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MEDICARE RECOVERY AUDIT CONTRACTORS AND CMS'S ACTIONS TO ADDRESS IMPROPER PAYMENTS, REFERRALS OF POTENTIAL FRAUD, AND PERFORMANCE

Daniel R. Levinson
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EXECUTIVE SUMMARY: MEDICARE RECOVERY AUDIT CONTRACTORS AND CMS'S ACTIONS TO ADDRESS IMPROPER PAYMENTS, REFERRALS OF POTENTIAL FRAUD, AND PERFORMANCE, OEI-04-11-00680

WHY WE DID THIS STUDY

Recovery Audit Contractors (RAC) are designed to protect Medicare by identifying improper payments and referring potential fraud to the Centers for Medicare & Medicaid Services (CMS). Prior Government Accountability Office work has identified problems with CMS's actions to address improper payment vulnerabilities, and prior Office of Inspector General (OIG) work has identified problems with CMS's actions to address referrals of potential fraud. Further, OIG has identified vulnerabilities in CMS's oversight of its contractors. Given the critical role of identifying improper payments, effective oversight of RAC performance is important.

HOW WE DID THIS STUDY

We collected RAC Data Warehouse (i.e., electronic database) files from CMS and data from RACs to determine their activities to identify improper payments and refer potential fraud in fiscal years (FYs) 2010 and 2011. We also collected data from CMS regarding activities to address vulnerabilities (i.e., improper payments exceeding $500,000 that result from a specific issue) and referrals of potential fraud. Finally, we collected RAC performance evaluations and performance evaluation metrics from CMS and determined the extent that RAC performance evaluations addressed these metrics. We also compared performance evaluation metrics to contract requirements to determine the extent that these metrics addressed contract requirements.

WHAT WE FOUND

In FYs 2010 and 2011, RACs identified half of all claims they reviewed as having resulted in improper payments totaling $1.3 billion. CMS took corrective actions to address the majority of vulnerabilities it identified in FYs 2010 and 2011; however, it did not evaluate the effectiveness of these actions. As a result, high amounts of improper payment may continue. Additionally, CMS did not take action to address the six referrals of potential fraud that it received from RACs. Finally, CMS's performance evaluations did not include metrics to evaluate RACs' performance on all contract requirements.

WHAT WE RECOMMEND

We recommend that CMS (1) take action, as appropriate, on vulnerabilities that are pending corrective action and evaluate the effectiveness of implemented corrective actions; (2) ensure that RACs refer all appropriate cases of potential fraud; (3) review and take appropriate, timely action on RAC referrals of potential fraud; and (4) develop additional performance evaluation metrics to improve RAC performance and ensure that RACs are evaluated on all contract requirements. CMS concurred with our first, second, and fourth recommendations. CMS did not indicate whether it concurred with our third recommendation but noted that it has reviewed the six RAC referrals of potential fraud in our review.

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OBJECTIVES

To determine the extent that:

1. Recovery Audit Contractors (RAC) identified improper payments;
2. the Centers for Medicare & Medicaid Services (CMS) took corrective actions to address vulnerabilities;
3. RACs referred potential fraud to CMS and CMS took action on these referrals; and
4. CMS evaluated RACs on all performance requirements.

BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated the establishment of a RAC demonstration project to determine effectiveness in (1) identifying improper payments (underpayments and overpayments) and (2) recouping overpayments in Medicare Parts A and B.[1] The demonstration project occurred in six States from March 2005 to March 2008.[2] During the demonstration project, RACs identified over $1.03 billion in improper payments.[3] Of these improper payments, $992.7 million were overpayments and $37.8 million were underpayments.

The Tax Relief and Health Care Act of 2006 required the Secretary of Health and Human Services to establish a national RAC program by January 1, 2010.[4] To fulfill this requirement, CMS awarded competitive contracts to four contractors to perform recovery audit functions in four separate geographical regions. All four RAC regions were operational by October 2009. See Appendix B for a map of States in each RAC region.

[1] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, Title III, § 306; CMS, *The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration*. Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/RACEvaluationReport.pdf on August 22, 2012.

[2] These six States were Arizona, California, Florida, Massachusetts, New York, and South Carolina.

[3] CMS, *The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration.* Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/RACEvaluationReport.pdf on August 22, 2012.

[4] The Tax Relief and Health Care Act of 2006, P.L. 109-432, Division B, § 302(h); Social Security Act, § 1893(h); CMS, *Implementation of Recovery Auditing at The Centers for Medicare & Medicaid Services*. August 2011. Accessed at https://www.cms.gov/Recovery-Audit Program/Downloads/FY2010ReportCongress.pdf on August 22, 2012.

Unlike other Medicare contractors, RACs are mandated to be paid on a contingency-fee basis.[5] Contingency fees are calculated as a percentage of improper payments that are recovered (overpayments) or returned (underpayments) to providers.[6] RACs do not receive these fees until improper payments are recovered or returned (i.e., the payments are contingent on the recovery or return).

RAC Claims Review Process

RACs' primary responsibility is to identify improper payments from Medicare Part A and B claims that have been paid by claims processing contractors.[7] RACs analyze claims and review those most likely to contain improper payments.[8] RACs may also request and analyze provider claim documentation to ensure services provided were reasonable and necessary. Improper payments may include: (1) payment for items or services that do not meet Medicare's coverage and medical necessity criteria, (2) payment for items that are incorrectly coded, and (3) payment for services where the documentation submitted did not support the ordered service.

Recovered and Returned Improper Payments. When RACs identify improper payments, they notify the claims processing contractor of the applicable claims. The claims processing contractor adjusts the claims to reflect the proper payment amounts.[9] If the improper payment is an overpayment, the claims processing contractor sends a demand letter to the provider to recover the improper payment.[10] The demand letter includes the overpayment amount, the reason for the overpayment, and payment instructions. If the improper payment is an underpayment, the

[5] Tax Relief and Health Care Act of 2006, P.L. 109-432, Division B, § 302(h)(1).

[6] In FY 2011, RACs received 9 to 17.5 percent in contingency fee payments, depending on the type of the claim with the improper payment. CMS, *Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011.* Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf on February 8, 2013.

[7] The Patient Protection and Affordable Care Act, P.L. 111-148, § 6411, expanded the RAC program to identify improper payments in Medicare Part D, Medicare Advantage, and Medicaid claims. CMS awarded the Medicare Part D RAC contract to ACLR Strategic Business Solutions in 2011, and this RAC began recouping improper payments on CMS's behalf in FY 2013. CMS is in the process of implementing a Medicare Advantage RAC. Additionally, approximately 40 States have awarded Medicaid RAC contracts.

[8] CMS, *Recovery Audit Program Final Statement of Work*. Accessed at https://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf on August 22, 2012.

[9] CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 4, § 100.5.

[10] Prior to 2012, RACs sent demand letters to providers.

claims processing contractor notifies the provider and pays the provider the underpaid amount.

RAC-identified improper payments are recorded in the RAC Data Warehouse (i.e., electronic database) and monitored by CMS.[11] When RACs identify improper payments that result from a specific issue (e.g., incorrect coding of diagnoses and procedure codes), that issue is classified as a vulnerability.[12] The CMS Division of Recovery Audit Operations provides further guidance that defines a vulnerability as a specific issue associated with more than $500,000 in improper payments.[13] When CMS identifies a vulnerability, it may develop a corresponding corrective action, such as conducting provider education or implementing computerized "edits" (i.e., system processes) to prevent future improper payments.

CMS also uses the RAC Data Warehouse to prevent RACs from reviewing claims that have already been reviewed or that are under review by other CMS contractors or law enforcement.[14] To do this, CMS contractors and law enforcement access the RAC Data Warehouse and exclude or suppress applicable claims from RAC review. Excluded claims include those that have already been reviewed by other CMS contractors. Suppressed claims include those that are currently under investigation by law enforcement or are under fraud/benefit integrity review by CMS contractors.[15]

Provider Appeals. Providers may appeal RAC-identified overpayments. Once a provider requests an appeal, overpayment recoupment must stop until a final determination has been made.[16] There are five progressive levels in the appeals process.[17] RACs do not receive contingency fees for overpayments that are appealed and ruled in the provider's favor (i.e., overturned appeals) at any of the five levels. CMS tracks appeals information in the RAC Data Warehouse.

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[11] CMS, *Recovery Audit Program Final Statement of Work*. Accessed at https://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf on August 22, 2012.

[12] CMS, *Standard Operating Protocol: Vulnerability Tracking Corrective Action Process*, February 7, 2011.

[13] CMS communicated this guidance to OIG during meetings in 2012.

[14] Other contractors may include claims processing contractors or program integrity contractors.

[15] CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 4, § 100.4.

[16] Social Security Act, § 1893(f)(2). This applies to overpayments that are appealed within 30 days of the date of the demand letter.

[17] The five appeals levels include (1) redetermination made by a claims processing contractor, (2) reconsideration made by a Qualified Independent Contractor (QIC), (3) Administrative Law Judge hearing, (4) appeals council review, (5) Federal District Court review. CMS contracts with QICs to process second-level appeals, or reconsiderations.

RAC Referrals of Potential Fraud. RACs' primary responsibility is to review claims for improper payments. However, if RACs encounter potential fraud, they are required to refer the provider to CMS.[18] RACs may continue to review claims that they have referred for potential fraud unless law enforcement or other CMS contractors instruct RACs to stop their reviews. Additionally, if improper payments are identified on claims included in fraud referrals, RACs receive contingency fees unless they are instructed to stop their review of these claims. RACs also refer external notifications (e.g., complaints from provider employees or beneficiaries) of potentially fraudulent providers to CMS.

CMS Actions on Vulnerabilities and Referrals of Potential Fraud

A 2011 CMS policy tasks various CMS components with responsibility for addressing vulnerabilities and referrals of potential fraud.[19]

CMS Corrective Actions on Vulnerabilities. The CMS Division of Data Analysis, in collaboration with the CMS Division of Recovery Audit Operations, monitors improper payment amounts. CMS classifies any specific issue resulting in more than $500,000 in improper payments as a vulnerability, or "major finding." These vulnerabilities receive high priority for corrective action; however, CMS determines which vulnerabilities it should address on the basis of several factors, such as improper payment amount and geographic scope (e.g., whether the vulnerability spans multiple RAC regions).[20, 21, 22] Vulnerabilities and applicable corrective actions are recorded in the Improper Payment Prevention Plan. Additionally, the Division of Data Analysis is responsible for evaluating corrective actions and determining their effectiveness in reducing improper payments.[23] Specifically, CMS does

[18] CMS, *Recovery Audit Program Final Statement of Work*. Accessed at https://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf on August 22, 2012. Examples of fraud may include incorrect reporting of diagnoses to maximize payments or billing for services not provided. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.2.1.

[19] CMS, *Standard Operating Protocol: Vulnerability Tracking Corrective Action Process*, February 7, 2011.

[20] CMS may determine various corrective actions are appropriate, such as computerized edits or provider education. CMS may also determine that no action is necessary.

[21] CMS, *Standard Operating Protocol: Vulnerability Tracking Corrective Action Process*, February 7, 2011.

[22] While vulnerabilities may span multiple regions, CMS calculates improper payment amounts identified by individual RAC regions only when determining whether they meet the Division of Recovery Audit Operations' vulnerability threshold. Government Accountability Office (GAO), *Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, GAO-13-102, November 2012.

[23] CMS, *Standard Operating Protocol: Vulnerability Tracking Corrective Action Process*, February 7, 2011.

not consider corrective actions closed until it has conducted analyses to determine their effectiveness.[24]

CMS Actions on RAC Referrals of Potential Fraud. The CMS Project Officer tracks the submission of RAC referrals of potential fraud and forwards them to the CMS Center for Program Integrity (CPI) for potential action.[25] Action may include referring the provider to program integrity contractors or law enforcement. CMS also provides training to RACs to help them identify potentially fraudulent claims or providers.

CMS Activities To Evaluate RAC Performance

The Federal Acquisition Regulation mandates that CMS evaluate contractor performance.[26] These evaluations enable CMS to provide feedback to contractors regarding their performance and determine whether to renew a company's contract. CMS may reduce contractor workloads or take other necessary action, such as reducing payments to contractors, if it determines that contractors are not meeting their performance requirements.

RAC Annual Performance Evaluations. CMS conducts RAC annual performance evaluations at intervals of no less than 12 months after the contract award date. RACs are assessed on the basis of performance evaluation metrics within categories established in the Contractor Performance Assessment Reporting System (CPARS) policy guide.

These categories include: (1) Business Relations, (2) Quality of Product or Service, (3) Schedule/Timeliness, (4) Management of Key Personnel, and (5) Utilization of Small Business. For each category, CMS provides a narrative describing RAC performance against performance evaluation metrics and assigns a rating.[27] However, CMS does not provide an overall performance rating, such as the average of all category ratings.

[24] Ibid.

[25] CMS merged the Medicaid and Medicare program integrity groups under one management structure in 2010 to create CPI. CMS, *CPI Key Antifraud Activities*. Accessed at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/downloads/cpiinitiatives.pdf on October 12, 2012.

[26] 48 CFR § 42.1502(a).

[27] RACs may receive five possible ratings for individual categories in the annual report. These include: (1) unsatisfactory, (2) marginal, (3) satisfactory, (4) very good, and (5) excellent.

CMS records completed performance reports in CPARS for RACs to access and view.[28] After reports have been recorded in CPARS, RACs have 30 days to review and respond if they disagree with the ratings that CMS has given them.

Related Work

In 2010, GAO reported that CMS lacked an effective process to address vulnerabilities identified during the 3-year RAC demonstration project (2005–2008).[29] GAO also determined that by January 2010, CMS had not addressed approximately 60 percent of improper payment vulnerabilities identified during the demonstration project. GAO recommended that CMS implement a process to decide on the appropriate response to address vulnerabilities. GAO also recommended that the agency act promptly to address vulnerabilities. CMS concurred with both of these recommendations.

OIG has also identified vulnerabilities in CMS's oversight of its contractors. Given the critical role of identifying improper payments, effective oversight of these contractors' performance is important. In 2010, the Office of Inspector General (OIG) reported that RACs referred two cases of potential fraud to CMS during the demonstration project.[30] However, CMS stated that it did not receive any referrals of potential fraud during this time. The report also indicated that RACs had not received formal training and guidance from CMS to help them identify fraud. OIG recommended that CMS require RACs to receive mandatory training on the identification and referral of fraud. CMS concurred with this recommendation.

METHODOLOGY

We collected RAC Data Warehouse files from CMS and data from RACs to determine activities performed to identify improper payments and refer

[28] RACs may view only reports specific to their performance and may not review reports from other regions and/or contractors. Additionally, CPARS helps the Government provide current and accurate data on contractor performance for use in source selections through the Past Performance Informational Retrieval System (PPIRS). For instance, completed performance assessments in PPIRS are used as a resource in awarding contracts and orders to contractors that consistently provide quality, timely products and services that adhere to contractual requirements. Department of Defense, *Contractor Performance Assessment Reporting System Policy Guide*. Accessed at http://www.cpars.csd.disa.mil/cparsfiles/pdfs/DoD-CPARS-Guide.pdf on November 14, 2012. CMS performance evaluations are retained in CPARS. The Department of Defense is responsible for managing this system.

[29] GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143, March 2010.

[30] OIG, *Recovery Audit Contractor's Fraud Referrals*, OEI-03-09-00130, February 2010.

potential fraud in FYs 2010 and 2011. We collected data from CMS regarding activities to address vulnerabilities resulting from RAC-identified improper payments and referrals of potential fraud. We also collected RAC performance evaluations and performance evaluation metrics from CMS. Both RACs and CMS submitted documentation to support their responses and we followed up with them, as appropriate. All four RACs were operational during our timeframe and were included in our review.

RAC Identification of Improper Payments

RAC Identification of Improper Payments. We collected RAC Data Warehouse files in June 2012 and calculated the number and dollar amount of improper payments that RACs identified and the amounts that were recovered from or returned to providers in FYs 2010 and 2011. We analyzed claims within the RAC Data Warehouse to determine (1) the percentage of improper payment amounts recovered from or returned to providers in each State and RAC region, (2) the provider types with the largest dollar amounts of recovered or returned improper payments, and (3) the reasons (e.g., coding or billing mistakes) for the recovered or returned improper payments. We did not determine the accuracy of RACs' improper payment determinations, nor did we assess the burden RACs placed on providers for requesting claim documentation (e.g., medical records).

We also collected from CMS the number of claims that RACs reviewed and the overpayment identifications that providers appealed in FYs 2010 and 2011. However, we did not analyze the accuracy of appeals determinations (e.g., overturned in the provider's favor). Finally, we analyzed claims within the RAC Data Warehouse files to determine whether providers received improper payments for billing potentially fraudulent claims. As is our typical process, we will forward to OIG's Office of Investigations (OI) any potential fraud that we identified so that OI may determine the appropriate course of action.

CMS Actions on Vulnerabilities and RAC Referrals of Potential Fraud

CMS Corrective Actions on Vulnerabilities. In May and June 2012, we collected all vulnerabilities that CMS identified in FYs 2010 and 2011.[31] We calculated the amount of improper payments associated with these vulnerabilities and determined the action that CMS took to address them.[32]

[31] These data were provided to OIG in the Improper Payment Prevention Plan. CMS may identify vulnerabilities resulting from region-specific or national issues.

[32] To make this determination, we asked CMS to describe and provide documentation regarding the actions it had taken to address vulnerabilities during our time frame.

We considered a corrective action to have been taken if CMS had taken steps to address the vulnerability, such as sending technical direction letters to contractors or putting computerized edits into place to prevent improper payments.[33] Additionally, if CMS indicated that no action was necessary to address the vulnerability, we considered this a corrective action. For example, if CMS determined that no action was necessary because a forthcoming policy would address the vulnerability. However, we did not consider a corrective action to be taken if CMS had only reviewed or discussed the vulnerability.

We asked CMS to specify the dates that it took corrective actions. If CMS had not taken corrective actions, we followed up to determine why. We then calculated the length of time between CMS's identifying a vulnerability and taking corrective action on it.[34] In addition, we collected data from CMS that documented whether it had evaluated the effectiveness of corrective actions. Using these data, we identified the number of corrective actions for which CMS had evaluated effectiveness. We considered a corrective action to have been evaluated for effectiveness if CMS provided documentation that it had determined whether the corrective action had reduced improper payments or affected provider billing patterns. Finally, we collected any documents that described CMS's processes or criteria for evaluating corrective actions.

CMS Actions on Referrals of Potential Fraud. We collected documentation of referrals of potential fraud that CMS received from RACs in FYs 2010 and 2011. For each referral, we collected the referral date, provider identification number, name of the RAC that sent the referral, reason for the referral, and resulting CMS actions (e.g., whether CMS referred the provider to CPI for further review). We requested information from CMS from October to November 2012 to determine whether and how it had addressed these referrals.

We also asked CMS to provide the dates that it or other agencies (e.g., Department of Justice) provided training to RACs on fraud identification and the referral process. We collected documentation, such as slides or handouts, from these sets of training.

[33] Technical direction letters provide additional details and guidance to contractors about tasks required of them. Contractors incorporate edits in their claims processing systems to verify and validate claims data by detecting errors or potential errors. Edits also verify that certain data are consistent and appropriate. CMS, *Medicare Administrative Contractor Workload Implementation Handbook (Legacy-to-MAC)*, ch. 4, § 4.10.3.2. Accessed at http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/Downloads/Handbooks/Legacy2MACImp.pdf on February 3, 2012.

[34] We used the date that vulnerabilities were added to the Improper Payment Prevention Plan as the date CMS identified them.

RAC Performance Evaluations

In April and May 2012, we collected the records for the annual RAC performance evaluations that CMS conducted in 2010 and 2011 and the performance evaluation metrics that CMS used.[35] We compared these items to determine the extent that RAC performance evaluations addressed performance evaluation metrics. We also compared RAC performance evaluation metrics to RAC contract requirements to determine the extent that performance evaluation metrics addressed contract requirements.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

[35] Performance periods are from February to February each year.

FINDINGS

In FYs 2010 and 2011, RACs identified half of all claims they reviewed as having resulted in improper payments totaling $1.3 billion

In FYs 2010 and 2011, RACs reviewed 2.6 million claims from approximately 292,000 providers.[36] During this period, RACs identified approximately 1.3 million claims with improper payments (50 percent) that totaled nearly $1.3 billion.[37] Of this amount, $903 million was recovered from or returned to providers in FYs 2010 and 2011.[38, 39] Approximately $768 of the $903 million was recovered from providers ($53 million in FY 2010 and $715 million in FY 2011). The remaining $135 million was returned to providers ($15 million in FY 2010 and $120 million in FY 2011).

Over half (57 percent) of all recovered or returned improper payments resulted from medical services being delivered in inappropriate facilities (32 percent) or providers billing incorrect codes on Medicare claims (25 percent).[40] Improper payments also resulted from other sources, such as providers billing Medicare for services for deceased beneficiaries. For instance, CMS recovered $3 million in improper payments stemming from approximately 27,000 claims for services billed for deceased

[36] There were a total of 2,608,481 claims from 292,265 unique providers.

[37] There were a total of 1,289,056 claims with $1,261,328,388 in identified improper payments. However, some of these identified improper payments ultimately may not have been recovered from or returned to providers for various reasons, such as CMS determining that the RAC made an incorrect improper payment determination.

[38] The average recovered overpayment amount in FYs 2010 and 2011 was $507. Recovered overpayments during this time ranged from less than $1 to over $156,000. The average returned underpayment amount in FYs 2010 and 2011 was $2,171. Returned underpayments during this time ranged from less than $1 to approximately $407,000. RACs typically do not forward any claims to the claims processing contractor for adjustment if the overpayment amount is less than $10 or the underpayment amount is less than $1. Recovered and returned amounts below these thresholds may have been due to various reasons, such as partial improper payment amounts being collected.

[39] Our reported recovered and returned amount ($903 million) differs from CMS's reported amount by approximately $127 million. In 2011 and 2013, CMS released its annual reports to Congress, as required by section 1893(h) of the Social Security Act. These reports stated that RACs recovered or returned improper payments of approximately $1.03 billion in FYs 2010 and 2011. Our amount differs because we analyzed recovered or returned improper payments that we could reliably match to improper payments identified in FYs 2010 and 2011.

[40] An example of medical services being delivered in an inappropriate facility could include providing services to a beneficiary in an inpatient setting when the beneficiary's medical record indicated that these services should have been provided in a different, less intensive and less costly setting. An example of a provider billing for incorrect codes on a Medicare claim could include billing incorrect diagnosis codes.

beneficiaries.[41] These improper payments represented less than one-half of one percent of total improper payments recovered or returned in FYs 2010 and 2011.

Two provider types accounted for 93 percent of all recovered or returned improper payments, and approximately one quarter of improper payments were for providers in two States

Claims from two provider types accounted for 93 percent of all recovered or returned improper payments: inpatient hospitals (88 percent) and physicians or nonphysician practitioners (5 percent).[42] Additionally, the five providers with the largest improper payment amounts were hospitals. Improper payments for these hospitals were $18.4 million in FYs 2010 and 2011, which was approximately 2 percent of total improper payments. Approximately 87 percent of these improper payments resulted from medical services being delivered in inappropriate facilities.[43] Further, approximately one quarter (23 percent) of all recovered or returned improper payments were for providers in California, with $156 million in such payments, and in New York, with $49 million in such payments.[44]

Providers did not appeal RACs' decisions for approximately 94 percent of claims identified with overpayments, but of those that were appealed, almost half were overturned

In FYs 2010 and 2011, RACs identified approximately 1.1 million claims with overpayments. During this time, providers appealed 65,198 (6 percent) of these overpayments. Of those appealed, nearly half (44 percent) were overturned in the providers' favor.

Previous OIG work on overpayments appeals found that 56 percent of all those appealed, not just those identified by RACs, were overturned at the Administrative Law Judge level in FY 2010.[45, 46] This overall percentage is

[41] Approximately $75,000 was recovered in FY 2010 and the remaining $2.9 million in FY 2011. These payments may represent potentially fraudulent billing that RACs could refer to CMS for action.

[42] Nonphysician practitioners include nurse practitioners, physician assistants, or certified nurses.

[43] This could include providing services to a beneficiary in an inpatient setting when the beneficiary's medical record indicated that these services should have been provided in a different, less intensive, and less costly setting.

[44] California had the largest number of Medicare Part A and B beneficiaries of any State in 2010, while New York had the fourth largest. CMS, *Medicare Enrollment Data by State and Age as of July 2010*. Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/Sageall10.pdf.

[45] OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012.

[46] Overpayments were appealed by providers, beneficiaries, and State Medicaid agencies. Additionally, this percentage includes only appeals that were fully overturned.

generally consistent with the percentage of RAC-identified overpayments appeals that were overturned in the providers' favor that we found when conducting this evaluation. This may indicate that the high Medicare overpayment appeal overturn rate is not limited to RACs.

Overturned overpayments in FYs 2010 and 2011 represented 3 percent of total claims identified as having overpayments in FYs 2010 and 2011, and accounted for approximately $40 million. See Table 1 for the number and percentage of appealed overpayment identifications in each RAC region for FYs 2010 and 2011. See Appendix A for the number and percentage of appealed overpayment identifications in FYs 2010 and 2011, by claim type. See Appendix B for a map of RAC regions and the States in each region.

Table 1: Number and Percentage of Appealed Overpayment Identifications in FYs 2010 and 2011

RAC Region	Number of Claims Identified With Overpayments	Number of Overpayment Identifications Appealed*	Percentage of Overpayment Identifications Appealed	Number of Appealed Overpayment Identifications Overturned	Percentage of Appealed Overpayment Identifications Overturned	Percentage of Appealed Overpayment Identifications Overturned out of Claims Identified With Overpayments
A	131,037	3,588	3%	955	27%	1%
B	110,468	15,726	14%	6,303	40%	6%
C	335,338	9,928	3%	3,612	36%	1%
D	490,168	35,956	7%	17,945	50%	4%
Total	**1,067,011**	**65,198**	**6%**	**28,815**	**44%**	**3%**

Source: OIG analysis of CMS appeals data, 2012.
*Because the outcomes could not be linked to specific RAC regions, these numbers exclude 3,968 unspecified appeals that were adjudicated by Administrative Law Judges.

CMS took corrective action to address the majority of vulnerabilities it identified in FYs 2010 and 2011; however, it did not evaluate the effectiveness of these corrective actions

CMS classifies any specific issue resulting in more than $500,000 in improper payments as a vulnerability. In FYs 2010 and 2011, CMS identified 46 vulnerabilities that resulted in improper payments. The majority of these vulnerabilities (26 of 46) were for improper payments under Medicare Part B. Examples included providers billing add-on codes without primary codes or indicating the incorrect place of service on claims for services performed in ambulatory surgical centers or outpatient hospitals. The remaining vulnerabilities (20 of 46) were for improper payments under Medicare Part A or in the area of durable medical

equipment (DME), such as DME suppliers and physicians billing separately for bundled services or billing services or supplies for deceased beneficiaries.[47] By June 2012, these vulnerabilities had resulted in improper payments of approximately $1.9 billion.

CMS took action to address 28 vulnerabilities that resulted in $1.86 of the $1.9 billion in improper payments

When CMS identifies a vulnerability, it may develop a corresponding corrective action to prevent future improper payments. By June 2012, CMS took corrective action to address the majority (28 of 46) of vulnerabilities identified in FYs 2010 and 2011. These corrective actions addressed almost all ($1.86 billion of $1.9 billion) improper payments that resulted from identified vulnerabilities. Corrective actions included contractor technical direction letters, computerized edits, and mailing quarterly provider education letters. We did not find that CMS determined any of the vulnerabilities required no action in order to address them.

CMS did not take action to address 18 vulnerabilities that resulted in $31 million in improper payments

As of June 2012, CMS had not taken corrective action on the remaining 18 of 46 vulnerabilities identified in FYs 2010 and 2011. These vulnerabilities resulted in $31 million in improper payments. As of June 2012, these 18 vulnerabilities were pending corrective action an average of 375 days, with 2 pending over 700 days.

CMS reported different reasons for not taking corrective actions on 18 of 46 vulnerabilities. For instance, one vulnerability resulted from underpayments made to multiple providers. CMS stated in June 2012 that it considered this vulnerability to be a low priority and planned to take corrective action after addressing higher priority vulnerabilities. CMS also reported that it had determined the appropriate corrective action for 8 of these 18 vulnerabilities but that actions were not scheduled to begin until late 2012. CMS had not determined corrective actions for the remaining 9 vulnerabilities because corrective actions were on hold or CMS planned to discuss potential actions at a later date. See Table 2 for the June 2012 status of vulnerabilities identified in FYs 2010 and 2011, by claim type.

[47] The DME benefit is covered under Medicare Part B; however, we analyzed DME vulnerabilities separately from Part B vulnerabilities because CMS records DME claims in separate data files and separates DME vulnerabilities from other Part B vulnerabilities.

Table 2: June 2012 Status of Vulnerabilities Identified in FYs 2010 and 2011, by Claim Type

Claim Type	Status of Vulnerabilities				
	Number of Vulnerabilities	Corrective Actions Taken		Corrective Actions Not Taken	
		Number of Vulnerabilities	Dollar Amount of Improper Payments	Number of Vulnerabilities	Dollar Amount of Improper Payments
DME	15	12	$56,032,825	3	$981,565
Part A	5	4	$1,735,100,796	1	$3,031,926
Part B	26	12	$72,962,567	14	$26,916,228
Total	**46**	**28**	**$1,864,096,188**	**18**	**$30,929,719**

Source: OIG analysis of CMS vulnerability data, 2012.

CMS did not evaluate the effectiveness of implemented corrective actions

CMS policy states that it is responsible for evaluating corrective actions and determining their effectiveness in reducing improper payments. Specifically, CMS does not consider corrective actions closed until it has conducted analyses to determine their effectiveness.[48] By June 2012, CMS had not evaluated the effectiveness of corrective actions it took to address 28 of 46 vulnerabilities totaling $1.86 billion in improper payments. CMS reported that it had not evaluated corrective actions because of lack of resources and the difficulty in determining causal relationships between corrective actions and reductions in improper payments. CMS also reported that some corrective actions should be in place for several years before it evaluates them. For instance, for computerized edits, CMS generally waits 1–2 years to evaluate effectiveness. However, if CMS does not evaluate corrective actions, it cannot determine whether its corrective actions are effectively addressing vulnerabilities, which may result in continued high amounts of improper payments.

CMS did not take action to address the six referrals of potential fraud that it received from RACs in FYs 2010 and 2011

RACs' primary responsibility is to review claims for improper payments, but if RACs encounter potentially fraudulent claims, they are required to

[48] CMS, *Standard Operating Protocol: Vulnerability Tracking Corrective Action Process*, February 7, 2011.

refer the providers that submitted the claims to CMS.[49] RACs may continue to review claims that they have referred for potential fraud unless law enforcement or other CMS contractors instruct RACs to stop their reviews.

In FYs 2010 and 2011, three of four RACs referred a total of six providers to CMS for potential fraud. RACs referred all six providers on the basis of external notifications (e.g., complaints from providers' employees of falsifying medical documentation or billing for supplies that were never provided).[50] Region B made three of the six referrals of potential fraud and Regions A and D made the remaining three referrals.[51] In contrast, the Region C RAC did not submit any fraud referrals to CMS in FYs 2010 or 2011. This RAC initially identified two providers engaged in potentially fraudulent activity; however, it determined that these providers were already under investigation and requested that applicable claims be suppressed in the RAC Data Warehouse.[52]

CMS indicated that it received the six referrals of potential fraud from RACs. However, by November 2012 it had not taken action (e.g., CPI review) to address them.[53]

Additionally, in response to a previous OIG report, in FY 2010 CMS provided RACs with two sets of training that directly addressed fraud identification and referral.[54, 55] One focused on examples of fraudulent schemes and billing practices, while the other covered the referral process

[49] All claims that RACs review have been screened to ensure they are not associated with ongoing reviews of potential fraud or ongoing investigations.

[50] None of these referrals resulted from RACs identifying improper payments for potentially fraudulent billing, such as providers billing for services after a beneficiary's death.

[51] Region A made two referrals and Region D made one referral in FYs 2010 and 2011.

[52] According to the Region C RAC, one of these providers allegedly added information to medical records after services were provided. The other provider had been asked by the RAC to return overpayments but the RAC had no record of their being returned. Further, the provider—although claiming to have returned the overpayments—had no documentation to give the RAC.

[53] OI has investigated three of these providers for potential fraud. One investigation was opened in 2011 and another in 2012. Neither investigation resulted in further actions, and both are now closed. The third provider was under investigation during our review timeframe and remains under investigation. According to OI, two of the three provider investigations were initiated from hotline complaints and the other from a contractor referral.

[54] Training was conducted by other agencies, such as the OIG or Department of Justice; OIG, *Recovery Audit Contractors' Fraud Referrals*, OEI-03-09-00130, February 2010.

[55] CMS provided two additional sets of training in FY 2010 that did not cover referral or identification of fraud. These sets of training covered the False Claims Act and affirmative civil enforcement.

for potential fraud. However, CMS did not provide related training to RACs in FY 2011.

CMS's performance evaluations did not include metrics to evaluate RACs' performance on all contract requirements

In 2010 and 2011, CMS evaluated RACs on all metrics in their performance evaluations. However, CMS's performance evaluations did not include metrics to evaluate RACs' performance on all contract requirements. Specifically, CMS did not evaluate RACs on the extent that they identified improper payments. Further, four of the eight performance evaluations that we reviewed did not describe RACs' ability, accuracy, or effectiveness in identifying improper payments. The other four performance evaluations we reviewed described RAC identification of improper payments to varying degrees; however, these descriptions were not linked to performance evaluation metrics. Finally, there were no performance evaluation metrics related to referring potential fraud to CMS, such as timeliness or documentation requirements, or related to whether RACs had systems in place to refer potential fraud to CMS on the basis of identified improper payments.

CONCLUSION AND RECOMMENDATIONS

RACs are designed to protect Medicare by identifying improper payments and referring potential fraud to CMS. Prior Government Accountability Office work has identified problems with CMS's actions to address improper payment vulnerabilities, and prior OIG work has identified problems with CMS's actions to address referrals of potential fraud. Further, OIG has identified vulnerabilities in CMS's oversight of its contractors. Given the critical role of identifying improper payments, effective oversight of RAC performance is important.

In FYs 2010 and 2011, RACs identified half of all claims they reviewed as having resulted in improper payments totaling $1.3 billion. CMS took corrective action to address the majority of vulnerabilities it identified in FYs 2010 and 2011; however, it did not evaluate the effectiveness of these actions, which may result in continued high amounts of improper payments. Additionally, CMS did not take action to address the six referrals of potential fraud that it received from RACs during this timeframe. Finally, CMS's performance evaluations did not include metrics to evaluate RACs' performance on all contract requirements.

Therefore, we recommend that CMS:

Take Action, as Appropriate, on Vulnerabilities That Are Pending Corrective Action and Evaluate the Effectiveness of Implemented Corrective Actions

CMS should assess vulnerabilities that are pending corrective action and address them, as appropriate. CMS should also develop timeframes for addressing vulnerabilities to ensure that they are resolved in a timely manner. Finally, while CMS has taken corrective actions on 28 of 46 vulnerabilities identified in FYs 2010 and 2011, it has not determined the effectiveness of these actions. CMS should evaluate whether these implemented corrective actions are effectively reducing improper payments.

Ensure That RACs Refer All Appropriate Cases of Potential Fraud

CMS should ensure that RACs refer all appropriate cases of potential fraud. To do this, CMS should identify specific examples of fraud that, if RACs encounter, they should refer to program integrity contractors. CMS should update these examples as needed to stay current with emerging fraud trends. CMS should also facilitate increased collaboration between RACs, CMS, and program integrity contractors. For instance, CMS should coordinate regular meetings between program integrity contractors and RACs to share information about fraudulent coding or billing schemes in their respective regions and to keep RACs aware of emerging fraud

schemes. Additionally, CMS should provide regular (e.g., annual) training to RACs to help them refer potential fraud, as appropriate.

Review and Take Appropriate, Timely Action on RAC Referrals of Potential Fraud

CMS did not provide documentation that it took action on six RAC referrals of potential fraud. If CMS has not already done so, it should review these referrals to determine whether additional actions (e.g., referrals to program integrity contractors) are necessary.

Develop Additional Performance Evaluation Metrics To Improve RAC Performance and Ensure That RACs Are Evaluated on Contract Requirements

CMS should develop additional performance evaluation metrics to improve RAC performance and ensure that RACs are evaluated on contract requirements (i.e., identifying improper payments). These metrics could include accuracy targets for RAC determinations of improper payments or similar measures (e.g., effectiveness ratings). CMS should also include timeliness and other metrics for RAC referrals of potential fraud. Although these should not be the only measures of contractor performance, these metrics could provide important information on contractor performance and improve oversight.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with our first, second, and fourth recommendations but did not indicate whether it concurred with our third recommendation.

CMS concurred with our first recommendation and as of June 2013 considers the 18 vulnerabilities pending corrective action to be closed. CMS also stated that it will explore the feasibility of developing a protocol that attempts to quantify the effectiveness of corrective actions using a combination of tools, including data analysis, error rate measurement, continued identification of overpayments via postpayment review, and other factors.

CMS concurred with our second recommendation and stated that it believes increased collaboration between RACs and ZPICs/Program Safeguard Contractors (PSCs) is important, and will also ensure that RACs continue to concurrently refer all instances of fraud to OIG and CMS.[56] Further, CMS stated that it has and will continue to provide regular training to the RACs on the identification of potential fraud.

Although CMS did not indicate whether it concurred with our third recommendation, it noted that it had reviewed the six RAC referrals of potential fraud in our review. Four of the six referrals were forwarded to ZPICs/PSCs to determine whether the providers have conducted potential Medicare fraud. One of the other RAC referrals did not include specific information to conduct an investigation. The remaining referral was previously received from the Medicare Administrative Contractor.[57] On the basis of that referral, an investigation was initiated by the PSC and the provider's billing privileges were subsequently revoked from the Medicare program in 2012.

CMS concurred with our fourth recommendation and stated that performance metrics, such as accuracy and appeal targets, are important measures and should be part of the regular performance evaluations. CMS has revised the 2012 CPARS evaluations to incorporate metrics on the RACs' identification of improper payments and accuracy rates.

[56] PSCs are responsible for preventing, detecting, and deterring fraud in the Medicare program. CMS is in the process of replacing PSCs with ZPICs.

[57] Medicare Administrative Contractors are responsible for making correct, reliable, and timely payment of Medicare home health claims. These contractors should also refer any instances of suspected fraud they encounter during their claims reviews to program integrity contractors.

CMS also provided technical comments. In response, we made revisions to the report where appropriate.

We ask that, in its final management decision, CMS more clearly indicate whether it concurs with each of our recommendations. For the full text of CMS's comments, see Appendix C.

APPENDIX A

Number and Percentage of Appealed Overpayment Identifications by Claim Type in Fiscal Years 2010 and 2011

Recovery Audit Contractor Region	Claim Type	Number of Claims Identified With Overpayments	Number of Overpayment Identifications Appealed*	Number of Appealed Overpayment Identifications Overturned	Percentage of Appealed Overpayment Identifications Overturned	Percentage of Appealed Overpayment Identifications Overturned out of Claims Identified With Overpayments
A	Part A	37,570	2,399	336	14%	1%
	Part B	80,116	521	512	98%	1%
	DME**	13,351	668	107	16%	1%
		131,037	**3,588**	**955**	**27%**	**1%**
B	Part A	57,473	12,589	5,510	44%	10%
	Part B	45,255	1,856	766	41%	2%
	DME	7,740	1,281	27	2%	<1%
		110,468	**15,726**	**6,303**	**40%**	**6%**
C	Part A	78,430	6,723	1,829	27%	2%
	Part B	118,986	535	210	39%	<1%
	DME	137,922	2,670	1,573	59%	1%
		335,338	**9,928**	**3,612**	**36%**	**1%**
D	Part A	68,213	10,554	1,319	13%	2%
	Part B	205,166	18,180	13,082	72%	6%
	DME	216,789	7,222	3,544	49%	2%
		490,168	**35,956**	**17,945**	**50%**	**4%**
Total		**1,067,011**	**65,198**	**28,815**	**44%**	**3%**

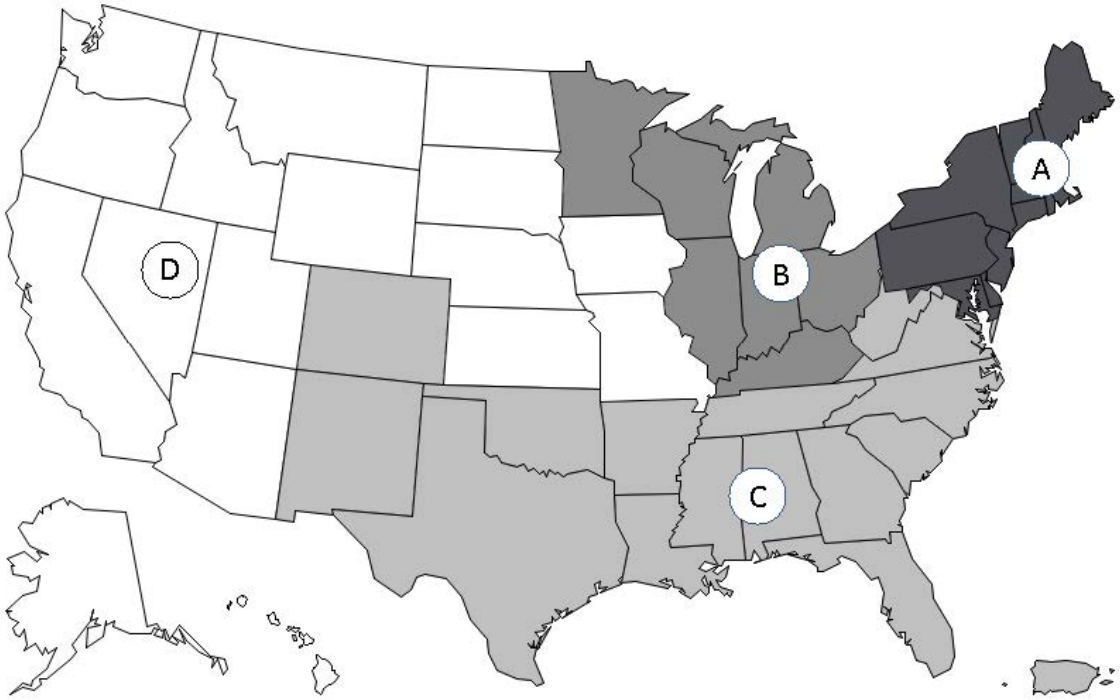
Source: Office of Inspector General analysis of Centers for Medicare & Medicaid Services appeals data, 2012.

*Because the outcomes could not be linked to specific RAC regions, these numbers exclude 3,968 unspecified appeals that were adjudicated by Administrative Law Judges.

**Durable medical equipment.

APPENDIX B

Map of Medicare Recovery Audit Contractor Regions



Recovery Audit Contactor Regions:

Region A*, Performant Recovery Inc. of Livermore, California: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

Region B, CGI Technologies and Solutions Inc. of Fairfax, Virginia: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

Region C, Connolly Consulting Associates Inc. of Wilton, Connecticut: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia.

Region D, HealthDataInsights Inc. of Las Vegas, Nevada: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming.

*Before August 2012, the company name was Diversified Collection Services, Inc., of Livermore, California.

APPENDIX C
Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 12 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance (OEI-04-11-00680)

Thank you for the opportunity to review and comment on OIG's draft report referenced above. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG has invested to review this issue. The OIG's audit focused on the corrective actions the CMS took to address Recovery Audit Contractor (RAC)–identified payment vulnerabilities and the actions the CMS took concerning RAC referrals of potential fraud. Lastly, OIG reviewed the extent that the RACs' performance evaluations addressed performance metrics and contract requirements.

By virtue of CMS's oversight of RACs, we continually strive to reduce the appeal rate to decrease provider burden and administrative costs. The majority of Recovery Auditor overpayment determinations are not appealed. Claims that are appealed can be overturned for a number of reasons. For example, the provider or supplier may present additional documentation during the appeal. All Medicare contractors that review claims, as well as the Qualified Independent Contractors and Administrative Law Judges (ALJ), are bound by all laws and regulations pertaining to the Medicare and Medicaid programs, National Coverage Determinations and CMS rulings. However, ALJs are not bound by CMS manuals and Local Coverage Determinations. While ALJs are required to provide substantial deference to this guidance, they are not bound by this guidance and may deviate from it in their decision-making. This creates discrepancies between the ALJ decisions and Medicare contractor decisions but does not necessarily mean the Medicare contractor's decision was incorrect. A recent OIG report[1] concluded, "most ALJ staff noted that ALJs often decided in favor of appellants when the intent, but not the letter, of a Medicare policy was met."

The oversight of the contractors, as well as the collaboration to assess RAC-identified vulnerabilities, is vital for the protection of the Medicare Trust Fund. The CMS continuously implements corrective actions on potential and known vulnerabilities and has implemented a dynamic process for addressing these vulnerabilities. The CMS also values the collaboration with program integrity contractors in our continued efforts to combat fraud, waste and abuse.

[1] Improvements needed at the Administrative Law Judge Level of Medicare Appeals – November 2012

The CMS has reviewed the report and responded to your recommendations below.

OIG Recommendation 1

Take action on vulnerabilities that are pending corrective action and determine the effectiveness of implemented corrective actions. The CMS should follow up on vulnerabilities that are pending corrective action and take appropriate, timely action. The CMS should also develop timeframes for addressing vulnerabilities to ensure that they are resolved in a timely manner. Finally, while the CMS has taken corrective actions on 28 of 46 vulnerabilities identified in FYs 2010 and 2011, it has not determined the effectiveness of these implemented actions. The CMS should determine whether implemented corrective actions are effectively reducing improper payments. We will provide the CMS with follow up information regarding vulnerabilities that have not been addressed by corrective action.

CMS Response

The CMS concurs with this recommendation. The CMS considers the 18 vulnerabilities pending action to be closed as of the date of this response. The CMS has taken corrective actions on the vulnerabilities that had pending actions at the time the OIG began their report.

The CMS agrees that determining the effectiveness of corrective actions is important. However, measuring the effectiveness of a corrective action can be challenging. Some vulnerabilities can be resolved with automated edits that can be easily monitored and measured to determine their effectiveness.

Other vulnerabilities require multiple corrective actions that are taken at different times and have varying implementation timeframes. Some are implemented within a few months, while others take significantly longer, hindering the CMS' ability to draw conclusions about the effectiveness of a specific corrective action.

Given the range of the complexity described above, the CMS will explore the feasibility of developing a protocol that attempts to quantify the effectiveness of corrective actions using a combination of tools including data analysis, error rate measurement, continued identification of overpayments via post payment review, and other factors.

OIG Recommendation 2

Increase RACs' referral of potential fraud. The CMS should increase RACs' referral of potential fraud. For instance, CMS should identify specific examples of fraud that, if RACs encounter, they should refer to program integrity contractors. The CMS should update these examples as needed to stay current with emerging fraud trends. The CMS should also facilitate increased collaboration between RACs, CMS, and program integrity contractors. For instance, CMS should coordinate regular meetings between program integrity contractors and RACs to share information about fraudulent coding or billing schemes in their respective regions and to keep

RACs aware of emerging fraud schemes. Additionally, CMS should provide regular (e.g., annual) training to RACs to help them identify and refer potential fraud.

CMS Response

The CMS concurs with this recommendation and believes facilitating increased collaboration between RACs and Zone Program Integrity Contractors (ZPICs)/ Program Safeguard Contractors (PSCs) is important. The RACs are required to establish Joint Operating Agreements with the applicable ZPIC/PSC in their region. Additionally, the CMS has referred providers to law enforcement based on the dollar amount demanded for a particular issue and CMS sends OIG every quarter a listing of all overpayments collected from individual practitioners above $5,000 and corporate entities above $25,000. The CMS has and will continue to provide regular training to the RACs on the identification of potential fraud.

Per the Office of Financial Management's Memorandum of Understanding with OIG regarding efforts to combat Medicare fraud, the CMS will ensure that the RACs continue to concurrently refer all instances of suspected fraud to the OIG and the CMS.

OIG Recommendation 3

Review and take appropriate, timely action on RAC referrals of potential fraud. The CMS did not provide documentation that it took action on six RAC referrals of potential fraud. If the CMS has not already done so, it should review these referrals to determine whether additional actions (e.g., referrals to program integrity contractors) are necessary.

CMS Response

The CMS has reviewed the six RAC referrals of potential fraud, and four of the six have been forwarded to our ZPICs/PSCs for further review to determine if the providers have conducted potential Medicare fraud. One of the RAC referrals did not include specific information to conduct an investigation on the referral. The remaining referral was previously received from the Medicare Administrative Contractor. Based on that referral, an investigation was initiated by the PSC, and the provider was subsequently revoked from the Medicare program in 2012.

OIG Recommendation 4

Develop additional performance evaluation metrics to improve RAC performance and ensure that RACs are evaluated on contract requirements. CMS should develop additional performance evaluation metrics to improve RAC performance and ensure that RACs are evaluated on contract requirements (i.e., identifying improper payments). These performance metrics could include accuracy targets for RAC determinations of improper payments or similar measures (e.g., effectiveness ratings). CMS should also include timeliness and other metrics for RAC referrals of potential fraud. Although these should not be the only measures of contractor performance, these metrics could provide important information on contractor performance and improve oversight.

CMS Response

The CMS concurs with this recommendation. Performance metrics such as accuracy and appeal targets are important measures and should be a part of the regular performance evaluations. The Federal Acquisition Regulation (FAR) requires past performance evaluations for contracts. It is CMS' policy that contracting staff use the Department of Defense's (DoD) Contractor Performance Assessment Reporting System (CPARS) for reporting Contractor performance evaluations. The evaluation criteria utilized in the CPARS system is established by the DoD and includes the following evaluation criteria: Quality of Product or Service; Schedule; Cost Control; Business Relations; Management of Key Personnel; and Utilization of Small Business.

The CMS has revised the 2012 CPARS evaluations to incorporate metrics on the RACs' identification of improper payments and accuracy rates. The RACs are required in their current SOW to refer all potential fraud to their CMS Contracting Officer Representative. The CMS will consider adding a timeliness and accuracy requirement to the next SOW to ensure timely and accurate referrals, but CMS does not believe it appropriate to include other metrics such as quotas. The CMS will also consider adding a metric based on the number of overpayment determinations overturned at the first level of appeal, as well as other relevant performance measures to the next SOW.

The CMS appreciates OIG's efforts and insight on this report. CMS looks forward to continually working with OIG on issues related to contractor oversight and the correction of improper payments in the Medicare program.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Durley, Deputy Regional Inspector General.

David Samchok served as the lead analyst for this study. Central office staff who provided support include Althea Hosein, Scott Manley, and Christine Moritz.

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