Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE'S PROGRAM SAFEGUARD CONTRACTORS: ACTIVITIES TO DETECT AND DETER FRAUD AND ABUSE

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EXECUTIVE SUMMARY

OBJECTIVE

To assess three selected activities that program safeguard contractors (PSC) performed in 2005 to detect and deter fraud and abuse in Medicare Parts A and B.

BACKGROUND

The Medicare Integrity Program was established in 1996 to strengthen the Centers for Medicare & Medicaid Services' (CMS) ability to reduce fraud and abuse in the Medicare program. In 1999, CMS began transferring the responsibility for detecting and deterring fraud and abuse in Medicare Parts A and B from carrier and fiscal intermediary fraud units to PSCs. CMS completed this transfer of responsibilities in 2006. CMS now awards benefit integrity task orders to PSCs to perform the work of detecting and deterring fraud and abuse. CMS has the option of renewing or terminating task orders at the end of a performance period. A typical performance period lasts 1 year. In 2005, the year of our evaluation, seven PSCs performed the work under 17 task orders (not including a 2-month task order that was excluded from our analysis). In this report, the term "PSC" represents a PSC benefit integrity task order.

As part of their duties, PSCs conduct investigations to determine the facts and magnitude of alleged fraud and abuse. Upon completing investigations, PSCs determine whether to refer the investigations as cases to law enforcement. CMS expects PSCs to be innovative and effective in data analysis, moving beyond the capabilities of carrier and fiscal intermediary fraud units. This was one of the reasons for awarding contracts to PSCs. CMS expects a significant part of PSC data analysis to be proactive, i.e., self-initiated exploratory analysis that seeks previously unidentified patterns or instances of fraud and abuse.

The Office of Inspector General conducted this study to gain an understanding of PSC accomplishments in the primary activities of investigations, case referrals to law enforcement, and proactive data analysis as reflected in PSC workload statistics.

We collected PSC workload statistics as well as all PSC monthly status reports for calendar year 2005 from CMS. The monthly status reports contain PSCs' narrative and numerical information about their activities and issues. We also collected budget allocation and level of

PSC oversight responsibility (i.e., dollar amount of paid claims) from CMS for each task order.

FINDINGS

Program safeguard contractors differed substantially in the number of new investigations and case referrals to law enforcement produced in 2005; some had minimal activity in these primary workload categories. PSCs produced between 5 and 479 new Part A investigations, with a median of 60. The four lowest PSCs had between 5 and 19 new Part A investigations for the year. PSCs produced between 0 and 10 new Part A case referrals to law enforcement, with a median of 3. Three PSCs had only one new Part A case referral, and two PSCs had none.

PSCs produced between 18 and 3,707 new Part B investigations, with a median of 196. Three of these PSCs had 80 or fewer new Part B investigations. PSCs referred between 2 and 39 Part B cases to law enforcement, with a median of 13. Three PSCs had two, three, and four new Part B case referrals, respectively.

Although PSCs might be expected to differ from one another in workload activity levels, neither the size of a PSC's budget nor its oversight responsibility was strongly correlated with the number of new investigations or the number of new case referrals to law enforcement produced in 2005.

Most program safeguard contractors had minimal results from proactive data analysis. Thirteen of seventeen PSCs (77 percent) reported 18 percent or less of new investigations from proactive data analysis. Of these 13 PSCs, 7 had 8 percent or less. Two of the seven PSCs produced no new investigations from proactive data analysis, and one PSC had only one new investigation from this source. Almost half the PSCs (7 of 17) had only one case referral to law enforcement that originated from proactive data analysis. One PSC had none.

In addition to conducting our review of workload statistics, we reviewed PSC monthly status reports for any descriptions of proactive data analysis. Although CMS does not specifically require that descriptions of proactive data analysis or its results be included in monthly status reports, we found that all PSCs mentioned proactive data analysis in at least one month's report during the year. We do not know if the absence of information about proactive data analysis in the remaining months indicates that the activity did not take place. In the reports that

mentioned proactive data analysis, some PSCs repeated the exact language about the same project in numerous monthly reports. Moreover, we found no consistency across PSCs regarding the level of detail about proactive data analysis included in the monthly status reports.

RECOMMENDATIONS

To determine why certain PSCs have minimal or no activity in new investigations or new case referrals to law enforcement, especially as a result of proactive data analysis, CMS should:

Review program safeguard contractors with especially low volumes of activity in investigations and case referrals for Medicare Parts A and B. For PSCs with no activity or low levels of activity, CMS should determine whether these PSCs have taken all the necessary steps to identify potential fraud and abuse. If CMS finds that not all necessary steps were taken, CMS could provide additional guidance to PSCs about their fraud and abuse detection and deterrence activity levels. CMS could also consider its remedies under the PSC contracts, up to and including contract termination.

Require program safeguard contractors to provide more detailed explanations of their investigations, case referrals, and proactive data analysis activities in their monthly reports. CMS should use this information to review PSCs for which activity levels appear low. If workload activity levels are high, CMS can determine the techniques those PSCs are using and share the techniques with other PSCs.

CMS should also require PSCs to provide more detailed information about their proactive data analysis efforts. PSCs should identify current proactive data analysis projects and identify the projects' innovative and/or effective aspects.

AGENCY COMMENTS

CMS concurred in part with our first recommendation. CMS stated that currently it is difficult to compare PSCs. However, CMS has begun implementing a new strategy of aligning PSC jurisdictions with jurisdictions of claims–processing contractors and believes this will make it easier to compare PSCs in the future. CMS also noted that it has begun allocating funds to PSCs based on PSC performance, workload, and Medicare program vulnerabilities.

CMS stated that acceptable performance of PSCs is not based solely on their development of cases for referral to law enforcement. CMS reports that law enforcement often indicates its preference that PSCs pursue administrative actions rather than referrals.

CMS concurred with our second recommendation. CMS stated that it has revised the monthly reporting system to collect more information and to improve reporting consistency across PSCs. Regarding proactive data analysis, CMS stated that this activity has other goals besides referring cases to law enforcement, such as identifying targets for edits, assessing the effectiveness of administrative actions, and assisting law enforcement with their open cases.

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INTRODUCTION

OBJECTIVE

To assess three selected activities that program safeguard contractors (PSC) performed in 2005 to detect and deter fraud and abuse in Medicare Parts A and B.

BACKGROUND

In our March 2006 study, "Medicare's Program Safeguard Contractors: Performance Evaluation Reports" (OEI-03-04-00050), the Office of Inspector General (OIG) reviewed annual PSC performance evaluation reports issued by the Centers for Medicare & Medicaid Services (CMS). OIG found that these reports provided minimal information and limited quantitative data about PSC achievements related to detecting and deterring fraud and abuse. The OIG report was preceded by a 2001 Government Accountability Office report (GAO-01-616) on PSCs, which found that CMS had "not established clear, measurable performance criteria to assess the PSCs' performance on individual task orders."

In 2004, CMS began collecting from PSCs a variety of monthly summary statistics for each benefit integrity task order. Because these statistics reflect the volume of PSC workload activities to detect and deter fraud and abuse in Medicare Parts A and B, OIG conducted this current study to gain an understanding of PSC accomplishments in primary workload activities (investigations, case referrals to law enforcement, and proactive data analysis) as reflected in the statistics.

Medicare Vulnerabilities

Medicare Parts A and B are vulnerable to fraud and abuse because of their size and complexity. In 2005, PSCs were responsible for fraud and abuse oversight of $303 billion in paid claims for Medicare Parts A and B. In addition to services provided by hospitals and physicians, Medicare Parts A and B cover services by home health agencies, laboratories, end stage renal disease facilities, physical therapy facilities, ambulatory surgical centers, rural health clinics, comprehensive outpatient rehabilitation facilities, hospices, ambulance suppliers, and medical equipment suppliers.

Fraud and Abuse Contractors

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), section 202, established the Medicare Integrity Program to strengthen CMS's ability to deter potential fraud and abuse in the Medicare program. It also gave CMS the authority to transfer the work

of detecting and deterring fraud and abuse from carrier and fiscal intermediary fraud units to new entities under competitive contracts.[1]

As part of the "Medicare Integrity Program," CMS replaced all carrier and fiscal intermediary fraud units with PSCs through the award of contracts called "benefit integrity task orders." In 2006, CMS completed the transfer of fraud and abuse work from the fraud units to the PSCs.

A typical PSC performance period lasts 1 year, after which CMS has the option of renewing or terminating the task order. In 2005, the year of our evaluation, seven PSCs performed fraud and abuse work under 17 benefit integrity task orders. This does not include a task order that lasted only 2 months and was not renewed by CMS. In this report, the term "PSC" represents a PSC benefit integrity task order.

Of the 17 PSCs, 14 have responsibility for both Medicare Parts A and B, 1 has Part A only, and 2 have Part B only.

Primary Activities of Program Safeguard Contractors

Pursuant to HIPAA, section 202, PSCs are expected to have capabilities surpassing those of carrier and fiscal intermediary fraud units to detect and deter fraud and abuse and are expected to cooperate with OIG and other law enforcement agencies in the detection and deterrence of fraud and abuse.

In CMS's comments on OIG's previous report on PSCs (OEI-03-04-00050), CMS stated that PSCs are tasked with identifying potentially fraudulent providers and supporting the efforts of law enforcement and CMS in pursuing civil, criminal, and administrative remedies for fraud. CMS also stated that PSCs focus primarily on investigating allegations of fraud, referring potential fraud cases to law enforcement, and conducting data analysis.

Investigations. CMS's "Program Integrity Manual" (Rev. 71, 04-09-04) states that the purpose of a PSC investigation is to determine the facts and magnitude of alleged fraud and abuse. This includes research and analysis conducted in followup to leads identified proactively or in response to complaints screened by the claims-processing contractor (formerly carriers and fiscal intermediaries and now transitioning to

[1] The 1998 and 2005 publications of CMS's proposed rules in the Federal Register (63 Federal Register 13590 and 70 Federal Register 35204, respectively) establish the "Medicare Integrity Program" permitting CMS to contract with eligible entities prior to the publication of a final rule.

Medicare administrative contractors). PSCs identify the actual or estimated overpayments associated with their investigations and notify the claims-processing contractor to collect the overpayments. PSCs reported to CMS that in 2005 they identified overpayments of $54,673,571 in connection with their investigations.[2]

Case Referrals to Law Enforcement. Upon completing its investigation, the PSC determines whether to refer the investigation to law enforcement, namely to OIG's Office of Investigations. Once the referral is made, it is counted as a case in the PSC statistics reported to CMS. Not all investigations become cases. In this report, we use the term "case referral" when discussing cases that have been referred to law enforcement.

PSCs identify the actual or estimated overpayments associated with case referrals and notify the claims-processing contractor to collect the overpayments. PSCs reported to CMS that in 2005 they identified overpayments of $119,053,255 in connection with case referrals to law enforcement.[3]

Data Analysis. PSCs are expected to conduct "innovative and effective data analysis for early detection, prevention, intervention, and investigation of potential fraud."[4] CMS expects a significant part of PSC data analysis to be proactive, i.e., self-initiated exploratory analysis that seeks previously unidentified patterns or instances of fraud and abuse.[5] PSCs are also expected to use equipment and software technologies that surpass the capability of the equipment and technologies used by their predecessors and to move beyond carrier and fiscal intermediary data analysis methods and choices in data-mining software.[6] Unlike the carrier and fiscal intermediary fraud units that had access only to either Part A or Part B data, most PSCs have access to both. This gives PSCs the ability to perform more comprehensive and proactive data analysis of Medicare Parts A and B.

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[2] CMS's Benefit Integrity Workload Template database, calendar year 2005.

[3] Ibid.

[4] CMS's 2004 "Record of Evaluation," an internal rating tool used during the annual performance evaluation of PSCs.

[5] CMS's 2006 PSC Performance Evaluations Guidelines.

[6] HIPAA, section 202, and CMS's 2006 PSC Performance Evaluations Guidelines.

Program Safeguard Contractor Workload Statistics

As of July 2004, CMS began collecting monthly summary statistics about PSC workload activities in the Benefit Integrity Workload Template database. This database is part of CMS's online CMS Analysis, Reporting, and Tracking System (CMS ARTS). The workload activities represented in the 2005 statistics include investigations, case referrals to law enforcement agencies, medical review in support of benefit integrity cases, payment suspensions, law enforcement data requests, fraud alerts, and training and conferences. The numbers of statistics for each activity vary. Below are examples of types of statistics available for investigations and case referrals for Medicare Parts A and B.

- Number of new investigations opened during the reporting month, source (e.g., proactive data analysis, complaints), and dollar amount of potential overpayments identified.
- Number of new case referrals to law enforcement during the reporting month, source (e.g., proactive data analysis, complaints), and dollar amount of potential overpayments identified.

In this report, the term "workload statistics" refers to statistics included in the Benefit Integrity Workload Template.

Program Safeguard Contractor Monthly Status Reports

At the time of our review, PSCs provided CMS with required monthly status reports that contained narrative and numerical information describing PSC activities and issues under a specific task order. CMS required that these reports be uploaded monthly into CMS ARTS. CMS did not require a standard format for the reports but did have minimum general requirements for what should be included, such as "prior month's activities by task and activity" and "any unresolved issues from the prior month."

Recent Changes to Benefit Integrity Workload Template

CMS reported that several changes were made to the Benefit Integrity Workload Template beginning in 2007. CMS will now include PSC budget and cost allocations in the template. CMS also eliminated the separate monthly status report and instead PSCs will now add narrative information to the statistics collected in the template.

METHODOLOGY

Scope

For calendar year 2005, we reviewed PSCs' workload activity for Medicare Parts A and B in the areas of investigations, case referrals to law enforcement agencies, and proactive data analysis. We reviewed data for 17 benefit integrity task orders. Fifteen of these task orders were in effect for 12 months and 2 were in effect for 10 months during 2005. Because one additional task order was in effect for only 2 months and it was not renewed by CMS, we did not include it in our review.

We assigned an identification letter, from A–Q, to the 17 PSCs in our review. We use these identification letters in our report so that the reader can identify information related to the same PSC across the different tables while still maintaining the confidentiality of the PSC.

Appendix A provides the following information about PSCs for 2005.

- Medicare programs covered by the task order
- Number of months the task order was active
- Budget allocation
- Number of paid Part A and Part B claims for which the PSC had oversight
- Dollar amount of paid Part A and Part B claims for which the PSC had oversight

Data Collection

For each PSC task order, we collected monthly workload statistics from the Benefit Integrity Workload Template. We also collected the 2005 and 2006 definitions of PSC workload categories in the Template.

We collected monthly status reports for each PSC task order. Because 15 task orders were in effect for 12 months and the remaining 2 task orders were in effect for 10 months, we collected a total of 200 reports.

We also collected the budget allocation and the oversight responsibility data associated with each task order. We use the term "oversight responsibility" to mean dollar amount of Medicare paid claims.

Analysis

We summarized the workload statistics by workload activity, by Medicare Parts A and B, by month, and by the entire year, for each PSC task order and across all PSC task orders. We identified averages, medians, maximums, and minimums for each activity.

We calculated the sum of new investigations and new case referrals from reactive and proactive sources in calendar year 2005. We also calculated the percentages of new investigations and new case referrals that originated from proactive data analysis.

We analyzed the correlation (strength of relationship) between the level of activity in new investigations and case referrals and the size of PSC budget and oversight responsibilities.

We reviewed the monthly status reports to determine whether PSCs addressed proactive data analysis.

Limitations

We did not collect information from CMS, PSCs, or claims-processing contractors to verify the workload statistics or information in the monthly status reports. We did not determine the quality of either the PSCs' investigations or their case referrals to law enforcement.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

Program safeguard contractors differed substantially in the number of new investigations and case referrals to law enforcement produced in 2005; some had minimal activity in these primary workload categories

The number of new investigations and case referrals varied greatly by PSC, and some PSCs produced few new investigations and case referrals in 2005.

As shown in Table 1, the 15 PSCs that had responsibility for Medicare Part A produced between 5 and 479 new Part A investigations, with a median of 60. The four lowest PSCs had between 5 and 19 new Part A investigations for the year. In the area of new case referrals to law enforcement, these 15 PSCs produced between 0 and 10 new case referrals, with a median of 3 for the year. Three PSCs had only one new Part A case referral, and two PSCs had none.

The 16 PSCs having responsibility for Medicare Part B produced between 18 and 3,707 new Part B investigations, with a median of 196. Three of these 16 PSCs had 80 or fewer new Part B investigations. In the area of new case referrals to law enforcement, these 16 PSCs referred between 2 and 39 Part B cases, with a median of 13 for the year. Three PSCs had only two, three, and four new Part B case referrals, respectively, for the entire year.

Table 1. PSC Part A and Part B Activity in New Investigations and New Case Referrals to Law Enforcement Agencies (sorted by case referrals, n=17)

PART A				PART B		
PSC Task Order	Investigations	Case Referrals		PSC Task Order	Investigations	Case Referrals
A	125	0		F	679	2
L	19	0		J	18	3
B	31	1		L	80	4
G	5	1		A	1,141	8
N	12	1		H	142	8
F	479	2		D	406	11
P	28	2		P	139	11
C	38	3		G	106	12
D	14	3		M	996	13
Q	84	3		B	153	14
H	224	4		K	75	14
K	79	4		Q	886	15
I	60	5		O	223	25
J	127	9		C	169	32
M	196	10		E	3,707	33
E	n/a	n/a		I	1,054	39
O	n/a	n/a		N	n/a	n/a
Total	1,521	48		Total	9,974	244
Median	60	3		Median	196	13

Source: OIG analysis of CMS's Benefit Integrity Workload Template 2005 data.

Neither the size of a program safeguard contractor's budget nor its oversight responsibility was strongly correlated with the number of new investigations or case referrals to law enforcement

Although PSCs might be expected to differ from one another in workload activity levels, neither the size of a PSC's budget nor its oversight responsibility (dollar amount of Medicare paid claims) was strongly correlated with the number of new investigations or the number of new case referrals to law enforcement produced in 2005. Appendix B contains the correlation coefficients.

For instance, as shown in Table 2 below, PSCs G and D are both responsible for Medicare Parts A and B. In 2005, PSC G had 111 new investigations and 13 new case referrals with the highest budget allocation and almost the highest oversight responsibility. In contrast, PSC D had 420 new investigations and 14 new case referrals but had less than half the budget and less than one-third of the oversight responsibility of PSC G.

Although PSCs C and P had similar levels of oversight responsibility, PSC C produced more investigations and more than twice as many case referrals with a smaller budget allocation than PSC P.

Table 2. Size of PSC Budget and Oversight Responsibility Compared to Workload Activity in New Investigations and New Case Referrals (sorted by budget allocation, n=17)

PSC Task Order	Budget Allocations	Dollar Amount of Paid Claims Parts A and B	Dollar Amount of Paid Claims Part A	Dollar Amount of Paid Claims Part B	Number of Investigations Parts A and B	Number of Case Referrals Parts A and B
G	$9,316,750	$32,608,874,051	$30,122,833,543	$2,486,040,508	111	13
I	$9,234,176	$16,061,254,458	$9,879,110,033	$6,182,144,425	1,114	44
H	$9,159,828	$38,627,435,953	$32,804,312,314	$5,823,123,639	366	12
K	$8,191,839	$21,959,723,581	$17,961,026,386	$3,998,697,195	154	18
Q	$7,159,648	$16,828,770,952	$8,372,462,619	$8,456,308,333	970	18
A	$7,083,680	$26,044,518,589	$22,433,987,042	$3,610,531,547	1,266	8
M	$7,035,096	$33,461,032,180	$24,767,547,520	$8,693,484,660	1,192	23
N	$6,941,000	$4,840,800,571	$4,840,800,571	$0	12	1
O	$6,579,116	$1,370,257,300	$0	$1,370,257,300	223	25
E	$5,201,210	$6,938,670,223	$0	$6,938,670,223	3,707	33
J	$4,708,763	$14,266,760,684	$13,118,796,561	$1,147,964,123	145	12
F	$4,643,975	$34,001,129,627	$31,486,329,750	$2,514,799,877	1,158	4
P	$4,208,991	$11,887,536,412	$8,291,721,600	$3,595,814,812	167	13
D	$4,042,433	$9,360,881,234	$6,142,707,019	$3,218,174,215	420	14
L	$3,226,096	$11,139,110,800	$7,148,627,324	$3,990,483,476	99	4
B	$3,038,729	$13,444,256,435	$9,463,286,619	$3,980,969,816	184	15
C	$2,332,467	$10,162,135,021	$7,485,513,031	$2,676,621,990	207	35
Totals	**$102,103,797**	**$303,003,148,071**	**$234,319,061,932**	**$68,684,086,139**	**11,495**	**292**

Source: CMS's Program Integrity Group and OIG analysis of Benefit Integrity Workload Template 2005 data.

Most program safeguard contractors had minimal results from proactive data analysis

There were minimal results from proactive data analysis in the areas of new investigations and case referrals to law enforcement in 2005. As shown in Table 3 below, three-quarters of PSCs (13 of 17) had 18 percent or less of their new investigations from proactive data analysis. Seven of these thirteen PSCs had 8 percent or less. Two of these PSCs produced no new investigations from proactive data analysis, and one PSC initiated one new investigation based on this source.

Table 3. Proactive Data Analysis as Source of New Investigations and New Case Referrals to Law Enforcement Agencies (n=17)

	Investigations				Case Referrals		
PSC Task Order	Number of Investigations	Number of Investigations From Proactive Data Analysis	Percentage of Investigations From Proactive Data Analysis	PSC Task Order	Number of Case Referrals	Number of Case Referrals From Proactive Data Analysis	Percentage of Case Referrals From Proactive Data Analysis
E	3,707	0	0%	F	4	0	0%
H	366	0	0%	E	33	1	3%
M	1,192	20	2%	M	23	1	4%
D	420	8	2%	B	15	1	7%
Q	970	55	6%	H	12	1	8%
C	207	12	6%	K	18	2	11%
N	12	1	8%	A	8	1	13%
B	184	24	13%	P	13	2	15%
L	99	13	13%	Q	18	3	17%
P	167	27	16%	L	4	1	25%
I	1,114	183	16%	C	35	10	29%
J	145	24	17%	I	44	13	30%
O	223	39	18%	J	12	4	33%
A	1,266	490	39%	D	14	8	57%
K	154	69	45%	O	25	17	68%
F	1,158	692	60%	G	13	12	92%
G	111	74	67%	N	1	1	100%
Totals	**11,495**	**1,731**	**15%**	**Totals**	**292**	**78**	**27%**

Source: OIG analysis of CMS's Benefit Integrity Workload Template 2005 data.

In the area of new case referrals to law enforcement, almost half the PSCs (7 of 17) had only one case referral originating from proactive data analysis. For 9 PSCs, 17 percent or less of their new case referrals resulted from proactive data analysis. Of these PSCs, five had 8 percent or less, and one had no new case referrals from this source.

In addition to conducting our review of workload statistics, we reviewed PSC monthly status reports for any descriptions of proactive data analysis. Although CMS does not specifically require that proactive

data analysis projects and their results be included in monthly status reports, it does ask that the PSCs' prior month's activities be included in the reports.

We found that all PSCs mentioned proactive data analysis in at least four monthly status reports during the year. We do not know if the absence of information about proactive data analysis in the remaining months indicates that the activity did not take place. In the reports that mentioned proactive data analysis, some PSCs repeated the exact language about the same project in numerous monthly reports. After the initial mention of a proactive data analysis project, subsequent reports that referenced the same project provided no new or additional information about the project or its results.

We found no consistency across PSCs regarding the level of detail about proactive data analysis included in the monthly status reports. Therefore, based on information in the reports, we could not determine whether the low numbers of proactive investigations and case referrals to law enforcement reported in the workload statistics were the result of PSCs performing proactive data analysis that did not yield cases of potential fraud and abuse for further investigation or the result of PSCs not performing substantial proactive data analysis overall.

RECOMMENDATIONS

PSCs were established to strengthen CMS's ability to detect and deter potential fraud and abuse in the Medicare program. OIG has not found strong evidence that this is occurring across all PSCs for the three workload activities we reviewed. Based on the 2005 Benefit Integrity Workload Template statistics and monthly status reports, OIG found that some PSCs had minimal or no activity in new investigations or case referrals to law enforcement. PSCs also had minimal results from proactive data analysis, which was expected to be a significant activity of PSCs and distinguish them from their predecessors.

To determine why certain PSCs have minimal or no activity in new investigations or new case referrals to law enforcement, especially as a result of proactive data analysis, CMS should:

Review program safeguard contractors with especially low volumes of activity in investigations and case referrals for Medicare Parts A and B

For PSCs with no activity or low levels of activity, CMS should determine whether these PSCs have taken all the necessary steps to identify potential fraud and abuse. If CMS finds that not all necessary steps were taken, CMS could provide additional guidance to PSCs about their fraud and abuse detection and deterrence activity levels. CMS could also consider its remedies under the PSC contracts, up to and including contract termination. Under the umbrella contracts governing the various task orders, CMS may terminate a contract if the PSC defaults in performing its obligations.

Require program safeguard contractors to provide more detailed explanations of their investigations, case referrals, and proactive data analysis activities in their monthly reports

CMS should use this information to review PSCs for which activity levels appear low. If workload activity levels are high, CMS can determine the techniques those PSCs are using and possibly share the techniques with other PSCs.

CMS should also require PSCs to provide more detailed information about their proactive data analysis efforts. PSCs should identify current proactive data analysis projects and identify the projects' innovative and/or effective aspects.

AGENCY COMMENTS

CMS concurred in part with our first recommendation to review PSCs with especially low volumes of activity in investigations and case referrals. CMS stated that the variation in workloads and geographical jurisdictions between PSCs makes it difficult to directly compare PSCs' efforts. However, CMS has begun implementing a new contracting strategy to align PSC jurisdictions with the jurisdictions of claims–processing contractors and believes this will make it easier to compare PSCs in the future. CMS also noted that it has begun allocating funds to PSCs based on PSC performance, workload, and Medicare program vulnerabilities.

CMS stated that acceptable performance of PSCs is not based solely on their development of cases for referral to law enforcement. CMS reports that law enforcement often indicates its preference that PSCs pursue administrative actions rather than referrals.

CMS concurred with our second recommendation to require PSCs to provide more detailed explanations of their investigations, case referrals, and proactive data analysis activities in their monthly reports. CMS stated that it has revised the monthly reporting system to collect more information and to improve reporting consistency across PSCs.

With regard to proactive data analysis, CMS stated that this activity has other goals besides referring cases to law enforcement, such as identifying targets for edits, assessing the effectiveness of administrative actions, and assisting law enforcement with their open cases. The full text of CMS's comments is provided in Appendix C.

APPENDIX A

2005 Program Safeguard Contractors (PSC) With Benefit Integrity Task Orders (n=17)

PSC Task Order	Medicare Programs	Months Task Order Was Active	Budget Allocation	Number of Paid Claims Part A	Number of Paid Claims Part B	Dollar Amount of Paid Claims Part A	Dollar Amount of Paid Claims Part B
A	Part A hospitals Part A home health Part B physicians	12	$7,083,680	20,807,426	43,984,933	$22,433,987,042	$3,610,531,547
B	Part A hospitals Part B physicians	12	$3,038,729	10,467,606	49,807,501	$9,463,286,619	$3,980,969,816
C	Part A hospitals Part B physicians	12	$2,332,467	7,362,719	30,442,872	$7,485,513,031	$2,676,621,990
D	Part A hospitals Part B physicians	12	$4,042,433	7,510,708	38,386,833	$6,142,707,019	$3,218,174,215
E	Part B physicians	12	$5,201,210	0	66,776,723	$0	$6,938,670,223
F	Part A hospitals Part B physicians	12	$4,643,975	21,875,279	31,118,549	$31,486,329,750	$2,514,799,877
G	Part A hospitals Part B physicians	12	$9,316,750	24,692,061	25,920,332	$30,122,833,543	$2,486,040,508
H	Part A hospitals Part A home health Part B physicians	12	$9,159,828	33,559,768	70,175,227	$32,804,312,314	$5,823,123,639
I	Part A hospitals Part B physicians	12	$9,234,176	11,505,945	72,066,690	$9,879,110,033	$6,182,144,425
J	Part A hospitals Part A home health Part B physicians	12	$4,708,763	6,563,509	13,460,733	$13,118,796,561	$1,147,964,123
K	Part A hospitals Part A home health Part B physicians	12	$8,191,839	15,766,970	46,711,525	$17,961,026,386	$3,998,697,195
L	Part A hospitals Part B physicians	10	$3,226,096	7,415,334	48,470,878	$7,148,627,324	$3,990,483,476
M	Part A hospitals Part B physicians	12	$7,035,096	22,647,652	90,720,697	$24,767,547,520	$8,693,484,660
N	Part A hospitals	12	$6,941,000	4,539,310	0	$4,840,800,571	$0
O	Part B medical equipment	12	$6,579,116	0	10,850,302	$0	$1,370,257,300
P	Part A hospitals Part B physicians	12	$4,208,991	7,884,208	44,326,406	$8,291,721,600	$3,595,814,812
Q	Part A hospitals Part B physicians	10	$7,159,648	7,361,298	79,739,197	$8,372,462,619	$8,456,308,333
	Totals		**$102,103,797**	**209,959,793**	**762,959,398**	**$234,319,061,932**	**$68,684,086,139**

Source: CMS, Program Integrity Group, 2005.

APPENDIX B

Correlation Coefficients

We performed Pearson's correlations to determine the strength of the relationship between the variables in each of the following four pairs:

- Budget allocations and new investigations
- Budget allocations and new case referrals
- Oversight responsibility and new investigations
- Oversight responsibility and new case referrals

As shown in the tables below, a correlation coefficent was calculated for each of the relationships listed above. The correlation coefficient is a number that ranges from -1 to +1. If a positive correlation exists between two variables, the value of one variable will increase as the value of the other variable increases. If a negative correlation exists between two variables, the value of one variable will decrease as the value of the other variable increases.

Table 1. Correlation: Budget Allocations and New Investigations

	Budget Allocations	Number of New Investigations
Budget allocations	1.0	0.06
Number of new investigations	0.06	1.0

Source: OIG analysis of 2005 CMS data.

Table 2. Correlation: Budget Allocations and New Case Referrals

	Budget Allocations	Number of New Case Referrals to Law Enforcement
Budget allocations	1.0	0.11
Number of new case referrals to law enforcement	0.11	1.0

Source: OIG analysis of 2005 CMS data.

Table 3. Correlation: Oversight Responsibility and New Investigations

	Dollar Amount of Paid Claims	Number of New Investigations
Oversight responsibility (Dollar amount of paid claims)	1.0	0.02
Number of new investigations	0.02	1.0

Source: OIG analysis of 2005 CMS data.

Table 4. Correlation: Oversight Responsibility and New Case Referrals

	Dollar Amount of Paid Claims	Number of New Case Referrals to Law Enforcement
Oversight responsibility (Dollar amount of paid claims)	1.0	-0.22
Number of new case referrals to law enforcement	-0.22	1.0

Source: OIG analysis of 2005 CMS data.

APPENDIX C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUN - 6 2007

TO: Daniel R. Levinson
Inspector General

FROM: Leslie Norwalk
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare's Program Safeguard Contractors: Activities To Detect and Deter Fraud and Abuse" (OEI-03-06-00010)

Thank you for the opportunity to review and comment on the OIG draft audit report. In 1996, Congress enacted the Health Insurance Portability and Accountability Act and the Medicare Integrity Program (MIP) which created authority for the Centers for Medicare and Medicaid Services (CMS) to contract with specialized entities to combat fraud, waste, and abuse in the Medicare program. In May 1999, CMS awarded contracts to 12 Program Safeguard Contractors (PSCs) to perform some or all of the following program safeguard functions: medical review, benefit integrity, cost report audit, data analysis, and provider education. In Fiscal Year 2007, CMS awarded $119 million in PSCs. Currently, CMS has 18 active Benefit Integrity (BI) PSC task orders --15 BI task orders for Medicare Parts A and B and 3 BI task orders for Durable Medical Equipment (DME). This report focused on evaluating PSC accomplishments in investigations, case referrals to law enforcement, and proactive data analysis.

OIG Recommendation

Review PSCs with especially low volumes of activity in investigations and case referrals for Medicare Parts A and B.

CMS Response

While we concur in part with this recommendation, due to the current PSC contracting structure, workloads vary between task orders. PSC BI task orders may include the review of Part A claims that cover skilled nursing facility, hospice, and certain home health services. The task orders may also include the review of Part B claims that cover physician and outpatient services, diagnostic tests, and other medical services and supplies and some task orders require the review of claims for DME. Further, we know that there is more Medicare fraud in certain geographic areas of the country, so logically, some PSCs have more work than others depending upon their geographic jurisdiction. Consequently, direct comparisons between PSC task orders are difficult to make.

CMS has just begun the implementation of a new PSC contracting strategy that will realign PSC jurisdictions with the Medicare Administrative Contractor (MAC) jurisdictions. As part of Medicare Contracting Reform, pursuant to the Medicare Modernization Act of 2003, AB MACs will handle both Parts A and B within their respective jurisdictions.. After this realignment occurs, comparisons between PSCs will be much easier.

There are numerous outcomes of the BI claims review process. Consequently, acceptable performance of PSCs is not based solely upon the development of cases for referral to law enforcement. While some investigations may be developed into referrals for prosecution, law enforcement often indicates its preference that the PSC instead pursue administrative actions such as overpayments, payment suspensions, prepay medical review, and edits. Currently, comparisons between the number of new investigations and case referrals to law enforcement are difficult to interpret accurately due to the characteristics of the PSC workload, the differing levels of fraud in various geographic regions, and the various interactions between PSCs and law enforcement.

The PSCs interact with law enforcement during the process of developing investigations and when referring cases. Many factors will have a direct impact on the number of referrals accepted by law enforcement. For example, local law enforcement staffing levels, resources, and current caseloads exert significant influence over the number and types of PSC investigations developed and the cases that are accepted by law enforcement. Some jurisdictions have a preference as to the type of case to accept based upon prior experience, expertise, and prosecutorial track records.

The OIG study indicated that there were minimal results from proactive data analysis. Proactive data analysis, however, has many goals other than the referral of a case to law enforcement. Significant resources may be devoted to proactive analysis which can be a useful tool in identifying targets for edits and for assessing the effectiveness of administrative actions. For example, infusion-specific prepayment review and auto denial edits implemented in Florida have resulted in nearly $1.8 billon in claim denials. Often, such actions effectively prevent further billing by providers who are then no longer of interest to law enforcement. Finally, a significant portion of data analysis resources are devoted to supporting requests for information by law enforcement. These activities do not result in new investigations or cases. Rather, they focus on previously referred cases which are going to trial or settlement negotiations.

OIG Recommendation

Require PSCs to provide more detailed explanations of their investigations, case referrals, and proactive data analysis activities in their monthly reports.

CMS Response

The CMS agrees with this recommendation and has made significant improvements in the areas of reporting costs and statistics. The new CMS Analysis, Reporting, and Tracking System BI template was developed for monthly PSC reporting. It includes a narrative section that has eliminated the need for separate monthly status reports. It also incorporates a feature that provides a definition of the data to be reported. This will prevent inconsistent reporting across task orders.

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In addition, improvements have been implemented for the allocation of funds to each PSC task order and a focus on administrative actions in geographic areas with high fraudulent activity. Now, to improve the effectiveness of the MIP, funds are now allocated based on PSC performance, workload, and Medicare program vulnerabilities.

We thank the OIG for its effort and the opportunity to comment on this report. We look forward to working together with you in the future as we continue to prevent fraud, waste, and abuse in the Medicare program.

ACKNOWLEDGMENTS

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Linda M. Ragone, Deputy Regional Inspector General.

Isabelle Buonocore served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Philadelphia regional office who contributed to this report include Cynthia Hansford and Conswelia McCourt; central office staff who contributed include Scott Manley and Barbara Tedesco.