cms.gov/informationsecurity> and the CMS System Lifecycle Framework, <http://www.cms.gov/SystemLifecycleFramework>. **The Contractor shall** review these websites monthly, at a minimum, given that the information is updated frequently.

The Contractor shall comply with the CMS IS Program requirements by performing, but not limited to, the following:

- Implement their own IS program that adheres to CMS IS policies, standards, procedures, and guidelines, as well as industry best practices;
- Participate and fully cooperate with CMS IS audits, reviews, evaluations, tests, and assessments of contractor systems, processes, and facilities;
- Provide upon request results from any other audits, reviews, evaluations, tests and/or assessments that involve CMS information or information systems;
- Report and process corrective actions for all findings, regardless of the source, IAW CMS procedures;
- Document its compliance with CMS security requirements and maintain such documentation in the systems security profile;
- Prepare and submit IAW with CMS procedures, an incident report to CMS of any suspected or confirmed incidents that may impact CMS information or information systems; and
- Participate in CMS IT conferences as directed by CMS.

The Contractor shall comply with the DHHS information security requirements by performing, but not limited to, the following:

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- The Contractor shall ensure new systems are configured with the applicable Federal Desktop Core Configuration (FDCC) (http://nvd.nist.gov/fdcc/download_fdcc.cfm) and applicable configurations from <http://checklists.nist.gov>, as jointly identified by the Operating Division (OPDIV)/Staff Division (STAFFDIV) Contracting Officer's Technical Representative (COR) and the Chief Information Security Officer (CISO).
- The Contractor shall ensure hardware and software installation, operation, maintenance, update, and/or patching will not alter the configuration settings specified in: (a) the FDCC (<http://nvd.nist.gov/fdcc/index.cfm>); and (b) other applicable configuration checklists as referenced above.
- The Contractor shall ensure applications are fully functional and operate correctly on systems configured in accordance with the above configuration requirements.
- The Contractor shall ensure applications designed for end users run in the standard user context without requiring elevated administrative privileges.
- Federal Information Processing Standard 201 (FIPS-201)-compliant, Homeland Security Presidential Directive 12 (HSPD-12) card readers shall: (a) be included with the purchase of servers, desktops, and laptops; and (b) comply with FAR Subpart 4.13, *Personal Identity Verification*.
- The Contractor shall ensure that all of its subcontractors (at all tiers) comply with the above requirements.

An approved *HHS Department Information Security Policy/Standard Waiver* is required to deviate from the technical standard set forth above.

As periodic updates are made to the Information Security requirements, it is recommended that the Contractor check the Information Security website on a monthly basis: www.cms.hhs.gov/InformationSecurity/01_Overview.asp#TopOfPage

4 Project Management Plan (PMP)

The contractor shall maintain a Project Management Plan (PMP) approved by the COR which shall address key projects mutually agreed by CMS and the contractor to support the management of the contract as needed.

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 programs functions for successful program execution.

4.1. Implementation Project Plan (IPP)

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The contractor shall adhere to the Implementation Project Plan (IPP) from the incoming contractor, as needed. The IPP includes a detailed work breakdown structure of all activities/tasks required to transfer all Medicare MSP Data Collection and Recovery functions and workloads to the incoming contractor.

4.1.1. Implementation and Transition Requirements

Upon award of contract, CMS may require that the Contractor attend a Post Award Conference. Should CMS determine that a Post Award Conference is necessary; the Post Award Conference will be conducted as follows:

Within ten (10) business days after the award of the contract, the Contractor shall meet with the Contracting Officer, the COR(s) and other government technical personnel to thoroughly review the requirements of the contract document, contract administration procedures and invoicing requirements. Contractor representatives attending the Conference shall consist of a company representative authorized to bind the company, the Program Director responsible for overall contract administration and all Key Personnel. The Conference may be held by telephone or at:

DHHS/CMS/OAGM/DPIFMC,
7500 Security Blvd., B3-30-03
Baltimore, MD 21244

The contractor shall facilitate an orderly transition of the contract and all Medicare MSP Data Collection and Recovery Activity data, records and workloads from the current Medicare contractor in accordance with the IPP. The contractor shall establish and maintain a transition team throughout the course of the transition.

The transition shall be considered successful when all Medicare MSP Data Collection and Recovery functions are performed by the incoming contractor beginning on the specified transition date. The workload transition is successful when all Medicare MSP Data Collection and Recovery information, records, and data have been accepted by the incoming contractor beginning on the specified transition date.

4.1.2. Contractor Transition Responsibilities

The contractor shall cooperate fully with the outgoing contractor and shall deliver all Medicare MSP Data Collection and Recovery data, records and workloads to the incoming contractor during the transition period.

The contractor shall submit a letter of readiness on the first business day after completion of the transition from the current contractor(s).

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4.1.3. Transition Project Plan (TPP)

The contractor shall adhere to the Transition Project Plan (TPP) to provide for the transfer and receipt of MSP Data Collection and Recovery functions and the transition of records and workloads. The TPP will be provided by the incoming contractor. The TPP shall be delivered 45 calendar days after award of the contract.

The TPP shall address workloads to be transitioned and contain a proposal of which workload categories to address and in what order of priority. For example, the incoming contractor's operational plans will focus on application of checks, and new NGHP demands to be issued subsequent to notice of settlement, judgment or award.

The incoming contractor's TPP will incorporate the acceptance of all transferred workloads by the first business day of implementation.

4.1.4. Implementation Transition and Cutover Meetings

The contractor shall attend and maintain all minutes for meetings in accordance with the IPP, TPP, or as directed by the COR.

4.1.5. Transition

During performance of this contract should termination or non-renewal of an existing contractor's contract occur, CMS may require the successor contractor to provide transition services beginning at the earliest mutually agreeable date. During this period, the incumbent contractor shall work with the new contractor, CMS staff, as well as other identified CMS contractors to ensure continued operation of the Program.

Prior to commencement of transition, CMS will request a transition plan from the incumbent contractor. The Transition Plan shall provide adequate coverage to ensure uninterrupted service to the Program, be effectively and efficiently administered, and be completed within a reasonable timeframe.

The successor contractor shall cooperate fully with the incumbent contractor, as directed by the COR, to ensure that all services continue without interruption.

4.1.6. Contract Phase-Out Services

At the end of this contract, if a determination is made to terminate or not renew the incumbent contractor's contract, the contractor shall provide similar transition/phase-in/ phase-out support to the successor contractor selected by CMS (refer to Federal Acquisition Regulation 52.237-3 Continuity of Services).

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4.1.7. Transition Plan

At a minimum, the Transition Plan shall provide detailed methods that will be used to ensure a smooth transition from the incumbent contractor's operation to sole operation by the successor contractor. At a minimum, the Transition Plan shall provide for the following:

- A milestone chart detailing the time lines and stages of transition from the effective date of contract performance until the contractor assumes sole responsibility for the Program work;
- An organizational chart that displays internal and external organizational relationships. The organizational chart shall identify the individuals (at all levels) who will be responsible for the transition and their respective roles; detail the lines of communication and how the contractor will interface with CMS during this phase of contract performance;
- Plans to communicate and cooperate with the current incumbent contractor;
- Transition services will include transfer of Government-Furnished Property (GFP) (e.g., hardware, software, records/data) from the incumbent contractor to the successor contractor, or to CMS or another CMS contractor. CMS may elect to require the transition of GFP as follows:
 - Prior to procurement of an asset, the contractor shall propose a transition charge to be evaluated and negotiated by the CMS.
 - A successor contractor to this contract, or CMS, will be afforded the opportunity to acquire contractor assets at a reasonable transition charge. All existing assets shall remain installed and usable by CMS through the transition of assets for their replacement by the successor contractor. In the event a decision is made not to procure the assets, the contractor has the responsibility to dispose of the assets as instructed by CMS.

4.2. Cost Management

The contractor shall produce on a monthly basis program Cost Management Reports describing budget versus actual cost data by cost account and shall submit these reports.

4.2.1. Incurred Cost Expenditure (ICE)

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FAR 52.216-7 (Allowable Cost and Payment Clause) requires that the prime contractor submit an adequate final incurred cost proposal, together with supporting data, within 6 months after the end of its fiscal year. More information, if needed, can be requested from the CMS Contracts Administrator. The CMS receipt of an adequate proposal from the contractor starts the audit process to determine final indirect rates (if the prime-contractor performs on a cost-type contract). This proposal should include a signed CERTIFICATE OF INDIRECT COSTS, IAW FAR 42.703-2. A copy of this certificate text may be found at FAR 52.242-4. Failure to comply will result in the Government protecting its interest through withholding of payment percentage on each invoice.

4.2.2. Bidding and Billing Rates

In the process of making a contract award, CMS will request an audit of any contractor direct and indirect proposed rates. It is requested that the contractor track actual costs monthly and compare actual incurred costs to initial proposed costs (in a cost-type contract). When there is significant divergence between proposed (budgeted) rates and actual incurred rates, the contractor should address the difference and work towards regaining convergence, in order to avoid large adjustment vouchers when annual incurred cost rates are settled. This activity is an ongoing process throughout the life of the contract.

The CMS may request new budget proposed direct and indirect rates at the beginning of each contract period of performance, which will be audited and utilized to build independent government cost estimates of new work.

4.2.3. Contractor Award Fee Evaluation

The Government will, at the conclusion of each specified evaluation period, evaluate the contractor's performance for a determination of award fee earned. The Fee Determination Official will make the determination as to the amount of the award fee earned.

The Government will evaluate the contractor's performance during each award fee period taking into account the factors, schedule, and scoring plan set forth in this document. The award fee amount available for each period will be a portion of the total award fee pool available for the entire period. The contractor may receive all, part, or no award in any award fee period. The contractor shall be promptly advised in writing of the determination, as well as the reasons for the determination.

It is further agreed that the contractor may submit a self-evaluation of performance for each period under consideration. The basis for determination of the fee shall be the evaluation by the Government. A self-evaluation, which is received within 10

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business after the end of the period may be given such consideration, if any, as the Fee Determination Official shall find appropriate.

4.3. Risk Management Plan

The contractor shall develop, execute, and maintain a Risk Management Plan.

The contractor shall include in the Risk Management Plan those MSP Data Collection and Recovery activities associated with continuing operations that may have a negative effect on the success of the contract if the specific requirements are not met. The contractor shall also include in the Risk Management Plan contingencies that will maximize successful contract administration. Before implementing a Risk Management Plan, the contractor shall obtain COR concurrence. An initial draft Risk Management Plan shall be submitted to CMS, 40 business days after the award of the contract. After CMS has completed the review of the draft, the contractor will have 10 business days to submit a final plan.

The Risk Management Plan shall be reviewed and updated as necessary on an annual basis. An updated plan shall be submitted to CMS 40 business days after the exercise of an option year.

4.4. Business Continuity Planning and Disaster Recovery

Policies and procedures shall be developed by the contractor to ensure essential business functions continue during a disaster. The contractor shall assess existing vulnerabilities; implement disaster avoidance and prevention procedures; and develop a comprehensive Disaster Recovery Plan that shall enable it to react appropriately and in a timely manner if disaster strikes.

The Disaster Recovery Plan shall address identified risks and vulnerabilities. The Disaster Recovery Plan shall be continually updated to reflect changes applied by the contractor due to operations or procedures. Elements of the plan shall include protection of physical infrastructure, IT disaster recovery, business continuity (with or without system availability), and other topics

An initial draft of the Disaster Recovery Plan shall be submitted to CMS, 60 business days after the award of the contract. After CMS has completed the review of the draft, the contractor will have 10 business days to submit a final plan.

The Disaster Recovery Plan shall be reviewed and updated as necessary on an annual basis. An updated plan shall be submitted to CMS 60 business days after the exercise of

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an option year.

4.5. Communication/Outreach Plan

The contractor shall develop, execute, and maintain a communication plan to identify the processes and procedures the contractor shall follow to inform all stakeholders about the implementation, its status and progress, and how changes may affect them; the contractor shall develop the plan with the goal of maximizing the effectiveness of its Data Collection Activities, Recovery efforts, and Debt collection. The Contractor shall work with the MSPIC to ensure the Communication Plan will provide for opportunities to engage the stakeholders in meetings to educate them about MSP Data Collection and Recovery Activities and to solicit their suggestions for a more efficient process.

4.5.1. Participation in Meetings and Work Groups

The contractor shall participate in scheduled and ad hoc meetings with CMS and the other COB&R contractors, as required by the CORs, and shall send the appropriate personnel. The COR may call for occasional subject specific meetings with appropriate contractor managers, members of the COR's staff, and other CMS officials. These meetings may occur either face to face or via teleconference. The contractor shall prepare brief written minutes of each meeting, including all agreements reached and action items pending and shall submit them (along with any handouts used at the meeting) to the COR within 2 business days. The minutes shall be in MS Word 2007 or compatible form. Additionally, as required by the COR, the contractor shall be available to meet with CMS staff to discuss issues, provide status updates, milestone achievements, and to resolve any problems related to the contract. The contractor shall meet with CMS on a bi-weekly basis. Agendas for this and other regularly scheduled and ad-hoc meetings should be received at CMS at least 1 business day prior to the meeting start time (24 hours). These meetings may take place at the contractor's site, CMS headquarters in Baltimore, Maryland or via teleconference. The contractor should assume that half of onsite meetings will be held at CMS, and half at the contractor site. The contractor shall prepare the minutes from all meetings/teleconferences unless CMS notifies them otherwise. The contractor shall forward meeting minutes to CMS within 2 business days of a meeting's conclusion.

4.5.2. Participation in Conferences

The contractor shall participate in, and send appropriate contractor personnel to, a variety of conferences as directed by CMS, including, but not limited to:

- Security best practices conferences;

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- Security Technical Advisory Group, as identified on the CMS Information Security homepage (<http://www.cms.hhs.gov/InformationSecurity/>);
- Conferences related to HIPAA requirements;
- QIC and AdQIC meetings;
- MSP National Conferences; and
- The CFO Financial Reporting Conference.

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5 ACRONYMS

ACA	Affordable Care Act
ACD	Automated Call Distributor
ADAP	AIDS Drug Assistance Program [state run pharmaceutical cash and product assistance program for state residents with HIV/AIDS]
AIS	Administrative Information Systems
AHIP	America's Health Insurance Plans [trade association for commercial GHP insurers that are not BCBS plans]
ANSI	American National Standards Institute [sets national technical IT standards]
APO	Alternate Project Officer
ASA	Average Speed of Answer
ASQ	American Society for Quality
ATB	Average Trunk Busy
ATO	Authority to Operate
BASIS	Beneficiary Automated Status and Inquiry System
BCC	Beneficiary Contact Center
BFL	Business Function Leader [CMS staff person with management responsibility of a particular program (business function)]
BI Tool	Business Intelligence tool [a program that helps manage large quantities of text and data, thus permitting easier use of the information]
BMAR	Beneficiary Medicare Attainment Record
BOI	Beneficiary Other Insurance
BPM	Business Process Model
BPSSM	Business Partners System Security Manual
BPOC	Business Program Operations Center
C & A	Certification & Accreditation
CAFM	Contractor Accounting and Financial Management (system)
CAP	Corrective Action Plan
CBT	Computer Based Training
CFACS	FISMA Control Tracking System
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CMMI	Capability Maturity Model Integration (CMMI) Registration

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CO	Contracting Officer
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement
contractor	Coordination of Benefits Contractor
COB&R	Coordination of Benefits & Recovery Contractor
Contractor	Business Program Operations Center Contractor
COIF	COBA Insurance File
COR	Contracting Officers' Representative
CQI	Continuous Quality Improvement
CR	Change Request
CWF	Common Working File
CSR	Customer Service Representative
CY	Calendar Year
DCIA	Debt Collection Improvement Act of 1996
DCN	Document Control Number
DDE	Direct Data Entry
DHHS	U.S. Department of Health and Human Services
DME	Durable Medical Equipment
DME MAC	DME Medicare Administrative Contractor
DSA	Data Sharing Agreement
DOJ	U.S. Department of Justice
DVT	Data Validation Team
ECRS	Electronic Correspondence Referral System
EDB	Enrollment Database
EDI	Electronic Data Interchange
EDI Rep	Electronic Data Interchange Representative
EPM DATE	Earliest Potential MSP Date
EIN	Employer Identification Number
ESRD	End-Stage Renal Disease
FAR	Federal Acquisition Regulation
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards
FOIA	Freedom of Information Act
FRC	Federal Records Center
FTS	Federal Telecommunications System
FY	Fiscal Year
GFP	Government Furnished Property
GHP	Group Health Plan
GPO	U.S. Government Printing Office
GSA	U.S. General Services Administration
GSS	General Support Systems
HICN	Health Insurance Claim Number

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GTL	Group Task Leader
HCPCS	Healthcare Common Procedure Coding System
HCPP	Healthcare Prepayment (Claims Review Process)
HDC	The CMS Data Center
HEW	HIPAA Eligibility Wrapper
HICN	Health Insurance Claim Number
HIMR	Health Insurance Master Record
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HRA	Health Reimbursement Arrangement
HUBO	Health Utilization Beneficiary Other Insurance
HUSP	Health Utilization Secondary Payer
IAW	In accordance with
ICD	International Classification of Disease
IEQ	Initial Enrollment Questionnaire
IOM	Internet Only Manual
IRM	Information Resource Management
IRR	Institutional Readiness Review
IRS	U.S. Internal Revenue Service
IT	Information Technology
IVR	Interactive Voice Response
JAD	Joint Application Development
LAN	Local Area Network
LEC	Local Exchange Carrier
LGHP	Large Group Health Plan
MA	Medicare Advantage
MA-PD	Medicare Advantage-Prescription Drug (plan)
MAC	Medicare Administrative Contractor
MBD	Medicare Beneficiary Database
MBR	Master Beneficiary Database
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MIP	Medicare Integrity Program
MIR	Mandatory Insurer Reporting
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
MOD	Short for "contract modification"
MOU	Memorandum of Understanding
MPaRTS	Mistaken Payment Recovery Tracking System
MS	Microsoft

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MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
NCPDP	National Council for Pharmacy Drug Programs
NGHP	Non-Group Health Plan
NIF	National Insurer File
NOMCI	Notice of Medigap Claim Information
OAGM	Office of Acquisition and Grants Management
OCR	Optical Character Recognition
OGC	Office of General Counsel
OIG	Office of the Inspector General
OIS	Office of Information Services
ORM	Ongoing Responsibility for Medicals
OMB	U.S. Office of Management and Budget
PAP	Pharmacy Assistance Program
PBM	Pharmacy Benefit Manager
PDP	Prescription Drug Plan
PEP	Performance Evaluation Plan
PHI	Protected Health Information
PO	Project Officer
QA	Quality Assurance
QC	Quality Control
RAC	Recovery Audit Contractor
RDS	Retiree Drug Subsidy
ReMaS	(Overpayment) Recovery Management and Accounting System
ReMIS	Renal Management Information System
RO	CMS Regional Office
RRB	U.S. Railroad Retirement Board
RRE	Responsible Reporting Entity
SA	Security Authorization
SBR	Supplemental Budget Request
SCHIP	State Children's Health Insurance Program
SHIP	State Health Insurance Program
SLA	Service Level Agreement
SMA	State Medicaid Agency
SME	Subject Matter Expert
SOW	Statement of Work
SP	Secondary Payer
SPAP	State Pharmaceutical Assistance Program
SSA	U.S. Social Security Administration
SSN	Social Security Number
SSO	Systems Security Officer

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SSP	Systems Security Plan
TC	Trauma Code
TCD	Trauma Code Development
TDD	Telephonic Device for the Deaf
TIN	Tax Identification Number
TFTS	Toll-Free Telephone Service
TPA	Third Party Administrator
TPOC	Total Payment Obligation to the Claimant
TrOOP	True Out-Of-Pocket expenses
TTY	Tele-Typewriter
VDSA	Voluntary Data Sharing Agreement
WC	Workers' Compensation
WCCCS	Workers' Compensation Case Control System
WCMSA	Workers' Compensation Medicare Set-Aside
WCRC	Workers' Compensation Review Contractor

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6 GLOSSARY

the Act	the Social Security Act
All Trunks Busy (ATB)	All operators of a phone system (<i>i.e.</i> , customer service line) are talking to customers so other callers must wait on hold for the next available operator.
Beneficiary Automated Status and Inquiry System	A tool available to participants of the Employer VDSA program that allows them to make online Medicare entitlement queries to EDB to determine if an individual is a Medicare beneficiary and, if so, to obtain available entitlement information.
Beneficiary Medicare Attainment Record (BMAR)	The detail of the record layout that CMS creates and sends to the contractor for those individuals who are approaching Medicare eligibility or have just applied for entitlement; these data are categorized by the five distinct types of Medicare eligibility.
CABEDMSP	The software used to perform certain edits upon the CWF MSP Maintenance Transactions.
Carrier	A private entity that contracts with CMS under § 1842 of the Act to process claims and make payments for Medicare Part B services or items furnished by physicians and other suppliers for a specified geographic area.
Centers for Medicare & Medicaid Services (CMS)	The agency within the Department of Health and Human Services established to administer the Medicare and Medicaid programs. Formerly known as the Health Care Financing Administration (HCFA).
Acceptable Response	A response to a Medicare questionnaire that does not require further development.
Common Working File (CWF)	A prepayment claims validation and Medicare Part A/Part B benefit coordination system that uses localized databases maintained by a host contractor.
Coordination of Benefits (COB)	The coordination that occurs between multiple payers so that payments are made in the proper order and claims are automatically transferred from the primary payer to the secondary payer for further processing. It includes sending claims to

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	Medigap insurers for secondary payment after Medicare has made a primary payment, crossing claims over to another insurer after Medicare has made a primary payment and MSP situations where primary insurance is coordinated with Medicare. It also includes the sharing of benefit information with primary payers other than Medicare.
Coordination of Benefits Agreement (COBA)	An agreement between CMS and another health care insurer to coordinate insurance information that involves (1) transferring Medicare paid claims data to other insurers; and (2) identifying payers primary to Medicare.
COBA Insurance File (COIF)	Insurer File that denotes the types of claims a COBA partner wants crossed over.
Document Control Number	A unique number used to identify a document within a series for identification and retrieval purposes.
Earliest Potential MSP Date (EPM DATE)	The program that calculates the earliest date that Medicare could potentially be a secondary payer for a specific beneficiary by using information such as Medicare entitlement date, year of earnings, and entitlement factor to determine the appropriate period for reporting MSP for both the employer and the employee.
Electronic Correspondence Referral System (ECRS)	The system the incumbent contractor developed to allow Medicare contractors to submit information about potential MSP situations for development.
End-Stage Renal Disease (ESRD)	A basis of Medicare entitlement involving a usually irreversible medical condition in which a person's kidneys cease functioning on a permanent basis, leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.
Enrollment Database (EDB)	The authoritative source for information on all individuals entitled to Medicare, including demographic information, enrollment dates, third party buy-in information, and Medicare managed care enrollment.
Federal Managers' Financial Integrity Act of 1982 (FMFIA)	A law that requires Federal agencies to establish internal accounting and administrative controls to prevent waste and misuse of agency funds and

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	property and to account for assets.
Fiscal Intermediary (FI)	A private agency or entity that contracts with CMS under sections 1816 and 1842 of the Act to determine and make Medicare Part A payments and in some instances, Part B payments, and to perform other related Medicare administrative services for providers (<i>i.e.</i> , hospitals, Skilled Nursing Facilities, Home Health Agencies, and hospices), within a defined geographic area.
Freedom of Information Act (FOIA)	A law that requires a federal agency to, upon request from any person, release any agency records that do not fall within one of the nine statutory exemptions and three exclusions.
Group Health Plan (GHP)	Any arrangement made by one or more employers or employee organizations to provide health care directly or through other methods such as insurance or reimbursement to current or former employees, the employer, current and former business associates or their families, which is insured, underwritten, sponsored or administered or contributed to by the employer.
Government Printing Office (GPO)	The Federal agency responsible for providing printing and binding services for all branches, departments, offices and agencies of the United States Government.
Health Insurance Claim Number (HICN)	The number that SSA assigns to a Medicare beneficiary; it is shown on the beneficiary's insurance card and is used to process the beneficiary's Medicare claims.
Health Maintenance Organization (HMO)	A legal entity which provides or arranges for the provision of basic and supplemental health services to its members and is organized and operated in the manner prescribed by, and otherwise meets the requirements of section 1301 of the Public Health Service Act and 42 CFR 417, Subparts B & C.
Host Contractor	The entity that provides Medicare contractors within a geographic area (referred to as a sector) with beneficiary entitlement and claims adjudication data through CWF.
HUSP Record	A transaction sent to update an MSP record in CWF.

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Incompletes	Surveys/questionnaires which do not contain all required information.
Initial Enrollment Questionnaire (IEQ)	A survey used to gather MSP information for most newly eligible beneficiaries approximately three months before they become entitled to Medicare. The IEQ is found in a hard copy and electronic format. (NOTE only for English version of the 65 and over questionnaire is an electronic format found on the MyMedicare.gov website.)
IRS/SSA/CMS Data Match (Data Match)	A process by which CMS uses information supplied by the IRS and SSA to contact employers concerning possible periods of MSP for identified employees. Information gathered through Data Match is used to update the CWF MSP Auxiliary File.
Internet Only Manuals (IOMs)	The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. Most manuals, including the Medicare Carriers and Intermediary Manuals were reorganized and transferred to the IOMs.
International Organization of Standardization (ISO)	An international, non-governmental organization made up of the national standards-setting bodies of 155 member countries, and the world's largest developer of (principally technical) standards.
Large Group Health Plan (LGHP)	A GHP of either an employer or employee organization that has 100 or more employees.
Medicare	A nationwide, Federal Health Insurance program authorized by Title XVIII of the Act for persons 65 years of age or older, certain younger disabled persons, and persons with permanent kidney failure.
Medicare Administrative Contractor (MAC)	An entity that contracts with CMS under § 911 of the MMA, which replaced the authority under which FIs and carriers currently administer the Medicare Part A and Part B FFS programs.

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Medicare Advantage (formerly Medicare + Choice) program	A program that allows beneficiaries to obtain their Medicare benefits by enrolling in a privately-administered plan. Some of these plans include Part D benefits and some do not.
Medicare Advantage-Prescription Drug (MA-PD) plan	A Medicare Advantage plan that provides Part D benefits.
Medicare Beneficiary Database	System of Record for Medicare Eligibility/ Enrollment/ Entitlement for Parts A,B,C and D Data. System of record for all private Prescription Drug coverage for Part D enrollees.
Medicare claims processing contractor	A term used in this document to refer collectively to FIs, carriers, and MACs.
Medicare contractor	A term used in this document to refer to any and all entities that contract with CMS to perform functions related to the Medicare program.
Medicare Secondary Payer (MSP)	The set of Medicare laws that lay out the circumstances under which certain other payers are required to make health care payments before Medicare.
MSP Auxiliary File	A file housed in CWF that contains MSP information on Medicare beneficiaries.
Medigap	An insurance policy specifically designed to supplement Medicare benefits.
Multi-Employer Plan	A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations (<i>e.g.</i> , unions).
Optical Character Recognition (OCR)	The ability of a scanning device with the proper software to capture, recognize and translate printed alpha-numeric characters into computer readable text.
Part A	The Hospital Insurance provision of Medicare that was established by section 1811 of Title XVIII of the Act and covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.
Part B	The Supplementary Medical Insurance provision of Medicare that was established by section 1831 of Title XVIII of the Act and covers services of physicians and other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by Medicare Part A.

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Part C	See –Medicare Advantage program”
Part D	The provision of Medicare that was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide prescription drug coverage to Medicare beneficiaries through privately-administered plans.
Contract Officers‘ Representative (COR)	The person within a government agency who has the authority to give technical direction and commit funds to a contract. In this document, all standalone occurrences of –COR” mean the COR for this contract, and any other contract’s COR will always be identified by the specific contract.
Provider	A hospital, a Community Access Hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
Railroad Retirement Board (RRB)	The Federal agency which administers the program for individuals entitled to Medicare benefits pursuant to § 226(a)(1)(B) of the Act and § 7(d) of the Railroad Retirement Act of 1974.
Recovery Audit Contractor (RAC)	A contractor that recovers Medicare overpayments (MSP and non-MSP) under the authority of a demonstration project that was made permanent by § 302 of the Tax Relief and Health Care Act of 2006.
Representative Payee	An individual formally designated by SSA (or other governmental agency) to receive benefits on behalf of a beneficiary who is physically or mentally incapable of managing his/her own benefits.
Social Security Administration (SSA)	The Federal agency that, among other things, determines eligibility for and entitlement to Medicare.
State Medicaid Agency (SMA)	The agency within a State government that

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	administers that State's Medicaid program.
Supplier	A physician or other practitioner, or an entity other than a provider (such as an entity furnishing durable medical equipment), that furnishes health care services under Medicare.
Tax Identification Number (TIN)	The number assigned to businesses by the Internal Revenue Services, and similar to an individual's SSN; this number is necessary as part of Data Match and CMS' voluntary agreements.
Third Party Administrator (TPA)	A business associate that performs claims administration and related business functions on behalf of a self-insured entity.
Trading Partner	An entity that has entered into a COBA with CMS.
Unacceptable Response	A response to a survey/questionnaire that requires further development.
Voluntary Agreement	Agreements between CMS and various entities to exchange Medicare information and group health plan eligibility information for the purpose of coordinating health benefit payments.
Workers' Compensation (WC)	A type of insurance, primary to Medicare under the MSP laws that employers are required to have to cover employees who get sick or injured on the job.
Workers' Compensation Case Control System (WCCCS)	The system used to track a WCMSA through to completion.
Workers' Compensation Medicare Set-Aside (WCMSA)	A voluntary arrangement a beneficiary may enter into upon receiving a WC settlement (or other monetary award) whereby s/he protects Medicare's financial interests by setting aside a portion of the money received to pay for future WC-related claims that would otherwise be payable by Medicare.
Workers' Compensation Review Contractor (WCRC)	The contractor CMS procured to review proposed WCMSAs.

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7 Appendices

Appendix 1 – Available CMS/COB&R Systems List

Appendix 2 – BPOC Deliverable List

Appendix 3 – BPOC Statistical Information

Appendix 4 – COBA ID List

Appendix 5 – COB&R Organization

Appendix 6 - MSP Integration Contractor (MSPIC) SOW

Appendix 7 – BPOC Monthly Status Report Components

Appendix 8 – MSP Recovery Policy