Zone Program Integrity Contractor Statement of Work

Centers for Medicare & Medicaid Services

1. GENERAL & ADMINISTRATION

1.1 – General

1.1.1 – Scope

1.1.1.1 - Background

Medicare was enacted in 1965 as Title XVIII of the Social Security Act (the Act). Medicare has two programs, the Hospital Insurance Program (HI or Part A) and the Supplementary Medical Insurance Program (SMI or Part B). Part A covers certain hospital and related health care services. A person who is entitled to Social Security monthly benefits or is a qualified railroad retirement beneficiary is automatically entitled to Medicare Part A beginning with the first day of the month in which the individual attains age 65. Medicare Part B is a voluntary program that pays all or part of the costs for physician services, laboratory services, ambulance services, durable medical equipment, prosthetics, orthotics, medical supplies, outpatient hospital services, certain home health services, services furnished by rural health clinics, ambulatory surgical centers, comprehensive outpatient rehabilitation facilities, and certain medical and other health services not covered by Part A of Medicare.

Sections 1816(a) and 1842(a) of the Act provide that public or private entities and agencies may participate in the administration of the Medicare program under agreements or contracts entered into with the Centers for Medicare & Medicaid Services (CMS) on behalf of the Secretary of the Department of Health and Human Services. These Medicare contractors are known as Fiscal Intermediaries (FIs) and Carriers. FIs have primarily processed bills and made payments for all facilities (Hospitals, Skilled Nursing Facilities (SNFs), Ambulatory Surgical Centers (ASCs), etc.). Carriers have primarily processed claims and made payments for all Part B services billed by a physician or supplier.

As part of these contractual duties, FIs and Carriers were charged to perform program integrity activities. These activities include, among other things, reviewing claims to make coverage determinations, deterring and detecting potential fraud and/or abuse, and auditing provider cost reports. In addition, FIs and Carriers performed the entire range of claims processing functions, including entering data, establishing computer edits to identify potential duplicate claims, and mailing notices to beneficiaries and providers. FIs and Carriers are referred to as affiliated contractors (ACs) throughout this umbrella SOW.

Approximately 19% or 8.3 million of the 43 million elderly and disabled people on

Medicare are enrolled in a Medicare Advantage Plan. While Medicare HMOs have been an option for beneficiaries since the 1970s, it was the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982 that allowed Medicare beneficiaries to enroll in HMOs reimbursed on a cost or "risk-contracting" basis. Medicare HMOs were paid on a capitated basis set at 95% of Medicare's fee-for-service costs in each county.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, Public Law 104-191) was enacted on August 21, 1996. Section 202 of Public Law 104-191 adds a new section, §1893, to the Social Security Act that establishes the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen CMS' ability to deter potential fraud, waste and abuse in the Medicare program. It provides a separate and stable long-term funding mechanism for MIP activities. By expanding CMS' contracting authority, MIP allows CMS to more aggressively carry out program safeguard functions. As part of this program, CMS created several new entities, including the Program Safeguard Contractors (PSCs). The PSCs were dedicated to program integrity and enhanced data capabilities.

The Balanced Budget Act of 1997 (BBA) added a Part C program to Medicare. At that time, it was referred to as Medicare+Choice (M+C). While health maintenance organizations (HMOs) have been an option under Medicare since the 1970s, the BBA authorized new Medicare plans, including preferred provider organizations, private fee-for-service plans and Medical Savings Accounts (MSA).

Under Medicare Advantage, plans must provide basic Medicare benefits, and plans must use any savings to reduce enrollee premiums or improve benefits. MA plans (excluding Private Fee for Service (PFFS) and cost plans) are required to offer at least one plan that includes the basic Medicare drug benefit or a plan with enhanced alternative drug coverage.

On December 8, 2003, the President signed into law the Medicare Modernization Act (MMA) (Public Law 108-173). Section 911 of MMA directed implementation of Medicare FFS contracting reform. Medicare Contracting Reform requires that CMS use competitive procedures to replace its current fiscal intermediaries and carriers with a uniform type of administrative entity, referred to as Medicare Administrative Contractors (MACs). MMA also establishes a new voluntary outpatient prescription drug benefit under Part D of title XVIII of the Social Security Act (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. Coverage for the drug benefit is provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage plans that offer both prescription drug and health care coverage (known as MA-PD plans).

The MMA renamed Medicare+Choice to Medicare Advantage and created new regional Preferred Provider Organizations (PPOs) and Special Needs Plans (SNPs)

for dual eligibles and other vulnerable populations. In addition, the MMA increased Medicare Advantage payment rates on average to 110 percent of Medicare FFS levels for HMOs and 119 percent of Medicare FFS for private fee-for-service (PFFS) plans. In 2007, due largely by the higher payment rates, Medicare Private Health Plan Contracts increased to 604 and enrollment increased to 8.3 million. From December 2005 to February 2007 there has been a 350% increase of private fee-for-service enrollment; 35% increase in Regional PPOs; and17% increase in local HMOs and PPOs. Today 18% of beneficiaries are enrolled in private plans compared to 11% in 2003.

The final rule implementing the new Medicare Prescription Drug Benefit, and the final rule establishing and regulating the Medicare Advantage (MA) program were published in the Federal Register on Friday, January 28, 2005 and are available from the Federal Register online database at http://www.access.gpo.gov/fr/index.html. Other information on MMA can be found on the CMS website at http://www.cms.hhs.gov/medZPICarereform/.

Section 6034 of the Deficit Reduction Act (DRA) of 2005 created the Medicaid Integrity Program and amended Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.). The national expansion of the Medicare-Medicaid (Medi-Medi) Data Match Program was implemented as part of the DRA. Medi-Medi is a partnership between Medicaid and Medicare that enhances collaboration to reduce fraud, waste, and abuse by matching claims data from both programs in order to identify improper billing and utilization patterns that may not be detected when the programs are viewed in isolation.

As result of contracting reform, seven zones have been created based on the newly established MAC jurisdictions. Included in the seven zones are five high risk areas. As a result of the seven zones, new entities entitled Zone Program Integrity Contractors (ZPICs) have been created to perform program integrity for Medicare Parts A, B, C, D, Durable Medical Equipment (DME), Home Health and Hospice (HH+H) and Medi-Medi.

1.1.1.1.1 - Medicare Integrity Program in the Health Insurance Portability and Accountability Act

One way CMS will carry out its authority under HIPAA, MIP and the MMA is through this Indefinite Delivery Indefinite Quantity (IDIQ) contract for work to be performed by a ZPIC. This umbrella Statement of Work (SOW) encompasses all of the fundamental activities that may be required of a ZPIC. However, no work will be performed on the umbrella SOW since individual Task Orders will be awarded under the IDIQ for specific requirements (refer to contract Section G - Contract Administration, for details on task ordering procedures).

Task Orders may be awarded by CMS or other government agencies identified

herein for some or all of the activities identified in this umbrella SOW.[1] For example; a Task Order may be issued for all of the activities identified in this umbrella SOW under a Task Order SOW that may read "The Contractor shall perform all of the requirements of the umbrella SOW as the Zone Program Integrity Contractor for a specified Carrier, FI or MAC." Or, a Task Order may be issued for some of the activities, such as "generate program safeguard edits," or "perform cost report audits on specified providers." Each Task Order will contain an individual statement of work for requirements to be performed that are within the scope of this umbrella SOW.

1.1.2 - Purpose

The purpose of this Statement of Work is twofold.

1. It provides a vehicle to promote the integrity of the Medicare and Medicaid programs by accomplishing the following objectives:

    - Identify, stop and prevent Medicare and Medicaid fraud, waste and abuse and refer instances of potential fraud, waste and abuse to the appropriate law enforcement agencies.

    - Decrease the submission of abusive and fraudulent Medicare and Medicaid claims.

    - Recommend appropriate administrative action (e.g., payment suspension recommendations and CMPs) to CMS as necessary in accordance with Medicare and Medicaid laws and regulations, etc., to ensure that appropriate and accurate payments for services are made, which are consistent with all Medicare and Medicaid rules and regulations.

    - Coordinate potential fraud, waste and abuse with appropriate Medicare & Medicaid Entities (MMEs).

2. It establishes the fundamental activities that may be awarded by individual Task Orders under the ZPIC umbrella SOW.

1.1.3 - Basic Requirements

The Zone Program Integrity Contractor (ZPIC) shall:

- Furnish the necessary services and qualified personnel, facilities, equipment, materials, and supplies not otherwise provided by the Government as needed to

[1] ZPIC

perform the requirements set forth in this Statement of Work (SOW) as indicated in each individual Task Order. The ZPIC shall have all the necessary resources required for performance as a ZPIC within 90 days of issuance of a Task Order, unless otherwise specified in each Task Order.

- As applicable, work jointly with the appropriate MMEs to perform the tasks and activities identified in this SOW through a Joint Operating Agreement (JOA). The JOA shall be modified and updated to reflect any changes in the project. One hard copy to the appropriate MME, one CD ROM to the CO, and entry into CMS ARTS, identifying the changes through an appropriate means, shall be distributed to the appropriate Government Task Leaders (primary GTL, associate GTL or Medi-Medi GTL) the AC(s), the MAC(s) and the Contracting Officer.

- Provide the Centers for Medicare & Medicaid Services (CMS) with complete and accurate information on all actions upon request.

- Perform requirements as defined in this SOW in accordance with applicable Medicare and Medicaid laws and regulations, CMS manuals, the Federal Managers' Financial Integrity Act (FMFIA), Government Auditing Standards (GAS), the Chief Financial Officer (CFO) Act of 1990 and others as may be identified herein.

- Continuously evaluate the effectiveness of all actions.

- Coordinate with the appropriate MMEs to ensure adequate training of staff on program integrity issues.

- Maintain records and files in accordance with Appendix D, Records Retention.

- Report in accordance with deliverables listed and the deliverables schedule in Chapter 1, §1.2.3 and in Appendix A, Deliverables.

- Maintain compliance with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d). Section 508 requires Federal agencies to purchase electronic and information technologies (EIT) that meet specific accessibility standards. This law helps to ensure that federal employees with disabilities have access to, and use of, the information and data they need to do their jobs. Furthermore, this law ensures that members of the public with disabilities have the ability to access government information and services.

- Comply with the standards, policies, and procedures below. In the event of conflicts between the referenced documents and this USOW, the USOW shall take precedence.

  Rehabilitation Act, Section 508 Accessibility Standards

  1. 29 U.S.C. 794d (Rehabilitation Act as amended)
  2. 36 CFR 1194 (508 Standards)
  3. www.access-board.gov/sec508/508standards.htm (508 standards)
  4. FAR 39.2 (Section 508)
  5. CMS/HHS Standards, policies and procedures (Section 508)

- Have all contract deliverables are subject to these 508 standards as applicable. Regardless of format, all Web content or communications materials produced, including text, audio or video - must conform to applicable Section 508 standards to allow federal employees and members of the public with disabilities to access information that is comparable to information provided to persons without disabilities. All contractors (including subcontractors) or consultants responsible for preparing or posting content must comply with applicable Section 508 accessibility standards, and where applicable, those set forth in the referenced policy or standards documents stated in this section. Remediation of any materials that do not comply with the applicable provisions of 36 CFR Part 1194 as set forth in the USOW, shall be the responsibility of the contractor or consultant. The following Section 508 provisions apply to the content or communications material identified in this USOW:

  - 36 CFR Part 1194.22 a – j, l – p
  - 36 CFR Part 1194.41 a – c

1.1.4 - Fundamental Activities

Fundamental activities of the ZPIC that will help ensure payments are appropriate and consistent with Medicare and Medicaid coverage, coding, and audit policy, and will also

identify, prevent, or correct potential fraud, waste and/or abuse may include, but are not limited to, the following:

- performing BI investigations;
- referring cases to law enforcement;
- making coverage and coding determinations;
- review of audit, settlement, and reimbursement of cost reports;
- reviewing bids for participation in the prescription drug program (Part C and Part D only);
- assisting CMS in developing a list of entities that may require future monitoring based upon past history;
- conducting specified audits;
- conducting specified complaint investigations (Part C and Part D only);
- conducting preliminary investigations into entities conducting fraudulent enrollment, eligibility determination and benefit distribution (Part C and Part D only);
- matching and analysis of Medicare and Medicaid data;
- responding to law enforcement requests and providing expertise to law enforcement on ongoing investigations;
- implementing appropriate administrative actions;
- coordinating potential fraud, waste and abuse activities with the appropriate MMEs; and
- complaint screening (Part C and Part D only).

NOTE: The list of activities above is in no special order that is indicative of priority or weight.

The ZPIC shall perform these activities as specified in this SOW in a manner that maximizes resources and produces the most effective and efficient results. See individual chapters for more detail on fundamental activities for specific workloads (e.g. Part A, B, HH+H, and DME; Part C; Part D; Medi-Medi).

1.1.5 - Coordination

The ZPIC's success in safeguarding the Medicare Trust Fund depends on a close and coordinated working relationship with its internal components and external organizations. The ZPIC and its partners shall work together and communicate frequently in order to keep each other apprised of potential areas of vulnerability and to avoid duplication of efforts. The ZPIC shall work with and coordinate with, as necessary, external entities including, but not limited to, those described in the following sections.

1.1.5.1 - Affiliated Contractors/Medicare Administrative Contractors

Whether a program integrity function is performed by the ZPIC or AC/MAC, it is imperative that both entities work together to achieve the common goal of ensuring the integrity of the Medicare program.

1.1.5.2 – One Program Integrity Project (One PI)

The One Program Integrity (PI) project, begun in FY 2006, will, for the first time, provide streamlined, centralized access and analysis for standardized Medicaid data across multiple states, integrated with data from Medicare Parts A, B, and D. The initial focus of the One PI contract is to obtain and store Medicaid data

The One PI project will address business needs for CMS organizations, such as Program Integrity, Center for Medicaid and State Operations (CMSO), Office of Research, Development and Information (ORDI), and Office of Clinical Standards & Quality (OCSQ); contractors, such as ZPICs; state Medicaid agencies; and law enforcement, to name a few. Expanding business service to these users will consist of adding analytic tools, adding data sources (such as more states), adding additional contractors, and adding new types of contractors. The addition of these new data sources will enable CMS to house a richer data environment that will drive new capabilities such as the identification of episodes of care and identification of potential fraud perpetrated across multiple government programs. Additionally, when completed, this project will provide regional and national norms for the state Medicaid fraud units while reducing the states' burden of multiple data submissions to CMS. Alternative analysis and cost benefit analysis will be used to select each new unit of business service.

Once One PI is completed, the ZPICs will be provided access to data that is standardized across states. One PI will also provide additional analysis to support potential fraud, waste and abuse by linking records together from the Medicare and Medicaid programs.

1.1.5.3 - Other Zone Program Integrity Contractors

The ZPIC shall coordinate with other ZPICs, when applicable, to ensure that efforts are coordinated to stop Medicare fraud, waste and abuse. The ZPIC shall utilize all available tools (e.g., the Fraud Investigation Database (FID) and CMS Customer Information System (HCIS)) to ensure coordination and the prevention of duplication of efforts. As a part of its coordination activities, the ZPIC shall participate in information sharing sessions, such as the Zone Program Integrity Contractor Data Users Group (ZPIC DUG).

In addition, the ZPIC shall work with other ZPIC contractors as needed when issues cross- zonal boundaries (e.g., when a case is national in scope). As a part of its coordination activities, the ZPIC shall participate in information sharing sessions, meetings, or conference calls as appropriate. The ZPIC shall share lessons learned, best practices and materials to the extent appropriate for greater success and enhanced coordination of the ZPIC program.

1.1.5.4 - Working with Other Affiliated Contractors and Medicare Administrative Contractors Outside the Zone Program Integrity Contractor Zone

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

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

1.1.5.5 - Office of the Inspector General

All referrals by the ZPIC for potential Medicare fraud will be made to the Office of the Inspector General, Office of Investigations (OIG OI). The ZPIC 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 F, MOU with Law Enforcement.) The ZPIC shall meet quarterly, or more frequently if necessary, with OIG agents in its zone to discuss pending or potential cases.

1.1.5.6 - Department of Justice

The ZPIC 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 F, MOU with Law Enforcement) The ZPIC shall meet with DOJ personnel when needed to enhance coordination between the ZPIC and the DOJ.

1.1.5.7 - Federal Bureau of Investigation

The ZPIC 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 F, MOU with Law Enforcement) The ZPIC shall meet with FBI personnel regularly to enhance coordination between the ZPIC and the FBI.

1.1.5.8 - 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 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 ZPIC shall meet with the appropriate entity in each state performing the Medicaid program integrity function to coordinate state and local potential fraud cases. The ZPIC shall maintain an ongoing dialogue with these entities and shall coordinate appropriate anti-fraud, waste and abuse initiatives.

1.1.5.9 - 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 ZPIC does not have responsibility for investigating or researching Medicaid fraud per se, but is responsible for coordination with MFCUs. The ZPIC shall meet with MFCUs in order to coordinate state and local potential fraud cases. The ZPIC shall maintain an ongoing dialogue with MFCUs and shall coordinate appropriate anti-fraud, waste and abuse initiatives.

1.1.5.10 - State Agencies for Survey and Certification

The ZPIC shall coordinate information (e.g., quality of care, potential fraud, waste and abuse) with the state agencies that perform under the §l864 agreements that are referred to collectively as the certification process.

1.1.5.11 - Law Enforcement Health Care Task Forces

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

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

1.1.5.12 - State Licensure Agencies

The ZPIC shall share information with the state survey and certification agency, or any other administrative agency able to, and interested in, sanctioning providers who either bill inappropriately, fraudulently or mistreat patients.

1.1.5.12.1 – State Licensure of Agents and Brokers

The ZPIC shall share information with the state licensure agencies, or any other administrative agency able to, and interested in, sanctioning agents and brokers who inappropriately or fraudulently enroll Medicare beneficiaries into Medicare Advantage plans.

1.1.5.12.2 - State and Local Licensure and Enforcement Agencies

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

1.1.5.13 - Professional Societies

The ZPIC shall meet as necessary with members of professional societies in order to gain input from the society, particularly with respect to the development of new/revised contractor policies.

1.1.5.14 - Quality Improvement Organizations

The ZPIC shall refer quality of care issues to Quality Improvement Organizations (QIOs) when these issues are discovered as part of the ZPIC's anti-fraud, waste and abuse activities.

1.1.5.15 - Managed Care Organizations

The ZPIC shall maintain an ongoing dialogue with the appropriate personnel or units in managed care organizations, including Medicare Advantage (MA) and 1876 Cost plans within its zone and shall coordinate appropriate anti-fraud, waste and abuse initiatives with them.

1.1.5.16 - Private Health Insurers

To the extent permitted by statute, CMS, and other government regulations, the ZPIC shall share information and maintain an ongoing dialogue with private health insurers and shall coordinate appropriate anti-fraud, waste and abuse initiatives. The ZPIC shall consult CMS before sharing information with private health insurers, and CMS will advise the ZPIC on the nature and extent of information sharing and coordination it may have with private health insurers.

1.1.5.17 - Other Specialty Contractors

In the future, as CMS develops new types of specialty contractors, the ZPIC will be charged with working with them in an appropriate manner defined by CMS.

1.1.5.18 - Other Federal and State Agencies

The ZPIC 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 ZPIC shall work with CMS to determine the best method of working and collaborating with other such agencies.

1.1.5.19 – Appropriate CMS Staff

The ZPIC shall work with the Project Officer, appropriate GTLs, and other designated CMS staff to coordinate work that the ZPIC needs to perform to fulfill the tasks under this umbrella SOW.

1.1.5.20 – Data Analysis Coordination

ZPICs shall be prepared to coordinate with other ZPICs and other MMEs, 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 (including CMS PDE data and retail pharmaceutical script data) to identify national trends. The ZPIC shall also utilize data from other sources, e.g. Medicare Beneficiary Database (MBD), National Counsel of Prescription Drug Programs (NCPDP), MediSpan, First Databank, as appropriate. In addition, the ZPIC shall be prepared to offer a strategy for obtaining and analyzing all data.

This ZPIC should be prepared to perform data analysis, utilizing an integrated database, within their zone, and refer these leads to CMS, CMS contractors (e.g., other ZPICs), and law enforcement as appropriate.

1.1.6 - Workload

All work required under this umbrella SOW will be designated by issuance of individual Task Orders. Task Orders awarded under this umbrella SOW are restricted to issuance by CMS and/or the OIG, FBI, DOJ, or other federal government agencies as may be identified by CMS. Task Orders will be issued for some or all of the tasks/requirements identified herein.

Furthermore, the ZPIC's workload volume designated at the time of award of a Task

Order may be increased during the period of performance of the Task Order. The Contracting Officer (CO) will notify the ZPIC reasonably in advance of assuming the increase in workload volume so that the appropriate actions may ensue.

CMS may issue task order(s) for specific fraud, waste and abuse activities on a national level. For example, if CMS has a requirement to perform a review of a certain type of claim and it is in CMS's best interest to have only one ZPIC perform the work, versus all seven ZPICs, CMS reserves the right to issue a task order to one specific ZPIC to perform the national work.

1.1.7 - Key Personnel

1.1.7.1 - General Requirements

When Task Orders are issued, key personnel positions will be identified in the Task Order Statement of Work (SOW).

1.1.7.2 - Key Personnel

The ZPIC shall maintain a staff of key personnel positions that are dedicated as FTEs, unless otherwise specified in the Task Order. Key personnel may be dedicated less than full time, unless otherwise noted, and may be shared across more than one Task Order as approved by the Contracting Officer (CO). Key personnel shall not serve dual responsibilities in key functions unless approved by the Contracting Officer (CO), e.g., the Program Director may not also serve as the Benefit Integrity Manager. Changes in key personnel positions shall be submitted to the Contracting Officer in writing for approval within 30 days prior to any change.

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

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

1.1.7.2.1 – Zone Program Director

The Zone Program Director shall be full time and employed by the prime contractor and possess:

Work Experience
Fifteen or more years of professional experience, with at least 5 years related to Medicare and Medicaid, and at least 5 years supervisory experience responsible for managing complex systems and work flow.

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

The Zone Program Director shall be responsible for the oversight of the IDIQ requirements as well as the overall operations of the task orders in the zone. In addition, the Zone Program Director shall oversee the coordination of activities to ensure the following:

- there is not duplication of effort;
- staffing is appropriate;
- there is a line of communication to task order staff;
- USOW requirements are met including quality of product and services, cost control, timeliness and business relations;
- ensure an adequate quality assurance program and process are in place and strictly adhered to for all products and services;
- monthly cost reports are submitted timely and accurately, including a plan to correct any cost variances or projected rate adjustments;
- all USOW deliverables and ad hoc requests are submitted in accordance to timeliness requirements; and
- business relations with CMS, Law Enforcement, ACs and MACs and all other stakeholders and partners are consistently maintained at the highest level.

1.1.7.2.2 Fee-for-Service Task Order Manager

The Fee-for-Service Task Order Manager shall possess:

Work Experience
Ten or more years of professional experience in Medicare with at least 3 years as a manager responsible for managing complex systems and work flow and experience related to the specific workload of the individual task order, which may be further defined in the Task Order Statement of Work.

Educational Requirements
A bachelor's degree from an accredited institution, plus a master's degree from an

accredited institution or substitution of 4 additional years of related work experience in lieu of the master's degree.

1.1.7.2.3 Medi-Medi Task Order Manager

The Medi-Medi Task Order Manager shall possess:

Work Experience
Ten or more years of professional experience in both a combination of the Medicare and Medicaid programs with at least 3 years as a manager responsible for managing complex systems and work flow and experience related to the specific workload of the individual task order, which may be further defined in the Task Order Statement of Work.

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

1.1.7.2.4 - Medical Director

The Medical Director shall possess:

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

Extensive knowledge of the Medicare program, particularly the coverage and payment rules, 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 3 years as a board-certified doctor of medicine or a doctor who is currently licensed.

See PIM Chapter 1, §1.4 for further Medical Director requirements.

1.1.7.2.4 5 - Cost Report Audit/Reimbursement Manager

The Cost Report Audit/Reimbursement Manager shall possess:

Work Experience
Three to 5 years management experience in Medicare cost report auditing, settlement, and reimbursement.

Educational Requirements
Bachelor's degree in accounting or equivalent with a master's and/or Certified Public Accountant (CPA) certification (or 4 additional years of related work experience in lieu of CPA certification).

Knowledge of Medicare law, regulations, manuals, and instructions, and Government Auditing Standards (GAS).

1.1.7.2. 6 – MMA Audit Manager
The Audit Manager shall possess:

Work Experience
Three to 5 years management experience in the auditing field. Knowledge of Medicare reimbursement principles as they apply to Part D, Retiree Drug Subsidy (RDS) and Medicare Advantage is preferred.

Educational Requirements
Bachelor's degree in accounting or equivalent with a master's and/or Certified Public Accountant (CPA) certification (or 4 years of related work experience in lieu of CPA certification).

Knowledge of Medicare law, regulations, manuals and instructions, and Government Audit Standards (GAS). Experience auditing pharmaceutical benefit managers is preferred.

1.1.7.2. 7 - Benefit Integrity Manager
The Benefit Integrity (BI) Manager shall possess:

Work Experience
A minimum of 3 years supervisory experience in the general area of benefit integrity investigation. Medicare and/or Medicaid knowledge and experience related to the specific workload of the individual task order, which may be further defined in the Task Order Statement of Work.

Educational Requirements
Bachelor's degree in criminal justice, health science, administration or such areas as specified in the Task Order. Education requirements may be substituted if the applicant has 10 or more years of related benefit integrity experience.

1.1.7.2. 8 - Medical Review Manager
The Medical Review Manager shall possess:

Work Experience
A minimum of 3 years supervisory experience in the general area of medical/ utilization review and Medicare.

Educational Requirements
Bachelor's degree in nursing with an active Registered Nurse license.

1.1.7.2. 9 - Chief Legal Counsel
The Chief Legal Counsel shall possess:

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

Educational Requirements
Must be a licensed attorney.

1.1.7.2. 10 - Chief Statistician
The Chief Statistician shall possess:

Work Experience
A minimum of 3 years experience using statistics to support corporate/business information needs.

Experience in statistical detection of potential fraud, predictive modeling, development of mathematical models, neural networks, and data mining or other analytical methods.

Demonstrated experience and knowledge of health care information (health claims data, ICD-9-CM codes, physician specialty codes, survey and certification data, pharmaceutical data including NCPDP file formats and codes, provider identifiers, etc.). Requirements may be further defined in the Task Order Statement of Work.

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

1.1.7.2. 11 – Pharmacy Specialist
The Pharmacy Specialist shall possess:

Work Experience
Extensive knowledge of how prescription drugs are developed and managed. The Pharmacy Specialist (PS) shall have a minimum of five (5) years experience in prescription drug benefit management with three (3) years experience managing a prescription drug formulary, medication therapy management, and drug interaction program. The PS shall have experience in the development of plans and the review

of claims to ensure clinically appropriate utilization. This shall include experience in claims analysis, claims data review for abnormalities, auditing of claims, and setting up edits and audits to ensure proper utilization of benefits. The PS shall also have knowledge and experience concerning the current uses of medications, new or emerging issues, issues related to electronic prescribing, among other general knowledge and experience in the prescription drug benefits.

Educational Requirements
The PS shall be a board trained certified pharmacist with a Doctorate of Pharmacy (Pharm. D) and trained in Biochemistry, Chemistry and Pharmacokinetics.

1.1.7.2. 12 - Chief Actuary
The Chief Actuary shall possess:

Work Experience
A minimum of 5 years actuarial experience, preferably in the pharmaceutical industry.

Educational Requirements
A four year degree from an accredited institution and shall also be a member of the American Academy of Actuaries.

1.1.8 - Other Essential Personnel

1.1.8.1 - Labor Category Personnel

Although not considered key personnel positions, the following labor category personnel may be required for Task Orders issued under this SOW. When required by the Task Order, the respective job classification requirements are essential for performance under this contract. Waiver(s) from the essential personnel requirements may be submitted in writing to the Contracting Officer for approval. All waiver requests should include a copy of a resume along with supporting rationale for the deviation from these requirements.

1.1.8.1.1 - Benefit Integrity (BI) Analyst
The BI Analyst shall possess:

Work Experience
At least 2 years of experience in benefit integrity investigation/detection or a related field that demonstrates expertise in reviewing, analyzing/developing information, and making appropriate decisions Medicare and/or Medicaid experience is preferred.

Educational Requirements

At a minimum, a high school diploma, with preference given to those candidates who have successfully completed college or technical courses related to the position (e.g., law enforcement investigation, statistics, data analysis) and those who have met all requirements to be designated a Certified Fraud Examiner.

1.1.8.1.2 - Senior Benefit Integrity (BI) Analyst
The Senior BI Analyst shall possess:

Work Experience
At least 3 years of experience in benefit integrity investigation/detection or a related field that demonstrates expertise in reviewing, analyzing, and developing information, and making appropriate decisions. At least 2 years of experience in project management. Medicare and/or Medicaid experience is preferred.

Educational Requirements
At a minimum, a high school diploma, with preference given to those candidates who have successfully completed college or technical courses related to the position (i.e., law enforcement investigation, statistics, data analysis) and have met all requirements to be designated a Certified Fraud Examiner.

1.1.8.1.3 - Supervisor - Audit/Reimbursement (S-A/R)
The S-A/R shall possess:

Work Experience
A minimum of 2 years in a Medicare audit and reimbursement setting.

Management skills (planning, organizing, controlling) and demonstrated ability to lead a team.

Understanding of Government Auditing Standards, audit procedures, and financial analysis techniques.

Previous supervisory experience in a Medicare audit and reimbursement setting is preferred.

Educational Requirements
Bachelor's degree in accounting or a related field with a minimum of 24 semester hours in accounting courses. A Certified Public Accountant (CPA) or Certified Management Accountant (CMA) certificate is preferred.

1.1.8.1.4 - Senior Auditor/Reimbursement Specialist (SARS)
The SARS will possess:

Work Experience

A minimum of 2 years of Medicare audit and reimbursement experience.

Educational Requirements
Bachelor's degree in accounting or in a related field with a minimum of 24 semester hours in accounting. A Certified Public Accountant (CPA) certificate is desirable.

1.1.8.1.5 - Auditor/Reimbursement Specialist (ARS)
The ARS shall possess:

Work Experience
One or more years of Medicare audit and reimbursement experience and training to perform all Medicare desk reviews, audits, and settlements as assigned.

Educational Requirements
Bachelor's degree in accounting or in a related field, with a minimum of 24 semester hours in accounting.

1.1.8.1.6 - Accounting/Reimbursement Technician (A/RT)
The A/RT shall possess:

Work Experience
Bookkeeping and personal computer experience.

Working knowledge of Medicare rules and regulations.

Educational Requirements
High school diploma. Accounting and/or business college courses are desirable.

1.1.8.1.7 - Lead Claims Review Analyst
The Lead Claims Review Analyst shall possess:

Work Experience
At least 2 years utilization/quality assurance review and ICD-9-CM/CPT-4 coding experience.

Experience in coding and abstracting, working knowledge of Diagnosis Related Groups (DRGs), Prospective Payment Systems, and Medicare coverage guidelines is required.

Advanced knowledge of medical terminology and experience in the analysis and processing of Medicare claims, utilization review/quality assurance procedures, ICD-9-CM and CPT-4 coding, Medicare coverage guidelines, and payment methodologies (i.e., Correct Coding Initiative, DRGs, Prospective Payment Systems, Ambulatory Surgical Center), NCPDP and other types of prescription drug claims is required.

Ability to read Medicare claims, both paper and electronic, and a basic knowledge of the Medicare claims systems is required.

Educational Requirements
Registered Nurse (RN) or Licensed Practical Nurse (LPN) with an active license.

Additional Requirements for Part D Task Orders:
Work Experience
Advanced knowledge of NCPDP and other types of prescription drug claims is required.

1.1.8.1.8 - Senior Claims Analyst
The Senior Claims Analyst shall possess:

Work Experience
Extensive knowledge of medical terminology and experience in the analysis and processing of Medicare claims is required 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.

Knowledge of Medicare guidelines and coverage is also required.

Ability to read Medicare claims, both paper and electronic, and a basic knowledge of the Medicare claims systems is required.

Educational Requirements
A high school diploma. Must have taken some college-level academic courses in the areas of disease process and human anatomy and physiology.

Additional Requirements for Part D Task Orders:
Work Experience
Extensive knowledge of NCPDP and other types of prescription drug claims is required.

1.1.8.1.9 - Junior Claims Analyst
The Junior Claims Analyst shall possess:

Work Experience
Working knowledge of medical terminology and experience in the review of Medicare electronic and paper claims are required 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.

Educational Requirements

A high school diploma.

Additional Requirements for Part D Task Orders:
Work Experience
Advanced knowledge of NCPDP and other types of prescription drug claims is required.

1.1.8.1.10 - Claims Review Analyst – Therapy
The Claims Review Analyst-Therapy shall possess:

Work Experience
At least 2 years utilization/quality assurance review, as well as ICD-9-CM and CPT-4 coding experience 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.

Experience in coding and abstracting, working knowledge of DRGs, Prospective Payment Systems, and Medicare coverage guidelines, advanced knowledge of utilization review/quality assurance procedures, ICD-9-CM and CPT-4 coding, Medicare coverage guidelines and payment methodologies (i.e., Correct Coding Initiative, DRGs, Prospective Payment Systems, Ambulatory Surgical Center).

Educational Requirements
A Registered Physical Therapist, Registered Occupational Therapist, Registered Speech Language Pathologist/Therapist, or Respiratory Therapist (currently licensed in the respective therapies).

Additional Requirements for Part D Task Orders:

Work Experience
Advanced knowledge of NCPDP and other types of prescription drug claims is required.

1.1.8.1.11 - Clinical Information Specialist
The Clinical Information Specialist shall possess:

Work Experience
At least 4 years clinical or coding experience (CPT-4 and ICD-9-CM), and utilization management, claims systems, and Medicare billing experience.

Educational Requirements
A Registered Nurse (currently licensed) or Registered Record Administrator.

1.1.8.1.12 - Coding Analyst
The Coding Analyst will possess:

Work Experience
Experience in coding and abstracting and working knowledge of DRGs and Prospective Payment Systems is required. Shall have recent experience in utilization review/quality assurance/advanced coding in an acute care facility as well as ICD-9-CM and CPT-4 coding and the ability to read and interpret Medicare claim data.

Educational Requirements
An Accredited Record Technician, and/or Certified Coding Specialist, Registered Nurse (RN), or Licensed Practical/Vocational Nurse (LPN/LVN) with current license and certification.

1.1.8.1.13 - Coding Coordinator
The Coding Coordinator shall possess:

Work Experience
A minimum 5 years coding experience.

Working knowledge of DRG assignment, ICD-9-CM and CPT-4 coding, knowledge of integrated health care systems, electronic medical records and personal computers.

Educational Requirements
An Accredited Record Technician (ART) or Registered Record Administrator (RRA) certification.

1.1.8.1.14 - Data Analyst
The Data Analyst shall posses:

Work Experience
At least 2 years of experience in data analysis as well as demonstrated knowledge of Medicare and Medicaid claims or a combination of education and equivalent work experience. The candidate shall possess knowledge of various database management systems in order to input, extract or manipulate information.

Demonstrated experience and knowledge of health care information (health claims data specifically Medicare and Medicaid), ICD-9-CM codes, physician specialty codes, pharmaceutical data including NCPDP file formats and codes, provider identifiers, etc) is preferred.

Educational Requirements
Bachelor's degree in statistics or related discipline.

1.1.8.1.15 - MAC Liaison

The Fee-For-Service MAC Liaison shall possess:

Work Experience

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

Educational Requirements

Bachelor's degree.

1.2 - Zone Program Integrity Contractor Administration

1.2.1 - Project Management

1.2.1.1 - Project Phases

Work performed as a ZPIC shall occur in either one or a combination of three phases:

- transition
- implementation
- fully operational.

The transition, implementation and fully operational phases, as applicable, will be determined in further detail for each task order and will provide the appropriate period of performance.

1.2.1.1.1 - Transitional Phase

If the ZPIC will be assuming workload(s) from one or more outgoing PSCs, the transitional phase may begin the day after task order award or another appropriate date as deemed necessary during the task order period of performance. This phase will include, but is not limited to, training staff, coordination, testing access to and ability to utilize claims or relevant data. All transitional activities will be included in the agreed upon Transitional Project Management Plan as prescribed under Chapter 1, §1.2.1.2 . The ZPIC shall work closely with all appropriate MMEs for the successful transition of workload(s). At the conclusion of the transition period, a fully operational period will begin. The ZPIC shall assume all functions prescribed in the SOW during the fully operational period.

1.2.1.1.2 - Implementation Phase

If the ZPIC will be developing a workload and/or starting a workload in an area in which no program integrity efforts have occurred, the ZPIC will begin an implementation phase the day after task order award or other appropriate date as deemed necessary during the task order period of performance. This phase shall include, but is not limited to, public relations, initiation of workload(s), training

staff, testing and development of data. The ZPIC shall work closely with all appropriate MMEs for the successful implementation of requirements as outlined in the SOW. All implementation activities will be included in the agreed upon Implementation Project Management Plan as prescribed under Chapter 1, §1.2.1.2. At the conclusion of the implementation period, a fully operational period will begin. The ZPIC shall assume all functions prescribed in the SOW during the fully operational period.

1.2.1.1.3 - Fully Operational Phase

After an implementation and/or transitional phase, the ZPIC is fully responsible for all activities prescribed in the SOW. Fully operational phase activities shall be included in the agreed upon Fully Operational Project Management Plan as prescribed under Chapter 1, §1.2.1.2 . The Fully Operational Project Management Plan shall be updated and modified throughout the task order period of performance.

1.2.1.2 - Project Management Plan

The ZPIC shall submit a Project Management Plan for the Transition and/or Implementation phases as well as the Fully Operational phase.

All project plans shall be modified and updated continuously after these initial submissions to reflect any major changes in the project. A major change is defined as something that shifts the work or plan by at least 30 days. When changes are identified, a draft plan will be submitted for review within 10 days of identifying the change. The appropriate GTLs will provide comments within 15 days and the final plan will be due 10 days after receipt of the appropriate GTL comments. If the appropriate GTL comments are not received within 15 days, the plan is assumed to be final.

Transition Project Management Plan

The ZPIC shall develop and submit a Transition Project Management Plan that defines the milestones, resources, and constraints of the project and addresses how the ZPIC proposes to transition the program integrity workload from the outgoing MME. The Project Management Plan should indicate the specific volume and types of claims, cost reports and benefit integrity workload that the ZPIC proposes to receive as well as timelines for these transitions. The ZPIC shall submit both a draft and a final Transition Project Management Plan during the transition phase. The draft plan and final plan shall include the information described as appropriate as well as in the individual chapters and shall be submitted as prescribed in the Deliverables Schedule.

In addition, the ZPIC shall submit a transition deliverables list no less than every 2 weeks during the transition period.

Implementation Project Management Plan

The ZPIC shall develop and submit an Implementation Project Management Plan that defines the milestones, resources, and constraints of the project and addresses how the ZPIC proposes to implement workload. In developing the Implementation Project Management Plan, the ZPIC shall place particular emphasis on the implementation process, workload, outreach activities, etc. The ZPIC shall indicate the specific implementation process as well as timelines for these implementations. The ZPIC shall submit both a draft and a final Implementation Project Management Plan during the implementation phase. The draft plan and final plan shall include the information described as appropriate as well as in the individual chapters and shall be submitted as prescribed in the Deliverables Schedule.

Fully Operational Project Management Plan

The ZPIC shall develop and submit a Fully Operational Project Management Plan that defines the milestones, resources, and constraints of the project and addresses how the ZPIC proposes to be successful once the fully operational phase is reached. In developing the Fully Operational Project Management Plan, the ZPIC shall place particular emphasis on the changeover from the transition and/or implementation phase. The ZPIC shall submit both a draft and a final Fully Operational Project Management Plan during the fully operational phase. The draft plan and final plan shall include the information described as appropriate as well as in the individual chapters and shall be submitted as prescribed in the Deliverables Schedule.

1.2.1.3 - Kickoff Meeting

Kickoff Meeting with CMS

CMS will arrange a Kickoff Meeting with the ZPIC after award of a Task Order to review the Task Order and answer any questions that the ZPIC has about the Task Order and to ensure that both the ZPIC and CMS have a joint understanding of all work, timeframes and deliverables required by the Task Order. The ZPIC will work with CMS to compile the agenda for this meeting. The ZPIC shall provide CMS with a brief presentation outlining the ZPIC's ideas for completing the requirements of the Task Order. This meeting shall be scheduled as soon as possible but not later than 15 calendar days after Task Order award. The ZPIC is responsible for preparing notes from the meeting and submitting them to their appropriate GTLs three business days after the Kickoff meeting.

Transition Activities

The ZPIC shall work with the outgoing MMEs to transition outgoing activities from these entities. It may also be necessary to transition work from one ZPIC to another ZPIC. On ZPIC to ZPIC transitions, the same transition activities as outlined below shall apply. The incoming ZPIC shall lead the transition teams and shall maintain minutes for all transition meetings and deliverables lists as required.

The ZPICs shall also work with the MACs on jurisdictional alignment as the MACs are awarded. The ZPICs shall coordinate with the MACs to perform the necessary

activities to achieve this alignment with the MACs within the specified timeframes.

In preparing to receive work from the outgoing MMEs, the incoming ZPIC should arrange a Kickoff Meeting with these entities. This meeting shall be held no later than 30 calendar days of the Task Order award. During the kickoff meeting, the ZPIC shall work with the outgoing MMEs to develop a final transition plan. The transition plan shall include, at a minimum, the following information:

- A list of transition workgroup members (e.g., benefit integrity, medical review and public relations).

- A list of all deliverables necessary to ensure a smooth transition between the outgoing MMEs and/or the ZPIC and the dates upon which these will be sent to the ZPIC.

- A schedule for when the workload will actually be shipped to the ZPIC (i.e., dates potential fraud cases and medical review cases will be sent to the ZPIC).

- A general orientation and a listing of the existing cost report audit workload, including identification of problem providers, and the identification of key issues/problems encountered.

- The dates when the ZPIC shall assume various functions prescribed in the SOW during the transition period.

- The ZPIC shall work with the outgoing MMEs to determine the appropriate types and timing of communication and education activities needed to inform providers about the ZPIC's role. These activities will address issues such as ensuring that, in response to development requests, providers send their documentation directly to the ZPIC instead of to the outgoing MME.

The ZPIC shall be responsible for providing meeting minutes and deliverables for all transition activities no later than 3 business days following each meeting.

The ZPIC and the outgoing MME shall work jointly to develop packing and forwarding procedures for the transfer of records during the transition. The outgoing MME shall be responsible for packaging and moving all files and the ZPIC shall be responsible for receiving and accepting these packages.

The outgoing MME will also meet at later dates to review the status and actions taken on all work being transitioned. At this time, the ZPIC shall obtain a general orientation and a listing of the existing cost report audit workload, including identification of problem providers and the identification of key issues/problems encountered. Following this kickoff meeting, the ZPIC shall, at a minimum, obtain the following:

Cost Reporting

- Cost report audit and reimbursement records for all unsettled cost reports and all settlements under appeal and reopening.
- Most recently settled cost reports, cost report audit work papers, and provider permanent files.
- Prior year's settled cost reports and cost report audit work papers.
- Base period and rate setting files.
- Periodic Interim Payment (PIP) records and files.
- Interim rate files, including hospital rates for Medicare inpatient capital related costs under the Prospective Payment System (PPS).
- Final rate files and payment methodology determinations for Medicare inpatient capital related costs under the PPS.
- Latest Provider Statistical and Reimbursement (PS&R) data, annual provider survey, and payment reconciliation reports.
- The AC's or MAC's reimbursement guidelines and any reimbursement directions/letters sent to providers.
- Status of AC or MAC provider appeals.
- The ZPIC shall establish a cut-off date for the outgoing MEDIC and/or the outgoing PSC and ZPIC, at which point the outgoing MEDIC and the outgoing PSC will take no further reimbursement action.

Fraud Reporting

- Provider tracking information, including a listing of providers.
- Current providers under payment suspension.
- Current claims reviewed, either prepayment or postpayment.
- Current providers being investigated for potential fraud or other allegations.
- Active potential fraud cases.
- Closed potential fraud cases (see PIM definition for closed fraud case).

- All complaints pending and closed against providers in their jurisdiction.

Transition Meetings

When applicable, the incoming ZPIC and outgoing MMEs shall work together to transition activities from the outgoing MME to the incoming one (e.g. PSC to ZPIC). The incoming ZPIC, with assistance from CMS, shall lead the transition teams and shall maintain minutes for all transition meetings and deliverables lists as required. The outgoing MME shall review all transition deliverables from the incoming ZPIC and provide any comments on the deliverables three business days after receiving the product.

At the first transition meeting, the outgoing MME shall work with the incoming contractor and CMS to develop final transition planning documents. The final transition planning documents shall include, at a minimum, the following information:

- Contact List: A list of transition workgroup members (i.e., benefit integrity, pharmacy specialist, public relations, etc) and their contact information. This shall be due five business days after the meeting.

- Transition Deliverables List: A list of all deliverables necessary to ensure a smooth transition between the appropriate outgoing MME and the incoming ZPIC and the dates on which these will be sent to the incoming ZPIC. This shall be due 10 business days after the meeting.

- Workload Release Dates and Transfer Procedures: A schedule for when the records will actually be shipped to the incoming ZPIC (i.e., dates potential fraud cases and medical review cases will be sent to the ZPIC). This shall be due 10 business days after the meeting. The outgoing MME and incoming ZPICs shall work jointly and with CMS to develop packing and forwarding procedures for the transfer of records during the transition. The outgoing MME shall be responsible for packaging all files, maintaining packing lists of box contents and moving these packages to the incoming ZPIC. The incoming ZPIC shall be responsible for receiving, accepting and verifying the contents of these packages. The above information shall be incorporated into the project management plan by the ZPIC, as described above in section 1.2.1.2, as soon as it is determined.

- Workload Review: a general orientation and a listing of the existing workload, including identification of problem entities (e.g. pharmacies, providers), and the identification of key issues/problems encountered during the outgoing MME's period of performance due 10 business days after the meeting. The appropriate outgoing MME shall provide the following to the incoming ZPIC:

    - Entity and individual tracking information, including a listing of the entities

and individuals involved with the Medicare and Medicaid program referenced in the incoming ZPIC's task order(s)

- Current entities or individuals who have been under sanction or are currently under sanction.
- Current claims reviewed either prepayment or postpayment.
- Current entities or individuals being investigated for potential fraud or other allegations.
- Active potential fraud cases.
- Closed potential fraud cases (see PIM definition for closed fraud case).
- All complaints pending and closed in the incoming ZPIC's zone.
- A list of entities that require further review
- Education logs of plans, providers, and subcontractors

- Work Start Dates: the dates when the incoming ZPIC shall assume various functions prescribed in the SOW during the transition period. This information shall be incorporated into the project management plan by the incoming ZPIC.

- Education of Providers: the appropriate types and timing of communication and education activities needed to inform providers about the incoming ZPIC's role. These activities will address issues such as ensuring that, in response to development requests, providers send their documentation directly to the incoming ZPIC instead of to the appropriate outgoing MME. This information shall be incorporated into the draft and final public relations plan by the incoming ZPIC.

The outgoing MME, CMS and the incoming ZPIC shall also meet on later dates, as needed, to review the status and actions taken on all work being transitioned to ensure that all work is efficiently and effectively exchanged between the outgoing MME and the incoming ZPIC. The incoming ZPIC and CMS shall be responsible for scheduling these subsequent meetings. The incoming ZPIC shall also be responsible for providing meeting minutes for the initial meeting and for all subsequent transition meetings no later than 5 business days following each meeting. The outgoing MME shall have 3 business days after receipt of these notes to comment on them.

Implementation Activities

The ZPIC shall work with CMS to implement activities. The ZPIC shall lead the

implementation team and shall maintain minutes for all implementation meetings and deliverables lists as required.

The ZPIC shall be responsible for providing meeting minutes and deliverables for all transition activities no later than 3 business days following each meeting.

1.2.2 – Financial Management

1.2.2.1 - CMS Analysis, Reporting, and Tracking System (CMS ARTS)

The CMS Analysis, Reporting, and Tracking System (CMS ARTS) is the system utilized by CMS to track and analyze ZPIC costs, hours, workload, performance, production and other features as may be developed. Information on the use of CMS ARTS can be found on-line within the User Guide section of the system and Appendix K, CMS Cost Reporting Definitions. The current web site for CMS ARTS is http://www.cmsartsystem.com/prod1206. Changes to the web address will be communicated to the ZPIC via the News/Updates feature of the CMS ART system.

The ZPIC shall submit the following in the CMS ART system:

- Monthly cost report that details all costs incurred for the previous month. A cost report may be submitted in hard copy with the monthly voucher. However, it shall be submitted electronically no later than the 20th of each month.

- Deliverable reports as defined in Appendix A, Deliverables.

All significant CMS ART system changes will be communicated to the ZPIC via the News/Updates feature of the CMS ART system.

1.2.2.2 - Payments from Providers or Beneficiaries

Should the ZPIC receive checks or other forms of financial payment from providers or beneficiaries, the ZPIC shall forward them via overnight mail to the appropriate MMEs. Before forwarding, the ZPIC shall make copies of and otherwise document these payments and transfers to the appropriate MME.

1.2.2.3 - Funding for Coordinated Zone Program Integrity Contractor/Appropriate MMEs

CMS will work closely with the appropriate MMEs and the ZPIC to establish a process to identify those costs associated with implementing this contract and the ongoing cost of coordination activities. CMS will provide a separate source of funds to the appropriate MMEs for carrying out program integrity-related activities on

which the ZPIC relies to do its work. These funds will be for activities or levels of activities that are over and beyond what MMEs normally would do for their operations, for sound stewardship, and for internal controls. Activities that might be funded in part under this arrangement include Automatic Data Processing (ADP), provider bulletins, and so on. The specific details of this funding process will be conveyed to the ZPIC and the appropriate MMEs during performance of the work.

1.2.3 - Deliverables

1.2.3.1 - Deliverables

Timely deliverables are critical to the success of the ZPIC contracts. Timely is defined as the deliverables being received by all parties by the due date referenced in the deliverable schedule. For e-mail deliverable submissions, the received date is the date the deliverable is e-mailed by the ZPIC to the recipient(s). Hard copy mail delivery is considered received on the date it arrives in the hands of the recipient(s). If deliverables are required in both electronic and hard copy, the e-mail copy shall be submitted by the due date. If the ZPIC anticipates problems with a deliverable, it should take steps to forward the deliverables earlier than the due date so that problems can be resolved prior to the due date. The ZPIC shall submit to its appropriate GTL and the Contracting Officer, at the end of the contract year, a CD ROM containing all the deliverables listed in Appendix A, Deliverables. The ZPIC shall submit the deliverables specified in Appendix A, Deliverables, of this SOW and/or the Task Order Statement of Work (SOW).

1.2.3.2 – Reporting Requirements

1.2.3.2.1 - Project Management Plan

The ZPIC shall develop a Project Management Plan in accordance with Chapter 1, §1.2.1.2 of this umbrella SOW. The plan shall be submitted as detailed in the following sections.

1.2.3.2.1.1 - Transition Phase

During the Transition Phase, the ZPIC shall submit both a draft Transition Project Management Plan and a final Transition Project Management Plan. These will be submitted in the form of Microsoft Project Management or an equivalent software package with applicable narrative information.

The draft Transition Project Management Plan shall include, at a minimum, the following:

- Work breakdown

- Key staff types devoted to each task or activity, if appropriate, and time allocation for each to ensure that sufficient and qualified personnel are available to accomplish all contractual requirements

- Key milestones signifying successful completion of each task and periodic internal assessment/progress reports planned

- Activity interdependency and critical path for completion of all tasks

- Equipment - The ZPIC shall provide an update to ensure all necessary equipment (e.g., telephones, PCs and T1 lines) is available to accomplish all contractual requirements.

- Space - The ZPIC shall provide an update to ensure that adequate building accommodations are available to house all staff and equipment. The ZPIC shall also ensure that a sufficiently-sized conference room is available to hold meetings among internal personnel (e.g., department staff meetings, board meetings) and with external groups (e.g., meetings with CMS staff).

The final Transition Project Management Plan shall include, at a minimum, the information identified above for the draft plan, plus:

- A list of transition workgroup members (e.g., benefit integrity, medical review and public relations)

- A list of all deliverables necessary to ensure a smooth transition between the appropriate MME and the ZPIC and the dates upon which these will be sent to the ZPIC or MME

- A schedule for when workload will actually be shipped to the ZPIC (i.e., dates that potential fraud cases and medical review cases will be sent to the ZPIC)

- The dates when the ZPIC shall assume various functions prescribed in the SOW during the transition period

1.2.3.2.1.2 - Implementation Phase

During the Implementation Phase, the ZPIC shall submit both a draft Implementation Project Management Plan and a final Implementation Project Management Plan. These will be submitted in the form of Microsoft Project Management or an equivalent software package with applicable narrative information.

The draft Implementation Project Management Plan shall include, at a minimum, the following:

- Work breakdown

- Key staff types devoted to each task or activity, if appropriate, and time allocation for each

- Key milestones signifying successful completion of each task and periodic internal assessment/progress reports planned

- Activity interdependency and critical path for completion of all tasks

The final Implementation Project Management Plan shall include, at a minimum, the information identified above for the draft plan, plus:

- A list of implementation workgroup members (i.e., benefit integrity, medical review, public relations, etc.)

- A list of all deliverables necessary to ensure a smooth implementation between the appropriate MME and the ZPIC and the dates upon which these will be sent to the ZPIC or MME

- A schedule for when workload will actually be implemented.

1.2.3.2.1.3 - Fully Operational Phase
The Fully Operational Project Management Plan shall include, at a minimum, the following:

- Work breakdown in accordance with ZPIC SOW Chapter 1, §1.2.1.2.

- Key staff types devoted to each task or activity, and if appropriate, time allocation for each

- Activity interdependency and critical path for completion of all tasks

- A schedule for when milestones will be reached by the ZPIC

During the fully operational phase, the ZPIC shall perform all of the requirements in this umbrella SOW and/or Task Order.

1.2.3.2.2 – Transition Deliverables List
The ZPIC shall submit to the transition workgroup members, including the appropriate GTLs, the outgoing MMEs, an updated listing of deliverables due from the outgoing MMEs to the ZPIC throughout the transition period. Information shall include, at a minimum, the task name, status, duration, start date, finish date, and

resources responsible for completing the task.

1.2.3.2.3 – Implementation Deliverables List
The ZPIC shall submit to the implementation workgroup members, including the appropriate GTLs, the outgoing MMEs an updated listing of deliverables due from the outgoing MMEs to the ZPIC throughout the implementation period. Information shall include, at a minimum, the task name, status, duration, start date, finish date, and resources responsible for completing the task.

1.2.3.2.4 – Fully Operational Deliverables List
Refer to Appendix A, Deliverables, and the Task Order Statement of Work for a list of deliverables due during the fully operational period.

1.2.3.2.5 - Joint Operating Agreement - Draft and Final
As applicable, a Joint Operating Agreement (JOA) shall be developed and maintained by the ZPIC to provide a documented means of identifying roles and responsibilities of the ZPIC and the appropriate MMEs. The ZPIC shall submit a draft written JOA to the appropriate Government Task Leader *(*GTL*)*, and the appropriate MMEs for comment in accordance with Appendix A. The ZPIC shall submit a final written JOA to the appropriate GTLs, and appropriate MMEs in accordance with Appendix A. The ZPIC shall obtain the appropriate MME and ZPIC signatures on the JOA and submit the final signed JOA in accordance with Appendix A. The ZPIC shall furnish a copy of the signed JOA to the appropriate GTLs, Contract Specialist, and the appropriate MMEs. The FFS Medicare task order shall be responsible for the AC/MAC JOA deliverable. However, the AC/MAC JOA shall include Medicare Fee-For-Service and Medi-Medi.

1.2.3.2.6 - Public Relations Plan
A public relations plan shall be submitted addressing how public relations, including, but not limited to, provider, medical society, Part D Plan, Medicare Advantage (MA) Plan, Retiree Drug Subsidy (RDS) sponsor, beneficiary and law enforcement outreach activities will be handled for each phase of the Task Order. The ZPIC shall submit to the appropriate GTL a draft public relations plan within 45 calendar days after the award of the Task Order and a final public relations plan within 60 days after the award of the Task Order. The appropriate GTL will provide comments on the draft plan within 5 days. The ZPIC shall incorporate all comments received and submit the final public relations plan no later than 60 days after contract award.

1.2.3.2.7 - Lessons Learned Reports
The Transition Lessons Learned Report shall include, at a minimum, the following items:

- Items that worked particularly well during the transition of the ZPIC workload

- Recommendations and insight into resolution of unanticipated problems

- Identification of other problems not anticipated at the beginning of the transition

The ZPIC shall submit a Transition Lessons Learned Report no later than 30 days after transition, which addresses areas that could be improved in future transitions. The transition report shall identify lessons learned after the first year of assuming the incumbent workload.

The Implementation Lessons Learned Report shall include, at a minimum, the following items:

- Items that worked particularly well during the implementation of this Task Order

- Recommendations and insight into resolution of unanticipated problems

- Identification of other problems not anticipated at the beginning of the contract

- Particular systems issues that made implementation of this contract challenging

- Identification of changes or recommendations that CMS should pursue when awarding another ZPIC Task Order for the same or similar work

The ZPIC shall submit an Implementation Lessons Learned Report no later than 30 days after completion of the first year of the Task Order. The implementation report shall identify lessons learned during the first year of the task order.

1.2.3.2.8 - Cost Report

The Cost Report will be submitted monthly for the prior month's activities in the CMS ART System. The report shall include, at a minimum:

- A summary of costs incurred (by each SOW section) during the previous month, in business proposal format;

- A narrative report of expenditures by each SOW section that exceeds 10% above or below the estimated expenditures, per SOW section, for the period of time that is being reported;

- Cumulative costs incurred to date on the Task Order;

- Funds remaining to be incurred on the Task Order;

- Costs by labor category, labor hours, labor rates, travel, subcontracts;

- Itemization of Other Direct Costs incurred;

- Narrative about the previous months significant activities by task; and

- Narrative on vulnerabilities identified throughout the month. Additionally, any time a vulnerability is identified, the ZPIC shall enter the vulnerability in the appropriate narrative in the ZPIC monthly cost report and send an e-mail with all of the pertinent information to vulnerability@cms.hhs.gov.

1.2.3.2.9 - Self-Assessment Report
The Self-Assessment Report shall capture a self-assessment of achievements and deficiencies, as well as, at a minimum, the items contained in the next two sections.

The ZPIC shall submit a self-evaluation that provides data on its past yearly performance in accordance with the following schedule.

Task Orders with Annual Renewals	5.5 Months Prior to anniversary date
Task Orders with Options	4.5 Months Prior to anniversary date

1.2.3.2.9.1 - Annual Self-Assessment Report
The ZPIC shall submit a self-assessment report 5.5 months prior to completion of the Task Order performance period, which addresses its performance over the past year. This report will be reviewed by the CMS, or other evaluation staff, when performing an assessment of contractor performance over the previous year.

The report shall include:

- The self-assessment format (which will be provided to the ZPIC one month prior to the due date), indicating how the ZPIC performed broken out by Quality of Product or Service, Cost Control, Timeliness of Performance, and Business Relations

- Recommendations for areas that could be improved

- Identification of problems not anticipated throughout the year

- Recommendations and insights into resolution of the unanticipated problems

- Areas of innovation where the ZPIC has gone above and beyond the SOW requirements

1.2.3.2.9.2 - Award Fee Plan Evaluation
The ZPIC shall submit a report on its performance IAW the award fee

evaluation criteria identified in each of the Task Order award fee plans.

1.2.3.2.10 - Information Technology Systems Plan
The ZPIC shall develop an IT Plan in accordance with Chapter 1, §1.5.3 of this umbrella SOW.

The Information Technology (IT) Systems Plan shall include, at a minimum, the following:

- Description of the ZPIC's data access plan, including the ZPIC's plan for, at a minimum, establishing read-only access to the appropriate MME's claims processing shared system(s) configuring the applicable data (i.e. Medicare Parts A, B, C, D, DME, HH+H and Medicaid), and obtaining denial data from the appropriate MME.

- Description of assumptions and constraints under which each type of analysis shall be performed.

- A list and description of data files necessary to conduct the data analysis.

- A list and description of data the ZPIC would be required to access from either CMS or the AC(s), MAC(s) or plan sponsors.

- Schedule of how often new or updated data would be needed.

- Description of the software systems, products, and tools that are being proposed for use under this Task Order, including the licensing restrictions.

- Certification that the hardware and software being proposed have the capacity to manipulate the anticipated volume of data.

- Description of how the ZPIC plans to use the hardware and software products.

- Description of how the ZPIC will ensure compliance with The Privacy Act of 1974 and CMS ZPIC Security Requirements (see SOW Chapter 1, §1.5).

- Discussion of how the proposed ZPIC data systems environment is appropriate, given CMS' system architecture.

- Other items as identified by the ZPIC.

1.2.3.2.11 - Systems Security Reporting
All requirements are identified in Appendix U, Business Partners System Security Manual.

1.2.3.2.12 - Freedom of Information Act Reports

The ZPIC shall submit an Annual FOIA Report in accordance with Appendix A, Deliverables. Since the format and due date for the Annual FOIA report varies annually, this will be communicated to the ZPICs by the CMS FOIA Coordinator at a later date.

The ZPIC shall also submit the following Freedom of Information Act (FOIA) deliverables IAW the FOIA Policy and Procedural Guide in Chapter 6 of Pub. 100-1 (Appendix H of the umbrella SOW):

- CMS Form 632 (FOIA Request Form)
- Contractor Summary Sheet
- Freedom of Information Log

If no requests are received in a particular month, the ZPIC shall submit the Contractor Summary Sheet indicating "0" requirements for that month. If no requests are received, the ZPIC does not need to submit the FOIA log that particular month.

1.2.3.2.13 - Law Enforcement Requests Report

The ZPIC shall submit a report on a quarterly basis broken out by each month, listing each Priority I and Priority II request for information that it receives from law enforcement each month. The report shall include, at a minimum, the costs and time required (estimated, where actual is not available) to fulfill each request and the status of each action. The ZPIC shall submit this report to the appropriate GTL on the 15th (i.e., 1/15, 4/15, 7/15, 10/15) of the month beginning each quarter, for the previous quarter's effort.

1.2.4 – Award Fee/Zone Program Integrity Contractor Performance Evaluation

1.2.4.1 - Award Fee

An Award Fee Evaluation Plan will be incorporated in all task orders issued on a cost plus award fee basis. The Award Fee Evaluation Plan defines the terms and the evaluation criteria for the award fees.

1.2.4.2 - Zone Program Integrity Contractor Performance Evaluation

The ZPIC shall successfully perform the specific requirements defined in this

Statement of Work, Medicare and Medicaid laws, regulations, manuals, instructions and any additional responsibilities assigned by the Contracting Officer. The ZPIC shall provide complete and accurate information, as requested by CMS, in order for its performance to be effectively evaluated. Specific minimum performance requirements are listed for some tasks. Where specific minimum requirements are not listed, the basic standard is assumed to be an accurate, timely, high-quality product that effectively performs its intended function. The Performance Evaluation Team (PET) may review performance on any and all requirements contained in this Statement of Work that apply to the Task Orders that the ZPIC has been awarded. Failure to meet the basic performance standards could result in administrative actions such as a reduction in work volume.

1.2.4.2.1 - Evaluation Overview

The Government will evaluate the ZPIC's performance on an annual basis for each Task Order.

1.2.4.2.2 - Objectives

The objectives of the CMS ZPIC Performance Evaluation Program are to:

- Measure and evaluate the ZPIC's performance
- Identify opportunities to improve performance
- Provide a fair and accurate system of review for CMS' use in ensuring effective and efficient Medicare and Medicaid program administration.
- Assess the degree to which the ZPIC's direct and indirect customers are satisfied with the services performed by the ZPIC.

1.2.4.3 - Evaluation

The CMS Project Officer will conduct a review of the ZPIC's performance with the appropriate Government Task Leaders (GTLs), Contracting Officer, and other CMS staff as required. CMS reserves the right to monitor any aspect of the ZPIC's operation at any time and is not limited to those areas specifically stated herein or in the Task Order Statement of Work.

CMS will provide the ZPIC with general information about the review process but is not obligated to provide the ZPIC with specific details relating to how the reviews will be conducted. The ZPIC is expected to perform effectively and efficiently in all areas of its operations, including those areas not specifically evaluated. CMS may elect to evaluate performance for any or all activities performed by the ZPIC.

1.2.4.3.1 - Annual Performance Evaluation Process

CMS will continuously monitor the ZPIC during the period of performance of this Statement of Work. The first annual performance evaluation review will be conducted approximately 6 months after each Task Order award. The purpose of the annual performance review is for CMS to, at a minimum, assess the ZPIC's overall performance to date, determine whether to award any upcoming option or renewal years, calculate the value of any incentive award as appropriate under this contract and/or determine whether the umbrella contract should be renewed.

The ZPIC shall register in the National Institutes of Health Contractor Performance System (NIH CPS) at http://cps.od.nih.gov, in order to receive and respond to performance evaluations. Dates are calculated from a 1 year anniversary date of receiving a Task Order and annually thereafter. For a Task Order with a period of performance less than 1 year, a performance evaluation process will be appropriately tailored to the Task Order.

1.2.4.3.2 - Performance Evaluation Data Sources

Below are examples of some of the data sources that the Performance Evaluation Team (PET) may use in evaluating the ZPIC's performance:

- ZPIC Supplied Data - The ZPIC shall prepare a self-evaluation that contains data on its performance specified by the PET. The data from the ZPIC self-evaluation will be considered as part of the annual performance evaluation.

- CFO Audit - In addition to the financial reporting requirements required by CMS to comply with the Chief Financial Officer (CFO) Act, CMS may periodically require the ZPIC to have a financial or internal control audit performed by an external auditor.

- Internal Controls - CMS may periodically conduct internal control reviews of the ZPIC. When these reviews are available, the PET will consider the information contained in them as part of its evaluation.

- ISO Compliance Report - The PET will consider the comments made by the registrar in assessing the ZPIC for ISO certification. See Chapter 1, §1.6.1.1.4, ISO Registration, for more information.

- PET Investigations - The PET may conduct primary investigations into any aspect of the ZPIC activities as part of the evaluation process. These investigations will be included as part of the annual performance evaluation.

1.3 – Benefit Integrity

1.3.1 - General

ZPIC personnel shall share, consult, and coordinate efforts with all internal and external partners (e.g., CMS, law enforcement, ACs, MAC, state agencies, different components within the same ZPIC, other ZPICs and the Plans) to ensure that the ZPIC's mission is being met.

The ZPIC shall review and analyze a variety of data in order to focus its program integrity efforts by identifying vulnerabilities and/or specific providers for review and investigation within its zone, referral of potential fraud, waste and abuse cases to law enforcement, and pursuance of administrative actions. Further, the ZPIC shall be proactive and aggressive in pursuing many different sources and techniques for analyzing data in order to reduce any of its risks within this SOW.

1.4 – Requests for Information

1.4.1 - Customer Service

Beneficiaries, providers, and others may have questions about the Medicare program, need instructions on how to complete a claim form, question why a claim was denied, or have other inquiries regarding a Medicare contractor's work. These inquiries may be in writing, by e-mail, or by telephone. The appropriate MME will have the primary responsibility for customer service; however, the ZPIC plays an important role in customer service.

1.4.1.1 - Zone Program Integrity Contractor Denial Inquiries

The ZPIC shall use its systems, augmented by access to the AC or MAC shared systems, or other systems as necessary, to respond to inquiries. The ZPICs shall be available on an ad hoc basis to respond to questions regarding ZPIC denials. ZPICs shall respond to denial inquiries within two business days.

1.4.1.2 - Telephone, Written, and Misdirected Inquiries

Where applicable, the ZPIC shall develop a JOA process for the appropriate MMEs to handle inquiries involving denials made by the ZPIC or any other inquiries, misdirected or otherwise.

1.4.1.3 - Other

Since program integrity functions have been a part of the activities undertaken by many different entities, there may be confusion with beneficiaries or providers as to who is responsible for which areas. In order to avoid confusion, the ZPIC shall take responsibility for ensuring that it will either resolve the matter or transfer the matter

to the appropriate entity for resolution.

NOTE: The ZPIC must work collaboratively with law enforcement agencies and other MMEs. The ZPIC shall prepare and maintain costs and estimated time needed to fulfill requests for information.

1.4.2 - Requests from Law Enforcement Agencies and Other Entities

The ZPIC shall fulfill all requests from law enforcement agencies and other entities in accordance with PIM Chapter 4, §4.4.1 and Appendix M as applicable.

1.4.3 - Freedom of Information Act Requests

The ZPIC shall process requests from members of the public for records/information within its files in accordance with the Freedom of Information Act (FOIA) (5 U.S.C. 552). Specifically, the ZPIC shall adhere to FOIA policy, procedure, and instructions contained within the Department of Health and Human Services FOIA regulations at 45 C.F.R. Part 5, Chapter 6 of IOM Pub. 100-1, the FOIA Policy and Procedural Guide, and any supplemental guidance issued by the Centers for Medicare & Medicaid Services (CMS) Freedom of Information Officer.

- The ZPIC's primary CMS FOIA contact shall be with the Regional Office (RO) FOIA coordinator that is located in the RO where the RO GTL is located.
- The primary contact for Part C and D requests shall be with the Central Office (CO) FOIA Coordinator for the Office of Financial Management.
- The ZPIC shall be responsible for all FOIA requests that pertain to ZPIC documents and should ensure that requests applicable to the AC are forwarded to the RO FOIA Coordinator so they can be forwarded to the AC within 30 days of receipt.
- Requests applicable to the DME MAC go to the DME MAC FOIA contact within 2 days of receipt.
- Requests applicable to the A/B MAC go to the MAC Contracting Officer within 2 days of receipt.
- If the ZPIC does not have a RO GTL, the primary CMS FOIA contact shall be the Central Office FOIA Coordinator for the Office of Financial Management.
- Contact information for the ZPIC's FOIA Coordinator shall be obtained by the ZPIC from the CMS Central Office FOIA Officer.
- If the ZPIC determines that FOIA costs will have a significant budgetary impact, the ZPIC shall notify the GTLs immediately.

1.4.4 - Ad Hoc Requests from the Centers for Medicare & Medicaid Services

CMS may need information on an ad hoc basis regarding its ZPICs' program integrity activities, often in regard to ZPIC activities dealing with a specific provider.
The ZPIC shall provide such information upon request.

1.5 – Information & Technology Systems and Security

1.5.1 - Access to Systems

1.5.1.1 - Data Use Agreement

The ZPIC 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 ZPIC of these requirements and a means of obtaining their agreement to abide by these requirements. The DUA shall be submitted to the appropriate GTLs no later than 30 days prior to the fully operational phase.

To create a DUA, the ZPIC shall complete the CMS DUA form (see Appendix Y, Data Use Agreement) and submit it the appropriate GTL for review. The appropriate GTL will then 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 ZPIC shall complete a DUA supplement to obtain access to that information.

1.5.1.2 - Other Systems Access Requirements

Within 30 days of Task Order award, the ZPIC shall have:

- Met with the ACs and MACs and AT&T Global Network Services (AGNS) team to collect required IT and other information about existing AC or MAC AGNS connectivity
- Created a network diagram detailing the proposed AGNS networking changes
- Submitted this detailed diagram via e-mail to the appropriate GTL for the ZPIC for prioritization and processing
- Where necessary, contact a network supplier to obtain access to MDCN.

All system access shall be completed by the time the ZPIC assumes responsibility for the new work, unless circumstances are beyond the control of the ZPIC.

The ZPIC shall have all employees requiring access to CMS systems complete an

Application for Access to CMS Computer Systems to obtain a user ID. The ZPIC shall submit this form to the CMS Central Office GTL for routing to the Resource Access Control Facility (RACF) administrator.

1.5.1.3 – Data Analysis Tools Available to the ZPIC at No Cost

While the ZPIC should continually review and implement innovative methods of data analysis techniques, data analysis tools available to the ZPIC at no cost through CMS licenses are as follows:

- Services, Tracking, Analysis, and Reporting System (STARS) – STARS is a PC-based health care data analysis tool. At the core of the STARS system is its data warehouse, which contains many months of adjudicated claims data and many types of ancillary data. This data can be used in different ways to find pertinent facts.
- LOLA (Limited On-Line Access) Plus - LOLA Plus is a system that was originally developed for use by contractors processing claims on the Arkansas System, but has been adapted to work with data from the Fiscal Intermediary Shared System (FISS). LOLA Plus was developed for experienced Medicare professionals who specialize in analyzing claim data for the purposes of identifying areas of potential fraud, waste and abuse. LOLA Plus queries do not yield absolute indications of aberrancies and any inferences drawn or action taken based on the results of a query are the sole responsibility of the persons using the LOLA Plus system. LOLA Plus links a vast array of off-the-shelf PC data analysis and manipulation tools to a database containing at least 18 months of detailed claim information.

  LOLA Plus allows four types of reports (called queries) to be requested:
  - Detailed queries that retrieve data from a specific claim or claims.
  - Summary queries that group similar claims together.
  - Trend queries that measure change for a particular Medicare issue over time.
  - Ping Pong queries that determine if one Medicare patient has received treatment from an unusually large number of different Medicare facilities.

  LOLA Plus data is taken from the contractor's Part A Claims Processing System and stored on the LOLA PLUS server. This allows access to the data from a PC without requiring connection to a mainframe. Most LOLA Plus users have access to 24 months of claim data. The data is refreshed every seven days. At the end of each quarter, claims for the earliest quarter in the database are removed.

  Queries may be done on either a sample drawn by LOLA or a universe. Future enhancements will modify LOLA Plus to reflect more closely FISS conventions. Most data elements from the shared system record are included in the LOLA Plus

database. A complete description of the system and the elements are included in an interactive users guide bundled with the system. A LOLA PLUS users group currently exists. The purposes of the group are to provide additional information on the use of the system and for users to identify additions to the system. The group meets monthly.

1.5.2 - Systems

1.5.2.1 - General System Requirements

The shared claims processing system for carriers and MACs is the Multi-Carrier System (MCS). The shared claims processing system for Fiscal Intermediaries (FIs) and MACs is the Fiscal Intermediary Standard System (FISS). The DME MACs continue to use the VMS system as their shared claims processing system.

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

The ZPIC shall submit change requests to the appropriate GTL as appropriate in accordance with the CMS Change Management process.

Each Part D, MA, and RDS sponsor will have their own claims processing system. The Part C and D sponsors are required to send the prescription drug event data elements listed in Appendix N, Prescription Drug Event Data. These elements will be stored in a database at the CMS Data Center.

1.5.2.2 - Functions to be Performed on a Specific System

Some ZPIC functions shall be performed using the Shared Claims Processing System. Other ZPIC functions shall be performed using the ZPIC's own computer system. It is incumbent upon the ZPIC to work with the AC and MAC to ensure that, in accessing the latter's systems, the ZPIC does not corrupt or degrade processing time through its actions, or cause system rejects or other downtime. The ZPIC shall clear any changes it proposes to AC and MAC systems with the AC and MAC prior to submitting the proposed change to the appropriate change control board.

1.5.2.2.1 - Functions to be Performed Using the Shared Claims Processing Systems

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

- Specify the program integrity prepayment edit criteria. Those ZPICs who have read and write access to their AC's and MAC's shared system are responsible for working their edits into the system in accordance with the edit differentiation chart; those with read-only access are to coordinate the implementation of these edits into the system with their AC or MAC.

- Manage the workflow of prepayment claims requiring manual review.

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

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

- Document the claim review findings.

- Access other online applications in the AC's or MAC's Shared Claims Processing System as necessary.

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

1.5.2.2.2 - Functions to be Performed Using the ZPIC System

CMS will not develop a "standard" ZPIC system. However, the ZPICs shall plan, design, and develop their own systems. The ZPIC shall provide and use hardware/ software to:

- ~~Operate supplemental edit software. This software will make automated coverage or local coding determinations on certain claims suspended by the appropriate MME's Shared Claims Processing System. The software shall be selected by the ZPIC, which will decide what the most effective combination of software packages given its workload.~~

- Communicate efficiently (e.g., e-mail) within its own departments, other specialty contractors (when implemented), CMS, ACs and MACs within the ZPIC's zone.

- Provide systems to compile information for management reports.

- View the claims attachment images, if applicable.

- View the PDE or payment attachment images, if applicable;

- Track ZPIC workload information or actions such as potential fraud

investigations, complaints, administrative actions for a specific provider, etc;

- Receive any applicable Medicare financial reports;
- Analyze PDE claims data and other Part D data;
- View the financial document images from the Part D Plans, as applicable;
- Analyze MA and RDS data;
- Provide systems to compile information for management reports (described in SOW Chapter 1, §1.2.3, Deliverables).
- View the claims attachment images, if applicable.

1.5.2.2.3 - Functions to be Performed Using Either System

For any task not listed in sections 1.5.2.2.1 or 1.5.2.2.2, above, the ZPIC has the discretion to perform the task on the ZPIC's own system, on the AC's or MAC's Shared Claims Processing System, or on the AC's or MAC's supplemental edit software. Examples include but are not limited to:

- Systems to track ZPIC workload information or actions such as BI investigations, complaints, administrative actions for a specific provider, etc.
- The capability to electronically receive any applicable Medicare cost reports using the software from any CMS-approved vendor
- System to analyze claims data and other provider data

1.5.2.2.4 - Imaging

The ZPIC shall work with the appropriate MME to ensure all imaged claims attachments are available to the ZPIC via the Shared Claims Processing System, if the MME has this feature.

1.5.2.3 - Hardware and Software Testing

1.5.2.3.1 - Affiliated Contractor and Medicare Administrative Contractor Shared Claims Processing System

The ZPIC, in conjunction with the appropriate MMEs, shall develop and implement a plan to thoroughly and completely test all relevant ZPIC interfaces with the existing shared claims processing system prior to the date the ZPIC shall begin performing prepayment claim reviews. The ZPIC shall also participate as necessary in the testing of any changes to the shared claims processing system(s) that may affect ZPIC interfaces.

1.5.2.3.2 - Zone Program Integrity Contractor Systems
The ZPIC shall thoroughly test all of the systems that it has developed or purchased to integrate with other systems. The ZPIC shall, at a minimum, maintain a database of the most recent 36 months of data for its zone. This database shall include Medicare Parts A, B, HH+H and DME data for all Beneficiaries for whom the AC or MAC has paid a claim. For additional guidance for Parts C and D data, see Appendix M, Part C and D Integrity Manual.

1.5.2.3.3 - Other Systems
The ZPIC shall participate in the testing of CMS or claims processing software as needed. CMS or the AC or MAC shall provide data necessary for this testing.

1.5.2.3.4 - Test Plan Guidelines
Test plans shall follow a standard format in describing the scope, approach, required resources, and schedule of the testing activities. Plans should identify the items being tested, the testing tasks to be performed, the personnel responsible for each task, and any risks associated with a plan. The following sections shall be included in test plans:

1. Identifier - Specify the unique identifier assigned to the test plan.

2. Introduction - Summarize the software items and features to be tested. The history and need for the software item may be included. List objectives and explain assumptions.

3. Test Items - Identify the test items, including their version/revision level. When applicable, reference the following test documents: requirements specifications, design specifications, user's guide, operations guide, and installation guide. If applicable, include characteristics of transmittal media that impact hardware requirements. Include any logical or physical transformations required before testing. Reference any incident reports related to the test items. Excluded items may be listed in this section.

4. Features to be Tested - Identify the software features or combination of features to be tested and the test design specifications associated with each feature. Include the names of any known critical files or databases, and any known data exchanges that require verification.

5. Features Not to be Tested - Identify the software features that will not be tested and explain why they will not be tested.

6. Approach - Provide an overall approach to testing. Specify each major group or feature and a precise approach that will ensure that they are adequately tested. Provide enough detail to identify testing tasks and to develop time

estimates. In addition:

- Specify the minimum comprehensiveness desired for the testing effort and the techniques used to verify this
- Identify and describe all test tools and how they will be used
- Identify critical test elements (files/databases) and how they are being verified
- Provide a list of major activities required for testing
- Identify and explain any additional completion criteria
- Identify all constraints on testing

7. There should be no contradictions between the information in this section and that of the Features to be Tested section.

8. Item Pass/Fail Criteria - Specify the criteria used to determine whether each test item has passed or failed.

9. Suspension Criteria and Resumption Requirements - Specify the criteria used to suspend all or a portion of the testing activity on the test items, the testing activities that must be repeated when testing is resumed, and the criteria to determine when testing may resume.

10. Test Deliverables - Identify the deliverable documents, including the test's plan, design specifications, case specifications, execution deliverables, case report, incident report, log, and summary report. Identify the test input and output. This section may include the test tools.

11. Test Tasks - Identify and describe the set of tasks necessary to prepare for and perform testing. Include any inter-task dependencies.

12. Environmental Needs - Specify the necessary and desired properties of the test environment, including physical characteristics of the facilities, the hardware, communications, system software, mode of usage, and any other software or supplies required. If applicable, specify the level of security that must be provided for the test facilities, system software, and proprietary components. Identify the reason for all unmet needs of the test group.

13. Responsibilities - Identify the groups responsible for managing, designing, preparing, executing, witnessing, checking, and resolving all test items, and the group responsible for providing the test items and environmental needs.

14. Staff and Training Needs - Specify test staffing needs by skill level and identify training options for providing necessary skills.

15. Schedule - Provide a detailed schedule with milestones for the entire project, indicating the timetable for tasks and milestones and the period of use for each testing resource.

16. Risk and Contingencies - Identify the high-risk assumptions of the test plan and the contingency plan for each.

17. Approvals - Provide names and titles of all persons who must approve of the test plan.

1.5.3 - Information Technology Systems Plan

The Information Technology (IT) Systems Plan shall describe the ZPIC's approach for combining claims data and other data to create a platform for conducting complex data analysis. By combining data from various sources, the ZPIC will present a picture of a beneficiary's entire claim history regardless of where claims were processed. The primary source of this data will be the CMS National Claims History (NCH), with additional data sources for Parts C and D. The ZPIC shall be responsible for obtaining data for all beneficiaries for whom the appropriate MMEs paid the claim.

Note: If the jurisdiction of the AC/MAC/Plan is not defined geographically, the expectation is that the ZPIC shall obtain a complete beneficiary claims history for each unique beneficiary that the AC/MAC/Plan paid a claim.

Example: The AC(s) or MAC(s) jurisdiction being competed covers Maryland but includes a hospital chain with facilities in Montana. The ZPIC would request claims history from NCH for all claims paid to that hospital chain by the AC(s) or MAC(s) for Maryland and Montana.

Example: The AC(s) or MAC(s) jurisdiction being competed covers Maryland, a beneficiary lives in Pennsylvania, and the beneficiary saw a doctor in Maryland. The ZPIC would request claims history from NCH for all claims paid to that beneficiary by the AC(s) or MAC(s) for Maryland and Pennsylvania.

ZPICs will not be permitted to tap data from the Common Working File. The CMS Office of Information Services (OIS) has informed us that this methodology for obtaining data will not be allowed.

ZPICs may, if agreement and cooperation of the AC(s) or MAC(s) are obtained, use data directly from the claims processing system of the AC(s) or MAC(s), and then supplement the other data using NCH.

In developing the IT Systems Plan the ZPICs shall address the above requirements and, at a minimum, establish read-only access to the AC's or MAC's shared claims processing system(s) no later than 15 calendar days prior to the fully operational date and access the Part A, B, and DME data available through the NCH for the zone defined in the Task Order. The ZPIC shall also work with the ACs and MACs to obtain denial data and document the process for obtaining this data for the ACs or MACs in the Joint Operating Agreement (JOA).

In addition, the Information Technology (IT) Systems Plan shall describe the ZPIC's approach for utilizing and analyzing Part C and D data based on the ZPIC's current data circumstances.

The ZPIC shall submit a draft IT Systems Plan to the appropriate GTL for approval no later than 30 days after contract award. The appropriate GTL will provide comments on the draft plan within 10 days. The ZPIC shall incorporate all comments received and submit the final IT Systems Plan no later than 60 days after contract award. If the appropriate GTL's comments are not received within 10 days, the plan is assumed to be final.

All IT Systems Plans shall be modified and updated continuously after these initial submissions to reflect any major changes in the plan. A major change is defined as something that shifts the work or plan by at least 30 days. When changes are identified, a draft plan will be submitted for review within 10 days of identifying the change. The sppropriate GTL will provide comments within 15 calendar days and the final plan will be due 10 days after receipt of the appropriate GTL comments. If the appropriate GTL's comments are not received within 15 days, the plan is assumed to be final.

1.5.4 - Telecommunications

Medicare and ancillary telecommunications services with CMS are provided by AT&T Global Network Services (AGNS) and other providers, through the Medicare Data Communications Network (MDCN) contract.

1.5.4.1 - General Requirements

The ZPIC may obtain telecommunications services from CMS through MDCN for linkage to:

- Each AC or MAC data center or shared processing data center or the enterprise data center (EDC) and shared claims processing system

- The Common Working File

- The CMS Data Center (CMSDC)

- Other specialty contractors such as the print mail contractor, customer service contractor, and others (when applicable)

- Other applicable secured CMS data repositories/portals

The ZPIC shall request such services through the appropriate GTL. CMS using AGNS as the contractor or the ZPIC using a provider that CMS recommends will provide and install the routers used for the Wide Area Network connectivity. The ZPIC is responsible for the LAN configuration to those routers, including any needed cables and hubs. The ZPIC shall install all necessary telecommunication software and have the ability to transmit and receive data via standard telecommunications protocols. Whenever necessary, the use of data compression software to effect rapid relay of data files is highly recommended.

CMS has transitioned all MDCN telecommunications services to frame-based T-1 services. The ZPIC shall provision a gateway to its internal LANs so as to efficiently interface with frame-based T-1 telecommunications technology, unless otherwise negotiated with CMS.

The ZPIC shall use MDCN telecommunications services for:

- Medicare communications between the ZPIC and subcontractors, if any

- Internal ZPIC communications across multiple sites (such as field offices or telecommuter personnel stations) supporting the ZPIC's Medicare contract

- Communication between the ZPIC and its AC(s) or MAC(s)

- Communications between the ZPIC and other Medicare contractors

- Communications between the ZPIC and CMS

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

1.5.4.2 - Service Request Process Requirements

The ZPIC shall designate a program Point-of-Contact (POC) and a technical POC to initiate, focus, and facilitate ongoing communications and information exchange with regard to telecommunications. These POCs shall have the authority to represent/bind the ZPIC within the scope of telecommunications operations and supporting

environments.

The ZPIC shall request telecommunications services through the appropriate GTL. The ZPIC shall participate in regular teleconferences with OIS, the AC, MAC and CMS program staff to ensure that all telecommunication needs are communicated accurately and in a timely manner, in order to ensure the most prompt installation.

The ZPIC shall request telecommunication services a minimum of 90 calendar days before the expected operational delivery date for those services. The ZPIC shall complete the technical information exchange (with AGNS technical representatives) or technical information requirements from another CMS approved network access provider within the first 15 calendar days following the request for services. The ZPIC shall grant AGNS or other CMS approved network access provider access to customer-premise equipment for installation, troubleshooting, and maintenance activities.

- The ZPIC shall document all network requirements and specifications before the 90-day time frame begins.

- The ZPIC shall have any facility leases signed and arrangements made for the local phone company and/or AGNS and/or other CMS approved network access provider staff to have access to buildings to install lines and/or equipment, prior to AGNS installation.

NOTE: AGNS is dependent upon the local phone company to install the lines. The local phone companies maintain their own schedules and may not be able to meet a customer's particular need for expedited installation and service.

1.5.5 - Secure E-mail System

To ensure contractors are compliant with the Health Insurance Portability and Accountability Act, Privacy Act requirements, and internal CMS policies, CMS has developed a secure e-mail system. Access and use of this system is not a requirement. However, if the ZPIC chooses not to utilize this system they shall comply with these laws through other means. Other acceptable methods of sending sensitive material are using a secure fax or the U.S. Postal Service or similar courier.

The ZPIC can gain access to the secure e-mail system through their appropriate GTL 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.

1.5.6 - Print/Mail Capability

The ZPIC shall use its own resources and equipment when it requests information from or provides information to any external entity or individual except as otherwise noted.

1.5.7 - Security

The ZPIC shall ensure that the highest level of security is maintained for all systems 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 (A, B, C and D), found at http://cms.hhs.gov/InformationSecurity. All ZPIC 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.

1.5.7.1 - Physical and Operational Security

Physical and operational security is essential. See the Program Integrity Manual Chapter 4, §4.2.2.6 for guidance on both physical and operational security.

1.5.7.2 - System Security

Where the word "contractor" " and "ZPIC" is used, it shall include all subcontractors and consultants.

Where "CMS" is used, it shall also mean agents of CMS, such as independent contractors.

All work on this contract shall be in compliance with the CMS Business Partners Systems Security Manual (BPSSM), http://cms.hhs.gov/manuals/downloads/117_systems_security.pdf 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 BPSSM CISS Self-Assessment Module as modified by CMS shall be submitted on April 1 of each year.

The ZPIC 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 SOW.

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

- National Audio Teleconferences
- Best Practices Security Conferences

1.5.7.2.1 - Certification for Compliance with CMS Systems Security Requirements

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

1.5.7.2.2 Administer Security Program

The ZPIC 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) (BPSSM), 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

The ZPIC shall adhere to all deadlines and formats outlined in official CMS communications (e.g., Program Integrity Manual sections and the BPSSM), as applicable.

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

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

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

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

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

1.5.7.2.3 Correct Deficiencies

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

The ZPIC 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.

1.5.7.2.4 Corrective Action Attestation

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

1.5.7.2.5 Security Review and Verification

The ZPIC shall comply with the CMS certification and accreditation (C&A) methodology, policies, standards, procedures, and guidelines for ZPIC facilities and systems. The CMS C&A methodology can be found on the CMS web site www.cms.hhs.gov/informationsecurity.

The ZPIC 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 ZPIC's first independent evaluation and test of its systems security program shall be completed prior to a date agreed to by CMS.

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

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

The ZPIC 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 ZPIC function and considers these controls adequate to meet CMS security standards and requirements.

1.6 – Quality Assurance and Improvement

1.6.1 - Quality Assurance

1.6.1.1 - Zone Program Integrity Contractor Quality Assurance Program

CMS will utilize a number of quality assurance procedures to ensure ZPIC compliance with this contract. Examples include inspection of deliverables, review of reports, onsite progress meetings and performance evaluations. Government quality assurance will be addressed in each Task Order for other than ZPIC activities identified herein.

1.6.1.1.1 - Cooperation/Coordination

The ZPIC shall cooperate and coordinate with stakeholders other than CMS, including appropriate MMEs (including other ZPICs), providers, and other entities as appropriate. ZPIC performance will be evaluated using measures including, but not limited to:

- Demonstration of ongoing dialogue or meetings with the appropriate and necessary parties
- Feedback from other entities
- Number and type of issues that arise and indicate communication, or lack of communication, between appropriate entities and the ZPIC

1.6.1.1.2 - Quality

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

- Completeness and accuracy of data analysis
- Completeness and accuracy of BI investigations and cases
- Completeness and accuracy of all deliverables
- Completeness and accuracy of medical reviews
- Completeness and accuracy of claims reviews
- Completeness and accuracy of audits

1.6.1.1.3 - Innovation

The ZPIC shall use creative approaches to protect the fiscal integrity of the Medicare Trust Fund. The ZPIC will be evaluated using measures including, but not limited to:

- Use of data query tools to access and perform multiple forms of analysis in trending data and finding indications of potential fraud, waste and abuse
- Use of effective and efficient forms of data analysis approaches

1.6.1.1.4 - ISO Registration

All work performed under this contract shall be ISO compliant**.** CMS requires ISO registration for ZPICs who annually perform work totaling more than $1 million

under all Task Orders. The ZPIC shall be ISO registered within 1 year of contract award.
ISO registration and compliance are defined as follows:

- ISO registered - The ISO Registrar Accreditation Board shall register the work processes performed under this Statement of Work according to the ISO standard by a registrar approved.

- ISO compliant - The work processes performed under this Statement of Work conform to the ISO standard and would pass an ISO registrar's examination if one were requested.

ISO standards are a product of the International Organization for Standardization (ISO). ISO is a specialized international agency for standardization with national standards bodies in 91 countries. The American National Standards Institute (ANSI) is the member body representing the United States. The purpose of the organization is to promote the development of standardization and related world activities to facilitate the international exchange of goods and services, and to develop cooperation in intellectual, scientific, technological, and economic activity. The ISO series standards are the product of the ISO Technical Committee 176, formed in 1979 to harmonize the international activity in quality management and quality assurance standards.

The American Society for Quality (ASQ) administers the Technical Advisory Group for ANSI that contributes to the ISO standards. ASQ publishes the standard and is an important source of information. A brief explanation of the ISO standard is available at the web site of the American Society for Quality, at www.asq.org. ASQ may be telephoned at 1-800-248-1946. A list of accredited registrars may be obtained from ASQ. Any registrar will be happy to explain their services and offer a cost estimate. The registrar's level of effort for auditing and registering the ZPIC operation is estimated according to a standard formula, so costs should not vary greatly from one registrar to another. CMS believes that ISO registration should not impose an undue burden on the ZPIC especially when the ZPIC establishes its operation as ISO compliant from the beginning.

Once the ZPIC operation is registered under ISO, the registration is good for 3 years. During that time, the registrar will perform maintenance audits at least annually. If the ZPIC is awarded additional work that is outside the scope of its current registration, the ZPIC shall expand the scope of the registration to cover this new activity at the time of the next maintenance audit.

1.6.1.2 – Continuous Improvement Program

The ZPIC shall develop and maintain a Continuous Improvement Program (CIP). As

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

1.6.1.3 – Earned Value Management System

If requested by CMS, the ZPIC shall maintain an earned-value management system (EVMS) that is in compliance with the ANSI/EIA Standard 748 as described in and that uses criteria acceptable to the CMS GTLs and Project Officer. The EVMS shall correlate cost and schedule performance with technical progress while performing all tasks. For additional information, please see https://acc.dau.mil/evm.

1.6.2 - Conflict of Interest

In an effort to safeguard the Government and protect the integrity of this effort, the ZPIC shall not include as part of an employee-incentive or evaluation program (i.e., salary rates, salary increases, bonuses and/or monetary or non-monetary awards) any of the following measures, whether based on individual employees' performance or on the performance of the ZPIC on any Task Order(s) as a whole:

- Number of denials or amount of savings associated with denials
- Number of convictions
- Number of referrals or outcome of referrals to the OIG
- Return on investment

1.7 – Medical Review

1.7.1 - Medical Review

ZPICs are authorized to conduct medical and utilization reviews (in accordance with 42 U.S.C. 1395ddd(b)(1)). These reviews, by necessity, have always included reopening the claim and obtaining and reviewing providers' medical records. In 1999, the Comptroller General concluded that ZPICs could perform activities that have been consistently

included in a Medicare Integrity Program function such as medical review (Comp. Gen. Dec. No. B-282777 at 2 (September 2, 1999)).

The ZPIC shall perform:

A. Prepay medical review (MR)
B. Postpay MR
C. Medical review in support of Benefit Integrity
D. Provider Notification and Feedback
E. Coordination with Provider Outreach and Education (POE) staff at the AC or MAC on education referrals
F. Program Integrity Management Reporting (PIMR)

The above MR requirements shall be designated in each individual Task Order, and the ZPIC shall perform medical review functions in accordance with Appendix V (the Program Integrity Manual).

The ZPICs shall only perform medical review not in support of benefit integrity until such time as the medical review not in support of benefit integrity functions are transitioned to a MAC.

2. PART A, B, DME AND HH+H

2.2 – General

ZPIC personnel shall share, consult, and coordinate efforts with all internal and external partners (e.g., law enforcement, ACs, MACs, state agencies, different components within the same ZPIC and other ZPICs) to ensure that the ZPIC's mission is being met.

The ZPIC shall review and analyze a variety of data in order to focus its program integrity efforts by identifying vulnerabilities and/or specific providers for review and investigation within its zone, referral of potential fraud and abuse cases to law enforcement, and pursuance of administrative actions, which include but are not limited to payment suspension, provider revocation and the implementation of claims processing edits that limit or stop payment to suspect providers. Further, the ZPIC shall be proactive and aggressive in pursuing many different sources and techniques for analyzing data in order to reduce any of its risks within this SOW.

2.3 – ZPIC Administration

In addition to Chapter 1 of this SOW, refer to the PIM (Appendix V) and CMS ARTS Cost Reporting Definitions (Appendix K) for further instruction related to ZPIC

Administration.

2.4 - Benefit Integrity

2.4.1 – Purpose

The ZPIC shall perform Benefit Integrity (BI) in accordance with Appendix V (the PIM), and follow all PIM requirements for PSCs until such time as the PIM is updated to include ZPICs. These activities shall be performed in order to identify, stop, or prevent Medicare potential fraud waste, and abuse as well to decrease the submission of abusive, wasteful or potentially fraudulent claims.

2.4.2 – Field Office Support

The ZPIC shall share, consult, and coordinate efforts with CMS central and regional offices and Field Offices, to address the fraud problems in areas identified as high risk as defined in PIM chapter 4, §4.32.1 and chapter 10, §10.20.1-10.20.2. Specifically, ZPICs shall support the CMS Field Office in high risk areas.

Field Offices may identify and refer problem providers to the ZPIC for further development. The ZPIC shall provide support to the CMS Field Office in regards to the implementation, management, and monitoring of administrative actions (prepayment edits for benefit integrity, payment suspension, PIN revocation, overpayment recoupment, etc.). The ZPICs are cautioned, however, that the Field Offices do not have the authority to provide technical direction unless specifically stated in the task order.

Regional and Field Offices may submit Requests for Information (RFIs) to the ZPICs in the form of regular reports and/or ad hoc requests as defined in the PIM. The ZPICs are expected to handle this RFI as they would handle a law enforcement request and respond to the CMS Field Office within the required time parameters.

The ZPICs shall also support the CMS Field Offices through the execution of a "Special Study." The special study or project requires a statement of work (SOW) and must be approved by the Contracting Officer prior to starting. The special study SOW defines a specific fraud problem that is occurring within the ZPIC and CMS Field Office's geographic zone. Also, the ZPICs shall furnish the deliverables requested for the Special Study and shall accomplish the outcomes directed by the Project Coordinator. Once direction is provided on the special study, the ZPIC shall work closely with the Project Coordinator with periodic updates to the appropriate GTL.

ZPICs shall work with the CMS Field Office to ensure that all federal and state healthcare partners within the respective jurisdiction are sharing fraud information and trends so that the fraud concerns of the respective zone are known to all. One such way this is done is through the establishment of a "Fraud Coordination Committee" (FCC)

that is led by the CMS Field Office and the applicable state Medicaid staff. The ZPIC shall attend regular meetings and support the FCC. In addition, the ZPICs shall regularly meet with ZPICs in other zones to share fraud-related information.

2.4.3 - Workload

The ZPIC is responsible only for those claims and cost reports that are processed by the ACs or MACs within its zone. The AC's or MAC's workload will be identified in each Task Order. Claims processed by an AC within the ZPIC's zone that create a perceived or actual conflict of interest may be transferred to another ZPIC for oversight. In these instances, the ZPIC shall notify CMS immediately of the potential or actual conflict, and coordinate with the ZPIC that CMS deems appropriate to receive those additional claims or cost report responsibilities. Approval for this workload exchange shall be obtained from both the sending and receiving GTLs responsible for those ZPICs as well as the Contracting Officer.

2.4.4 – Reporting Requirements

2.4.4.1 – AC or MAC Joint Operating Agreement (JOA)

The JOA shall be updated on a regular basis in accordance with Appendix A, Deliverables, and the Task Order Statement of Work. If no changes are identified the ZPIC shall submit a statement to this effect. One hard copy to the appropriate AC or MAC, one CD ROM to the CO, and entry into CMS ARTS, tracking the changes through an appropriate means from the previous document, shall be distributed to the Contracting Officer, appropriate GTL, and the appropriate AC or MAC.

The JOA will not be incorporated into task order contracts as this document is a mutual agreement between the ZPIC and the appropriate AC or MAC. However, the JOA shall contain among other things, a dispute resolution process, which details the steps to be followed in the event of a dispute between the ZPIC and the appropriate AC or MAC with regard to the terms and conditions of the JOA. At a minimum, the ZPIC and appropriate AC or MAC counterparts shall first attempt to resolve the above issue(s). If they are unable to come to a resolution, the matter shall be raised to a level above the working counterparts. In the event that a dispute between the ZPIC and the appropriate AC or MAC cannot be resolved, the issue shall be directed in writing to the CMS Contracting Officer, appropriateGTL, and Project Officer for resolution by a JOA Alternative Dispute Resolution (ADR) team. CMS will determine the members of the ADR team on a case-by-case basis depending on the issue(s). The ADR team will issue a determination on the matter in writing to both the ZPIC and the appropriate AC or MAC.

In the event that the appropriate AC or MAC is found to be in non-compliance with the terms of the JOA, the matter shall first be addressed by the ZPIC and appropriate

AC or MAC for resolution. If the non-compliance issue is not resolved between the parties within 30 days (excludes AM or MAC budget issues), the ZPIC shall submit a written report of the AC or MAC non-compliance issue to the Contracting Officer, Project Officer, and appropriate GTL. Budget related non-compliance issues shall be submitted by the appropriate AC or MAC or ZPIC to their appropriate CMS Contracting Officer and/or Project Officer for resolution (ZPICs shall work with the appropriate AC or MAC in order to be apprised of these budget issues as they occur.)

The appropriate ACs or MACs will also be expected to report ZPIC non-compliance with the terms and conditions of the JOA to CMS. AC or MAC reports to CMS of ZPIC non-compliance will be investigated. If the non-compliance issue is validated, at a minimum, it will be considered an adverse finding in the annual performance evaluation.

See PIM Chapter 4, §4.28 for topics that shall be addressed in the Joint Operating Agreement (JOA) between the ZPIC and the AC(s) or MAC(s).

2.4.4.2 – Other

See Chapter 1 of this Umbrella SOW, the Task Order SOW, and CMS ARTS Cost Reporting Definitions (Appendix K) for additional reporting requirements and instructions.

2.5 – Requests for Information

In addition to Chapter 1 of this SOW, refer to the PIM chapter 4, §4.4.1 and CMS ARTS Cost Reporting Definitions (Appendix K) for further instruction related to Requests for Information activities.

2.6 – IT Systems and Support

In addition to Chapter 1 of this SOW, refer to the PIM (Appendix V) and CMS ARTS Cost Reporting Definitions (Appendix K) for further instruction related to IT Systems and Support activities.

2.7 – Quality Assurance and Improvement

In addition to Chapter 1 of this SOW, refer to the PIM (Appendix V) and CMS ARTS Cost Reporting Definitions (Appendix K) for further instruction related to Quality Assurance and Improvement activities.

3. PART C AND PART D (MEDICARE ADVANTAGE AND MEDICARE PRESCRIPTION DRUG BENEFIT)

3.1 – General and Administration

3.1.2 - Assumptions and Constraints

This Chapter has been developed to provide **additional** tasks and guidance specific to Part C and Part D. The requirements outlined in this Chapter should not to be interpreted as the sole requirements for Part C and Part D. Task Orders for Part C and Part D can be issued for any tasks in this USOW.

The Contractor shall assume:

- An estimated 39 million beneficiaries will receive drug benefits through a Medicare Part D sponsor or through an employer/union sponsored retiree plan that is eligible for the Medicare retiree drug subsidy;
- An estimated 19% of Medicare Beneficiaries are enrolled in a Part C Medicare Advantage Plan;
- Approximately 10.9 million beneficiaries will enroll in the low-income subsidy program;
- Approximately 60 MAs, 500 MA-PDPs (inclusive of Cost Plans) and 100 PDPs will participate in the program;
- There will be approximately 100 employer Part D sponsors; and 10 Direct Employer sponsors;
- Approximately 40,000 to 400,000 Retiree Drug Sponsors will participate in the program; and
- There will be zero (0) Fallback Prescription Drug Plans.

3.2 - Administration

3.2.1 - Kickoff Meeting and Transition Activities

3.2.1.1 - Kickoff Meeting with Law Enforcement Agencies

In preparing to begin its work, the ZPIC shall arrange a Kickoff Meeting or series of meetings which shall include the local and regional law enforcement agencies, including HHS/OIG/OI, FBI, and DOJ/US Attorneys' Offices, within the ZPIC's zone. This meeting (or series of meetings) shall be held during the 60 calendar days

following the task order award date. The ZPIC shall be responsible for: establishing the agenda for these meetings; leading the meetings; taking notes during the meetings; maintaining all notes from these meetings; and maintaining a deliverables list for these meetings, as required. The ZPIC shall submit all notes from these meetings to the appropriate GTL within three business days of the meeting date.

3.2.2 – Deliverables and Reporting Requirements

3.2.2.1 - Law Enforcement Meeting Notes

Notes from the kickoff meeting with law enforcement and any subsequent meetings with law enforcement shall be due within 3 business days after each meeting.

3.2.2.6 - Audit Report

The ZPIC shall submit a narrative report for each onsite or off-site audit that the ZPIC performs. This audit report should detail the entity subject to review, how the entity subject to review was identified, the purpose of the audit, what material was examined during the audit, and the findings resulting from the audit. This report shall be submitted with 20 business days of the completion of the audit.

3.2.2.7 - Executive Summaries of Law Enforcement Referrals

As the ZPIC makes referrals to law enforcement regarding cases, the ZPIC shall also submit to the appropriate GTL an executive summary of the law enforcement referral within 2 business days of the referral to law enforcement.

3.2.2.8 - Improper Payments Report

The Part C and Part D Improper Payments Report shall be submitted in accordance with instructions described in Appendix M, Part C and Part D Integrity Manual, Section 12. The report shall be submitted to the appropriate GTL and the Director, Division of Program Integrity Analysis and Evaluation, on November 1st of each calendar year.

3.2.2.9 - Deceased Beneficiary Postpayment Review Report

On an annual basis, ZPICs shall submit a report on the accounting of the improper payments resulting from deceased beneficiary overpayments. This report shall be due on December 5th of each calendar year and sent to the appropriate GTL and the Director of the Division of MMA Integrity.

3.3 - Benefit Integrity

The ZPIC shall perform Benefit Integrity (BI) in accordance with Appendix M, Part C and D Integrity Manual. These activities shall be performed in order to identify, stop, or prevent Medicare fraud, waste and abuse as well to decrease the submission of abusive or fraudulent claims.

3.4 - Requests for Information

In addition to Appendix M, Part C and D Integrity Manual, refer to the PIM chapter 4, §4.4.1 and CMS ARTS Cost Reporting Definitions (Appendix K) for further instruction related to Requests for Information activities.

4. MEDICARE-MEDICAID (MEDI-MEDI)

4.1 - Background

4.1.1 – Vision

The Medicare-Medicaid Data Match Program (Medi-Medi) is a partnership between Medicare and Medicaid that enhances collaboration and reduces potential fraud, waste and abuse in the Medicare and Medicaid programs.

4.1.2 - Functional Statement

Medi-Medi is accomplished by matching Medicaid and Medicare data to identify improper billing and utilization patterns. Medi-Medi includes state, regional, and national efforts and requires collaboration among state Medicaid agencies, CMS, and state and federal law enforcement officials.

CMS has increased its efforts to use advanced technology to detect and prevent potential fraud, waste and abuse and to ensure that CMS pays the right provider the right amount, for the right service, on behalf of the right beneficiary. Combining claims data from two major payers for health care services, Medicare and Medicaid, to search for aberrancies indicative of potential fraud, waste or abuse, should increase the likelihood of detecting activity that may fall below the detection threshold in either program individually. Reasons for this include the fact that many providers serve both the Medicare and Medicaid-eligible populations, and that there are a large number of beneficiaries eligible for both Medicare and Medicaid benefits. Substantial administrative hurdles, however, have generally prevented the combining of data, and the benefits that would flow there from.

4.1.3 – Purpose

The purpose of Medi-Medi is to pursue the hypothesis that examining health care claims data from multiple health care programs that share a number of common beneficiaries and providers for aberrancies indicative of potential fraud, waste or abuse will increase the likelihood of detecting aberrant activity falling below the detection threshold of any single program.

The expected outcomes are:

- Combining the most recent three years worth of health care claims data from the Medicare and Medicaid programs;
- Identification and use of data matching and analysis methods and techniques to detect and develop potential fraud cases;

- Statistical analysis and trending activities;
- Proper support in the development of appropriate and quality potential fraud cases for referral to appropriate health care oversight or law enforcement agencies; and
- Establishment and maintenance of good working relationships and extensive networking with both internal components and external partners.

4.2 - General Requirements

The ZPIC shall provide a variety of data analysis, statistical analysis, and trending activities to enhance the detection and prevention of Medicare and Medicaid potential fraud, waste and abuse in the participating state(s). The ZPIC shall use appropriate CMS Medicare data, as well as data from other sources such as Medicaid data, to reach this end.

Successful accomplishment shall require a significant amount of cooperation with the participating state(s), law enforcement, and other task orders within the ZPIC zone. It may also require significant cooperation with other ZPICs.

The required services are delineated in this SOW and include activities such as:

- Employing qualified professionals for performing proactive data analysis;
- Exploring potential Medicare fraud leads in participating state(s);
- Matching the most recent 36 months worth of Medicare/Medicaid data including physician and provider claims, pharmaceutical claims, and enrollment data;
- Developing appropriate, well developed and well documented cases for referral to civil and criminal law enforcement authorities;
- Identifying payments made as a result of potential fraud;
- Identifying program vulnerabilities; and
- Completing all reporting requirements.

In general, the ZPIC shall combine Medicare and Medicaid data, coordinate data/IT, benefit integrity, and steering committee activities with participating states, pursue potential fraud leads through proactive data matching and analysis, perform analyses requested by law enforcement entities, develop potential fraud cases, and produce reports that will serve as case referrals. Additional tasks not currently identified may be associated with this SOW. CMS reserves the right to expand upon this current workload for similar activities as required.

The ZPIC shall perform Medi-Medi tasks in accordance with Appendix V (the PIM) and Appendix L (the Medi-Medi Policies and Procedures Manual (PPM)).

4.3 - Workload

All work required under this umbrella SOW will be designated by award of individual Task Orders. Task Orders will be awarded for some or all of the tasks/requirements

identified herein.

Further, the ZPIC(s) workload volume designated at the time of award of a Task Order may be increased during the period of performance of the Task Order. The Contracting Officer (CO) will notify the ZPIC(s) reasonably in advance of assuming the increase in workload volume in order that the appropriate actions may ensue.

The ZPIC shall be responsible for claims submitted by Medicare and Medicaid providers and for Medicare beneficiaries & Medicaid recipients for states awarded in the zone.

4.4 – Administration

4.4.1 - Transition Phase

The ZPIC shall work with the incumbent Medi-Medi contractor and other appropriate MMEs as appropriate to transition workload in the timeframe specified in the task order.

4.4.2 - Implementation Phase

The ZPIC shall perform the following tasks during the implementation phase:

4.4.2.1 - Project Initiation Meeting

The ZPIC shall follow the PPM and shall convene separate project initiation meetings for each state and regional program.

4.4.2.2 - Implementation Project Management Plan

In addition to requirements in this SOW, the ZPIC shall follow the PPM (Appendix L). The ZPIC shall submit the Implementation Project Management Plan for each state and/or regional project in accordance with Appendix A, Deliverables.

4.4.2.3 - Coordination and Information Sharing

The ZPIC shall coordinate Medi-Medi activities with participating states. This shall include, but not be limited to, holding regular project management meetings, sharing deliverables and project documents when appropriate, and soliciting, receiving, and incorporating participating state feedback in deliverables and other project documents.

4.4.2.3.1 – Medi-Medi Joint Operating Agreement

In addition to Chapter 1, §1.2.3.2.5, the ZPIC shall adhere to the PPM (Appendix L). The ZPIC shall submit the JOA in accordance with Appendix A, Deliverables.

4.4.2.4 - Establish Medi-Medi Steering Committee

The ZPIC shall convene an initial steering committee meeting. The ZPIC shall submit a Steering Committee Charter for each state and/or regional project in accordance with Appendix A, Deliverables. The ZPIC shall adhere to the PPM with regard to the Steering Committee meetings and charters.

4.4.2.5 - Monthly Reporting

The ZPIC shall submit Monthly Status Reports and Cost Reports in accordance with Appendix A, Deliverables. Cost reports shall be broken out by state project and subtask.

4.4.3 - Fully Operational Phase

4.4.3.1 - Coordination and Information Sharing

The ZPIC shall coordinate Medi-Medi activities with participating states. This shall include, but not be limited to, holding regular project management meetings, sharing deliverables and project documents when appropriate, and soliciting, receiving, and incorporating participating state feedback in deliverables and other project documents.

4.4.3.1.1 – Medi-Medi Joint Operating Agreement
In addition to Chapter 1, §1.2.3.2.5, the ZPIC shall adhere to the PPM (Appendix L). The ZPIC shall submit the JOA in accordance with Appendix A, Deliverables.

4.4.3.2 - Medi-Medi Steering Committee

State and Regional Medi-Medi Steering Committees provide opportunities for collaboration, guidance, and information sharing on benefit integrity activities. The ZPIC shall provide full administrative support for each Committee, including provision of meeting space and preparation and distribution of meeting minutes, for the Medi-Medi Steering Committee, which should meet not less frequently than quarterly. The ZPIC shall submit Medi-Medi Steering Committee minutes to all attendees in accordance with Appendix A, Deliverables. The ZPIC shall adhere to the PPM (Appendix L) with regard to Medi-Medi Steering Committees.

4.4.3.5 - Monthly Reporting

The ZPIC shall submit Monthly Status Reports and Cost Reports in accordance with Appendix A, Deliverables. Cost reports shall be broken out by state project and subtask.

4.5 - Data/IT Systems

The ZPIC shall have available for analysis at a minimum 36 months of Medicare Part A, B, HH+H, DME and Medicaid data, including pharmaceutical claim data to the extent permissible by the participating state Computer Matching Agreement (CMA). To ensure the participating state(s) ability to utilize the data for such purposes, the ZPIC(s) shall work closely with the participating state(s) or the appropriate state agencies (including state IT entities) to assure direct, secure on-line access during normal business hours to receive matched data and applications used to assess matched data. The key to this is consideration of competing agencies/interests and prevailing operational requirements. Details of these arrangements shall be addressed in a joint operating agreement to be agreed upon by the ZPIC(s) and the participating state(s). Data will be updated by the ZPIC(s) on a monthly basis.

4.5.1 - Transition Phase

The ZPIC shall work with the incumbent contractor and appropriate MME's to transition workload such as data files and data dictionaries when appropriate.

4.5.2 - Implementation Phase

In addition to Chapter 1, §1.5of this SOW, the ZPIC shall follow the PPM (Appendix L) with regard to data connectivity/sharing and the IT Plan. The ZPIC shall submit the IT Plan in accordance with Appendix A, Deliverables.

4.5.3 - Fully Operational Phase

In addition to Chapter 1, §1.5 of this SOW, the ZPIC shall follow the PPM (Appendix L) with regard to data connectivity/sharing and the IT Plan. The ZPIC shall submit the IT Plan in accordance with Appendix A, Deliverables.

4.6 - Data Matching

4.6.1 - Transition Phase

The ZPIC shall work with the incumbent contractor and appropriate MME's to transition workload such as data matching protocols when appropriate.

4.6.2 - Implementation Phase

The ZPIC shall develop data matching protocols and cross-reference files for, at a minimum, beneficiaries/recipients and providers. The ZPIC shall submit the Data Matching Protocol in accordance with Appendix A, Deliverables. The ZPIC shall adhere

to the PPM (Appendix L) with regard to data matching.

4.6.3 - Fully Operational Phase

The ZPIC shall continue to develop and make improvements to data matching protocols and cross-reference files for, at a minimum, beneficiaries/recipients and providers. The ZPIC shall submit the Data Matching Protocol in accordance with Appendix A, Deliverables. The ZPIC shall adhere to the PPM (Appendix L) with regard to data matching.

4.7 - Data Analysis

4.7.1 - Transition Phase

The ZPIC shall work with the incumbent contractor and appropriate MME's to transition workload such as past data analysis projects and data analysis plans when appropriate.

4.7.2 - Implementation Phase

The ZPIC shall collaborate with the participating state and the applicable Medi-Medi Steering Committee(s) and submit a Data Analysis Plan in accordance with the PPM (Appendix L) and Appendix A, Deliverables.

4.7.3 - Fully Operational Phase

The ZPIC shall use Medicare Part A, B, DME, HH+H and Medicaid data, including pharmaceutical claim data to the extent permissible by the participating state Computer Matching Agreement (CMA), to provide comprehensive problem identification, research, data analysis, and trending to CMS in a coordinated, efficient, and effective manner.

The ZPIC(s) shall use such means necessary to research and analyze data, and in such a format, as to permit the ZPIC(s) and the participating state(s) to be able to utilize the matched data for purposes of potential fraud, waste and abuse analysis and detection.

The ZPIC(s) shall identify potential Medicare and/or Medicaid program vulnerabilities that may result or have resulted in inappropriate Medicare and/or Medicaid payment due to abuse, waste or potential fraud. Armed with this knowledge, the ZPIC(s) shall perform a wide variety of data matching, analysis, trending, and statistical activities to enhance the detection and prevention of Medicare and Medicaid fraud, waste and abuse in the participating state(s). Data analysis activities should enable the ZPIC(s) to quickly identify the scope and potential impact of emerging program integrity issues, and may require quick turnaround data runs.

Types of data analysis performed may include:

- Analyzing data for a particular service or group of services that appear to be experiencing unusual growth in utilization;
- Analyzing data for a specific time frame;
- Analyzing data for a particular provider or beneficiary demographic;
- Examining utilization patterns and trends for newly covered services;
- Determining if a particular claims system edit is having the intended effect;
- Performing and validating new types of analysis or experimental analysis; and
- Other analysis as may be identified by the ZPIC(s).

Upon approval by the GTL(s), the ZPIC(s) shall prepare in-depth data analysis reports focusing upon particular problems that are complex, long term, and/or that demand particular scientific methods of analysis. The ZPIC(s) shall recommend topics, as necessary, for such in-depth reports. Concepts for data analysis focus areas shall be discussed with the GTL(s) before a more comprehensive analysis shall take place. The ZPIC shall provide an update of progress and shall notify the GTL(s) of its findings upon completion of the analysis.

The ZPIC shall collaborate with the participating state and the applicable Medi-Medi Steering Committee(s) and submit a Data Analysis Plan in accordance with the PPM (Appendix L) and Appendix A, Deliverables. The ZPIC shall submit Cross Claim Analysis Catalog entries in accordance with the PPM (Appendix L) and Appendix A.

4.8 - Investigations and Cases

4.8.1 - Transition Phase

The ZPIC shall work with the incumbent contractor and appropriate MME's to transition workload when appropriate.

4.8.2 - Implementation Phase

The ZPIC shall work with the participating state(s) to develop processes for joint BI activities and information sharing for BI activities to incorporate into the JOA. A template for the JOA is provided in the PPM (Appendix L).

4.8.3 - Fully Operational Phase

In addition to performing benefit integrity activities in accordance with the PIM, the ZPICs shall perform benefit integrity activities using procedures in the PPM (Appendix L) and the state project's JOA.

4.9 - Requests for Information

In addition to Chapter 1 of this SOW, refer to the PIM chapter 4, §4.4.1, the PPM, and CMS ARTS Cost Reporting Definitions (Appendix K) for further instruction related to Requests for Information activities.

4.10 – Deliverables

In addition to the deliverables set forth in Chapter 1, §1.2.3 of this SOW, the ZPIC shall submit the additional Medi-Medi deliverables in this chapter. The ZPIC shall submit each deliverable described in this section for each state or regional project in its task order. All deliverables shall be submitted in accordance with Appendix A.

4.10.1 - Monthly Status Report

The ZPIC shall submit to CMS and the participating state(s) a monthly status report that reflects the previous month's effort. This report is separate from the base work in the contract, and the report shall be submitted in accordance with the deliverable schedule for monthly status reports in Appendix A, Deliverables. The Monthly Status Report shall include, at a minimum:

- A Summary of Current Investigations including:
    - The source of the investigation (self-initiated, proactive data analysis, contractor referral, law enforcement referral, etc.);
    - The nature of the investigation, including the potential violations;
    - The name(s) of the provider(s) under investigation shall not be included by name in the report, but shall be available to CMS and the participating state if needed; and
    - Potential Medicare and/or Medicaid dollars at risk.
- A full report of its efforts and findings for any in-depth data analysis reports completed during the month, as well as a summary of activities and preliminary findings for any ongoing in-depth data analysis reports;
- Data and statistical assistance initiated and/or completed;
- Report of any continuous quality improvement activities and findings;
- A cumulative status on all cases referred to law enforcement including the following information:
    - The provider(s) being referred and date of referral;
    - The nature of the case, including potential Medicare and/or Medicaid violations
    - The date of law enforcement acceptance or declination;
    - Final disposition, such as civil or criminal prosecution or administrative action; and
    - Overpayments collected.

4.10.2 - Cost Reports

The ZPIC shall report all costs associated with the Medi-Medi project in a separate cost report with one spreadsheet per state including the six tasks in this chapter. In addition, the ZPIC shall break out all labor categories, travel and other direct costs associated with the Medi-Medi workload as part of their monthly cost report. The ZPIC shall submit the cost report in accordance with Appendix A, Deliverables.

4.10.3 - Project Management Plans

The ZPIC shall submit Transition, Implementation and Fully Operational Project Management Plans in accordance with the PPM (Appendix L) and Chapter 1, §1.2.3.2.1 and Appendix A, Deliverables, of this SOW.

4.10.4 – Medi-Medi Joint Operating Agreement

In addition to Chapter 1, §1.2.3.2.3, the ZPIC shall develop and fully execute the JOA in accordance with the PPM (Appendix L).

4.10.5 - Information Technology (IT) Plan

The ZPIC shall submit the IT Plan in accordance with the PPM (Appendix L) and Chapter 1, §1.2.3.2.8 and Appendix A, Deliverables, of this SOW.

4.10.6 - Data Analysis Plan

The ZPIC shall submit the Data Analysis Plan in accordance with the PPM (Appendix L) and Appendix A, Deliverables.

4.10.7 - Data Matching Protocol

The ZPIC shall submit the Data Matching Protocol in accordance with the PPM (Appendix L) and Appendix A, Deliverables.

4.10.8 - Cross Claims Analysis Catalog Entries

The ZPIC shall submit Cross Claims Analysis Catalog Entries in accordance with the PPM (Appendix L) and Appendix A, Deliverables.

4.10.9 - Medi-Medi Steering Committee Charter

The ZPIC shall submit the Medi-Medi Steering Committee Charter in accordance with the PPM (Appendix L) and Appendix A, Deliverables.

4.10.10 - Medi-Medi Steering Committee Minutes

The ZPIC shall submit the Medi-Medi Steering Committee Charter in accordance with the PPM (Appendix L) and Appendix A, Deliverables.

5. COST REPORT AUDIT, SETTLEMENT, AND REIMBURSEMENT

Refer to Appendix K, CMS ARTS Cost Reporting Definitions, for CMS ARTS reporting requirements and definitions for the sections addressed in this chapter.

5.1 - Background and Purpose

The Centers for Medicare & Medicaid Services (CMS) has the overall responsibility to implement and carry out the Medicare regulations as promulgated in the Code of Federal Regulations (CFR) 42 CFR 405, 42 CFR 412, and 42 CFR 413. Accordingly, some of CMS' payment safeguard responsibilities are to issue guidelines on Medicare payment issues, interpret Medicare reimbursement policy, and determine that correct payment is made to participating providers.

An effective tool for determining proper reimbursement is the cost report audit of the provider's Medicare cost report. Institutional providers of health care services participating in the Medicare program are required to file a Medicare cost report on an annual basis. The Medicare cost report audit is a special-purpose, limited-scope cost report audit, used to determine the amount of Medicare payment due to the provider, with adherence to Medicare policies and principles being the primary focus of concern. In addition to determining the allowability of claimed costs, the cost report audit also may serve to discover indications of potential fraud, waste and abuse, and to develop information CMS needs to fulfill its financial responsibilities.

To perform Medicare cost report audits and settlements, CMS has developed various manuals, instructions, desk reviews, and cost report audit programs to enable the cost report auditor(s) to perform a review of the provider's cost report and accounting systems (as required). Medicare audit instructions are covered in IOM Pub. 100-6 Chapter 8 of the Financial Management Manual. Desk review and audit programs, and instructions, are also issued and updated by CMS on a periodic basis (these may or may not be formally incorporated into CMS manuals). The cost report audit and desk review programs are designed to enable the cost report auditor to determine if providers are adhering to the Medicare reimbursement principles contained in the CMS Provider Reimbursement Manual (CMS Pub. 15-1 and 15-2) (see Exhibits E-12 and E-13).

Except as specifically directed in this Statement of Work (SOW), the ZPIC should follow desk review, audit, settlement, and reimbursement policies and procedures covered in CMS regulations, manuals, and instructions.

Acronyms Used in Charts

AC	Affiliated Contractor

BI	Benefit Integrity
CMS	Centers for Medicare & Medicaid Services
HCRIS	Health Care Provider Cost Report Information System
MAC	Medicare Administrative Contractor
MCR	Medicare Cost Report
NPR	Notice of Program Reimbursement
OP	Overpayment
PIP	Periodic Interim Payments
PRRB	Provider Reimbursement Review Board
SNF	Skilled Nursing Facility
STAR	System for Tracking Audit and Reimbursement
TEFRA	Tax Equity and Fiscal Responsibility Act

5.2 - Requirements

In performance of the contract, the ZPIC shall perform desk reviews, audits, settlements, and reimbursement of cost reports as follows:

1. In the case of a few provider types, the ZPIC shall mail the appropriate blank Medicare cost report and instructions to the designated providers and advise those providers of the Medicare cost report filing requirements. Most providers retrieve the cost reports electronically.

2. Receive the Medicare cost report from the provider.

3. Review the National and Restricted Fraud Alerts.

4. Access the Fraud Investigation Database (FID) to determine if the provider is under investigation. If the provider is actively being investigated, consult with Benefit Integrity (BI) staff to obtain further information. However, even if the provider is not under investigation, the cost report auditor should contact BI to learn if there are any issues regarding a particular provider or type of provider. After doing this, the auditor can proceed with the cost report audit process.

5. Complete an acceptability checklist and then either accept or reject the cost report.

6. Advise the applicable Affiliated Contractor (AC) or Medicare Administrative Contractor (MAC) to issue a tentative settlement.

7. Perform the Medicare desk review, including making desk review adjustments as needed.

8. Make a determination to audit or not to audit the provider.

9. Perform either a field or in-house cost report audit when necessary.

10. Perform a supervisory review of the cost report audit working papers.

11. Hold a pre-exit and final audit exit conference with the provider.

12. Revise the Medicare cost report to reflect any desk review or cost report audit adjustments.

13. Refer providers with large aberrancies and significant audit adjustments to BI staff for its awareness and/or review.

14. Issue a Notice of Program Reimbursement (NPR) and advise the AC or MAC to either make the applicable payment or begin overpayment collection activity.

15. Perform Periodic Interim Payment (PIP) activities.

16. Establish, review, and revise interim payment rates.

17. Process exceptions to CMS cost limits for Tax Equity and Fiscal Responsibility Act (TEFRA) target amounts.

18. Conduct reopenings of the Medicare cost report.

19. Conduct hearings and appeals activities.

20. Perform internal quality control activities in accordance with CMS and the American Institute of Certified Public Accountants (AICPA) instructions.

21. Maintain records necessary to settle the Medicare cost reports (i.e., such as those for hospital-based physicians and renal dialysis, etc.).

22. Perform, along with the AC or MAC and other applicable ZPICs, other tasks as necessary or as directed by CMS, including issuing provider bulletins, educating providers, advising providers on Medicare recordkeeping requirements, responding to inquiries, participating in cost report audit and reimbursement-related work groups, and attending meetings.

23. Prepare and submit administrative reports designated by CMS to include the submission of cost-report information into CMS' Health Care Provider Cost Report Information System (HCRIS.)

24. In addition to the workload designated by CMS, the ZPIC shall conduct fraud cost report audits and/or any special reviews that may be necessary.

25. Perform Intern and Resident Information System (IRIS) activities.

26. Perform wage index reviews.

5.3 - Coordination with Benefit Integrity Staff

The ZPIC shall be responsible for assisting Medicare in protecting the program's Trust Funds from those persons and entities that would seek payment for items and services under false or potentially fraudulent circumstances. Upon discovery of potentially fraudulent situations during cost report audits, the audit staff shall consult with BI staff and take action accordingly. Actions taken will depend on the circumstances. The auditors may be instructed to complete the audit and settle the cost report or terminate the review. This includes identifying vulnerable areas on cost reports that are related to potentially fraudulent situations.

5.4 - Types of Reviews and Cost Report Audits

Providers receiving payments under Parts A and B of Title XVIII of the Social Security Act, as amended, are subject to cost report audits for all payments applicable to services rendered to Medicare beneficiaries. The ZPIC shall conduct cost report audits with the primary focus on proper payment.

The ZPIC shall determine whether to conduct a field or in-house cost report audit. Cost report audits are determined based on several factors: the Uniform Desk Review (UDR) results, the past history of the provider, and the relative risk associated with the related settlement.

Providers are required to submit cost reports to the ZPIC in accordance with 42 CFR 413.24(f)(2). If the cost report is not received, the ZPIC shall notify the AC or MAC, within 5 working days, of those providers that fail to submit cost reports within prescribed time frames. After the cost report is received, a desk review is performed (IOM Pub. 100-6 Chapter 8, §20). The purpose of the desk review is to determine if 1) the cost report is acceptable, and 2) there is need for further review. All desk reviews shall be performed in accordance with the latest CMS approved Medicare Uniform Desk Review program.

The sections below provide more detail on the various cost report reviews and audits.

5.4.1 - Cost Report Review with Benefit Integrity Staff

The ZPIC shall access the FID to determine if the provider is under investigation. If the

provider is actively being investigated, consult with BI to obtain further clarification. If the provider is not actively being investigated, proceed with the cost report audit process.

5.4.2 - Desk Reviews

The ZPIC shall perform the following desk review tasks:

1. Determine acceptability of cost report - The first step in the desk review process is to determine if the cost report is acceptable. Within 30 days of receipt, the ZPIC shall make a determination of the acceptability of the cost report. A cost report will be considered acceptable if it meets the requirements specified in 42 CFR 413.24(f)(4) and (5). If the cost report is considered unacceptable, the ZPIC shall return the cost report to the provider within 5 days with a letter explaining the reason for rejection (42 CFR 413.24(f)(5)(iii)). Also, the AC or MAC should be notified within 5 days. If the rejection involves potential fraud and/or abuse the auditor shall refer the issue to BI. Implementing instructions, including applicable acceptability checklists, are contained in the UDR.

2. Determine need for further review or cost report audit - The next step in the desk review process is to determine the need for further review or cost report audit. The ZPIC shall perform this portion of the desk review on all acceptable cost reports. The review will help the auditors determine whether to 1) go directly to final settlement based upon the desk review (including any desk review adjustments), or 2) perform a cost report audit.

   The desk review shall be performed in accordance with the UDR program. The UDR package contains both full and limited desk reviews for the various provider types.

3. Communicate with AC(s) or MAC(s) - It is essential that the ZPIC communicate in a timely manner with the AC(s) or MAC(s) on all desk review activities that may affect reimbursement. In this regard, the ZPIC shall notify the AC or MAC of those providers that (1) fail to submit cost reports within the prescribed time frames, (2) fail to submit acceptable cost reports, or (3) are referred to BI staff for additional review. Within 60 days of the acceptance of the cost report, the ZPIC shall make tentative settlement of the report. (The ZPIC shall notify the AC or MAC to make a tentative settlement payment to the provider within 5 days after completion of this process.) Providers must include a check with the cost report if it indicates an overpayment. The ZPIC shall forward any checks received from a provider to the appropriate AC or MAC or specialty contractor by overnight mail within 24 hours of receipt.

5.4.3 - Field or In-house Cost Report Audits

In performing field or in-house cost report audits, the ZPIC shall perform the following

activities:

1. Determine the scope and level of the cost report audit - The ZPIC should take into account those providers with significant Medicare payments, providers with change of ownership, results of the UDR, and other considerations that may warrant an audit of the Medicare cost report.

2. Schedule the cost report audit - This activity involves the determination of dates to begin and end cost report audits, the location, and the ZPIC's available resources. In order to make this determination a review must be made of total available cost report audit funds, the mix of providers serviced, and any special initiatives requested by CMS. The ZPIC shall exercise professional judgment and be prepared to re-evaluate priorities on an as needed basis.

3. Inform the provider of the cost report audit - This activity involves formal notification to the provider that the ZPIC cost report auditors have scheduled a cost report audit of the provider's Medicare cost report for a certain time period. A request for necessary materials for the entrance conference as well as provider staff that need to be available is made at this time. Provider confirmation should be obtained regarding arrangements for performing the cost report audit. (See IOM Pub. 100-6 Chapter 8, §60)

4. Conduct an entrance conference - This activity is performed onsite or via phone for in-house audits. It includes a review of the materials requested when the provider was informed of the cost report audit. The provider should have the proper personnel present, and provide the cost report auditor(s) with the appropriate contacts (cost report audit liaison) needed to perform the cost report audit. (See IOM Pub. 100-06 Chapter 8, §60.2)

5. Perform the cost report audit - This activity can be performed at the provider's site or at the contractor's location. It also includes the review of items such as financial records, documentation supporting the cost/payment requested on the cost report; statistics such as cost allocation statistics; Intern/Resident counts, beds, settlement data, etc. It results in the production of cost report audit work papers, adjustments, and a cost report audit report by the ZPIC. During the cost report audit, the ZPIC shall identify potentially fraudulent or abusive inappropriate activities and, if applicable, refer them to BI staff.

6. Perform a supervisory review - This activity requires the ZPIC to ensure that prior to the exit conference, working papers were prepared in accordance with Generally Accepted Government Auditing Standards (GAGAS); all adjustments identified during the cost report audit were made; the provider has been advised of proposed adjustments and given sufficient time to respond; all cost report audit objectives were met; the cost report audit program is cross-referenced to the cost report audit procedures; and all conclusions are substantially supported.

7. Conduct a pre-exit conference - This allows the provider a chance to supply documentation and additional information on its behalf prior to the final exit conference. The provider should have received a copy of all adjustments by the pre-exit conference. Refer to IOM Pub. 100-06 Chapter 8, §60.10 for more information concerning the pre-exit conference.

8. Review all additional documentation and hold a final exit conference - These activities are performed after the receipt of all additional documentation requested at the pre-exit conference. Based on the ZPIC's review, cost report audit adjustments will be made if deemed appropriate and included in the cost report audit adjustment report discussed below. This provides the necessary documentation to prepare and issue the Notice of Provider Reimbursement, which is issued within 60 days of the final exit conference or within 60 days after the audit adjustments are finalized if the exit conference is waived.

9. Prepare the cost report audit adjustment report - This report provides a summary of the results of the cost report audit. This report illustrates the individual findings of the cost report audit, the inclusion of the latest Provider Statistical and Reimbursement Report (PS&R) information (information which the ZPIC shall obtain from AC or MAC), and references these findings to the appropriate law(s), regulation(s), or manual source(s) that support the adjustment. The working paper reference for each adjustment should also be included in the audit adjustment report. The ZPIC shall reconcile the cost report audit adjustment report to the cost report audit work papers to ensure that every adjustment is listed. The supervisor must approve these adjustments during the supervisory review. If the reason for the adjustment's exclusion is immateriality, the total of immaterial adjustments should be accumulated to determine if they are material in total. If they are material in total, the adjustments should be made. Any adjustment not included in the report should be explained and the rationale provided in the working papers.

10. Perform other audit activities - The System Tracking of Audit and Reimbursement (STAR) and the Health Care Provider Cost Report Information System shall be updated, as applicable.

5.4.4 - Special Cost Report Audit Initiatives

Special Cost Report Audit Initiatives (SAIs) are used to implement new legislation and policy and respond to issues raised by agencies such as the General Accounting Office (GAO), the Office of the Inspector General (OIG), and CMS. The SAIs may include cost report audits of health maintenance organizations. SAIs are performed by the ZPIC cost report audit staff based on specific instructions issued by CMS. Specific instructions will be issued on a case-by-case basis for the SAI to be performed. In many instances, the SAIs are planned in advance. However, in some instances, the SAIs are initiated after the contract has been awarded and may involve multiple jurisdictions.

The ZPIC shall perform the following tasks:

- The ZPIC shall thoroughly review instructions issued and submit a plan to complete the additional work, in accordance with the instructions and time frames issued.

- The ZPIC shall contact the Project Officer to receive clarification on issues related to the SAI.

- Depending on the SAI, the ZPIC is responsible for issuing notices of cost report reopenings, scheduling dates to go onsite to the provider, and scheduling and conducting the entrance and exit conferences, as necessary.

- The ZPIC Audit Managers or supervisors shall review the work done by the cost report auditors to ensure that it is in accordance with instructions and is properly documented by cost report audit working papers. The working papers must be maintained on file at the ZPIC for CMS review.

5.4.5 - Other Cost Report Audit and Reimbursement Related Activities

The ZPIC shall perform the following activities.

5.4.5.1 - Update the Health Care Provider Cost Report Information System

The ZPIC shall perform this activity for all Medicare cost reports received from all health care providers. The activity includes two transmissions to CMS of cost report data. The first transmission is the "as submitted" cost report data from the provider. The second transmission is made subsequent to final settlement of the Medicare cost report. If a cost report is reopened, additional transmissions are required.

5.4.5.2 - Perform Periodic Interim Payment Reviews

This process involves the establishment of a fixed biweekly payment to providers based upon an estimate of total annual payments to the provider. The ZPIC shall review a provider's request for PIP. The ZPIC decides whether to accept or reject the request. If PIP payments are approved, the ZPIC monitors the rates for cost reimbursed providers such as TEFRA hospitals on a quarterly basis and Prospective Payments System (PPS) providers on a semi-annual basis. The ZPIC shall also monitor a provider's payment record in order to determine if the provider should remain on PIP, and/or if payments need to be adjusted.

5.4.5.3 - Interim Rate Review Process

The ZPIC shall establish an initial interim rate for the fiscal year. Periodically, the rate must be reviewed to determine its accuracy. The ZPIC shall then generate a voucher for system input, and advise the provider of any overpayments resulting from a rate change.

5.4.5.4 - CMS' Interim Payment Expectations

The ZPIC shall ensure all payments to each provider approximate actual costs within the following CMS defined ranges:

- Interim Payments to Hospitals - Target: 96% to 102% of Total Medicare Reimbursable Costs.
- Interim Payments to Home Health Agencies (HHAs) - Target: 94% to 103% of Total Medicare Reimbursable Costs.
- Interim Payments to SNFs - Target: 96% to 104% of Total Medicare Reimbursable Costs.

These target ranges are subject to change, and CMS will notify the ZPIC of the exact ranges prior to their effective dates.

5.4.5.5 - TEFRA Exception Requests

The ZPIC shall review provider exception requests filed under the Tax Equity and Fiscal Responsibility Act for a new base period and submit the required documentation to CMS, along with its recommendation for approval or disapproval. The ZPIC must ensure all adjustment applications to TEFRA target amounts are processed in accordance with program instructions within 75 days of receipt, or return them to the provider within 60 days if the application was incomplete.

5.4.5.6 - Intern and Resident Information Systems

The ZPIC shall perform IRIS activities as required by CMS (see Appendix E, IRISFI Operating Instructions (August 1995)).

5.4.6 - CMS' Expectations

Audits and desk reviews performed by the ZPIC are subject to review by CMS using programs such as the Audit Quality Review Program (AQRP) or its successor(s). To ensure that it has performed quality audits and desk reviews, the ZPIC must apply and follow applicable CMS audit instructions, CMS policies and procedures, Government Auditing Standards (GAS), and American Institute of Certified Public Accountants (AICPA) professional standards for all audit activities. Additionally, for all audit, settlement, and reimbursement activities, the ZPIC must also ensure that Medicare pays no more or less than required by Medicare reimbursement policy as covered under Medicare laws, regulations, rulings, program instructions, and manuals.

5.5 - Settlement of Cost Reports

Upon receipt of a provider's cost report, or amended cost report where permitted or required, the ZPIC shall furnish the provider and other parties as appropriate a written

Notice of Program Reimbursement (NPR), reflecting the ZPIC's determination of the total amount of reimbursement due the provider. This cost report settlement process is necessary to reconcile reimbursement amounts claimed by the provider on its cost report submission with the amounts determined by the ZPIC, and to give notice to the provider of its appeal rights. If the NPR indicates an amount due the provider, the AC or MAC must issue payment. If the NPR indicates amounts due the Medicare Program from the provider, it is used as the basis for identifying overpayments and to start collection procedures. Therefore, the completed NPR must be communicated from the ZPIC to the AC or MAC at the time that the NPR is issued to the providers.

Requirements of settling cost reports are:

1. The ZPIC shall revise the provider's cost report to incorporate all adjustments made. Included as part of the adjustments is the latest PS&R information, which the ZPIC will receive from the AC or MAC. The AC or MAC is responsible for keeping and updating the PS&R.

2. After the cost report has been revised, the ZPIC shall prepare a written NPR reflecting its determination of the total amount of reimbursement due the provider or due the Medicare program. The information to be included in the notice is specified in 42 CFR §405.1803 and CMS Pub. 15-1 §2906. The NPR is considered the ZPIC's final determination for purposes of any future appeals/appeal rights and cost report reopening requests.

3. The ZPIC shall issue the NPR to the provider. Within one business day of mailing the NPR to the provider, the ZPIC will send the AC or MAC a copy via secure e-mail. The AC or MAC will use the NPR as the basis for making payments or demand to the provider for the period covered by the determination.

5.6 - Processing Provider Cost Report Hearing Requests

The ZPIC's determination in an NPR is final and binding unless a timely request for a hearing is filed with the ZPIC or the Provider Reimbursement Review Board (see 42 CFR 405.1807) and a decision is rendered, or unless one of the provisions for reopening in PRM §2931.1 is exercised. Therefore the ZPIC's NPR is the base determination for appealing either to the ZPIC or to the Board (providers only), depending on the jurisdictional amounts (see CMS Pub. 15-1 §2906 D).

The NPR contains language advising the provider of its right to a hearing if it is dissatisfied with the determination and the amount in controversy is at least $1,000. If the amount at issue is $10,000 or more, the provider is advised of its right to a hearing before the Board. A request for hearing must be filed with the ZPIC or with the Board, as appropriate, within 180 calendar days from the date of the NPR.

The ZPIC shall be responsible for processing hearing requests until a decision is reached

by the ZPIC hearing officer or the Board, in accordance with the following guidelines.

5.6.1 - For Amounts in Controversy of at Least $1,000 But Less than $10,000

- Maintain a separate hearing file for each appeal. The file should contain all evidence used in making the determination. The file should also include a copy of the provider's cost report, related cost report audit reports, desk review determinations, the NPR, related correspondence with the provider, and related payment records maintained and considered by the ZPIC in connection with its determination.

- Acknowledge the appeal request to the provider or other entity and include a copy of the acknowledgment in the hearing file.

- Designate a hearing officer to conduct the hearing in accordance with CMS Pub. 15-1, §2913.

- Perform all the responsibilities of the hearing officer(s) contained in CMS Pub. 15-1, §2914.

- Conduct the hearing in accordance with the procedures outlined in CMS Pub. 15-1, §2915.

- As soon as possible after the close of the hearing, the hearing officer makes a decision in the case based exclusively upon the hearing record (CMS Pub. 15-1, §2916).

- If the hearing officer's decision is in favor of the provider, initiate a reopening and correction of the cost report in accordance with procedures outlined in CMS Pub. 15-1, §2931 and 2932.

- Issue a revised NPR within 180 days of the hearing officer's decision. Within one business day of mailing the revised NPR to the provider, the ZPIC shall send the AC or MAC a copy via secure e-mail. The AC or MAC will issue any applicable payment or demand.

5.6.2 - For Amounts in Controversy of $10,000 or More

- Maintain a separate hearing file for each appeal. The file should contain all evidence used in making the determination. The file should also include a copy of the provider's cost report, related cost report audit reports, desk review determinations, the NPR, related correspondence with the provider, and related payment records maintained and considered by the ZPIC in connection with its determination.

- Review the provider's appeal request to determine the appealed issues. Notify the provider and the Board if there appears to be an impediment to Board jurisdiction (e.g., it appears that the request for hearing was not timely or the amount in controversy is not $10,000 or more). This should be done within 60 days following the receipt of the provider's appeal request.

- Review the record (i.e., working papers) that was the basis for its determination of the total amount of payment due the provider.

- Meet with the provider in an attempt to resolve the issues in dispute prior to sending the issues to the Board. If resolution is not possible, and there are no impediments to Board jurisdiction, send a copy of the signed list of issues to the Board and to the provider.

- Within 60 days of receipt of the provider's draft position paper, the ZPIC shall prepare its own position paper and return it to the provider. The ZPIC then has 60 days to submit its final position to the Board and send a copy to the provider. The position paper must be prepared and submitted in accordance with specific instructions in CMS Pub. 15-1, §2921.5.

- Conduct all pre-hearing activities related to the appeal, including but not limited to those outlined in CMS Pub. 15-1, §2924.

- At the Board hearing, the ZPIC is responsible for defending its position in the dispute by presenting testimony, witnesses, and evidence for consideration by the Board. The ZPIC shall also conduct cross-examination of other parties and witnesses to rebut the position taken by the provider (see CMS Pub 15-1, §2925).

- Review requests for expedited judicial review made by provider to the Board and send comments to the Board and to the provider (see CMS Pub. 15-1, §2926).

- Request a review of the Board's decision by the CMS Administrator as appropriate and in the interest of the Medicare program on the basis of the ZPIC's judgment.

- Revise the provider's cost report if necessary after the decision of the Board and/or the CMS Administrator is rendered.

- Issue a revised NPR within 180 days of the board's decision. Within one business day of mailing the revised NPR to the provider, the ZPIC shall send the AC or MAC a copy via secure e-mail. The AC or MAC will issue any applicable payment or demand.

5.7 - Cost Report Reopenings and Corrections

Cost Report Reopenings should be conducted in accordance with 42 CFR Section 405.1885 and IOM Pub.100-06 Chapter 8, §100.

- The ZPIC shall be responsible for ensuring that all cost report reopenings are adjudicated accurately and in accordance with Medicare reimbursement policy, CMS guidelines, law, and regulations (see CMS Pub. 15-1, §2931 and §2932).

- The ZPIC shall process cost report reopening requests received from providers and decide if a reopening of a determination is appropriate. Whether or not the ZPIC will reopen a determination will depend upon whether new and material evidence has been submitted, a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, and rulings, or general instructions.

- The ZPIC shall take the following actions on cost report reopening requests received from providers or other entities:

    - If the ZPIC determines that a reopening is not warranted, a notice will be sent to the provider or other entity explaining the basis for refusing to reopen or correct the determination.

    - If the ZPIC determines that a reopening is warranted, the ZPIC shall ensure that the reopening is settled within 180 days of receipt of the required documentation necessary to support the reopening. When all the necessary documentation has been received the ZPIC shall complete the revision of the cost report and issue the revised NPR to the provider.

    - Within one business day of mailing the revised NPR to the provider, the ZPIC will send the AC or MAC a copy via secure e-mail. The AC or MAC will use the revised NPR as the basis for issuing a payment or demand to the provider.

5.8 - Improving the Cost Report Audit Process

CMS looks to the ZPIC to be innovative in continuously improving how it carries out the cost report audit process, measured both by the levels of the process' performance and the enhancements made to the process to gain in the levels. Activities such as the following lead to such improvement:

- Planning and conducting cost report audits utilizing data analysis and statistical sampling. The ZPIC shall use data to determine the entities on which it will carry out cost report audit. Statistical sampling shall be used to project overpayments

and make inferences about the area being cost report audited.

- Cost report audit plans shall also be designed to identify and quantify program weaknesses. Special emphasis shall be placed on projecting dollar losses locally and nationally. In this regard, the ZPIC shall report program weaknesses as soon as they are identified and make recommendations to CMS CO/RO to rectify them.

The ZPIC cost report audit plan shall designate a portion of the ZPIC's cost report audits as team reviews (including BI staff) in order to make maximum use of the abilities of its staff and resources.