DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

SEP 12 2007

The Honorable John Dingell, Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Dingell:

Thank you for giving the Centers for Medicare & Medicaid Services (CMS) the opportunity to testify before the House Energy & Commerce Subcommittee on Oversight and Investigations regarding "Predatory Sales Practices in Medicare Advantage" on June 26, 2007.

Enclosed is the edited transcript and answers for the record to the additional written questions submitted after the hearing. A similar letter also has been sent to Chairman Bart Stupak, Rep. Joe Barton, and Rep. Ed Whitfield.

Your continued interest and support are essential for the Medicare and Medicaid programs' success. If you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,

Donald N. Johnson
Acting Director
Office of Legislation

Enclosures

The Honorable Bart Stupak

1. The Center for Medicare and Medicaid Services (CMS) posts information on its website regarding nursing homes so that Medicare beneficiaries and their families have information about staffing levels, health outcome measures, and any sanctions that CMS has imposed. CMS also posts information on home health agencies and hospitals. Will CMS post on its website copies of Corrective Action Plans imposed on Medicare Advantage (MA) Plans, and information regarding complaints and plan disenrollment data? When will such information be posted?

Answer: CMS will post information regarding Corrective Action Plans imposed on Medicare Advantage plans early in the fall to the CMS website.

Plan disenrollment rates are available on the CMS website through the Medicare Personal Plan Finder. Reasons for disenrollment are captured informally from various sources, some of which are posted on the CMS website. Going forward, CMS is looking into whether this information can be aggregated in a meaningful way.

At this time, CMS does not post complaint information on its website. However, CMS is exploring options to provide this data in the future.

2. What utilization data do MA Plans provide to CMS so that it can monitor the benefits Medicare beneficiaries receive from MA Plans?

Answer: Each year MA plans submit to CMS their bids for the upcoming year. These bids reflect the benefits that will be provided to beneficiaries. Changes to these benefit packages must be submitted to CMS for approval. Additionally, a component of the bid submission is aggregate actual medical expenditures, which typically represents experience for two years prior to the contract year. A component of the bid audits is the reconciliation of this data with audited plan financial statements.

In addition, through primarily the Health Plan Employer Data and Information Set (HEDIS), MA plans provide specific utilization data for several general categories. The categories include:

- Effectiveness of care
- Access/availability of care
- Health plan stability
- Use of services
- Health plan descriptive information
- Cost of care

Some of the specific measures for utilization of services (partial list) include:

- Frequency of selected procedures
- Inpatient utilization—general hospital/acute care
- Ambulatory care
- Inpatient utilization—non-acute care

- Mental health utilization

For more information on utilization measures reported by MA plans see: http://www.cms.hhs.gov/manuals/downloads/mc86c05.pdf.

3. We understand that CMS has contracted with IntegriGuard, LLC (IntegriGuard) to process certain disenrollments from MA Plans. What types of disenrollments is IntegriGuard processing (e.g., all retroactive disenrollments or certain retroactive disenrollments)? How long is it currently taking IntegriGuard to process disenrollment requests?

Answer: IntegriGuard reviews plan submitted requests for retroactive disenrollment. Plans send requests for retroactive actions to IntegriGuard, which reviews these requests to ensure that they are in accordance with CMS' policies and procedures. IntegriGuard reviews retroactive requests that cannot be processed by batch submission and where the retroactivity extends back three months or less. IntegriGuard performs a review of the request and the documentation submitted by the plan. If the documentation supports the request, IntegriGuard inputs the disenrollment into the MARx system.

IntegriGuard usually processes these requests in 14 business days when the system is active. This timeframe could be expanded to 20 business days depending on the MARx system availability.

4. Please provide a copy of the Scope of Work relating to CMS's contract with IntegriGuard to process disenrollments.

Answer: See attached.

5. What discretion do CMS Regional Offices and/or IntegriGuard have with respect to the granting or denial of disenrollment from an MA Plan? Is there an appeal procedure for Medicare beneficiaries who are denied disenrollment? If so, what is the procedure? If there is no appeal procedure, why not?

Answer: Beneficiaries who want a retroactive disenrollment from an MA plan may call 1-800-MEDICARE for assistance 24 hours a day, 7 days a week. The Customer Service Representative (CSR) will assist the individual by helping them review other plan coverage options, should they desire them, and can submit a request to enroll in a different plan if one is chosen. The CSR will then forward the beneficiary's request for a retroactive disenrollment (and, if applicable, retroactive enrollment into another MA plan or a stand-alone Prescription Drug Plan (PDP)) to the appropriate CMS Regional Office for processing by a CMS caseworker.

Special protections are in place for beneficiaries requesting retroactive enrollment or disenrollment because they were misled into enrolling in an MA plan. In the event that the caseworker determines that the retroactive enrollment and/or disenrollment for such a beneficiary is not warranted, s/he will forward the request to another caseworker for a second

review. If the second caseworker upholds the earlier decision, s/he will notify the beneficiary in writing of the decision. CMS Regional Offices rarely deny disenrollment requests from beneficiaries so there has not been an identified need to create a formal appeal process.

Beneficiaries who request retroactive disenrollment under these circumstances also receive important information about the impact that retroactive coverage changes can have on them and the payment for services they have already received. Once the disenrollment is entered into the MARx system, the plan is notified via Transaction Reply Reports, records the action in its records, and provides a refund of any plan premiums paid directly to the plan.

In response to IntegriGuard's role, which is limited to plan requested disenrollments, documentation submitted by the plans is reviewed by IntegriGuard to ensure compliance with established CMS guidelines. If the documentation does not meet the applicable guidelines, the disenrollment request is either: 1) denied and the reason for the denial is communicated to the plan, 2) returned to the organization for additional documentation, or 3) sent to the applicable RO to determine how the request should be handled. If the documentation meets the established guidelines, IntegriGuard processes the retroactive disenrollment into the MARx system.

IntegriGuard may deny a plan's request for a retroactive disenrollment request based upon the documentation submitted by the plan and the information reflected in the CMS systems. IntegriGuard ensures plans are following the guidelines established by CMS for retroactive disenrollment requests.

When there is a dispute with the disenrollment, the plan is referred to CMS staff for assistance. If a request from the plan is denied, the plan has the opportunity to submit additional documentation to substantiate the retroactive disenrollment request, submit the requested change to the RO, or contact the CMS CO regarding the requested change.

6. How many requests for disenrollment have been denied by CMS and/or IntegriGuard, and on what basis?

Answer: For the period of August 1, 2006 through July 31, 2007, IntegriGuard has received 89,601 retroactive disenrollment requests from plans. Of this amount 158 were sent to the RO to determine how the adjustment request should be handled, 3,090 were returned to the plans for addition supporting documentation, and 19,562 requests could not be processed by IntegriGuard. These latter requests were not processed mainly because they were already implemented in the system (by the RO or 1-800-MEDICARE) or it was a duplicate request to one that Integriguard already had in its queue to be worked.

CMS Regional Offices generally do not collect this data because, as stated earlier, Regional Offices rarely deny disenrollment requests from beneficiaries. However, beginning in June 2007, CMS Regional Offices began keeping track of some types of requests under Section 30.4.2 of the Managed Care Manual, those relating to beneficiary allegations of material misrepresentation and inaccurate marketing on the part of the plan. Since CMS began tracking these types of requests, there have been no denials.

7. CMS recently expanded the complaint procedures used by 1-800-Medicare that allow Customer Service Representatives (CSRs) to assist Medicare beneficiaries with disenrollment from an MA Plan. The scripts used by CSRs refer to "urgent complaints." How does CMS define "urgent" in this context?

Answer: The 1-800-MEDICARE CSRs have always been able to assist beneficiaries with an MA disenrollment so that process is not new. If the caller wants a prospective disenrollment (e.g., calls on August 10 to request a disenrollment effective August 31), the 1-800-MEDICARE CSR would handle that action. If the caller needs a retroactive disenrollment, the 1-800-MEDICARE CSR would file a complaint and the plan or CMS regional office would process the retroactive action.

In terms of the complaint script, 1-800-MEDICARE CSRs use predefined categories and subcategories outlined in the CTM database. One of the fields in the CTM database requires CSRs to enter the number of medications beneficiaries have left. The CSR will ask the beneficiary how much medication he or she has left. Based on the conversation, if the CSR selects the drop down option of 0-2 days, the complaint is categorized as an urgent complaint.

8. Vantage, Inc., which holds the CMS contract for 1-800-Medicare, currently is marketing a product called "Informis" to MA Plans. "Informis" would allow MA Plans to use their customer service call centers to identify "hot leads" and close a sale on the same call. What firewalls are in place to prevent Vantage from using its access to CMS databases and beneficiary information in connection with "Informis?"

Answer: Vangent is installing Informis at customer sites. The product is not installed at any existing Vangent properties and therefore there is no opportunity for anyone using Informis to access any systems associated with the BCC contract. Vangent takes great precautions in ensuring that data remains contractually within the program so there is no improper sharing of data with an Informis customer that may provide some type of unfair advantage. Vangent is compliant with HIPAA privacy regulations and all that entails.

9. Why has CMS failed to impose mandatory minimum training requirements and/or a required core curriculum for the marketing and sales of MA Plans?

Answer: The Medicare Marketing Guidelines require organizations that directly employ or contract with a person to market an organization's products must ensure that the agent complies with all applicable MA and /or Part D laws, all Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure beneficiaries receive truthful and accurate information. In addition, the plan is required to conduct monitoring activities to ensure compliance with all applicable MA and/or Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines. Plans accomplish this primarily through agent training. During routine or focused audits, CMS staff review agent training and other methods the plan employs to ensure agents are familiar with CMS requirements as well as the products sold. CMS has not developed agent/broker training programs for Medicare products including Medigap. Brokers generally sell a variety of products including PFFS and Medigap.

However, based on the issues that developed in marketing PFFS plans over the past year, CMS specifically requires PFFS plans to train brokers/agents on applicable federal and state regulations, marketing guidelines, compliance requirements, and PFFS product specific policies. We will continue to monitor the marketing of all Medicare products to determine if additional agent/broker training is required. In addition, CMS reviews and investigates beneficiary/advocate complaints. In the May 25, 2007, memo "Ensuring Beneficiary Understanding of Private Fee-for-Service Plans, CMS released guidance to all PFFS plans specifying additional outreach and oversight measures directed at ensuring that beneficiaries and providers receive accurate and meaningful information about the unique features of PFFS plans. While some of these provisions are unique to PFFS, in the future others could apply to all MA plan types, i.e., secret shopper and outbound education/verification calls.

1) The **STATEMENT OF WORK** - For clarity, the Statement of Work is deleted in its entirety and the following is substituted in lieu thereof: (changes are annotated in ***bold italics***)

STATEMENT OF WORK (Revised 05/13/2007)

Medicare Managed Care Payment Validation

I. SCOPE

The contractor shall support the Centers for Medicare and Medicaid Services' (CMS) program integrity efforts by completing the retroactive payment adjustments, reconciling the final payment for non-renewal contracts, and performing monthly analyses of any discrepancies submitted by the Medicare Advantage Organizations (MAO's), Medicare Advantage Prescription Drug Plans (MA-PDs), and Prescription Drug Plans (PDPs) and reporting on these activities.

A. Background

Medicare managed care programs operate under Section 1876, Section 1833, and Sections 1851 through 1859 of the Social Security Act. These statutory provisions authorize the Centers for Medicare and Medicaid Services (CMS) to make payments to eligible managed care organizations on both a cost and a risk basis. Currently there are over 25 million Medicare beneficiaries enrolled in 622 organizations that are paid over 9.5 billion dollars, on a monthly basis.

Cost-based organizations are paid based upon an annual budget submission by the contracting organization. Risk-based payments to Medicare Advantage Organizations (MAOs) and some demonstration projects consist of a monthly capitation payment based upon demographic characteristics of each Medicare enrollee. Demographic characteristics include age, sex, county of residence, Medicaid status, inpatient status, employment status, end stage renal disease status, and hospice election. Information regarding the demographic characteristics of each beneficiary comes from several sources, including Medicare beneficiaries, CMS databases, Social Security Administration (SSA) data, and contracting managed care organizations.

Monthly capitation payments are calculated differently for cost versus risk-based organizations. However, all requests for enrollment are received from the MAOs and submitted to the CMS Medicare Advantage and Pharmacy System (MARx). The CMS master beneficiary database (MBD) record is checked for Medicare entitlement, and the individual's residence and health status information (demographics) is collected from the source databases. This information, along with the type of managed care organization, determines the capitation amount the MAO will be paid for the beneficiary for that month. There are several special factors, which impact the individual beneficiary payment, and therefore, the aggregate payment to the organization. Those special factors include Medicaid status; institutional status; and ESRD status. Many of these parameters are self-reported by the MAO (e.g., institutional status) or require complex system interaction. In some instances (e.g., ESRD status) the payment level is significantly

impacted. In addition to the special factors, the geographic component of the payment, the "state and county code," is especially susceptible to fraud and error.

The Part C regulation requires that managed care organizations provide CMS with a certification of all data that affects the calculation of CMS' payments to the organizations. Pursuant to that authority, CMS has implemented a requirement that managed care organizations submit monthly statements certifying the accuracy of the enrollment data submitted to CMS for use in the calculation of payments. To make this statement, MAOs must certify the accuracy of not only their data, but also the data provided by CMS. The implementation of this requirement has led to increased scrutiny by MAOs of CMS' payment systems and reluctance to **attest** to the accuracy of data that is not controlled by the managed care organization, but rather is provided to CMS by several State and Federal agencies according to widely varying schedules. Because the certification is required monthly, MAOs now rightly expects that all adjustments, with the exception of ESRD, brought to CMS' attention will be corrected in the next month's report. While CMS is requiring MAOs to dedicate resources to meeting the certification requirement, it must also be prepared to address more timely the adjustments brought to its attention. For example, since the implementation of the certification requirement, the San Francisco Regional Office has received a significant increase in the number of requests for "state and county code" adjustments.

There have been numerous reports developed by oversight agencies that focus on the Medicare Advantage inaccurate payment issues. The recent testimony of the Government Accounting Office to the Senate Committee on Appropriations, *Medicare CMS Faces Challenges to Control Improper Payments*, cites a number of issues specific to the Medicare + Choice program. The draft testimony, dated March 9, 2000, states: "As for Medicare Advantage, CMS similarly lacks the data needed to monitor the appropriateness of payments made to health plans and the services Medicare enrollees receive." The testimony further cites that since payment rates are based in part on plan-provided information, erroneous or misreported data could lead to inappropriate payments. It suggests that CMS needs to improve its capacity to monitor MAO performance and ensure that payments are appropriate and that MAOs fulfill their obligations.

Additionally, the 1998 Chief Financial Officer's (CFO) Audit of CMS identified a number of vulnerabilities in the managed care payment system and provided recommendations for corrective action. This audit has increased the need to revise the payment validation and certification process. The current process relies heavily upon manual review of sample data and is, therefore, vulnerable to inaccuracies and potential fraud. Although CMS reconciles the retroactive payment adjustments on a monthly basis, e.g., changes to enrollment status, ESRD-status, address changes, etc.; recent CFO investigation has shed doubt on the accuracy and efficiency of the process with an assertion that there is significant opportunity for MAO fraud. CMS requires assistance in assessing and implementing the CFO audit recommendations to better ensure the integrity of the Medicare Advantage program, with consideration of industry 'best practices'.

The implementation of the Medicare Modernization Act of 2003 has created many unexpected challenges for MA, MA-PD and PDP Organizations. Enrollment, disenrollment and Plan Benefit

Package adjustment transactions processed per month have nearly tripled and become more complex. The advent of the Plan to Plan reconciliation process has created a need for monthly certifications (attestations) from Prescription Drug Plans.

B. Purpose

The purpose of this task order is to:

- Complete all retroactive payment adjustments and enrollment adjustments submitted by MAO's, Medicare Advantage Organizations, Medicare Advantage Prescription Drug Plans, and Prescription Drug Plans, including in Drug Card Sponsors.
- Complete final reconciliation of payment for non-renewals of MAO, Medicare Advantage Organizations, Medicare Advantage Prescription Drug Plans, and Prescription Drug Plans.
- Make reconsideration determinations with plans that are appealing decisions regarding payments.
- Complete monthly analysis of plan discrepancies and report out.

II. REQUIREMENTS

Independently and not as an agent of the Government, the contractor shall furnish all the necessary services, qualified personnel, materials, equipment, and facilities, not otherwise provided by the Government, as needed to perform the requirements of the Statement of Work (SOW).

The following SOW sections are incorporated by reference with the same force and effect as if they were provided in full text:

A. Tasks to be Performed/Requirements

CMS is interested in finding and implementing new and innovative approaches for performing Medicare Advantage program integrity activities. The contractor shall implement innovative techniques as appropriate for payment review and other processes to be accomplished under this SOW. The contractor shall provide a wide variety of statistical analysis, data analysis, and trending to support payment review activities. The contractor shall use all appropriate CMS Medicare data, as well as data from other sources in accomplishing requirements.

The contractor shall possess appropriate hardware, software and telecommunications equipment. All hardware and software purchases, changes, or leasing arrangements shall be approved in advance by the Contracting Officer (CO). The contractor shall maintain back up copies of all critical data. In addition, the MMC-PIC shall meet all of the minimum technical requirements defined in the umbrella SOW.

Task 1: Project Plan

The contractor shall submit an updated project plan within 30 calendars days, in accordance with SOW Section. The project plan shall be updated within 10 business days after any subsequent

change has been determined. The Government reserves the right to approve the modified project plan if necessary.

The plan shall be submitted to CMS for approval. Any additional deliverables identified by the Contractor as part of the project plan shall be added or modified as necessary.

Task 2: Data Systems Plan

The Contractor shall submit an up-date to the GTL final data/systems plan semi-annually. The Contractor shall identify, from a data/systems perspective, how it shall perform the Standard Data Analysis. It shall include a separate section reflecting the accomplishments achieved during the previous contract period.

Contractor shall track and report systems issues related to CMS System Updates to the MARx and MBD Systems. Contractor shall report any systems issue that prohibits processing of transactions or result in incorrect payments generated to organization. Contractor should periodically retry those transactions to verify systems correction and report ongoing problems to the GTL or any other established CMS Contacts designated.

Task 3: Conduct Pre-Payment Review on Proposed Retroactive Adjustments

Within 45 days of receipt, the Contractor shall conduct pre-payment review on proposed retroactive adjustments for changes in state and county code, institutional and special status categories (ESRD, Medicaid, State and County code, institutional status) and enrollment changes. After conducting pre-payment review the contractor shall process the adjustment. As part of the system implemented to process the adjustments, the Contractor shall continue the process by which MCOs, Medicare Advantage Organizations (MAO's), Medicare Advantage Prescription Drug Plans, and Prescription Drug Plans may appeal determinations made by the Contractor in processing the pre-payment reviews (See Standard Operating Procedure for the MAO Appeals Process). The contractor will follow the policies and procedures that are in place at CMS for the completion of all retroactive adjustments. See the standard operating procedures that are in the Medicare Managed Care Manual, Chapter 2, Chapter 7 and Chapter 19, Section 60.

In addition the contractor is required to maintain the ability to create special review teams as required. This will be based on the fluctuating work load. This may be the result of the number of new organizations participating in the MA, MA-PD and PDP programs, the annual enrollment period, implementation of changes in the law and/or the implementation of new systems, both at the organizations and at CMS.

Task 4: Complete all Final Reconciliations for Non-Renewing Plans

Medicare Advantage Organizations (MAO's), Medicare Advantage Prescription Drug Plans and Prescription Drug Plans that decide not to renew their contract with CMS shall submit all of their reports and documentation for any final reconciliations of payment within 45 days after the termination of their contract. The contractor will process all of these requests within 45 days of

receipt. An acknowledgement letter will be sent to the MCOs within 10 days of the contractor receiving the request. Approximately nine months after the contract termination, the contractor will process a final amount, based on final report data, if requested by the Government.

Task 5: Review Monthly Discrepancies Submitted by the Plans

Contractor will review all discrepancy reports submitted by the plans each month and provide a response to each plan by the end of the next month.

Contractor will produce a monthly and annual summary report by plan number, contract number and by region. It will list all reconciliations, retroactive payments and adjustments by special categories (i.e. institutional, ESRD). This report should provide analysis, trends and identification of any outliers in order for CMS to conduct any further investigation.

Contractor shall receive Monthly Certifications of Enrollment Changes (Attestations) from all MA, MA-PD, and PDP plans. Contractor shall process and review attestations for compliance with CMS program requirements and report the results monthly.

Contractor shall receive Monthly Plan 2 Plan Certifications (Attestations) from all PDP plans. Contractor shall process in accordance with CMS program requirements.

Task 6: Provide Information to CMS Staff to Assist in Monitoring Activities

The contractor will develop standard reports to provide data to CMS staff on a monthly basis. Additionally, the contractor will provide additional information to CMS Central Office and Regional Office upon request.

Contractor shall provide client services to MA, MA-PD and PDP Organizations, Regional Office and Central Office personnel. Contractor shall contact CMS Staff and MA, MA-PD and PDP Organizations to complete any or all of the task outlined in the SOW to as required.

Contractor shall provide MA, MA-PD and PDP Organizations with a Final Disposition Report upon completion of their request for action. Request should contain detail of actions taken and corrective actions if known.

B. Reporting Requirements

All written documents for this project, with the exception of the IntegriGuard ScoreCard, shall be delivered via a single hard copy plus an electronic version via e-mail, 3.5-inch diskette, or compact disk. The IntegriGuard ScoreCard shall be delivered electronically via e-mail. The GTL may request additional hard copies as necessary. All electronic files shall be submitted in a format that is compatible with Microsoft Office 2000. This is subject to change, and the Contractor shall be prepared to submit deliverables in any new CMS standard.

The GTL shall provide the Contractor with comments on draft reports within two (2) weeks of

receipt. If no response is received within two (2) weeks, the Contractor may assume that the draft report is approved for development of final reporting.

1. **Project Plan**: The Project Plan shall include planning for each of the requirements for this Task Order and shall highlight each step of implementation of this Task Order. The project plan shall include, at a minimum, the following information (not necessarily in the order presented here):

- Descriptions of Contractor methods for satisfying task requirements or task protocol including:
- Resource planning by activity (description of the activity, anticipated results, activity implementation schedule and delivery schedules/completion dates).
- Activity interdependency and critical path for completion of all tasks.
- Key staff types devoted to each task or activity, if appropriate, and time allocation for each.
- Key milestones signifying successful completion of each task and periodic internal assessment/progress reports planned.

2. **Data/Systems Plan**: The Contractor shall prepare a detailed plan that outlines how it shall receive, store, safeguard, manipulate, and analyze data necessary to perform data systems security in accordance with OMB Circular A-130 Management of Federal Information Resources, Appendix III, "Security of Federal Automated Information Systems" necessary for maintaining the strict confidentiality requirements of all CMS data obtained from CMS files, as well as all data collected under any potential contracts. These confidentiality requirements shall also include all requirements under the HIPAA regulations, as well as all requirements for successfully safeguarding any and all data that could identify individual Medicare beneficiaries. This data/systems plan shall, at a minimum, include the following:

- A description of assumptions and constraints under which each type of analysis shall be performed.
- A list and description of data files necessary to conduct the data analysis, given the constraints that only data stored at CMS would be provided by the GTL.
- A list and description of data the Contractor would want to access that is not stored at CMS, if necessary (e.g., stored at the local MAO site).
- A schedule of how often new or updated data would be needed (e.g., weekly, monthly, other).
- A certification that the hardware and software being proposed have the capacity to manipulate the anticipated volume of data.
- A description of how the Contractor plans to use the hardware and software products.
- A description of how the contractor will ensure compliance with The Privacy Act of 1974 and CMS MMC-PIC Security Requirements. (MMC-PIC SOW Section 11.B, Security & Appendix E)
- A discussion of how the proposed Contractor data systems environment is appropriate, given CMS' system architecture.
- List of the hardware, software and telecommunications equipment required to accomplish this Task Order, including the licensing restrictions.

- Other items as identified by the Contractor.

3. **Standard Quarterly Data Report**: The Standard Quarterly Data Report shall include at a minimum, the following:
- Statement of number of records examined, broken down by special status category and MA.
- Statement of records received and processed by RO broken down by special status, enrollment, disenrollment, PBP changes and the financial impact.
- Statement of number of records for which discrepancies were identified, broken down by special status category and MA
- Statement of number of pre-payment reviews on proposed retroactive adjustments *received*, processed.
- Statement of meaningful trends discovered during data analysis
- Statement of number of final reconciliations is being completed.
- Description of special reviews/actions being conducted as directed by Central Office.
- Statement of number of special reviews being conducted as directed by Central Office.
- Statement of the number of Probe Studies by MA, including the number of items identified and the quality of the supporting data by the MA.

4. **Meetings Every Two Weeks**: The contractor will meet, via teleconference, with the GTL and the appropriate staff to discuss progress, the reports and any issues that are identified while performing the tasks listed above.

5. **Monthly Report to CMS and Regional Offices:** Contractor shall prepare a monthly and annual summary report by plan number, contract number and by region to CMS and the Regional Offices that contains a summary of adjustments processed. It will list all special projects for CMS, reconciliations, retroactive payments and adjustments by special categories (i.e. institutional, ESRD). This report should provide analysis, trends and identification of any outliers in order for CMS to conduct any further investigation.

6. ***Report on Content of Final Report: The contractor shall provide the GTL with sample data to be approved by the GTL for submission to CBC Senior Leadership.***

7. ***Final Report: The contractor shall submit final report based on approved data approved by the GTL.***
8. Integriguard ScoreCard: The Contractor shall submit a snapshot of the status of the pending and processed transactions. It will include pertinent information related to the accomplishment of work such as transactions that cannot be processed due to systems issues, transactions that can be processed (now), and availability of the UI etc.

C. Period of Performance

The period of performance work under this Task Order be August 1, 2007 through ***July 31, 2008.***

II. Personnel Requirements

The personnel requirements for this Task Order are as defined in the MMC-PIC SOW, Section 5,

MMC-PIC Project Management. Additional requirements not otherwise identified in the umbrella SOW are identified below as appropriate.

All contractor and subcontractor personnel working on this Task Order must submit a signed Non-Disclosure Statement (Appendix D to this SOW) prior to the start of the project. The Contractor shall retain the Non-Disclosure Statements on file at the place of performance.

Key Personnel: Following are the Key Personnel positions for this task order. They are not required to be full time:

Utilization Management/Benefit Integrity (UMBI) Manager
Program Director

III. QUALITY ASSURANCE

Quality assurance for this Task Order is governed by Section 10, parts A, B, and C of the MMC-PIC SOW, Quality Assurance and MMC-PIC Evaluation Plan. In addition, the following quality assurance monitoring and performance indicators are applicable:

Cooperation/Coordination (Level of interaction between the Contractor and appropriate stakeholder(s)): The Contractor may be required to cooperate and coordinate with stakeholders other than CMS. They are MAO, providers, and other entities as appropriate. Some examples of how CMS will evaluate Contractor performance include the following:

- Demonstration of ongoing dialogue or meetings with the appropriate and necessary parties,
- Feedback from other entities with which the Contractor has had to work with, and
- Number and type of issues that arise and indicate communication, or a lack of communication, between appropriate entities and the Contractor.

- Quality (Appropriateness, completeness and error free nature of all activities conducted by the Contractor): The Contractor shall maintain the highest degree of quality for all activities performed throughout the period of performance of this contract. Some examples of how quality shall be evaluated include the following:
- Completeness and accuracy of rate cell reviews, and
- Completeness and accuracy of all deliverables.

Innovation (Creative approaches identified and/or used to protect the fiscal integrity of the Medicare Trust Fund): Some examples of how the Contractor shall be evaluated include the following:

- Review of Continuous Improvement Report,
- The extent to which the Contractor used and/or analyzed innovative data analysis approaches,
- Review of the processes that the Contractor implements and utilizes to carry out the effective and efficient performance of this contract, and
- Assessment of the outcomes that the Contractor achieves in relation to all government priorities.

Timeliness (Ability to meet established time lines): This Task Order is particularly time sensitive. The Contractor shall submit all deliverables to CMS so that they are received on or before the due dates specified. Some examples of how the Contractor performance shall be evaluated include the following:

- Demonstration that the Contractor performed tasks in accordance with the schedule set forth in this Task Order.
- The time frame under which enrollment reviews are completed.
- The time frame under which reports were completed.

Value Added (Ability of the Contractor to illustrate in a deliverable how its performance adds value to the Medicare program): Some examples of how contractor performance shall be evaluated include the following:

- CMS adopts the Contractor's approaches used in the performance of this Task Order,

Satisfaction (Ability of the Contractor to meet and manage customer expectations) The Contractor shall provide at a minimum professional and courteous service to the different entities involved with this Task Order. Some examples of how the Contractor performance shall be evaluated include the following:

- Feedback from MAs, MA-PDs and PDPs (if appropriate),
- Feedback from CMS Regional Offices (ROs), and
- Feedback from CMS Central Office (CO).

Integrity (Ability of the Contractor to uphold the highest standards of professional integrity and act in the best interest of the Medicare program): The Contractor or any Sub-Contractors, shall not engage in fraud and abuse or be found to have non-disclosed conflicts of interest while work is performed on this contract or other government contracts. Some examples of how the Contractor performance shall be evaluated include the following:

- Demonstration that the Contractor continuously maintained professionalism and honesty in its business activities.
- Demonstration that all activities were carried out in a legal and ethical manner.

The GTL shall use the performance indicators above in evaluating contractor performance and the acceptance of Contractor deliverables as appropriate. The following criteria shall be used to indicate the measure of acceptance:

- Excellent: Significantly exceeds requirements.
- Good: Exceeds requirements.
- Acceptable: Fully meets requirements.
- Poor: Requires modification to meet requirements.
- Unacceptable: Does not meet requirements.

ITEMS TO BE FURNISHED AND DELIVERABLE SCHEDULE

The Contractor shall submit all required reports and deliverables in accordance with the following schedule. Reports and/or deliverables submitted under this contract shall be in accordance with the Statement of Work entitled Medicare Managed Care Payment Validation.

ITEM	DESCRIPTION	RECIPIENT	DELIVERY DATE
1.	Updated Project Plan IAW SOW II.B.1	GTL	Quarterly; By the 15th/mo which follows the end of the contract quarter
2.	Updated Data/Systems Plan		Semi Annually; by the 15th
	IAW SOW II.B.2	GTL	(1st report within 45 days of renewal date. Updated Data/Systems Plan by the 15th of the month which follows the end of the sixth month of the contract quarter
3.	Standard Quarterly Data IAW SOW II.B.3	GTL	Quarterly (By the 15th of the month following the end of the contract quarter.
4	Telephone Conference Calls IAW SOW II.B.4	GTL	Every 2 weeks
5.	Monthly Report to Reg. Office and Central Office IAW SOW II.B.5	GTL, Regional Office Point of Contact	By the 20th of the each month.
6.	***Report on Content of Final Report IAW SOW II.B.6***	***GTL***	***90 Days before end of Task Order***
7.	***Final Report II.B.7***	***GTL***	***Draft: Aug 16, 2007 Final: Aug 31, 2007***
8.	IntegriGuard Scorecard II.B.8	GTL/DEPO Dir.	Weekly on Tuesdays

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