I.   GENERAL QUESTIONS:

Question #1: The following questions are in response to the above RFQ for Recovery Audit Service:

1) Is there a current contractor?
2) If so, who is the contractor?
3) What was the previous award amount?

ANSWER: CMS has currently contracted with three (3) RACs. The RACs are HealthData Insights, PRG Schultz International and Connolly Consulting. The award amounts are based on the negotiated contingency fee percentages, which are proprietary.

Question #2: **REFERENCE -** Transition From Existing RAC To Region RAC *Transition* mechanisms, obligations, and responsibilities...

QUESTION: In case a particular region is awarded to a contractor that is not performing recovery auditing in that region under the demonstration project, there will be a transition between the contractors. In that case, what happens to the financial liabilities (e.g. overturned appeals, backlog) and the financial recoverables (e.g. pipeline and in-transition mailings) for both the new contractor and the exiting contractor.

ANSWER: The CMS transition plan will take into account outstanding receivables.   Financial transactions currently take place by the Fiscal Intermediary or Carrier. It is not expected that a new RAC will be responsible for transactions completed by an outgoing RAC.

Question #3: **General Question:** To provide for accurate cost and recovery estimates (and to provide non-pilot RACs with a more level playing field for estimating purposes), would CMS consider providing data regarding pilot project results to date for each claim type, as follows:

–   Number and Medicare-paid amount of claims chosen for potential review
–   Number and Medicare-paid amount of medical records requested
–   Number and Medicare-paid amount of demand letters sent
–   Number of claims and recovery amount collected through provider check
–   Number of claims and recovery amount collected through provider offset process
–   Number of claims and recovery amount appealed (appeals upheld)
–   Number of claims and recovery amount appealed (appeals denied)
–   Number of claims and recovery amount appealed (total—appeals upheld and denied)
–   Number of claims and recovery amount appealed (appeals pending)

ANSWER: FY 2006 data from the RAC demonstration can be found at www.cms.hhs.gov/RAC. In addition, the Comprehensive Error Rate Testing (CERT) report at www.cms.hhs.gov/CERT includes information that bidders may find helpful.

Question #4: How long did it take for the RACs in the demonstration project to receive any meaningful payments from the project?

ANSWER: It took between 6-12 months for the RACs to receive payments from CMS.

Question #5: When will the RAC Program 2007 report be available to the public?

ANSWER: CMS is currently analyzing data for a Report to Congress. The Report to Congress is due December 31, 2007. It is not expected that the RAC 2007 Status Report will be released prior to the Report to Congress.

Question #6: If the following information is not confidential, please provide:

1. Contingency fee charged by Connolly Consulting, PRG Schultz, and Health Data Insights
2. Fee amount/dollars paid by CMS to Connolly Consulting, PRG Schultz and Health Data Insights by year and total project.
3. List of top ten overpayment reasons identified by each vendor and amounts associated with each.
4. Total dollars identified by each vendor for life of project and by year.
5. Total recoveries by vendor for life of project and by year.
6. Do prime contractors Connolly Consulting, PRG Schultz and Health Data Insights have subcontractors assisting in performing the work? If so, can you identify the subcontractors?
7. Having gone through an extensive pilot project, what are the top lessons learned?

ANSWER: The contingency fees of each RAC are proprietary. FY 2006 data regarding the RAC demonstration can be found at www.cms.hhs.gov/RAC. While subcontractor names will not be released, potential bidders may refer to the interested vendor listing. CMS has incorporated lessons learned into the SOW.

Question #7: Is it possible for one RAC to win multiple regions?

ANSWER: No. CMS as stated in Sections L.9 and M.1 of the RFP, it is the Government's intent to issue an Offeror only one (1) RAC jurisdiction.

Question #8: Can the RACs audit E & M codes?

ANSWER: CMS anticipates the RACs being able to review E & M codes at some point in the RAC program. All audits must be pre-approved by CMS and a validation contractor before review.

Question #9: Can the RACs audit claims that are less than a year old?

ANSWER: Yes. This has been clarified in the SOW.

Question #1:   One year lookback for medical necessity changed to a 3-year lookback. We need to clarify when this period begins (date of initial determination/pay date vs continuing to allow the fiscal intermediary/carrier to review the claim for a year and then moving it to the RAC).

ANSWER: The look back period is counted starting from the date of the initial determination and ending with the date the RAC issues the medical record request letter (for complex review) or the date of the overpayment request letter (for automated reviews). The date of initial determination is the same as the claim paid date. CMS will revise the SOW to clarify this.

We can not refile claims after one year, so why can you review and take back funds after one year?

ANSWER: The RAC Program is required to follow all applicable Medicare regulations such as payment policies, reopening timeframes, and appeal rights for providers. This includes the "timely filing limits" for claims. 42 CFR 405.980 allows CMS to reopen claims with good cause up to four (4) years from the date of the initial determination. CMS is limiting the RACs to three (3) years to limit the administrative burden on providers and/or physicians.

Question #2:   In generally accepted government auditing standards (GAGAS), as established by the Government Accountability (GAO), states that "[H]igh-quality auditing is essential for government accountability to the public and transparency regarding linking resources to related program results. Auditing of government programs should provide independent, objective, fact-based, nonpartisan assessments of the stewardship, performance, and cost of government policies, programs, and operations. Government audits also provide key information to stakeholders and the public to maintain accountability; help improve program performance and operations; reduce costs; facilitate decision making; stimulate improvements; and identify current and projected crosscutting issues and trends that affect government programs and the people those programs serve.

The professional standards presented in this document provide a framework for performing high-quality audit work with competence, integrity, objectivity, and independence." (GAO-07-731G Government Auditing Standards page1)

The reference to the word "audit" referred to in the solicitation implies that the work performed under this procurement will be performed in accordance with GAGAS. With this introduction, we pose the following questions/clarification regarding CMS' RAC solicitation, RFP-CMS-2007-0022:

Is it CMS' intent that the work performed under this contract be in accordance with GAGAS?

ANSWER: The word audit is used to describe a review of a medical claim and/or record. CMS does not intend for this contract to be in accordance with GAGAS. Instead the contract must meet the requirements of CMS' manuals and regulations regarding personnel and when stated in the SOW meet certain government wide internal control standards.

If so, GAGAS defines that audits are to be conducted by audit organizations which "refer to government audit organizations as well as public accounting firms (GAO-07-731G Government Auditing Standards page 6, footnote 3). As such, does CMS intend to limit the procurement to public accounting firms as GAGAS requires?

ANSWER: No.

If CMS is limiting the procurement to only those firms that can comply with GAGAS standards, it is a common understanding that public accounting firms cannot enter into audit contracts where payment is made on a contingent basis due to the fact that contingent fee-based contracts impair the auditor's integrity, objectivity, independence, and judgment in the performance of an audit. Thus, will CMS amend the solicitation to a contract that is other than contingent fee-based?

ANSWER: No.

If it is CMS' intent that the work performed under this contract is not to be performed in accordance with GAGAS, the use of the word audit, by implication, misleads the public, taxpayers, and/or legislators to believe that the work performed under this procurement has been performed in accordance the GAGAS. Will CMS amend the solicitation to remove any reference to the word "audit" in the solicitation to ensure that the public, taxpayers, and/or legislators are not misled as to the standards and quality of the services that are to be performed under this procurement that imply that they were conducted in accordance with GAGAS?

ANSWER: No. CMS makes no reference to GAGAS in the SOW. The word audit has multiple meanings and in the healthcare industry it refers to a review of a medical claim and/or record. By statute and by industry these are recovery audit contractors. The word audit is only used in reference to the name or to outside audits of the RAC program.

Question #3: REFERENCE - SOW IV Task 2, A -- Identification of Non-MSP Overpayment page 7

• Medicare claims through the complex post payment review process where it is probable that a duplicate primary payment was made. This includes situations where Medicare paid a claim to a provider as the primary payer and another group health plan insurer paid the claim as the primary payer.
• Medicare claims through the complex post payment review process where it is probable that a Medicare Secondary Payer situation has occurred.

QUESTION: The referenced text appears to address Medicare Secondary Payer (MSP) circumstances. Does CMS intend to expand recovery efforts for this RFP beyond Non-MSP claims, and, if so, will CMS provide sufficient information to enable such judgments?

ANSWER: No MSP identification is included in the potential recovery efforts. CMS has clarified this in the SOW.

Question #4: REFERENCE - SOW Task 2 and Task 4, Section letter headings, pages 12,19,23,24

Task 2 - section headings E, F, and I are used twice. First use is for "E. The Claim Review Process"(pg13), "F. Activities Following Review"(pg19), and "I. RAC Medical Director"(pg23). These sections are followed by "E. Potential Fraud"(pg23), "F. Potential Quality Problems."(pg23) and "I. Assisting CMS in development of the Improper Payment Prevention Plan"(pg24).

Task 4 - (pg35) repeats section heading G.Various portions of SOW

QUESTION - Suggest Task 2 and 4 be structured to eliminate repeated letter headings.

ANSWER: The SOW has been updated to reflect sequential numbering.

Question #5: REFERENCE - SOW IV Task 2, E, 2 -- Minor Omissions, page 15
"Consistent with Section 937 of the MMA, the RAC shall not make denials on minor omissions such as missing dates or signatures. See Section 10.4 of the "

OBSERVATION - The second sentence is missing text.

QUESTION - Missing dates or signatures are extremely important in the DMEPOS environment. Without dates one would not know when the item was ordered. "Written Order Prior To Delivery" regulations depend on signatures and signature dates. Certificates of Medical Necessity are not valid if the physician or acceptable medical professional has not signed the form. For example, the date a physician evaluated the patient for a power mobility device (PMD) is important when determining whether or not to pay for the PMD. Lack of physician signature on ambulance transfers is also a significant omission. Without dates and signatures Medicare would not be able to make full determination of coverage.

ANSWER: CMS has revised the SOW. CMS retained the 'minor omission' language as it is required by statute (MMA 937).

Question #6: REFERENCE - SOW IV Task 2, E, 9 – Staff Performing Complex /Coding Reviews, page 18
"Whenever performing complex coverage or coding reviews (i.e. reviews involving the medical record), the RAC shall ensure that coverage/medical necessity determinations are made by RNs or therapists… and that the coding determinations are made by certified coders"

QUESTION - The PIM (100-8 Chapter 3 C) allows LPNs to perform coverage determinations. Is it CMS intent to modify the PIM for the RAC expansion program?

ANSWER: No. The SOW states the personnel requirements for the RACs. The PIM is only applicable when referenced in the SOW. CMS intentionally required RACs to use RNs and therapists to make medical necessity determinations. The CMS RAC Team is not aware of any planned PIM changes regarding this issue.

Question #7: REFERENCE - SOW, Task 2, E, 10, Timeframes for Completing Complex Coverage/ Coding Reviews, page 18
"RACs shall complete their complex reviews within the timeframes listed in the Program Integrity Manual section 3.5.1"

OBSERVATION**:** Program Integrity Manual section 3.5.1 addresses "Automated Prepayment Review"

QUESTION: As RAC activity is Post-Payment, should the text reference the post-payment review in PIM sections 3.6.5 and 3.6.6?

ANSWER: CMS has revised the RAC SOW to clarify that the RACs shall complete their complex reviews within 60 days.

Question #8: REFERENCE: SOW IV Task 7, C -- Payment Methodology -- bullets 2 and 4, page 41
"* The RAC shall not receive any payments for the identification of the non-MSP overpayments or underpayments
• For a RAC for the identification of non-MSP overpayment and underpayments and the recovery of non-MSP overpayments: -- The RAC shall be paid a percentage of the amount that is collected through its recovery efforts. A RAC's recovery efforts are defined as a recoupment received through a demand letter or telephone call or some other form of contact through a check from the provider. Recoupment by offset shall not be considered a RAC recovery effort for the purposes of establishing the contingency percentage to be paid. "

OBSERVATION: The referenced text appears to be self-conflicting and does not clearly stipulate the payment of a contingency fee for underpayments identified or paid. Additionally, the referenced text conflicts with the text that follows in the SOW (see question 6 below) which states a factored contingency fee WILL be paid to the RAC when offset is the recoupment mechanism.

ANSWER: RACs are not paid contingency fees for identifications. RACs are paid contingency fees for overpayments recouped and for underpayments paid back to providers.

Question #9: REFERENCE: SOW IV Task 7, C -- Payment Methodology -- bullet 5, page 41
"• The RAC shall receive 50% of the agreed upon contingency percentage for any of the following recovery efforts: -- Recovery efforts accomplished through the offset process of a fiscal intermediary or carrier."

OBSERVATION: This provision causes RACs to raise their base contingency fee to achieve financial objectives when offset is applied and the base fee reduced. That increased RAC fee then applies across all recovery actions and payments. A single fee not subject to factoring would enable RACs to bid a lower contingency fee.

QUESTION: The reference text conflicts with the Payment Methodology Scale on page 47 of the SOW. Is it fair to assume that the Payment Methodology Scale table supercedes any other payment text in the SOW or contract provisions? If so, would CMS amend the SOW to so state?

ANSWER: CMS will amend the SOW so that the SOW and Payment Methodology scale are equal.

Question #10: REFERENCE: SOW Task 7, L Quality Assurance, pages 44, 45
"Each RAC shall be required to complete a Statement of Auditing Standards No. 70 (SAS 70) Audit. Each RAC shall be responsible for contracting with an independent and certified public accounting (CPA) firm to perform the audit."

QUESTION: As the SAS 70 audit is a CMS required subcontracting effort and SAS 70 audits are performed by large businesses (to be CMS credible), would CMS consider excluding the SAS 70 audit cost from the subcontracting $ used to compute small-business subcontracting percentages?

ANSWER: CMS does not anticipate that the cost of the SAS 70 audit will be excluded from the subcontracting dollars used to compute small-business subcontracting percentages.

Question #11: REFERENCE: SOW IV Task 8 Final Report, page 45
"The final report shall include a synopsis of the entire contract project. This includes a final report identifying all amounts identified and demanded, all amounts collected and all amounts still outstanding at the end of the **demonstration**.....any final thoughts on the **demonstrations**..."

QUESTION: Suggest changing "demonstration(s)" to "contract." While the demonstration end is clearly specified, the expansion contract "end" is not. Is it the end of the last option contracted for, the end of the first year, etc.? As the final report will be an important summary of the demonstration results, issues, and challenges it serves a strong purpose. Does the RAC Expansion contract need a final report? If so, suggest CMS clarify the "contract end" to which the final report relates.

ANSWER: Each contract by CMS requires a final report. CMS will remove the word demonstration from Task 8.

Question #12: REFERENCE**:** SOW Appendix 3 Regional Schedules, pages 50-53
"Dates of Claims the RAC May Review: Claims submitted ... prior to the date the RAC contacts the provider. "

QUESTION: Please clarify the definition of "submitted."

ANSWER: Submitted refers to claims being submitted for readjudication to the FI/Carrier.

Question #13: REFERENCE: SOW Appendix 3 Regional Schedules, pages 50-53
Periods of claims investigations for Regions A/B and Regions C/D

QUESTION: Why is there a difference between the allowable review periods for Regions A/B (3 years) and Regions C/D (4 years)?

ANSWER: The correct timeframe for all regions is 3 years.

Question #14: J.1. Section II. Background
The RAC Status Document available on the referenced website
www.cms.hhs.gov/rac was published in November 2006. Is there any more
recent data available for the past 11 months worth of the current RAC's
performance? If so, please reference the location for potential bidder's review.

ANSWER: CMS has not yet released the FY 2007 Status Report.

Question #15: J.1 Section IV. Task 1 General Requirements E.
It states "Each RAC will perform recovery audit services for all claim types."
Please provide the annual number and the associated paid claim dollar figures for
each claim type by region.

**ANSWER: Statistical data concerning the Medicare Fee for Service
utilization rates can be found at http://www.cms.hhs.gov/home/rsds.asp.**

Question #16: J.1 Section IV. Task 2 Identification of Non-MSP Overpayments. B.3
Are all of the records reviewed and complete for past years by the current RACs?
If not, what are the last dates of service for review completed by each RAC for
all provider service types?

**ANSWER: This detailed information is not currently available. However,
RACs have not reviewed all claims/claim types in their particular state(s).
Additional statistical data concerning the Medicare Fee For Service
programs can be found at   http://www.cms.hhs.gov/home/rsds.asp   .**

Question #17: J.1 Section IV. Task 2 Identification of Non-MSP Overpayments. C.1
What volume of claims have been excluded to date for review in the master table
by provider type? What is the total number of claims per provider type for the
applicable years of review?

**ANSWER: As of October 30, 2007 approximately 10 million claims or claim
lines have been excluded.**

Question #18: J.1 Section IV. Task 2 Identification of Non-MSP Overpayments. D.
The RFP states "At CMS discretion, CMS may institute a medical record request
limit." Will this be a blanket limit per provider type and/or size? Will the RAC
have the ability to provide input on the limit depending on the patterns and trends
of overpayments for a specific provider? Will CMS have the ability to make an
exception for additional reviews if necessary?

**ANSWER: CMS has revised the SOW to clarify that CMS will establish a
nationwide RAC medical record request limit that will at a minimum, vary
by provider type and size. In addition, CMS will revise the SOW to indicate
that the RAC medical record requests cannot be "bunched." For example, if
a RAC had a imposed a limit of 50 medical records per month on a given
provider type, the RAC could not request 0 medical records from a
particular provider in January, 0 medical records in February, and 150
medical records in March. While CMS would have the ability to make an
exception this has rarely occurred during the demonstration.**

Question #19: J.1 Section IV. Task 3 Non-MSP Underpayments
Please provide the historical volume and associated dollars of underpayments for each provider type for each RAC.

ANSWER: According to the Improper Medicare FFS Payments Report, November 2006, CMS estimates that there to be:
$0.2B in underpayments on claims billed to carriers
< $0.1B in underpayments on claims billed to DMACs
$0.2B in underpayments on non-inpatient-hospital claims billed to fiscal intermediaries,
$0.6B in underpayments on inpatient hospital claims billed to fiscal intermediaries
Actual underpayment refunds made by RACs can be found in the FY 2006 RAC Status Document on www.cms.hhs.gov/RAC**.**

Question #20: J.1 Section IV. Task 4. Recoupment of Non-MSP Overpayments
Can you publish examples of each current letter sent to providers?

ANSWER: Sample demand letters can be found in IOM Pub. 100-06, Chapter 3, Section 40.2 and Chapter 4, Section 90, Exhibit 1. IOM publications can be found at www.cms.hhs.gov/manuals. These are standard CMS demand letters. Through cooperation with various associations CMS is developing new demand letters for use by the RAC program. The letters will not significantly increase in size.

Question #21: J.1 Section IV. Task 4. Recoupment of Non-MSP Overpayments
The RFP denotes backlogs related to manual adjustments, has this occurred in the current RAC contract? If so, for what length of time did it occur? If you envision this scenario in the future, what length of time would you estimate for this backlog?

ANSWER: Backlogs are possible and have been present in the RAC demonstration. Time periods for backlogs in the demonstration were between 60 days and 6 months. CMS is developing standard system changes to decrease the backlogs however backlogs may be present if manual adjudication is necessary. Since each backlog scenario is different, it is difficult to estimate the timeframe for any backlog.

Question #22: J.1 Section IV, Task 4. Recoupment of Non-MSP Overpayments. B.
Please provide the number of claims and the associated identified overpayment dollars by provider service type that were recovered through the FI/Carrier/MAC/DME MAC?

ANSWER: This detailed information is not available. However, additional statistical data concerning the Medicare Fee For Service programs can be found on http://www.cms.hhs.gov/home/rsds.asp **. Actual overpayment collections made by RACs can be found in the FY 2006 RAC Status Document on** www.cms.hhs.gov/RAC **and the Comprehensive Error Rate Testing (CERT) reports c an be found on** www.cms.hhs.gov/CERT**.**

Question #23: J.1 Section IV, Task 4. Recoupment of Non-MSP Overpayments. C. Please provide the number of claims and the associated identified overpayment dollars by provider service type that were repaid through installment agreements?

ANSWER: Less than 1% of all overpayments in the RAC demonstration were repaid by installment agreements.

Question #24: J.1 Section IV, Task 4. Recoupment of Non-MSP Overpayments. D. Please provide the number of claims and the associated identified overpayment dollars by provider service type that were referred to the Department of Treasury?

ANSWER: The purpose of the RAC demonstration was to identify and recoup improper payments. The majority of identifications were recouped and less than 5% were referred to the Department of Treasury.

Question #25: J.1 Section IV, Task 4. Recoupment of Non-MSP Overpayments. D. What is the historical average recovery time frame after referral to the Department of Treasury from RAC identified overpayments? How many claims and associated overpaid dollars remain uncollected after 3 months, after 6 months, after 12 months, after 18 months and after 24 months for each provider type?

ANSWER: The purpose of the RAC demonstration was to identify and recoup improper payments. The majority of identifications were recouped and less than 5% were referred to the Department of Treasury. The length of the demonstration and the start up time limited analysis. Not enough time has passed and not enough claims have been referred to the Department of Treasury to have complete analysis and statistics from the RAC demonstration.

Question #26: J.1 Section IV, Task 4. Recoupment of Non-MSP Overpayments. E. What is the historical annual claim volume and associated identified overpayment dollars by provider service type that resulted in compromise or settlement from RAC actions? What is the adjusted identified overpayment amount in dollars that resulted in compromise or settlement?

ANSWER: Less than 1% of total collections resulted in a compromise or settlement from RAC actions.

Question #27: J.1 Section IV, Task 4. Recoupment of Non-MSP Overpayments. F. What is the historical annual claim volume and associated identified overpayment dollars by provider service type where a self-disclosure is made by the provider as a result of a prior RAC identified request for medical record requests or demand letter?

ANSWER: Less than 5% of total collections were because of a self-disclosure made by a provider because of a RAC identification.

Question #28: J.1 Section IV, Task 7 Administrative and Miscellaneous Issues. F. Please provide the volume of claims and associated paid claim dollars and if applicable the associated identified overpayment dollars by provider service type that have been recalled during the demonstration project..

ANSWER: Recalls were made in the demonstration when extraordinary circumstances existed. Dollar amounts of the claims were not kept.

Question #29: Section J.1 (Statement of Work), Task 2 (Identification of Non-MSP Overpayments), Item F.4.c (Extrapolation), p, 22. Under what circumstances would CMS envision a Non-MSP RAC contractor using extrapolation?

ANSWER: CMS envisions a RAC contractor using extrapolation in cases where there was evidence of a sustained or high level of payment error or documented education intervention by the carrier/FI/MAC/QIO had failed to correct the payment error.

Question #30: Section J.1 (Statement of Work), Task 4 (Adjustment Process), p. 31. For both the Part A and Part B process, the SOW states that "the CMS Project Officer shall approve all written notifications to the provider before any letters can be sent." As the volume of written notifications is likely to be large, please confirm that CMS intends for the Project Officer to review all correspondence, including all demand and follow up letters.

ANSWER: CMS expects the RAC to utilize form letters with the ability to have free form text boxes for specific claim level detail. The CMS Project Officer shall approve a sample demand letter/correspondence before it is sent. In addition, any correspondence that is not routine and not an approved form letter shall be approved by the CMS Project Officer.

Question #31: Section J.1 (Statement of Work), Task 7 (Administrative and Miscellaneous Issues), Item C (Payment Methodology), p. 41. This section of the SOW indicates that "the RAC shall receive 50% of the agreed upon contingency percentage for any of the following recovery efforts….Recovery efforts accomplished through the offset process of a fiscal intermediary or carrier." However, RFP Section B.3 (Contingency Fee), p. 6, states that the RAC shall receive "75% of the contingency fee specified in number 1 above when non-MSP recovery is made through the offset process by the Medicare fiscal intermediary shared system (FISS)."
Can CMS confirm that RACs will receive 75% of the contingency fee for fiscal intermediary recoveries?

ANSWER: CMS will modify the SOW to make the SOW and Payment Methodology Scale equal.

Question #32: Page 7, Task 2.A., Non-MSP Improper Payments Included in the SOW: If a RAC identifies MSP claims through complex review, what are the payment terms? These terms are not included in the fee schedule on page 47 of the SOW.

ANSWER: See Answer to Question # 3.

Question #33: Page 7, Task 2.A., Non-MSP Improper Payments Included in the SOW: If CMS decided to stop or limit a review type, or not to pursue certain incorrect payments made, is the RAC paid for all the reviews completed, but not processed for recoupment, or for all the charts ordered and on the way to the RAC from the hospitals? What would the criteria be for limiting a review type? Is the RAC at risk of performing work, only to have CMS stop or limit the review?

ANSWER: The RAC is only paid for recoupments. The RAC is not paid for identifications. In rare cases, CMS may instruct the RAC to not continue a review that is had previously started. The use of the RAC Data Warehouse and the validation process should help limit the number of times this occurs. The RAC is at risk of performing work and later having CMS stop or limit the review. RACs can minimize this risk by disclosing all new issues for review to CMS, validating issues with the RAC Validation Contractor, evaluating appeal results and adjusting future claim sampling strategies and review methodologies as needed, and limiting the impact of the review and collections process on providers.

Question #34: Page 7, Task 2.B.1., Services Provided under a program other than Medicare Fee For Services: Although the Tax Relief and Healthcare Act making the RAC program permanent and nationwide only applies to Part A and B claims, does CMS have any future plans to apply the RAC process to managed care and Part D claims? If so, when?

ANSWER: CMS does not have plans to expand to Part C and part D at this time.

Question #35: Page 8, Task 2.B.6., Claims Identified with a Special Processing Number: What percentage or dollar amount of claims does CMS estimate would be eliminated from consideration due to claims involved in Medicare demonstrations?

ANSWER: CMS estimates that less than $10 million per year nationwide will be eliminated due to claims being involved in other Medicare demonstrations.

Question #36: Page 9, Task 2.C.1.&2., Preventing Overlap: The SOW indicates that the RACs will not review claims that other contractors are reviewing. A recent change at CMS has moved certain review tasks away from the QIO to the Fiscal Intermediary. If the RAC and the FI/Carrier/MAC review claims in the current fiscal year, what types and numbers of claims would the FI/Carrier/MAC be allowed to review, and how would these reviews overlap with the RAC reviews?

ANSWER: The shifting of inpatient hospital claim reviews from QIOs to FIs and MACs should not cause overlap with RAC reviews. Careful use of the of the RAC Data Warehouse will be critical to preventing overlaps.

Question #37: Page 9, Task 2.C.1., Preventing Overlap: Many Fiscal Intermediaries/Carriers/MACs do not have comprehensive internal review capabilities or staffs, and the Tax Relief and Healthcare Act precludes an FI/Carrier/MAC from being a RAC. However, if both the FI/Carrier/MAC and the RAC review concurrent claims, there is a potential conflict for the FI/Carrier/MAC, and the RAC program may suffer if they feel obligated to compete with the RACs; for example, the FI/Carrier/MAC may not co-operate fully with the RAC, may not re-adjudicate the claims in a timely manner, may delay the implementation of the RAC program, may not validate claims for the RAC, may attribute all voluntary returns to themselves and not the RAC? How does CMS intend to address this potential conflict.

ANSWER: During the RAC demonstration, CMS found that the all carriers, FIs, and MACs worked cooperatively with the RACs. CMS expects the same to occur in the future. Given that carrier/FI/MAC review

resources are limited, it is likely that in future years, carriers/FIs/MACs will come to see RACs as an additional tool they can use to help lower their error rates. In addition the RAC and the FI/Carrier/MAC are required to establish Joint Operating Agreements (JOA) which will ensure all entities understand their role and duties.

Question #38: Page 9, Task 2.C.1.&2., Preventing Overlap. Will the FI/Carrier/MAC be limited in the number of post-payment reviews they do in the current fiscal year? How many claims are the FIs/Carriers/DMEMACs expected to review? How will the change to the MAC contractors away from Carriers and FIs impact this?

ANSWER: CMS will not limit either carriers/FIs/MACs or RACs but instead will rely on a "first come first serve" philosophy for post payment reviews. Careful use of the of the RAC Data Warehouse will be critical to preventing overlaps.

Question #39: Page 9, Task 2.C.1.&2., Preventing Overlap. If a group of claims is suppressed after a RAC has ordered the claims and started the review process, will the RAC be reimbursed for the work and costs (e.g. medical records and postage) prior to suppression? Will CMS limit the amount of claims that can be suppressed after the fact (that a RAC is reviewing the claims) or is the RAC at total risk? Does the RAC have to pay for medical records for claims suppressed or excluded after records were ordered?

ANSWER: CMS will not limit either carriers/FIs/MACs or RACs but instead will rely on a "first come first serve" philosophy for post payment reviews. The RAC is only paid for dollars it recoups. If the RAC starts a review and enters the appropriate claim information into the RAC Data Warehouse, the carrier/FI/MAC will be on notice not to choose that claim for review. In limited situations, the RAC could start a review and then find that a PSC or law enforcement organization needs to suppress records after the fact. The RAC has to pay providers for all medical records requested and returned.

Question #40: Page 10, Obtaining and Storing Medical Records for non-MSP reviews: Please clarify the statement "At CMS' discretion, CMS may institute a medical record request limit" in light of the following: since the RACs are paid for results and bear the entire risk of their underpayment and overpayment findings all the way through the identification and recovery process, it is important for bidders to understand the potential limits, as they will impact results in a major way. There are many fixed costs and investments in IT, personnel, equipment, etc. that must be made by a RAC. An understanding of limits is a major key to estimating risk and pricing considerations. Accordingly, under what conditions are such limits likely to be imposed? Will these requirements be the same across all RAC Regions? What is the rationale for enacting different record request limits for different claim types?

ANSWER: See answer #18 regarding new nationwide limits on the number of medical record requests per month per provider. CMS will set different limits by provider type because a large facility will be better equipped to respond to medical record requests than a solo physician provider.

Question #41: Page 10, Task 2.D., Obtaining and Storing Medical Records for non-MSP reviews: Does the definition of "securely transmit" include sending the records via a File Transfer Protocol (FTP) methodology?

ANSWER: Potential bidders should review the CMS Business Systems Security Manual to determine the acceptable means of securely transmitting records.

Question #42: Page 13, Task 2.D.4., Storing and sharing medical records: Where can interested vendors locate the additional CMS requirements for a document management system? Please provide a citation to the additional requirements.

ANSWER: CMS has revised the SOW to delete the requirement that the RAC document management system "meet CMS requirements."

Question #43: Page 13, Task 2.D.4, Storing and sharing medical records references sharing imaged medical records via FTP. Is this considered an approved method of "secure transmittal"?

ANSWER: Potential bidders should review the CMS Business Systems Security Manual to determine the acceptable means of securely transmitting records.

Question #44: Page 15, Task 2.E.3., Medicare Policies and Articles: The SOW states that ALJs are not bound by all CMS policies, for example, LCDs. However, the RACs will be held accountable at all levels of appeal for their fees. The risk of reversal at the ALJ level has historically been high. What is CMS' current overall experience at the ALJ level? What is the experience with the RAC program? Will the RAC be allowed to represent itself at each level of appeal? What recourse does the RAC have at each step of the appeal process?

ANSWER: No statistics are currently available regarding appeals of RAC-initiated overpayments at the ALJ level. Very few RAC cases have been heard at the ALJ level. Potential bidders should assume that they will NOT be allowed to represent themselves at each level of appeal. The best recourse available to the RAC in the appeal process is a well documented case with a clear, concise, and complete overpayment notification letter to the provider.

Question #45: Page 15, Task 2E.3, Medicare Policies and Articles: If the RAC loses at the 1st level of appeal, can the RAC appeal the finding to the 2nd level? If the RAC loses at the 2nd level of appeal, can the RAC appeal the finding to the 3rd level, and so on? How can a RAC mitigate the extreme business risk of the appeals process; i.e., what are the RACs appeal rights?

ANSWER: Potential bidders should assume that they will not have an opportunity to appeal at any level. RACs can mitigate against this business risk by 1) choosing to review issues that are clear improper payments, 2) ensuring that all their claim determinations are well documented in the case file especially in terms of the RAC's good cause for reopening (see 42 CFR 405.980) and 3) all overpayment notification letters to the provider are clear, concise, and complete.

Question #46: Page 18, Task 2E.9: Staff Performing Complex/Coding Reviews: The SOW states that the RACs shall ensure that no nurse or coder reviews claims from a provider who was their employer within the previous 12 months. Why should a nurse or coder be precluded from reviews for 12 months when all findings have at least two independent reviews? What if the nurse or coder was not employed

for 12 months at a hospital? What if the nurse or coder was not employed during the data years under review?

ANSWER: This prohibition helps mitigate against the possibility that a disgruntled former employee of a provider would attempt to harm their former employer.

Question #47: Page 20, Task 2.F.2., Validation Process: A Validation Contractor will validate new issues/projected findings. How and in what format will data be transferred from the RAC to the Validation Contractor? What will be the turn-around time for the Validation Contractor to complete its reviews? What delays in implementation of new findings can the RACs anticipate from this process? What processes will be utilized if the RAC and the Validation Contractor cannot agree?

ANSWER: Initially, data will be transferred between the RAC and the Validation Contractor via Excel spreadsheets, Access databases, and delimited flat files. Initially, medical records will be transferred via images on a CD/DVD. Eventually, a password protected web-based application will be used for most data transfers and 277 transactions will be used to transfer medical records. Generally, the delays will be less than 45 days. The RAC can discuss all Validation Contractor findings with the Validation Contractor and/or CMS during a monthly conference call.

Question #48: Page 20, Task 2.F.2., Validation Process: Is CMS anticipating that the post-review accuracy process will be implemented with the Validation Contractor? If so, how many accuracy reviews will be performed? What will the RACs have to do to support the process (data, medical records, policy support, etc.)? What is the process for the RACs to appeal/rebut the findings if it does not agree? Will the determinations affect the RACs fees?

ANSWER: As stated in Task 7, section L. Quality Assurance, number 3, "At CMS discretion, CMS may contract with an independent contractor to perform an accuracy audit on a RAC's identifications. At a minimum, this audit would be performed annually". At this time, CMS anticipates that the accuracy audit will be statistically valid and that RACs will have an opportunity to submit a written response to CMS regarding the findings. The RAC will be required to provide medical records and support to the contractor completing the audit. The results of the accuracy audit will not directly affect the RAC fees but will be one of the performance metrics used to evaluate the RAC's effectiveness.

Question #49: Pages 21 Task 2.F.4., Determine the Overpayment Amount on Non-MSP Cases: When a DRG is changed, a RACs fee is calculated on the difference between the old DRG and the new DRG. However, if an inpatient service should have been performed in an outpatient setting, will the RAC fee be calculated on the inpatient amount, due to the fact that it would be difficult, if not impossible, to determine what should have been billed if performed in the outpatient setting?

ANSWER: CMS intends to pay RAC fees based on the difference between the inpatient service that was billed and the outpatient service that is rebilled by the provider. RACs may be paid a contingency fee based on the full denial amount if CMS has not developed a mechanism to pay contingency fees only for the difference.

Question #50: Page 27, Task 4, Adjustment Process: In the pilot, claims less than $10.00 could be aggregated to meet the threshold. What is the reason for not allowing aggregation in the permanent program?

ANSWER: Aggregation is not included in the RAC program because of cost efficiencies by the Medicare contractors and by physicians.

Question #51: Page 27, Task 4, Adjustment Process: For claims where the system adjusts claims due to system edits "associated findings", the SOW states that "The RAC receives credit for the entire claim adjustment and the RAC shall include these additional lines and denial reason codes on the written notification to the provider." However, for Part A overpayment findings, the FISS system cannot create an account receivable; rather, the claim is adjusted 31 days from the date of overpayment notification. How does CMS propose that the RACs include the additional lines and denial reason codes in this circumstance, since the Part A Notification Letter was mailed 30 days prior to the offset?

ANSWER: The SOW has been clarified to state that at this time it is not possible for a RAC to know any associated findings at the time of issuance of the Part A written notification. However, once the claim is adjusted the RAC is required to know and understand any associated findings on the claim.

Question #52: Page 34, Task 4.F., Voluntary/Self-Reported Non-MSP Overpayments by the Provider: The SOW states that "If a provider voluntarily self-reports an overpayment after the RAC issues a demand letter or request for medical record, the RAC will receive a discounted fee". How will the FI or carrier track these related, additional, voluntary overpayments?

ANSWER: The tracking of voluntary/self-reported overpayments is currently manual. It is not up to the FI/Carrier/MAC to solely identify these situations. The RAC is responsible for tracking the recoupment of all of its identified overpayments.

Question #53: Page 36, Task 5, Supporting Identification of Non-MSP Overpayment in the Medicare Appeal Process and/or in the DCIA Process: The RACs are financially responsible for all reversals at every level of the appeals process, and are obligated to assist CMS with support of the overpayment determinations. Will the RACs be allowed to appeal all reversals to additional appellate levels (e.g., from reconsideration to ALJ, or ALJ to Departmental Appeals Board)?

ANSWER: No. The decision to take a claim to another level is made by another contractor. In some extreme cases, the RAC may be able to request that CMS appeal to the next level but another contractor is responsible for those decisions.

Question #54: Page 37, Task 5, Supporting Identification of Non-MSP Overpayment in the Medicare Appeal Process and/or in the DCIA Process: how will CMS ensure that a RAC will be notified of a pending appeal at all levels of the appeals process? If a RAC is not notified of the pending appeal, the RAC will be unable to fully support the appeals process, and the RAC is also at risk of a reversal. Without a fully functioning notification system, why would the RACs be held responsible for a reversal at all levels of the appeals process?

ANSWER: The use of a contingency fee in Medicare requires several checks and balances to ensure that accurate overpayment identifications are made. One of the checks and balances CMS has decided to use is the financial responsibility of the identification throughout the appeals process. CMS currently has manual tracking of RAC initiated appeals and is exploring an automated means of reporting. RACs currently know of an appeal at all levels once the FI/Carrier/MAC is notified of the appeal.

Question #55: Page 39, Task 6a, Reporting of Identified, Demanded and Collected Medicare Non-MSP Overpayments and Identified Medicare Non-MSP Underpayments, "Inaccurate Information Input into the RAC Data Warehouse": In the event that the RAC Data Warehouse Maintainer makes errors that cause the RACs to have to re-enter data multiple times, or fix errors, will those extra costs that the RAC incurs be absorbed by either CMS or the Data Warehouse maintainer? Also, can the RAC system be constructed to allow a RAC, if it is necessary, to correct the data the RAC entered to minimize the maintainer's cost?

ANSWER: During the RAC demonstration CMS and the RAC Data Warehouse maintainer spent a large part of its time getting the RACs and other entities to understand the Data Warehouse and its importance. The success of the RAC program will be limited without use of the RAC Data Warehouse. As CMS transitions to the Enterprise Data Center, CMS expects unexpected occurrences. CMS will continue to work with the RACs and all other entities using the RAC Data Warehouse. Large errors by the RAC that could have easily been detected with a little due diligence and a quality assurance program take time away from the main tasks of CMS and the RAC Data Warehouse contractor.

Question #56: Page 41, Task 7, Payment Methodology states that the RAC shall receive 50% of the agreed upon contingency percentage for recovery efforts accomplished through the offset process of a fiscal intermediary or carrier. Shouldn't this read 75% for fiscal intermediary and 50% for carrier?

ANSWER: See the answer to Question 31.

Question #57: Page 42, Task 7, Data Accessibility states in part: "As CMS moves toward utilizing EDCs, the transmission of data may cease." Does this mean that the $185,000 Stellant Direct: Connect software will not be utilized in conjunction with an EDC to retrieve extracts? Would there be additional equipment and costs associated with utilizing a CMS system in a CMS Data Center? If so, what additional equipment is necessary, and what are the estimated additional costs? Is the Stellant software utilized within the EDC?

ANSWER: At this time CMS is not sure what the move towards the EDC will mean. However, the Stellant software provides access into the CMS Data Center, which will still be required under the EDC.

Question #58: Page 44, Task 7, Quality Assurance: Certain other programs at CMS require an ISO 9001 certification; can a RAC have an ISO 9001 certification that reviews the control objectives instead of a SAS 70 Audit?

ANSWER: The SAS 70 control objectives are specific to Medicare and CMS believes they provide better insight into the Recovery Audit Contractor operations and internal controls than a ISO 9001 certification.

Question #59: Pages 50-53, Appendix 3, RAC Expansion Schedules, Dates of Claims the RAC May Review: Jurisdictions A & B are listed as having 3 year look back periods, but Jurisdictions C & D provide for 4 year look back periods. Please clarify which is correct. Also, how will the RAC expansion/rollouts be affected by MAC implementations across the Jurisdictions?

ANSWER: CMS will make the correction to Region C & D. The correct timeframe is 3 years. CMS plans to implement the RAC program working with and around the MAC transitions. Current thoughts are that a RAC would not contact providers for three (3) months before and three (3) months after the MAC "cutover date".

Question #60: Pages 50-53, Appendix 3, RAC Expansion Schedules, Dates of Claims the RAC May Review states that RACs may review claims <u>submitted</u> no more than 3 years prior to the date the RAC contacts the provider. Does CMS mean instead that RACs may review claims no more than 3 years from the <u>claim paid date prior</u> to the date the RAC contacts the provider?

ANSWER: The RAC may not reopen a claim if it has been more than 3 years from the claim's initial determination date or claim paid date.

Question #61: Page 2 - Transitions from Outgoing RAC to Incoming RAC - Does CMS assume that the existing demonstration contractors will continue in their current regions? If not, what is the transition plan and why isn't it included in the SOW?

ANSWER: CMS does not assume the existing demonstration contractors will continue in their current regions. The transition plan is not applicable to this SOW. It is a modification to the current SOW. If necessary, a transition plan will be made public once the awards are made. It is not expected that more than one RAC will be in a state at the same time or that an incoming RAC will be required to take responsibility for an outgoing RAC's identifications.

Question #62: Page 4 - Monthly Progress Reports - Will these reports be made available to the state associations?

ANSWER: The monthly progress reports are designed primarily for internal oversight and monitoring purposes. CMS does not intend to release these reports publicly.

Question #63: Page 6 - Geographic Region - Are contractors submitting region-specific bids or will the winning bidders be allowed to select their region as part of the award?

ANSWER: Please refer to the response to Solicitation Question #10

Question #64: Page 7 - Non-MSP Improper Payments EXCLUDED from This Statement of Work - If the RAC has the authority to review claims within three years of initial determination, does this eliminate current year, post-pay review on the part of the FI, carrier, or QIO? How does this play with the Hospital Payment Monitoring Program (HPMP) of the QIOs?

ANSWER: CMS will not limit either carriers/FIs/MACs or RACs but instead will rely on a "first come first serve" philosophy for postpayment reviews. CMS recently announced that it intends to move claim review and provider education of inpatient hospitals regarding improper payments from the QIOs to the FIs. The RAC SOW has been updated to reflect this change.

Question #65: Page 10 - Obtaining and Storing Medical Records for Non-MSP Reviews - What process is required to assure appropriate destruction of records deemed to be without issue?

ANSWER: RAC should shred all paper medical records and destroy all imaged medical records it not longer needs.

Question #66: Page 11 - Paying for Medical Records - What is the timeframe after billing for the RAC to make payment for copies for hospital inpatient services?

ANSWER: During the RAC demonstration providers were paid on a monthly or quarterly basis. In the RAC program CMS will require at least monthly payments to affected parties that have submitted medical records during the month. For example, a RAC may choose to issue checks on the 10th of every month for all medical records received the previous month. All checks should be issued within 45 days of receiving the medical record.

Question #67: Page 15 - Medicare Policies and Articles - Are the RACs required to follow established Cooperating Parties Coding Guidelines applicable to the time of billing/coding when conducting coding reviews and rendering coding determinations?

ANSWER: RACs must apply all Medicare coding policies in effect on the date of service. The SOW has been revised to clarify this.

Question #68: Page 18 - Timeframes for Completing Complex Coverage/Coding Review - The section cited in the SOW for timeframes (3.5.1) is applicable to automated rather than complex reviews. Do you mean 3.41?

ANSWER: See the answer Question #7.

Question #69: Page 22 - Extrapolation - If extrapolation is not allowed, why is it even mentioned in the SOW?

ANSWER: CMS has revised the SOW to clarify that RACs may use extrapolation but only in situations where there is a sustained or high level of payment error or document that the carrier/FI/MAC educational interventions have failed to correct the payment error. CMS has revised Task 2B4 of the SOW (excluding random reviews) to indicate that RACs may perform random review only for the purposes of conducting extrapolated reviews.

Question #70: Task 1- General Requirements
Section C: Monthly Progress Reports
How will CMS accept the submission of reports (i.e. electronic or paper copy)?
Will CMS provide the report layout or will the Contractor be responsible?

ANSWER: CMS will provide the report layout and CMS expects electronic submission of reports.

Question #71: Task 1- General Requirements
Section D: RAC Data Warehouse
In addition to uploading data to the RAC Data Warehouse, will contractors have the ability to extract and download data as well?

ANSWER: The RAC will be able to extract and download their own data in the RAC Data Warehouse.

Question #72: Task 2 – Identification of Non-MSP Overpayments
Section B: Non-MSP Improper payments EXCLUDED from this Statement of Work Number 3: Claims more than three years past the date of the initial determination Please confirm the definition for date of initial determination.

ANSWER: The date of initial determination is the claim paid date.

Question #73: Task 2 – Identification of Non-MSP Overpayments
Section B: Non-MSP Improper payments EXCLUDED from this Statement of Work Number 4: Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayment
Is there a code tied to the Advance Beneficiary Notice? If so, is this reference code identifiable on the data extract the contractor receives?

ANSWER: Bidders should assume that no such code exists or where it does, it is not used systematically. The ABN is not the sole reason a without fault finding could occur.

Question #74: Task 2 – Identification of Non-MSP Overpayments
Section F: Activities Following Review
Number 4.c. Extrapolation
Please provide a situation where the current RAC's have extrapolated? Please describe the frequency in which extrapolation is used.

ANSWER: As of October 30, 2007, no demonstration RAC had chosen to use extrapolation. Demonstration or permanent RACs could use extrapolation in instances where there is a sustained or high level of payment error or document that the carrier/FI/MAC educational interventions have failed to correct the payment error.

Question #75: Task 2 – Identification of Non-MSP Overpayments
Section F: Activities Following Review
Number 4.d. Recording the Improper Payment Amount in the RAC Data Warehouse Describe the timing of entering overpayments or suspected overpayments into the RAC for both those identified by medical record review and automated review. For example: after suspecting an overpayment but prior to finalization and letter generation?

ANSWER: The chart listed under Task 6a indicates when an entry should be made into the RAC Data Warehouse.

Question #76: Task 4 – Recoupment of Non-MSP Overpayments
Part B and Part A Adjustment Process Flowchart
Step two on the Part B adjustment process and Steps two and three on the Part A adjustment process appear to be incomplete. Please provide the full text.

ANSWER: The SOW has been amended.

Question #77: Task 4 – Recoupment of Non-MSP Overpayments
Section A: Written notification of the overpayment
Part A Process
The CMS project officer shall approve all written notifications to the provider before letters can be sent. Please clarify if a one-time approval of notifications is what is meant by this statement, or if CMS wishes to approve letters to each provider in each instance of overpayment.

ANSWER: See the answer to Question #30.

Question #78: Task 4 – Recoupment of Non-MSP Overpayments
Section D: Referral to the Department of Treasury
Please describe the referral process to the Department of Treasury.

ANSWER: Additional information concerning the referral process to the Department of Treasury can be found in IOM Pub. 100-06, Chapter 4, Section 70.

Question #80: Task 4 – Recoupment of Non-MSP Overpayments
Section H: Customer Service
Does CMS wish all calls to providers be monitored for quality assurance, or just those that CMS is monitoring?

ANSWER: Prospective bidders are required to submit a Quality Assurance (QA) program with their proposal. The RACs are required to provide for remote call monitoring capabilities by CMS in Central Office or in the Regional Offices. The RACs are required to announce to all callers that the call may be monitored for quality assurance. Outside of the requirements in the SOW, prospective bidders are required to determine the QA program that will meet the SOW needs and their internal company requirements.

Question #81: Obtaining and Storing Medical Records for Non-MSP reviews
On page 13 of the SOW, Section D.4, Storing and Sharing of Medical Records, reads: "The RAC shall, on the effective date of this contract, be prepared to store and share imaged medical records. The RAC shall Provide a document management system that meets CMS requirements"

Question: What are the specific CMS document management system requirements, and where can we access them?

ANSWER: See the answer to Question #42.

Question #82: Updating the Case File
On page 12 of the SOW, Section D, Obtaining and Storing Medical Records for non-MSP Reviews, states:

Updating the Case File

The RAC shall indicate in the case file (See Task 7, **section H** for additional case record maintenance instructions.)
A copy of all request letters,
Contacts with ACs, CMS or OIG,
Dates of any calls made, and
Notes indicating what transpired during the call.

Question: Clarification – should the reference above, be instead, section **G** (instead of H) for additional case record maintenance instructions?

ANSWER: The SOW has been updated to reflect the section G.

Question #83: SOW, Task 7, Administrative and Miscellaneous Issues, Subsection B, Separate reporting, page 40
Subsection B states "If a single entity is awarded a single contract that includes more than one of the five major tasks identified in section I of this SOW, the reporting and data for each of those for major takes must be kept separate."

Please provide guidance or further explain the separation of data required.

ANSWER: The tasks are separated by identifications and recoupments for overpayments, identification and reimbursement for underpayments, appeal support, provider outreach and vulnerability reporting. Each of these tasks exist independently and shall be reported on independently. At any time CMS could request data on just one of the tasks.

Question #84: SOW, Task 2, Section F, Activities Following Review, 1. Rationale for Determination, page 19
The first paragraph states that the RAC must provide rationale for determinations that "b) did not affect payment". Throughout the SOW it is noted that only those cases that resulted in "improper payment" are to be reported.

Please provide clarification on the reporting of rationale for those cases that did not affect payment

ANSWER: The RAC shall keep a case file for all medical records reviewed. This includes claims without a finding. These claims are in the RACs universe of reviewed claims and may be subject to review by an independent auditor. The RACs are required to keep a case file and an audit trail as supporting documentation for each claim reviewed.

Question #85: SOW IV. Task 1, Section A, Subsection 1 Pg.3 (Project Plan)
This section indicates that the project plan is due two weeks following the initial meeting with the PO. It notes that the project plan will include detailed quarterly projection by vulnerability issue. In order to determine what the vulnerability issues are, an analysis of the claims data needs be performed first.
▪ Is it expected that the initial project plan will need to include the detailed quarterly projection of vulnerability issues? Or is does this requirement apply only to project plan updates?

ANSWER: It is expected that the potential bidders and eventual awardees will come to the RAC program with pre-existing ideas for vulnerabilities.

- The way the project plan is described, it appears to be a plan of how the RAC/subcontractors will operate or review claims vs. what coordination, development, integration etc. needs to be done to get ready to process automated reviews. Is that an accurate read?

ANSWER: That is a high-level accurate interpretation.

Question #86: SOW IV. Task 1, Section C Pgs. 4 – 6 (Monthly Progress Reports)
Does the RAC determine the priority of vulnerabilities for discussion? If so, does CMS have a method or formula for determining the weight, impact, or importance of a vulnerability?

ANSWER: The RAC determines the priority of vulnerabilities it chooses to review. CMS and the validation contractor only determine the identifications accuracy. CMS does not determine importance but may use historical evidence in making its determination and/or recommendation.

Question #87: SOW IV. Task 1, Section C Pgs. 4 – 6 (Monthly Progress Reports)
The italicized paragraph at the end of this section indicates the deadline for monthly reports. Does this deadline apply to both types of reports under section C or only to the monthly financial report in sub-section 2?

ANSWER: All reports are due by the close of business on the fifth business day following the end of the month.

Question #88: SOW Task 1.Section B.1 Pg 4 (Monthly calls):
Similar to the project plan, the monthly calls, which start just a couple of weeks after award date seem to focus on Progress of automated and/or complex review of the claims, This does not seem to contemplate the "spin up" time to get ready to conduct those reviews. Does CMS anticipate all prep work is done ahead of award and that in first of monthly call the RAC is prepared to discuss auto/complex review results?

ANSWER: CMS anticipates the monthly calls being used to discuss open issues with the RAC. These issues may be start up related, claim related, JOA discussions, vulnerabilities or whatever other open issues are present.

Question #89: SOW Task 1.Section C.2 Subsection A & B Pg 5 (Monthly reports)
These two points imply over/under payments collected/returned through FI/Carrier/MAC etc. but the RAC is not mentioned. How does this synchronize with the RAC issuing demand letters? Are all collections intended to be processed back through FI's etc?

ANSWER: All collections are processed through the FI/Carrier/MAC.

Question #90: SOW Task 1.Section D Pg 6 (RAC Data Warehouse):
This section refers to a web-based capability used to update claim information; this implies a user interface for people to make updates; Will CMS support connecting to the RAC DW through an automated solution updating claims in mass?

ANSWER: The RAC Data Warehouse is a web based application. CMS will provide user access.

Question #91: SOW Task 2, Section E, Subsection 7.a Pgs. 16 – 17 (Automated review vs. Complex review)
This section lists examples of Medicare-sanctioned coding guidelines. Is there an official list of Medicare-sanctioned coding guidelines that identifies other sources beyond what is listed in the SOW?

ANSWER: No concise list exists. RACs must rely on language in various CMS manuals, the Medicare coverage database (www.cms.hhs.gov/mcd), Coding Clinic and CPT Assistant.

Question #92: SOW Task 6 Section A Pg. 39, (Inaccurate Information Input into the RAC Data Warehouse)
Will CMS provide a list detailing the standard work effort (i.e. number of hours) required for typical errors such as those mentioned in the SOW?

ANSWER: An accurate example is listed in the SOW. The standard for IT hours utilized by CMS is $100 per hour. This would be a good estimate but the actual amount could vary depending on the extent and size of the error. RACs should assume a minimum of four (4) hours.

Question #93: SOW Task 2.Section E. Subsection 2, Pg 15 (Identification of Non-MSP Overpayments)
This section is incomplete please provide the rest of the sentence.

"2. Minor Omissions: Consistent with Section 937 of the MMA, the RAC shall not make denials on minor omissions such as missing dates or signatures. See Section 10.4 of the"

ANSWER: CMS has revised the SOW to fix this typo.

Question #94: SOW Task 2 Section F. Subsection 2.b, Pg. 20 (Validating the Claims at CMS or the RAC Validation Contractor)
How will CMS validate the claim and how long will the process take?

ANSWER: CMS will award an independent cost based contract to a contractor whose main task will be validation of the overpayment identification. This will occur through a review of a sample of claims, a review of the RAC's interpretation of the policy and review of the medical records, if applicable. The validation process will take between 30-45 days.

Question #95: SOW Task 4, Pgs. 27 & 28 (Recoupment of Non-MSP Overpayments)
Section "Adjustment Process" last paragraph states:
"If an entire claim is denied because of managed care eligibility or a known MSP occurrence the RAC will not receive credit for the denial and will not receive credit for the adjustment identified by the RAC."

Will the RAC have access to CWF to check for MSPD's prior to audit?

ANSWER: The RAC may request CWF access.

Question #96: SOW Task 2 Section.B.3 Pg 7 (Identification of Non-MSP Overpayments)
Under **"Note":** Please provide specification and clarification. Does this mean that the contract may be less than 1 year?

ANSWER: The note in Task 2 Section B.3 means that CMS may: limit one or all RACs to reviewing using a less-than-3-year look back period (e.g., 2 years), limit one or all RACs to reviewing only certain states (e.g., Georgia), limit one or all RACs to reviewing only certain claim types (e.g., outpatient hospital) limit one or all RACs to limiting their reviews in any other way deemed appropriate by CMS.

Question #97: SOW Task 7. Section C Pgs. 41 & 47 (Administrative and Miscellaneous Issues) Please provide clarification on the discrepancies found in the following sections:

Contingency Fees (Task 7 C. fifth bullet Pg. 41) The RAC shall receive 50% of the agreed upon contingency percentage for any of the following recovery efforts: Recovery efforts accomplished through the offset process of a fiscal intermediary or carrier.

"PAYMENT METHODOLOGY SCALE" Page. 47, number 2) 75% of the contingency fee specified in number 1 above when non-MSP recovery is made through the offset process by the Medicare fiscal intermediary

ANSWER: CMS will modify the SOW so that the SOW and Payment Methodology Scale are equal.

Question #98: SOW Task 2.C.2 Pg 10 (Preventing Overlap - Suppressed Claims) Is it reasonable to assume that once a suppressed claim is released that it will contain the same information as before being suppressed?

ANSWER: A suppressed claim means that another entity is reviewing the claim. After suppression this claim may or may not be available for the RAC to review. It is dependent on actions taking by the entity originating suppression.

Question #99: SOW Section E. Pg. 42 (Data Accessibility) SOW states: "In addition, the RAC must acquire the appropriate software to enter into the CMS Data Center. Stellant Direct: Connect software is currently being utilized by CMS for this purpose. " As a current RAC, we already established the data exchange process to receive quarterly updates. Sterling Commerce Direct: Connect software is being utilized to receive update files. We are unable to find any information on the Stellant Direct: Connect package. Pleas clarify the connectivity requirements.

ANSWER: In order to receive data all RACs must have access into the CMS Data Center. Additional information can be found at http://www.cms.hhs.gov/AccesstoDataApplication/ . The connectivity requirements of the Medicare Direct Connect Network have not changed and if a current RAC has the connectivity this would most likely be sufficient if awarded a national RAC contract.

Question #100: SOW Part A Pg. 30 (Adjustment Process) On the diagram, steps 2 and 3 are identical and part of the sentence is left off. Please clarify what the steps are.

ANSWER: The SOW has been amended to show the entire step.

Question #101: SOW Task 2, Section E, Subsection 7.a Pgs. 16 – 17 (Automated review vs. Complex review) and SOW Appendix 3 pgs 50-53(Expansion Schedule for Region A, B, C, and C RAC)

Pages 16, 17, and 18 of the SOW describe automated review vs. complex review. In the description of the reviews, the automated review includes a coverage/coding review whereas complex review describes a review requiring a medical record. Pages 50-53 of the SOW describe the expansion schedule for the RAC regions. In the expansion areas for Inpatient hospital and outpatient hospital most regions have a different implementation schedule for coding review verses coverage reviews. Please describe in more detail the role out of reviews as it relates to automated and complex reviews. Specifically, is it the intent of CMS that coding reviews are automated reviews and coverage reviews are complex reviews or can coding reviews and coverage reviews both be automated and complex?

ANSWER: CMS defines coding as coding reviews and DRG validations. Coding reviews can be complex or automated. Coverage reviews normally involve medical necessity and are complex. Medical necessity and complex coverage reviews will have different start dates.

Question #102: SOW Task 2 Section E 4 Pg. 16 (Internal Guidelines)
The SOW mentions internal guidelines for NCD and LCD's however does not specifically address if guidelines will be needed for all sources utilized (i.e. coding publications etc.?)

ANSWER: The internal guidelines are not for NCDs and LCDs. The internal guidelines shall be developed to support all potential improper payment identifications.

III.   SOLICITATION QUESTIONS:

Question #1: What % of the bid contingency is payable when part A claims are offset by the Medicare fiscal intermediary?

On page 6 of 82 in the RFP, under Contingency Fee, Section B.3b1.(i), it specifies that 75% of the bid contingency fee will be paid when non-MSP recovery is made through the offset process by the Medicare fiscal intermediary shared system (FISS).

On page 41 of the Statement of Work, however, it states that the RAC shall receive 50% of the agreed upon contingency percentage for "Recovery efforts accomplished through the offset process of a fiscal intermediary or carrier".

On page 47 of the Statement of Work, the Payment Methodology Scale specifies that 75% of the bid contingency fee will be paid when non-MSP recovery is made through the offset process by the Medicare fiscal intermediary.

ANSWER: The SOW has been amended so that the SOW and payment methodology scale are equal. The correct contingency fee payable when Part A claims are offset by the Medicare Fiscal Intermediary is 75%.

Question #2: What are the points available for award in these four (4) categories?

On page 77 of the RFP, Section M.2, Technical Evaluation Criteria, the evaluation criteria in the chart specify the following points to be assigned in the categories below:

3. Key Personnel Qualifications & Availability & Overall Staffing: 190
4. Communications Plan: 270
6. Security Plan: 160
7. Past Performance: 225

In subsequent pages, however, some of the point values differ:

Page 79 c.   Key Personnel Qualifications & Availability & Overall Staffing: 225
Page 79 d. Communications Plan: 250
Page 80 f.   Security Plan: 175
Page 81g.   Past Performance: 250

ANSWER: The available points for the evaluation criteria are clarified in the following chart:

		Technical Evaluation Criteria	
	1	Technical Approach for Identification of Non-MSP Improper Payments	525
	2	Technical Approach for Collection/Payment of Non-MSP Improper Payments	250
	3	Key Personnel Qualifications & Availability & Overall Staffing	225
	4	Communications Plan	250
	5	Reporting - Includes all Vulnerabilities, Identifications and Collections/Payments (Underpayments)	150
	6	Security Plan - includes IT and Physical Security	175
	7	Past Performance	250
	8	Subcontractor/Teaming	Pass/Fail
		Business Proposal Criteria	
	1	Financial Capability	Pass/Fail
	2	Conflict of Interest (COI)	Pass/Fail

Question #3: It is clear that the intent is to issue an offeror only 1 jurisdiction but can you clarify if this is for a prime-only and can the offeror participate as a sub in a different region?

ANSWER: Offeror's may submit proposals as a subcontractor in multiple regions. The Government is concerned with Conflict of Interest mitigation strategies and capacity constraints associated with a vendor performing services in more than one region.

Question #4: Are there specific minimum %'s that the prime/sub must maintain?

ANSWER: We are unable to answer this question because the requestor did not provide enough detail.

Question #5: Can the offerer participate as a prime for one region/jurisdiction and sub for another region/jurisdiction?

ANSWER: Please see the response to Question #3.

Question #6: REFERENCE: Section L.11 Technical Proposal Instructions, page 67
"The technical proposal shall address all jurisdictions an Offeror is submitting a proposal against. If sections of the technical proposal are specific to a RAC jurisdiction, the Offeror shall clearly identify which region is applicable to the text.

QUESTION: As there may be substantive differences between recovery auditing in the various jurisdictions, if a bidder desires to bid on multiple jurisdictions (regions) there is an inherent page count inequity caused by the necessity to clearly describe activities and plans for each region bid on. Those descriptive pages reduce the proposal pages available to describe other portions of the proposal if all such pages are to be within the 80 page limit. Would CMS consider requiring an appendix excluded from the 80 page limit that contains all jurisdictional specifics? The appendix would a) be easier to evaluate and b) restore page count equity to the main proposal body.

ANSWER: No, Section L.11 shall remain as stated.

Question #7: REFERENCE: Section L.11. Technical Proposal Instructions page 73
"Detailed curriculum vitae, **project summaries**, work breakdown charts, and compliance matrixes may be included in the proposal as separate attachments with no length restrictions."

QUESTION: As there is no stipulation in the proposal instructions for a maximum or minimum number of projects to describe in the Past Performance section of the Technical Proposal and there are no page limitations on project summaries, a bidder could provide a large number of past performance project summaries as a separate attachment. This would slow evaluation and complicate the evaluation of past performance. Would CMS consider placing limits on the number of projects to include in Past Performance (e.g. minimum of 3 maximum of 5) to avoid being excessively burdened by a multitude of project summaries?

ANSWER: No, Section M.2 limits Offeror's to past performance within the last three (3) years.

Question #8: REFERENCE: Section M.1.a, General Procedures for Award of Contracts, page 74
"Under this solicitation, the "best value" will be made on the basis of the lowest price of proposals meeting or exceeding the acceptability standards for non-cost factors. In other words, the "best value" will be made using a method in which technical (non-cost) factors are significantly less important than cost/price (contingency fee percentage) and allows the Government to consider award to the lowest price technically acceptable Offeror."

QUESTION: How will acceptability and lowest contingency fee percentage be combined in the evaluation? Specifically will only "acceptable" bids be further assessed for lowest contingency fee, or will only the lowest contingency fee bids be considered regardless of acceptability and then relative acceptability be used to distinguish winning proposals, or some other combination of assessment and ranking?

ANSWER: First, technical and business proposals will be evaluated in accordance with Section M.2 to determine technically acceptability. The Offeror's determined to be technically acceptable will then be reviewed for lowest contingency fee. Please note, as stated in Section M.1 the Government intends to evaluate and award without discussions however the Government reserves the right to conduct discussions if the Contracting Officer determines them to be necessary.

Question #9: REFERENCE: Section M.1.a, General Procedures for Award of Contracts, page 74
"..."best value" will be made on the basis of the lowest price of proposals meeting or exceeding the acceptability standards for non-cost factors."

QUESTION: How will "acceptability" be determined? For example, will it be a total score that must exceed some threshold value (assuming **passes** on **pass/fail** criteria), or will it be individual criterion scores that exceed threshold value for each criterion, or some other approach? We note that individual scoring prevents disproportionately large scores in some criteria from offsetting low or zero scores in other criteria.

ANSWER: Acceptability will be determined based on a comprehensive review of the proposals in accordance with the technical and business evaluation criteria.

Question #10: REFERENCE: Section M.1.a, General Procedures for Award of Contracts, page 74
"Four (4) Recovery Audit Contractor (RAC) contracts shall be awarded as a result of this solicitation. Each of the four (4) RAC Jurisdictions shall receive one (1) award. It is the Governments intent to issue an Offeror only one (1) RAC Jurisdiction. For example, an Offeror selected for the award of RAC Jurisdiction B will not be eligible for award of any additional RAC jurisdictions (i.e A, C, D)."

QUESTION: How does CMS envision determining which region to assign to which bidder? For example, could any bidder be assigned a region that was not included in the bidder's proposal? If a bidder was highly ranked and offered to perform recovery auditing for any of multipile regions would CMS approach the bidder and inquire which of the proposed regions the bidder would prefer? In that case, having gotten a response (say Region C) and another (but lower ranked) bidder had proposed only for Region C, would the lower ranked bidder be eliminated from the competition?

ANSWER: No, an Offeror cannot be assigned a region that was not included in the Offeror's proposal. In a case where an Offeror is technically acceptable and proposed the lowest contingency fee in multiple regions, the Government will provide the Offeror an opportunity to decide which region they receive an award. Per the evaluation criteria, the Offeror is considered the "best value" in multiple regions however can only perform as a RAC in one region.

Question #11: REFERENCE: Section M.1.d Past Performance., page 75 and Section M.2.g Past Performance, page 82
M.1.d... "...In accordance with FAR 9.104-1, General standards, the Offeror must have a satisfactory performance record in order to be considered for award. See also FAR 9.104-3(b), Satisfactory Performance Record, and FAR 42.15, Contractor Performance Information."
M.2.g....."...An offeror without a record of past performance shall receive a neutral rating for past performance. That is, the offeror shall not be evaluated favorably or unfavorable for past performance."

QUESTION: Would CMS please reconcile the two statements? Can an offeror without a record of past performance be considered for an award regardless of evaluation?

ANSWER: As stated in Section M.1.d, Past Performance information will be used for both the responsibility determination and as an evaluation factor. The FAR references listed under Section M.1.d refer to past performance as a responsibility determination. Section M.2.g refers to Past Performance as an evaluation factor.

Question #12: REFERENCE: Section M.2, pages 77 – 81,
Evaluation weights in table on page 77 and the individual sections text in M.2.a differ. Specifically evaluation points listed in the table on page 77 for sections 3(190 pts), 4(270 pts), 6(160 pts), and 7(225pts) do not agree with points listed in the equivalent sections text -- c.(225 pts), d.(250pts), f.(175pts), and g. (250pts).

QUESTION: Please clarify the point values intended for each evaluation criterion.

ANSWER: Please refer to Question #2 above.

Question #13: REFERENCE   Sections L and M, multiple pages
Section L.10C.2 Statement on the Offeror's Financial Capability requires that the statement be included as part of the business proposal (page 71)
Section M.1c. <u>Business Evaluation</u> lists the Offeror's financial capability as part of the Business Evaluation. (page 75)
Section L.11 Page 73 <u>Technical Proposal Instructions</u> specifies the minimum number and the order of sections 1 – 8. and does not include Financial Capability as a section. (page 74)
Section M.2 <u>TECNICAL EVALUATION CRITERIA</u> list a total of 9 criteria with the addition of Financial Capability as number 8. (page 77)

QUESTION: Is financial capability a Business Proposal evaluation criterion or a Technical Proposal Evaluation criterion? If it is a Technical Proposal Evaluation criterion, does CMS plan to increase page count limit and specify where in the Technical Proposal that information is to be provided?

ANSWER: Yes, Financial Capability is a business proposal criterion and Offeror's must include information relative to Financial Capability in their business proposal as required in Section L.10. The evaluation grid stated in Section M.2 was revised and Offeror's should refer to the response to Question #2 to view the revised evaluation scoring.

Question #14: REFERENCE: Section M. pages 74-83 Evaluation approach

QUESTION: A reasonable assumption is that CMS has a goal of increasiing returns of improper payments to the Medicare Trust Fund. If that assumption is true, it would seem that RAC expansion contractor evaluation would center around achieving that goal with "best value" obtained from those contractors most likely to deliver high yields from their recovery efforts. When "best value" is defined as "lowest fee, acceptable technical performance", winning contractors' presumed low fees will constrain investigation efforts and related provider outreach while also limiting the information technology infrastructure that can be applied to the recovery audit. Would CMS consider re-casting their definition of "best value" to be those bidders who can deliver the highest returns to the Medicare Trust Fund?

ANSWER: No, CMS is not reconsidering the definition of "best value".

Question #15: REFERENCE: Section M.2, pages 77-83 Evaluation criteria and weights

QUESTION: Given the legislative stipulation to prefer the Demonstration RACS in considering candidates for RAC Expansion contracts, how is CMS implementing that requirement? For example, the current 12-13% weighting of Past Performance does not seem to give preference to Demonstration experience (e.g. a bidder who scored well on other criteria and poorly on past performance could still overcome a Demonstration contractor by offering an excessively low contingency fee).

ANSWER: The legislative stipulation requires the Secretary to give preference to those risk entities that the Secretary determines have demonstrated more than three years direct management experience and a proficiency for cost control or recovery audits with private insures, health care providers, health plans, under the Medicaid program under title XIX, or under this title. Therefore, the past performance evaluation criteria meets this requirement.

Question #16: REFERENCE Contract Clause H.9 Information Technology Investment Acquisition Request
"The Contractor must obtain written CMS, Office of Information Services' (OIS) approval for all Information Technology (IT) Investments (e.g. acquisition of hardware, software, telecommunication protocols, networking, etc.), to ensure compatibility and successful integration with CMS' infrastructure. Any request for an IT investment acquisition should be submitted to the Government Project Officer (PO) or Government Task Leader (GTL) with a copy to the Contracting Officer. The Contracting Officer shall notify the contractor in writing of CMS' approval or disapproval of the acquisition requests. If approved, the contract shall be modified accordingly and the contractor may proceed with the IT investment acquisition. The Government may disallow any contractor incurred costs that would not be allocable to the approved IT investment acquisition."

QUESTION: The RFP language in clause H.9 above notes contract modifications, typically for additional funding, in connection with Information Technology Acquisition Requests. Given that the RAC program's entire funding is derived from contingency fees, does CMS require approval for Information Technology acquisitions by the RAC that are consistent with the CMS Target Enterprise Architecture even though no additional funding will be requested?

ANSWER: Yes, RAC contractors are required to be consistent with CMS target enterprise architecture. CMS will not provide additional funding, outside of the contingency fee payments, for these purchases.

Question #17: The award description states the government's intent is to issue an Offer only one (1) RAC jurisdiction. Are contractors allowed to participate in more than one region if they are the prime contractor in one region, but a subcontractor in another region?

Award Description: CMS intends to award multiple contingency-fee contracts as a result of this solicitation. Awards will be made in accordance with the four (4) Recovery Audit Contractor (RAC) jurisdictions described in the SOW.
One (1) award shall be made for each of the four (4) RAC jurisdictions. It is the Governments intent to issue an Offeror only one (1) RAC jurisdiction.
For example, an Offeror selected for the award of RAC Jurisdiction B will not be eligible for award of any additional RAC jurisdictions (i.e. A, C, D

ANSWER: Please refer to the responses to Questions #3 & #10 above.

Question #18: Are there minimum % thresholds that the prime and secondary must maintain?

ANSWER: Please refer to the response to Question #4.

Question #19: F.2 Period of Performance
Will contingency fees be paid after the period of performance?

ANSWER: A properly recouped overpayment must have been accomplished within the period of performance to be properly invoiced. Payment of this invoice could occur outside of the period of performance provided recovery was completed within the RAC contract's period of performance.

Question #20: L.9 General Instructions d.
Per this section, the business and technical proposals are due on Tuesday, November 20, 2007. The RFP was released on Friday, October 19, 2007. For such a complex process with a necessity for partnerships in most cases, the preparation period is somewhat limited. Would you consider granting an extension of 30 days to the now established proposal due date?

ANSWER: CMS granted an extension via Amendment #1 & #2 to the RFP.

Question #21: Section L.9.c.3, General Instructions/Proposal Organization, p. 67. The RFP states that "font shall be Times New Roman Size 12 with no less than single spacing between lines." Is it acceptable to use a smaller font size in graphics, provided the font is clearly legible?

ANSWER: No, all font size must by Times New Roman 12 with no less than single spacing between lines.

Question #22: Section L.11, Technical Proposal Instructions (p. 73) and Section M.2, Technical Evaluation Criteria, p. 77. The Technical Evaluation Criteria in Section M.2 (p. 77) include item 8, Financial Capability—a section that is not listed in the Technical Proposal Instructions, Section L.11 (p. 73). Please clarify whether or not the Technical Proposal should include Section 8, Financial Capability. (Note: this item requires presentation of financial statements, which is also a required item for the Business Proposal, per RFP Section L.10.c.3 (Financial Statements, p. 72)).

ANSWER: Please see the response to Question #13 above.

Question #23: Section M.2, Technical Evaluation Criteria, p. 77. Paragraph one on page 77 references "letters of commitment." For which personnel (titles or categories) does CMS require letters of commitment?

ANSWER: Section M.2 refers to the evaluation of written material including letters of commitment. Offeror's shall submit letters of commitment if necessary.

Question #24: Section M.2, Technical Evaluation Criteria, pp. 77 – 82. The table on page 77 identifies total points for several evaluation criteria that vary from the corresponding points identified in the section descriptions on pages 77 – 82. Specifically:
Item 3 – Key Personnel Qualifications & Availability & Overall Staffing: Scoring points on page 77 are 190; scoring points identified in item M.2.c (p. 79) are 225.
Item 4 – Communications Plan: Scoring points on page 77 are 270; scoring points identified in item M.2.d (p. 79) are 250.

Item 6 – Security Plan: Scoring points on page 77 are 160; scoring points identified in item M.2.f (p. 80) are 175.
Item 7 – Past Performance: Scoring points on page 77 are 225; scoring points identified in item M.2.g (p. 81) are 250.

Please clarify the actual total points corresponding to each of these sections.

ANSWER: Please refer to the response to Question #2 above.

Question #25: Section M.2.g, Past Performance, p. 81. Is there a minimum or maximum number of contract references that an Offeror may submit?

ANSWER: Yes, as stated in Section M.2.g Offeror's are limited to past performance within the three (3) years.

Question #26: Page 6, B.3, Contingency Fee provides in part that "If, during the period of performance, the RAC is overturned at any level of appeal, the RAC shall repay Medicare the payment for that recovery." Does this mean there is no obligation after the end of the option period to repay if an appeal is lost? How long on average does it take appeals to go through the system? Is the RAC responsible to re-pay the fees at the final level of appeal, after all recourse has been made available to the RAC?

ANSWER: There is no obligation to repay the contingency fee if the appeal is lost after the period of performance of the RAC contract. There is no official average for appeals through the system. Some appeals may take as long as two years and others far less or even greater. The time frames for appeals would be the same of any Medicare appeal.

Question #27: Page 34, H.9 Information Technology Investment Acquisition Request and Page H.16, Approval of Contract Acquired Information Technology provide that the contractor must obtain the Contracting Officers written approval prior to the acquisition of any IT investments. When would CMS pay for IT investment related to the RAC program?

ANSWER: Please refer to the response to Question # 16.

Question #28: Page 77, M.2., Technical Evaluation Criteria: The lowest priced company may not be able to recover the most money for the government; shouldn't the government consider the best return for the government as the best value, not the lowest price? Isn't it more important to the government to recover the highest amount of dollars, net of any fees?

ANSWER: The RAC demonstration does not mirror the assumption that the lowest priced company may not be able to recover the most money for the Government.

Question #29: Page 81, M.2.g., Past Performance: What does it mean that "an offeror without a record of past performance shall receive a neutral rating for past performance?" Also, Section 302 of the Tax Relief and Healthcare Act of 2006, which makes the RAC program permanent and national in scope, contains a requirement that preferences be granted to entities with demonstrated proficiency, including at least 3 years experience in auditing healthcare claims. How will CMS apply this requirement in its evaluation criteria?

ANSWER: Please refer to the response to Question #11 above.

Question #30: Page 82, M.2.h., Financial Capability: Since the RAC should not expect cash for six to nine months, and must assume the risk of appeals, how will CMS evaluate the financial capability for a passing score? What level of available cash on a company's Balance Sheet, maximum amount of debt, if any, debt coverage ratios, minimum revenues in this field, minimum profitability criteria, level of positive cash flow, and number of employees, is necessary for a passing score?

ANSWER: Offeror's are expected to present individual details as listed above in to establish financial capability. This should support the contingency fee structure commensurate with the staffing plan and overall technical approach.

Question #31: Page 82, M.2.i., Subcontracting/Teaming: How does a pass/fail score on sub-contracting affect the overall rating of a proposal?

ANSWER: As stated in Section M.2, if a vendor is utilizing subcontractors for this effort they must receive a "Pass" in the subcontractor evaluation in order to be considered for award.

Question #32: The Technical Proposal is limited to 80 pages; can supporting documents, e.g., resumes of key staff, Internal Review Manuals, etc. be added as exhibits or appendices which would bring total over 80 pages?

ANSWER: As stated in Section L.11 detailed curriculum vitae, project summaries, work breakdown charts, and compliance matrixes may be included in the proposal as separate attachments with no length restrictions.

Question #33: H.8 Conflict of Interest
Situation: a team consists of a subcontractor that is currently a QIO in the territory to be bid upon, yet the QIO work is performed under a separate corporation with a separate board of directors than the portion of the entity that will be used to perform the RAC contract. Will CMS accept this as enough separation to mitigate the conflict of interest as defined in Section H.8?

ANSWER: This particular scenario is more of an appearance of COI rather than actual COI. The question, as written, indicates your entity is currently a QIO and therefore you have not mitigated the appearance concern. If the separate entity were another named firm then you would have addressed the COI appearance concern. The COI concern with QIO's is that it would be difficult for a QIO, charted to improve processes for providers/hospitals/suppliers also serve to recover overpayment from the same parties.

Question #34: Section B: Disclosure
This subsection references attachment J.7 for a mitigation plan. Please provide the location of attachment J.7.

ANSWER: Attachment J.7 is reserved for incorporation of a Contractor's Organization Conflict of Interest plan which includes a mitigation plan.

Question #35: Technical Proposal Instruction
On page 73 of the RFP, Section L.11, Technical Proposal Instructions, reads:
"The proposal should be an example of the Offeror's ability to communicate clearly and concisely the requirements set forth in the Statement of Work. Offeror's proposals that simply repeat the requirements of the SOW and state "we will conform to the requirements as stated" are not acceptable and will be considered non-responsive."

Question: Is it CMS's intent that in addition to the items listed in M.2, Technical Evaluation Criteria, that contractors also respond separately to each Task Order section of the SOW.

ANSWER: As stated in Section L.11, "Offeror's shall submit a technical proposal with, <u>at a minimum</u>, the following sections in the order in which they are listed (See also Section M.2)…."

Question #36: Inconsistent References to Section B.2
On page 6 of the RFP, within Section B, Supplies or Services and Prices/Cost, Section B.2 is titled "Type of Contract." Section L.9.a (page 67 of the RFP) refers to Section B.2 as "Schedule of Payments" and Section L.10.d (page 72 of the RFP) refers to Section B.2 as Payment Methodology scale.

Question: Can it be assumed that all of these references are actually for B.3, Contingency Fee on pages 6 and & of the RFP? If not, can CMS please provide clarification?

ANSWER: Yes, the references listed above should all read B.3 Contingency Fee.

Question #38: Small Business Subcontracting Plan

Question 1: On page 1 of the Small Business Subcontracting Plan, what is the difference between the Total Modification Amount and the Total Task Order Amount?

ANSWER: These sections are not applicable to this contract. These sections refer to modifications to existing contracts and task order awards.

Question 2: Since this is a contingency-fee based award, with uncertainties in terms of claim volume, timing, accessibility, success, etc., what guidance can you give for estimating Total Contract Amount and Option year values?

ANSWER: Offeror's should use their estimates for recovered contingency fee payments in order to calculate the total contract amount and option year values.

Question #39: Section G.16, Subcontracting Program for Small and Disadvantaged Businesses, page 22
Please provide guidance on developing the Subcontracting Program for Small and Disadvantaged Business under a contingency fee contract since typically the subcontracting plan goals are based on anticipated contract value

ANSWER: Please refer to the response to Question #38-2.

Question #40: Section H.8, Conflict of Interest, Page 28 and Section L.10.2, Business Proposal Instructions, page 71
Please confirm that the CMS Systems Maintainers referenced in Section H.8 and Section L.10.2 are those contractors who maintain the Fiscal Intermediary Shared System (FISS), the Multi-Carrier System (MCS) and/or the VIPS Medicare System (VMS) and that they are the only Systems Maintainers covered by the Organizational Conflict of Interest provision.

ANSWER: The programs identified in Section H.8 and L.10.2 of the RFP are an example of contracts, identified by CMS, as having actual, apparent, or potential conflicts of interest. Offeror's must review their business relationships to determine if an actual, apparent, or potential conflict exists.

Question #41: Section H.8, Conflict of Interest, Page 28 and Section L.10.2, Business Proposal Instructions, page 71.
There are a number of management and information systems at CMS which relate to providers and their claims/appeals information. Would contractors involved in developing and maintaining those systems on CMS's behalf be precluded from bidding on RAC opportunity?

ANSWER: The only entities precluded from bidding on a RAC contract are stated in Section 302 of the Tax Relief and Health Care Act of 2006 and Section H.6 of the RFP. Offeror's shall evaluate Conflict of Interest to determine if a mitigation plan is necessary.

Question #42: Section L.2, FAR 52.252-1, Solicitation Provisions incorporated by Reference, page 60 - FAR Clause 52.237-10, Identification of Uncompensated Overtime (Oct 1997) doesn't seem to apply to this solicitation. As indicated in FAR 37.115, the clause should be used for professional or technical services to be acquired on the basis of the number of hours to be provided.

ANSWER: Yes, FAR 52.237-10 is not applicable to a contingency fee type contract. The clause will be deleted.

Question #42: Section L.10, Business Proposal, page 70
There are no instructions related to pricing except a requirement to propose the contingency fee payment methodology scale identified in Section B.3, Contingency Fee. Please confirm that no pricing data or buildup is required. If that is not the case, please provide pricing guidance.

ANSWER: The Business Proposal must contain all information stated in Section L.10. CMS is requesting vendors submit only a contingency fee, by RAC region, and no additional cost or fee information is required.

Question #43: Section M.2.c, Key Personnel Qualifications and Availability and Overall Staffing Plan
This section indicates the compensation plan should be part of the technical proposal and not the business proposal. Please confirm that is correct since often it is a requirement in the business proposal.

ANSWER: Yes, compensation plans will be evaluated under the Business Proposal, Financial Capacity evaluation critiera.

Question #44: RFP Section 3g Page 81 (Past Performance)
The RFP requires Past Performance questionnaires to be completed by clients of the Contractor.
If we are currently a contractor for CMS on a RAC project, can we use CMS as a reference?

If so, who should we send the questionnaire to?

ANSWER: Yes, Offeror's may submit past performance questionnaires for contracts performed in the past three (3) years. CMS can not direct the contractor who to submit the questionnaire to.

Question #45: RFP Section 3g Page 81 (Past Performance)
The RFP requires Past Performance questionnaires to be completed but it does not specify how many. Is their a specific quantity required? Is their a specific requirement for the subcontractors?

ANSWER: As stated in Section M.1.d, past performance questionnaires shall be submitted directly by the references listed in an Offeror's proposal. CMS did not establish a minimum or maximum number of references.

Question #46: RFP M.2.a.1.VI Pg, 7 (Contingency Fees)
Regarding the technical ability for the bidder to make changes to their internal system in a short period of time to accommodate the changes in a CMS standard system or the RAC Data Warehouse. What is the expectation or range parameter for 'short period of time'?

ANSWER: Offeror's should respond with their proposed time frame.

Question #47: RFP M.2 D.5, Pg. 79 (Communications Plan)
What are the requirements of the MAC Blackout Period or where can they be found?

Question #48: RFP Section M2 Pg 77 (Technical Evaluation Criteria)
The chart specifies the points given for each of the evaluation criteria. However, the point next to each of the criteria on the following pages 79, 80 and 81 are not consistent with the points listed on the chart. Please clarify the correct amount of points assigned with each of the criteria.

ANSWER: Please refer to the response to Question #2.

Question #49: RFP Section M2. Subsection A1. IV Pg 77 (Technical Evaluation Criteria)
Please clarify the requirements in the statement:

"Technical approach to share identification information with appropriate entities so validation/claim adjustment/reporting may occur"

ANSWER: The proposal shall indicate the technical approach that will be utilized to ensure all necessary information is shared with the appropriate entities to enable validation/claim adjustment/reporting to occur.

Question #50: RFP Section L.10, Pg 70 (Business Proposal Instructions)
The RFP states: "One business proposal shall be submitted for all RAC Jurisdictions (A,B,C,D) for which the Offeror is interested in proposing." Do we also need one technical proposal for each region, or only one business proposal for each region? Please clarify.

ANSWER: Offeror's shall submit one business proposal and one technical proposal (multiple copies as stated in Section L.9.d) in response to this solicitation. Within each proposal, Offeror's shall identify the jurisdictions they are proposing to perform as a RAC.