

Part II:

Medicare Part C and Part D and Medicare Administration

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Medicare Part C (Medicare Advantage)	1
Modify Payments to Medicare Advantage Organizations	1
Address Vulnerabilities Within Sales Agents' Marketing of Medicare Advantage Plans (New)	3
Medicare Part D (Prescription Drug Program)	5
Ensure Accuracy of Prescription Drug Plan Sponsors' Bids and Prospective Payments	5
Ensure the Accuracy of Plans' Drug Prices on the Medicare Prescription Drug Plan Finder (New)	9
Ensure That Marketing Materials for Medicare Prescription Drug Plans Comply With Program Guidelines	11
Support Outreach and Education for Beneficiaries Before They Enter the Coverage Gap	13
Track Beneficiaries' True Out-of-Pocket Costs	15
Ensure Adequacy of Sponsors' Compliance Plans	17
Implement a Safeguard Strategy To Prevent and Detect Fraud and Abuse in Prescription Drug Plans	19
Ensure That Plan Sponsors Have Comprehensive and Effective Programs To Detect and Deter Fraud and Abuse	21
Ensure that Plan Sponsors Completely Implement E-Prescribing Standards to Support Connectivity with Prescribers and Dispensers (New)	23
Improve Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse (New)	25
Ensure the Validity of Prescriber Identifiers on Medicare Part D Drug Claims (New)	27

Improve Medicare Systems Controls	29
Financial Management: Improve CMS's Financial Reporting Systems and Processes	31
Improve the Performance Evaluation Process for Program Safeguard Contractors	33
Follow Up On Recovery Audit Contractors' Fraud Referrals (New)	35
Determine the Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors (New).....	37
Determine Medicare Overpayments Identified by Program Safeguard Contractors (New).....	39
Increase Medicare Providers' and Plans' Implementation of Standards for Culturally and Linguistically Appropriate Services (New).....	41
Improve CMS Reporting to the Healthcare Integrity and Protection Data Bank (New).....	45

Medicare Part C (Medicare Advantage)

Medicare Part C > Payments > Capitation Rates

Modify Payments to Medicare Advantage Organizations

Background: The Balanced Budget Act of 1997 (BBA) established the Medicare+Choice (M+C) program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The BBA also modified the payment methodology under the program to correct excess payments, reduce geographic variations in payments, and align payments to reflect beneficiaries' health status. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which increased payments, redesignated the M+C program as Medicare Advantage (MA). Participating managed care organizations are designated as MA organizations.

Findings: The 1997 data and estimates used as the basis to calculate monthly capitation payments to MA organizations were flawed, resulting in higher-than-necessary payments. Based on numerous reviews (which are summarized in our September 2000 report), studies by other agencies, and MA organization data, we concluded that from calendar year (CY) 1997 through CY 2000, MA organizations received more funds than necessary to deliver the Medicare package of covered services. Medicare payments funded excessive administrative costs, and MA organizations did not account for investment income earned on Medicare funds.

Improper payments made in Medicare fee-for-service (FFS) expenditures also contributed to the flaws in the 1997 managed care base rates. Our review of Medicare's 1996 and 1997 financial statements identified substantial FFS improper payments. The standardized county rates for 1997 were calculated using 1996 base FFS expenditure data, and the overpayment errors were carried over into the 1997 managed care rates. We estimated the 1996 FFS error rate as 14 percent of FFS benefit payments.

Recommendation(s): The Centers for Medicare & Medicaid Services (CMS) should modify monthly capitation rates to a level fully supported by empirical data.

Savings: \$1.97 billion*

**Estimated savings are based on the 3.077-percent overstatement of 1997 base rates applied to the 2006 managed care payments.*

Management Response Summary: CMS did not concur with our recommendation to modify payments to MA organizations, noting that the BBA and the Balanced Budget Refinement Act of 1999 (BBRA) had increased these payments.

Status: Improvements have been made to modify payment rates to levels supported by empirical data. For example, the Health Care and Education Reconciliation Act of 2010, § 1102 (amending § 3201 of the Patient Protection and Affordable Care Act (Recovery Act)), freezes MA payments in 2011 and further reduces MA benchmarks relative to current levels beginning in 2012. However, recent Office of Inspector General (OIG) work confirms that additional adjustments are needed. In January 2011, we issued a report following up on our prior work on interest income associated with repayments to MA organizations. The interest income that MA organizations earn on prepayments from Medicare, in effect, constitutes a portion of their total Medicare-related income. Based on the results of our followup review, we recommended that CMS (1) pursue legislation to adjust the timing of Medicare's prepayments to MA organizations to account for the time that these organizations invest Medicare funds before paying providers for medical services or (2) develop and implement regulations that require MA organizations to reduce their revenue requirements in their bid proposals to account for anticipated investment income. CMS has not agreed to implement either recommendation; however, the empirical results of the audit indicate that the recommended adjustments are warranted.

Related Report:

2000 SEP *Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997.* A-14-00-00212 [Report](#)

See also:

2011 JAN *Rollup Review of Impact on Medicare Program for Investment Income That Medicare Advantage Organizations Earned and Retained From Medicare Funds in 2007.* A-07-10-01080 [Report](#)

Medicare Part C > Marketing Activities > Regulations and Guidance

Address Vulnerabilities Within Sales Agents' Marketing of Medicare Advantage Plans (New)

Background: The MMA replaced the M+C program with the MA program and made qualified prescription drug coverage available to Medicare beneficiaries by contracting with private companies known as plan sponsors to provide health insurance plans under MA. Plan sponsors may offer multiple MA plans and market through advertisements and sales agents to attract Medicare beneficiaries to enroll in their plans. In addition, field marketing organizations (FMO) typically provide sales agents with enrollment leads and marketing assistance.

Between January 2008 and September 2009, enrollment in MA plans increased from 9.2 million Medicare beneficiaries to over 11.2 million, nearly a quarter of the more than 45 million Medicare beneficiaries. In response to Medicare beneficiaries' and consumer advocates' complaints of aggressive, deceptive, and fraudulent marketing practices, Congress held three hearings between June 2007 and June 2008 examining MA plan marketing. In July 2008, Congress enacted the Medicare Improvements for Patient and Providers Act of 2008 (MIPPA), which prohibited or limited certain marketing activities by plan sponsors or sales agents. Later in 2008, CMS promulgated regulations implementing these prohibitions and limitations, including specific regulations concerning sales agent compensation and qualifications.

Findings: We selected six MA plan sponsors for review, and we determined that all five of the sponsors employing independent sales agents had compensation practices that resulted in inappropriate financial incentives for sales agents and FMOs. Five of the six sponsors did not ensure that all of their sales agents were qualified under CMS's regulations. We also found that the number and types of beneficiary complaints remained unchanged after CMS's implementation of sales agent marketing regulations.

Recommendations: CMS should (1) issue regulations concerning FMO payments, (2) issue regulations requiring plan sponsors to contact all new enrollees to ensure they understand plan rules, and (3) issue guidance clarifying that plan sponsors should terminate unlicensed sales agents immediately upon discovery.

Management Response Summary: In its comments on the final report, CMS concurred with our recommendation that it issue additional regulations concerning FMO payments and said that it will consider additional and more specific regulations. CMS maintains that the CMS agent/broker compensation regulations apply to FMOs

and that it is therefore unnecessary for it to issue regulations specifically targeting FMO compensation payments. CMS stated, however, that it believes it is appropriate to clarify guidance on payments to third-party marketing organizations like FMOs in the next revision of the *Medicare Marketing Guidelines*.

CMS also concurred with our recommendation to issue regulations requiring plan sponsors to contact all new enrollees to ensure they understand plan rules. Regulations (42 CFR part 422) require that organizations establish and maintain a system for confirming that enrolled beneficiaries have in fact enrolled in the plan and understand plan rules.. Therefore, all sponsors are required to conduct outbound education and verification calls to ensure that beneficiaries who request enrollment understand plan rules.

Finally, CMS concurred with our recommendation to issue guidance clarifying that sponsors should terminate unlicensed sales agents immediately upon discovery. On November 22, 2010, CMS published a proposed rule at [75 Fed. Reg. 71190](#), which would require sponsors to terminate unlicensed sales agents upon discovery and notify any beneficiaries who were enrolled in their plans by unlicensed agents. CMS believes that the changes proposed in 75 Fed. Reg. 71190 are consistent with the statute and with the beneficiary protections specified in CMS's regulations implementing MIPPA.

Status: We continue to monitor CMS's implementation of our recommendations.

Related Report:

2010 MAR *Beneficiaries Remain Vulnerable to Sales Agents' Marketing of Medicare Advantage*, OEI-05-09-00070 [Report](#)

Medicare Part D (Prescription Drug Program)

Medicare Part D > Bids and Payments > Sponsor Accountability

Ensure Accuracy of Prescription Drug Plan Sponsors' Bids and Prospective Payments

Background: The Medicare prescription drug program provides an optional outpatient drug benefit to Medicare beneficiaries. CMS contracts with private insurance companies, known as Part D sponsors, to provide prescription drug coverage for beneficiaries who choose to enroll. During 2006, the first year of the benefit, Part D expenditures totaled more than \$47 billion.

CMS makes monthly prospective payments to sponsors for providing prescription drug coverage to Medicare beneficiaries. These payments are based on estimates that sponsors provide in their approved bids before the plan year begins. CMS makes prospective payments to sponsors in the form of three separate subsidies to cover the Federal Government's share of the cost of direct, catastrophic, and low-income prescription drug benefits. The amounts of the three subsidies are based on sponsors' approved bids. After the close of the plan year, CMS must reconcile these prospective payments with sponsors' actual costs to determine whether sponsors owe money to Medicare, Medicare owes money to sponsors, or payment to CMS or to a sponsor is required to share the risk of unexpected losses (or the benefit of unexpected profits).

Findings: In October 2007, we issued a report that estimated that Part D sponsors owed Medicare a net \$4.4 billion for the 2006 benefit year. Eighty percent of sponsors owed money to Medicare, and 20 percent of sponsors were to receive money from Medicare. The majority of the funds that sponsors owed were a share of excess profits that they must return to Medicare pursuant to risk-sharing requirements. CMS had no mechanisms in place to collect funds owed by sponsors until it had completed reconciliation, which at the time of our review was scheduled to occur more than 9 months after the 2006 plan year had ended. CMS also had no mechanism in place to adjust prospective payments before reconciliation.

A subsequent report issued in September 2009 found that sponsors owed a net \$18 million to Medicare for reconciliation of the 2007 benefit year.

We found that sponsors continue to make large unexpected profits in addition to expected profits that they included in their bids. We also found that CMS collected almost all of the funds that sponsors owed from the 2006 benefit year to Medicare in November and December 2007. We reported in 2007 that CMS had not collected \$14 million from five sponsors for 2006. However, CMS noted that it has since collected amounts owed.

Recommendations: The recommendations of our 2009 report were similar to those of our 2007 report, including that CMS should (1) ensure that sponsors' bids more accurately reflect their costs of providing the benefit to Medicare beneficiaries, (2) hold sponsors more accountable for inaccuracies in the bids, (3) determine whether changes to the risk corridors (triggers that protect plans from unexpected losses and allow the Government to share in unexpected gains) are appropriate, (4) determine whether alternative methodologies would better align payments with sponsors' costs for the low-income cost-sharing and reinsurance subsidies

Management Response Summary: In response to our first recommendation, CMS concurred and stated that it has already incorporated plan-level experience in its current bid-desk review. In response to our second recommendation, CMS stated that it has the authority to ensure Part D sponsors' compliance with the operational requirements of the Part D program. However, CMS subsequently indicated that it did not concur with this recommendation. In response to our third recommendation, CMS stated that it has reviewed the statutory risk corridors and risk-sharing percentages and does not believe that changes would be appropriate. Further, CMS noted that it estimates that because plans' bids dropped significantly for the 2008 benefit year, the Government, on average, will owe plans for the 2008 reconciliation. In response to our fourth recommendation, CMS concurred and stated that it was considering changing the method for paying the low-income cost-sharing subsidy.

Status: We will continue to monitor the actions CMS takes to further address our recommendations, including that CMS use its current authority to hold sponsors more accountable for inaccuracies in their bids. However, we note that CMS's current authority may not allow it to impose sanctions in all situations that lead to inaccuracies in the bids.

Related Reports:

2009 SEP *Medicare Part D Reconciliation Payments for 2006 and 2007.*
OEI-02-08-00460 [Report](#)

2007 OCT *Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006.*
OEI-02-07-00460 [Report](#)

Medicare Part D > Information for Beneficiaries > Reliability of Estimated Costs

Ensure the Accuracy of Plans' Drug Prices on the Medicare Prescription Drug Plan Finder (New)

Background: The Medicare prescription drug program provides an optional prescription drug benefit for Medicare beneficiaries. CMS contracts with private insurance companies, known as Part D sponsors, to provide outpatient prescription drug coverage for beneficiaries who choose to enroll. Medicare created the Plan Finder, an online tool to help beneficiaries compare and select Part D plans. The plans' drug prices are a significant factor in selecting a plan. Drug prices listed on the Plan Finder that do not reflect actual drug costs may cause beneficiaries to enroll in a plan based on incorrect information, incur unexpected costs, or decline to enroll in a Part D plan. The Plan Finder indicates on the plan drug details screen that "actual drug costs at the pharmacy may vary slightly." To determine whether Plan Finder drug prices accurately reflect actual drug costs, we compared plans' retail prices listed on the Plan Finder for 10 drugs commonly used by Medicare beneficiaries to actual drug costs on corresponding prescription drug event (PDE) claims for the same period (September 24 to October 7, 2007).

Findings: Drug prices posted on the Plan Finder exceeded actual drug costs for 92 percent of the claims. The median amount by which the Plan Finder exceeded the actual price was 28 percent. The Plan Finder price was less than the actual price for 7 percent of claims and equaled the actual price for only 1 percent of claims. Percentage differences between Plan Finder prices and actual costs were generally greater for the generic drugs we reviewed, while dollar differences were greater for the brand-name drugs reviewed.

Recommendation: CMS should modify the disclaimer on the Plan Finder search results screen to indicate that drug cost estimates may differ more than "slightly" from actual drug costs.

Management Response Summary: CMS did not concur with our recommendation. CMS asserts that the current disclaimer on the Plan Finder indicating that drug cost estimates may differ slightly from actual drug costs is sound and that modification to the disclaimer is unwarranted. Subsequently, CMS said that the review's methodology has limitations regarding the relationship between prices displayed on the Plan Finder and the prices charged at the point of sale because we conducted a general search rather than a pharmacy-specific search in the Plan Finder. Consequently, CMS considers that findings of frequent price differences between Plan Finder and PDE data are misleading. CMS continues to recommend that beneficiaries perform a general (non-pharmacy-

specific) search to find the least expensive plan for their needs. For the past 3 years, CMS has compared drug pricing displayed on the Plan Finder to prices charged at the point of sale (pharmacy). The results of these analyses have been presented on www.medicare.gov as ratings of Part D plans.

Status: We continue to encourage CMS to modify the disclaimer on the Plan Finder search results screen to indicate that drug cost estimates may differ more than “slightly” from actual drug costs. We also encourage CMS to raise beneficiaries’ awareness of potential significant discrepancies between drug prices displayed on the Plan Finder and actual drug costs.

Related Report:

2009 JUL *Accuracy of Part D Plans’ Drug Prices on the Medicare Prescription Drug Plan Finder.* OEI-03-07-00600 [Report](#)

Medicare Part D > Information for Beneficiaries > Accuracy Compared to Guidelines

Ensure That Marketing Materials for Medicare Prescription Drug Plans Comply With Program Guidelines

Background: CMS's Medicare Marketing Guidelines specify what information the marketing materials must include when describing prescription drug plan (PDP) coverage. To help ensure accuracy and expedite the review of certain marketing materials, CMS created model documents, which include uniform text that contains pertinent information. Before PDP sponsors distribute marketing materials, they must submit them to CMS under one of its review processes: standard review or "file & use." The guidelines also outline CMS's oversight activities in monitoring marketing materials, including requiring identification numbers on materials. We assessed CMS's oversight of PDP marketing materials based on its oversight strategy.

Findings: We found that CMS's oversight for PDP marketing materials is limited. For example, CMS did not complete a retrospective review of file & use marketing materials for 2006 until April 2008. Although CMS completed standard reviews of marketing materials in a timely manner, the reviews lacked consistency across regions. Identification numbers from 45 percent of the materials we reviewed failed to match the numbers in CMS's system. CMS also lacked a systematic way to track materials. We also found that CMS's model documents were not consistent with its guidelines. In addition, we found that overall, PDP marketing materials did not meet CMS guidelines. Eighty-five percent of marketing materials failed to meet at least one element of the guidelines.

Recommendation: CMS should revise model documents to ensure consistency between the model documents and the guidelines.

Management Response Summary: CMS concurred with our recommendation. In its update for 2011, CMS reported that it has developed a standard operating procedure for the review of marketing materials and that it has implemented a tracking system for non-English and alternative format materials, which are given a unique material ID.

Status: We continue to monitor CMS's implementation of its commitment to revise the model documents to better align with the guidelines.

Related Report:

2008 SEP *Marketing Materials for Medicare Prescription Drug Plans.*
OEI-01-06-00050 [Report](#)

Medicare Part D > Information for Beneficiaries > Preparation for Coverage Gap

Support Outreach and Education for Beneficiaries Before They Enter the Coverage Gap

Background: Medicare Part D provides an optional outpatient drug benefit to beneficiaries. During the coverage year, the financial responsibilities of beneficiaries, plan sponsors, and CMS vary during four distinct coverage phases: annual deductible, initial coverage, coverage gap, and catastrophic coverage. Beneficiaries may receive financial assistance for drug costs during the coverage gap from several sources (such as from low-income subsidies or third-party payers), but some do not. Some research suggests that beneficiaries who entered the Medicare Part D coverage gap may have changed their prescription drug use behavior because they were responsible for 100 percent of their drug costs during the coverage gap. OIG studied the prescription drug use of beneficiaries who entered the coverage gap without financial assistance in 2006.

Findings: Seven percent of Part D beneficiaries entered the coverage gap and did not receive financial assistance with prescription drug costs in 2006. During the coverage gap, drug-purchasing behavior changed for 98 percent of the beneficiaries, with 69 percent reducing the average number of drugs they purchased during the coverage gap. The greater the average number of drugs per month that they purchased before the coverage gap, the more they reduced the average number of drugs purchased during the coverage gap. Beneficiaries who purchased an average of at least nine drugs per month had the largest decrease at 18 percent. When surveyed, beneficiaries identified specific changes in the way they purchased or used drugs during the coverage gap, including 38 percent who reported seeking at least one less-costly alternative to purchasing drugs and one-third who compromised their drug regimens.

Recommendations: CMS should (1) support outreach and education targeted at beneficiaries who make more prescription drug purchases before entering the coverage gap (such as by encouraging plan sponsors to augment outreach and beneficiary education efforts, supplementing those efforts by working with beneficiaries to explore cost-saving strategies, and targeting these beneficiaries for counseling about choosing the most cost-effective plan in the following year) and (2) target low-income subsidy outreach to beneficiaries who entered the coverage gap in previous years without financial assistance.

Management Response Summary: CMS concurred with one of our two recommendations. CMS said that it would not be feasible to provide additional personalized outreach to individual beneficiaries who used a large number of drugs

each month based on the prior year's PDE data. We continue to recommend that targeting beneficiaries who had more prescription drug purchases before the coverage gap for outreach and education would assist those beneficiaries in identifying cost-saving strategies. CMS concurred with our second recommendation and said that it would continue to emphasize the value of the low-income subsidy to attract beneficiaries with significant drug utilization who might benefit from the subsidy. In its December 2009 update, CMS indicated that it had taken several steps to refine outreach methods. However, the actions CMS said it would take may not fully address our concerns. In its update for 2011, CMS indicated that it continues to refine outreach methods and will use research findings to shape future outreach strategies, including how to communicate the value of the low-income subsidy program to those with high drug utilization.

Status: CMS has not yet fully addressed our concerns. We continue to recommend focusing on a specific category of beneficiaries for outreach and using prescription drug utilization data to identify potential beneficiaries for the subsidy.

Related Report:

2009 MAR *Effect of the Part D Coverage Gap on Medicare Beneficiaries Without Financial Assistance in 2006.* OEI-05-07-00610 [Report](#)

Medicare Part D > Data Management > Tracking and Oversight of Costs

Track Beneficiaries' True Out-of-Pocket Costs

Background: The Medicare Prescription Drug program, known as Medicare Part D, provides an optional outpatient prescription drug benefit for beneficiaries. Beneficiary, Medicare, and plan sponsor cost-sharing obligations vary across four phases of the standard Part D benefit: deductible, initial coverage, coverage gap, and catastrophic coverage. Part D plans are responsible for tracking beneficiaries' true out-of-pocket (TrOOP) costs. TrOOP costs are the prescription drug expenditures that count toward the annual out-of-pocket threshold that beneficiaries must reach before catastrophic drug coverage begins. Medicare beneficiaries enrolled in Part D plans may also have other prescription drug coverage. Tracking TrOOP costs involves coordination and communication among CMS; contractors, such as coordination of benefits contractors; Part D plans; and other payers of prescription drug benefits. The amount of beneficiaries' TrOOP costs affects their cost sharing as well as CMS payments to Part D plans.

Findings: We found that information on Part D plan enrollees' other prescription drug coverage was not consistently submitted in 2006. Nearly two-thirds of Part D plans cited problems with transferring TrOOP balances when enrollees changed plans. More than one-third of Part D plans failed in 2006 to submit PDE data to CMS in accordance with CMS requirements. We also found that CMS has conducted limited oversight of Part D plans' tracking of TrOOP costs.

Recommendations: CMS and its contractors should (1) ensure that Part D plans collect, process, and submit all of the data that are required to track enrollees' TrOOP costs in a timely manner; (2) consider options for increasing the number of data-sharing agreements and for seeking to expand its authority to collect data under those agreements; and (3) begin or complete implementation of oversight activities regarding tracking TrOOP costs.

Management Response Summary: CMS agreed that the report identified potential issues linked to the accurate tracking of TrOOP costs and that more work is needed to ensure that Part D plans are calculating TrOOP costs correctly. The agency did not concur with our three recommendations but noted that it had taken or will take steps to respond to each of our recommendations. In its March 2009 status update to OIG, CMS said that it had implemented an automated TrOOP balance transfer process among Part D plans and between Point-of-Sale Facilitated Enrollment (POS FE) Contractors and Part D plans, which went into effect on January 1, 2009. CMS said that it would monitor performance via standard and exception reporting.

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), all group health plans are required to report coverage information related to hospital and medical benefits that are primary to Medicare. Although MMSEA does not specifically mandate the reporting of private prescription drug coverage, this reporting option is being offered to all entities required to report under the section 111 reporting processes. As a result, CMS expected to receive a significant number of reports of prescription drug data via the section 111 process. CMS also stated in its March 2009 status update that it was conducting audits of one-third of the MA and Medicare PDPs. The audit protocol includes a review to verify that PDPs are accurately calculating TrOOP costs. In CMS's December 2009 status update, it indicated that as of November 2009, it had started its financial audits for 2006 and 2007. However, until one-third of financial audits are completed and show that TrOOP is calculated correctly, our recommendations are not fully implemented.

Status: We continue to monitor CMS's implementation of oversight activities related to the tracking of TrOOP costs.

Related Report:

2007 DEC *Tracking Beneficiaries' True Out-of-Pocket Costs for the Part D Prescription Drug Benefit.* OEI-03-06-00360 [Report](#)

Medicare Part D > Program Integrity > Sponsors' Compliance Plans

Ensure Adequacy of Sponsors' Compliance Plans

Background: The MMA established Medicare Part D to provide outpatient prescription drug benefits under the Medicare program beginning January 1, 2006. Part D prescription drug coverage is provided by private entities known as plan sponsors. Federal regulations at 42 CFR § 423.504(b)(4)(vi) require that PDP sponsors have compliance plans in place to protect the integrity of Medicare funds by preventing fraud, waste, and abuse and that these compliance plans address eight elements. In June 2005, CMS issued a summary document, *Review of Sponsor Fraud, Waste, and Abuse Responsibilities*, and in April 2006 issued its *Prescription Drug Benefit Manual*, Chapter 9, which outlined requirements that compliance plans must address to ensure that the eight elements established by the regulation are met.

In December 2006, we released a report on PDP sponsors' compliance plans, finding that most compliance plans did not address all of CMS's requirements or recommendations, and in October 2008, we issued a followup report.. In August 2008, the Government Accountability Office (GAO) released a report saying that some PDP sponsors had not completely implemented fraud and abuse programs and that CMS oversight had been limited.

Findings: In our 2008 followup, we found that CMS conducted only one audit of a PDP sponsor's compliance plan in 2007. CMS instructed PDP sponsors to complete compliance plan self-assessments, but we found that CMS did not verify sponsors' responses. The self-assessments were based on requirements and recommendations in CMS's *Prescription Drug Benefit Manual*, Chapter 9. However, some self-assessments did not include all of the compliance plan requirements that are in Chapter 9. Although CMS followed up with 23 PDP sponsors that attested that they had not implemented one or more of the compliance plan requirements in the self-assessments, CMS did not request supporting documentation to confirm that these PDP sponsors corrected their compliance plans.

Recommendation: CMS should conduct audits to verify that PDP sponsors' compliance plans meet requirements (covering all of the compliance plan requirements that are contained in regulations and in Chapter 9 of CMS's *Prescription Drug Benefit Manual*).

Management Response Summary: CMS concurred with our recommendation in the 2006 report that it should ensure that PDP sponsors' compliance plans address all

requirements set forth in regulation and provide sufficient detail in their compliance plans to demonstrate implementation of compliance plan requirements.

In its comments on our 2008 report, CMS agreed that it is important to conduct reviews of compliance plans but said that because of critical funding shortfalls, it had to reprioritize its program integrity oversight activities and was not able to conduct compliance plan audits before our report was issued. CMS said that it would begin a limited number of desk audits of Part D sponsors' compliance plans in September 2008. As more resources become available, CMS said, it would include more audits, onsite reviews, and other more comprehensive fraud-prevention activities. However, in response to an October 2009 review, CMS acknowledged that there had been a delay in starting the compliance plan audits.

In December 2009, CMS reported that Medicare Prescription Drug Integrity Contractors (MEDIC) had conducted compliance plan audits of 16 stand-alone PDP sponsors in fiscal year (FY) 2009. In an effort to strengthen its compliance oversight activities, CMS restructured the MEDIC program for FY 2010 contract year, with one MEDIC focusing solely on compliance activities for the entire country and being responsible for conducting compliance plan audits in addition to other compliance-related activities. CMS also informed us that the MEDICs had approval to conduct compliance plan audits in FY 2010 for PDP and MA organizations to include assessing an entity's compliance with CMS requirements in 42 CFR §§ 422.504(b)(4)(vi) and 422.503(b)(4)(vi), which contain measures to detect, correct, and prevent fraud, waste, and abuse.

In its 2011 update of our recommendation, CMS said it conducted program compliance audits in the fall of 2010 that included reviews of Part D sponsors' compliance plans.

Status: We will continue to monitor CMS's implementation of our recommendation as it analyzes and takes appropriate action, if needed, on the findings of those audits.

Related Reports:

2008 OCT *Oversight of Prescription Drug Plan Sponsors' Compliance Plans.*
OEI-03-08-00230 [Report](#)

2006 DEC *Prescription Drug Plan Sponsors' Compliance Plans.*
OEI-03-06-00100 [Report](#)

See Also:

2009 OCT *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse.* OEI-03-08-00420 [Report](#)

Medicare Part D > Program Integrity > Safeguard Strategies

Implement a Safeguard Strategy To Prevent and Detect Fraud and Abuse in Prescription Drug Plans

Background: CMS is responsible for safeguarding the Medicare Part D program against fraud and abuse. CMS is statutorily required to perform financial audits of PDPs that are contracted to provide outpatient prescription drug benefits to beneficiaries. Beyond this, CMS has discretion in structuring program safeguards.

We identified six major safeguards conducted by CMS during FY 2006: implementation of a complaint process, data-monitoring, financial audits, monitoring PDP sponsors' compliance with contract requirements, oversight of PDP sponsors' efforts to reduce fraud and abuse, and providing education and guidance to stakeholders on fraud and abuse identification. During FY 2006, CMS had contracted with one MEDIC to perform some of these functions. We reviewed a variety of documents and conducted interviews with CMS and MEDIC staff members to determine the status of safeguards at the time of our review.

Findings: We found that CMS implemented safeguards throughout FY 2006; however, further development or application of these activities is needed. CMS relied largely on complaints to identify potential fraud and abuse, but some complaints were not investigated in a timely manner. Limits to legal authority, jurisdiction, and CMS's ability to monitor enrollees switching plans had complicated efforts to safeguard Medicare Part D PDPs.

Recommendation: CMS should develop a comprehensive safeguard strategy for Medicare Part D PDPs,.

Management Response Summary: CMS did not indicate whether it concurred with the recommendation in our draft report. In its March 2009 status update to OIG, CMS reported that it had developed a corrective action plan to address OIG's recommendation and had completed the following activities: (1) implementing a regional TriMEDIC structure in which the three MEDICs work together to analyze data and identify national fraud schemes, (2) assigning a Government Task Leader to each regional MEDIC to oversee and monitor all MEDIC activities, and (3) rewriting the MEDIC Umbrella Statement of Work (SOW) to further refine CMS's coordination and oversight of the MEDICs.

In 2009, CMS restructured the MEDIC program, designating one MEDIC to focus solely on compliance activities for the entire country and the other to concentrate on efforts

against fraud, waste, and abuse. CMS expects this specialization to reduce administrative barriers and to enable it to leverage efficiencies, strengthening CMS's compliance and fraud prevention efforts.

CMS states that it is concerned about the risks that potential fraud poses to the Part D program. The agency says that it continues to take actions to address the program's needs. Providing improved access to data will enable the MEDICs to identify, prevent, and fight fraudulent activity in the Part D program. Currently, MEDICs use an integrated data repository to access information on Part D prescription drug events and Parts A and B claims data. CMS is building "One PI," a system that will pull data from this integrated data repository and from other systems.

CMS has issued guidance and clarification to MA organizations and PDP sponsors indicating that sponsors must apply training on fraud, waste, and abuse to all entities with which they are partnering to provide benefits or services under the Part C and the Part D programs, not just to their own organizations' direct employees.

Status: We continue to recommend that CMS implement a comprehensive safeguard strategy for Medicare Part D PDP sponsors. We will continue to monitor CMS's implementation of its safeguard strategy.

Related Report:

2007 OCT *CMS's Implementation of Safeguards During Fiscal Year 2006 To Prevent and Detect Fraud and Abuse in Medicare Prescription Drug Plans.*
OEI-06-06-00280 [Report](#)

See Also:

2010 MAR *OIG Testimony Before the Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security: "Oversight Challenges in the Medicare Prescription Drug Program."*
[Testimony](#)

Medicare Part D > Program Integrity > Fraud Prevention, Detection, and Response

Ensure That Plan Sponsors Have Comprehensive and Effective Programs To Detect and Deter Fraud and Abuse

Background: The MMA established Medicare Part D to provide outpatient prescription drug benefits under the Medicare program beginning January 1, 2006. Part D prescription drug coverage is provided by private entities known as plan sponsors. Part D expenditures for 2007 were about \$49.5 billion. As of August 2008, 26 million beneficiaries were enrolled in Part D, and two-thirds of this total were in stand-alone drug plans. Plan sponsors are private companies that contract with CMS to provide Part D drug coverage to beneficiaries. Sponsors are required to have a comprehensive program to detect and deter fraud and abuse. When potential fraud or abuse is found, sponsors must conduct an inquiry and initiate corrective action and are advised to refer incidents to a MEDIC for investigation. The only fraud and abuse information that CMS requires sponsors to report is the quarterly number of fraud and abuse complaints they receive from beneficiaries. We analyzed data for the first 6 months of 2007 from 86 of 91 stand-alone drug plan sponsors.

Findings: We found that 24 of 86 Part D stand-alone plan sponsors did not find any potential fraud and abuse incidents and that most such incidents were associated with only a small number of plan sponsors. We also found that inappropriate billing was the most prevalent type of potential fraud and abuse and that pharmacies were associated with most of the incidents. We found that of the 62 plan sponsors that identified potential fraud and abuse, not all conducted inquiries, initiated corrective actions, or made referrals for investigation.

Recommendations: CMS should (1) review Part D plan sponsors to determine why certain sponsors have especially high or low volumes of potential fraud and abuse incidents, (2) determine whether the Part D plan sponsors that found potential fraud and abuse initiated inquiries and corrective actions and made referrals for investigations as recommended by CMS, (3) require Part D plan sponsors to maintain and report information about the results of sponsors' fraud and abuse programs, and (4) use this information to help determine the effectiveness of the programs.

Management Response Summary: CMS concurred with our first and second recommendations. It did not indicate whether it concurred with our third recommendation, and it did not address our fourth recommendation. With regard to the first recommendation, in its 2011 update, CMS said that it provided our findings to the

MEDICs, but it did not report the results of the MEDICs' reviews. CMS revised the reporting requirements to provide the Part D sponsors with specific parameters for tracking and properly labeling any incidents. With regard to the second recommendation, CMS provided the data in our report to the MEDICs for investigation but did not report the results.

Status: CMS has taken some steps toward implementing our recommendations. We will continue to monitor this implementation and will attempt to determine whether the results of the MEDICs' reviews address our recommendations.

Related Report:

2008 OCT *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse.*
OEI-03-07-00380 [Report](#)

See Also:

2010 MAR OIG Testimony Before the Senate Committee on Homeland Security and
Governmental Affairs, Subcommittee on Federal Financial Management,
Government Information, Federal Services, and International Security:
"Oversight Challenges in the Medicare Prescription Drug Program."
[Testimony](#)

Medicare Part D > E-Prescribing > Connectivity Standards

Ensure that Plan Sponsors Completely Implement E-Prescribing Standards to Support Connectivity with Prescribers and Dispensers (New)

Background: The MMA established the Medicare Part D e-prescribing program, which stipulates that plan sponsors must implement e-prescribing standards specified by the Secretary of Health & Human Services (HHS). On behalf of the Secretary, CMS established e-prescribing standards. These standards facilitate the communication of prescription information between prescribers (e.g., doctors); plan sponsors; and dispensers (e.g., pharmacies). The plan-to-prescriber standards include: Accredited Standards Committee (ASC) X12N 270/271, SCRIPT 8.1, and Formulary & Benefits Standard 1.0. The plan-to-dispenser standard is Telecommunication 5.1. CMS required that plan sponsors implement ASC X12N 270/271 and Telecommunication 5.1 by January 2006 and SCRIPT 8.1 and Formulary & Benefits Standard 1.0 by April 2009. We surveyed all plan sponsors for plan year 2008 between August and September 2008 to determine the extent of their implementation of the standards.

Findings: Based on plan year 2008 sponsors' responses to our survey, we found that nearly 80 percent of sponsors reported at least partial plan-to-prescriber connectivity but that few reported complete connectivity. We found that problems in implementing Formulary & Benefits Standard 1.0—one of the plan-to-prescriber standards—limit complete plan-to-prescriber connectivity. Moreover, plan sponsors reported incomplete implementation of Formulary & Benefits Standard 1.0 because their systems are not fully compatible with the standard. Finally, we found that most sponsors had complete plan-to-dispenser connectivity. Only 5 percent of sponsors reported no plan-to-dispenser connectivity.

Recommendations: CMS should (1) ensure that plan sponsors completely implement the plan-to-prescriber and plan-to-dispenser standards and (2) collaborate with plan sponsors and industry representatives to address barriers to full implementation of Formulary & Benefits Standard 1.0.

Management Response Summary: In its comments on the draft report, CMS concurred with both of our recommendations. In response to the first recommendation, CMS indicated it will continue to educate sponsors about e-prescribing requirements. CMS indicated that if necessary, it will use available compliance mechanisms to bring plan sponsors into compliance. With regard to the second recommendation, CMS indicated that it plans to continue collaboration with the National Council for

Prescription Drug Programs to continually update and develop new e-prescribing standards.

Status: We will continue to monitor CMS's implementation of our recommendations.

Related Report:

2009 OCT *Part D E-Prescribing Standards: Early Assessment Shows Partial Connectivity.*
OEI-05-08-00320 [Report](#)

Medicare Part D > Program Integrity > MEDICs' Authority and Access to Data

Improve Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse (New)

Background: The MMA established Medicare Part D to provide prescription drug benefits under the Medicare program beginning January 1, 2006. Prior to implementing Part D, CMS developed a strategy to help combat Part D fraud and abuse. One of the key aspects of this strategy was the use by MEDICs of innovative techniques for data analysis. Beginning in FY 2007, CMS awarded contracts to three regional MEDICs to address potential fraud and abuse related to the Part D benefit. According to the MEDICs' SOW and their individual task orders, MEDICs' responsibilities include, but are not limited to, identifying potential Part D fraud and abuse through external sources and proactive methods; fulfilling requests for information from law enforcement agencies; investigating potential Part D fraud and abuse; referring cases and making immediate advisements regarding potential Part D fraud or abuse to OIG; recommending appropriate administrative actions to CMS; identifying program vulnerabilities; and auditing the fraud, waste, and abuse programs that are part of plan sponsors' compliance plans.

Findings: Most incidents of potential Part D fraud and abuse in FY 2008 were identified through external sources rather than through proactive methods. Problems with accessing and using data hindered the MEDICs' ability to identify and investigate potential fraud and abuse incidents. All MEDICs reported that they need both PDE data and Medicare Part B data to effectively identify and investigate instances of potential fraud and abuse. However, MEDICs did not receive access to PDE data until August 2007, nearly a year after their contracts began. In addition, two MEDICs were not given access to Part B data until the fall of 2008, and the third MEDIC did not receive access to Part B data before its contract ended. MEDICs' lack of authority to directly obtain information such as prescriptions and medical records from pharmacies, pharmacy benefit managers, and physicians hindered their ability to investigate potential fraud and abuse incidents. In addition, MEDICs may not have been aware of some potential fraud and abuse incidents because plan sponsors are not required to refer them. Finally, CMS did not give MEDICs approval to conduct audits of plan sponsors' compliance plans in FY 2008.

Recommendations: CMS should (1) authorize MEDICs to directly obtain information that they need to identify and investigate potential fraud and abuse from entities such as pharmacies, pharmacy benefit managers, and physicians, even if statutory or regulatory change is required to do so.

Management Response Summary: CMS did not concur with our recommendation to authorize MEDICs to directly obtain information needed to identify and investigate potential fraud and abuse from entities such as pharmacies, pharmacy benefit managers, and physicians, even if statutory or regulatory change is required to do so. CMS stated that it recognizes the value of the recommendation but that the current structure is appropriate given the structure of the Part D program and the contractual relationship with the plans. CMS concurred with our recommendation that when referring fraud and abuse incidents to law enforcement, plan sponsors should also report that information to the MEDICs. CMS stated that those expectations are outlined in Chapter 9 of the *Part D Drug Benefit Manual*.

Status: We will continue to monitor CMS's implementation of our recommendations.

Related Report:

2009 OCT *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse*. OEI-03-08-00420 [Report](#)

Medicare Part D > Prescription Drugs > Prescriber Identifiers

Ensure the Validity of Prescriber Identifiers on Medicare Part D Drug Claims (New)

Background: The MMA established Part D to provide an optional prescription drug benefit for all Medicare beneficiaries. CMS contracts with private companies, called plan sponsors, to administer the benefit through Part D drug plans. Part D plans must submit to CMS an electronic record, called a PDE record, for each covered prescription filled for their enrollees. CMS requires that most PDE records contain an identifier for the drug's prescriber. Acceptable prescriber identifiers include National Provider Identifiers (NPI), Drug Enforcement Administration (DEA) registration numbers, Unique Physician Identification Numbers (UPIN), and State license numbers.

Findings: We found that \$1.2 billion in Medicare Part D prescription drug claims contained invalid prescriber identifiers in 2007. Invalid identifiers were used on more than 18 million prescription drug claims. These identifiers were either (1) not listed in the NPI, DEA number, or UPIN registry databases; or (2) had been deactivated or retired before January 1, 2006. For 17 percent of the PDE records that contained invalid prescriber identifiers, the identifiers did not conform to length or format specifications. These PDE records represented \$213 million in payments by Medicare drug plans and enrollees. Our review also revealed that 10 of the nearly 530,000 invalid identifiers accounted for 17 percent or \$237 million of all drug claims with invalid prescriber identifiers in 2007.

Recommendations: CMS should conduct periodic reviews to ensure the validity of prescriber identifiers used on PDE records. In addition, CMS should require Part D plans to institute procedures to (1) identify invalid identifiers in the prescriber identifier field on Part D drug claims and (2) flag for review Part D drug claims that contain invalid identifiers in the prescriber identifier field.

Management Response Summary: CMS concurred with both of our recommendations. CMS stated that it agrees that invalid prescriber identifiers can hinder program oversight efforts for monitoring prescribing practices but that invalid prescriber identifiers are not an automatic indication of invalid prescriptions or pharmacy claims. OIG agrees with CMS that invalid prescriber identifiers do not automatically indicate invalid prescriptions or pharmacy claims.

In its update for 2011, CMS said that it will evaluate its authority to mandate use of the NPI as the standardized prescriber identifier for PDE records and expects to undertake rulemaking as necessary to address the use of that single prescriber identifier for PDE

records. To the extent that CMS implements a requirement for the use of a single prescriber identifier, it also expects to implement a process for verifying the accuracy of that number.

Status: CMS's efforts to determine the validity, medical necessity, or appropriateness of Part D prescriptions and drug claims may be limited without valid prescriber identifiers. After the implementation of the NPI in 2008 as the standard identifier on electronic health care transactions, CMS completed an initial review of 2009 PDE data and learned that the NPI was reported on over 75 percent of PDEs. In September 2010, CMS awarded a contract to investigate the issues identified in its analysis and to periodically review and evaluate the use of prescriber identifiers on PDE records. CMS stated that it will implement a process to periodically review and evaluate trends associated with the validity of prescriber identifiers on PDE records. In the March 2011 hearing before the United States Senate Committee on Homeland Security and Governmental Affairs, CMS stated that it plans to require that all Part D claims include a valid NPI, which would be enforced by system checks on claims data CMS receives from Medicare drug plans. CMS intends to begin systems checks in 2012 that validate the NPI format on claims data it receives from drug plans. In addition, starting in 2012, CMS intends to require that Part D plans validate that prescriptions for Schedule II drugs are within the prescriber's scope of practice by ensuring that the NPI included on pharmacy claims submissions links to or includes a valid DEA number. These safeguards are outlined in the draft 2012 Call Letter for Part D plan sponsors, which CMS released on February 18, 2011. We will continue to monitor CMS's implementation of our recommendations.

Related Report:

2010 JUNE *Invalid Prescriber Identifiers on Medicare Part D Drug Claims.*
OEI-03-09-00140 [Report](#)

Medicare Administration

Medicare Administration > Information Systems > Controls and Corrective Actions

Improve Medicare Systems Controls

Background: The Federal Financial Management Improvement Act of 1996 (FFMIA) requires Federal agencies to maintain acceptable accounting systems. Also, the Federal Managers' Financial Integrity Act of 1982 (FMFIA) requires agencies to develop, maintain, and test their internal controls and financial management systems and to report any material weaknesses and planned corrective actions.

A substantial portion of CMS transactions and administration of programs is performed by geographically dispersed contractors. The contracts between CMS and its contractors that have information technology (IT) responsibilities include provisions requiring the contractors to follow security standards detailed in CMS's *Business Partners Systems Security Manual*. Specific security standards followed by a contractor are to be documented in the contractor's System Security Plan.

Findings: Information systems controls were considered a significant deficiency in the FY 2010 financial statement audit because: (1) CMS did not ensure that all Medicare contractors performed periodic reviews of user access and unauthorized wireless access to Medicare networks was observed; (2) shared system maintainers had not completed their implementation of CMS-required computer system security configuration settings, including their performance of user security administration reviews; (3) segregation of duties conflicts continued to exist at its central office between the business function and information security administration function of CMS's Office of Financial Management (OFM) for the Financial Accounting and Control System (FACS); (4) CMS has not provided guidance to the Medicare Administrative Contractors (MACs) on how to establish segregation of duties between business processes for the shared systems applications.

Recommendations: CMS should (1) strengthen its IT systems by ensuring that system and security settings have been implemented and monitored for compliance; (2) ensure that appropriate segregation of duties is established in all systems that support Medicare and financial processing to prevent excessive or

inappropriate access; (3) address the FACS deficiency by moving the FACS application security administration process and configuration management process from personnel within OFM to its Office of Information Systems; and ensure that all changes to Medicare and financial applications follow the National Institute of Standards and Technology (NIST) guidance regarding reviewing and approving all changes.

Management Response Summary: According to CMS's Financial Report for FY 2010, CMS has continued making progress to remediate specific information security weaknesses and continues to focus its efforts in FY 2011 on addressing the remaining significant deficiencies.

Status: OIG completed the Chief Financial Officers audit for FY 2010 and noted that improvement was made concerning the FY 2009 material weakness associated with Medicare systems controls. In addition, OIG attended CMS's monthly Risk Management meetings that discussed and tracked the progress of CMS's corrective action plans. As part of our FY 2011 financial statement audit, we will review CMS's corrective action plan to ensure that it adequately addresses our findings and recommendations.

Related Report:

2010 NOV *CMS Financial Report, Fiscal Year 2010. Audit Opinion Section.*
Daniel R. Levinson, Inspector General, *Report on the Financial Statement*
Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2010.
A-17-10-02010 [Report](#)

Medicare Administration > Information Systems >

Financial Management: Improve CMS's Financial Reporting Systems and Processes

Background: Financial management in the Federal Government requires accountability by financial and program managers, control over the Federal Government's financial resources, and protection of Federal assets. To meet these needs, financial management systems must be in place to process and record financial events effectively and efficiently and to provide complete, timely, and reliable financial information. The Office of Management and Budget's (OMB) Circular A-127, *Financial Management Systems*, prescribes the policies and standards that each agency should follow in developing, operating, evaluating, and reporting on financial management systems. CMS relies on a decentralized organizational structure and complex financial management systems—not only within its central office and regional offices' processes, but also within many of the Medicare contractor organizations—to accumulate data for its financial reporting.

Findings: The FY 2010 financial statement audit noted a significant deficiency in financial reporting systems and processes because CMS: (1) did not critically assess its process for managing the cross-functional teams of financial management, information technology, actuarial, general counsel, operations, and other personnel to better monitor business activities, generate and share financial and other information, and identify situations where accounting evaluation or decisionmaking may be required to arrive at and document an appropriate conclusion in a timely manner; (2) did not perform a claims-level detailed look-back analysis of the \$27 billion accrual for Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various State calculations of unpaid claims; (3) needed to do more to ensure that its monitoring activities regarding Comprehensive Error Rate Testing (CERT) and Payment Error Rate Measurement (PERM) programs were well understood, susceptible to replication, and highly credible; (4) lacks a single integrated accounting system, which impairs CMS's ability to efficiently and effectively support and analyze financial reports even though CMS continued its efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS); (5) needs improvements in the both the prevention and detection controls performed by and as oversight of the Medicare contractors; and (6) has not developed auditable estimates for the statement of social insurance (SOSI) that fairly present the financial condition of the Trust Funds, which may require revisiting provisions of Federal accounting standards and reformulating the assumptions used in SOSI and the Trustees Report to help improve the usefulness of the estimates provided.

Recommendations: CMS should: (1) establish specific policies and procedures and a protocol to address situations or transactions that require cross-functional involvement to ensure that interim and year-end financial statements are accurate and complete; (2) continue to enhance its process related to the development, documentation, and validation of critical accounting matters and to delegate the responsibility of the centers or offices to provide robust analyses to OFM on routine and recurring basis; (3) establish a process to perform a claims-level detailed look-back analysis of the Medicaid EBDP to determine the reasonableness of the methodology used to estimate the accrual; (4) continue to improve the integrity and efficiency of the various error rate development and analysis tools; (5) continue to implement an integrated financial management system to promote consistency and reliability in accounting and financial reporting; and (6) continue and broaden discussions with key stakeholders and standard setting bodies on the presentation of the SOSI.

Management Response Summary: CMS concurred with these recommendations made in the FY 2010 financial statement audit report. In FY 2010, the agency continued to improve its financial management performance in many areas and continues to focus its efforts in FY 2011 to address the remaining significant deficiencies.

Status: We acknowledge that CMS is developing corrective actions for the FY 2010 audit findings, and as part of our FY 2011 financial statement audit, we will review CMS's corrective action plan to ensure that it adequately addresses our findings and recommendations.

Related Report:

2010 NOV *CMS Financial Report, Fiscal Year 2010. Audit Opinion Section.*
Daniel R. Levinson, Inspector General, *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2010.*
A-17-10-02010 [Report](#)

See Also:

2010 NOV *Department of Health and Human Services Fiscal Year 2010 Agency Financial Report. Section II. Daniel R. Levinson, Inspector General, Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2010. A-17-10-00001 (pp. II-7, II-11) [Report](#)*

Medicare Administration > Contractors

Improve the Performance Evaluation Process for Program Safeguard Contractors

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), § 202, authorized CMS to contract out program integrity functions for the Medicare program and required a competitive process for awarding contracts. CMS entered into the first contract under this authority in 1999. Entities awarded such contracts are called Program Safeguard Contractors (PSC). Once under contract, PSCs are awarded task orders to carry out specific duties.

Findings: We found that performance evaluation reports issued by CMS from 1999 to 2004 contained minimal information about PSC achievements in detecting and deterring fraud and abuse under benefit integrity task orders. Because these reports were limited in their description of the results that PSCs may have been achieving, they provided limited information on which to base task order renewal decisions. We also found that 72 percent of final performance evaluation reports were issued on time. However, only 5 of 32 final reports were issued 3 months before the task orders ended, which is the time by which CMS was required to notify the PSCs whether the contracts would be renewed. The unavailability of milestone dates prevented us from identifying where delays occurred in the evaluation process.

Recommendations: CMS should (1) address PSC results in performance evaluation reports that include (a) quantitative as well as qualitative information and (b) information about required fraud and abuse detection and deterrence activities, (2) ensure that all draft and final reports are issued on time, and (3) establish a means to track and save evaluation milestone dates.

Management Response Summary: CMS partially concurred with our recommendations. The agency disagreed with our recommendations about the areas that should be addressed in PSC performance evaluation reports. In April 2009, CMS said that it has been collecting and tracking quantitative data about PSCs in its CMS Analysis, Reporting, and Tracking System (CMS ARTS) database. It did not indicate that the data have been included in performance evaluation reports, nor did it provide documentation showing that the data are now used in performance evaluation reports. Although the umbrella SOW was revised, it no longer contains a timetable for issuing draft and final reports. CMS also indicated that it complies with the time constraints associated with contract renewal dates so that only PSC contracts with acceptable performance are renewed. However, it has not explained how it ensures that

performance evaluation reports are issued by the time the task order renewal notices are due, and it has not provided documentation showing how or whether this has been accomplished.

CMS also reported in its March 2009 status update that it had developed a milestone date chart reflecting the significant evaluation dates. However, because of resource constraints, the chart is updated manually, and CMS has not been able to enhance CMS-ARTS to capture this information. The purpose of central tracking is to identify where delays occur so that improvements can be made in the agency's performance evaluation process. Thus, we continue to recommend that the milestones be tracked in a central system that can be accessed by management.

In its December 2009 update, CMS indicated that it had contracted to develop a template for monthly reporting, including fraud and abuse activities. CMS also began to transition PSCs and MEDICs to new Zone Program Integrity Contractors (ZPIC). Eventually, the new contractors will be responsible for ensuring the integrity of all Medicare-related claims under Parts A, B, C, and D and for coordinating Medicare and Medicaid (Medi-Medi) data matches. (Part A and Part B include, for example, hospital, skilled nursing, home health, durable medical equipment (DME), and other provider and supplier claims. Part C includes MA health plans, and Part D includes PDPs.) The first two ZPIC contracts were awarded to Health Integrity (Zone 4) and SafeGuard (Zone 7), and CMS is in the final stages of awarding more contracts.

Status: We will continue to monitor CMS's implementation of its safeguard strategy.

Related Report:

2006 MAR *Medicare's Program Safeguard Contractors: Performance Evaluation Reports.*
OEI-03-04-00050 [Report](#)

Medicare Administration > Contractors

Follow Up On Recovery Audit Contractors' Fraud Referrals (New)

Background: OIG conducted a review of fraud referrals by Recovery Audit Contractors (RAC) during the RAC 3-year demonstration project. Contracted by CMS, RACs are responsible for identifying improper payments of Medicare Part A and Part B claims. RACs conduct postpayment reviews to identify overpayments and underpayments and attempt to recoup any overpayments they identify. They receive contingency fees based on the amount of improper payments identified. RACs are not responsible for reviewing claims for fraudulent activity; however, they are responsible for referring to CMS any cases of potential fraud identified during their reviews. RACs do not receive contingency fees for cases they refer that are determined to be fraud. Thus, there may be a disincentive for RACs to refer cases of potential fraud.

Findings: We found that between March 2005 and March 2008, RACs referred two cases of potential fraud to CMS. However, CMS reported that it received no potential fraud referrals from RACs during this period. We also found that during the demonstration project, RACs received no formal training from CMS regarding the identification and referral of potential fraud.

Recommendation: CMS should implement a system to track fraud referrals.

Management Response Summary: CMS concurred with our recommendation and stated that it is developing a system to track the RAC claims review process. In its update for 2011, CMS reported that it and OIG had developed a Memorandum of Understanding (MOU) regarding fraud referrals as well as a referral template for the Medicare FFS Recovery Auditing program. CMS said that it has used the referral template and sent fraud referrals to OIG. CMS also said that it has developed an internal database to track all Medicare FFS Recovery Auditing fraud referrals made to OIG.

Status: Section 6411 of the Affordable Care Act expanded the RAC program, giving it additional responsibilities to address improper payments. In August 2010, CMS expanded RAC reviews to encompass medical necessity; during the RAC demonstration, medical necessity reviews yielded 40 percent of the improper payments that RACs identified. We believe that CMS should track all fraud referrals it receives from RACs, not just those passed on to OIG. We will continue to monitor CMS's implementation of our recommendation.

Related Report:

2010 FEB *Recovery Audit Contractors' Fraud Referrals.* OEI-03-09-00130 [Report](#)

Medicare Administration > Contractors

Determine the Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors (New)

Background: OIG conducted a review regarding the overpayment amounts that have been collected as a result of PSC activities. The PSCs' identification and referral of overpayments to claims processors for collection is important because it can lead to the recovery of funds to the Medicare program. In our report, we determined the collection status as of June 2008 of overpayments referred by PSCs for collection in CY 2007. At the time of our review, PSCs were not required to keep track of the amount that claims processors collect on PSC overpayment referrals. CMS is transitioning PSCs to seven ZPICs and is providing ZPICs an incentive to keep track of the amount claims processors collect on ZPIC overpayment referrals.

Findings: Overpayments referred for collection by PSCs in 2007 did not result in significant recoveries to Medicare. PSCs referred 4,239 overpayments totaling \$835 million to claims processors in 2007, but only 7 percent (\$55 million of \$835 million) had been collected by claims processors as of June 2008. Of the \$55 million collected, 27 percent was for Part A claims, 56 percent was for Part B claims excluding durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and 17 percent was for Part B DMEPOS claims.

As of June 2008, 53 percent (\$446 million) of the \$835 million in overpayment dollars that PSCs referred to claims processors for collection in 2007 was sent to the Department of the Treasury's cross-servicing program for collection. However, this program does not have a high rate of return. Claims processors reported that collection was not complete for \$40 million, or 5 percent of the \$835 million in overpayments that PSCs referred for collection. Another 5 percent of the PSC overpayment dollars will not likely be collected by claims processors because the provider stopped billing, filed for bankruptcy, went out of business, or was deceased. For 17 percent of the PSC overpayment dollars, collection was on hold pending investigation or appeal.

As of June 2008, 6 percent of the PSC overpayment dollars was no longer owed by providers because of revisions that claims processors made to overpayment collection amounts and appeal decisions that were favorable to providers. Finally, claims processors could not provide data for one in four PSC overpayment referrals, which accounted for 8 percent of the PSC overpayment dollars. Claims processors reported that they did not receive or could not provide any collection information for 1,060 of 4,239 overpayments.

Recommendations: CMS should (1) regularly collect all necessary information to determine the overpayments that PSCs and ZPICs refer to claims processors for collection, the collection status of these overpayments, and the percentage of overpayments in each category of collection status; (2) require PSCs, ZPICs, and claims processors to have controls in their tracking systems to ensure that all overpayment referrals and data related to their collection status can be found; and (3) determine what happened to the 1,060 overpayments that PSCs referred to claims processors in 2007 for which claims processors could not provide any collection information.

Management Response Summary: CMS concurred with all three recommendations. At the time of our review, PSCs were not required to keep track of the amount claims processors collect on PSC overpayment referrals. CMS is transitioning PSCs to seven ZPICs and is providing ZPICs with an incentive to keep track of the amount claims processors collect on ZPIC overpayment referrals. CMS is also now providing incentives to claims processors to provide collection information to ZPICs. According to CMS staff, CMS also expects ZPICs in high-fraud regions to focus on quick response to fraud and administrative actions. In October 2009, CMS added the data field of amount of overpayments recovered to the CMS ARTS template for monthly reporting, which is a required submission for the PSCs and ZPICs. Pursuant to the Affordable Care Act, CMS recently added the number of overpayments recovered to CMS ARTS. Lastly, a Joint Signature Memorandum was issued on May 19, 2010, instructing Medicare contractors to recover the overpayments for which claims processors could not provide collection information.

Status: We will continue to monitor CMS's implementation of our recommendations including requiring ZPICs to keep track of the amount claims processors collect on ZPIC overpayment referrals..

Related Report:

2010 MAY *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors.* OEI-03-08-00030 [Report](#)

edicare Administration > Contractors

Determine Medicare Overpayments Identified by Program Safeguard Contractors (New)

Background: OIG conducted a review to determine the number, dollar amount, and claim type of Medicare overpayments that PSCs identified and referred to claims processors for collection in 2007.

Findings: In total, the 18 PSCs referred 4,239 overpayments totaling \$835 million to claims processors for collection in 2007. However, two PSCs were responsible for 62 percent of this amount. PSCs differed substantially in the dollar amount of overpayments that they referred for collection in 2007, referring from \$3 million to \$266 million with a median of \$15 million.

We also found that although Part B payments represented 29 percent of PSCs' oversight responsibility (\$87 billion of \$296 billion), Part B overpayments accounted for 89 percent of PSCs' overpayment dollars referred for collection (\$747 million of \$835 million). Part A payments represented 71 percent of PSCs' oversight responsibility (\$209 billion of \$296 billion), and Part A overpayments accounted for 11 percent of PSCs' overpayment dollars referred for collection (\$88 million of \$835 million).

CMS is transitioning PSCs to seven ZPICs. Each ZPIC will be responsible for all claim types in its geographic zone.

Recommendations: OIG recommended that CMS (1) determine why certain PSCs have low levels of overpayment dollars referred for collection compared to their oversight responsibility and (2) determine why certain PSCs have low Part A overpayment dollars referred for collection compared to their Part B overpayment dollars referred for collection.

Management Response Summary: CMS concurred with both recommendations and stated that the change to the new ZPIC contracting strategy should address OIG's concerns. As of February 2011, CMS has not awarded all ZPIC contracts.

Status: OIG will continue to monitor CMS's implementation of our recommendations including whether the ZPIC contracting strategy will address our recommendations.

Related Report:

2010 MAY *Medicare Overpayments Identified by Program Safeguard Contractors.*
OEI-03-08-00031 [Report](#)

Medicare Administration > Language Access Services

Increase Medicare Providers' and Plans' Implementation of Standards for Culturally and Linguistically Appropriate Services (New)

Background: Language access services are designed to promote effective communication between Limited English Proficient (LEP) persons and non-LEP persons. Language access services can include oral interpretation, written translation, and other provisions that enhance communication, such as translated signs. Office for Civil Rights (OCR) guidance and the Office of Minority Health's (OMH) Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards address the provision of language access services. OCR guidance recommends a four-factor assessment to help health care providers determine what language access services to offer. OMH's CLAS standards can help providers become responsive to the cultural and linguistic needs of diverse populations. Four of the fourteen CLAS standards focus on the provision of language access services. These standards are (1) providing services during all business hours, (2) providing verbal offers and written notices of rights to services, (3) assuring the competence of language assistance provided by staff, and (4) providing written materials and signage translated into appropriate languages.

We conducted two companion studies, one on Medicare providers and another on Medicare plans, to examine the extent to which they conducted the four-factor assessment recommended by OCR; offered language access services consistent with OMH CLAS standards; and reported benefits and encountered obstacles in providing such services.

Findings: In our review of Medicare providers, we found that 69 percent of providers conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer. However, only 33 percent of providers offered services consistent with all four of OMH's CLAS standards on language access services. Seventy-three percent of providers reported benefits to offering language access services and 54 percent reported obstacles (e.g., a lack of training resources for staff, costs of providing language access services, and the broad range of languages spoken in the providers' communities). Few providers reported data on the costs of providing language access services, and the data provided were not comparable.

In our review of Medicare plans, we found that 88 percent of plans conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer. However, a lower percentage of plans—67 percent of plans—offered services consistent with all four of OMH's CLAS standards on language access

services, largely because Medicare plans did not verbally inform LEP persons of their right to language access services. Forty-nine percent of Medicare plans reported benefits to offering language access services and 57 percent reported obstacles. We could not compare data on the costs of providing language access services because plans use different methods to calculate costs.

Recommendations:

Medicare providers. To improve Medicare providers' awareness and implementation of CLAS standards and to help providers offer language access services, (1) OCR should inform providers about OMH's CLAS standards, (2) OMH should increase outreach to providers to familiarize them with CLAS standards, and (3) OMH should offer model translated written materials and signs to providers.

Medicare plans. To improve Medicare plans' awareness and implementation of CLAS standards, OMH should collaborate with CMS to inform Medicare plans that they should notify LEP persons both verbally and in writing of their right to receive language access services. CMS has an established infrastructure for communicating with Medicare plans.

Savings: TBD*

** Savings not estimated.*

Management Response Summary: For the report on Medicare providers, OCR and OMH concurred with our recommendations and CMS indicated that it did not have any substantive comments. In its comments on the draft report, OMH stated that it will develop specific marketing strategies to inform providers of the CLAS standards and will disseminate information through existing CMS communication channels (e.g., listservs, Web sites, and provider partner organizations). OMH also planned to partner with medical provider networks (e.g., Quality Improvement Organizations (QIO)) to link their Web sites to OMH's CLAS standards Web site. As of January 2011, OMH is continuing to work on these activities. In response to the second recommendation, OMH is developing products, including signage, that CMS will disseminate to Medicare providers through the existing Medicare Learning Network (MLN).

For the report on Medicare plans, OMH and CMS both concurred with our recommendation. CMS and OMH collaboratively drafted a memorandum that was sent to all Medicare Part C and D organizations on December 9, 2010, describing the OMH

CLAS standards and how they apply to Part C and Part D organizations. However, the memorandum did not address OIG's specific recommendation that CMS instruct Medicare plans to provide both verbal and written notices to beneficiaries of their right to receive language access services.

Status: We will continue to monitor OCR, OMH, and CMS implementation of our recommendations.

Related Reports:

2010 JULY *Guidance and Standards on Language Access Services: Medicare Providers.*
OEI-05-10-00050 [Report](#)

2010 JULY *Guidance and Standards on Language Access Services: Medicare Plans.*
OEI-05-10-00051 [Report](#)

Medicare Administration > Program Integrity

Improve CMS Reporting to the Healthcare Integrity and Protection Data Bank (New)

Background: The Healthcare Integrity and Protection Data Bank (HIPDB) is a national data bank containing reports of adverse actions against health care practitioners, providers, and suppliers. The HIPDB plays an important role in preventing the employment of potentially fraudulent or abusive health care providers. Federal and State government agencies and health plans are required to report to the HIPDB. CMS takes several types of adverse actions that are required to be reported to the HIPDB, including revocations and suspensions of laboratory certifications; terminations of providers from participation in Medicare; and civil monetary penalties against all types of providers, managed care plans, and prescription drug plans.

Findings: We found that CMS took adverse actions against providers, but did not report all of these actions to the HIPDB as required. It failed to report 148 adverse actions imposed against laboratories in 2007 and 30 adverse actions imposed against managed care and prescription drug plans between January 1, 2006, and July 31, 2009. None of the adverse actions against DME suppliers taken after 2008 had been reported to HIPDB at the time of our review. However, as of April 30, 2009, the HIPDB contained 5,125 adverse actions against DME suppliers imposed from 1998 through 2008. None of the 45 nursing homes terminated from participating in the Medicare program from 2004 through 2008 were reported to the HIPDB until 2009, well after the required reporting timeframe. The Division of National Systems, the group within CMS responsible for reporting adverse actions against certified provider types, did not report any actions between 2001 and 2008.

Recommendation: CMS should report all adverse actions as required. To accomplish this, CMS should educate staff and contractors about the types of adverse actions required to be reported and the timeframes for reporting.

Management Response Summary: CMS concurred with our recommendation. It described planned efforts to report adverse actions imposed against nursing facilities, laboratories, and DME suppliers, including working with the Health Resources and Services Administration (HRSA), which maintains the HIPDB, to develop technical procedures and educating staff and contractors about HIPDB reporting. In its update for 2011, CMS reported that the HIPDB records on revocations among DME suppliers had been updated through August 2010.

Status: In its update for 2011, CMS did not provide information on its efforts to report adverse actions against provider types other than DME suppliers (e.g., Medicare providers, nursing facilities, laboratories, managed care plans, and prescription drug plans). We will continue to monitor CMS's implementation of our recommendation.

In addition to maintaining the HIPDB, HRSA maintains a similar database of adverse actions against practitioners, the National Practitioner Data Bank (NPDB). Section 6403 of the Affordable Care Act requires the elimination of duplicative data reporting and access requirements between the NPDB and the HIPDB. The Secretary of HHS is required to establish a transition period to transfer all data in the HIPDB to the NPDB and, once completed, to cease operations of the HIPDB. Information previously collected and disclosed through the HIPDB will continue to be collected and disclosed through the NPDB. Therefore, CMS should continue its efforts to report all adverse actions as required—currently to the HIPDB and, when it ceases operation, to the NPDB.

Related Report:

2010 SEPT *CMS Reporting to the Healthcare Integrity and Protection Data Bank.*
OEI-07-09-00290 [Report](#)