

**Round 5 Questions and Answers for  
RFP Number 2013-CMFD-01**

<b>Question</b>	<b>Response</b>
<b>Question 1:</b> On page 12, requirement 701: Could you please elaborate on the Agency security models that are required to be met (Network, Database and File Systems)?	<b>Vendor is expected to create levels of access to the system based on the staff classification (administrative, supervisory, and user).</b>
<b>Question 2:</b> What is the approximate volume of claims for a 12 month period?	<b>34,269,771</b>
<b>Question 3:</b> What is the split between Professional (HCFA) and Facility (UB) claims?	<b>The number of professional claims is 16,368,715 (47.76%) and the number of facility claims is 2,581,532 (7.53%).</b>
<b>Question 4:</b> Please describe how the state envisions potential FWA identification and recovery to work in a managed care environment?	<b>This is still being determined.</b>
<b>Question 5:</b> 207 Provide a detailed plan for data migration of all existing cases and scanned and uploaded documents from various Agency drives into vendor's proposed case management system. Old cases must maintain the association with their scanned and uploaded documents.  What are the critical fields that need to be transferred?  Is there a current specification of fields that the agency can share?	<b>207 refers to data/information maintained in the Agency's current system (spreadsheets, Word documents, Access database, queries, Outlook emails, etc.) that will need to be transferred to the case management system. As stated in 207, "cases must maintain the association with their scanned and uploaded documents". Therefore, all information is considered "critical".</b>  <b>Not at this time.</b>
<b>Question 6:</b> What type of integration to other systems do you require for the case management system? For instance, does it need to pass status information to other systems?	<b>Staff should be able to import information into the case management system from various drives without having to exit the case management system.</b>  <b>The system will not have to pass status information to other systems.</b>
<b>Question 7:</b> Please identify data sources that are expected to be integrated with this solution per requirement # 402 "Connect to other agency databases for data sharing (internal and external databases)".	<b>It is expected that vendor will be able to connect to databases from other state and federal agencies to include but not limited to the Department of Labor, Department of Revenue, Department of Public Health (Vital Statistics), and OIG MED Exclusion database.</b>
<b>Question 8:</b> The RFP provides on page 8 that the Agency intends to pay a contingency fee for the advanced fraud analytic component, and that this fee should not exceed 9.5%. Furthermore, Pricing	<b>The answer to both questions is "No".</b>

Schedule B, Contingency Fee Services on page 57 states that the contingency fee will be based upon recovered monies identified through the analytics tool, and again reiterates that the contingency fee percentage is capped at 9.5%.

Many otherwise technically responsive and financially responsible bidders may be prevented from bidding on this RFP, for one or more of the following reasons:

1. The Vendor's obligation is to supply staff, support and updates in addition to the advanced fraud analytics and case management tool that will comprise the Advanced Fraud Detection System. In the case of a vendor-hosted solution, the vendor would need to procure hardware and any COTS software required by the solution. The structure of the RFP requirements suggests that the additional costs for staff to establish connectivity to the Agency's systems and to set up the system to accommodate the State's data would also be part of the contingency-priced analytics component.
2. The Vendor's obligation is essentially to help identify, not recover, instances of fraud, waste and abuse. Recoveries—which are a significant component of the Vendor's compensation given the contingency fee requirement—are both outside the scope of the Vendor's work, as well as out of the Vendor's control.
3. The Vendor will experience significant upfront costs in the development, deployment and operation of the advanced fraud analytics that will not be reimbursed via the Case Management implementation costs.
4. Fraud cases generally take many months to years to resolve and generate recoveries. Recoveries and settlements are often much

smaller than the amounts originally identified. Accordingly, the Vendor may be placed in a position of expending significant upfront monies and successfully identifying fraud cases, yet not receive monies for those cases for months to years, and the fees paid to the Vendor could be based on recoveries much smaller than the cases the Vendor's analytics and the Advanced Fraud Detection System originally identified due to settlement or the fraudulent party's inability to pay.

- 5. Based upon the more recent experience of several states in their Medicaid Recovery Audit Programs (in which payment via contingency fee is statutorily mandated and capped at 12.5% of recoveries vs. the RFP's cap of 9.5%), states have had either one or no bidders, demonstrating that the vendor communities are not satisfied with contingency fee-based compensation methodologies for similar work.

Accordingly, will the Agency amend the RFP to allow Vendors to propose a fixed price instead of contingency fee for the staff, support and updates requirements for the Advanced Fraud Detection Analytics component?

Alternatively, will the Agency amend the RFP to allow Vendors to propose a fixed price for the design, development and implementation of the Advanced Fraud Detection Analytics component?

**Question 9:** The RFP states "Other divisions within the Agency will also be able to utilize the Case Management System". Please provide the type of work, scope and estimates of quantities the vendor's software and hardware should be prepared to process and store for those other divisions.

**At the time the Agency does not anticipate other divisions utilizing the case management system.**

**Question 10:** Page 14, C.4. Implementation Requirements - Is the State flexible on the five month installation period? If not, can you share your concerns for having the system in place in this specified amount of time?

**See Amendment 3 for changes to this section.**

<p><b>Question 11:</b> Does the State prefer pre-built algorithms for fraud detection or do you have range of custom ones that is preferred?</p>	<p><b>The state will utilize pre-built algorithms, where appropriate. The parties will then determine if additional algorithms should be considered.</b></p>
<p><b>Question 12:</b> Is the State interested in optional prevention methodologies?</p>	<p><b>Yes.</b></p>
<p><b>Question 13:</b> How many cases are typically worked simultaneously?</p>	<p><b>The number of cases typically worked simultaneously varies by unit. The analysts in the Provider Review Unit works 1 case at a time and have 2 or 3 in the queue ready to work; the investigators in the Investigations Unit works 3 -5 cases simultaneously; and the analysts in the Recipient Review Unit works 6 cases simultaneously.</b></p>
<p><b>Question 14:</b> How many cases are typically worked over the course of one year?</p>	<p><b>The number of cases worked over the course of one year is 84 for Provider Review; 140 cases per year for Investigations; and 1,565 for Recipient Review.</b></p>
<p><b>Question 15:</b> What is the percentage or dollar value of annual recovered claim payments?</p>	<p><b>Provider Review Unit - A 3 year average of approximately \$2million</b>  <b>Investigations – A 3 year average of approximately \$140,000</b>  <b>Recipient Review – A 3 year average cost savings of approximately \$524,217.16</b></p>