Unified Program Integrity Contractor (UPIC)

Umbrella Statement of Work (USOW)

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# 1. Table of Contents

2. Scope ................................................................................................................................................. 7
2.1. Purpose of Contract............................................................................................................................. 7
2.2. Background ......................................................................................................................................... 8
2.3. UPIC Jurisdictions ............................................................................................................................. 9
2.4. Medicare ........................................................................................................................................... 9
2.5. Medicaid .......................................................................................................................................... 10
2.6. Roles and Responsibilities .................................................................................................................. 11
2.6.1. The Centers for Medicare & Medicaid Services ........................................................................... 11
2.6.2. State Medicaid Agency .................................................................................................................. 12
2.6.3. Law Enforcement ........................................................................................................................... 14
2.6.4. Unified Program Integrity Contractor .......................................................................................... 14
3. Applicable Statutes, Regulations, and Documents .............................................................................. 15
3.1. The Medicare Integrity Program ....................................................................................................... 15
3.2. The Medicare-Medicaid Data Match Program .................................................................................. 16
3.3. The Medicaid Integrity Program ....................................................................................................... 16
3.4. The Patient Protection and Affordable Care Act .............................................................................. 16
3.5. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) .............. 16
3.6. Healthcare Fraud Prevention Partnership ......................................................................................... 17
4. Program Goals ...................................................................................................................................... 17
5. Implementation and Transition Requirements .................................................................................... 18
5.1. Implementation Requirements ......................................................................................................... 18
5.1.1. Implementation Period ................................................................................................................... 18
5.1.2. Jurisdiction Implementation Project Plan ....................................................................................... 19
5.1.3. Risk Management Plan .................................................................................................................. 20
5.1.4. Communication Plan ..................................................................................................................... 20
5.1.5. Lessons Learned Documentation ................................................................................................. 20
5.2. Fully Operational Requirements ..................................................................................................... 20
5.2.1. Fully Operational Period .............................................................................................................. 20
5.3. Outgoing Transition Activities (End of Contract) .......................................................................... 21
5.3.1. Workload Closeout Project Plan .................................................................................................... 21
5.3.2. Workload Closeout Meetings ........................................................................................................ 21
5.3.3. Workload Closeout Risk Management Plan ................................................................................ 21
6. UPIC Functional Requirements ......................................................................................................... 22
6.1. Identification of Vulnerabilities ........................................................................................................ 22
6.1.1. Regional Steering Committee ...................................................................................................... 23
6.1.1.1. Initial Meeting ............................................................................................................................ 23
6.1.1.2. Timing and Purpose .................................................................................................................... 23
6.1.2. National Conference ..................................................................................................................... 24
6.1.3. National Statistics Conference ..................................................................................................... 24
6.2. Data Analysis and Matching Requirements ..................................................................................... 24
6.2.1. Data Analysis Planning .................................................................................................................. 24
6.2.2. Data Analysis Expectations & Responsibilities ............................................................................. 25
6.2.3. Collaboration with States – Data Analysis ..................................................................................... 26
6.2.4. Functional Data Analysis & Management Activities .................................................................... 27
6.2.5. Data Analysis & Management Reporting ..................................................................................... 31
6.3.  Lead Management ................................................. 32
   6.3.1.  Workload Categories ........................................ 32
   6.3.2.  Sources of Leads ........................................... 33
   6.3.3.  Lead Management Protocol ................................. 34
   6.3.4.  Lead Prioritization ......................................... 34
   6.3.5.  Tracking .................................................... 37
6.4.  Investigation Requirements ..................................... 37
   6.4.1.  Planning Requirements ...................................... 38
   6.4.2.  Executing Requirements ..................................... 38
   6.4.3.  Referring Requirements ..................................... 39
      6.4.3.1.  Referral to CMS ....................................... 39
      6.4.3.2.  Referral to State Medicaid ............................ 39
      6.4.3.3.  Referral for Quality of Care Issues .................. 39
      6.4.3.4.  Referral to HHS OIG ................................ 39
      6.4.3.5.  Referral to the MAC .................................. 40
      6.4.3.6.  Referral to Law Enforcement .......................... 40
   6.4.4.  Appeals .................................................... 40
   6.4.5.  Closing Investigations ..................................... 40
6.5.  Cost Report Audits and Reviews ................................ 41
   6.5.1.  Cost Report Audits for Medicaid providers .............. 41
   6.5.2.  Cost Report Review for Medicare providers .............. 41
   6.5.3.  Coordination with CMS .................................... 41
   6.5.4.  Findings and Recommendations ............................ 41
6.6.  Medical Review Requirements .................................. 42
6.7.  Edits ................................................................... 43
   6.7.1.  Program Integrity Edits ..................................... 43
   6.7.2.  Shared Systems .............................................. 43
   6.7.3.  Evaluating Edit Effectiveness .............................. 44
   6.7.4.  Edit Implementation ......................................... 44
6.8.  Support to CMS ................................................ 45
   6.8.1.  Healthcare Fraud Prevention Partnership (HFPP) ....... 45
   6.8.2.  Command Center ............................................ 46
      6.8.2.1.  Command Center Activities ............................ 46
   6.8.3.  Program Integrity Projects .................................. 47
6.9.  Support to States ................................................ 48
6.10. Support to Law Enforcement .................................... 49
   6.10.1.  Requests from Law Enforcement Entities ................. 49
   6.10.2.  UPIC Role in Support to Law Enforcement .............. 49
   6.10.3.  Constraints, Assumptions, and Other Issues ............ 49
   6.10.4.  Reporting/Monitoring ...................................... 50
6.11. Education Requirements ........................................ 51
   6.11.1.  Educating the Providers .................................... 52
   6.11.2.  Educating the Stakeholders ............................... 52
   6.11.3.  Educating the States........................................ 52
   6.11.4.  Documentation of Provider Education Regarding Improper Actions ........................ 53
7.  Expected Outcomes .................................................. 53
7.1. Recommending Administrative Actions .......................................................... 53
7.2. Prepayment Review ....................................................................................... 54
7.3. Identify Medicare and Medicaid Overpayments ............................................. 54
7.4. Referrals to Law Enforcement ....................................................................... 55
7.5. Coordination ................................................................................................. 55
7.6. Tracking and Reporting ................................................................................ 55
7.7. Performance Measures .................................................................................. 55
8. Administrative Requirements .......................................................................... 55
8.1. Meetings, Workgroup, and Conferences ....................................................... 56
8.1.1. Kickoff Meeting ....................................................................................... 56
8.1.2. Command Center Missions ..................................................................... 56
8.1.3. Jurisdictional Fraud, Waste, and Abuse Workgroup ................................ 56
8.2. Joint Operating Agreements (JOAs) ............................................................... 56
8.3. Key Personnel Requirements ....................................................................... 57
8.3.1. Jurisdiction Program Director ................................................................. 57
8.3.2. Medicare Operations Lead ....................................................................... 58
8.3.3. Medicaid Operations Lead ....................................................................... 58
8.3.4. Medical Director ...................................................................................... 59
8.3.5. Program Integrity Manager ...................................................................... 59
8.3.6. Medical Review Manager ........................................................................ 59
8.3.7. Data Manager ........................................................................................ 60
8.3.8. Communication and Coordination Manager ............................................ 60
8.3.9. Chief Legal Counsel ................................................................................ 60
8.3.10. Chief Statistician .................................................................................... 60
8.3.11. Administrative Action Coordinator ........................................................ 61
8.4. Stakeholder Coordination and Communication Requirements ................. 61
8.4.1. Appropriate CMS Staff ............................................................................ 61
8.4.2. Medicaid State Agency and Medicaid Fiscal Agents ............................... 62
8.4.3. Medicare Administrative Contractors ...................................................... 62
8.4.4. Medicaid Fraud Control Units (MFCUs) .................................................. 62
8.4.5. One Program Integrity (OnePI) and the Integrated Data Repository (IDR) 62
8.4.6. Other Unified Program Integrity Contractors ............................................ 63
8.4.7. Working with Other Medicare Organizations .......................................... 63
8.4.8. Office of Inspector General ...................................................................... 63
8.4.9. Department of Justice ............................................................................. 63
8.4.10. Federal Bureau of Investigation .............................................................. 64
8.4.11. State Agencies for Survey and Certification ............................................ 64
8.4.12. Law Enforcement Health Care Task Forces ............................................ 64
8.4.13. State Licensure Agencies ........................................................................ 64
8.4.14. State Licensure of Agents and Brokers .................................................... 64
8.4.15. State and Local Licensure and Enforcement Agencies ........................... 65
8.4.16. Professional Societies ............................................................................ 65
8.4.17. Quality Improvement Organizations ....................................................... 65
8.4.18. Managed Care Organizations ................................................................. 65
8.4.19. Private Health Plans ............................................................................. 65
8.4.20. Other Contractors ................................................................................ 66
8.4.21. Other Federal and State Agencies .......................................................... 66
8.4.22. Data Analysis Coordination ................................................................. 66
8.4.23. Coordination with Other Contractors .................................................... 66
8.5. Information Technology and Security ........................................................ 67
  8.5.1. CMS Provided Datasets and Systems .................................................... 67
  8.5.1.1. Integrated Data Repository (IDR) .................................................... 67
  8.5.1.2. One Program Integrity (One PI) ....................................................... 67
  8.5.1.3. Fraud Prevention System ............................................................... 68
  8.5.1.4. Medicare Fee-for-Service (FFS) Claims Processing Shared Systems ...... 68
  8.5.1.5. Medicaid Data.................................................................................. 69
  8.5.1.6. Unified Case Management System (UCM)........................................ 71
  8.5.1.7. Electronic Submission of Medical Documentation System (eSMD) ......... 71
  8.5.1.8. Secure E-mail System ..................................................................... 71
  8.5.1.9. Other Contractor Proposed Resources ............................................. 72
  8.5.1.10. Other CMS Provided Systems ....................................................... 72
  8.5.2. Contractor-Provided Functions ................................................................ 73
  8.5.3. Access to CMS Systems ...................................................................... 73
  8.5.3.1. Data Use Agreement ...................................................................... 73
  8.5.3.2. Other Systems Access Requirements .............................................. 73
  8.5.4. Hardware and Software Testing .......................................................... 74
  8.5.4.1. Test Plan Guidelines ...................................................................... 74
  8.5.5. Telecommunications .......................................................................... 74
  8.5.5.1. General Requirements ................................................................... 74
  8.5.6. Security ............................................................................................... 75
  8.5.6.1. Physical and Operational Security ................................................... 75
  8.5.6.2. System Security ............................................................................. 76
  8.5.6.3. Certification for Compliance with CMS Systems Security .................. 76
  8.5.6.4. Authority to Operate ....................................................................... 77
  8.5.6.5. Administer Security Program .......................................................... 77
  8.5.6.6. Correct Deficiencies ........................................................................ 78
  8.5.6.7. Corrective Action Attestation .......................................................... 79
  8.5.6.8. Security Review and Verification ...................................................... 79
8.6. Unified Case Management (UCM) System Requirements ............................. 80
  8.6.1. Introduction/Overview ....................................................................... 80
  8.6.1.1. System Activities .......................................................................... 80
  8.6.2. Planning ............................................................................................. 81
  8.6.3. Executing/Reporting ......................................................................... 82
  8.6.4. Managing and Monitoring ................................................................. 83
8.7. Quality Assurance Program Requirements .................................................... 83
  8.7.1. Cooperation/Coordination .................................................................. 83
  8.7.2. ISO-9000 Certification ...................................................................... 83
  8.7.3. Quality Control Plan ......................................................................... 84
  8.7.4. Quality Evaluations .......................................................................... 85
  8.7.5. Continuous Improvement Program .................................................... 85
  8.7.6. Data Matching Quality Assessment .................................................... 85
  8.7.7. Innovation and Technology ............................................................... 86
2. **SCOPE**

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

For purposes of this contract, when differences or conflicts occur, **the order of precedence shall be this SOW followed by Task Order SOWs and then IOMs** unless otherwise specified. The Contractor shall contact the Contracting Officer (CO) and the Contracting Officer’s Representative (COR) when discrepancies are identified. The Contractor shall identify any budgetary concerns that may occur as a result of the conflict. The Contractor is advised that any and all references in the SOW (including manuals, IOMs) to “RO-Regional Office” shall include CPI field offices unless otherwise specified in this SOW. Appendix C contains definitions of all abbreviations used in this SOW.

2.1. **PURPOSE OF CONTRACT**

The purpose of this contract is to obtain a Unified Program Integrity Contractor (hereinafter, referred to as “Contractor” or “UPIC”) to predict, detect, prevent, and deter fraud, waste, and abuse in the Medicare and Medicaid programs. The Contractor shall perform its responsibilities under the direction of the Centers for Medicare & Medicaid Services (CMS).

Under this contract, the Contractor shall perform numerous functions to predict, detect, prevent, and deter specific risks and broader vulnerabilities to the integrity of the Medicare and Medicaid programs including those that may result from historic billing approaches, as well as those resulting from payment reforms and healthcare innovations such as the use of electronic health records (EHRs). The Contractor shall operate in a geographic area or “jurisdiction” defined by individual Task Orders. The Contractor shall perform the requirements of this contract in accordance with applicable federal and state laws, regulations, Medicare and Medicaid manuals, and CMS requirements to ensure the integrity of the Medicare and Medicaid programs. Internet-Only-Manuals can be found at the following location: [http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage](http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage).
The Contractor shall use or interact with certain CMS-required systems in the performance of its functions. Further, the Contractor shall coordinate its activities not only with CMS, but also with agencies at the federal, state, and local levels of government as well as other CMS partners and Contractors.

CMS's goals for unifying this work are to achieve enhanced prediction, detection, and prevention of fraud, waste and abuse across the Medicare and Medicaid programs by:

- Consolidating Medicare and Medicaid program integrity activities currently handled by separate contractors;
- Sharing and coordinating information among Medicare and Medicaid partners;
- Emphasizing timely administrative actions; and,
- Strengthening data matching across programs to expand the view of provider billing patterns.

CMS anticipates that this integrated and data-driven approach will lay the groundwork for fostering further program integrity coordination with other private and governmental payers across the entire health care industry. Ultimately, it is through partnership and increased awareness across a variety of programs that health care fraud, waste, and abuse can be reduced; therefore benefiting all beneficiaries and patients.

2.2. **BACKGROUND**

CMS currently relies on a network of Contractors to carryout program integrity work in Medicare and Medicaid. The Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) are under contract to perform specific Medicare program integrity functions. The Medicare-Medicaid Data Match (Medi-Medi) program is incorporated under the current ZPIC scope of work. The ZPICs are under contract to conduct Medi-Medi activities including matching Medicare and Medicaid data and investigating potential instances of fraud, waste, and abuse. The Medicaid Integrity Contractors (MICs) are under contract to perform specific Medicaid program integrity functions, including provider audits. The UPIC will combine and integrate these existing functions into a single contractor in a defined geographic area performing Medicare and Medicaid program integrity work on behalf of CMS.
2.3. **UPIC JURISDICTIONS**

The Contractors shall operate in five defined geographic areas, or jurisdictions, as found in the map in Appendix B. At a minimum, the Contractor shall have a physical office location in the jurisdiction where the majority of staff is located to perform the functional requirements outlined in the SOW. The physical location should be as close to any HEAT strike force city as possible. See Section 8.3 Key Personnel for additional requirements.

2.4. **MEDICARE**

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Nearly all Medicare beneficiaries access the majority of their insurance benefits through one of two health care delivery systems – traditional Medicare, also known as Medicare Fee-for-Service (FFS), or Medicare Advantage (MA).

**Medicare FFS (Medicare Parts A and B)**

The Medicare FFS program consists of two distinct parts: (1) Medicare Hospital Insurance (HI) often referred to as “Medicare Part A” and (2) Supplementary Medical Insurance (SMI), or “Medicare Part B”. Services covered under Part A are: hospital inpatient services, skilled nursing facility (SNF) inpatient services, and swing bed services (SNF level in a rural hospital having less than 50 beds), hospice services, and some Home Health services. Services covered under Part B include, the professional medical services of physicians and certain other licensed practitioners, a variety of other services and items such as ambulance, durable medical equipment, and certain institutional services. These include hospital outpatient services, SNF outpatient services, all specialty facility services, such as dialysis for End Stage Renal Disease beneficiaries, outpatient rehabilitation services, regardless of the type of institution, and some Home Health services.

Benefits under Medicare FFS are largely provided under an indemnity insurance model. That is, the beneficiary chooses his/her health care providers, the providers bill the appropriate Medicare claims administrator for their services, and the claims administrator pays the provider based on Medicare eligibility, coverage, and payment rules. The CMS relies on a network of contractors to process Medicare FFS claims; enroll health care
providers and educate them on Medicare billing requirements; handle claims appeals; answer beneficiary and provider inquiries; and detect and prevent Medicare fraud, waste and abuse.

**Medicare Advantage (Part C)**

In the Medicare Advantage Program, or Part C, beneficiaries have the option to enroll in one or more privately sponsored Medicare plans that contract with CMS and provide all the benefits available under Medicare Part A and B. These private Medicare plans may organize themselves in keeping with one of several health care delivery and payment models (e.g. health maintenance organizations, preferred provider organizations). The plans are required to cover the same basic benefits that the traditional Medicare program offers, but they are given fairly broad responsibility and latitude to set up their internal requirements and processes as they see fit.

**Medicare Drug Coverage (Part D)**

CMS contracts with licensed risk-bearing entities to administer the prescription drug benefit (Medicare Part D). These Part D plans are referred to as stand-alone, risk-bearing Prescription Drug Plans (PDPs). Many Medicare managed care plans also added a Part D benefit to their existing program. These plans are known as Medicare Advantage Prescription Drug Plans (MA-PDs). All Part D plans must offer a standard drug benefit, but may also vary the benefit offering within defined parameters.

### 2.5. **MEDICAID**

Medicaid is a joint federal-state funded health insurance program that is the primary source of medical assistance for millions of low-income, disabled, and elderly Americans. The federal government establishes minimum requirements for the program and states design, implement, administer, and oversee their own Medicaid programs. In general, states pay for the health benefits provided, and the federal government, in turn, matches qualified state expenditures based on the Federal medical assistance percentage (FMAP), which can be no lower than 50 percent.

All states participate in the Medicaid program and as a requirement for receipt of federal matching payments must cover individuals who meet certain minimum categorical and financial eligibility standards. Additionally, they must cover certain medical services, such as physician, hospital and nursing home care, and are provided the flexibility to offer a
large number of optional benefits to beneficiaries\(^1\). State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments.

### 2.6. **Roles and Responsibilities**

#### 2.6.1. The Centers for Medicare & Medicaid Services

The CMS Center for Program Integrity (CPI) oversees Medicare and Medicaid fraud, waste and abuse activities. Program integrity encompasses all causes of improper payments, and covers fraud, waste, and abuse. The Affordable Care Act of 2010 (ACA) strengthened program integrity efforts across Medicare and Medicaid and established requirements for proactive detection and prevention of fraud, waste, and abuse, as well as robust program management, performance measurement, and reporting.

The ultimate objective of strengthening Medicare and Medicaid program integrity is achieved when claims are paid correctly for covered services appropriately provided. In pursuing this objective, CPI strives to have positive impact on the costs and appropriateness of the care provided to Medicare and Medicaid beneficiaries by adhering to the principles of operational excellence, leadership and coordination. For the UPIC program, CPI exhibits these principles by:

- Setting national goals and priorities that ensure that local and regional program integrity activities are consistent with CPI’s national-level strategy, while allowing for swift response to local or regional trends in fraud, waste, and abuse.

- Integrating critical Medicare and Medicaid program integrity activities, including provider investigations, to support a truly holistic and coordinated Medicare and Medicaid program integrity strategy.

- Leveraging CPI’s centralized fraud detection mechanisms and other tools, for example the Fraud Prevention System and OnePI/IDR.

- Adopting a data driven approach to management of contractors’ work and measurement of their performance using timely and accurate data.

\(^1\) [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html).
information about their workload and activities through a centralized case management system.

- Requiring contractors to share information (e.g. leads, vulnerabilities, concepts, approaches) with each other whenever that would promote the goals of the program and the efficiency of operations at other contracts.

CPI manages the work of contractors engaged in program integrity activities by issuing guidance in communications such as manual updates describing changes in policy and operations; evaluation of the performance of those contractors based on the work it engages them to do, and activities such as periodic conferences on topics of general interest and targeted sessions with selected subsets of the contractors.

Within CMS, specialists on various Medicare and Medicaid topics will serve as Business Function Leads (BFLs) to assist the Contracting Officer’s Representative (COR) and the Contracting Officer in administering the contract. These BFLs will provide technical guidance to the Contractor on matters within each BFL’s area of responsibility. The BFLs are not authorized to direct changes to contract work.

2.6.2. STATE MEDICAID AGENCY

Both federal and state governments are accountable for the effective oversight of the Medicaid program. States establish and administer their own Medicaid programs; they determine the type, amount, duration, and scope of benefits within broad federal guidelines. While all state Medicaid programs have financial responsibility for any improper payments identified through program integrity activities, the scope and execution of program integrity activities varies by state. State entities that may be involved in the program integrity oversight include State Medicaid Agencies (SMAs), State Medicaid Inspectors General, Medicaid Fraud Control Units (MFCUs), Medicaid Fiscal Agents (MFAs), State Attorneys General, or Agencies for Program Integrity.

States are critical partners in stewardship of the public trust and are strongly committed to ensuring the accuracy of Medicaid payments and detection/prevention of fraud, waste, and abuse. States promote coordinated efforts to Medicaid program integrity while balancing their existing program integrity efforts, meeting new requirements, and coordinating with federal program integrity efforts.
The states’ roles and responsibilities in the new UPIC environment may include:

a. Learning about, as well as using federal data to support state efforts to deter, prevent, and reduce fraud, waste and abuse, as well as allowing access to state databases to support further state, regional, and national coordination.

b. Assisting the Contractor in identifying and prioritizing the specific risks and broad vulnerabilities to program integrity in each of their Medicaid programs.

c. Educating the Contractor about their state-specific policies, program characteristics, organizational structures, and identifying state-specific priorities and vulnerabilities so that program integrity activities can be tailored to fit an individual state.

d. Identifying more sophisticated tools for data mining and technology deployment that the state may need to assist them in their program integrity efforts or educating others in those tools that the state may already possess that they are using successfully.

e. Collaborating with the Contractor to reduce overlap, inefficiency, and confusion with program integrity efforts, while improving communication and sharing.

f. Assisting in creation of a pathway to leverage the best data sources possible, as well as Medicare’s data analytics, predictive modeling and other resources.

g. Identifying and proposing solutions to remedy the barriers to conducting effective program integrity activities.

h. Defining and communicating the states’ vision and expectations for a high performing Medicaid integrity program.

In addition, States have a role in responding to emerging program integrity problems and issues and assisting in rapid course-correction to ineffective approaches and programs. States are important partners in the development of reasonable and useable program integrity policies and functional data exchange systems between Medicare and Medicaid.
2.6.3. LAW ENFORCEMENT

Some causes of improper payments are potentially fraud, and to address those issues, CMS must work closely with law enforcement. There must be close collaboration between a variety of partners, including CMS, other program integrity contractors, state agencies, law enforcement agencies, and other entities. Subject to the requirements in the IOM Pub.100-08, the Contractor shall provide support to law enforcement agencies for investigations of potential fraud and abuse.

Law enforcement is an important stakeholder in the program integrity process. Each Contractor’s local interactions with law enforcement must remain aligned with CMS’s agency-level approach to such interactions. It is crucial that each Contractor provide CMS with ongoing and sufficient information about its law enforcement interactions so that it is assured that they are in alignment with CMS’s overall approach. Referrals from the Contractor to law enforcement are discussed in the “Investigations” section of this SOW.

2.6.4. UNIFIED PROGRAM INTEGRITY CONTRACTOR

The CMS currently fulfills its duty to predict, detect, prevent, and deter threats to the integrity of the Medicare and Medicaid programs by engaging separate Medicare and Medicaid integrity contractors. To improve its capacity to swiftly anticipate and adapt to the ever changing and dynamic nature of those involved in health care fraud, waste, and abuse, CMS will engage contractors to perform work across the Medicare and Medicaid program integrity continuum. The UPICs will integrate the program integrity functions for audits and investigations across Medicare and Medicaid, and ensure that CMS’s national priorities for both Medicare and Medicaid are executed and supported locally. Through its expertise in proactive data analysis, ability to harmonize Medicare, Medicaid and private sector data and its knowledge of Medicare and Medicaid-related law enforcement processes and actions, each jurisdictional Contractor will also advise CMS regarding possible national strategies, as well as recommending locally or regionally targeted variations and additions in its own jurisdiction to support CMS’s national-level program integrity strategy.

The program integrity requirements that the Contractors will perform, including the expected outcomes, are set out more fully in this document and may be further defined in subsequent Task Orders.
The Contractor shall perform activities that identify and reduce fraud, waste, and abuse by individuals and entities furnishing items and services under Medicare and Medicaid. Under the direction of CPI, the Contractor shall perform specific activities as indicated by the nature and severity of the issue for each healthcare provider under review and the policies, rules, and guidelines set forth in the Medicare and Medicaid programs. The Contractor shall maintain documentation to support all activities, including any referrals of analytic results or research provided to appropriate entities, as well as completion of the feedback loop with respect to these referrals. The Contractor may be asked to respond to requests for information from CMS at any time. All activities undertaken by the Contractor shall be aligned with the national-level and regional program integrity priorities identified by CMS.

To promote open, cooperative, and transparent relationships between Contractors and with CMS, the government retains intellectual ownership not only of products, such as software and models, but also of concepts and approaches that are based in the data made available for the use of the Contractor. Contractors are expected and required to share leads, vulnerabilities, conclusions, concepts, approaches, processes, policies, desk references and other intellectual property based on the UPIC data and operations whenever that intellectual property could promote the goals of the program and the efficiency of operations at other contracts.

3. APPLICABLE STATUTES, REGULATIONS, AND DOCUMENTS

As a result of combining the work across the Medicare and Medicaid continuum, the Contractor shall implement and operate under multiple legislative authorities (refer to Appendix D for more information). This is not an exhaustive list:

3.1. THE MEDICARE INTEGRITY PROGRAM

The Medicare program integrity responsibilities of the UPICs are authorized by Section 1893 of the Social Security Act (which establishes the Medicare Integrity Program).
3.2. **THE MEDICARE-MEDICAID DATA MATCH PROGRAM**

The Medicare-Medicaid data match responsibilities of the UPICs are authorized by Section 1893(g) of the Social Security Act (enacted in Section 6034(d) of the Deficit Reduction Act of 2005).

3.3. **THE MEDICAID INTEGRITY PROGRAM**

The Medicaid program integrity responsibilities of the UPICs are authorized by Section 1936 of the Social Security Act (which established the Medicaid Integrity Program).

3.4. **THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

CMS intends to use contractors to implement the augmented program integrity authorities found in the Patient Protection and Affordable Care Act of 2010 (more commonly known as the Affordable Care Act or ACA). There are four principal ways that the ACA seeks to improve benefit integrity efforts:

a. Providing additional funding to prevent and fight fraud,

b. Improving provider screening and compliance,

c. Providing new penalties and allowing for enhanced administrative actions, and

d. Enabling improved data sharing.

CMS is using these authorities to move the Medicare and Medicaid program integrity environment beyond the “pay and chase” model and towards a “prevention and detection” model. (More details on these legislative authorities can be found in the attachment section of this SOW.)

3.5. **THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)**

Title I of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) was signed into law on December 8, 2003. The MMA established a new voluntary outpatient prescription drug benefit under Part D of Title XVIII of the Social Security Act (the Act). The prescription drug benefit, referred to as Medicare Part D, as well as an employer subsidy for qualified retiree health plans, began on January 1, 2006.

Title II of the MMA modified and renamed the Medicare+Choice (M+C)
program established under Part C of Title XVIII of the Act. The program is now called the Medicare Advantage (MA) program. The MMA also introduced a new process for determining beneficiary premiums and benefits for 2006 and future years under which MA organizations will submit a "bid" reflecting their revenue needs for covering the benefits they plan to offer. This new process applied to all MA plans beginning in 2006.

3.6. **HEALTHCARE FRAUD PREVENTION PARTNERSHIP**

Section 1128C (a) (2) of the Social Security Act provides authority for the Secretary of HHS and the Attorney General, in carrying out the Fraud and Abuse Control Program established by section 1128C(a)(l), to consult with, and arrange for the sharing of data with representatives of health plans, including Medicaid as well as private plans. CMS has established the Healthcare Fraud Prevention Partnership (HFPP), an ongoing partnership to fight fraud, waste, and abuse across the health care system. The (HFPP) currently has 35 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. The partnership is sharing data to assist payers in evaluating trends, recognizing patterns consistent with potential fraud, waste, and abuse, and potentially uncovering schemes or bad actors they could not otherwise identify using only their own information.

4. **PROGRAM GOALS**

This SOW supports the mission of the Centers for Medicare & Medicaid Services to predict, detect, prevent, and deter fraud, waste, and abuse in the Medicare and Medicaid programs. Specifically, the UPIC program is designed to:

a. Integrate Medicare and Medicaid program integrity activities to support a truly holistic and coordinated Medicare and Medicaid program integrity strategy;

b. Set national goals and priorities to ensure that local or regional program integrity activities are consistent with the CPI's national-level strategy, while still allowing for regional program integrity activities to respond to local or regional trends in fraud, waste and abuse;

c. Further enable cooperation, communication and sharing of information and best practices between the program integrity Contractors to ensure a truly national approach to providers or trends that cut across jurisdictions;
d. Adopt a data-driven approach to CMS’s national-level direction of the Contractors’ work by using timely and accurate information about the contractors’ workload and activities;

e. Leverage CPI’s evolving centralized fraud detection mechanisms and other tools, for example the Fraud Prevention System predictive analytics tool (“FPS”) and the Healthcare Fraud Prevention Partnership (“HFPP”), across the entire nation;

f. Reduce improper payments caused by fraud, waste and abuse.

5. IMPLEMENTATION AND TRANSITION REQUIREMENTS

The following section outlines the functional requirements that shall be performed by the Contractor for an effective and efficient implementation of program integrity operations. Specific tasks and workload details will be included in subsequent Task Orders.

5.1. IMPLEMENTATION REQUIREMENTS

The Contractor shall carry out the orderly transfer of all Medicare and Medicaid data, records, and operations from all outgoing ZPICs, PSCs, and MICs within its jurisdiction. The Contractor shall develop a Jurisdiction Implementation Project Plan. The Contractor shall establish and maintain through the course of the implementation an experienced implementation management team.

5.1.1. IMPLEMENTATION PERIOD

The start of any implementation period will be defined in individual Task Orders and shall include, at a minimum:

a. Transition of workload from one or more outgoing contractors. The transition period will be defined in subsequent Task Orders but is expected to last no longer than ninety (90) calendar days unless otherwise identified by CMS.

b. Coordination with stakeholders.

c. Working with the entities listed in Section 8.2 on establishing Joint Operating Agreements (JOAs).
d. Establishing connectivity to systems and testing access, including but 
not limited to Data Use Agreements (DUAs). DUAs should be 
addressed early in the implementation period so that contractors have 
access to systems and can begin processing work as soon as the fully 
operational period begins.

e. Hiring and training staff.

5.1.2. JURISDICTION IMPLEMENTATION PROJECT PLAN

The Contractor shall develop, execute, and maintain a Jurisdiction 
Implementation Project Plan. The plan shall be consistent with the 
Contractor’s proposed implementation efforts. The Jurisdiction 
Implementation Project Plan shall include a detailed description of all 
activities required to transfer all operations, including but not limited to:

a. Open, Closed, and Pending Investigations

b. Open, Closed, and Pending Cases

c. Open, Closed, and Pending Audits

d. Open, Closed, and Pending Administrative and Enforcement Actions
   i. Payment Suspensions
   ii. Revocations
   iii. Prepayment Review
   iv. Post-payment Review
   v. Civil Monetary Penalties
   vi. Exclusions
   vii. Recalcitrant Providers
   viii. Do Not Pursue (DNP)
   ix. Other administrative or enforcement actions specific to the 
       outgoing contractor

e. Open, Closed, and Pending Requests for Information

f. IT Implementation and Test activities

g. Medical Records

h. Stakeholder Contacts

The Contractor shall define a work breakdown structure (WBS) that 
addresses the milestones, resources, and constraints of the project and
how to transition the program integrity workload from the outgoing contractor(s).

5.1.3. **Risk Management Plan**

The Contractor shall develop, execute, and maintain a Risk Management Plan. The Risk Management Plan shall include jurisdiction-wide risks and a periodic assessment of new risks as well as mitigation and contingency planning where appropriate. The Risk Management Plan shall serve as a project management tool for the Contractor to successfully implement the program and for CMS to effectively oversee the transition.

5.1.4. **Communication Plan**

The Contractor shall develop, maintain, and execute a communications plan. The Communications Plan shall include jurisdiction-wide outreach activities aimed at stakeholders. The Contractor shall coordinate with the outgoing contractor(s) to identify key stakeholders and develop rollout activities necessary for successful implementation of the program. For example, the Contractor shall work with the MAC(s) and State Medicaid Agencies that are aligned with their jurisdiction. The Contractor shall coordinate with the MACs and States to perform the necessary activities to educate stakeholders about the UPIC implementation within the specified timeframes of the implementation period.

5.1.5. **Lessons Learned Documentation**

The Contractor shall identify the lessons learned during the implementation period in an Implementation Lessons Learned Report. The report is due after all work has been transitioned to the incoming contractor from the outgoing contractor and shall identify at a minimum, processes that worked particularly well, insight and recommendation into challenges and unanticipated problems, information technology and systems issues, and recommendations for changes during future contract implementations. CMS expects to share lessons learned reports with contractors during subsequent implementations.

5.2. **Fully Operational Requirements**

5.2.1. **Fully Operational Period**

After the implementation period, the Contractor shall assume full responsibility for all activities prescribed in the SOW and subsequent Task Order SOWs. The Contractor shall develop a Fully Operational Project Management Plan that outlines the work anticipated to occur during this
phase. The Fully Operational Project Management Plan shall be updated and modified throughout the task order period of performance.

5.3. **OUTGOING TRANSITION ACTIVITIES (END OF CONTRACT)**

5.3.1. **WORKLOAD CLOSEOUT PROJECT PLAN**

The CMS may exercise this optional task at the end of a contract period to require the outgoing Contractor to develop, maintain, update, and follow a Workload Closeout Project Plan to provide for the transfer of functions and operations at contract end and report its status.

The outgoing Contractor’s plan shall provide detailed tasks reflecting the activities necessary for the outgoing Contractor to provide data to the incoming Contractor, and to maintain operational standards during the workload closeout period, and shall include all the tasks required for the transition of program integrity activities.

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

5.3.2. **WORKLOAD CLOSEOUT MEETINGS**

The CMS may exercise this optional task at the end of a contract period to require the Contractor to attend meetings and provide appropriate staff to participate in the various functional workgroups that may be established during the workload closeout period, including:

a. Kickoff meeting organized by the incoming Contractor;

b. Weekly transition workgroup teleconferences or meetings;

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

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

e. Ad hoc meetings as necessary.

5.3.3. **WORKLOAD CLOSEOUT RISK MANAGEMENT PLAN**

The CMS may exercise this optional task at the end of a contract period to require the outgoing Contractor to develop, execute, and maintain a Workload Closeout Risk Management Plan. The Workload Closeout Risk Management Plan shall include a monthly assessment of new risks and
mitigation and contingency planning where appropriate for the transition of its operations and the transfer of Medicare and Medicaid data or through identification of patterns of behavior reports by beneficiaries, employees, or other individuals, or by analysis of the payment systems for potential weaknesses.

6. **UPIC FUNCTIONAL REQUIREMENTS**

This section describes the program integrity functional requirements the Contractor shall perform. The UPIC program integrity activities will be based on CMS-directed prioritization of work and highly focused on activities leading to timely and successful implementation of administrative actions.

6.1. **IDENTIFICATION OF VULNERABILITIES**

A vulnerability is an instance of potential Medicare or Medicaid fraud, waste, or abuse identified through the analysis and management of provider, supplier, and beneficiary data or through identification of patterns of behavior reports by beneficiaries, employees, or other individuals, or by analysis of the payment systems for potential weaknesses. The UPIC and its partners (e.g., MACs, Law Enforcement, and State Medicaid Agencies) shall work together and communicate frequently in order to keep each other apprised of potential areas of vulnerability and to avoid duplication of efforts.

Based on CMS-directed prioritization of its work, the Contractor shall review and analyze a variety of data to identify vulnerabilities and specific providers/suppliers for review and investigation within its jurisdiction. Central to this analysis is the Fraud Prevention System (see Section 6.2.2.d.). The Contractor shall provide CMS with recommendations for possible controls, audits, or policy changes to reduce the vulnerability. Further, the Contractor shall be proactive and innovative, using many different sources and techniques for analyzing data in order to reduce any of its risks within this SOW.

The Contractor shall work with and coordinate with, entities including, but not limited to, CMS, State Medicaid Agencies, MACs, Federal stakeholders, the HFPP, and Law Enforcement representatives.

The Contractor shall submit identified program vulnerabilities to CMS as outlined in IOM Pub.100-08, or in other formats as directed by CMS. As
part of the vulnerability submission, the Contractor shall provide recommended corrective actions to address the vulnerability identified. For example, the Contractor may recommend Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), state policy changes, model development, provider education, system edits or other actions needed to address the vulnerability.

6.1.1. **REGIONAL STEERING COMMITTEE**

The general purpose of the regional steering committee is to support CMS and State program integrity efforts by convening program partners and to provide opportunities for collaboration, guidance, and information sharing on program vulnerabilities and analysis results. The Contractor shall serve as the organizer of the steering committee and conduct the administrative work of facilitating steering committee meetings. With input from CMS, States, and other participants, the Contractor shall also customize a charter for the steering committee.

Participating State Medicaid Agencies will be asked to assign a person to act as a member of the steering committee (this person shall be identified in JOAs with State Medicaid Agencies).

6.1.1.1. **INITIAL MEETING**

The Contractor is responsible for the logistics of setting up the first meeting of the steering committee. This includes locating a venue, notifying participants of the date, drafting the agenda, and obtaining input from the co-chairs.

6.1.1.2. **TIMING AND PURPOSE**

The initial steering committee meeting should occur during the implementation period of the program. Its purposes include:

a. Briefing members on the Contractor’s purpose and function.

b. Providing an update to the partners on the progress of implementation.

c. Drafting the steering committee’s charter.

d. Discussing and defining the members’ roles and responsibilities.
e. Brainstorming potential vulnerabilities for the UPIC to consider as it develops its analysis strategy.

f. Arranging for ongoing vulnerability identification, analysis, and mitigation activities to occur between meetings.

g. Planning for future meetings.

6.1.2. NATIONAL CONFERENCE

The national conference provides a forum for education and information sharing. The conference will focus on two main areas. The first is the sharing of standard information on Medicare and Medicaid policy and data. This allows new staff and programs to get a basic understanding of the two programs and provides updated information on the changes that are occurring. The second area of focus is UPIC information sharing. This includes challenges and lessons learned relating to issues with connectivity, data matching, and investigation development as well as success stories relating to the discovery of program vulnerabilities, and development of leads, investigations, and fraud cases.

6.1.3. NATIONAL STATISTICS CONFERENCE

The Contractor shall participate in the National Statistics Conference for statistical tools and the defense of statistical methodologies during appeals and prosecution of large cases.

6.2. DATA ANALYSIS AND MATCHING REQUIREMENTS

CPI is committed to driving continuous improvements in program integrity performance and believes that accurate data and relevant, efficient data analysis is integral to strong program integrity efforts. The knowledge of data and experience with a wide range of analytical tools is integral to the work performed by the Contractor.

In performing this work, the Contractor shall be prepared to work in CMS systems, with CMS as the owner of the data, algorithms and statistical methods, and results. Results of data analysis, including leads, shall be documented by the Contractor and maintained in the Unified Case Management System or an alternative system as directed by CMS.

6.2.1. DATA ANALYSIS PLANNING

Work phases involving data, data analysis, and data matching include:
a. During the Implementation Phase, the Contractor shall participate in meetings with the outgoing Contractor(s) and CMS regarding the transfer of data and information. The Contractor shall collaborate with participating stakeholders and submit a Data Analysis Project Management Plan that describes current status, as well as future plans for the data.

b. During the Fully Operational Phase, the Contractor shall use data and tools to perform comprehensive research, data analysis, and trending activities. The planned source for the majority of the data and tools to be used will be in the OnePI/IDR. While awaiting data sources that may not be fully available in the IDR, the Contractor shall collaborate with CMS to determine innovative approaches so that the most complete and accurate data possible becomes available to perform data analysis work in pursuit of strong program integrity.

(For more information on implementation activities, please Section 5, Implementation Requirements)

6.2.2. DATA ANALYSIS EXPECTATIONS & RESPONSIBILITIES

a. The Contractor shall perform a range of fraud, waste, and abuse data analysis and matching activities on Medicare-only claims, Medicaid-only claims, and Medicare-Medicaid (Medi-Medi) claims as well as any other claim information or datasets identified in specific Task Orders. This includes the analysis and matching of Medicaid encounter data for providers participating in Managed Care. In addition, when private sector data is available through the HFPP this shall also be included in the match when appropriate. The Contractor shall undertake these efforts based on CMS-directed prioritization of its work. The Contractor shall place high emphasis on activities leading to successful administrative actions. These shall be conducted with a high level of initial and ongoing direction and approval from, and collaboration with, a CPI team led by the UPIC COR and including Subject Matter Experts (SMEs) or Business Function Leads (BFLs) both within CPI and across the Agency.

b. The Contractor shall perform data analysis work through the One Program Integrity (One PI) portal, which is a centralized suite of tools to support fighting fraud, waste, and abuse. The data source available through the OnePI portal is a data warehouse called the Integrated Data Repository (IDR), which provides a single national view of integrated Medicare claims, provider, beneficiary, and related data.
The vision of the IDR is that of a national level repository, which will contain Medicare Parts A, B, C, and D claims/encounter data and relevant reference data (e.g., provider, beneficiary, and plan) integrated with Medicaid data. Through the OnePI portal, the Medicaid data will be placed in a secure and private space in the IDR to perform data matching and analytics.

c. The Contractor shall analyze the applicable data, including data from multiple healthcare databases, internal and external to CMS, when performing their work. Please note that the names and status of the healthcare databases, both internal and external to CMS are subject to change at any time and CMS expects that the Contractor shall be flexible and able to adapt as needed.

d. The Contractor shall use the Fraud Prevention System (FPS) as a source for leads on specific providers/suppliers as well as for further data analysis. FPS is a predictive analytic tool that screens all national Medicare Parts A and B claims before payment and consolidates alerts by provider. It presents findings in a prioritized list, including detailed claim, provider, and beneficiary information and tracks the information related to investigation and actions taken. While FPS is a powerful lead generation tool, it is one of many the Contractor shall use in generating leads. Information from the Healthcare Fraud Prevention Partnership (HFPP) is an example of another tool contractors may use.

e. Examples of data sources for the work to be performed by the Contractor can include those listed in Appendix A (these are subject to change at any time).

6.2.3. **Collaboration with States – Data Analysis**

The Contractor shall collaborate with the states in their jurisdiction to develop a comprehensive strategy for data analysis involving Medicaid data. Additionally, the Contractor shall collaborate with states in their jurisdiction to understand the status and capability of the States’ data systems, to document and update status when changes occur, and to use this information to assess how to conduct data analysis efforts. The Contractor shall also help the States identify any constraints and proactively address these to help produce the most accurate data analysis results for program integrity purposes.
6.2.4. **FUNCTIONAL DATA ANALYSIS & MANAGEMENT ACTIVITIES**

a. **Data Analysis, Data Matching, and Other Data-Related Activities**

The Contractor shall perform data analysis, data matching, statistical analysis, trending activities, and collaborative efforts that result in the detection and prevention of potential fraud, waste, and abuse within and across Medicare and Medicaid. The Contractor shall use a variety of Medicare, Medicaid, and non-CMS data to perform data analysis. There may also be the potential for certain data from the private insurance sector to be provided and to be included in the data analysis performed, for example, private insurance data received from HFPP to support provider/supplier investigations.

b. **Medi-Medi Activities & Data Dictionaries**

The Contractor shall perform the specific activity that is currently known as “Medi-Medi data matching and analysis”. The entire process for performing Medi-Medi data matching is detailed in the Medicare-Medicaid Data Match Program Policies and Procedures Manual (PPM). The Contractor shall use these matched datasets to conduct data analysis for the purpose of identifying leads for further pursuit.

The Contractor shall develop, maintain, and update data dictionaries relevant to the Medi-Medi program. An exchange of data dictionaries between the State Medicaid Agency and the Contractor is a basic method to allow both sides to understand the others’ data and it is necessary for successful Medi-Medi analysis. In some cases, data dictionaries may already exist; however, when data dictionaries do not exist or are not adequate for Medi-Medi purposes, they must be developed or modified. The Contractor shall provide data dictionaries to the OnePI and IDR contractors and support the loading of data in the system as described in individual Task Orders.

The Contractor shall perform data cleansing and a validation test plan once the data dictionary is completed. This activity will provide support for the data matching effort. The process for cleansing and validating data should be included in the IT Plan. (Refer to the IT section of the SOW for additional information.)

c. **The Contractor shall conduct both basic and advanced data analysis in the IDR and shall combine data from a variety of sources to determine a provider/supplier’s billing pattern and the beneficiary’s claim history.**
In order to obtain a complete history of claims, it is possible that the Contractor will have to obtain data outside of its assigned jurisdiction.

d. The Contractor may be requested by CMS to conduct simulations using models or other analytics to test the business rules in real world conditions and provide or suggest enhancements as necessary, especially when new data technology becomes available.

e. The Contractor shall recommend new business rules and analytics based on the results of existing models, coordination with other stakeholders, or through other means as defined by CMS.

f. The Contractor shall be prepared to update and/or adjust previously run analytics based on the availability of improved source data or more state-of-the-art data analysis techniques.

g. When the needed data cannot be found in the IDR or via OnePI, the Contractor shall offer a strategy for obtaining and analyzing data to continue the performance of their program integrity work.

h. The Contractor shall perform data analysis within their assigned jurisdiction, across jurisdictions or states, or from a national perspective (i.e., special projects or studies) as assigned by CMS. The outcome of data analysis activities will be actionable leads that the Contractor shall develop and refer to CMS, other CMS contractors, and law enforcement entities as appropriate, as well as the identification of regional or national trends.

i. The Contractor shall coordinate with other contractors, as directed by CMS, to address nationwide strategies. These coordination projects may include integration and analysis of data across one or more programs (i.e., Medicare, Medicaid, Medi-Medi) to identify trends in fraud, waste, and abuse, as well as other projects as requested by CMS. As directed by CMS, the Contractor may also be required to coordinate the review of data or data analysis results with other stakeholders. As part of the coordination activities, the Contractor shall participate in information sharing sessions, which could include the Program Integrity Data Users Group (PIDUG).

j. The Contractor shall employ qualified professionals to perform a wide variety of data analytics that have relevance to the prevention and detection of fraud, waste, and abuse. This contract will allow for a
broad range of experience using analytical tools, that can include, but is not limited to the following:

i. Executing rule-based algorithms (or improving upon those that already exist) to produce actionable and defensible results that incorporate national and/or state specific rules, as appropriate.

ii. Creating and developing new algorithms and data models that produce actionable and defensible results.

iii. Providing innovative solutions to filling in the gaps regarding incomplete or inaccurate baseline data; to more efficiently and effectively detect fraud, waste, abuse or other errors in payment; to identify areas of emerging risk and make recommendations for actions.

iv. Performing trend analysis.

v. Support creation, testing, and implementation of predictive analytics in FPS.

vi. Providing a testing base for potential enhanced data or data from sources that are unfamiliar to the Medicare or Medicaid perspective.

vii. Performing social networking analyses, using data that is structured, but may also be unstructured.

viii. Identifying and documenting any vulnerabilities or gaps found during data analysis activities and informing CMS, as well as other stakeholders as directed by CMS.

ix. Conducting data analysis in Medicaid Managed Care using encounter data or claims data.

x. Conducting data analysis in Medicare Part C and D using encounter data, prescription drug event data, or claims data.

k. The Contractor shall perform work on data analysis types that may include, but are not limited to the following:
• Provider matches
• Beneficiary matches

• Scheme-based matches
• Procedure-based matches
• Specific time-based matches (Time bandit analyses)
• Demographic-based matches
• Benefit and utilization-based matches
• Classification analyses
• Trend analyses
• Factor analyses
• Spike analyses

• Top biller reporting
• Normative analyses, benchmarking, and peer comparisons
• Specialty outlier analysis
• Provider outlier analysis
• Provider-level analysis
• Tax ID summary
• Never events analysis
• Medically unlikely event analysis
• Episode grouping
• Link analysis
• Pattern recognition

• Cross claims analysis
• Recipient history

• Cluster analysis
• Decision tree analysis
• Neural network analysis
• Geographic hot spot analysis
• Multivariate analysis
• Sampling analysis
• Profiling (provider, service)
• Statistical sampling
• Other analyses as may be identified by the UPIC and CMS

I. The Contractor shall also use data analysis and statistical sampling techniques for other activities, such as Medicaid cost report audits or Medicare cost report reviews.

m. The Contractor shall provide training materials and a training plan to CMS and other stakeholders regarding data mining tools and risk assessment tools; these training materials shall be updated as necessary or as requested by CMS.

n. The Contractor shall maintain documentation and files that are associated with all data analysis and matching work. It is envisioned that the majority of the Contractor’s data work shall be stored in the IDR and/or the CMS Unified Case Management System, or in an alternative environment as directed by CMS. The results of data analysis, including whether there are possible actionable or non-actionable findings will be also be maintained in the CMS Unified Case Management System, or alternative environment as directed by CMS.
(For more information regarding the CMS Unified Case Management System, refer to Section 8.6 of this SOW.)

6.2.5. DATA ANALYSIS & MANAGEMENT REPORTING

There are a variety of reports that the Contractor shall generate as a result of its Medicare and Medicaid data analysis activities. These reports shall be submitted by the Contractor into Unified Case Management System, or alternative environment as directed by CMS:

a. The Contractor shall prepare a Data Analysis Project Management Plan report (details to be included in a Task Order SOW) and submit it to CMS. The Data Analysis Project Management Plan will be submitted during the implementation phase with revisions and updates occurring throughout the fully operational period. In addition to the plan, the Contractor shall report status of ongoing projects. From the Medicaid perspective, each state may have unique fraud, waste, and abuse issues, so the Contractor shall use this Data Analysis Project Management Plan to document the data issues/projects that are specific to the states in their region. The frequency of the submission of these plans will be quarterly, but CMS may revise the frequency as needed.

b. The Contractor shall prepare an Analytic Findings Report regarding the variety of data analysis activities it performs for each lead. The report shall summarize the data analysis performed, identifies potential leads that justify further action (also referred to as “actionable”), and provides recommendations for activities that can include further investigation, audit, referral to law enforcement, or administrative action. The Contractor shall provide this report to CMS through the Unified Case Management System or an alternative environment as directed by CMS. This Analytic Findings Report will also serve as a vehicle to provide information to Law Enforcement, State Medicaid Agencies, and other entities. CMS expects to use the information from Analytic Findings Reports to share best practices among contractors and develop models for the FPS or HFPP studies, where appropriate.

c. In order to accomplish the data matching process, the Contractor shall prepare a Data Matching Protocol with the collaboration and agreement of the State Medicaid Agency, and then submit it to CMS. The Contractor shall refer to the PPM for more information regarding the Data Matching Protocol. The Data Matching Protocol shall be
provided to CMS and may be shared with other contractors to facilitate best practices and lessons learned.

6.3. **LEAD MANAGEMENT**

All Contractor activities shall be aligned with CMS-determined priorities, including the most fundamental priority of protecting program dollars by stopping future inappropriate payments by use of any appropriate administrative action or remedy, or identifying past improper payments for recovery. The Contractor shall partner with CMS to identify and prioritize leads for investigation. A lead is an indication that points toward a suspected instance of fraud, waste, or abuse.

6.3.1. **WORKLOAD CATEGORIES**

The Contractor workload shall be split into four categories with corresponding levels of effort assigned to each category. CMS shall prescribe specific levels of effort in individual Task Orders. The Contractor shall use the Unified Case Management System to track and report all activities performed within these categories, and CMS will determine any adjustments to the levels of effort in support of priority work.

a. The first workload category shall be leads prioritized centrally through the Fraud Prevention System based on the results of sophisticated analytics. The leads prioritized in the FPS include vulnerabilities identified by many sources, including data models, HFPP, and CMS and UPIC intelligence, among others. The Contractor shall work with CMS to develop actionable models for the FPS, to include, the regional or national implementation of models developed in workload category "b" below. The Contractor shall also work with CMS to refine established leads for FPS.

b. The second workload category shall be leads identified and prioritized through collaboration between the Contractor, CMS, and State Medicaid Agencies. These would include leads developed through Contractor-developed data models in addition to the approved data project plan, rapid response leads for urgent matters, emerging issues and leads addressing local (e.g. Medicaid) issues.

c. The third workload category shall be leads provided by external sources or referrals. The Contractor shall accept referrals from external sources and prioritize them using a defined triage protocol for identifying leads with the greatest potential of fraud, waste, and abuse.
Those leads shall be assigned to the contractor’s workload. Leads that do not require further action will be stored in the UCM in the event additional information is provided at a later date.

d. The fourth workload category shall be leads that are requested to be worked by law enforcement that were not already part of the workload assigned to the Contractor. For example, requests for information (RFIs), requests for Medical Review in support of law enforcement cases, and requests for investigation support for leads generated by law enforcement.

6.3.2. SOURCES OF LEADS

The Contractor may identify leads through any number of sources, including but not limited to:

a. Data Analysis: Discussions should take place between all stakeholders about data project analyses to facilitate the detection and prevention of fraud, waste, and abuse. In addition, the progress of data projects and investigations is communicated to partners on an ongoing basis through informal communications between the Contractor and the stakeholders. Prioritization is critical to ensure that resources are devoted to projects that are high-priority to all the stakeholders including CMS, State Medicaid officials, and Law Enforcement.

b. State Identified Leads: The State Medicaid Agency may provide leads to the UPIC that result from data analytics, tips, or any other source provided to the State.

c. Medicare Leads: The Contractor may receive Medicare leads from an external source such as the second level screening at the MAC, Senior Medicare Patrol, and other stakeholders participating in the Medicare program.

d. Law Enforcement: The Contractor may receive Medicaid or Medicare-related leads from law enforcement entities.

e. CMS Identified Leads: The Contractor may receive leads directly from CMS related to program integrity operations (e.g. FPS, HFPP) or other special projects (e.g. moratorium).

f. General Leads: The Contractor may receive or identify Medicaid or Medicare-related leads from any source not identified above. These could include tips or newspaper and internet articles.
6.3.3. **Lead Management Protocol**

The Contractor shall develop an administrative protocol, or triage process, that governs the disposition of leads based on the likelihood of fraud, waste, and abuse identification. The protocol shall accurately link screening measures to potential fraud, waste, and abuse risk factors to ensure that Contractor resources are dedicated to leads with the highest likelihood of fraud, waste, and abuse. The protocol must be flexible to allow the Contractor and CMS to address evolving fraud, waste, and abuse issues. The Contractor shall submit their protocol to CMS for review and approval and shall continually assess and modify the protocol to ensure the accurate identification of leads for further investigation. This protocol must specify that all leads shall be identified and assessed regardless of whether or not they are eventually worked. Assessment must include both an assessment of the specific lead and also some assessment of the possible global risk to the Programs across all providers.

6.3.4. **Lead Prioritization**

The Contractor shall consider the overarching principles documented in IOM Pub.100-8 when identifying priorities. The Contractor shall apply these principles in conjunction with the established Lead Management Protocol to ensure investigations are conducted on leads with the highest risk of potential fraud, waste, and abuse. The Contractor shall be flexible and shall have the capability to adapt to the changing landscape of fraud, waste, and abuse in their jurisdiction. The Contractor shall keep CMS informed as to the highest investigative priorities in such a way as to ensure that CMS always has a full understanding of the Contractor’s highest priorities, most common investigative techniques, and how the Contractor is allocating its resources among these activities.

Specific requirements include:

a. Conduct data analysis to identify trends and patterns (local, regional, national) of potential fraud, waste, and abuse from three perspectives: the Medicare-only perspective, the Medicaid-only perspective, and the joint/composite Medicare and Medicaid perspective. The Contractor shall develop annual data analysis plans that address methodologies and findings within and across both programs.

b. Track all analysis activities based on the primary source of the issue, such as Medicare-only, Medicaid-only, and Joint Medicare/Medicaid.
c. Accept leads from a variety of external sources that can include, but are not limited to: the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), the Assistant U.S. Attorney (AUSA), the 1-800-Medicare call center (a CMS contractor), the CMS/CPI Field Offices, the NBI MEDIC, the CMS Medicare claims processing contractors known as Medicare Administrative Contractors (MACs), State Medicaid Program Integrity units, State Medicaid Fraud Control Units (MFCUs), and direct complaints from program beneficiaries and healthcare providers.

d. Develop a triage protocol for evaluating and proceeding with the referrals submitted based on the priority of cases having the greatest program impact and/or urgency, focusing on saving future expenditures, or otherwise protecting Program funds. Examples of protocol standards may include referencing pertinent statutes, regulations, guidance and practice standards. The protocol shall be approved by CMS.

e. Review the referral and determine if any additional data analysis or any other follow-up work is needed. If additional work is needed, then the Contractor shall perform the necessary tasks. After the referral has been completely evaluated, the Contractor shall determine whether or not to close the issue, open an investigation, or refer the issue to an appropriate entity.

f. In the event the Contractor receives a lead specific to the Medicare or Medicaid program, the Contractor shall compare the lead with any other data sources available to determine if the issue exists across programs.

g. Analyze data on a multi-state or national level to identify national and regional trends and patterns that may assist in the identification of issues that cross state borders and may require further evaluation.

h. Update and refine data mining techniques or risk assessment techniques based on any updates or availability of improved source data (including the FPS and other CMS analytics), reference files, or other successful innovative techniques. Improvements shall be implemented after consultation with CPI.

i. Support CMS in the evaluation of information and data from the HFPP. The HFPP is an opportunity for public and private sectors to exchange facts and information in order to reduce the prevalence of fraud in the
healthcare industry. As requested by CMS, the Contractor shall provide input to CMS in support of HFPP projects. As requested by CMS, the Contractor shall analyze and research data developed by a Trusted Third Party (TTP) (on behalf of the HFPP) and furnished to CMS. The Contractor shall develop leads referred to it by CMS identified through the HFPP.

j. Provide support to CMS and State Medicaid Agencies in the evaluation of information and data from any new sources that may become available during the course of the contract.

k. The Contractor shall assess leads identified during analysis to avoid duplication of efforts and promote activities that will generate actionable results, calculated to minimize future program expenditures. Leads shall be vetted with the appropriate stakeholders.

l. To improve the efficiency of CMS’ program integrity efforts, the Contractor shall consider the following as it develops leads:

   i. Relevant national Medicare policies;
   ii. Relevant local Medicare coverage determinations and policies;
   iii. Relevant State Medicaid policies (for those States within the jurisdiction);
   iv. Relevant local Medicaid policies, if any (e.g. county);
   v. Other relevant policies (e.g., State licensure requirements);
   vi. Published coding guidance (e.g. CPT, NCCI);
   vii. Typical practice patterns and standards of care;
   viii. Other CMS PI efforts, the efforts of other Contractors, and other State and Federal law enforcement efforts, to the extent known to the UPIC.

m. The Contractor shall coordinate its lead development efforts with other entities, such as CPI Field Offices (FOs) and Regional Offices, other CMS contractors, as well as State or Federal agencies, as directed by CMS. Support to CMS Field and Regional Offices may include, but not be limited to, providing clinical support during field interviews and collaborating on investigations of specific providers.

n. As the Contractor identifies and develops leads through its analysis, the Contractor shall create reports containing suspect claims and suspect providers, and recommendations for further action. The Contractor shall filter, document, and prioritize leads that have the greatest likelihood to produce actionable and defensible results that
are cost effective in nature. The Contractor shall keep CPI apprised of its activities, and will as appropriate seek guidance from CPI regarding significant activities and priorities, as well as any proposed changes to previously set priorities.

6.3.5. TRACKING

The Contractor shall use CMS’ Unified Case Management System, or other systems defined by CMS, to track all leads, investigations, and referrals unless alternate reporting systems are specified. The UCM allows the Contractor to identify the initiation of an investigation, follow its progress, and note specific outcomes.

6.4. INVESTIGATION REQUIREMENTS

The Contractor shall investigate suspected instances of fraud, waste, and abuse involving Medicare and Medicaid providers, suppliers, and other entities receiving reimbursement under one or both of the Medicare and Medicaid programs. This includes providers, suppliers, and other entities performing under Medicare Advantage, Part D, Medicaid Managed Care, and other programs administered or operated by CMS or State Medicaid Agencies. The Contractor shall open investigations on leads with the highest priority of potential fraud, waste, and abuse. The Contractor shall investigate to determine the facts and the magnitude of the alleged fraud. The Contractor shall apply the Lead Management Protocol to ensure that the resources available are devoted primarily to high-priority investigations. The Contractor shall investigate potential fraud related to the use of Electronic Health Records (EHRs).

As directed by CMS, the Contractor shall be prepared to serve as the lead for investigations or provide subject matter expertise based on the needs of CMS, law enforcement including DOJ and OIG, and the individual State Medicaid Agencies in their jurisdiction. For example, the State may request specific clinical expertise from the Contractor to augment the work of State investigators. The Contractor shall notify the COR when the State requests specific assistance to support ongoing investigations.

Note: The Medicaid Integrity Contractors (MICs) previously conducted “audits” of providers to identify overpayments. For the purposes of this contract, the term investigation shall be used to describe audit activities previously performed by Audit MICs for the review of providers or suppliers furnishing items or services under the Medicaid program.
6.4.1. PLANNING REQUIREMENTS

The Contractor shall develop an investigative plan of action for each investigation. The Contractor shall determine the potential scope of the allegation including the programs involved (Medicare, Medicaid or a combination). The scope will be a guiding factor to the planning and coordination process during the course of investigation. For example, an investigation that only impacts Medicare beneficiaries will not have significant state collaboration, whereas in a Medicaid investigation or a Medicare-Medicaid (Medi-Medi) investigation the State will have a major and essential part of the investigation.

The plan shall include, at a minimum, the following:

a. Primary nature and complexity of the allegations (criminal, civil, or administrative);

b. Possible violation(s) of law, rule, or regulation and the corresponding elements of proof or standards;

c. Coordination with appropriate authorities, if necessary (OIG, the Federal Bureau of Investigation, State Medicaid Agency);

d. Applicable judicial venue and coordination with prosecutors, when appropriate;

e. Steps necessary to meet investigative objectives; and

f. Resources necessary to meet investigative requirements.

The Contractor shall add any additional items as appropriate to the investigation plan.

6.4.2. EXECUTING REQUIREMENTS

The Contractor shall conduct a variety of activities to substantiate the allegations during the course of an investigation. Examples of activities that may be appropriate can be found in IOM Pub.100-8. The Contractor is not restricted to these activities and will determine the appropriate methods based on the nature of allegation and the facts that are uncovered. During the course of conducting an investigation, the Contractor may determine the scope extends beyond the initial plan. For example, the initial allegation involved only Medicare but the contractor later determined that potential fraud, waste, or abuse in the Medicaid program is also involved. The Contractor shall notify the CMS and include these new findings in their investigation plan.
6.4.3. Referring Requirements

6.4.3.1. Referral to CMS

The Contractor shall refer recommendations for appropriate administrative action in accordance with laws and regulations to ensure that appropriate and accurate payments for items or services are made, which are consistent with Medicare coverage policies. The formats for referrals to CMS can be found in IOM Pub. 100-08 (Refer to the Expected Outcomes section for more information on referring administrative actions).

6.4.3.2. Referral to State Medicaid

The Contractor shall work collaboratively with the State Medicaid Agency and refer findings (e.g. overpayments and administrative actions) based on the results of investigations. The Contractor shall refer actions in accordance with laws and regulations to ensure that appropriate and accurate payments for items or services are made, which are consistent with Medicaid coverage policies. The Contractor shall coordinate with the State on an agreed upon format for referrals with the goal of providing the State with an actionable package of information. The Contractor shall coordinate with Law Enforcement to notify the State Medicaid Agency when a fraud referral is submitted.

6.4.3.3. Referral for Quality of Care Issues

The Contractor shall also refer instances of apparent unethical or improper practices or unprofessional conduct (e.g. quality of care issues) to the appropriate entity. For Medicaid-related issues, the Contractor shall coordinate with the State Program Integrity Unit and any other entities within the State responsible for ethical, professional or quality of care issues. For Medicare-related issues, the Contractor shall coordinate with the Quality Improvement Organization (QIO). For issues involving both programs, Contractor shall coordinate across these entities.

6.4.3.4. Referral to HHS OIG

The Contractor shall identify suspected fraud and refer investigations to HHS OIG following the instructions in the
IOM Pub.100-8. The format for a referral fact sheet and investigation summary are available in IOM Pub.100-8 and the Contractor shall prepare the referral packages according to these instructions.

The Contractor shall be available to provide information and support for investigations that were referred and accepted by Law Enforcement. In addition, the Contractor shall be prepared to implement other referrals or administrative actions in situations where Law Enforcement declines the referral.

6.4.3.5. **REFERRAL TO THE MAC**

The Contractor shall refer Medicare overpayments to the MAC for recovery. In addition, the Contractor shall refer providers to the MAC for education, if appropriate.

6.4.3.6. **REFERRAL TO LAW ENFORCEMENT**

The Contractor may be required to refer to other law enforcement entities in accordance with IOM Pub. 100-08.

6.4.4. **APPEALS**

The Contractor shall support appeals related to Medicare and Medicaid administrative actions (e.g. claims determinations, overpayment determinations, payment suspensions, provider revocations, provider terminations). The contractor shall also support appeals of judgments or convictions related to Medicare and Medicaid law enforcement activities.

6.4.5. **CLOSING INVESTIGATIONS**

The Contractor shall close an investigation from their active workload once all activities (e.g. CMS and State administrative actions are completed, law enforcement referrals are completed) are finalized. As previously stated, the Contractor shall be available to provide ongoing support for accepted referrals. The Contractor shall also close an investigation if the allegations were not substantiated, however, the information should be documented in the UCM for reference in the future if new information is provided. The Contractor shall close an investigation if the provider is referred back to the MAC or another contractor due to an incorrect referral or misrouting.
6.5. **COST REPORT AUDITS AND REVIEWS**

Institutional providers of healthcare services participating in the Medicare and Medicaid programs are required to file separate Medicare and Medicaid Cost Reports on an annual basis. Medicare Cost Reports are submitted to CMS while Medicaid Cost reports are submitted to the individual State.

6.5.1. **COST REPORT AUDITS FOR MEDICAID PROVIDERS**

The Contractor may conduct cost report audits of Medicaid providers. The audits shall be conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS). The Contractor shall be responsible for issuing notices for the audits and scheduling entrance and exit conferences.

6.5.2. **COST REPORT REVIEW FOR MEDICARE PROVIDERS**

Medicare cost report audits are conducted by MACs. The Contractor may use the cost report as part of an investigation to substantiate an allegation but will not be responsible for conducting the audit.

The Contractor shall establish a point of contact with the MAC to access cost reports as part of an investigation. In addition, the Contractor shall coordinate with the MAC when provider cost report fraud is suspected. The Contractor shall also refer any issues to the MAC identified with the cost report when using the information as part of an investigation.

6.5.3. **COORDINATION WITH CMS**

The Contractor shall coordinate with CMS upon discovery of potentially fraudulent situations during Medicaid cost report audits or when using the Medicare cost reports as part of an investigation. The Contractor shall recommend the appropriate action to CMS and the State Medicaid Agency.

6.5.4. **FINDINGS AND RECOMMENDATIONS**

The UPIC shall coordinate with the State Medicaid Agency to develop a referral process for findings resulting from a Medicaid cost report audit. If potentially fraudulent information is discovered through the Medicare cost report investigation, the UPIC shall coordinate with the MAC and CMS to potentially expand the review.
6.6. **MEDICAL REVIEW REQUIREMENTS**

As stated in IOM Pub.100-8, the CMS’ national objectives and goals as they relate to medical review are as follows: 1) Increase the effectiveness of medical review payment safeguard activities; 2) Exercise accurate and defensible decision making on medical review of claims; 3) Place emphasis on reducing the paid claims error rate by notifying the individual billing entities (i.e., providers, suppliers, or other approved clinicians) of medical review findings and making appropriate referrals to provider outreach and education (POE); and 4) Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of potential fraud, waste, and abuse.

The Contractor is authorized to conduct medical and utilization reviews (in accordance with 42 U.S.C. 1395ddd (b)(1) and 42 U.S.C.§ 1396U–6). When necessary these reviews will include reopening the claim and obtaining and reviewing providers’ medical records and medical documentation. The Contractor shall provide medical review (MR) in support of an investigation to determine the appropriateness and medical necessity of the services in question.

The Contractor shall perform:

- a. Prepayment MR
- b. Post-payment MR
- c. MR in support of other Program Integrity (e.g., law enforcement requests or State Medicaid Agency requests)
- d. Provider Notification and Feedback in support of Medicare

The workload for the above MR requirements shall be designated in each individual Task Order, and the Contractor shall perform Medicare MR functions in accordance with IOM Pub.100-08 unless specifically directed otherwise in the SOW or other CMS instruction.

The Contractor shall conduct Medicaid MR in support of program integrity activities. The Contractor shall conduct Medicaid MR in accordance with existing state policy rules and relevant guidance.

Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), the Contractor shall ensure that coverage/medical necessity determinations are made by Registered
Nurses (RN) nurses (RNs) or therapists and that coding determinations are made by certified coders or clinicians with approved coding credentials. When necessary, these audits will include determinations of medical necessity by licensed practitioner(s), as required by State rules and regulations. The Contractor shall comply with all National Coverage Determinations (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, local coverage determinations (LCDs) (formerly called local medical review policies (LMRPs) and local coverage/coding articles in their jurisdiction.

The Contractor shall document the rationale for denial and include the basis for revisions in each case. The Contractor shall send a review results letter to the Medicare provider or appropriate Medicaid State Agency contact. The Contractor shall include copies of the NCD, coverage provisions from interpretive manuals, LCD or applicable references needed to support individual case determinations.

6.7. Edits

6.7.1. Program Integrity Edits

The Contractor shall develop edits for the Medicare fee-for-service claims processing systems, as well as recommend edits to State Medicaid Agencies, as appropriate based on the findings of data analysis and the identification and prioritization of known issues. When appropriate, the Contractor shall implement or recommend a suitable action that may include but is not limited to prepayment review, payment suspension, provider revocation and the implementation of claims processing edits that limit or stop payment to suspect providers in accordance with direction provided in IOM Pub.100-08.

6.7.2. Shared Systems

This section is applicable to Medicare program integrity support

The Contractor shall use the Shared Claims Processing System (data centers and software) when appropriate to perform the following tasks:

a. Specify the program integrity edit criteria. Those Contractors who have read and write access to the MAC’s shared system are responsible for working their edits into the system. Those with read-only access are to coordinate the implementation of these edits into the system with the MAC.
b. Manage the workflow of prepayment claims requiring manual review.

c. Access the online claims history file, the claims-in-process file, and the provider file.

d. Access claims attachments that were imaged by the MAC (if this feature is present on the Shared Claims Processing System).

e. Access other online applications in the MAC’s Shared Claims Processing System as necessary.

The UPIC shall submit change requests to the appropriate COR in accordance with the CMS Change Management process.

6.7.3. Evaluating Edit Effectiveness

The Contractor shall work with the MAC or other entities to receive reports on the results of edits. Edit evaluations are used to determine the effectiveness of the edit on the program integrity issue while assessing the effect of the edit tasks on workload. This includes the specificity of the edit in relation to the identified problem(s). The Contractor shall consider an edit to be effective when it has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. The Contractor shall revise or replace edits that are ineffective. Edits may be ineffective when payments or claims denied are very small in proportion to the volume of claims suspended for review. The Contractor shall provide information on edit effectiveness through the Unified Case Management System or alternative mechanism as identified by CMS.

The Contractor shall coordinate with the State Medicaid Agency to determine the effectiveness of recommended edits to the Medicaid program. The State Medicaid Agency will determine the effectiveness of implemented edits and the Contractor shall support state efforts update or refine edits as necessary.

6.7.4. Edit Implementation

As the functionality becomes available, the Contractor shall coordinate with CMS to develop edits in the FPS as appropriate. The Contractor shall assist States in developing edit parameters based on the specific issues under review.
6.8. SUPPORT TO CMS

The Contractor shall provide support to CMS’ program integrity efforts. The Contractor may be required to attend meetings, provide subject matter expertise, or offer ideas in support of CMS-driven initiatives.

6.8.1. HEALTHCARE FRAUD PREVENTION PARTNERSHIP (HFPP)

CMS is responsible for the operations of the HFPP, including managing the various committees and convening forums for information sharing and data exchange. The Trusted Third Party (TTP) is responsible for collecting data from the partners, conducting data analysis, and providing the results of data analysis to the partners participating in the studies. CMS is a partner and as such, responsible for contributing ideas, data, and utilizing outputs from the HFPP to inform CMS business operations and program integrity efforts. For more information about the HFPP visit the webpage at www.hfpp.cms.gov.

The Contractor shall support CMS in its activities and responsibilities regarding HFPP through the following activities listed below. Specific workload will be designated in individual Task Orders.

a. Provide input and suggestions for studies to be conducted by the HFPP which would aid in CMS’ FWA activities. As studies are being proposed the Contractor shall provide insights into how the study topic manifests within their zone and activities, how private sector data would help their activities and overall, provide transparency into the research study ideas which would maximize the value to the Contractor and CMS.

b. Review and analyze study findings and information from the HFPP for applicability and use in UPIC activities.

c. Provide performance management feedback regarding use and value of HFPP study data to UPIC activities (e.g. lead generation, number of investigations opened or augmented by HFPP information, revocations or other administrative actions)

d. Participate in regular HFPP and UPIC coordination missions to discuss current and past studies, input for future studies and general information sharing and lessons learned.
e. Coordinate with HFPP partners and other relevant parties (e.g. payers, providers) within the Contractor’s jurisdiction to support the HFPP regarding activities noted above.

6.8.2. COMMAND CENTER

The Command Center serves as the Center of Excellence for collaborative capabilities in the prevention and detection of Medicare and Medicaid fraud, driving innovation and improvement. The Center provides an environment for multi-disciplinary teams, including clinicians, data analysts, fraud investigators, and policy experts, to develop consistent approaches for modeling development, investigation and swift action once potential fraud is identified. The Center brings together Medicare and Medicaid officials, as well as law enforcement partners from the HHS Office of the Inspector General, the Federal Bureau of Investigation, and CMS’s anti-fraud subject matter experts. CMS CPI coordinates “mission” events within the Command Center.

6.8.2.1. COMMAND CENTER ACTIVITIES

The Contractor shall participate in Command Center missions in support of the following activities. Specific workload will be designated in individual Task Orders.

a. Status Missions: The Contractor shall participate in Command Center Rotations (CCRs) to discuss new issues around fraud, waste, and abuse and enable the Contractors to take swift action as a result of collaboration.

b. Contractor Executive Mission: This mission will be conducted with Senior Executives from all UPICs (and other CMS contractors at CPI’s invitation) and will discuss pertinent information related to issues impacting the Medicare and Medicaid program with an emphasis on those issues with greatest impact to program integrity.

c. Model Development Missions: The Contractor shall participate in model development missions. The purpose of these missions will be to test models scheduled to be released in the FPS, provide feedback on existing models, and discuss ideas for new and innovative models for future releases.
d. Problem/Investigation-Specific Missions: As required, the Contractor shall participate in other missions as directed by CMS, such as focused Missions addressing specific PI problems and/or significant investigations.

6.8.3. PROGRAM INTEGRITY PROJECTS

The Contractor shall support CMS with projects that combat fraud, waste, and abuse within their jurisdiction. The workload associated with these projects shall be identified in subsequent Task Orders.

a. CMS may identify and refer problem providers to the Contractor requiring further investigation or analysis.

b. The Contractor shall provide Medical Review in support of CMS requests. This could include provider specific Medical Review or Medical Review to validate patterns identified in data.

c. The Contractor shall provide support to CMS in regards to the implementation, management, monitoring and reporting of administrative actions (e.g., prepayment edits for program integrity, payment suspension, PTAN revocation, and overpayment recoupment).

d. The Contractor shall respond to Requests for Information (RFIs) in the form of regular reports and/or ad hoc requests as defined in the IOM Pub.100-08. The Contractor shall handle CMS RFIs as they would handle a law enforcement request and respond to CMS within the required time parameters.

e. The Contractor shall support CMS through the execution of “Special Studies.” The special study or project requires approval of the COR prior to starting. The COR will define the specific fraud, waste, or abuse problem that is occurring and the Contractor shall provide a detailed project plan for each special study.

f. The Contractor shall work with CMS to ensure that all federal, state, and local healthcare partners within the respective jurisdiction are sharing fraud, waste, and abuse information and trends so that the fraud concerns of the respective jurisdiction are known to all.

g. In addition to actions identified by contractor analysis, CMS Regional and Field Offices may identify and refer problem providers to the Contractor for further development and may also develop
investigations on providers. The Contractor shall share information/reports on all providers under investigation in their jurisdiction with the Regional and Field Offices. The Contractor shall provide support to the CMS Regional and Field offices in regards to the implementation, management, monitoring and reporting of administrative actions (e.g., prepayment edits for program integrity, payment suspension, PTAN revocation, and overpayment recoupment).

6.9. SUPPORT TO STATES

The Contractor shall collaborate with State Medicaid Agencies as equal partners in efforts to build an effective program integrity strategy and combat fraud, waste, and abuse. The goals for collaboration include, but are not limited to;

a. Strengthened and coordinated Federal and State oversight of program integrity efforts;

b. Improved information sharing of program integrity activities across Medicare and Medicaid;

c. Assistance in the identification of vulnerabilities; and

d. Streamlined program integrity efforts and support efforts to move beyond pay and chase to prevention.

The Contractor shall support all of the functional tasks outlined in this SOW in support of Medicaid program integrity actions. Specific activities will be detailed in individual Task Order SOWs but may include;

a. Coordinating with CMS and States to identify vulnerabilities impacting the Medicaid program and manage Medicaid and Medicare-Medicaid leads;

b. Conducting data analysis and matching;

c. Investigating providers and suppliers. This includes providers/suppliers in fee-for-service, managed care, or any other reimbursement arrangement specific to a State Medicaid program;

d. Identifying overpayments and recommending appropriate administrative actions against providers/suppliers (e.g. revocations/terminations, payment suspensions, pre and postpayment edits);
e. Conducting Medical Review in support of Medicaid program integrity activities; and

f. Providing training to State Medicaid Agencies on Medicare policies and data analysis.

The CMS will be an active participant in the Contractor’s efforts to coordinate with State Medicaid Agencies. As outlined in this SOW, the Contractor shall develop a plan for coordinating with State Medicaid Agencies and CMS and the States will routinely assess the effectiveness of Medicaid program integrity efforts to ensure Contractor resources are appropriately utilized.

6.10. SUPPORT TO LAW ENFORCEMENT

6.10.1. REQUESTS FROM LAW ENFORCEMENT ENTITIES
The Contractor shall document all requests for information from Law Enforcement in the Unified Case Management System. The Contractor shall respond to requests from Law Enforcement in accordance with the requirements outlined in IOM Pub.100-08. The Contractor shall coordinate requests from a number of Law Enforcement entities, including but not limited to:


b. State Attorneys General and State Agencies.

c. Request from Medicaid Fraud Control Units (MFCUs).

d. Local AUSA and the Department of Justice (DOJ).

6.10.2. UPIC ROLE IN SUPPORT TO LAW ENFORCEMENT

a. The Contractor shall support Federal, State, and local law enforcement agencies in accordance with IOM 100-08.

b. The Contractor shall document all activities related to Law Enforcement support in the UCM.

6.10.3. CONSTRAINTS, ASSUMPTIONS, AND OTHER ISSUES

a. Regarding requests from law enforcement to send providers document requests or to go on site to obtain medical records, the Contractor shall consult with CPI first.
b. To be in full compliance with the Privacy Act, the Contractor must receive all requests for information in writing and must satisfy the requirements of the disclosure provision. However, subsequent requests for the same provider that are within the scope of the initial request do not have to be in writing. The Contractor shall refer requests that raise Privacy Act concerns and/or issues to the CMS COR team for further consideration.

c. If the query requested by law enforcement is outside of the scope or requires major resources on behalf of the Contractor, then the Contractor shall seek approval from the CMS COR before proceeding.

d. There may be situations where OIG/OI or other law enforcement agencies might recommend that overpayments are postponed or not collected so as not to disrupt an active case. The Contractor shall refer such requests, with any correspondence from law enforcement, to the CMS COR team. The CMS COR team will provide direction to the Contractor, after discussion with law enforcement.

6.10.4. REPORTING/MONITORING

a. Reporting:
   i. The Contractor shall report each data request received from law enforcement into the Unified Case Management System or in an alternative system as directed by CMS. The Contractor shall thoroughly document the details regarding the requestor, nature of the request, any intervention by the CMS COR team, any modifications to the request, and the cost of furnishing the request.
   ii. The Contractor shall complete a report for each Priority I and Priority II Request for Information and submit it into the Unified Case Management System, or an alternative system as directed by CMS.
   iii. The Contractor shall maintain Do Not Pursue (DNP) reporting information via the Unified Case Management System, or an alternate system as directed by CMS, ensuring that the DNP data remains current and accurate.
   iv. On a quarterly basis, the Contractor shall submit a report that identifies trends and patterns regarding requests for
information from law enforcement, with suggestions for improved efficiency and innovation.

v. The Contractor shall submit costs by labor category, labor hours, labor rates, travel, and subcontracts pertaining to any assistance or support provided to law enforcement (e.g., the HHS-OIG, MFCU) for requests that did not begin with a Contractor referral to law enforcement.

vi. Additional reporting requirements may be defined in subsequent Task Orders.

b. Monitoring:

i. The Contractor shall cooperate and coordinate with stakeholders, including law enforcement.

ii. CMS expects that the Contractor will keep CMS apprised of its interactions with law enforcement, and will seek CMS approval for new, different, or innovative policies, strategies or procedures for interactions with law enforcement.

iii. CMS expects that the Contractor shall follow-up with the requestor of information to find out if the assistance provided satisfies the request, and to determine if there is further action (e.g. appropriate administrative action) that CMS can take to minimize future Program expenditures or otherwise protect Program funds.

iv. Additional monitoring requirements may be defined in subsequent Task Orders.

6.11. **EDUCATION REQUIREMENTS**

The Contractor shall focus its education efforts on three objectives; 1) The Contractor shall educate Medicare Part A and B providers, managed care entities, beneficiaries and Medicaid providers about Medicare and Medicaid program integrity and quality of care issues. 2) The Contractor shall educate the stakeholders\(^2\) about the contractor’s role in Medicare and Medicaid fraud waste and abuse prevention and detection, 3) The Contractor shall educate the states about the contractor’s role and methods for collaborating on program integrity efforts, and 4) The

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\(^2\) As defined in section 4.8.2. *Stakeholder Coordination and Communication Requirements*
Contactor shall provide education to entities subject to review by the contractor

6.11.1. **EDUCATING THE PROVIDERS**

The Contractor shall coordinate with MAC provider outreach and education (POE) staff to determine what, if any, education has been provided before any investigation is pursued.

If an investigation does not warrant referral for sanctions the Contractor shall refer the matter to the POE for education and identify specific subject matter about which the provider needs to be educated. If an investigation concludes in an overpayment determination as a result of an error in billing and not fraudulent intent, then the Contractor shall provide written education to the provider with a request from the MAC to also send out an overpayment letter.

The MAC is responsible for informing the provider of the questionable or improper practices, the correct procedure to be followed, and the fact that continuation of the improper practice may result in administrative sanctions, referral to law enforcement or other necessary actions.

6.11.2. **EDUCATING THE STAKEHOLDERS**

During the implementation period of the contract, and throughout if necessary, the Contractor shall educate the stakeholders about the contractor’s role in Medicare and Medicaid fraud, waste, and abuse prevention and detection.

6.11.3. **EDUCATING THE STATES**

In order to facilitate understanding across the Medicare and Medicaid programs, the Contractor shall share educational materials with the State and maintain key documents that explain the agency’s programs. The Contractor shall also collaborate with States to define roles and responsibilities for conducting fraud, waste, and abuse activities. The Contractor may prepare educational materials to help the State reduce practices that lead to fraud, waste, and abuse.
6.11.4. DOCUMENTATION OF PROVIDER EDUCATION REGARDING IMPROPER ACTIONS

The Contractor shall document contacts with written reports and correspondence and place them in the investigation file. If the improper practices continue, the Contractor shall consult with CMS before referring to appropriate entities.

7. EXPECTED OUTCOMES

The Contractor shall conduct the activities outlined in Section 6 above and recommend administrative program actions against Medicare and Medicaid providers that engage in fraud, waste, or abuse to CMS or States. Administrative actions that protect program dollars either by stopping future payment or recovering monies are the highest priority for CMS, and the Contractors’ highest priority shall be activities leading to their recommendation. Administrative actions are the first step to stopping inappropriate payments to providers or removing abusive or fraudulent providers from the Medicare and Medicaid programs.

The Contractor shall prepare high-quality recommendations for appropriate and timely administrative actions to CMS, the State Medicaid Agency, or Law Enforcement. The Contractor shall refer administrative actions in accordance with IOM Pub.100-08 and shall track all referrals using the Unified Case Management System (more information on the UCM can be found in Section 8.6 of the SOW).

7.1. RECOMMENDING ADMINISTRATIVE ACTIONS

The range of administrative actions to be supported, developed and recommended by the Contractor to the appropriate Federal or State authority include but are not limited to the following:

a. Medicare payment suspensions (42 CFR §405.370-405.375)
b. Medicaid payment suspensions (42 CFR §455.2 and 455.23)
c. Medicare enrollment revocations
d. Medicaid enrollment revocations
e. Medicare and Medicaid program exclusions
f. Civil Monetary Penalties
The Contractor shall support CMS in identifying innovative approaches to implementing administrative actions based on the authorities available to CMS and the States. Additionally, the Contractor shall be prepared to support additional administrative actions as the Congress provides increased program integrity legal authorities to CMS.

7.2. **PREPAYMENT REVIEW**

The Contractor shall use prepayment reviews as outlined in Sections 6.6 and 6.7 above. The Contractor shall coordinate prepayment review actions with CMS, State Medicaid Agencies, and other contractors as appropriate and shall offer to provide the criteria of its pre-payment edits, develop the pre-payment edits, review the effectiveness of the edits, and provide related assistance to the State Medicaid Agency.

7.3. **IDENTIFY MEDICARE AND MEDICAID OVERPAYMENTS**

During the course of its analysis of Medicare and Medicaid payments, the Contractor shall identify improper payments that do not necessarily involve fraudulent intent. The Contractor shall identify, determine, and refer the overpayments made to providers (individuals or entities) receiving Federal funds under Medicare and Medicaid.

a. The Contractor shall follow the guidelines of all applicable Federal debt collection statutes, CMS regulations and manuals with regard to ensuring that it adequately documents all identified overpayments.

b. The Contractor shall refer Medicare overpayments to the MAC that made the initial claims payment for collection, as required by CMS. The Contractor shall supply the required documentation supporting each overpayment to the MAC.

c. The Contractor shall coordinate with CMS and State Medicaid Agencies to develop an agreed upon format for referring potential Medicaid overpayments. The Contractor shall document the protocol applicable to each State. The Contractor shall identify potential Medicaid overpayments as well as opportunities to minimize future inappropriate program expenditures.

d. The Contractor shall coordinate with the MAC (in the case of Medicare overpayments) and the State Medicaid Agency (in the case of Medicaid overpayments) to track the collection progress of all potential overpayments referred by the Contractor. The Contractor shall document collections using the UCM.
7.4. **Referrals to Law Enforcement**
   a. The Contractor shall refer potential fraud to law enforcement and provide support, as required and requested by law enforcement, in accordance with IOM Pub.100-08.
   b. In referring a Medicaid or a joint Medicare-Medicaid fraud allegation, the Contractor shall first make the referral to HHS-OIG unless otherwise directed by task order or TDL, and shall notify the appropriate State Medicaid Agency office.

7.5. **Coordination**
   a. When the Contractor recommends an administrative action to CMS (or the MAC) for a provider that is also enrolled in Medicaid, the Contractor shall notify the State Medicaid agency. When the Contractor recommends an administrative action to the State Medicaid agency for a provider that is also enrolled in Medicare, the Contractor shall notify CMS CPI (and/or the MAC in keeping with IOM Pub.100-08 instructions).
   b. The Contractor shall coordinate with the State Medicaid Agency to identify the appropriate administrative actions available and determine how to apply the rules so the actions are applied effectively as a result of data analysis or investigative work.

7.6. **Tracking and Reporting**
   The Contractor shall document and track all Medicare and Medicaid administrative actions, including the disposition of each, in the Unified Case Management System or other alternative system as directed by CMS. The Contractor shall continue appropriate coordination with CMS, the State Medicaid Agency, and Federal and State law enforcement while administrative actions are proceeding.

7.7. **Performance Measures**
   Individual Task Orders shall provide the performance measures applicable to these program integrity outcomes. CMS will provide specific performance measures in individual Task Order SOWs.

8. **Administrative Requirements**
   This section describes the administrative requirements expected to be performed by the Contractor.
8.1. **MEETINGS, WORKGROUP, AND CONFERENCES**

The Contractor shall participate in meetings, workgroups, and conferences as necessary and approved by CMS to carry out the requirements of the SOW. The Contractor shall ensure that appropriate Contractor personnel attend these activities. The specific meetings, workgroups, and conferences, including their frequency, will be identified in subsequent Task Orders. The Contractor shall be prepared to participate or lead these activities as directed by CMS. Examples may include:

8.1.1. **KICKOFF MEETING**

The Contractor shall schedule and administer a contract kickoff meeting within a time specified by CMS. The purpose and agenda for this meeting will be identified in individual Task Orders.

8.1.2. **COMMAND CENTER MISSIONS**

As stated in Section 2.6.8.1, the Contractor shall participate in a variety of Command Center missions.

8.1.3. **JURISDICTIONAL FRAUD, WASTE, AND ABUSE WORKGROUP**

The Contractor shall coordinate with CMS to attend or establish regional fraud, waste, and abuse meetings.

8.2. **JOINT OPERATING AGREEMENTS (JOAs)**

The Contractor shall execute, update, and perform associated duties in accordance with a JOA that defines roles and responsibilities and creating mutually agreed upon and cost-effective methods to work with and support the Centers for Medicare & Medicaid Services’ (CMS’) mission. At a minimum, the Contractor shall initiate JOAs with the following stakeholders:

a. MACs;

b. State Medicaid Agencies;

c. PDAC;

d. NSC;

e. Recovery Auditors

f. QICs; and

g. MEDIC.
The JOA is meant to serve only as an outline of the principles, approaches, and processes that will be used to create, implement, and maintain effective working relationships, communications, and information flows between the Contractor and the entities involved. It does not create affirmative duties, rights, or legal obligations between the parties nor does it create any rights in any third party. All time frames set forth herein are mutually agreed to unless otherwise provided by law of the parties’ respective contracts with CMS.

8.3. **KEY PERSONNEL REQUIREMENTS**

The Contractor shall maintain a staff of key personnel positions, which are dedicated as FTEs, unless otherwise specified. The Contractor shall adhere to the requirements set forth in Section G of the contract regarding key personnel.

The key personnel shall work in the office located in the jurisdiction where the majority of the work is being performed. If the position does not require day-to-day interaction with staff the Contractor may request an exception to this requirement. Key personnel shall not serve dual responsibilities in key functions (e.g. the Program Director may not also serve as the Program Integrity Manager). The CMS reserves the right to add key personnel positions within individual task orders.

Unless otherwise approved by the Contracting Officer, the key personnel noted below shall possess the following minimum work experience\(^3\) and educational requirements (other key personnel may be identified in a Task Order along with the respective work experience and educational requirements):

8.3.1. **JURISDICTION PROGRAM DIRECTOR**

The Jurisdiction Program Director shall be responsible for the oversight of the contract requirements as well as the overall operations in the jurisdiction. In addition, the Jurisdiction Program Director shall oversee the coordination of activities to ensure the following:

a. Staffing is appropriate;
b. Effective lines of communication with internal staff and external stakeholders;
c. Contract requirements are met including quality, cost control, timeliness and business relations;

\(^3\) Work experience shall be within the last five years.
d. Ensure an adequate quality assurance program and process are in place and strictly adhered to for all tasks;
e. Monthly cost reports are submitted timely and accurately, including a plan to correct any cost variances or projected rate adjustments;
f. Timely and quality submission of deliverables and ad hoc requests; and
g. Maintain superior business relations with CMS, Law Enforcement, MACs and all other stakeholders and partners are consistently maintained at the highest level.

Work Experience: Fifteen or more years of professional experience, with at least eight years in healthcare, Medicare, Medicaid, or a related private insurance field and a minimum of seven years in a progressive management capacity with responsibility for managing complex systems and workflows.

Educational Requirements: A master’s degree from an accredited institution or a bachelor’s degree from an accredited institution plus an additional five years of related professional experience.

8.3.2. MEDICARE OPERATIONS LEAD

Work Experience: Eight or more years of professional experience with a minimum of three years of experience in the Medicare program and a minimum of five years in a progressive management capacity responsible for complex systems and workflows. Individual must demonstrate experience and knowledge in providing guidance to data analysts, investigators and medical staff.

Educational Requirements: A master’s degree from an accredited institution or a bachelor’s degree from an accredited institution plus an additional five years of related work professional experience.

8.3.3. MEDICAID OPERATIONS LEAD

Work Experience: Eight or more years of professional experience with a minimum of three years in Medicaid and a minimum of 3 years in a progressive management capacity responsible for complex systems and workflows. Individual must demonstrate experience and knowledge in providing guidance to data analysts, investigators and medical staff.

Educational Requirements: A master’s degree from an accredited institution or a bachelor’s degree from an accredited institution plus an additional five years of related work professional experience.
8.3.4. **MEDICAL DIRECTOR**

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

Extensive knowledge of the Medicare and Medicaid programs, particularly the coverage and payment rules, as well as experience related to the specific workload of the individual task order, which may be further defined in the Task Order Statement of Work.

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

Educational Requirements: Experience practicing medicine for at least five years as a licensed and board-certified doctor of medicine or Osteopathy.

See IOM Pub.100-08 for further Medical Director Requirements.

8.3.5. **PROGRAM INTEGRITY MANAGER**

Work Experience: Eight years of professional experience with a minimum of three years supervisory experience in the general area of program integrity investigations. Medicare and Medicaid knowledge and experience is required.

Educational Requirements: A master’s degree from an accredited institution with or a bachelor’s degree from an accredited institution plus an additional five years of related work professional experience. Education requirements may be substituted if the applicant has fifteen or more years of related program integrity experience.

8.3.6. **MEDICAL REVIEW MANAGER**

Work Experience: Six years of professional experience with an active Registered Nurse license with a minimum of three years supervisory experience in the general area of medical/ utilization review. Individual must demonstrate experience and knowledge with healthcare coding.

Educational Requirements: An active Registered Nurse license is required with a bachelor’s degree in nursing or social or health service.
8.3.7. DATA MANAGER

Work Experience: A minimum of ten years of experience in program integrity data analysis as well as demonstrated knowledge of healthcare claims. At least three years of supervisory experience in data management and analysis. The candidate shall possess knowledge of various database management systems in order to input, extract or manipulate information.

Demonstrated experience and knowledge of healthcare information (e.g., health claims data specifically Medicare and Medicaid and health care coding) is required.

Education Requirements: A Bachelor’s degree in Information Systems, Computer Science, Statistics, Mathematics, Information Technology, Computer Engineering, or a related field.

8.3.8. COMMUNICATION AND COORDINATION MANAGER

Work Experience: Eight or more years of professional experience with a minimum of three years in healthcare, Medicare, Medicaid or a related private insurance field with a minimum of three years in a progressive management capacity responsible for complex systems and workflows. Individual must demonstrate experience and knowledge in communication and coordination with various government and private entities.

Educational Requirements: A master’s degree from an accredited institution or a bachelor’s degree from an accredited institution in a related field plus an additional five years of related work professional experience.

8.3.9. CHIEF LEGAL COUNSEL

Work Experience: A minimum 3 years of experience applying Medicare and Medicaid regulations.

Educational Requirements: Must be a licensed attorney.

8.3.10. CHIEF STATISTICIAN

Work Experience: A minimum ten years of experience using statistics with demonstrated experience and knowledge of health care information, for example health claims data, ICD-9/10-CM codes, physician specialty codes, survey and certification data, and provider identifiers. Additional requirements may be further defined in the Task Order Statement of Work. Individual must demonstrate
experience in statistical detection of potential fraud and abuse, using tools such as predictive modeling, development of mathematical models, neural networks, and data mining or other analytical methods.

Educational Requirements: A minimum of a master’s degree in statistics or related discipline.

8.3.11. **ADMINISTRATIVE ACTION COORDINATOR**

This individual is responsible for all administrative action coordination with CMS (e.g. suspensions, revocations). The objective is to coordinate the referral of actions to CMS and serve as the single point of contact for following up on questions and comments from CMS.

Educational Requirements: A bachelor’s degree from an accredited institution.

8.4. **STAKEHOLDER COORDINATION AND COMMUNICATION REQUIREMENTS**

The Contractor shall coordinate with a number of stakeholders in order to carry out the program integrity functions described in this SOW as well as future Task Order SOWs. The Contractor shall expect to develop Joint Operating Agreements (JOAs) with entities that require routine communication and collaboration. Additional stakeholders may be defined in subsequent Task Orders.

8.4.1. **APPROPRIATE CMS STAFF**

The Contractor shall work with the appropriate CORs, and other designated CMS staff to coordinate work that the Contractor needs to perform to fulfill the tasks under this SOW.

The CMS expects the Contractor to interact with Subject Matter Experts (SMEs) or Business Function Leads (BFLs) both within CPI and across the Agency. For example, a SME or BFL for provider enrollment may be identified in a Task Order to coordinate enrollment activities, including but not limited to, revocations. The Contractor shall also work with CMS Field and Regional Offices to coordinate fraud, waste, and abuse activities. The Contractor shall adhere to the terms and conditions of the contract regarding the role of the COR in providing technical direction.
8.4.2. **Medicaid State Agency and Medicaid Fiscal Agents**

Medicaid State Agencies identify aberrant practices and abnormal patterns that may constitute potential fraud, waste and abuse in the State Medicaid program. Unlike Medicaid Fraud Control Units, these agencies investigate but do not prosecute potential fraud. Medicaid Fiscal Agents are responsible for processing Medicaid claims for the state. The Contractor shall meet with the appropriate entity in each state performing the Medicaid program integrity function to coordinate state and local potential fraud, waste, and abuse investigations. The Contractor shall maintain an ongoing dialogue with these entities and shall coordinate appropriate anti-fraud, waste and abuse initiatives. The Contractor shall document an organizational chart of each State in their jurisdiction and maintain the document to improve collaboration.

8.4.3. **Medicare Administrative Contractors**

It is imperative that the MAC and UPIC work together to achieve the common goal of ensuring the integrity of the Medicare program.

The Contractor shall work with MACs outside of its jurisdiction to share ideas and coordinate program integrity efforts as necessary (e.g., attend national and Contractor Medical Director (CMD) conferences and participate in national conference calls).

8.4.4. **Medicaid Fraud Control Units (MFCUs)**

Located in the office of the State Attorney General, Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid fraud cases. The Contractor shall meet with MFCUs in order to coordinate state fraud investigations. The Contractor shall maintain an ongoing dialogue with MFCUs and shall coordinate appropriate anti-fraud, waste and abuse initiatives.

8.4.5. **One Program Integrity (OnePI) and the Integrated Data Repository (IDR)**

The Contractor shall coordinate with the OnePI and IDR contractors as necessary to carryout program integrity activities using the systems maintained by these contractors. Training is available for these tools and the Contractor is encouraged to attend training sessions. Additional information on OnePI and the IDR can be found in Section 8.5: Information Technology.
8.4.6. OTHER UNIFIED PROGRAM INTEGRITY CONTRACTORS

The Contractor shall coordinate with other UPICs, when applicable, to ensure that efforts are coordinated to stop Medicare and Medicaid fraud, waste, and abuse. The Contractor shall utilize all available tools (e.g., the Fraud Prevention System (FPS), the Unified Case Management System (UCM)) to ensure coordination and the prevention of duplication of efforts. As a part of its coordination activities, the Contractor shall participate in information sharing sessions, such as the Program Integrity Data Users Group (PIDUG). In addition, the Contractor shall work with other UPICs as needed when issues cross jurisdictional boundaries (e.g., when an investigation is national in scope). As a part of its coordination activities, the Contractor shall participate in information sharing sessions, meetings, or conference calls as appropriate. The Contractor shall share lessons learned and best practices for greater success and enhanced coordination of the program.

8.4.7. WORKING WITH OTHER MEDICARE ORGANIZATIONS

The Contractor shall work with other organizations that assist Medicare beneficiaries including, but not limited to, the Senior Medicare Patrols (SMPs), which use volunteers to help identify and report Medicare potential fraud, waste and abuse and the State Health Insurance Assistance Programs (SHIPs), which provide counseling and assistance to Medicare beneficiaries.

8.4.8. OFFICE OF INSPECTOR GENERAL

All referrals by the Contractor for potential Medicare and Medicaid fraud will be made to the Office of Inspector General, Office of Investigations (OIG OI) first. The Contractor shall provide the OIG with access, as needed, to its files, records, and data in accordance with the Memorandum of Understanding (MOU), and other relevant program guidance, among the Department of Justice (DOJ), the OIG, and CMS (see Appendix X, MOU with Law Enforcement). The Contractor shall meet regularly with OIG agents in its jurisdiction to discuss pending or potential investigations and referrals.

8.4.9. DEPARTMENT OF JUSTICE

The Contractor shall provide the DOJ with access as needed to its files, records, and data in accordance with the MOU and other relevant program guidance (see Appendix X, MOU with Law Enforcement). The Contractor shall meet with the DOJ when needed to enhance coordination between
the Contractor and the DOJ. The Contractor shall support the DOJ (AUSA) in its prosecution of Medicare and Medicaid fraud and abuse cases.

8.4.10. **FEDERAL BUREAU OF INVESTIGATION**

The Contractor shall provide the Federal Bureau of Investigation (FBI) with access as needed to its files, records, and data in accordance with the MOU and other relevant program guidance (See Appendix X, MOU with Law Enforcement). The Contractor shall meet with FBI personnel regularly to enhance coordination between the Contractor and the FBI.

8.4.11. **STATE AGENCIES FOR SURVEY AND CERTIFICATION**

The Contractor shall coordinate information (e.g., quality of care, potential fraud, waste and abuse) with the state agencies that perform under the §1864 agreements that are referred to collectively as the certification process.

8.4.12. **LAW ENFORCEMENT HEALTH CARE TASK FORCES**

The Contractor shall coordinate information about potential fraud, waste and abuse issues with national, state, and local Law Enforcement Health Care Task Forces within its jurisdiction.

The Contractor shall exchange information about potential fraud, waste and abuse issues/matters with national, state and local Law Enforcement Health Care Task Forces within its jurisdiction and participate in such Task Force meetings on a regular and consistent basis.

8.4.13. **STATE LICENSURE AGENCIES**

The Contractor shall share information with the state survey and certification agency or any other administrative agency with the ability to sanction providers who either bill inappropriately, fraudulently or mistreat patients.

8.4.14. **STATE LICENSURE OF AGENTS AND BROKERS**

The Contractor shall share information with the state licensure agencies or any other administrative agencies with the ability to sanction agents and brokers who inappropriately or fraudulently enroll Medicare or Medicaid beneficiaries.
8.4.15. STATE AND LOCAL LICENSURE AND ENFORCEMENT AGENCIES

The Contractor shall share information with the state survey and certification agency, or any other administrative agency and/or local agency with the responsibility for sanctioning providers who either bill inappropriately or fraudulently misrepresent themselves or mistreat patients.

8.4.16. PROFESSIONAL SOCIETIES

The Contractor shall meet as necessary with members of professional societies in order to gain input from the society, particularly with respect to contractor activities.

8.4.17. QUALITY IMPROVEMENT ORGANIZATIONS

The Contractor shall refer quality of care issues to Quality Improvement Organizations (QIOs) in accordance with IOM-100-08 when these issues are discovered as part of the Contractors’ potential fraud, waste and abuse activities.

8.4.18. MANAGED CARE ORGANIZATIONS

The Contractor shall maintain an ongoing dialogue with the appropriate personnel or units in managed care organizations, including Medicare Advantage (MA) and 1876 Cost plans and Medicaid Managed Care plans within its region and shall coordinate appropriate fraud, waste and abuse initiatives with them. The Contractor shall coordinate with the NBI MEDIC to develop contacts. The Contractor shall coordinate with the State Medicaid Agency to develop contacts at the Medicaid Managed Care Organizations.

8.4.19. PRIVATE HEALTH PLANS

To the extent permitted by statute, CMS, and other government regulations, the Contractor shall share information and maintain an ongoing dialogue with private health insurers and shall coordinate appropriate fraud, waste and abuse initiatives. The Contractor shall consult CMS before sharing information with private health insurers, and CMS will advise the Contractor on the nature and extent of information sharing and coordination it may have with private health plans.
The Contractor shall participate in the Healthcare Fraud Prevention Partnership (HFPP) and the Trusted Third Party (TTP).

8.4.20. OTHER CONTRACTORS

In the future, as CMS develops new programs with additional contractors, the Contractors will be charged with working with them in an appropriate manner defined by CMS.

8.4.21. OTHER FEDERAL AND STATE AGENCIES

The Contractor shall work with other federal and state agencies not listed above (e.g., Drug Enforcement Agency, Food and Drug Administration, Federal Trade Commission, and Office of Personnel Management) as appropriate. Under these circumstances, the Contractor shall work with CMS to determine the best method of working and collaborating with other such agencies.

8.4.22. DATA ANALYSIS COORDINATION

The Contractor shall be prepared to coordinate with other entities, as applicable, to address nationwide data strategies that will integrate and analyze all applicable Medicare Part A, B, C, Medicaid and DMEPOS data, RDS data and Medicare Part D data (PDE data) to identify national trends. The Contractor shall perform data analysis within their jurisdiction, and refer leads to CMS, CMS contractors (e.g., other UPICs, MEDIC, MAC), and States. The Contractor shall use detailed CERT and PERM information to help identify potential fraud and abuse leads.

8.4.23. COORDINATION WITH OTHER CONTRACTORS

The Contractor shall coordinate with the contractors listed below in their jurisdictions. When necessary, the Contractor shall meet with these contractors and/or CMS to discuss issues.

a. National Supplier Clearinghouse (NSC)

b. Pricing, Data Analysis and Coding (PDAC)

c. Qualified Independent Contractors (QICs)

d. National Benefit Integrity Medicare Drug Integrity Contractor (NBIMEDIC)

e. Recovery Auditors
8.5. **INFORMATION TECHNOLOGY AND SECURITY**

**8.5.1. CMS PROVIDED DATASETS AND SYSTEMS**

The Contractor shall interact with and utilize a robust CMS dataset and CMS-provided IT toolset to perform its work rather than developing its own proprietary systems and datasets. In general the Contractor shall be prepared to use any standard interfaces available in CMS systems to avoid duplication of information and data entry and to ensure the ease of accessibility of all information during contract performance. A list of CMS data sources can be found in Appendix A, however, the primary systems and datasets shall be:

**8.5.1.1. INTEGRATED DATA REPOSITORY (IDR)**


The Contractor shall access and use the Integrated Data Repository (IDR), CMS’s data warehouse for claims and related reference information to perform tasks associated with fraud, waste, and abuse prevention and detection. The IDR is located at the CMS Baltimore Data Center. It provides a single national view of timely and integrated Medicare claims, provider, beneficiary, and related data as well as the capability to import, store and manipulate Medicaid claims, provider, beneficiary and related data. As T-MSIS data become available, CMS will provide access to it.

**8.5.1.2. ONE PROGRAM INTEGRITY (ONE PI)**

The Contractor shall use the One Program Integrity (One PI) portal and centralized suite of robust business intelligence and modeling tools for fighting fraud, waste, and abuse. The One PI/IDR system will replace the numerous and standalone data warehouses that are currently in place for this purpose. The system will allow for cross program analysis with harmonized data simplifying comparisons of data from multiple data sources.

One PI includes the following tools to access data in the IDR:
a. Business Objects, a business intelligence tool available for analyzing data in the IDR.
b. Services Tracking Analysis and Reporting System (STARS)
c. SAS Enterprise Miner

8.5.1.3. **FRAUD PREVENTION SYSTEM**

The Small Business Jobs Act of 2010 mandates that CMS implement predictive modeling and other advanced analytic technologies to prevent potential fraud, waste, and abuse. CPI implemented this requirement through the launch of the Fraud Prevention System (FPS) on June 30, 2011.

The FPS applies effective predictive models and other advanced algorithms to identify providers exhibiting a pattern of behavior that is indicative of potential fraud, waste, and abuse. The system screens all national Medicare Part A, Part B, and DME claims prepayment and consolidates alerts by provider. It is CMS' intention to expand the FPS to include Medicaid data-related models over time as feasible.

The FPS is one of several tools the contractor shall use to identify and prioritize vulnerabilities for administrative action or other appropriate prevention and detection actions.

8.5.1.4. **MEDICARE FEE-FOR-SERVICE (FFS) CLAIMS PROCESSING SHARED SYSTEMS**

The Contractor shall perform some functions using the Medicare Parts A, B and DME Shared Claims Processing Systems. The Contractor shall use the Shared Claims Processing Systems (data centers and software) to perform the following tasks:

a. Develop the program integrity prepayment edit criteria, as system access allows.

b. Manage the workflow of prepayment claims requiring manual review.

c. Access the online claims history file, the claims-in-process file, and the provider file.
d. Access claims attachments that were imaged by the MAC (if this feature is present on the Shared Claims Processing System).

e. Document claim review decisions in the shared system.

f. Use data form the shared systems base job reports that CPI has determined are necessary for the correct reporting of UPIC activities to CMS.

g. Access other online applications in the MAC Shared Claims Processing System as necessary.

The Contractor shall work with its MACs to gain access to the FFS claims processing systems and ensure that, in accessing the systems, the Contractor does not corrupt or degrade processing time through its actions, or cause system rejects or other downtime.

The Contractor shall coordinate any proposed changes to the Medicare FFS systems with its COR and MACs prior to submitting the proposed change to the appropriate change control board. The Contractor shall submit change requests as appropriate in accordance with CMS Change Management processes.

The Contractor shall participate in user groups, Systems Advisory Boards (SAB), or other committees, upon request by CMS, for any CMS legacy systems, DME MAC and A/B MAC shared claims processing systems, or any other system that the Contractor will use to undertake the activities described in other sections of the SOW.

8.5.1.5. **Medicaid Data**

Currently, the Medicaid and CHIP data submitted to CMS is MSIS data. CMS has recognized the need for more timely, comprehensive and accurate Medicaid and CHIP data and over the past two years has been working with pilot states and other stakeholders to refine and enhance the MSIS dataset and to modernize the ongoing submission and quality review process for the dataset. The result is T-MSIS, which encompasses the set of data produced in the daily operation of the Medicaid and CHIP programs. Initially, the
enhanced data available from T-MSIS will support improved program and financial management and more robust evaluations of demonstration programs. It will also enhance the ability to identify potential fraud and improve program efficiency. Ultimately, the transformed infrastructure will support the ability to do the following at the state and national levels:

a. Study encounters, claims, and enrollment data by claim and beneficiary attributes;

b. Analyze expenditures by medical assistance and administration categories;

c. Monitor expenditures within delivery systems and assess the impact of different types of delivery system models on beneficiary outcomes;

d. Examine the enrollment, service provision, and expenditure experience of providers who participate in our programs (as well as in Medicare); and

e. Observe trends or patterns indicating potential fraud, waste, and abuse in the programs so we can prevent or mitigate the impact of these activities.

CMS anticipates State transition away from submission of MSIS data to submission of TMSIS data to begin during calendar year 2014 and occur in phases. CMS will coordinate with States and UPICs to determine timing of availability of TMSIS data for UPIC activities. In the interim, the Contractor shall work with States to obtain MMIS data.

The Contractor shall work with Medicaid fee-for-service and encounter data to conduct data analysis and investigations of providers. The Contractor shall work collaboratively with the State Medicaid Agency to ensure that all data sources are made available to support Medicaid program integrity activities.
8.5.1.6. **UNIFIED CASE MANAGEMENT SYSTEM (UCM)**

The Contractor shall use the UCM for lead and investigation management as well as for reporting all workload information except when alternative reporting systems are specified by Task Order or as jointly established by the Contractor CMS. The UCM will serve as the central repository for all contractor workload reporting. See Section 8.6 for specific requirements.

8.5.1.7. **ELECTRONIC SUBMISSION OF MEDICAL DOCUMENTATION SYSTEM (eSMD)**

CMS encourages the Contractor to be as efficient as possible in receiving responses to additional documentation requests (ADRs) from providers. One way a Contractor can be efficient is to allow providers to submit ADR responses via CMS’ Electronic Submission of Medical Documentation (esMD) system. Background information about the esMD system can be found at [www.cms.gov/esMD](http://www.cms.gov/esMD). Also, more information can be found in the IOM Pub.100-08.

The Contractor shall be esMD capable and perform the following:

a. Develop a system interface to accept ADR responses in PDF format through the inbound esMD system.

b. Ensure that all system interfaces developed by the Contractor conform to all design requirements and standards published by the esMD program.

c. Support the esMD system through 4 or more major releases per year.

8.5.1.8. **SECURE E-MAIL SYSTEM**

To ensure Contractors are compliant with the Health Insurance Portability and Accountability Act (HIPAA), Privacy Act requirements, and internal CMS policies, CMS has developed a secure e-mail system. All UPICs shall have access to the secure e-mail system. Other acceptable methods of sending sensitive material are using a secure fax
or the U.S. Postal Service. All personally identifiable data and sensitive data exchanged through other means must be encrypted with a CMS approved encryption method. The Contractor shall contact the CPI Systems Security Officer for information on encryption.

The Contractor shall gain access to the secure e-mail system through the COR and by downloading and completing the Application for Access to CMS Computer Systems, which is found at [www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf](http://www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf).

### 8.5.1.9. Other Contractor Proposed Resources

Where the Contractor proposes to use resources in addition to the CMS resources listed above, the Contractor shall seek CMS approval of its proposal, including describing how the use of such resources aligns with CMS’s regional and/or national-level priorities. Any use of such independent resources will be subject to the same transparency, accountability and reporting requirements as the use of CMS-provided resources, in order to enable full CMS and outside oversight of Contractor activities. Approval of contractor proposed resources shall not impact the ability to carry out the work outlined in this SOW or in subsequent Task Orders.

### 8.5.1.10. Other CMS Provided Systems

The Contractor shall work with and update other CMS systems to conduct program integrity activities. These systems include, but are not limited to;

a. Fraud Investigation Database (FID)

b. Compromised Numbers Checklist (CNC)

c. Recovery Audit Contact (RAC) Data Warehouse

d. Medicare Exclusion Database (MED)

e. Provider Enrollment Chain Ownership System (PECOS)

f. National Plan Provider Enumeration System (NPPES)
8.5.2. **Contractor-Provided Functions**

The Contractor shall provide and use hardware/software to:

a. Receive, store and manipulate data and records prior to submission to the UCM or other CMS systems;

b. Communicate efficiently (e.g., e-mail) within its own departments, other specialty Contractors, CMS, and MACs; and

c. Enable Print/Mail Capability.

8.5.3. **Access to CMS Systems**

8.5.3.1. **Data Use Agreement**

The Contractor shall enter into a Data Use Agreement (DUA) with CMS. The agreement shall delineate confidentiality requirements of the Privacy Act, implement CMS security safeguards, and explain CMS' data use policies and procedures. The DUA serves as both a means of informing the Contractor of these requirements and a means of obtaining their agreement to abide by them. The timeline for submitting the DUA shall be defined in Task Orders but is expected to be no later than 30 days prior to the fully operational phase of implementation.

To create a DUA, the Contractor shall complete the CMS DUA form and submit it the COR for review. The COR will coordinate with the CMS Privacy Officer for authorization and assigning of a DUA number. If additional data not identified in the DUA is required, the Contractor shall complete a DUA supplement to obtain access to that information.

8.5.3.2. **Other Systems Access Requirements**

The Contractor shall adhere to the CMS systems access requirements as appropriate for the systems to which they request access and are approved. The Contractor shall coordinate these efforts with their COR and appropriate CMS Office of Information Services (OIS) contacts as directed by the COR.
8.5.4. **Hardware and Software Testing**

The Contractor, in conjunction with the appropriate MACs, shall develop and implement a plan to thoroughly and completely test all relevant contractor interfaces with the existing shared claims processing system.

The Contractor shall also participate as necessary in the testing of any changes to the shared claims processing system(s) that may affect contractor interfaces.

The Contractor shall participate in the testing of CMS or claims processing software as needed. CMS or MACs shall provide data necessary for this testing.

8.5.4.1. **Test Plan Guidelines**

The Contractor shall follow the testing and validation guidelines outlined by the OIS XLC.

8.5.5. **Telecommunications**

Medicare and ancillary telecommunications services with CMS are provided by CMS VPN and other providers.

8.5.5.1. **General Requirements**

The Contractor shall obtain telecommunications services from CMS through CMS VPN for linkage to:

a. Each MAC data center or shared processing data center or the enterprise data center (EDC) and shared claims processing system

b. The CMS Data Center (CMSDC)

c. Other specialty Contractors such as the print mail Contractor, customer service Contractor, and others (when applicable)

d. Other applicable secured CMS data repositories/portals

The Contractor shall install all necessary telecommunication hardware and software and have the ability to transmit and receive data via standard telecommunications protocols in the most efficient and cost effective manner possible.
The Contractor shall use CMS VPN telecommunications services for:

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

b. Internal Contractor communications across multiple sites (such as field offices or telecommuter personnel stations) supporting the UPIC’s Medicare contract

c. Communication between the Contractor and the MAC(s)

d. Communications between the Contractor and other Medicare Contractors

e. Communications between the Contractor and CMS

The Contractor shall not utilize CMS-provided and CMS VPN telecommunication for health care providers to submit information and/or inquiries to development requests, or for any other communication with the providers.

8.5.6. Security

The Contractor shall ensure that the highest level of security is maintained for all systems and data accessed and that its physical and operational processes are in accordance with the Business Partners System Security Manual (BPSSM) (IOM Pub. 100-17), the Program Integrity Manual (IOM Pub.100-08), the Core Security Requirements and its operational appendices, found at [http://cms.hhs.gov/InformationSecurity](http://cms.hhs.gov/InformationSecurity).

This is Version 8 of the BPSSM. For a copy of version 10, please contact the CPI Systems Security Officer. All contractor staff shall be 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.

8.5.6.1. Physical and Operational Security

8.5.6.2. **SYSTEM SECURITY**

All work on this contract shall be in compliance with the CMS BPSSM, and the CMS Policy for IT Security [http://www.cms.hhs.gov/InformationSecurity/Downloads/IS_Policy.pdf]. CMS’ Core Security Requirements, as defined in the CMS BPSSM, including security standards adopted under the Health Insurance Reform regulations published pursuant to the Health Insurance Portability and Accountability Act (HIPAA) (FR Volume 68, Number 34 of February 20, 2003), are applicable to this contract and to all subcontracts (see http://cms.hhs.gov/manuals/downloads/117_systems_security.pdf for BPSSM).

The CISS FISMA Evaluation as modified by CMS shall be submitted by close of business on the last business day of April, each calendar year.

The Contractor shall check the following web site frequently for updates to the manuals and tools: http://cms.hhs.gov/InformationSecurity/. This page contains links to all of the security references needed for this USOW.

The Contractor may also be asked to participate in a variety of security conferences. Access the Medicare Contractor System Security homepage for further details. Examples include, but are not limited to:

a. National Audio Teleconferences
b. Best Practices Security Conferences

8.5.6.3. **CERTIFICATION FOR COMPLIANCE WITH CMS SYSTEMS SECURITY**

The system owner of the contractor’s data storage and analysis systems shall certify compliance with the Centers for Medicare & Medicaid Services (CMS) systems security requirements.

The CMS must certify and accredit contractor systems before the system may become operational. Certification and accreditation requires successful completion of an independent certification and accreditation (C&A) evaluation)
that CMS will arrange and conduct. CMS must arrange for C&A at least one month before the desired date for the C&A and must have all security artifacts when it is arranged. The C&A usually requires six weeks to conduct. The Contractor must develop a corrective action plan (CAP) to correct any deficiencies found as part of the evaluation within 30 days of its completion. Certification and accreditation requires a minimum of two weeks after development of a CAP. Upon award, the Contractor shall begin developing system artifacts to prepare for the C&A Evaluation.

8.5.6.4. AUTHORITY TO OPERATE

An Authority to Operate (ATO) is required for any Contractor that accesses CMS Personal Health Information.

8.5.6.5. ADMINISTER SECURITY PROGRAM

The Contractor shall conduct all security administration activities for all parts of the review and analysis activities in accordance with Internet-only manual (IOM Pub. 100-17), the Core Security Requirements and its operational appendices (A, B C and D), found at [http://www.cms.hhs.gov/manuals/downloads/117_systems_security.pdf](http://www.cms.hhs.gov/manuals/downloads/117_systems_security.pdf)

The Contractor shall adhere to all deadlines and formats outlined in official CMS communications (e.g., IOM Pub. 100-08 sections and the BPSSM), as applicable.

The Contractor shall comply with the CMS Information Security Virtual Handbook and all CMS methodologies, policies, standards and procedures contained within the Virtual Handbook.


The Contractor shall comply with and utilize standards and guidelines promulgated by the National Institute of Standards and Technology (NIST) in its entity-wide information security program.
The Contractor shall comply with the applicable standards, implementation specifications, and requirements of the Health Insurance Portability and Accountability Act (HIPAA) security rule covering electronically protected health information.

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

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

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

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

The Contractor shall allow CMS to observe Contractor-conducted audits, reviews, evaluations, tests and assessments of the Contractor’s security program and facilities.

The results of any Contractor conducted annual audits, reviews, evaluations, tests and assessments shall be made available to the Government for review.

The Contractor shall allow CMS to conduct periodic audits, reviews, evaluations, tests and assessments of the Contractor’s security program and facilities.

8.5.6.6. **CORRECT DEFICIENCIES**

The Contractor shall correct any security deficiencies, conditions, weaknesses, findings, or gaps identified by all audits, reviews, evaluations, tests, and assessments,
including but not limited to Office of the Inspector General (OIG) audits, self-assessments, and vulnerability assessments in a timely manner. (Time is of the essence in correcting the deficiencies or in remediating the findings of an audit.)

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

The Contractor shall validate and document that corrective actions are implemented, tested, and effective. The Contractor shall provide attestation and documentation of corrective actions to CMS.

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

The Contractor shall correct weaknesses, findings, gaps, or other deficiencies or develop plans acceptable to CMS to make needed corrections within 30 days of receipt of the final audit or evaluation report, unless authorized by CMS otherwise.

8.5.6.7. **CORRECTIVE ACTION ATTESTATION**

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

8.5.6.8. **SECURITY REVIEW AND VERIFICATION**

The Contractor shall comply with the CMS certification and accreditation (C&A) methodology, policies, standards, procedures, and guidelines for contractor facilities and systems. The CMS C&A methodology can be found on the CMS web site [www.cms.hhs.gov/information security](http://www.cms.hhs.gov/information.security).

The Contractor shall conduct or undergo an independent evaluation and test of its systems security program in accordance with section 1874A, as added by MMA section 912. The contractor's first independent evaluation and test of
its systems security program shall be completed prior to a date agreed to by the CMS.

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

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

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

8.6. Unified Case Management (UCM) System Requirements

8.6.1. Introduction/Overview

The UCM for Program Integrity is a government-owned workflow management, electronic case file system that aligns with the CMS strategy to implement a coordinated approach to support cooperation and efficiency between jurisdictional program integrity contractors while ensuring implementation of a national approach to fraud, waste, and abuse trends that cut across jurisdictions. The UCM system eliminates duplicate systems and tracking, increases the accuracy and transparency in reporting workload and return on investment, and provides CMS/CPI with direct access to allow for oversight of each contractor’s work.

The UCM system will be accessible through the secure OnePI Portal and incorporates a central repository to track all leads and investigations, in an effort to improve Medicare and Medicaid fraud, waste, and abuse analysis and resolution. The UCM will eventually integrate actions such as prepay integration into the Medicare shared systems, or provide suspension or removal from participation in any of the CMS programs.

8.6.1.1. System Activities

The UCM system will allow users to perform the following activities:

a. Input information, for example; leads, investigations, and data analysis results
b. Analyze data and other information

c. Manage workflows and a variety of investigation activities

d. Track work products from multiple inside or outside sources (including preserving the evidentiary chain of custody), not only leads and investigations, but also referrals to law enforcement, requests for information, cost report audits (to name a few), as well as the outcome of every case

e. Track administrative actions, including those referred to MACs and other contractors, State agencies, CMS, or other entities

f. Allow for tracking and documentation on work performed on special projects, and any other dynamic fraud, waste, and abuse projects

g. Generate reports

The UCM system will support email notifications to remind users to accomplish certain tasks; free form narratives to allow those users to input information that may not be standard, and templates for issuing form letters to customers. All information in the case management system will be auditable and traceable. Users will be able to create and participate in ad-hoc workflow as well as structured processes with notifications and configurable alerts.

UCM capabilities are subject to change as the system evolves. This section sets forth the current expectations. The Contractor may be expected to use alternate reporting methods and alternate processes within the UCM and as directed by CMS.

8.6.2. Planning

a. During the implementation period, CMS will provide the Contractor with the capability to achieve secure access through OnePI, and assist the Contractor with the procedures needed to access the Unified Case Management system.
b. During the transition period, the Contractor shall participate in training sessions for the Unified Case Management System, as directed by the CMS COR team. CMS will provide the Contractor with any additional training information or manuals for the UCM and the CMS COR team will be the conduit through which the Contractor shall provide suggestions or recommendations for updates or improvements to the UCM.

c. During the transition period, the Contractor shall work with the CMS COR team to identify the roles that the Contractor staff will play in the authorization scheme that will be present in the UCM. The authorization scheme will address issues such as multiple permissions, roles, investigation assignments, and prioritization of work.

8.6.3. Executing/Reporting

a. As the Contractor is performing the functional tasks of this SOW, the Contractor shall enter or track information, reports, or other documentation to support the work done on the following:

i. All aspects of initial lead generation
ii. Sampling decisions and data analysis results
iii. The range of investigation activities, which could include provider look-ups, medical record review and cost report audits
iv. Details regarding requests for information or assistance
v. Documentation of administrative actions, with a focus for complete feedback and finalization.

b. The quality and completeness of the documentation in the UCM is very important, allowing for historical perspective that will reduce duplication of effort and increase efficiency, as well as provide crucial input to the investigative process. With this in mind, the Contractor shall work with other contractors, agencies, organizations, and CMS to obtain the information needed to provide closure to the fraud, waste, and abuse program integrity work that is being performed. This follow-up loop is very important and may represent such processes as:

i. Status of overpayments recovered
ii. Status of appeals
iii. Outcomes of referrals made by the Contractor to any law enforcement entity or other organization
iv. Details/outcomes regarding administrative actions
c. The Contractor’s documentation entered into the Unified Case Management system shall be presented in such a way that it is fully understandable by the CMS COR team.

d. The Contractor shall not use the Unified Case Management system as the system of record for the data.

8.6.4. **MANAGING AND MONITORING**

a. CMS expects that the information entered by the Contractor will be accurate; therefore, CMS will conduct open and closed review of work in the UCM on an ongoing basis and use that data as an element of performance monitoring.

b. CMS has a contractor that maintains and enhances the Unified Case Management system.

8.7. **QUALITY ASSURANCE PROGRAM REQUIREMENTS**

CMS will utilize a number of quality assurance procedures to ensure UPIC compliance with this contract. Examples include inspection of deliverables, review of reports, onsite progress meetings and performance evaluations.

8.7.1. **COOPERATION/COORDINATION**

The UPIC shall cooperate and coordinate with stakeholders other than CMS, including other UPICs, law enforcement, providers, and other entities as appropriate. Contractor performance will be evaluated using measures including, but not limited to:

a. Demonstration of ongoing dialogue or meetings with the appropriate and necessary parties

b. Feedback from other entities

c. Number and type of issues that arise and indicate communication, or lack of communication, between appropriate entities and the contractor

8.7.2. **ISO-9000 CERTIFICATION**

The Contractor shall demonstrate prior experience compatible with the ability to achieve ISO-9000 certification and is expected to achieve ISO-9000 certification within one (1) year of the start of the contract.
8.7.3. **QUALITY CONTROL PLAN**

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

The Contractor shall submit a Quality Control Plan (QCP) specifying procedures and resources applied to ensure services meet contract performance requirements to the COR. Timelines for submitting the plan will be defined in individual Task Orders.

The Contractor shall submit an updated copy of the QCP to the COR in the following instances: annually at contract renewal; when substantive changes occur to the QCP, and when changes occur in the Contractor’s quality operations. The Contractor shall submit the QCP updates in redline format (track changes), denoting changes from the previous version. The Contractor's comprehensive quality program shall include, but not be limited to, the following:

a. Documented procedures and processes for services to ensure that services of this Statement of Work (SOW) meet contract performance requirements.

b. Documented change management program to ensure that correct procedures and processes are followed.

c. Provide and maintain an inspection and audit system to ensure that services meet contract performance requirements.

d. Provide a method of identifying nonconformance or deficiency in the quality of services performed.

e. Provide a formal system to implement corrective action.

f. Provide a file of all quality records relating to inspections and audits conducted by the Contractor and the corrective action implemented. This documentation shall be made available to the Government during the term of the contract.

g. Provide for Government inspections and audits while work is in process or complete.
8.7.4. **QUALITY EVALUATIONS**

The Contractor shall maintain the highest degree of quality for all activities performed throughout the period of performance of the contract. CMS will evaluate UPIC performance using measures including, but not limited to:

a. Completeness and accuracy of data analysis

b. Completeness and accuracy of PI investigations

c. Completeness and accuracy of all deliverables

d. Completeness and accuracy of medical reviews

e. Completeness and accuracy of claims reviews

f. Completeness and accuracy of audits

8.7.5. **CONTINUOUS IMPROVEMENT PROGRAM**

The Contractor shall develop and maintain a Continuous Improvement Program (CIP). As part of this program, the Contractor shall implement continuous improvements and innovations in adapting to unforeseen circumstances and become increasingly effective in achieving its goals. Additionally, the UPIC’s CIP shall include areas that can be improved within the contractor’s own operations. These may include items that were discovered as part of the QA program or based upon feedback from the CMS, employees, and others. Lastly, based upon its experience with performing the requirements in this contract, the Contractor shall recommend to the CMS changes in the programs that it believes will help reduce fraud, waste and abuse. The Contractor shall submit Continuous Improvement Reports to the appropriate COR as determined in each Task Order.

8.7.6. **DATA MATCHING QUALITY ASSESSMENT**

There are multiple methods that can be used to evaluate the quality of data matching. The Contractor shall coordinate with stakeholders to develop the appropriate methodology for data matching. The Contractor shall define a quality assurance methodology for data matching that minimizes the occurrence of false positive/negative matches. The method that is agreed upon should be detailed in the Data Matching Protocol and submitted to CMS.
8.7.7. **INNOVATION AND TECHNOLOGY**

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

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

b. Foster efficiencies in the administration of the Medicare and Medicaid programs to promote best value for the government.

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