

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE CLAIMS
ADMINISTRATION
CONTRACTORS' ERROR RATE
REDUCTION PLANS**



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January 2014
OEI-09-12-00090

EXECUTIVE SUMMARY: MEDICARE CLAIMS ADMINISTRATION CONTRACTORS' ERROR RATE REDUCTION PLANS, OEI-09-12-00090

WHY WE DID THIS STUDY

According to the Centers for Medicare & Medicaid Services' (CMS) Comprehensive Error Rate Testing (CERT) program, Medicare claims administration contractors improperly paid an estimated \$29.6 billion during the Federal fiscal year 2012 reporting period. The improper payment rate (error rate) was 8.5 percent, above the target rate of 5.4 percent. To reduce the error rate, CMS requires claims administration contractors to submit error rate reduction plans. In these plans, contractors must describe the corrective actions that they will take to lower their error rates. In addition to overseeing contractors' efforts to reduce their error rates, CMS has the authority to offer financial incentives to the new type of claims administration contractor, Medicare Administrative Contractors (MACs).

HOW WE DID THIS STUDY

We reviewed error rate reduction plans submitted for calendar year 2011 or 2012 to describe plan content and determine whether the plans included the required elements. To assess CMS's oversight of the plans, we analyzed interview responses about reviews of the plans by CMS staff. We also analyzed information about the incentives that CMS offered to MACs in 2011 and 2012 to reduce their error rates.

WHAT WE FOUND

Most error rate reduction plans included the required elements. However, corrective actions were not always relevant to claims administration contractors' CERT results and varied substantially in number. CMS oversight of error rate reduction plans is limited. CMS staff who reviewed the plans may have been unable to determine whether the plans addressed their most recent CERT results. Additionally, although some of the sampled plans did not include the five required elements or were for contracts with high error rates, CMS approved all sampled plans without recommending different or additional corrective actions. Finally, limitations in CMS's administration of incentives for error rate reduction may reduce their effectiveness.

WHAT WE RECOMMEND

CMS concurred with our four recommendations to (1) review its process for overseeing claims administration contractors' error rate reduction, (2) ensure that contractors submit clear plans for reducing their error rates, (3) provide additional guidance for contractors and CMS staff who review plans, and (4) provide error rate reduction incentives that are aligned with the contracts' error rates and performance periods.

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OBJECTIVES

1. To describe claims administration contractors' error rate reduction plans.
2. To assess the Centers for Medicare & Medicaid Services' (CMS) oversight of error rate reduction plans.
3. To assess the financial incentives that CMS offered to Medicare Administrative Contractors (MACs) to reduce their error rates.

BACKGROUND

Medicare Claims Administration Contractors

CMS uses contractors to process claims and pay for services provided to beneficiaries in the Medicare fee-for-service program (claims administration contractors).¹ The scope of each claims administration contract covers a specific jurisdiction (i.e., States) and one or more claim types. Claim types include durable medical equipment (DME), Part A claims, Part B claims, and home health and hospice claims. Some of these contractors are awarded and administer multiple contracts.

CMS has completed the process of replacing all other claims administration contractor types with MACs.² When the jurisdiction consolidation is complete, 10 MACs will process all Medicare Part A and Part B claims (A/B MACs) and 4 MACs will process all DME claims.³ For the purpose of this report, "claims administration contractors" or "contractors" refers to all types of claims administration contractors, including MACs. Use of the term "MACs" refers solely to MACs.

The primary goal of each claims administration contractor is to "pay it right," i.e., to pay the proper amount for covered, medically necessary, and correctly coded services.⁴ In Federal fiscal year 2011, claims

¹ At the time of data collection, claims administration contractors consisted of fiscal intermediaries, carriers, and regional home health intermediaries, all of which have historically processed Medicare fee-for-service claims, and MACs.

² Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, expanded CMS's authority to contract with entities such as MACs.

³ Administration of home health and hospice claims will be consolidated into four of the A/B MAC contracts.

⁴ CMS, *Medicare Fee-for-Service 2011 Improper Payments Report*, p. 6. Accessed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/2011-Medicare-FFS-Improper-Payment-Report-.pdf> on May 9, 2013.

administration contractors collectively processed about 1.2 billion claims.⁵ Because of the large number of claims that contractors must process, they cannot manually review every claim submitted by providers. Instead, contractors take two main types of actions to prevent improper payments: (1) medical review of selected claims and (2) provider outreach and education. Medical review actions include identifying claims for review and determining whether they meet Medicare coverage criteria, implementing automated prepayment edits,⁶ and developing local coverage policies. Provider outreach and education is provided through a variety of media, such as articles, conference calls, and Web-based training.⁷

Measuring Improper Payments Made by Claims Administration Contractors

CMS's Comprehensive Error Rate Testing (CERT) program measures the improper payment rate (error rate) in the Medicare fee-for-service program. CERT contractors review a stratified random sample of submitted claims to determine whether the claims met Medicare requirements. The CERT program found that during the 2012 fiscal reporting period, claims administration contractors improperly paid an estimated \$29.6 billion out of the \$349.7 billion in total program expenditures.⁸ The national error rate was 8.5 percent,⁹ above CMS's target error rate of 5.4 percent.¹⁰

In addition to measuring the national error rate, the CERT program measures the error rate for each claims administration contract. In the 2010 and 2011 reporting periods, the CERT program found that claims administration contractors improperly paid between an estimated \$17 million and \$3.2 billion annually, per contract. Contract-specific error rates ranged from 1 to 76 percent.^{11, 12}

⁵ Government Accountability Office (GAO), *Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment* (GAO-13-102), November 2012, p. 6.

⁶ "Edits" are coded into the claims payment system to automatically deny all or part of a claim or suspend all or part of a claim for manual review. CMS, *Medicare Program Integrity Manual*, ch. 3, § 3.2, and ch.7, § 7.2.8.1.

⁷ CMS, *Medicare Contractor Beneficiary and Provider Communications Manual*, ch. 6, § 20.

⁸ Department of Health and Human Services, *Fiscal Year 2012 Agency Financial Report: Other Accompanying Information*, pp. 164-165.

⁹ Ibid.

¹⁰ CMS, *Medicare Fee-for-Service 2011 Improper Payments Report*, p. 32.

¹¹ Office of Inspector General (OIG) analysis of CMS improper payment and error rate data, 2013.

¹² During this time, DME MACs had error rates between 61 and 76 percent. The remaining contractor types had error rates between 1 and 24 percent.

Related Work on Improper Payments Made by Claims Administration Contractors

GAO has considered Medicare to be a high-risk program since 1990. In February 2013, GAO found that although CMS had made progress in measuring and reducing Medicare improper payments, it had yet to demonstrate sustained progress in lowering the error rates.¹³

Recent OIG reports have found that claims administration contractors did not take consistent and sufficient action to avoid making improper payments. OIG reported in October 2010 that contractors did not use historical CERT data to identify error-prone providers for corrective action.¹⁴ Another OIG report found that only one of the nine MACs it reviewed performed activities to detect and deter fraud by community mental health centers in 2010, although, at the time, approximately half of the centers exhibited questionable billing characteristics.¹⁵ A third OIG report found that of the two MACs included in the review, one processed claims for 95 percent of the home health agencies in the MACs' two regions in 2011, but identified only 2 percent of improper payments that were prevented for home health services by the two MACs.¹⁶

Error Rate Reduction Plans

To reduce the Medicare fee-for-service error rate, CMS began requiring claims administration contractors to submit error rate reduction plans in 2003. The *Medicare Program Integrity Manual* states that these plans are the “cornerstone of ... efforts to prevent improper payments.”¹⁷ In their plans, contractors must describe the corrective actions (that is, medical review and provider outreach and education actions) that they plan to take to lower their error rates.¹⁸

Data Used To Develop Error Rate Reduction Plans. CMS requires that claims administration contractors use their CERT results to develop error rate reduction plans.¹⁹ Every November, CMS provides contractors with

¹³ GAO, *GAO's 2013 High-Risk Update: Medicare and Medicaid* (GAO-13-433T), February 2013. GAO stated that because the size of Medicare relative to other programs leads to aggregate improper payments that are extremely large, continuing to reduce improper payments in this program should remain a priority for CMS.

¹⁴ OIG, *Centers for Medicare & Medicaid Services' Use of Medicare Fee-for-Service Error Rate Data To Identify and Focus on Error-Prone Providers* (A-05-08-00080), October 2010.

¹⁵ OIG, *Vulnerabilities in CMS's and Contractors' Activities To Detect and Deter Fraud in Community Mental Health Centers* (OEI-04-11-00101), January 2013.

¹⁶ OIG, *CMS and Contractor Oversight of Home Health Agencies* (OEI-04-11-00220), December 2012.

¹⁷ CMS, *Medicare Program Integrity Manual*, ch. 1, § 1.3.1.

¹⁸ *Ibid.*, ch.12, § 12.3.9.

¹⁹ *Ibid.*, ch. 12, § 12.3.9, and ch. 7, §§ 7.1 and 7.8.1.1.

CERT results specific to each contract. The CERT results include information about each improper payment, such as the procedure code, service setting, and error type, which contractors can analyze to identify common reasons for errors in their jurisdictions. According to CMS, contract-specific CERT results “provide...contractors with valuable information to assist in the development of specific, robust corrective actions to prevent improper payments from occurring in the future.”²⁰ Contractors also have continuous access to CERT-identified improper payments through a private Web site.

CMS expects, but does not require, claims administration contractors to use information about improper payments identified by Recovery Audit Contractors (RAC) to identify areas needing corrective action.^{21, 22} RACs and contractors share data with each other on improper claims and overpayment recoupment efforts. Contractors have continuous access to RAC-identified errors through the RAC Data Warehouse.²³ Contractors also analyze internal data, such as results of medical record reviews, to determine which corrective actions would best prevent the CERT- and RAC-identified errors in the future.

Error Rate Reduction Plan Requirements. For each contract they administer, claims administration contractors must develop and submit an error rate reduction plan that addresses the contract’s annual CERT results.^{24, 25} A/B MACs receive separate Part A and Part B error rates and must submit a plan for each Part. The plan is due 30 days after each contractor receives its annual CERT results.

²⁰ CMS, *Medicare Fee-for-Service 2011 Improper Payments Report*, p. 8.

²¹ CMS, *Medicare Program Integrity Manual*, ch.1, § 1.3.1.

²² RACs are responsible for identifying overpayments and underpayments and are paid according to the amount of improper payments they correct. CMS, *Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011*, pp. 2-3.

²³ CMS, *Statement of Work for the Recovery Audit Program*, September 1, 2011, p. 12.

²⁴ CMS, *Medicare Program Integrity Manual*, ch.12, § 12.3.9. New contractors are required to submit error rate reduction plans if their contracts were in effect when the contract-specific error rates became available, even if their contracts were not in effect during the CERT review period.

²⁵ The *Medicare Program Integrity Manual* states that DME Program Safeguard Contractors (another type of Medicare contractor) are responsible for DME MAC contracts’ error rate reduction plans. However, CMS informed OIG that this is not the case: DME MACs are responsible for their contracts’ plans.

The plan must follow the format required by CMS's data entry system.²⁶
The plan must also include five elements that describe:

1. reasons for error in the contractor's jurisdiction,²⁷
2. corrective actions in place and new corrective actions planned for the future,
3. adjustments that the contractor has made or will make to its Medical Review Strategy,²⁸
4. coordination activities among components²⁹ within the contractor, and
5. the ways in which the contractor will use the CERT results to develop and implement provider outreach and education efforts.³⁰

CMS Oversight of Error Rate Reduction Plans. CMS staff review each error rate reduction plan to determine whether it is a "reasonable response to the contractor's error rate."³¹ CMS regional office staff review the medical review sections of the plans. CMS central office staff review the provider outreach and education sections of the plans. According to regional office guidance, CMS staff review the plan "in conjunction with the applicable...CERT Improper Payment Report" and "ensure the plan sufficiently addresses the reasons for errors within the [claims administration contractor's] jurisdiction."³² CMS staff are also required to ensure that each plan includes the five required elements. If CMS staff have a question or concern about the plan, they may provide comments or suggestions to the contractor. Contractors may submit multiple versions between the initial submission and CMS approval.

²⁶ CMS maintains the data entry system, which is available to contractors to enter their error rate reduction plans. The system includes fields that identify the contract, fields used by the contractors to enter plan content, and fields used by CMS staff to enter comments and identify CMS staff who reviewed the plan.

²⁷ According to CMS, this element requires contractors to report the types of CERT errors (e.g., service types or provider types) that, on the basis of their analysis of their CERT results, require corrective action. Contractors should also report why those CERT errors require corrective action (e.g., a high percentage of claims with a procedure code had errors) and the results of their internal data analyses.

²⁸ Claims administration contractors are required to develop an annual Medical Review Strategy for each contract. The strategy details the medical review issues, actions, and projected goals for reducing the error rate. CMS, *Medicare Program Integrity Manual*, ch. 7, § 7.1.

²⁹ For example, medical review and provider outreach and education divisions.

³⁰ CMS, *Medicare Program Integrity Manual*, ch. 12, § 12.3.9.

³¹ Ibid.

³² CMS, *Standard Operating Procedure M-4: Review of the Comprehensive Error Rate Testing (CERT) Error Rate Reduction Plan (ERRP)*, p. 2. The CERT Improper Payment Report is published annually and reports the national error rate, the common causes of improper payments, and the steps CMS is taking to reduce the error rate.

Once any comments are addressed, CMS staff who reviewed the medical review and provider outreach and education sections each communicate the results of their review to central office staff. Generally, CMS staff who review the plans assist CMS contracting officers and technical representatives in interpreting Medicare program requirements and ensuring that claims administration contractors follow the technical requirements of their contracts.³³

Other Documents Used for CMS Oversight of Claims Administration Contractors' Error Rate Reduction Efforts. In addition to reviewing error rate reduction plans, CMS staff monitor claims administration contractors' error rate reduction efforts throughout the year using a variety of other oversight documents. CMS staff responsible for the medical review section of plans review Medical Review Strategies, Strategy Analysis Reports, and Monthly Status Reports.³⁴ CMS staff responsible for the provider outreach and education section of plans review Provider Service Plans, Educational Activities Reports, and Monthly Status Reports.³⁵

Performance-Based Incentives to MACs

To improve Medicare's administrative services to beneficiaries and health care providers, Congress replaced all other claims administration contractor types with MACs and authorized CMS to use new contracting tools.³⁶ These tools include performance-based financial incentives. Unlike the other types of claims administration contractors, MACs are paid on a cost-plus-award-fee basis.³⁷ CMS reimburses MACs for the cost of fulfilling their contract responsibilities and offers incentives to "motivate contractor efforts that might not otherwise be emphasized and discourage contractor inefficiency and waste."³⁸

³³ CMS, *MAC Contract Administration Guide*, revised June 3, 2011, p. 7.

³⁴ The Strategy Analysis Report is the annual update to the Medical Review Strategy Report and describes progress towards goals and any changes to the strategy. CMS, *Medicare Program Integrity Manual*, ch. 7, §§ 7.1 and 7.8. MACs submit Monthly Status Reports that include updates about all aspects of the contracts, including the achievement of milestones and deliverables.

³⁵ The Provider Service Plan outlines the contractor's strategies and actions planned for the coming year to support provider outreach and education and contains an evaluation of the success of the previous year's provider outreach and education. The Educational Activities Report summarizes the contractor's provider outreach and education actions during the previous time period. CMS, *Medicare Contractor Beneficiary and Provider Communications Manual*, ch. 6, §§ 20.7.1 and 20.7.2.

³⁶ CMS, *Medicare Administrative Contractors*. Accessed at <http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html> on August 12, 2013.

³⁷ Social Security Act, § 1874A(b)(1)(D), requires CMS to provide incentive payments to MACs to ensure service quality and promote efficiency.

³⁸ Federal Acquisition Regulation, Subpart 16.4—Incentive Contracts.

Before the beginning of each year of a MAC's contract,³⁹ CMS offers incentives for the MAC's performance during the upcoming year (performance period).⁴⁰ CMS selects certain metrics from the MAC's contract for which to offer these incentives. Examples of these metrics include claims administration timeliness, responsiveness to beneficiary inquiries, and error rate reduction. CMS weights each metric to determine the percentage of the total incentive payments the MAC can earn for its performance in each metric. CMS may change the metrics at any time, although it must inform the MAC of any revisions to the evaluation criteria before the performance period begins.⁴¹

At the end of each performance period, CMS determines the amount of incentive payments, if any, a MAC has earned. CMS makes this determination on the basis of its annual evaluation of the MAC and the MAC's self-reported performance assessment. In November 2012, GAO found that CMS provided relatively small incentives—3 percent or less of total incentives—to promote MACs' use of effective prepayment edits.⁴²

METHODOLOGY

Data Collection and Analysis

Error Rate Reduction Plan Content. From CMS, we collected all error rate reduction plans that were in effect during calendar year 2011 or 2012.⁴³ We received 42 plans in effect during 2011 and 34 plans in effect during 2012. We also requested a list of all claims administration contractors that received CERT results and determined whether a plan was submitted for each contract, as required.

We reviewed each error rate reduction plan and recorded information about all corrective actions (i.e., we created a corrective action database). CMS does not define "corrective action" for the purpose of reporting them in error rate reduction plans. In this report, we define "corrective action" as an action that has been or will be taken by the claims administration contractor to address a specific target and reduce its error rate. Corrective

³⁹ The term of a MAC contract is 5 years.

⁴⁰ Performance metrics and evaluation criteria are set in the MAC's annual Award Fee Plan. The Award Fee Plan's performance period begins with the first full month and ends with the last full month of the contract performance period.

⁴¹ CMS, *Award Fee Plan for Part A and Part B Medicare Administrative Contractor (A/B MAC) Jurisdiction 7*, p. 3.

⁴² GAO, *Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, GAO-13-102, November 2012.

⁴³ During data collection, CMS inadvertently did not submit one error rate reduction plan that was in effect during 2012. Therefore, although 77 plans were in effect during 2011 or 2012, our analysis is of the 76 submitted plans.

action targets include, but are not limited to, specific providers (e.g., providers with CERT errors), error types (e.g., documentation errors), service types (e.g., an ambulance transport procedure code or a group of procedure codes for chiropractic services), provider types (e.g., cardiologists), and facility types (e.g., skilled nursing facilities). A statement such as “we will publish articles to educate providers” does not identify the type(s) of error the articles will target and thus would not count as a corrective action for the purpose of this report. However, a statement such as “we will publish articles about power wheelchair billing requirements” would count as a corrective action.

We determined whether error rate reduction plans included each of the five required elements. Because CMS does not provide specific guidance on what is required to meet each element, we adopted a lenient approach to making this determination. Table 1 presents the minimum criteria we used as review standards for the required elements.

Table 1: Required Elements and OIG Review Standards for Error Rate Reduction Plans

Required Element	OIG Minimum Criteria Review Standard
Reasons for error in the contractor’s jurisdiction	✔ Plan identified types of error in the contractor’s CERT results and explained why they required corrective action (e.g., a high percentage of claims for a service type had errors)
Corrective actions in place and new corrective actions planned for the future	✔ Plan listed at least one past and one new (i.e., planned or ongoing) corrective action
Adjustments that the contractor has made or will make to its Medical Review Strategy	✔ Plan listed at least one medical review corrective action and had medical review sections that were up-to-date
Coordination activities among components within the contractor	✔ Plan described any type of internal coordination
How the contractor will use the CERT results to develop and implement provider outreach and education efforts	✔ Plan described the process for use of CERT results for provider outreach and education efforts or provided a specific example(s)

Using our corrective action database, we determined the range and average numbers of new, medical review, and provider outreach and education corrective actions in error rate reduction plans. We compared the numbers of these corrective actions with contracts’ error rates.

Using our corrective action database, we determined whether corrective actions listed in error rate reduction plans applied to each contracts’ CERT results. Specifically, we determined whether they targeted the appropriate timeframe, claim type(s), and jurisdiction.

CMS Oversight of Error Rate Reduction Plans. Using date fields in the error rate reduction plans we collected, we determined whether CMS's plan reviews were timely. We calculated the average number of days between the effective date of each 2011 and 2012 plan and the date of CMS's approval as recorded in the data entry system.

We determined the extent to which claims administration contractors did not report characteristics of corrective actions that could have affected reviewers' ability to determine the extent to which a corrective action addressed an error. Using our corrective action database, we identified corrective actions for which we could not determine one or more of the following: status, service target, action, number of providers affected,⁴⁴ and/or number of times the action had been or would be performed.⁴⁵

We conducted structured telephone interviews with CMS staff in the central and regional offices. In 2012, every error rate reduction plan received a review of its medical review section by one of nine staff in CMS regional offices and a review of its provider outreach and education section by one of three staff in the central office. We interviewed and collected supporting documentation from all 12 CMS staff who reviewed plans about their general oversight of plans and claims administration contractors' error rate reduction efforts. We also interviewed them about a sample of their plan reviews to determine the extent to which they recommended different or additional corrective actions or had concerns about the plans.⁴⁶ We asked about reviews of the medical review and provider outreach and education sections of 18 sampled plans. Therefore, we collected interview data for 36 reviews.

We determined the extent to which sampled error rate reduction plans did not include the five required elements or were associated with contracts with error rates above CMS's target during the Federal fiscal year 2010 and 2011 reporting periods (i.e., in the 2 years before the sampled plans' reviews). We compared the results of these analyses to our findings on CMS's review of the sampled plans.

Financial Incentives for MACs' Error Rate Reduction. To analyze the incentives that CMS offered to MACs to reduce their error rates, we

⁴⁴ Applies only to corrective actions that contractors indicated were specific to certain providers.

⁴⁵ Applies only to corrective actions that contractors indicated had been or would be performed multiple times.

⁴⁶ We selected a sample of 2012 error rate reduction plans so that staff members' responses were based on the most recent plan reviews. The nine CMS staff who were responsible for the plans' medical review content each reviewed between two and seven plans in 2012. We selected two plans from each of these staff members, using random sampling to select plans for staff members who reviewed more than two plans.

identified MACs with performance periods in calendar years 2011 and 2012. We requested information from CMS about the incentive payments offered and MACs' error rates.⁴⁷ We also conducted a telephone interview with CMS to collect information about how and when MACs' incentives for error rate reduction are set.

We determined the extent to which the size of incentives for error rate reduction varied according to MACs' error rates at the time incentives were offered. We compared the contract performance periods with the date range for sampled CERT claims that CMS used to measure MACs' error rate reduction performance.

Our analysis focuses on the incentives that CMS offered to MACs at the beginning of their performance periods and does not address the extent to which MACs successfully reduced their error rates and received incentive payments.

Limitations

We compared the numbers of corrective actions listed in error rate reduction plans with contracts' error rates. However, because the scopes of corrective actions may vary, the number of corrective actions in a plan may not necessarily measure the plan's effectiveness. As a result, the number of corrective actions listed in a plan may be a limited indicator of a contractor's response to its error rate.

At the time of our review, CMS did not document the dates that claims administration contractors initially submitted error rate reduction plans. Therefore, we were unable to determine whether plans were submitted within the required timeframe (i.e., 30 days after the contractor received its CERT results). We were also unable to determine the total time for CMS's plan reviews.

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.

⁴⁷ CMS provided contract information for 13 MACs with contracts in effect during 2011 and for 15 MACs with contracts in effect during 2012.

FINDINGS

Most error rate reduction plans included the required elements, but corrective actions were not always relevant to claims administration contractors' CERT results and varied substantially in number

Although most error rate reduction plans met the minimum criteria we established to determine whether plans included the five required elements, some plans listed corrective actions that were irrelevant to claims administration contractors' CERT results. The numbers of corrective actions listed in plans varied substantially, but not according to contractors' error rates.

Sixty-seven of seventy-six plans included the five required elements

All 76 error rate reduction plans were submitted as required, and 67 of 76 plans met the minimum criteria we established to determine whether plans included the 5 required elements.⁴⁸ All plans included the element to describe coordination between each claims administration contractor's components by meeting our minimum criterion of referencing any type of internal coordination. All plans also included the element to describe how the contractors would use their CERT results to develop and implement provider outreach and education efforts by meeting our minimum criterion of generally describing these efforts and/or providing at least one example.

Seven error rate reduction plans did not include the element to describe adjustments that the claims administration contractors had made or would make to their Medical Review Strategies. These plans did not meet our minimum criterion of including at least one medical review corrective action and having a medical review section that was up-to-date. The contractors responsible for these plans had error rates ranging from 0.5 to 67.4 percent.

Three error rate reduction plans did not meet the requirement to describe corrective actions in place and new corrective actions planned for the future. These plans did not meet our minimum criterion of including at least one past and one new corrective action in response to claims administration contractors' recent CERT results. For example, one plan reported only five corrective actions, all of which had occurred in the past. The contractors responsible for these plans had error rates ranging from 0.5 to 23.7 percent.

⁴⁸ Six plans did not include one required element and three plans did not include two required elements.

Two error rate reduction plans did not meet the requirement to describe reasons for error in the claims administration contractors' jurisdictions. These plans did not meet our minimum criterion of identifying types of error in their CERT results and explaining why they were considered priorities. These plans did not include any analysis of the contractors' CERT results, such as providing error rates for identified services. The contractors responsible for these plans had error rates of 8.0 and 75.1 percent.

Plans' corrective actions were not always relevant to contractors' CERT results

Some plans listed corrective actions that were outside the timeframe of their CERT results or the scope of their contracts.

Twenty-seven plans listed at least one corrective action outside the timeframe of their CERT results. Error rate reduction plans should address the claims administration contractor's most recent CERT results.

However, 27 of 76 plans listed at least 1 corrective action outside the timeframe of their most recent CERT results. Contractors that submitted the 27 plans reported actions taken prior to the CERT review period or used CERT results from prior years as a rationale for corrective actions. Thirteen plans each listed more than 20 of these corrective actions. For example, to explain why corrective actions would be taken, a plan that was submitted in April 2012 stated: "The error rate [for oxygen supplies] increased from 26% on the [contract-specific] November 2009 CERT Error Report to 73% on the November 2010 report," but did not include information from the contract's most recent (i.e., 2011) CERT results.

Sixteen plans listed at least one corrective action outside the scope of their contracts' claim types or jurisdictions. Claims administration contractors' CERT results are specific to the claim type(s) and jurisdiction included in the scope of their contracts. However, 16 of 76 plans listed at least 1 corrective action outside the scope of their contracts' claim type or jurisdiction. For example, one contract covered Connecticut and New York, but its plan described in-person provider workshops in Kentucky, Michigan, Indiana, and Wisconsin. Corrective actions outside the scope of the contract do not indicate that the contractor's plan was deficient, but rather that the plan was not tailored to the errors specific to the contract.

The numbers and types of corrective actions in plans varied, but not according to contractors' error rates

Although most error rate reduction plans met our minimum criteria for including the five required elements, the numbers and types of corrective actions listed in plans varied.

Most error rate reduction plans included the element to describe adjustments to the contracts' Medical Review Strategies. However, the numbers of medical review corrective actions listed in all plans varied from 0 to 97, with an average of 21 per plan. Twenty-four of seventy-six plans listed 10 or fewer of these corrective actions. Medical review corrective actions varied from postpayment reviews of individual providers' claims to prepayment reviews of all claims submitted with certain procedure codes.

All error rate reduction plans included the element that claims administration contractors describe how they will use CERT results to develop and implement provider outreach and education efforts. However, the numbers of provider outreach and education corrective actions listed in plans varied from 3 to 969, with an average of 74 per plan. Provider outreach and education corrective actions varied from a letter educating a single provider to an in-person training attended by hundreds of providers.

Although most error rate reduction plans listed at least 1 new (i.e., planned or ongoing) corrective action, the numbers of new corrective actions listed in plans varied from 0 to 529, with an average of 28 per plan. On average, less than one-third (32 percent) of the corrective actions listed in plans were new; the remaining actions were already completed.⁴⁹ Additionally, 24 of 76 plans listed 10 or fewer new corrective actions. Although CMS expects claims administration contractors to report what they have done in the past to address a particular problem, plans should also list new corrective actions that a contractor will take to address its most recent CERT results.⁵⁰

The numbers of corrective actions in error rate reduction plans did not vary according to claims administration contractors' error rates.⁵¹ Contractors with high error rates did not always submit plans that listed more corrective actions than contractors with low error rates. See Table 2 for examples of plans' corrective actions and their contracts' error rates. For example, one plan for a contract with an error rate of 23.7 percent and \$1.7 billion in projected improper payments did not list any new corrective actions or medical review corrective actions (Plan 10 in Table 2). In contrast, one plan for a contract with an error rate of 4.7 percent and \$254 million in projected improper payments listed

⁴⁹ Because we could not determine the status of 5 percent of corrective actions, these are excluded from this analysis.

⁵⁰ CMS, *Medicare Program Integrity Manual*, § 12.3.9.

⁵¹ Because contractors may take a wide range of corrective actions, the number of corrective actions listed in a plan may be a limited indicator of a contractor's response to its error rate.

58 new corrective actions and 21 medical review corrective actions (Plan 2 in Table 2).

Table 2: Contractors’ Error Rates and Corresponding Numbers of Corrective Actions in Example Error Rate Reduction Plans

Plan	Error Rate	Number of New Corrective Actions	Number of Medical Review Corrective Actions	Number of Provider Outreach and Education Corrective Actions
1	4.3%	6	6	35
2	4.7%	58	21	51
3	6.7%	3	20	11
4	6.7%	77	71	43
5	8.8%	69	57	85
6	9.0%	0	0	34
7	13.5%	65	50	79
8	14.4%	13	4	61
9	22.4%	75	19	84
10	23.7%	0	0	35

Note: The numbers used in the table are not the numbers used by CMS to identify claims administration contracts. We use them to delineate the individual plans that are the subject of our review. For one plan in this table, a few months remained on the contract at the time its plan was submitted; contracts for the other nine plans in this table each had at least 1 year remaining.

Source: OIG analysis of 2011 and 2012 error rate reduction plans, 2013.

CMS oversight of error rate reduction plans is limited

CMS does not use error rate reduction plans to oversee claims administration contractors’ error rate reduction efforts to the extent possible. CMS staff reviewed plans after the start of the plans’ effective year. CMS staff did not typically use CERT data to ensure that plans addressed contractors’ errors. Further, CMS staff may be unable to determine whether contractors’ plans address their most recent CERT results because of contractors’ unclear reporting of their corrective actions. Finally, in our sampled plan reviews, CMS approved all plans without recommending different or additional corrective actions. This occurred even though some of the plans did not include the five required elements or were associated with contracts with high error rates.

Some CMS reviews were completed well into the plans’ effective year

Because the 2011 and 2012 error rate reduction plans were not due from claims administration contractors until January 2012 and 2013, respectively, CMS staff completed all reviews after the plans’ effective year began. Twenty of seventy-six plans were approved by CMS more than 2 months into the plans’ effective year (i.e., on or after March 1). One of those plans was approved by CMS nearly 5 months into the

plan's effective year. These delayed approval dates may have been caused by late submissions from the contractors. However, we could not make this determination because CMS did not document the dates it received the initial plans and documented only the date the contractors submitted the last version of the plans.

CMS does not independently verify contractors' top errors using CERT results

CMS staff who review error rate reduction plans do not use contract-specific CERT results to independently verify the reasons for claims administration contractors' errors. According to CMS regional office guidance, CMS staff review the plans "in conjunction with the applicable...CERT Improper Payment Report."⁵² However, this report is not specific to each contract, and 10 of 12 CMS staff we interviewed stated that they do not review contract-specific CERT results.⁵³ Instead, CMS staff rely on contractors to analyze their CERT results and identify their reasons for error.

In addition to not using CERT results, CMS staff who review error rate reduction plans rarely use other data sources to identify reasons for error in the contractors' jurisdictions. None of the staff reported that they review contract-specific RAC data. Two staff mentioned that they review summaries of provider inquiries (providers who called the contractor to ask, for example, about documentation or billing requirements) to identify areas needing provider outreach and education corrective actions. Data from RACs and other sources could help CMS staff identify additional areas in need of corrective action.

CMS reviewers may have been unable to determine whether contractors' plans addressed their most recent CERT results

Claims administration contractors often did not clearly report information about corrective actions in error rate reduction plans that could have affected reviewers' ability to determine whether plans were a reasonable response to contractors' most recent CERT results. For an average of 41 percent of corrective actions per plan, we could not determine one or more of the characteristics below:

⁵² CMS, *Standard Operating Procedure M-4: Review of the Comprehensive Error Rate Testing (CERT) Error Rate Reduction Plan (ERRP)*, p. 2.

⁵³ CMS central office staff stated that they began providing contract-specific CERT analyses to staff who review plans in December 2012. However, when we interviewed them in January 2013, 7 of 12 CMS staff we interviewed were unaware that this information was available.

- *Status*. The contractor did not indicate whether these actions were already completed or were new actions in response to the most recent CERT results.
- *Service target*. The contractor did not indicate the specific service(s), such as spinal adjustment, or category of service(s), such as chiropractic services, with errors being addressed by these actions. For example, a corrective action that is described as addressing errors for “general surgery” is not specific enough to be matched with the contract’s CERT results.
- *Action*. For these actions, the contractor did not indicate what it had done or planned to do. For example, some plans were vague and stated that they would “conduct education” and others listed a range of potential actions, such as “articles, targeted mailings, or web[-based trainings]” without specifying which would be taken.
- *Number of providers affected*. Although the contractor indicated these actions were specific to certain providers, it did not identify the numbers of providers affected by the actions (for example, “there have been multiple face to face meetings with facility providers”).
- *Number of times the action was or would be performed*. Although the contractor indicated these actions were or would be performed multiple times, it did not identify the numbers of times the actions were or will be performed (for example, “conduct web-based trainings on physical therapy services”).

CMS approved all sampled plans without recommending different or additional corrective actions

CMS staff approved all sampled error rate reduction plans, including plans that did not include the five required elements or were for contracts with high error rates.⁵⁴ Three of the eighteen sampled plans did not include one or more of the five required elements, according to our review. CMS staff did not note this in their plan reviews. Additionally, eight sampled plans were associated with contracts that had error rates above CMS’s national error rate targets in the 2 years before the plans were submitted. The error rates for these plans ranged from 8.8 to 71.3 percent. Although CMS staff asked for clarifications or additional information from claims administration contractors in their reviews of some of these plans, CMS staff did not recommend that contractors take different or additional corrective actions for any of the sampled plans.

⁵⁴ This analysis is based on CMS interview responses about a sample of 18 of the 34 error rate reduction plans in effect during 2012.

Several CMS staff stated that they did not recommend that claims administration contractors address specific errors or take specific actions because they do not have the authority to require contractors to take specific corrective actions. Although this is true, CMS staff who review error rate reduction plans may make suggestions to contractors. Additionally, CMS contracting officers rely on other CMS staff, including those who review error rate reduction plans, to ensure that MACs meet contractual requirements.⁵⁵ CMS contracting officers have the authority to issue technical direction, as needed, to redirect contractors' efforts.⁵⁶

Limitations in CMS's administration of incentives for error rate reduction may reduce their effectiveness

Although CMS has the authority to offer incentives to MACs to reduce their error rates, limitations in the incentives' administration may reduce their effectiveness. CMS offered incentives to MACs only in certain years of their contracts. For MACs that were offered incentives for error rate reduction, the amount of incentive payments offered did not vary according to the MACs' error rates. Additionally, because of the timing of CERT reviews, MACs' incentive payments often were not aligned with the appropriate performance period.

CMS offers incentives for error rate reduction in only 2 of the 5 years of MACs' contracts

In 2011 and 2012, CMS offered error rate reduction incentives to each MAC that was entering the third or fourth year of its 5-year contract. These MACs were eligible to earn error rate reduction incentive payments by (1) meeting CMS's national error rate goal and/or (2) reducing their error rates from the previous year.

CMS stated that it does not offer error rate reduction incentives in the first and second years of MACs' contracts because their baseline error rates are established during that time.⁵⁷ CMS does not offer error rate reduction incentives in the fifth year of MACs' contracts because of delays in CERT error rate reporting. Seven A/B MACs and all four DME MACs were not eligible to earn error rate reduction incentives in 2011 and/or 2012 because they were in the first, second, or fifth years of their contracts.

⁵⁵ CMS, *MAC Contract Administration Guide*, revised June 3, 2011, p. 7.

⁵⁶ *Ibid.*, pp. 6-7. Technical direction can be given to MACs but not the other claims administration contractor types.

⁵⁷ During the first year, or base year, of the contract, which is composed of implementation and operational periods, the performance period may be 6 months. The second year, or first option year, is the first year in which the contract is fully operational.

The dollar amounts of error rate reduction incentives did not vary according to MACs' error rates

CMS allocates a set percentage of a MAC's available incentive payments to the error rate performance metrics.⁵⁸ Because the amount of available incentive payments varies for each MAC, the amount offered for error rate reduction also varies. However, MACs with higher error rates and higher amounts of total improper payments are not necessarily offered larger error rate reduction incentives than MACs with lower error rates and lower total amounts of improper payments. Table 3 presents MACs' error rates, projected improper payments, and incentive payments offered for MACs' error rate reduction in 2011 or 2012.

Table 3: MACs' Error Rates and Error Rate Incentives Offered in 2011 or 2012

MAC	Error Rate	Projected Improper Payments	Total Incentive Payment Offered for Error Rate Performance
K	21.1%	\$1,838,556,166	\$25,624
L	14.4%	\$2,588,848,665	\$23,396
M	12.9%	\$3,486,959,464	\$36,354
N	12.4%	\$2,742,378,638	\$12,474
O	9.2%	\$1,691,643,349	\$23,362
P	7.9%	\$673,036,000	\$4,308
Q	7.0%	\$940,201,239	\$5,610
R	6.6%	\$949,329,121	\$25,520
S	5.5%	\$1,497,499,970	\$36,312
T	5.3%	\$612,733,603	\$23,316
U	4.7%	\$603,679,066	\$81,966
V	4.0%	\$273,368,227	\$24,428
W	3.5%	\$28,572,533	\$19,620

Note: The letters used in the table are not the letters used by CMS to identify MAC contracts. We use them to identify the individual MAC contracts that are the subject of our review.

Source: OIG analysis of award fees offered to MACs, 2013.

In 2011 and 2012, the incentives for error rate reduction ranged from \$4,308 to \$81,966 per contractor, out of total possible incentive payments between \$891,752 and \$3.5 million. Total contract values in the years in which incentives were offered were between \$49.6 million and \$122.1 million.

⁵⁸ For the 2011 and 2012 performance periods, CMS allocated 5 percent of the Medicare Integrity Program pool, one of two funding pools for MACs' incentive payments, to error rate reduction.

Among MACs that were offered error rate reduction incentives, the MAC with the second highest projected improper payment amount (listed as “N” in Table 3) was offered one of the smallest incentives for error rate reduction. CMS offered the MAC \$12,474 to lower its error rate. At the time the incentive was offered, the MAC had an error rate of 12.4 percent, resulting in \$2.7 billion in projected improper payments. In contrast, the MAC that was offered the largest incentive for error rate reduction (listed as “U” in Table 3) had one of the lowest error rates. That MAC was offered an incentive to lower its error rate of \$81,966 and had an error rate of 4.7 percent at the time that the incentive was offered.

CMS did not align MACs’ incentive payments with the appropriate performance periods

The timing of the CERT program and the error rate reduction incentive performance period often did not align. At the time that CMS offered the incentives, an average of 4 months remained in the years during which MACs’ error rate performance was to be measured. For example, one MAC’s incentive performance period covered its performance between October 2010 and September 2011. This MAC was offered incentives to reduce its error rate. However, CMS used the MAC’s error rate for claims processed during calendar year 2010 to determine the incentive payments the MAC earned. Therefore, at the time the incentives were offered, the MAC had only 3 months remaining in the measurement period. For two MACs, there was no overlap between the error rate measurement period and incentive performance period. The lack of alignment between the measurement and incentive performance periods may lessen the effectiveness of error rate reduction incentives.

CONCLUSION AND RECOMMENDATIONS

OIG has consistently found vulnerabilities in CMS's oversight of contractors. The primary goal of claims administration contractors is to "pay it right."⁵⁹ During the 2012 fiscal reporting period, claims administration contractors improperly paid an estimated \$29.6 billion out of the \$349.7 billion in total Medicare Part A and Part B expenditures. Error rate reduction plans are intended to outline contractors' strategies for reducing their error rates and serve as the cornerstone of these efforts. Plans that include comprehensive medical review and provider outreach and education corrective actions may help protect the integrity of Medicare funds.

Claims administration contractors must process and pay large volumes of claims timely. Implementing medical review actions to detect and prevent improper payments slows claims processing, and both medical review and provider outreach and education incur costs for the contractor. Given this, effective CMS oversight of contractors' responses to their CERT results is essential.

CMS monitors claims administration contractors' error rate reduction efforts using a variety of oversight documents. However, our review identified vulnerabilities and opportunities for improvement in two tools central to CMS's oversight of contractor error rates: error rate reduction plans and performance-based financial incentives.

Therefore, we recommend that CMS:

Review Its Process for Overseeing Contractors' Error Rate Reduction

CMS should review its process for overseeing claims administration contractors' error rate reduction. Although CMS reviews a variety of documents submitted by contractors, unlike the other documents, error rate reduction plans are designed specifically to address the contractors' most recent errors. However, if CMS determines that its oversight of other documents, such as the Medical Review Strategy and the Provider Service Plan, are fulfilling the goal of overseeing contractors' response to their CERT results, CMS should reevaluate the usefulness of error rate reduction plans.

⁵⁹ CMS, *Medicare Fee-for-Service 2011 Improper Payments Report*, p. 6. Accessed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/2011-Medicare-FFS-Improper-Payment-Report-.pdf> on May 9, 2013.

Ensure That Contractors Submit Clear Plans for Reducing Their Error Rates

CMS should ensure that error rate reduction plans are sufficiently clear so that staff who review them can determine whether claims administration contractors are planning corrective actions that will effectively reduce their error rates. CMS could require that the format in which contractors report corrective actions, whether in error rate reduction plans or another document reviewed by CMS, clearly convey basic information about each action. This should include the status and target of the action.

Provide Additional Guidance for Contractors and CMS Staff Who Review Plans

CMS should give claims administration contractors and CMS staff who review error rate reduction plans specific guidance on what is required to meet the five required elements and what constitutes an “appropriate response to the contractor’s error rate.” Although regional office guidance directs CMS staff to ensure that “program funds, resources and actions planned are appropriate to reduce the claims payment error rate within their jurisdiction,” it does not specify how staff should make this determination. Issuing such specific guidance may improve the quality of plan submissions and CMS reviews.

Although CMS stated that it provides staff with analyses of contract-specific CERT results, CMS should ensure that staff are aware of these analyses. CMS should also provide guidance to staff on how to use these analyses in their plan reviews. CMS could also provide its staff with additional analyses of contract-specific RAC data. Doing so is especially important for contractors with persistently high error rates.

CMS should provide guidance to its staff about what to do if error rate reduction plans do not include the required elements or do not address claims administration contractors’ error rates. The guidance should address when staff who review plans should make suggestions to the contractor or recommendations to contracting officers, as appropriate.

Provide Error Rate Reduction Incentives That Are Aligned With the Contracts’ Error Rates and Performance Periods

If allowed under the Federal Acquisition Regulation, CMS should explore offering incentives for error rate reduction in more than 2 years of MACs’ contracts. CMS should take into account MACs’ error rates when setting the incentives.

CMS should use error rate data that match the incentive performance periods. If this is not possible using CERT data, CMS should explore using alternate error rate performance measures.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations. CMS described current and future steps to improve error rate reduction plans and to ensure its effective oversight of the plans and the financial incentives it offers contractors to reduce their error rates. Among these steps, CMS has already begun to provide quarterly contractor-specific improper payment reports and will develop an interactive dashboard containing real-time data to help CMS and its contractors address the most recent improper payment findings. We note that in its comments about our recommendation to provide error rate reduction incentives that are aligned with contracts' error rates and performance periods, CMS did not indicate whether it will take into account MACs' error rates when setting the incentives. For the full text of CMS's comments, see the Appendix.

APPENDIX

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 19 2013
TO: Daniel R. Levinson
Inspector General
FROM: Marilyn Tavenner *ISI*
Administrator
SUBJECT: Office of the Inspector General (OIG) Draft Report: "Medicare Claims Administration Contractors' Error Rate Reduction Plans" (OEI-09-12-00090)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above mentioned OIG report. This report examined error rate reduction plans for calendar year 2011 and 2012, described plan content and determined whether the plan included required elements. OIG also assessed CMS's oversight of the plans and analyzed information about the incentives that CMS offered to Medicare Administrative Contractors (MACs) in 2011 and 2012 to reduce their error rates. OIG's recommendations and the CMS response to those recommendations are discussed below.

OIG Recommendation

The OIG recommends CMS review its process for overseeing contractors' error rate reduction.

CMS Response

The CMS concurs with this recommendation to review the process for overseeing contractors' error rate reduction plans (ERRPs).

CMS has processes in place to ensure that all plans are approved and properly address reductions in improper payments. CMS requires that MACs submit ERRPs on at least an annual basis. The ERRPs are reviewed and approved by CMS medical review and provider outreach and education staff for accuracy and corrective actions. CMS provides feedback to the MACs during the ERRP evaluation process but the process may not be formally documented. We plan to continue monitoring the ERRPs and will formally document the process.

As a result of OIG's work on this report and to avoid repetitive reporting, we are evaluating alternatives for overseeing the contractor's ERRPs.

APPENDIX

Agency Comments Continued

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OIG Recommendation

The OIG recommends CMS ensure that contractors submit clear ERRPs for reducing their error rates.

CMS Response

The CMS concurs with the recommendation to ensure that the ERRPs are sufficiently clear to determine whether the contractors are planning corrective actions that will effectively reduce their error rates. CMS will add these requirements to the Program Integrity Manual and will explore the best way to facilitate streamlined reporting of this information.

The CMS believes that corrective actions should be clearly tied to claims analysis and research. Therefore, we added additional error subcategories to describe the specific reasons for insufficient documentation errors and to help develop targeted corrective actions. In addition, we distributed quarterly contractor-specific improper payment reports and the most recent improper payment data are available to contractors on the Comprehensive Error Rate Testing (CERT) Claims Status Website. CMS will be developing a new web-based interactive dashboard which will contain real-time data for contractors to use when developing the Fiscal Year 2014 and future ERRPs. This will enable CMS and contractors to evaluate the relevance of the ERRPs to address the most recent improper payment findings and current vulnerabilities. CMS expects the contractors to use this robust information when creating the ERRPs.

OIG Recommendation

The OIG recommends CMS provide additional guidance for contractors and CMS staff who review plans.

CMS Response

The CMS concurs with this recommendation. Chapter 12 of the Medicare Program Integrity Manual currently contains instructions on how contractors should develop their ERRPs and will be updated as described above. Additionally, steps have been taken to encourage collaboration between CMS staff who reviews the ERRPs. For example, a teleconference with the reviewers was held on February 4, 2013, during which CMS CERT staff answered questions on CERT sampling methodology, the Claims Status Website, weighing of improper payments and common misconceptions about the CERT program. As another example, the CMS CERT team presented CERT data to the MACs during the 2013 Medical Review Operational Meeting. We plan to continue offering additional guidance using teleconferences and face-to-face meetings.

APPENDIX

Agency Comments Continued

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OIG Recommendation

The OIG recommends CMS provide error rate reduction incentives that are aligned with the contracts' error rates and performance periods.

CMS Response

The CMS concurs with this recommendation. Effective October 1, 2013, CMS is including a CERT award fee metric for newly awarded MAC contracts to create performance incentives for MACs to reduce the national error rate over the period of their contracts. As much as possible, the error rate data matches the incentive performance periods. CMS believes that final action has been taken and considers the recommendation closed.

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Sarah Ambrose served as the team leader for this study, and Rosemary Rawlins served as the lead analyst. Other Office of Evaluation and Inspections staff from the San Francisco regional office who conducted the study include Bi Nguyen. Central office staff who provided support include Althea Hosein and Scott Manley.

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