G A O
Accountability * Integrity * Reliability

Comptroller General
of the United States

United States Government Accountability Office
Washington, DC 20548

Decision

Matter of: HealthDataInsights, Inc.; CGI Federal Inc.

File: B-409409, B-409449, B-409449.2, B-409470, B-409470.2, B-409482, B-409482.2

Date: April 23, 2014

Kenneth B. Weckstein, Esq. and Shlomo D. Katz, Esq., Brown Rudnick LLP, for HealthDataInsights, Inc.; and Scott M. McCaleb, Esq., Daniel P. Graham, Esq., W. Barron A. Avery, Esq., and Christine Reynolds, Esq., Wiley Rein LLP, for CGI Federal Inc., the protesters.
Jeffri Pierre, Esq. and Anthony E. Marrone, Esq., Department of Health and Human Services, Centers for Medicare and Medicaid Services, for the agency.
Noah B. Bleicher, Esq. and Sharon L. Larkin, Esq., Office of the General Counsel, GAO, participated in the preparation of the decision.

DIGEST

Protests that the payment terms included in solicitations for recovery audit contracts are inconsistent with commercial practices, unduly restrictive of competition, and in violation of statute and regulation are denied where the solicitations were properly issued in accordance with FAR Subpart 8.4, the agency reasonably justified the payment terms, and the terms are in accord with statute and regulation.

DECISION

HealthDataInsights, Inc. (HDI), of Las Vegas, Nevada, and CGI Federal Inc., of Fairfax, Virginia, protests the terms of solicitation Nos. RFQ-CMS-2014-Region 1, RFQ-CMS-2014-Region 2, and RFQ-CMS-2014-Region 4, issued by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), for recovery audit contracts. HDI also protests the terms of solicitation No. RFQ-CMS-2014-Region 3. The protesters raise a number of challenges to the solicitations' payment terms, including that the terms are inconsistent with customary commercial practices.

We deny the protests.

BACKGROUND

Each year, CMS processes more than one billion claims for payment under the Medicare fee-for-service federal health insurance program. CMS relies on a variety of tools to ensure that claims paid to health care providers are proper and in accordance with Medicare guidelines. One such tool to reduce improper payments is the Recovery Audit Program, which Congress authorized on a nationwide basis in December 2006.[1] See Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2991 (2006) (codified at 42 U.S.C. § 1395ddd(h) (2014)). Under the program, CMS contracts with Recovery Audit Contractors (RACs) to identify overpayments and underpayments and recoup overpayments under Medicare Part A and Part B. HDI Agency Report (AR), Tab 2, Report to Congress--Recovery Auditing in the Medicare & Medicaid Programs FY 2011, at iii.

CMS previously awarded four contracts to four firms in late 2008, with each contractor serving as a RAC in a different region of the country. See, e.g., HDI AR, Tab 3, Contract No. HHSM-500-2009-00006C, at 1-2. The solicitations at issue here are for the follow-on contracts of those first awarded in 2008.

CMS issued the four solicitations pursuant to the General Services Administration's (GSA) Federal Supply Schedule (FSS) procedures, as set forth at Federal Acquisition Regulation (FAR) Subpart 8.4. RFQ at Cover Letter.[2] The RFQs, posted to GSA's e-Buy system, were limited exclusively to vendors holding schedule contracts 520-9 for "Recovery Audits." Id.; see, e.g., CGI AR, Tab 10, CGI's GSA Contract, at 1-5. Each of the solicitations require the contractor to perform the same services but in a different region of the country.[3]

The RFQs, issued on a rolling basis between December 2013 and January 2014, provide for the issuance of a contingency fee task order with a 1-year base period and varying option periods, including option periods exclusively for "reconciliation and contract closeout."[4] RFQ § 3.1. Pursuant to the RFQs, CMS anticipates

---

[1] The Recovery Audit Program began as a demonstration in six states from 2005 through 2008. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256 (2003).

[2] Citations in this decision to the solicitation are to RFQ-CMS-2014-Region 4, unless otherwise indicated.

[3] For example, RFQ-CMS-2014-Region 3, seeks RAC services in the southeastern United States.

[4] The RFQ for Region 3, issued on December 6, 2013, included two option periods for recovery audit work and two 1-year periods for reconciliation and closeout. RFQ-CMS-2014-Region 3 at Cover Letter, § 3.1. The RFQ for Region 4, issued on January 10, 2014, included three option periods for recovery audit work and two

(continued...)

issuing an order to a vendor for each region whose quote represents the best value to the agency, considering price and four non-price evaluation factors: past performance, technical approach, key personnel and staffing, and financial capability.[5] Id. § 9.2.

Each solicitation includes the same detailed statement of work (SOW) that identifies the various tasks and responsibilities associated with the recovery audit work. As stated in the SOW, the RACs are to identify and collect Medicare overpayments and underpayments.[6] Id. § 2.0; SOW at 1, 14. In addition, the SOW requires the RACs to provide support to CMS throughout the appeals process, collaborate with other Medicare contractors and CMS partners to adjust improperly paid claims and avoid duplicative reviews, maintain a customer service center to respond to CMS and provider inquiries, and other tasks. SOW at 1-2. The RFQs also anticipate the payment of contingency fees based on the amount of Medicare overpayments recovered. Id. at 50. Since the process for the recovery of overpayments is central to the resolution of the protest issues here, it is set forth in greater detail below.

When a RAC identifies an overpayment of a claim, a demand letter is sent to the provider to recoup the overpayment. Id. at 33; HDI AR, Tab 2, Report to Congress--Recovery Auditing in the Medicare & Medicaid Programs FY 2011, at 4. The provider then either repays the overpayment or appeals the improper payment determination. HDI AR, Tab 2, Report to Congress--Recovery Auditing in the Medicare & Medicaid Programs FY 2011, at 5. Specifically, if the provider disagrees with the overpayment determination, the provider may seek a

---

(...continued)
1-year periods for reconciliation and closeout. RFQ-CMS-2014-Region 4 at Cover Letter, § 3.1. The RFQ for Region 1, issued on January 16, included three option periods for recovery audit work and two 1-year periods for reconciliation and closeout. RFQ-CMS-2014-Region 1 at Cover Letter, § 3.1. The RFQ for Region 2, issued on January 17, included four option periods for recovery audit work and two 1-year periods for reconciliation and closeout. RFQ-CMS-2014-Region 2 at Cover Letter, § 3.1.

[5] The RFQs identified the following three technical approach subfactors: legislative requirement, claim reviews, and systems security and IT specifications. RFQ § 9.2.

[6] Improper payments include, for example: (1) payment for items or services that do not meet Medicare's coverage and medical necessity criteria, (2) payment of items that are incorrectly coded, and (3) payment for services where the documentation submitted does not support the ordered services. HDI AR, Tab 2, Report to Congress--Recovery Auditing in the Medicare & Medicaid Programs FY 2011, at 1-2.

"redetermination" within 120 days of the demand letter.[7] HDI AR, Tab 25, Medicare Appeals Process Fact Sheet, at 2. CMS reports that redeterminations are "generally" resolved within 60 days of receipt of the redetermination request. Id. If dissatisfied with the outcome of the redetermination, the provider has 180 days to request reconsideration by a "Qualified Independent Contractor" (QIC), a CMS contractor responsible for reconsiderations. Id. at 2-3. The QICs decide reconsiderations within 60 days "in most cases." Id. at 3. The next levels of appeal involve review by an administrative law judge, an appeals council review, and, lastly, review in a district court. Id. at 3-4. Because the contingency fees contemplated by these solicitations are defined as a percentage of the improper payment recovered, if an appeal is adjudicated in the provider's favor at any level, the RAC is required to repay any portion of a contingency fee it has received that is associated with that recovery. RFQ § 1.3; SOW at 50.

As relevant to this protest, the solicitations include a "Schedule Of Payments" provision that describes when the RACs are permitted to invoice the agency for their contingency fee. The payment terms stipulate as follows:

> The contractor shall be paid in accordance with their contingency fee . . . . Recovery Auditors shall not receive any payments for the mere identification of improper overpayments. Recovery Auditors may invoice for the applicable contingency fees when all required claim elements are input into the Data Warehouse[8] and the improperly paid claims have exited the second level of the appeals process (QIC level). There are specific statutory timeframes for filing appeals at each level. If no appeal has been filed within the initial 120 days that a provider has to appeal, Recovery Auditors may then invoice for their contingency fee payment. If no additional appeal is submitted within the required timeframe, the claim may be invoiced for payment.

RFQ § 1.3. Thus, under the solicitations, the RACs are required to wait until the expiration of the 120 days permitted for first-level appeals before the contractors can invoice for payment. Id. If a redetermination is requested, the RAC must wait to invoice until after a decision is issued (no more than 60 days after requested) and the time for requesting a reconsideration expires (180 days after redetermination

[7] If the provider submits a request for redetermination within 40 days of the demand letter, then it is not required to repay the identified overpayment until a final determination is made. HDI AR , Tab 26, Limitation on Recoupment for Provider, Physicians, and Supplier Overpayments, at 5. Recoupment can begin on the 41st date after the demand letter is issued. Id.

[8] The Data Warehouse serves as the web-based central repository for all claims information in the Recovery Audit Program. SOW at 8.

decision). If a reconsideration is requested, then the RAC must wait to invoice until the reconsideration is decided (60 days after requested), and the overpayment is confirmed. HDI AR at 5; CGI AR at 4. In sum, the RFQs require the RACs to wait a minimum of 120 days and no more than 420 days before they can invoice for their contingency fee. As discussed in more detail below, the agency explains that the payment terms, which are the subject of these protests, are necessary to address situations where a RAC has to reimburse CMS for an overpayment determination that is overturned on appeal after the contract period of performance has ended. HDI AR, Tab 1, Contracting Officer's Statement, at 3.

Prior to the deadline for the submission of quotes, HDI and CGI--both incumbent RACs--filed protests challenging the solicitations' payment terms.[9]

DISCUSSION

The protesters argue that the payment terms of these solicitations are inconsistent with customary commercial practice, are unduly restrictive of competition, violate the Recovery Audit Program's enabling statute, and violate prompt payment requirements. As discussed below, we find no basis to sustain the protests.

Customary Commercial Practice

First, both protesters assert that the solicitations' payment terms, which require the contractors to wait more than 120 days and as long as 420 days to invoice for payment, are inconsistent with customary commercial practice, and thus could not be properly included in these commercial item acquisitions. HDI Protest at 9; CGI Protest at 6.[10] In support of this assertion, the protesters point to their incumbent contracts, which provided for payment once the overpayment was collected; payment was not conditioned on the appeals process. HDI Protest at 10; CGI Protest at 6-7; see also CGI AR, Tab 4, Contract No. HHSM-500-2009-00003C, § B.3. The protesters argue that it was improper for the agency to include in the solicitations payment terms different than those in the incumbent contracts without

[9] As explained above, HDI protested all four solicitations whereas CGI protested three; CGI did not challenge the RFQ for Region 3. GAO docketed HDI's protests in the order received: the challenge to the RFQ for Region 3 as B-409409; Region 4 as B-409449; Region 1 as B-409470; and Region 2 as B-409482.2. CGI's protest of the Region 4 RFQ is docketed as B-409449.2; Region 1 as B-409470.2; and Region 2 as B-409482.

[10] HDI's four protests are essentially the same. Nevertheless, citations to HDI's filings refer to its protest challenging the terms of the RFQ for Region 3 (B-409409), unless otherwise indicated. Citations to CGI's filings refer to its challenge of Region 4's RFQ (B-409449.2).

first issuing a waiver, in accordance with the procedures outlined in FAR § 12.302. HDI Protest at 10; CGI Protest at 6. In this regard, FAR § 12.302(c) bars the tailoring of solicitations for commercial items in a manner inconsistent with customary commercial practice unless a waiver is approved. FAR § 12.302(c); see also, e.g., Smelkinson Sysco Food Servs., B-281631, Mar. 15, 1999, 99-1 CPD ¶ 57 at 6 (sustaining protest of the terms of a solicitation where the agency failed to obtain a waiver prior to including terms in the solicitation that were inconsistent with customary commercial practice).

We disagree with the protesters that CMS was required to follow FAR Part 12 procedures, including those concerning the tailoring of solicitations or contracts, when it ordered the recovery audit services off of a GSA schedule contract. In this regard, FAR Part 12 identifies policies and procedures for the acquisition of commercial items, and contracting officers are instructed to use Part 12 procedures in conjunction with those prescribed in FAR Parts 13 (simplified acquisition procedures), 14 (sealed bidding), or 15 (contracting by negotiation), as appropriate for the particular acquisition. FAR §§ 12.102(b), 12.203. FAR Part 12 does not mandate its use in connection with FAR Subpart 8.4 procurements, like the acquisition here. Instead, agencies are required to use the procedures detailed in FAR Subpart 8.4 when placing orders (or establishing a blanket purchase agreement (BPA)) against a GSA schedule contract.[11] FAR § 8.405. Moreover, FAR Subpart 8.4 does not require agencies to issue a waiver before including terms or conditions that are inconsistent with customary commercial practice in a solicitation.[12] Accordingly, because FAR Part 12 procedures do not apply to orders being placed against the FSS, and CMS was not required to issue a waiver before including any provisions in the solicitations that were inconsistent with customary

[11] When, "for administrative convenience," an agency wishes to add items or services that are not on the schedule to an FSS BPA or task or delivery order, FAR § 8.402(f) requires the agency to follow "[a]ll applicable acquisition regulations" that pertain to the purchase of the items not on the schedule, including FAR Part 12 procedures. FAR § 8.402(f). Here, there is no dispute that the items being procured, recovery audit services, are already included on the vendors' 520-9 "Recovery Audits" schedules; CMS is not adding "open market items" to this procurement. See CGI AR, Tab 10, CGI's GSA Contract, at 1-5. Thus, the requirement to use FAR Part 12 (or other applicable acquisition regulations) to purchase items that are not on a vendor's schedule, as outlined in FAR § 8.402(f), is not applicable in this instance.

[12] We note that FAR Part 12 would apply to GSA's initial award of a contract to be included on the FSS. See GSA Acquisition Manual (GSAM) § 512.203(a) ("For Federal Supply Schedule contracts, the [GSA] contracting officer shall use the policies in FAR Part 12 and [GSAM] Part 512 in conjunction with the policies and procedures in FAR Part 38 and [GSAM] Part 538.").

commercial practices, the protesters arguments in this regard do not provide a basis to sustain the protest.[13]

Additionally, in support of their position that CMS was required to issue a waiver before including the payment terms in the RFQs, the protesters rely on our decision in Verizon Wireless, B-406854, B-406854.2, Sept. 17, 2012, 2012 CPD ¶ 260. See HDI Protest at 9-10; CGI Protest at 6. In Verizon Wireless, we sustained a challenge to the terms of a GSA solicitation establishing a BPA under FAR Subpart 8.4, holding that GSA had not performed adequate market research to demonstrate that certain solicitation terms were consistent with customary commercial practice, and that the agency erred by not issuing a waiver before it included the terms in the RFQ. Verizon Wireless, supra, at 6. In that case, unlike the one here, the applicability of FAR § 12.302 to the establishment of a BPA pursuant to FAR Subpart 8.4 was not disputed. Moreover, the protester in Verizon Wireless argued that some of the RFQ clauses being challenged were "substantially different" from related clauses in the underlying FSS contract, creating a conflict, and other clauses were inconsistent with GSA regulations, points not raised in this protest. See id. at 7, 11. We note further that we sustained Verizon Wireless in part because the agency there failed to respond to the merits of various arguments presented by the protester. Id. at 14. Accordingly, we distinguish Verizon Wireless on these bases. To the extent that the decision here, as it relates to the applicability of FAR Part 12 procedures to FSS procurements, contradicts our holding in Verizon Wireless, that case will no longer be followed in this respect.

Restrictive of Competition

Next, CGI objects to the solicitations' payment terms on the basis that they are unduly restrictive of competition.[14] CGI Protest at 8. CGI complains that the terms "present an intolerable revenue flow model that . . . renders it commercially impracticable" for CGI to submit a quote.[15] Id. at 9; CGI Comments at 11.

---

[13] Because we find that the agency was not required to issue a waiver before including clauses in the solicitations that the protesters argue are inconsistent with commercial practices, we need not reach the issue of whether the payment terms actually are inconsistent with customary commercial practices.

[14] HDI raised a similar challenge in its protests, but it failed to respond in its comments to the agency's arguments in the agency report. See HDI Protest at 11. Consequently, we view HDI's complaints regarding the payment terms restricting competition to have been abandoned by HDI. See, e.g., CHE Consulting, Inc., B-297534.4, May 17, 2006, 2006 CPD ¶ 84 at 4 n.6.

[15] HDI submitted quotes in response to the RFQs. HDI AR at 6. CGI did not. CGI AR at 5.

CGI similarly asserts that "many companies simply cannot maintain adequate liquidity" to perform the RAC services under the payment terms. CGI Protest at 8.

Where a protester challenges a solicitation provision as unduly restrictive of competition, the procuring agency must establish that the provision is reasonably necessary to meet the agency's needs. See Total Health Res., B-403209, Oct. 4, 2010, 2010 CPD ¶ 226 at 3. We examine the adequacy of the agency's justification for a restrictive solicitation provision to ensure that it is rational and can withstand logical scrutiny. SMARTnet, Inc., B-400651.2, Jan. 27, 2009, 2009 CPD ¶ 34 at 7. The fact that a requirement may not have been included in a prior solicitation or contract does not by itself establish that the new requirement is unduly restrictive of competition when included in a subsequent solicitation for similar items. JRS Mgmt., B-402650.2, June 25, 2010, 2010 CPD ¶ 147 at 4; Harris Enters., Inc., B-311143, Mar. 27, 2008, 2008 CPD ¶ 60 at 3.

Here, we find that CMS has reasonably established a legitimate basis for the solicitations' payment terms. The agency maintains that during the course of preparing to re-compete the recovery audit contracts that were awarded in 2008, the agency identified "problems effectuating the transition of the outgoing RAC to the potential awardee . . . ." CGI AR, Tab 1, Contracting Officer's Statement, at 2. As described above, in the predecessor contracts, the RACs invoiced for their contingency fees once the Medicare overpayment was collected.[16] See CGI AR, Tab 4, Contract No. HHSM-500-2009-00003C, § B.3. If the overpayment determination was overturned on appeal, CMS would recoup the contingency fee from the RAC by offsetting against future invoiced contingency fees. See id.; CGI AR, Tab 1, Contracting Officer's Statement, at 2. In its report to our Office, the agency explains that this presents a risk for contingency payments made in the last option year, when the RACs might not be invoicing for any future fees. CGI AR, Tab 1, Contracting Officer's Statement, at 2. Similarly, the agency recognized that the predecessor contracts did not "clearly address" situations where a RAC would have to reimburse CMS for an overpayment determination that is overturned on appeal after the expiration of the contract. Id. Therefore, the agency asserts, the solicitations' payment terms are in the government's "best interest" because the terms "increase the likelihood that payments made to the RACs are made on those recoveries that are less likely to be overturned on appeal." Id. at 3; CGI AR at 5, 10.

CGI generally disagrees with the agency's rationale for the payment terms, responding that "very few improper payments are overturned on appeal" and the fees to be repaid are "relatively small." See CGI Protest at 8; CGI Comments at 12. However, CMS maintains that it "struck a balance" by not requiring the RACs to wait

[16] CMS begins the process of recouping an overpayment 41 days after the issuance of a demand letter. CGI AR, Tab 5, Report to Congress--Recovery Auditing in the Medicare and Medicaid Programs FY 2011, at 5.

longer than the second-level appeal process before invoicing. CGI AR at 10. Moreover, although the protester argues that the agency has "not identified a single instance" when it was unable to recoup a contingency fee, CGI has not demonstrated that the recoupment risks identified by CMS are unreasonable or unfounded. See CGI Comments at 11-12. We find that the protester's disagreement with the agency's assessment of its needs and solicitation requirements related to those demonstrated needs does not show that they are unreasonable. See Computers Universal, Inc., B-296501, Aug. 18, 2005, 2005 CPD ¶ 161 at 4.

Additionally, the agency maintains that in the "vast majority of cases," the RACs can invoice for payment after the initial 120-day waiting period, "nothing close" to the protester's 14-month claim.[17] CGI AR at 5, 6. In this regard, the agency reports that in fiscal year 2011--the only available data in the record--the four incumbent RACs identified 903,372 improper overpayments. CGI AR, Tab 5, Report to Congress--Recovery Auditing in the Medicare and Medicaid Programs FY 2011, at 33. Of those overpayment determinations, providers sought a redetermination (first-level appeal) in 5.8 percent of the cases and requested a reconsideration (second-level appeal) in 0.84 percent of the cases.[18] Id. As the agency points out, applying the fiscal year 2011 data to the payment terms here, the RACs will be able to invoice for payment after the initial 120-day period in 94.2 percent of the cases, and the RACs will have to wait to invoice until the claims have exited the second level of the appeals process (as long as 420 days total) in less than 1 percent of the cases. CGI AR at 5-6, 11. While we recognize that the 2011 figures merely reflect historical data, CGI has not argued that the data is outside of the expectations for similar future recovery audit efforts. Given these figures, we fail to see how the RFQs' payment terms, which result in the RACs waiting no more than 80 days longer for payment than under the current contract in nearly 95 percent of the cases, restrict competition to an "unjustifiable extent." See CGI Protest at 9.

[17] As the protester acknowledges, the 120-day period is actually about 80 days longer than provided under the incumbent contracts because recoupment by CMS of an overpayment begins 41 days after the issuance of the demand letter. CGI Supplemental Protest at 2; Comments at 5; see CGI AR, Tab 5, Report to Congress--Recovery Auditing in the Medicare and Medicaid Programs FY 2011, at 5.

[18] Providers sought a redetermination in 52,422 cases and requested a reconsideration in 7,561 cases in fiscal year 2011. CGI AR, Tab 5, Report to Congress--Recovery Auditing in the Medicare and Medicaid Programs FY 2011, at 33. Of those, 741 overpayment determinations were appealed to an administrative law judge (third-level appeal). Id.

Finally, the agency notes that the payment terms did not have a "chilling effect" on the level of competition received in response to these RFQs. CGI AR at 9. The agency reports that it received quotes from five vendors in response to each of the solicitations for Regions 1, 2, and 4. CGI AR, Tab 1, Contracting Officer's Statement, at 5. It received four quotes in response to the solicitation for Region 3. HDI AR, Tab 1, Contacting Officer's Statement, at 5. Moreover, as the agency points out, vendors must demonstrate in their quotes that they have "adequate financial resources to sustain operations without any payment from CMS during the initial phase of the contract . . . ." RFQ § 7.1.4. Therefore, CMS will have insight into the financial capabilities of the vendors as it relates to their ability to perform under the payment terms.

The considerations discussed above support the reasonableness of the RFQs' payment terms. In our view, the agency has established a legitimate need for the payment terms in light of the risk associated with contingency fees paid near or at the expiration of the contract that must be recouped. Although the protester contends that the payment terms are "burdensome" and have a "severe impact on a company's cash flow, CGI Protest at 9; CGI Comments at 10, the fact that a requirement may be burdensome or even impossible for a particular firm to meet does not make it objectionable if the requirement properly reflects the agency's needs. JBG/Naylor Station I, LLC, B-402807.2, Aug. 16, 2010, 2010 CPD ¶ 194 at 4. On the record here, there is no basis to find the payment terms unduly restrictive of competition.

Enabling Statute

Next, HDI asserts that the solicitations' payment terms violate the Recovery Audit Program's enabling statute. HDI Protest at 8. The statute authorizing the program provides in part:

> Use of Recovery Audit Contractors.--
>
> (1) In General.--Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under [Medicare] part A or B. Under the contracts--
>
> (A) payment shall be made to such a contractor only from amounts recovered;

(B) from such amounts recovered, payment--

(i) shall be made on a contingent basis for collecting overpayments; and

(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

Pub. L. No. 109-432, § 302, 120 Stat. at 2991 (codified at 42 U.S.C. § 1395ddd(h)). The protester argues that this statute specifically requires CMS to pay the RACs "when a recovery occurs" and not after an appeal process.[19] HDI Protest at 8; HDI Comments at 7.

Here, we find that the language of the statute simply does not support the protester's position that CMS is required by law to pay a RAC its contingency fee at the time that an overpayment is first recouped without regard to the appeal process. See id. In this respect, while the statute dictates that payment is made from, and contingent on, the amount recovered, we agree with CMS that the statute is silent with regard to when payment must be made. See AR at 8. HDI has not provided any support for its interpretation that the statute institutes timing requirements for payment, and we see no basis to impose, or read-in, payment deadlines or requirements, as advocated by the protester. See Space Exploration Techs. Corp., B-402186, Feb. 1, 2010, 2010 CPD ¶ 42 at 9. Accordingly, we deny this aspect of the protest.

[19] HDI also argues that the terms are in violation of the statute because a scenario could arise where a RAC might not be paid its contingency fee for work performed near the end of the period of performance if CMS does not exercise one or more of the reconciliation/contract closeout option periods. HDI Region 2 Protest at 10; HDI Comments at 8. The agency counters that "[t]here is no credible basis for the assertion that CMS intends to deny earned contingency fee payments to RACs . . . ." HDI Region 2 AR at 11. Moreover, as CMS points out, the RAC would have the right to submit a claim under the Contract Disputes Act if moneys properly owed to the firm were withheld by the agency. See id. In any event, HDI's speculation about the administration of the option periods provides no basis to sustain the protest.

Prompt Payment Requirements

Lastly, HDI complains that the solicitations' payment terms result in the agency imposing an "extended acceptance period," such that CMS is in violation of regulatory prompt payment requirements. HDI Protest at 8-9. Specifically, HDI contends that the payment terms run counter to the requirements of 5 C.F.R. § 1315.4, which stipulate that agencies should "ensure that acceptance is executed as promptly as possible" and that purchases of commercial items should "not be subject to extended acceptance periods." See 5 C.F.R. § 1315.4(e) (2014). HDI also points to FAR § 32.904 to argue that CMS was required to document a justification for an extended acceptance period. See FAR § 32.904(b)(1)(ii)(B)(4).

We disagree with the protester that the payment terms result in an extended acceptance period, such that these regulations (detailing payment timeframes after acceptance) are implicated. In this regard, the acceptance of a RAC's services, and the triggering of the prompt payment requirements, does not occur at the moment an overpayment is identified or recouped by CMS, as the protester suggests.[20] Instead, as outlined above, the RAC is still required to perform additional services for CMS related to that overpayment, including supporting the agency during the appeals process. See SOW at 40; Protest at 5. Because the RAC's services are not complete when an overpayment is identified (or recouped by CMS), we fail to see how the solicitations' payment terms result in an extended acceptance period, particularly where the solicitations expressly require the RACs to assist during the appeals process. Therefore, we find that the solicitations' payment terms do not violate the prompt payment requirements cited by the protester.

In sum, we find that CMS was not required to issue a waiver prior to including the payment terms in the solicitations. In addition, the protesters have not demonstrated that the terms are unduly restrictive of competition or in violation of statute or regulation.

The protests are denied.

Susan A. Poling
General Counsel

[20] The regulations cited by the protester define acceptance as "acknowledgment by an authorized Government official that goods received and services rendered conform with the contract requirements." 5 C.F.R. § 1315.2(b).