Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ENHANCEMENTS NEEDED IN THE TRACKING AND COLLECTION OF MEDICARE OVERPAYMENTS IDENTIFIED BY ZPICS AND PSCS

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by ZPICs and PSCs

Why OIG Did This Review

This study continues the Office of Inspector General's (OIG's) body of work examining overpayments made by Medicare. Overpayments can be identified by a number of key players, including providers and Medicare contractors. Recovering overpayments is critical to reducing improper payments in the Medicare program. Past OIG work found that overpayments referred by program safeguard contractors (PSCs) for collection did not result in significant recoveries to the Medicare program. As of 2012, the Centers for Medicare & Medicaid Services (CMS) had transitioned the workload of most PSCs to six zone program integrity contractors (ZPICs). In 2016, CMS began transitioning the remaining PSCs and ZPICs to unified program integrity contractors (UPICs). OIG's work on both PSCs and ZPICs identified deficiencies in how contractors were tracking and reporting overpayment data. This study provides an update on the collection of ZPIC- and PSC-referred overpayments and identifies ongoing challenges that contractors face in tracking and collecting overpayments identified by ZPICs and PSCs.

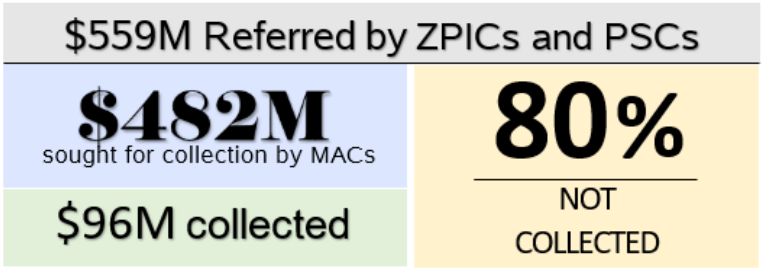
How OIG Did This Review

Our study focused on overpayments that ZPICs and PSCs sent to Medicare administrative contractors (MACs) for collection in fiscal year (FY) 2014. We collected and analyzed overpayment referral and collection data from ZPICs, PSCs, and MACs, and we surveyed them to understand their procedures for tracking overpayment referrals and collections. We also asked them to identify any barriers and challenges they face in performing these tasks.

What OIG Found

ZPICs and PSCs are key players in identifying Medicare overpayments, and they referred $559 million in overpayments in FY 2014 to the MACs responsible for collecting overpayments. The dollars referred varied widely across ZPICs and PSCs, with just 2 of 10 contractors identifying half of the total overpayment dollars. Based on ZPIC and PSC referrals, MACs sought to collect $482 million but collected only $96 million, or 20 percent; 80 percent remained uncollected as of September 30, 2015. Although the collection rate remains low, it is almost three times the 7-percent collection rate for PSC-identified overpayments that OIG found in its 2010 review when only PSCs were in existence. MACs' collection rates ranged from a low of 11 percent for home health and hospice overpayments to a high of 59 percent for Part A overpayments referred by ZPICs and PSCs. We found that ZPICs, PSCs, and MACs continue to experience challenges in tracking referrals and collections of overpayments. In particular, the number and amount of overpayment referrals reported by ZPICs and PSCs often did not match what was reported by MACs—with discrepancies totaling $130 million. Furthermore, ZPICs, PSCs, and MACs used different report formats, which can lead to difficulty in tracking overpayment referrals.

Collection Status of FY 2014 ZPIC-Referred Overpayments



What OIG Recommends

We recommend that CMS identify and implement strategies to increase the identification of overpayments as well as MACs' collection of ZPIC- and UPIC-referred overpayments. To increase collections, CMS should implement the surety bond requirement for home health providers and consider surety bonds for other providers based on their level of risk. Furthermore, we recommend that CMS improve the ability of ZPICs, UPICs, and MACs to track overpayment referrals and collections by creating a standard report format for all contractors and requiring ZPICs, UPICs, and MACs to use a unique identifier for each overpayment**.** CMS concurred with all of our recommendations except the one regarding surety bonds. CMS did not concur or non-concur with this recommendation; it stated that it is evaluating how to effectively implement the surety bond requirement while avoiding undue provider burden.

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OBJECTIVES

1. To determine the number and amount of Medicare overpayments that zone program integrity contractors (ZPICs) and program safeguard contractors (PSCs) referred to Medicare administrative contractors (MACs) for collection in fiscal year (FY) 2014.
2. To determine the collection rate of Medicare overpayments sought by MACs based on referrals from ZPICs and PSCs in FY 2014.
3. To determine how ZPICs, PSCs, and MACs track Medicare overpayment referrals and collections.

BACKGROUND

This study continues the Office of Inspector General's (OIG's) body of work examining overpayments made by Medicare to providers. Overpayments can be identified by a number of key players, including providers, Medicare contractors, and OIG. OIG has identified ensuring program integrity in Medicare Parts A and B as a top management challenge for the Department of Health and Human Services.[1] One of the key focus areas in addressing this challenge is reducing improper payments, which includes recovering overpayments. With Medicare Parts A and B payments totaling $366 billion in 2016, identifying and recovering overpayments is critical to reducing improper payments in the Medicare program. Past OIG work has found that overpayments referred for collection by PSCs did not result in significant recoveries to the Medicare program. As of 2012, the Centers for Medicare & Medicaid Services (CMS) had transitioned the workload of most PSCs to six ZPICs. In 2016, CMS began transitioning the remaining PSCs and ZPICs to unified program integrity contractors (UPICs).[2] OIG work on both PSCs and ZPICs has identified deficiencies in how Medicare contractors were tracking and reporting overpayment data.[3] This study provides an update on the collection rate of ZPIC- and PSC-referred overpayments. It also identifies ongoing challenges that contractors face in collecting and tracking overpayments.

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[1] OIG, *Top Management & Performance Challenges Facing HHS*. Accessed at https://oig.hhs.gov/reports-and-publications/top-challenges/2016/TMC_2016_508.pdf on February 7, 2017.

[2] UPICs will eventually perform all of the benefit integrity functions performed by ZPICs and PSCs.

[3] OIG, *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010; OIG, *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011.

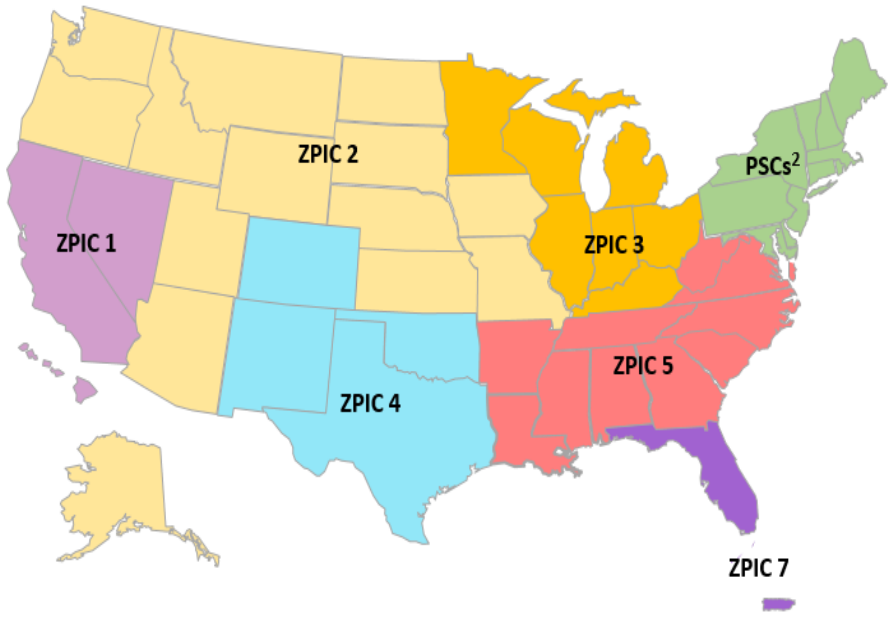
ZPICs and PSCs

ZPICs and PSCs are the benefit integrity contractors that detect and deter fraud and abuse in Medicare Parts A and B, including the areas of home health and hospice and durable medical equipment, prosthetics, orthotics, and supplies (DME).

As part of their role in detecting and deterring fraud and abuse, ZPICs and PSCs conduct investigations and refer cases of potential fraud to law enforcement; they also take administrative actions, such as referring overpayments to MACs. In their investigative work, ZPICs and PSCs review Medicare payments and may identify overpayments. When they identify overpayments, they are required to refer them to MACs for collection.

PSCs were the first benefit integrity contractors that CMS created. As part of Medicare contracting reform, CMS established ZPICs to replace PSCs. As of 2012, CMS had transitioned most PSCs to ZPICs. In FY 2014, ZPICs were fully operational in six of seven geographical zones (see Exhibit 1). One zone still had four PSCs conducting benefit integrity activities.

Exhibit 1. ZPIC and PSC Jurisdictions and Associated MACs in FY 2014[1]



ZPICs/PSCs	Associated MACs
ZPIC 1	J6, JE, DME D
ZPIC 2	J5, J6, J15, JF, JL, DME D
ZPIC 3	J6, J8, J15, JM, DME B
ZPIC 4	J15, JH, JM, DME C
ZPIC 5	J15, JH, JJ, JM, DME C
ZPIC 7	J6, JM, JN, DME C
DME PSC	DME A
EA BISC	JK, JL
NE BISC	J6, J15, JK, JL
PA BISC	JL

Source: OIG summary of ZPIC, PSC, and MAC information from CMS, 2014.

[1] Not shown on this map are the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands. The first three territories are in ZPIC 1's jurisdiction, the last one is in ZPIC 7's jurisdiction.

[2] DME PSC oversees DME in all States in the PSC coverage area. Eastern Benefit Integrity Support Center (EA BISC) oversees Parts A and B in New Jersey and New York. New England Benefit Integrity Support Center (NE BISC) oversees home health and hospice for all States in the PSC coverage area; Parts A and B in Connecticut, Delaware, the District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, Rhode Island, and Vermont; and Part B in the counties of Arlington and Fairfax, VA, and the city of Alexandria, VA. Pennsylvania Benefit Integrity Support Center (PA BISC) oversees Parts A and B in Pennsylvania.

Task orders are awarded to ZPICs and PSCs, each of which specifies the requirements for the benefit integrity work that the contractor will perform. One type of task order is the fee-for-service task order, which covers detecting, deterring, and preventing fraud, waste, and abuse within that ZPIC's or PSC's jurisdiction. CMS may award additional task orders to ZPICs and PSCs to perform other types of work, such as for specific projects or tasks. ZPICs and PSCs may identify overpayments during the course of their work on any of these types of task orders.

MACs

CMS contracts with MACs to provide administrative services for Medicare Parts A and B, including processing and paying claims for Medicare services. As part of their responsibilities, MACs collect overpayments, including those identified by ZPICs and PSCs. MACs have responsibility for specific geographic jurisdictions (e.g., J5, J6, or JE) and specific claim types (i.e., Part A, Part B, home health and hospice, and DME). ZPICs, PSCs, and MACs do not cover identical jurisdictions and claim types. Therefore, a single MAC can receive overpayment referrals from multiple ZPICs and PSCs.

Identification and Collection of Medicare Overpayments

ZPICs and PSCs may identify overpayments during the course of their work and are required to refer them to MACs for collection.[4] Overpayments are payments made to providers in excess of amounts properly payable under Medicare statutes and regulations.[5]

An overpayment referral that a ZPIC or PSC sends to a MAC for collection may include multiple claims for service, i.e., the amount in a single referral may represent overpayments made to a provider for multiple claims. The ZPIC or PSC also may extrapolate overpayment amounts based on a sample of the provider's claims.[6] Although ZPICs and PSCs refer overpayment amounts to the MACs, the MACs make the final determinations of the dollar amounts to be collected from providers.[7]

When a MAC makes an overpayment determination, it sends a demand letter to the provider that contains the dollar amount that it is seeking to collect, i.e., the initial demand amount. This dollar amount may be the same as, more than, or less than the dollar amount that the ZPIC or PSC referred. Additionally, because providers have the right to appeal

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[4] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4 § 4.9.6.3.

[5] In this report, provider refers to any type of Medicare provider or supplier, e.g., hospital, physician, or supplier of DME.

[6] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.4.1.1.

[7] CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 4, §§ 10 and 90.2, and *Medicare Program Integrity Manual*, Pub. No. 100-08 ch. 8 § 8.2.

overpayment determinations, the initial demand amount is not always the same as the final overpayment amount for which the MAC seeks collection.

A provider can repay its overpayments immediately, or MACs may withhold the overpayment amount from a provider's future Medicare payments as long as a provider continues billing Medicare. If an overpayment remains unpaid after 120 days, MACs must refer the overpayment to the U.S. Department of the Treasury for collection.[8] In the case of DME providers that have surety bonds, DME MACs must first request payment from the surety (up to the full amount of the surety bond) before referring the overpayment to the U.S. Department of the Treasury.[9] A surety bond is a bond issued by an entity (the surety) guaranteeing that a provider will fulfill an obligation or series of obligations to Medicare. If the obligation is not met, the surety covers losses up to the bond amount. Exhibit 2 shows the key players in the overpayment process.

Exhibit 2. Key Players in the Identification and Collection of Overpayments Identified by ZPICs and PSCs in FY 2014

Tracking Overpayment Referrals and Collections

MACs, ZPICs, and PSCs all play a role in tracking and reporting overpayments.

MAC responsibilities. MACs are responsible for keeping track of collection information on overpayments they seek to recover. MACs must submit monthly reports to CMS that identify overpayment collections deposited in the Medicare trust funds. In addition, each MAC sends a monthly report to the ZPICs and PSCs that shows the amounts that the MAC collected on ZPIC and PSC overpayment referrals.

ZPIC and PSC responsibilities. ZPICs and PSCs are required to report monthly workload statistics to CMS's Analysis, Reporting, and Tracking System (CMS ARTS). This includes reporting the number and amount of

[8] CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 4, § 10.
[9] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.21.7.1.

overpayment referrals sent to MACs as well as collection information on these referrals that is received from MACs.

Joint Operating Agreements. CMS requires MACs to enter into joint operating agreements with ZPICs/PSCs.[10] A joint operating agreement delineates the roles and responsibilities of each entity and outlines how the MAC and ZPIC or PSC intend to interact to complete the tasks outlined in their task orders, including the processing of overpayments. With regard to overpayments, the joint operating agreements outline each contractor's responsibility to refer, collect, report, and track overpayments. For example, a joint operating agreement may specify the method by which a ZPIC or PSC should send the overpayment referral to a MAC, or whether the MAC should send to the ZPIC or PSC a list of demand letters issued to providers.

Related OIG Work

In 2010, OIG reported that overpayments referred by benefit integrity contractors (then PSCs) to claims processors (now referred to as MACs) for collection did not result in significant recoveries.[11] Specifically, as of June 2008, claims processors collected only 7 percent, or $55 million, of the $835 million in overpayments that PSCs referred in 2007. In a second report, OIG found that the amounts of overpayments that PSCs referred were not always related to the size of their respective oversight responsibilities.[12] In addition, OIG reported that claims processors could not provide data for more than a quarter of the overpayment referrals, representing $64 million of the overpayment dollars. In response to our report recommendations, CMS stated that it was adding reporting requirements that would improve the tracking of overpayments. However, in 2011 OIG reported that ZPICs continued to experience issues with tracking the collection of overpayments.[13]

In a 2016 report, OIG found continued variation in the amount of overpayments referred by benefit integrity contractors, and this variation could not be explained solely by differences in oversight responsibility, i.e., the dollar amount of paid claims for which a given ZPIC has oversight.[14] OIG recommended that CMS examine the variation among

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[10] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.28.

[11] OIG, *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010.

[12] OIG, *Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00031, May 2010.

[13] OIG, *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011.

[14] OIG, *Medicare Benefit Integrity Contractors' Activities in 2012 and 2013: A Data Compendium*, OEI-03-13-00620, May 2016.

benefit integrity contractors and—as appropriate—identify performance issues that needed to be addressed, best practices that could be shared, and workload definitions that needed to be clarified to ensure that contractors report data uniformly and in the way CMS intends. CMS concurred with this recommendation and stated that it was developing the Unified Case Management system, which will collect contractors' workload statistics in a unified manner.

METHODOLOGY

Scope

Our study focused on overpayments that ZPICs and PSCs referred to MACs in FY 2014 (October 1, 2013, to September 30, 2014). We also reviewed collection information on these referrals through September 30, 2015. Because we collected information through September 30, 2015, MACs had 12 to 24 months to collect the overpayments, depending on when in FY 2014 they were referred. Although MACs collect overpayments identified through other means, in this report we use the term "overpayments" to mean only ZPIC- or PSC-referred overpayments.

Data Collection

We collected data from the 6 ZPICs and 4 PSCs that were operational as of December 2015, as well as from the 16 MACs that were operational during that time. Although all ZPICs, PSCs, and MACs responded to our data request, ZPIC 3 was unable to provide data regarding overpayment referrals and collections for FY 2014, as there was a different contractor operating in that zone in FY 2014.

Data from ZPICs and PSCs. We requested data from the six ZPICs and four PSCs regarding their FY 2014 overpayment referrals. These data included the following: the total number and amount of overpayments referred to MACs in FY 2014; the total initial amount demanded by the MAC; the total amount sought for collection (this is the final overpayment amount that the MAC requested from the provider); and the total amount collected by MACs as of September 30, 2015. We asked the ZPICs and PSCs to report these data for each claim type (Part A; home health and hospice; Part B; and DME), task order, and associated MAC. In addition, we asked each ZPIC and PSC to report its total oversight responsibility, i.e., total number and amount of claims paid in its jurisdiction in FY 2014.

We also requested information about procedures regarding the transmission of overpayment data between ZPICs/PSCs and MACs as well as barriers and challenges that ZPICs and PSCs face when sending overpayment information to MACs and receiving overpayment information from them.

Finally, we requested copies of all written policies and procedures, including joint operating agreements, and examples of overpayment referrals that were sent to MACs for September 2014 and September 2015, and copies of the monthly overpayment collection reports sent to ZPICs and PSCs by the MACs for September 2014 and September 2015.

Data from MACs. From the 16 MACs, we requested data regarding the overpayments referred by ZPICs and PSCs in FY 2014. These data included the following: the total number and amount of overpayments referred by ZPICs/PSCs in FY 2014; the total number of overpayments for which collection had begun; the total initial demand amount; total amount sought for collection; the total principal amount collected; the total interest collected; and the total amount (principal plus interest) collected as of September 30, 2015. We asked each MAC to report these data for each ZPIC and PSC and claim type (Part A; home health and hospice; Part B; and DME).

We also asked MACs for information about their procedures for receiving overpayment referrals from ZPICs and PSCs, tracking overpayments, sending overpayment collection reports to ZPICs and PSCs, and the barriers and challenges they face in performing these tasks and collecting overpayments.

Data from CMS. We requested information on how much CMS paid to each ZPIC and PSC in FY 2014.

Data Analysis

Overpayment referrals. We used the overpayment referral data that we received from the ZPICs and PSCs to calculate the total number and amount of overpayments that ZPICs referred to the MACs in FY 2014. We summarized these data by ZPIC and PSC and by claim type. Because the current ZPIC 3 could not provide overpayment referral data, for our calculations we used the referral data that the MACs associated with ZPIC 3 had reported to us.

To make meaningful comparisons across ZPICs and PSCs, we determined the amount of overpayments each ZPIC and PSC referred for its fee-for-service task order, then calculated the amount referred per $1 million in oversight responsibility, i.e., the dollar amount of paid claims for which a given ZPIC has oversight. We also determined the amount of overpayments each ZPIC and PSC referred for all task orders, then calculated the amount referred per $1 million paid to the contractor.

We compared the ZPIC- and PSC-reported referral data to the MAC-reported referral data to identify differences. Because ZPIC 3 could not report referral data, we excluded ZPIC 3 from this comparison.

Overpayment collection. We used the MAC-reported overpayment collection data to calculate the total amount of overpayments collected and each MAC's collection rate. We calculated collection rates as a percentage, using the total dollar amount collected divided by the dollar amount of the final overpayment sought for collection. We summarized these data by MAC and claim type.

Review of Procedures. We reviewed and summarized ZPIC, PSC, and MAC responses to our questions regarding their policies and procedures; joint operating agreements; and barriers and challenges to collecting and tracking overpayments. We reviewed and summarized supporting documentation that we received from ZPICs and PSCs to identify the types of information contained in ZPIC and PSC referral reports and MAC monthly collection reports. We also reviewed and summarized information contained in the joint operating agreements to determine how ZPICs/PSCs and MACs agreed to report and track overpayment information. Although there are 35 ZPIC/PSC and MAC combinations, some of the joint operating agreements covered multiple MACs or ZPICs/PSCs; for example, ZPIC 1 has a single joint operating agreement that covers all three of its associated MACs. Therefore, we reviewed 30 distinct joint operating agreements.

Limitations

We did not independently verify the information reported by the ZPICs, PSCs, and MACs. However, we reviewed the data for consistency and possible data-entry errors and followed up with contractors when we identified potential errors or inconsistencies.

At the time of our data collection, MACs had 12 to 24 months to collect FY 2014 overpayments. However, it is possible that CMS could still collect on certain overpayments if they were undergoing multiple levels of appeal or were placed on an extended repayment plan.

Standards

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

FINDINGS

ZPICs and PSCs referred a total of $559 million in overpayments to the MACs in 2014; however, the dollar amounts referred varied widely across ZPICs and PSCs

In FY 2014, ZPICs and PSCs referred 4,058 overpayments, totaling $559 million, to MACs for collection. Across the ZPICs and PSCs, referral amounts in FY 2014 ranged from $3.5 million to $159 million. Referrals from two ZPICs—ZPIC 5 and ZPIC 7—accounted for half of the total overpayment dollars referred. Combined, these two ZPICs referred a total of $283 million in overpayments to the MACs. Exhibit 3 shows the distribution of overpayments that ZPICs and PSCs referred in FY 2014, ranked by each ZPIC's and PSC's percentage of the total amount referred.

Exhibit 3. Distribution of Overpayment Referrals and Dollars by ZPIC and PSC in FY 2014

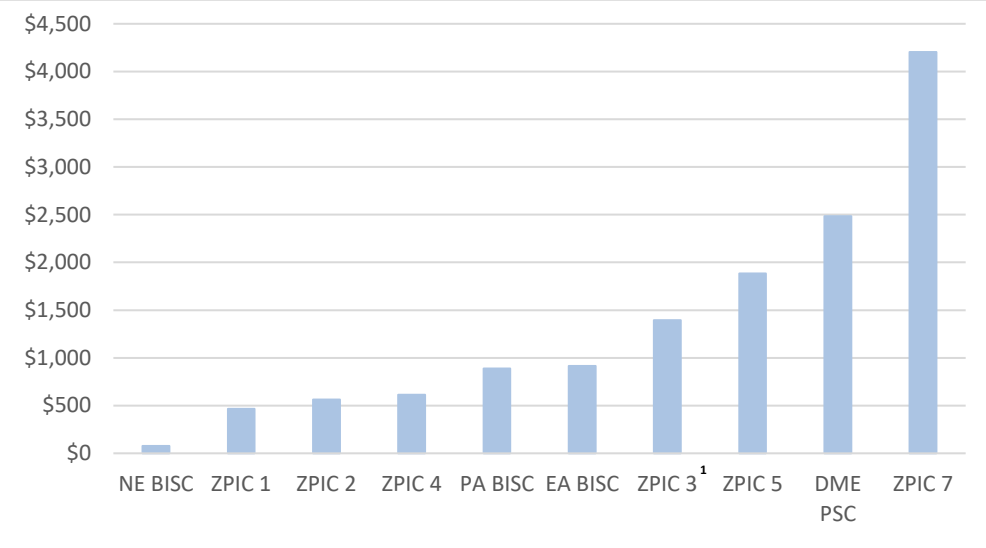
ZPIC/PSC	Amount Referred	Percentage of Total Amount Referred
ZPIC 5	$159,256,463	28%
ZPIC 7	$123,249,353	22%
ZPIC 3[1]	$89,203,327	16%
ZPIC 4	$80,313,745	14%
ZPIC 2	$39,526,105	7%
EA BISC	$31,246,510	6%
ZPIC 1	$17,581,573	3%
PA BISC	$11,512,991	2%
NE BISC	$3,525,202	1%
DME PSC	$3,522,088	1%
Total	**$558,937,358**[2]	**100%**

Source: OIG analysis of ZPIC and PSC data for overpayments referred in FY 2014.
[1] Because ZPIC 3 was unable to provide overpayment referral data for FY 2014, we used the overpayment referral data reported by its associated MACs to calculate the amount referred.
[2] The amounts referred do not add up to the total because of rounding.

There was substantial variation across ZPICs and PSCs in the amount of overpayments they referred, even after adjusting for differences in oversight responsibility, i.e., the dollar amount of paid claims for which a given ZPIC has oversight. ZPICs' and PSCs' respective oversight responsibilities in FY 2014 ranged from $1.4 billion to $63.9 billion. Under their fee-for-service task orders, ZPICs and PSCs referred between $77 (NE BISC) and $4,204 (ZPIC 7) per $1 million in oversight responsibility. Exhibit 4 shows the amount of overpayments referred per

$1 million in paid claims for each ZPIC and PSC. There also was substantial variation in the amount of overpayments ZPICs and PSCs referred for all task orders, even after adjusting for differences in the amount that ZPICs and PSCs were paid to perform their tasks. Appendix B presents the results of this analysis.

Exhibit 4. Amount of Overpayments Referred for Fee-for-Service Task Order per $1 Million in ZPIC and PSC Oversight Responsibility



Source: OIG analysis of ZPIC and PSC data for overpayments referred in FY 2014.
[1] Because ZPIC 3 was unable to provide overpayment referral data for FY 2014, we used the overpayment referral data reported by its associated MACs to calculate the amount referred.

The highest number of overpayment referrals was for Part B and DME, but home health and hospice referrals accounted for the largest overpayment amount

There was a substantial difference in the total number and amount of overpayments referred based on claim type. As shown in Exhibit 5, Part B and DME claims represented the majority of overpayments referred, 60 percent and 26 percent, respectively. However, the largest overpayment referral dollars were for home health and hospice. Of the $559 million ZPICs and PSCs referred to MACs, home health and hospice overpayments constituted $242 million, or 43 percent, of that total amount.

Exhibit 5. Number and Amount of Overpayments Referred by ZPICs and PSCs by Claim Type (FY 2014)

Claim Type	Number Referred	Percentage of Total Referrals	Amount Referred	Percentage of Total Amount Referred
Part A	280	7%	$29,518,176	**5%**
DME	1,038	26%	$64,370,669	**12%**
Part B	2,445	60%	$223,290,932	**40%**
Home Health and Hospice	295	7%	$241,757,581	**43%**
Total	**4,058**	**100%**	**$558,937,358**	**100%**

Source: OIG analysis of ZPIC and PSC data for overpayments referred in FY 2014.

MACs did not collect 80 percent of the $482 million they sought to collect from ZPICs' and PSCs' overpayment referrals in 2014

Of the overpayments referred by ZPICs and PSCs in FY 2014, MACs sought to collect $482 million from providers.[15] As of September 2015, MACs had collected $96 million, or 20 percent, of the amount they sought to collect from providers as a result of these overpayment referrals. While this is an improvement from the 7-percent collection rate that OIG reported in 2010,[16] MACs did not collect 80 percent of overpayment dollars sought for collection based on ZPIC and PSC referrals from FY 2014.

As shown in Exhibit 6, MACs' collection rates for overpayments referred by ZPICs and PSCs ranged from less than 1 percent to 81 percent. The amount sought for collection by MACs ranged from $2 million to $134 million, and the amount collected by MACs ranged from $56,533 to $19.3 million. The highest collection rate was for overpayments referred to MAC DME A. This MAC collected 81 percent of the dollars sought for collection.

[15] Because MACs make the final determination of the overpayment amount, the amount that a MAC seeks to collect from a provider can differ from the amount that a ZPIC or a PSC initially refers to the MAC.

[16] OIG, *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010. The collection rate provided in this report was based on the amount of overpayments that PSCs referred to claims processors (now referred to as MACs) in 2007 and that claims processors had collected as of June 2008.

Exhibit 6. MAC Collection Rates for FY 2014 ZPIC- and PSC-Referred Overpayments

MAC	Total Amount Sought for Collection	Total Amount Collected	Collection Rate
DME B	$24,769,170	$56,533	**< 1%**
J15	$20,066,952	$1,559,820	**8%**
J6	$39,155,699	$4,360,747	**11%**
JE	$1,951,916	$223,961	**11%**
JK	$40,513,062	$4,834,557	**12%**
JM	$134,192,729	$19,257,589	**14%**
JH	$84,880,694	$14,220,124	**17%**
J8	$10,246,196	$2,714,224	**26%**
JJ	$21,663,257	$5,938,983	**27%**
DME C	$18,053,038	$6,061,003	**34%**
JF	$15,674,260	$6,082,960	**39%**
JL	$12,932,825	$5,107,016	**39%**
DME D	$18,299,710	$7,078,323	**39%**
JN	$26,308,240	$10,592,425	**40%**
J5	$10,363,724	$5,355,563	**52%**
DME A	$3,167,527	$2,559,222	**81%**
Total	**$482,238,999**	**$96,003,049**[1]	**20%**

Source: OIG analysis of MAC data for overpayments referred by ZPICs and PSCs in FY 2014 and collected by MACs as of September 30, 2015.

[1] The amounts collected do not add up to the total because of rounding.

Fifty-nine percent of Part A overpayments sought were collected, but the collection rate for other claim types ranged from 11 to 25 percent

As shown in Exhibit 7, the collection rate of overpayments for Part A services—which are mainly delivered by institutional providers such as inpatient hospitals—was 59 percent, almost three times the collection rate for all overpayments sought. Collection rates for the other claim types were 25 percent or lower. The lowest collection rate was for home health and hospice overpayments—only 11 percent of overpayment dollars sought were collected. However, home health and hospice overpayments accounted for the second largest percentage of dollars that MACs sought for collection.

Exhibit 7. Overpayment Collection Rates by Claim Type

Claim Type	Amount Sought for Collection	Amount Collected	Collection Rate
Home Health and Hospice	$170,353,725	$19,471,526	**11%**
Part B	$217,270,107	$42,807,719	**20%**
DME	$64,289,444	$15,755,081	**25%**
Part A	$30,325,724	$17,968,723	**59%**
Total	**$482,238,999**	**$96,003,049**	**20%**

Source: OIG analysis of MAC data for overpayments referred by ZPICs and PSCs in FY 2014 and collected by MACs as of September 30, 2015.

MACs reported challenges with collecting overpayments from providers referred by ZPICs and PSCs

When asked about barriers and challenges to collecting overpayments, many MACs reported that collections can be a challenge if a provider has filed for bankruptcy or is no longer in business. Some MACs also raised the issue of providers being revoked from the Medicare program or on payment suspension, which can make collecting overpayments from these providers challenging. Because a primary goal of the ZPICs and PSCs is to identify cases of suspected fraud, waste, or abuse, the providers they are identifying—and subsequently referring to the MACs for overpayment collection—are potentially problematic providers. Therefore, it is likely that some of these providers may no longer be billing Medicare and may be revoked or excluded from the Medicare program as a result of their actions. Once a provider is no longer billing Medicare, it can be difficult for MACs to recover overpayments because they no longer have the ability to withhold or suspend future payments to these providers as a way to recoup these overpayments.

ZPICs, PSCs, and MACs continue to experience challenges in tracking referrals and collections of overpayments

Tracking referrals continues to present a challenge for the ZPICs, PSCs, and MACs. In previous reports, OIG has highlighted problems with the tracking of overpayment referrals and collections.[17] Specifically, OIG found that the claims processors (now referred to as MACs) could not

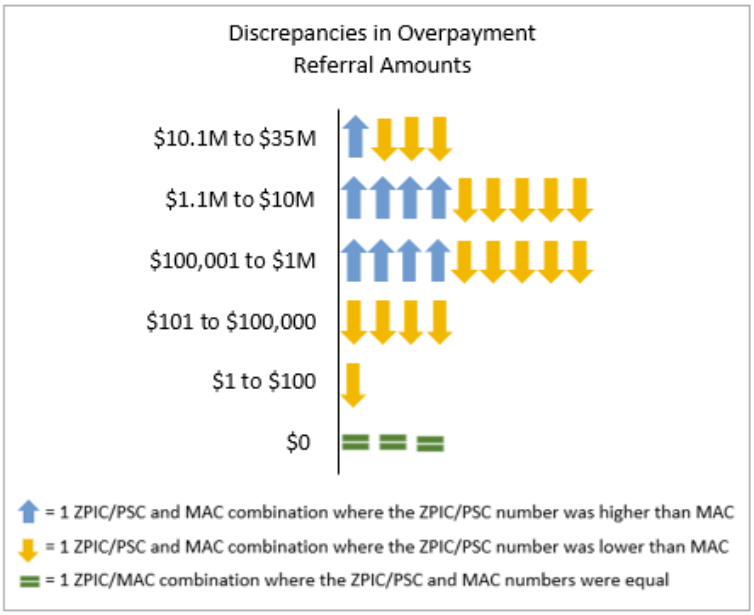
[17] OIG, *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010; OIG, *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011.

provide data for 26 percent of the overpayments referred by the PSCs in 2007. In addition, OIG has previously reported issues with overpayment reporting that made it difficult for ZPICs to track collections on their overpayment referrals. Some of these issues still persist among the current ZPICs, PSCs, and MACs.

Overpayment referral data reported by ZPICs/PSCs and MACs often did not match

The amount of overpayment referrals that was reported by ZPICs/PSCs and MACs often differed. A comparison of the amount of overpayment referrals reported by each ZPIC/PSC to the amount reported by each of their associated MACs showed discrepancies that equaled $130 million.[18] As shown in Exhibit 8, almost half of the discrepancies between individual ZPICs/PSCs and MACs totaled more than $1 million, and four ZPIC/PSC and MAC combinations differed by more than $10 million. The number of referrals reported by ZPICs/PSCs and MACs also differed. Appendix C shows the differences in amount and number of referrals for each ZPIC/PSC and MAC combination.

Exhibit 8. Almost Half of the Discrepancies in Overpayment Referral Amounts Reported by Individual ZPICs/PSCs and MACs Differed by More Than $1 Million[1]



Source: OIG analysis of ZPIC, PSC, and MAC data for overpayments referred in FY 2014.
[1] ZPIC 3 did not report data for FY 2014; thus, comparisons could not be made between this ZPIC and its five associated MACs. Therefore, our analysis included only 30 of the 35 unique ZPIC/PSC and MAC combinations.

[18] Because ZPIC 3 was unable to provide overpayment referral data for FY 2014, we excluded ZPIC 3 data in this comparison.

When we followed up with MACs to determine the reason for the discrepancies in their overpayment data compared to the ZPIC and PSC data, MACs could not give definitive explanations for these differences. However, some MACs offered possible explanations for these discrepancies, such as differences in how MACs and ZPICs/PSCs count referrals. For example, a MAC might count one ZPIC/PSC referral that contained multiple claims as multiple referrals. Timing could also create discrepancies—for example, if a ZPIC sent a referral in FY 2013, but the MAC recorded having received it in FY 2014.

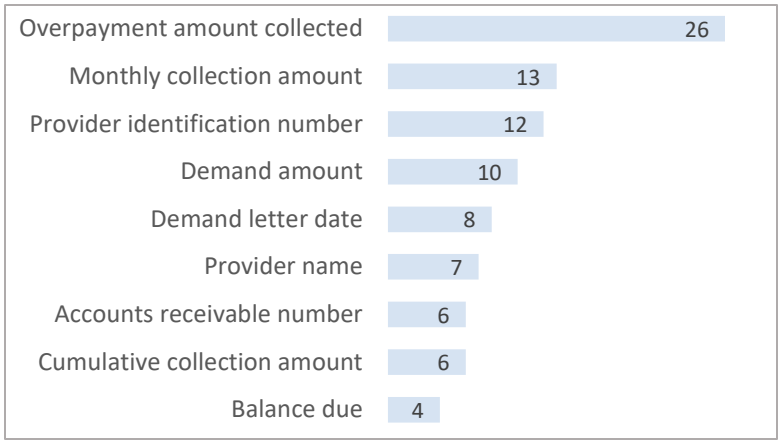
Variation in joint operating agreements may contribute to inconsistent and incomplete data sharing across ZPICs/PSCs and MACs

Joint operating agreements are designed to promote cooperation between ZPICs/PSCs and MACs and establish the shared expectations among contractors. CMS provides minimum guidelines as to what should be included in these agreements, but ZPICs/PSCs and MACs are responsible for developing the terms of their respective joint operating agreements. As a result, the level of specificity and detail varies across joint operating agreements.

Collection reports are not standard across MACs. Although all MACs submitted monthly collection reports to ZPICs and/or PSCs, not all joint operating agreements specified the types of information that should be included in these reports. While 26 of the 30 joint operating agreements stated that MACs need to send a monthly report of overpayment collections, joint operating agreements varied with regard to the data elements that should be included. For example, 13 joint operating agreements specified that MACs should report the monthly amounts collected. However, six joint operating agreements specified that MACs should provide the cumulative collection amounts. Exhibit 9 shows how many of the 30 joint operating agreements specified certain data elements to be included in the MACs monthly collection reports.

Consequently, some ZPICs and PSCs identified the lack of a standard, consistent report format that MACs could use to send collection information as a challenge. Because most of the ZPICs/PSCs are associated with multiple MAC jurisdictions—and therefore have multiple joint operating agreements—there may be variation across the collection report that a ZPIC or PSC receives from each of its MACs. This lack of a standard, consistent format can make it difficult for ZPICs and PSCs to easily track collections on their referred overpayments. The ability of ZPICs and PSCs to track overpayment collections back to their original referrals is important to ensure that no overpayment is left unaccounted for and, therefore, uncollected.

Exhibit 9: Monthly Collection Report Data Elements Specified in Joint Operating Agreements (N = 30)



Source: OIG analysis of joint operating agreements between ZPICs/PSCs and MACs.

Referral reports are not standard across ZPICs/PSCs. Most of the joint operating agreements specified that a referral template be used by ZPICs/PSCs to send referral information to MACs. However, because ZPICs/PSCs and MACs adhere to multiple joint operating agreements, the format of these templates varies. The difference in formats may present difficulty for MACs when they receive referrals from multiple ZPICs or PSCs. One MAC noted that the format of referral data differs among its ZPICs, which results in additional time and effort for the MAC to ensure that it receives all required information. Some MACs also stated that the referral reports they receive from ZPICs/PSCs sometimes contain incorrect claim or beneficiary numbers or may lack certain information (such as dates) necessary to process overpayments.

MACs expressed concerns about the manual efforts to track and report overpayment collections and the room for error involved in the process

According to some MACs, the electronic Healthcare Integrated General Ledger Accounting System (HIGLAS) used by most MACs presents challenges for their tracking and reporting of collections associated with ZPIC/PSC referrals.[19] When asked about the challenges and barriers of the HIGLAS system, some MACs reported that the HIGLAS-generated collections report gives cumulative overpayment collection amounts, not monthly amounts. To produce the monthly report for ZPICs/PSCs, some MACs reported that they have to use the previous month's report and

[19] HIGLAS is the financial accounting system that processes payments for Medicare claims. Most MACs use the system to process and track overpayment collections and to help produce the monthly collection reports that they send to ZPICs and PSCs. DME MACs do not use HIGLAS.

manually go through each transaction to calculate the total collected for the current month. This manual effort requires additional time and increases the possibility of errors.

CONCLUSION AND RECOMMENDATIONS

This study is part of OIG's continued efforts to monitor CMS's progress in improving its identification, recovery, and tracking of overpayments. In this study, we found substantial variation in the amount of overpayments that ZPICs and PSCs referred, even after adjusting for differences in oversight responsibility. We also found that—while the collection rate for FY 2014 ZPIC- and PSC-referred overpayments has improved compared to the collection rate that OIG reported in 2010—MACs did not collect 80 percent of overpayment dollars they sought. Furthermore, the tracking of these overpayments remains a challenge for most MACs, ZPICs, and PSCs, and the discrepancies between the ZPIC- and PSC-reported data and the MAC-reported data continue to raise questions regarding the effectiveness of the procedures currently in place to track overpayments. These discrepancies raise concerns that overpayment dollars may be left unaccounted for and uncollected.

Given our findings, we recommend the following:

To improve identification of overpayments, CMS should share best practices across ZPICs and UPICs and address challenges that hinder their identification of overpayments

CMS should work with ZPICs and UPICs to identify best practices to improve the identification of overpayments. We found that referrals from two ZPICs accounted for half of the total overpayment dollars referred. We also found substantial variation in the amount of overpayments referred by ZPICs and PSCs even after adjusting for differences in oversight responsibility, i.e., the dollar amount of paid claims for which a given ZPIC has oversight. CMS should examine overpayment identification methods used by ZPICs and the UPIC to determine if there are best practices that other ZPICs and UPICs can use.

CMS should identify strategies to increase MACs' collection of ZPIC- and UPIC-referred overpayments

CMS should work with MACs to identify strategies to improve collection rates. CMS should examine the collection methods of MACs with the highest collection rates and determine if there are best practices or strategies that other MACs can use. CMS also should determine the barriers or challenges to collection that the MACs with the lowest collection rates are experiencing as a means to help identify strategies to improve these MACs' collection rates.

To improve overpayment tracking, CMS should work with ZPICs, UPICs, and MACs to create a standard report format both for overpayment referral reports and overpayment collection reports

ZPICs, UPICs, and MACs should receive the same types of information on referrals and collections to allow them to easily review and track the information they receive. In fact, 7 of the 10 ZPICs/PSCs specifically stated that they would prefer that MACs use a single standard format to report overpayment collections. CMS should work with ZPICs, UPICs, and MACs to create a standard report format both for referral and collection reports. This should include a standard report for referring overpayments that all ZPICs and UPICs use to send referral data to MACs, as well as a standard MAC collections report that all MACs use to send collections data to ZPICs and UPICs. Finally, these contractors should incorporate any updated tracking procedures into their joint operating agreements.

To improve overpayment tracking, CMS also should require ZPICs, UPICs, and MACs to use a unique identifier for each overpayment

Because there were discrepancies between ZPIC- and PSC-reported overpayment data and MAC-reported overpayment data, CMS should require all ZPICs, UPICs, and MACs to use a unique identifier or tracking number for each overpayment. A unique tracking number would allow ZPICs, UPICs, and MACs to more easily match collections data to the original referrals.

To increase the likelihood of overpayments being recovered, CMS should implement the surety bond requirement for home health providers and consider the feasibility of implementing surety bonds for other providers based on their level of risk

Overpayments referred by ZPICs and UPICs may involve providers who have been revoked or excluded from Medicare, which creates a challenge for MACs in their attempts to collect overpayments from these providers. To ensure that at least some money owed is collected from these providers, CMS could implement a surety bond requirement for additional providers. Federal law requires surety bonds specifically for DME and home health providers. CMS has implemented this requirement for DME providers but not for home health providers. Therefore, we recommend that CMS implement the statutory requirement for home health providers to have surety bonds. Furthermore, in addition to requiring surety bonds for DME and home health providers, the Secretary of HHS has the authority to require surety bonds for other providers based on their level of risk. CMS should consider implementing a surety bond requirement for other types of Medicare providers determined to be a high financial risk to the program. Previous OIG reports

found that the use of surety bonds could result in substantial recoveries for the Medicare program.[20]

[20] OIG, *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments*, OEI-03-12-00070, September 2012; OIG, *Surety Bonds Remain an Underutilized Tool to Protect Medicare From Supplier Overpayments*, OEI-03-11-0350, March 2013.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In response to our draft report, CMS noted its commitment to robust program integrity efforts in Medicare and highlighted some program integrity initiatives underway. CMS reported that it began transitioning the workload of ZPICs and PSCs to the UPICs. CMS believes that the UPICs' ability to look across the Medicare and Medicaid programs to pursue potential fraud, waste, and abuse; perform data analysis; and identify improper payments will enhance program integrity. To assist in its oversight, CMS is developing the Unified Case Management system. The Unified Case Management system supports cooperation and communication among regional program integrity contractors to ensure a national approach to trends that occur across regions.

CMS concurred with the first four of our five recommendations. CMS agreed that it will work to:

- identify and share best practices implemented by ZPICs and UPICs to enhance program integrity;
- identify strategies to increase MACs' collection of ZPIC-referred overpayments;
- create a standard reporting format for both overpayment referral reports and overpayment collection reports; and
- require a unique identifier for each overpayment.

In response to our fifth recommendation to implement the surety bond requirement for home health providers and consider implementing surety bonds for additional providers based on risk, CMS did not state whether it concurred or not. CMS reported that it is evaluating how to effectively implement a surety bond requirement while avoiding undue provider burden.

OIG believes that implementation of these recommendations—including the surety bond requirement—will improve the identification, recovery, and tracking of overpayments, thereby reducing waste and saving taxpayer dollars. We look forward to receiving updates from CMS on its progress toward these recommendations through the initiatives described.

The full text of CMS's comments can be found in Appendix D.

APPENDIX A

Exhibit A-1. Matrix of ZPICs/PSCs and Associated MAC Jurisdictions

ZPIC/PSC	Associated MACs (Including Types of Claims Processed by MAC)
ZPIC 1 Safeguard Services, LLC	JE—Noridian Healthcare Solutions, LLC (Part A, Part B) J6—National Government Services, Inc. (Home Health and Hospice) DME D—Noridian Healthcare Solutions, LLC (DME)
ZPIC 2 AdvanceMed Corporation	J5—Wisconsin Physicians Service Insurance Corporation (Part A, Part B) JF— Noridian Healthcare Solutions, LLC (Part A, Part B) JL—Novitas Solutions, Inc. (Part A) J6—National Government Services, Inc. (Home Health and Hospice) J15—CGS Administrators, LLC (Home Health and Hospice) DME D—Noridian Healthcare Solutions, LLC (DME)
ZPIC 3 AdvanceMed Corporation	J6—National Government Services, Inc. (Part A, Part B, Home Health and Hospice) J8— Wisconsin Physicians Service Insurance Corporation (Part A, Part B) J15—CGS Administrators, LLC (Part A, Part B) JM—Palmetto GBA, LLC (Home Health and Hospice) DME B—National Government Services, Inc. (DME)
ZPIC 4 Health Integrity	JH—Novitas Solutions, Inc. (Part A, Part B) J15—CGS Administrators, LLC (Home Health and Hospice) JM—Palmetto GBA, LLC (Home Health and Hospice) DME C—CGS Administrators, LLC (DME)
ZPIC 5 AdvanceMed Corporation	JM—Palmetto GBA, LLC (Part A, Part B, Home Health and Hospice) JJ—Cahaba Government Benefit Administrators, LLC (Part A, Part B) JH—Novitas Solutions, Inc. (Part A, Part B) J15—CGS Administrators, LLC (Home Health and Hospice) DME C—CGS Administrators, LLC (DME)
ZPIC 7 Safeguard Services	JN—First Coast Service Options, Inc. (Part A, Part B) J6—National Government Services, Inc. (Home Health and Hospice) JM—Palmetto GBA, LLC (Home Health and Hospice) DME C—CGS Administrators, LLC (DME)

Continued on next page

Exhibit A-1. Matrix of ZPICs/PSCs and Associated MAC Jurisdictions (continued)

ZPIC/PSC	Associated MACs (Including Types of Claims Processed by MAC)
New England Benefit Integrity Support Center PSC (NE BISC) Safeguard Services	J6—National Government Services, Inc. (Home Health and Hospice) JK—National Government Services, Inc. (Part A, Part B, Home Health and Hospice) JL—Novitas Solutions, Inc. (Part A, Part B) J15—CGS Administrators, LLC (Home Health and Hospice)
Eastern Benefit Integrity Support Center PSC (EA BISC) Safeguard Services	JK—National Government Services, Inc. (Part A, Part B) JL—Novitas Solutions, Inc. (Part A, Part B)
Pennsylvania Benefit Integrity Support Center PSC (PA BISC) Safeguard Services	JL—Novitas Solutions, Inc. (Part A, Part B)
DME PSC TriCenturion	DME A—NHIC, Inc. (DME)

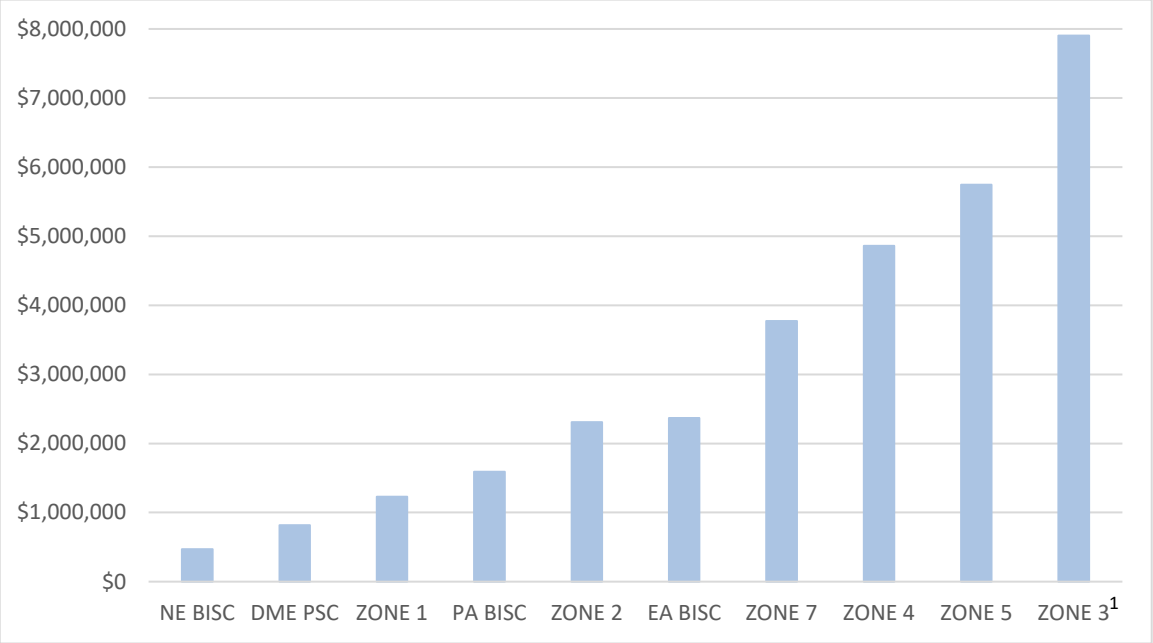
Source: OIG summary of ZPIC, PSC, and MAC information from CMS.

APPENDIX B

Amount of Overpayments Referred per $1 Million Paid to ZPICs and PSCs

There was substantial variation in the amount of overpayments that ZPICs and PSCs referred for all task orders even after adjusting for differences in the amount that ZPICs and PSCs were paid to perform their tasks. ZPICs and PSCs were paid between $4.3 million and $32.7 million in FY 2014. After adjusting for these differences, the amount of overpayments referred ranged from $469,451 (NE BISC) to almost $8 million (ZPIC 3) for every $1 million paid to ZPICs and PSCs. Exhibit B-1 shows the amount of overpayments each ZPIC and PSC referred for all task orders per $1 million paid for their tasks.

Exhibit B-1. Amount of Overpayments Referred for All Task Orders per $1 Million Paid to ZPICs and PSCs



Source: OIG analysis of ZPIC and PSC data for overpayments referred in FY 2014.

[1] Because ZPIC 3 was unable to report overpayment referral data for FY 2014, we used the overpayment referral data reported by its associated MACs to calculate the amount referred.

APPENDIX C

Comparison of ZPIC/PSC-Reported and MAC-Reported Data on FY 2014 ZPIC and PSC Overpayment Referrals to MACs

Exhibit C-1. Comparison of Referral Amounts Reported by ZPICs/PSCs and MACs for FY 2014[1]

ZPIC/PSC	Associated MAC	Amount Reported by ZPIC/PSC	Amount Reported by MAC	Difference
DME PSC	DME A	$3,522,088	$3,167,527	$354,561
EA BISC PSC	JL	$850,295	$1,115,354	$265,059
EA BISC PSC	JK	$30,396,215	$38,230,990	$7,834,775
NE BISC PSC	J15	$108,468	$137,421	$28,953
NE BISC PSC	JK	$2,134,212	$1,857,258	$276,954
NE BISC PSC	JL	$1,282,523	$1,282,595	$73
NE BISC PSC	J6	$0	$0	$0
PA BISC PSC	JL	$11,512,991	$12,411,360	$898,368
ZPIC 1	DME D	$4,154,370	$21,436,076	$17,281,706
ZPIC 1	J6	$11,562,204	$32,850,298	$21,288,094
ZPIC 1	JE	$1,864,999	$1,958,447	$93,448
ZPIC 2	J6	$1,144,524	$334,504	$810,020
ZPIC 2	J5	$13,401,445	$15,672,844	$2,271,399
ZPIC 2	JF	$13,803,644	$16,046,836	$2,243,192
ZPIC 2	J15	$5,019,906	$5,829,926	$810,020
ZPIC 2	DME D	$5,978,874	$5,981,790	$2,915
ZPIC 2	JL	$177,710	$177,710	$0
ZPIC 4	JM	$27,354,494	$19,772,483	$7,582,010
ZPIC 4	JH	$46,788,709	$50,992,555	$4,203,847
ZPIC 4	DME C	$6,170,543	$6,385,115	$214,572
ZPIC 4	J15	$0	$0	$0
ZPIC 5	JJ	$25,197,294	$43,212,671	$18,015,377
ZPIC 5	JM	$94,642,618	$62,231,299	$32,411,319
ZPIC 5	DME C	$8,956,687	$6,569,398	$2,387,289
ZPIC 5	JH	$15,585,476	$14,052,030	$1,533,445
ZPIC 5	J15	$14,874,389	$14,885,206	$10,817
ZPIC 7	J6	$622,519	$104,073	$518,446
ZPIC 7	JM	$85,128,914	$78,102,303	$7,026,611
ZPIC 7	DME C	$10,804,973	$11,357,341	$552,367
ZPIC 7	JN	$26,692,947	$27,976,970	$1,284,023
Total		**$469,734,030**[2]	**$494,132,379**[2]	**$130,199,659**[3]

Source: OIG analysis of ZPIC, PSC, and MAC referral data for overpayments referred by ZPICs and PSCs in FY 2014.

[1] The current ZPIC 3 contractor was not operational in FY 2014 and was unable to provide overpayment data for this timeframe.

[2] The referral amounts do not add up to the total because of rounding.

[3] This column shows the absolute difference between the referral amounts reported by the ZPICs/PSCs and the MACs; therefore, the total of $130 million is the sum of all the differences. The total net difference between the ZPIC/PSC- and MAC-reported amounts was $24 million.

Exhibit C-2. Comparison of Referral Numbers Reported by ZPICs/PSCs and MACs for FY 2014[1]

ZPIC/PSC	Associated MAC	Number Reported by ZPIC/PSC	Number Reported by MAC	Difference
DME PSC	DME A	40	50	10
EA BISC PSC	JL	86	102	16
EA BISC PSC	JK	127	171	44
NE BISC PSC	J15	1	2	1
NE BISC PSC	JK	44	42	2
NE BISC PSC	JL	23	25	2
NE BISC PSC	J6	0	0	0
PA BISC PSC	JL	98	115	17
ZPIC 1	DME D	51	81	30
ZPIC 1	J6	10	16	6
ZPIC 1	JE	32	28	4
ZPIC 2	J6	2	1	1
ZPIC 2	J5	45	42	3
ZPIC 2	JF	306	293	13
ZPIC 2	J15	5	6	1
ZPIC 2	DME D	43	42	1
ZPIC 2	JL	1	1	0
ZPIC 4	JM	40	51	11
ZPIC 4	JH	82	94	12
ZPIC 4	DME C	10	16	6
ZPIC 4	J15	0	0	0
ZPIC 5	JJ	660	619	41
ZPIC 5	JM	786	656	130
ZPIC 5	DME C	780	795	15
ZPIC 5	JH	337	321	16
ZPIC 5	J15	19	20	1
ZPIC 7	J6	5	3	2
ZPIC 7	JM	86	86	0
ZPIC 7	DME C	107	40	67
ZPIC 7	JN	133	77	56
Total		**3,959**	**3,795**	**508**[2]

Source: OIG analysis of ZPIC, PSC, and MAC referral data for overpayments referred by ZPICs and PSCs in FY 2014.

[1] The current ZPIC 3 contractor was not operational in FY 2014 and was unable to provide overpayment data for this timeframe.

[2] This column shows the absolute difference between the referral numbers reported by the ZPICs/PSCs and the MACs; therefore, the total of 508 is the sum of all the differences. The total net difference between the ZPIC/PSC- and MAC-reported numbers was 164.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUL 28 2017

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by Zone Program Integrity Contractors and Program Safeguard Contractors, OEI-03-13-00630

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to robust program integrity efforts in Medicare.

CMS has implemented several initiatives to investigate and eliminate fraud, waste, and abuse in the Medicare program. As OIG noted, CMS contracted with Zone Program Integrity Contractors and Program Safeguard Contractors to investigate instances of suspected fraud, waste, and abuse in the Part A and Part B programs. Each Zone Program Integrity Contractor and Program Safeguard Contractor investigates cases in its assigned region. The Zone Program Integrity Contractors and Program Safeguard Contractors identify and develop cases of suspected fraud and take action to ensure that Medicare Trust Fund monies are not paid inappropriately. These contractors perform data analysis to identify inappropriate activity, refer cases to law enforcement or take administrative action as appropriate, support ongoing law enforcement investigations, and identify improper payments to be corrected.

CMS engages in comprehensive oversight of contractors through recurring meetings with senior management and key personnel from each Zone Program Integrity Contractor and Program Safeguard Contractor to discuss CMS' goals and strategies, and aligning contractor activities to these goals. In addition, CMS performs quarterly evaluations of these contractors to provide timely feedback and oversight. To assist in oversight and operations, CMS is developing the Unified Case Management system. The Unified Case Management system supports cooperation and communication between regional program integrity contractors to ensure a national approach to providers or trends that cut across regions. The Unified Case Management system will provide the capability to track leads, audits, and investigations, capture and manage workflow activities, report workload metrics, report status of administrative actions and referrals to law enforcement, and record outcomes or disposition of CMS program integrity audit and investigative actions across Medicare and Medicaid programs.

In July 2016, CMS began transitioning the Zone Program Integrity Contractors' and Program Safeguard Contractors' workload to Unified Program Integrity Contractors with the award of the

first Unified Program Integrity Contractor contract. The Unified Program Integrity Contractors consolidate the Medicare and Medicaid program integrity functions currently performed by the Zone Program Integrity Contractors and Program Safeguard Contractors. CMS believes the Unified Program Integrity Contractors' ability to look across Medicare and Medicaid programs to pursue potential fraud, waste, and abuse, perform data analysis, and identify improper payments will enhance program integrity.

OIG's recommendations and CMS' responses are below.

OIG Recommendation
To improve Zone Program Integrity Contractors' and Program Safeguard Contractors' identification of overpayments, CMS should share best practices across Zone Program Integrity Contractors and Program Safeguard Contractors and address challenges that hinder their identification of overpayments.

CMS Response
CMS concurs with this recommendation. CMS will work to identify and share best practices implemented by Zone Program Integrity Contractors and Unified Program Integrity Contractors to enhance program integrity.

OIG Recommendation
CMS should identify strategies to increase Medicare Administrative Contractors' collection of Zone Program Integrity Contractor-referred overpayments.

CMS Response
CMS concurs with this recommendation. CMS will work to identify strategies to increase Medicare Administrative Contractors' collection of Zone Program Integrity Contractor-referred overpayments.

OIG Recommendation
To improve overpayment tracking, CMS should work with Zone Program Integrity Contractors, Program Safeguard Contractors and Medicare Administrative Contractors to create a standard report format for both overpayment referral reports and overpayment collection reports.

CMS Response
CMS concurs with this recommendation. CMS will work to create a standard reporting format for both overpayment referral reports and overpayment collection reports.

OIG Recommendation
To improve overpayment tracking, CMS also should require Zone Program Integrity Contractors, Program Safeguard Contractors and Medicare Administrative Contractors to use a unique identifier for each overpayment.

CMS Response

CMS concurs with this recommendation. CMS will work to require Zone Program Integrity Contractors, Unified Program Integrity Contractors and Medicare Administrative Contractors to use a unique identifier for each overpayment.

OIG Recommendation

To increase the likelihood of overpayments being recovered, CMS should implement the surety bond requirement for home health providers and consider the feasibility of implementing surety bonds for other providers based on their level of risk.

CMS Response

CMS is currently evaluating how to effectively implement a surety bond requirement while avoiding undue provider burden.

ACKNOWLEDGMENTS

Maria Schepise Johnson served as the team leader for this study. Others in the Office of Evaluation and Inspections who conducted the study include Jacqualine Reid. Office of Evaluation and Inspections staff who provided support include Joe Chiarenzelli, Kevin Farber, Lucia Fort, Evan Godfrey, and Christine Moritz.

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

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of individuals served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and individuals. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.