

OFFICE OF INSPECTOR GENERAL

Management Information Report

Railroad Medicare Progress and Challenges

Report No. 14-09

July 25, 2014



RAILROAD RETIREMENT BOARD

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INTRODUCTION

This management information report presents the results of the Office of Inspector General's (OIG) review of the progress and challenges of Railroad Medicare.

Background

Beginning in April 2000, the Railroad Retirement Board (RRB) contracted with Palmetto GBA, LLC (Palmetto) to process nationwide Railroad Medicare Part B claims. An appropriations law restriction prohibited the Railroad Retirement Board Office of Inspector General (RRB-OIG) from conducting oversight of the Railroad Medicare program until December 2007. During this period of approximately eight years, Palmetto was not subject to OIG audits or investigations as required by law for Medicare contractors.

Since the restoration of its oversight authority, the RRB-OIG performed six audits of Palmetto, with each revealing significant program weaknesses and control vulnerabilities. During fiscal year (FY) 2013, the Centers for Medicare & Medicaid Services (CMS) designated Palmetto as a Specialty Medicare Administrative Contractor (SMAC). Palmetto's revised contract provided additional resources for addressing some of the weaknesses identified by the RRB-OIG.

Objective

The objective of this review was to assess Railroad Medicare's program administration and oversight since Palmetto's designation as a SMAC.

Scope

The scope of this review was the Railroad Medicare SMAC operations as of March 2014, and open audit recommendations issued from FY 2009 through FY 2013.

Methodology

To accomplish our objective, we:

- performed a walkthrough of Palmetto's Railroad Medicare operations;
- conducted interviews and roundtable discussions with key officials;
- acquired and reviewed SMAC work instructions; and
- discussed concerns and prior audit findings with Palmetto's internal audit office.

We conducted our fieldwork at the RRB's headquarters in Chicago, Illinois from January 2014 through May 2014, and at Palmetto's Augusta, Georgia facility during March 2014.

RESULTS OF REVIEW

Our review found that Palmetto made progress towards improving its claims processing control environment through technical innovation and resource deployment. However, Palmetto's program, budgetary, system, and resource limitations continue to restrict progress and its organizational communication and operational processes can be further refined to minimize improper payments. In addition, the RRB has not always implemented Railroad Medicare corrective actions in an expeditious manner. Both the RRB and Palmetto must address these challenges to minimize improper payments and adapt to future program and organizational change. The progress and challenges identified during our review are discussed below.

Progress

Palmetto Has Made Progress to Strengthen Its Control Environment

Palmetto strengthened its control environment through innovation and resource deployment. During FY 2013, Palmetto completed its SMAC transition and in FY 2014 entered year one of its option contract. Palmetto implemented a number of technical innovations and applied SMAC resources in areas where improper payments can be minimized. According to Palmetto, these innovations will result in:

- increased medical necessity control;
- automated medical record processing;
- strengthened user access controls;
- expedited pre-payment reviews;
- improved medical review decisions;
- increased electronic workflow;
- refined provider and beneficiary customer service; and
- automated duplicate billing review.

Additionally, Palmetto stated that pending innovations would:

- improve predictive modeling and provider profiling;
- enhance provider communication and education;
- increase the efficiency of medical review processing;
- minimize claims appeal errors;
- expedite processing of payments and outstanding debts;
- reduce human transaction errors; and
- decrease document processing time using electronic workflow.

Palmetto concluded that these innovation and resource efforts would minimize operational costs and increase efficiency.

Challenges

Zone Program Integrity Contractor Resources Are Not Readily Accessible

Railroad Medicare has not benefited from the efforts of the Zone Program Integrity Contractors (ZPIC). Palmetto officials stated that it has been difficult to obtain responses to their inquiries and acquire regional fraud and abuse information. The difficulty in obtaining responses occurred because communication between Palmetto and the ZPICs was not properly established.¹

According to Palmetto's statement of work, the benefit integrity unit will use available tools to ensure coordination and prevent duplication of effort. As part of its coordination activities, the SMAC shall participate in information sharing sessions with the ZPIC data users group.

Although Palmetto had been classified as a SMAC, the Railroad Medicare program was never assigned to a ZPIC. As a result, when Palmetto requested information from the ZPICs to prevent improper payments it was not readily available. In addition, the ZPICs have not proactively released information regarding suspect providers to Palmetto. They did not release the information because the ZPICs consider Railroad Medicare inquiries and referrals to be outside of their assigned workload.

¹ The ZPICs are comprised of dedicated teams of investigators, data analysts, and medical reviewers – all performing a range of actions to examine potential fraud. ZPIC investigators conduct provider audits, make site visits to suspect providers' offices, and interview Medicare beneficiaries. ZPIC data analysts, including statisticians, examine Medicare claims and other data to support investigations and search for fraudulent transactions and improper payments. ZPIC medical reviewers, primarily nurses, provide clinical knowledge to support the work of investigators and data analysts.

Without proper communication, providers enrolled in both Medicare and Railroad Medicare could receive improper payments from either program; however, neither Palmetto nor the ZPIC would detect the improper payments.

Recommendations

We recommend that the Office of Programs work with Palmetto to:

1. establish a system of communication and information sharing with the ZPICs; and
2. determine if Railroad Medicare inquiries and referrals can be directly assigned to a ZPIC.

Management's Response to Recommendation No. 1

The Office of Programs concurred with our recommendation. The Office of Programs stated that the CMS contacted Palmetto and the RRB in 2013 to discuss developing a partnership with the ZPIC to ensure that Medicare overpayments are pursued for RRB beneficiaries. CMS is currently working on a joint operating agreement between the RRB SMAC and the ZPIC.

Management's Response to Recommendation No. 2

The Office of Programs did not concur with our recommendation. The Office of Programs stated that the RRB SMAC performs its own benefit integrity activities. Similar to the ZPICs, the RRB SMAC identifies and investigates program vulnerabilities and determines patterns of fraud. The RRB SMAC also examines Medicare claims and other data to support investigations and search for fraudulent transactions and improper payments. The RRB SMAC follows CMS' guidelines found in the Internet-Only Manual Publication 100-08, Chapter 4, Section 4.18.1.1.

RRB-OIG's Comments on Management's Response

This recommendation is intended to strengthen Palmetto's benefit integrity efforts and minimize improper payments efficiently. At the time of our review, Palmetto's benefit integrity unit doesn't have the same capabilities as a ZPIC. Palmetto's benefit integrity unit is staffed with three personnel; while the regional ZPICs are comprised of dedicated teams of investigators, data analysts, and medical reviewers – all performing a range of actions to examine potential fraud. ZPIC investigators conduct provider audits, make site visits to suspect providers' offices, and interview Medicare beneficiaries. ZPIC data analysts, including statisticians, examine Medicare claims and other data to support investigations and search for fraudulent transactions and improper payments.

Additionally, Palmetto's benefit integrity unit is being tasked with assignments that do not always support its improper payment initiatives or fraud investigations. Further, Palmetto doesn't have access to the same information as the nationwide ZPICs, which limits its ability to analyze the integrity of Railroad Medicare claims data and conduct fraud investigations. If the Railroad Medicare program was assigned to a ZPIC, improper payments could be further reduced.

Palmetto's Inability to Participate in the Comprehensive Error Rate Testing Program Has Impacted Oversight

The Railroad Medicare program's exclusion from the Comprehensive Error Rate Testing (CERT) program and resulting lack of benchmarks weakened oversight.² CMS declined the RRB's FY 2011 request that Railroad Medicare be included as a participant in the CERT program.

Palmetto and RRB officials expressed disappointment regarding CMS' decision, but stated that participation may not be feasible. These officials indicated that because of the differences in Railroad Medicare and Medicare Administrative Contractor (MAC) claims volume and sample sizes, CERT national error rates would not be equivalent to Railroad Medicare error rates. Further, Railroad Medicare claims are processed based on national coverage determinations; whereas, MAC claims are processed based on local coverage determinations. However, the Medicare Statistical Analysis Department (MSAD) agreed that the CERT national error rates would be the best estimate if Railroad Medicare's actual error rates cannot be determined.

According to Palmetto's statement of work, the RRB SMAC shall work with CMS to interface with programs, including CERT. Participation in the CERT allows contractors to quantify payments that do not meet Medicare requirements.

If Railroad Medicare does not participate in the CERT program, Palmetto will not have adequate error rate benchmarks to measure future progress and identify improper payments.

Recommendations

We recommend that the Office of Programs request that Palmetto:

3. issue an appeal to CMS for inclusion in the CERT program, stressing the impact on oversight of the Railroad Medicare program; and
4. apply CERT national error rates of comparable claim types during the medical review and benefit integrity process, to identify additional improper payments.

² CMS implemented the CERT program to measure improper payments in the Medicare Fee-for-Service program. CERT is designed to comply with the Improper Payments Information Act (IPIA) of 2002, as amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.

Management's Response to Recommendation No. 3

The Office of Programs concurred with our recommendation. The Office of Programs stated that CMS has already agreed to review and coordinate with the RRB how and when the CMS CERT program will apply to the RRB SMAC.

Management's Response to Recommendation No. 4

The Office of Programs did not concur with our recommendation. The Office of Programs stated that on page 4 of the study, "Palmetto does not find participation feasible with applying the CERT national error rate for comparable services in the RRB SMAC program." The OIG further explains the reasons that Palmetto disagrees with using the CERT error rate; referencing the inclusion of Local Coverage Determinations in a MAC's CERT error rate and the differences in claims processing volumes and sample sizes between the MAC and the RRB SMAC. Although the Office of Programs did not concur with this recommendation, it will have Palmetto use the National CERT report for analysis and, if applicable, incorporate those findings into their Medical Review strategy. The Office of Programs will have Palmetto continue this process until such time that the RRB SMAC is approved for participation in the CERT program.

RRB-OIG's Comments on Management's Response

While the Office of Programs did not concur with our recommendation, its proposed action to have Palmetto use the National CERT report for analysis and, if applicable, incorporate those findings into their Medical Review strategy addresses the intent of our recommendation. Palmetto's MSAD supported the use of the CERT error rates as a best estimate.

Palmetto's Cross Unit Communication and Fraud Referral Process Can Be Improved

Palmetto has not established optimal communication between its key fraud and abuse units. During our review, we observed that fraud referrals had not been shared between the provider enrollment, medical review, benefit integrity, and Medicare secondary payer units.

Additionally, these units were not exchanging information about current fraud scenarios and trends in the Medicare program. Communication was not optimal because knowledge sharing was lacking between key units.

According to the U.S. Government Accountability Office's (GAO) report, *Standards for Internal Control in the Federal Government*, dated November 1999, one of the five standards for internal control is information and communication. The report states, "Information should be recorded and communicated to management and others within the entity who need it and in a form and within a timeframe that enables them to carry out their responsibilities. Effective communications should occur in a broad sense with information flowing down, across, and up the organization."

If communication is not optimal, Palmetto units could be duplicating their efforts and failing to respond to fraud indicators. Greater cross unit communication would positively influence operational efficiency and increase the identification of fraud and abuse.

Recommendation

5. We recommend that the Office of Programs ensure that Palmetto periodically conducts meetings and training with key fraud and abuse units including provider enrollment, medical review, benefit integrity, and Medicare secondary payer.

Management's Response to Recommendation No. 5

The Office of Programs concurred with our recommendation. The Office of Programs stated that Palmetto's Railroad Medicare Benefit Integrity unit would work with their corporate training department to expand the current technology based training activities. Training classes and discussions will be conducted for key ancillary units to promote fraud and abuse awareness and highlight potential problem areas of fraud within the Medicare program.

Specialized Nurse Clinicians Are Needed to Detect Fraud and Abuse

Palmetto can strengthen its medical review process and its efforts to reduce fraud and abuse by employing nurse clinicians with specialized experience in fraud and abuse intensive specialties. Specialized experience is important because specialized areas such as physical therapy, mental health, sleep medicine, and chemotherapy are experiencing high rates of improper payments. In lieu of specialized experience, continuing education in areas such as medical auditing and specialized medical coding would also be beneficial. Nurse clinicians support both the medical review and benefit integrity units by reviewing medical records, examining procedural coding, and identifying suspect and high-risk claims and services.

Palmetto increased its medical review staff by recruiting additional nurse clinicians.³ However, the nurse clinicians do not have specialized experience because Palmetto did not make it a requirement during their recruitment.

³ In FY 2013, Palmetto employed 14 medical review nurses, which was an increase of 600 percent from the 2 nurses employed during FY 2012.

Without specialized experience, fraud detection efforts are weakened. For example, a nurse clinician with background in sleep medicine may be unable to identify a complex fraud scenario involving outpatient surgical procedures or chemotherapy.

Recommendations

We recommend that the Office of Programs work with Palmetto to:

6. develop and implement a comprehensive fraud training plan for the nurse clinician staff that addresses medical procedures with an inherent risk of fraud; and
7. evaluate the current nurse clinician staff's medical experience during the recruitment process and determine how specialized nurse clinician experience could be used to minimize improper payments.

Management's Response to Recommendation No. 6

The Office of Programs concurred with our recommendation. The Office of Programs stated that the Medical Review manager has extensive experience in the field of fraud and abuse investigation and will work in collaboration with the Benefit Integrity manager. Together they will provide the clinical staff with information gathered from the annual CMS Medical Review Operational Meeting as well as the annual National Health Care Anti-Fraud Association conference.

Management's Response to Recommendation No. 7

The Office of Programs did not concur with our recommendation. The Office of Programs stated that the RRB SMAC Medical Review clinical staff has an extensive range of clinical experience, covering multiple specialties and clinical areas. Palmetto hires clinical staff according to the direction supplied in the Internet-Only Manual Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.1.1. While it is impossible to predict where the latest focus for fraud will originate; the wide variety of experience held by Palmetto's clinical staff makes it possible to cover the spectrum of multiple areas of vulnerability.

RRB-OIG's Comments on Management's Response

This recommendation is intended to strengthen Palmetto's medical review process and its efforts to reduce fraud and abuse. GAO identifies staff training as a key element in any effort to prevent improper payments from occurring. During our site visit, Palmetto indicated that nurse clinician experience was lacking in evolving areas of fraud and abuse. Therefore, we continue to recommend that, where deficiencies are present, Palmetto recruit and hire nurse clinicians with specialized clinical knowledge and experience that can be used to deter fraud and abuse.

Palmetto Was Not Using the Healthcare Integrated General Ledger Accounting System for Railroad Medicare

The Railroad Medicare program has not benefited from the use of the standardized CMS Healthcare Integrated General Ledger Accounting System (HIGLAS). While Palmetto officials expressed immediate interest in the HIGLAS, Railroad Medicare implementation may not occur for several years due to contractor resource limitations.

The HIGLAS provides greater transaction detail and additional edits that ensure the integrity of the claims processing system's data prior to issuing payments to providers. The HIGLAS can generate automated demand letters and the system's overpayment data is exportable for further investigative analysis. Palmetto officials stated that HIGLAS resulted in notable benefits in financial reporting capability when used with its other Medicare contract.

According to Palmetto's statement of work, Palmetto should be using the HIGLAS for its processing of provider claims. The RRB anticipated transition of the RRB SMAC to the HIGLAS in FY 2012; however, the transition to HIGLAS has not yet occurred.

GAO's November 1999 report *Standards for Internal Control in the Federal Government*, states that one of the five standards for internal control is information and communication. Program managers need both operational and financial data to determine whether they are meeting their agency's strategic and annual performance plans and accountability goals.

Because Palmetto could not use HIGLAS for Railroad Medicare, system compatibility, operational efficiency, and fraud detection were not maximized.

Recommendation

8. We recommend that the Office of Programs work with Palmetto and CMS to expedite the implementation of the HIGLAS for Railroad Medicare.

Management's Response to Recommendation No. 8

The Office of Programs concurred with our recommendation. The Office of Programs stated that a tentative time frame has been established with CMS on the HIGLAS implementation. CMS has agreed that the RRB SMAC would migrate to HIGLAS once the Affordable Care Act changes were completed and the Durable Medical Equipment MACs were migrated to HIGLAS.

Palmetto's Medicare Secondary Payer Controls Do Not Ensure the Identification of Abusive Billing Practices

Palmetto had not established a control process for identifying providers with a frequent pattern of submitting claims to both the primary insurer and Medicare. Although Medicare Secondary Payer (MSP) data and statistics were readily available, Palmetto did not use the information to identify suspicious claim patterns. A control process was not in place because Palmetto did not assess the potential for MSP fraud and abuse.

During our review, we determined that Palmetto's MSP claims are a potential target for abusive billing practices. When a private insurer is responsible for healthcare coverage, Medicare as the secondary payer may not be responsible for payment of the claim or may be responsible for only a portion of the claim. Medicare claims inadvertently paid by both the primary insurer and Medicare are subject to recovery by Medicare.

Palmetto's statement of work requires that it support the RRB and its field offices in their efforts to combat fraud and abuse.

Since Palmetto had not established an MSP process to identify patterns of abuse, providers could invest the duplicate payments for personal financial gain until insurer litigation is completed and recovery actions are taken.

Recommendation

9. We recommend that the Office of Programs work with Palmetto to establish a process for identifying providers who are frequently involved in MSP recoveries and referring these providers to the provider education and benefit integrity units for monitoring and follow-up action.

Management's Response to Recommendation No. 9

The Office of Programs did not concur with our recommendation. The Office of Programs stated that CMS' purpose to centralize the Benefits Coordination and Recovery Center contractor (BCRC) operation was to ensure the integrity of the Medicare Trust funds. CMS assigned responsibility to the BCRC for MSP recoveries resulting from liability claims. All MACs as well as Palmetto have been instructed to refer all inquiries related to the collection of debts related to Auto, No Fault, Workers Compensation, or Liability to the BCRC to be researched. The BCRC will take the appropriate action based on the outcome of the research for each scenario previously listed.

RRB-OIG's Comments on Management's Response

Information concerning the abilities of the BCRC to address providers who are frequently involved in MSP recoveries was not brought forward during our site visit. We will consider the BCRC's effectiveness in preventing abusive MSP billing practices during future audits

Greater Resources and Increased Data Analysis Can Further Minimize Improper Payments

The Palmetto MSAD had not fully applied its data analysis resources to minimize Railroad Medicare claims error rates. Palmetto officials indicated that MSAD could do more to identify improper payments if its budget allocation provided additional resources for data analysis. For example, additional MSAD data mining and analysis could further:

- identify aberrant coding and service patterns;
- refer questionable providers and claims to medical review or benefit integrity for further investigation; and
- prevent improper payments before they occur.

Palmetto also indicated that overpayment data by location and provider type was collected; however, it had not been used for data analysis.

The necessary resources were not available because of Palmetto's limited contract budget, which establishes its allowable costs.

The MSAD's data analysis resources are critical to Palmetto's enrollment, medical review, and benefit integrity efforts. Palmetto has used the past results of its analysis to increase the performance of these units. Therefore, Palmetto should strive to maximize its MSAD efforts, while maintaining its cost competitiveness as a claims processor. If Railroad Medicare does not receive adequate budgetary resources, it cannot maximize its MSAD analysis to reduce claims error rates.

Recommendation

10. We recommend that the Office of Programs and Palmetto conduct a cost benefit analysis to determine the optimal budgetary resources needed for MSAD data analysis directed toward minimizing fraud and improper payments.

Management's Response to Recommendation No. 10

The Office of Programs did not concur with our recommendation. The Office of Programs stated that they would like further clarification on this recommendation. Presently, the recommendation does not accurately describe Palmetto's utilization of MSAD resources or the effectiveness of the services they provide to the Railroad Medicare operation. The budget that was requested by Palmetto and approved by the RRB for option year 1 for MSAD services has allowed Palmetto to implement a successful, data-driven medical review program. MSAD reports are highly relied upon to assist with identifying potential vulnerabilities within the Railroad Medicare program.

RRB-OIG's Comments on Management's Response

The recommendation is intended to have Palmetto maximize its MSAD analysis to reduce Railroad Medicare claims error rates. According to MSAD, the department could expand its capability to identify improper payments if Palmetto allocated additional resources for data analysis. MSAD's data analysis is critical to Palmetto's enrollment, medical review, and benefit integrity efforts. Expanded efforts support the need to further reduce improper payments.

Returned Provider and Beneficiary Mailings Are Not Used to Generate Fraud Referrals

Palmetto's returned mail was not being used as a resource for investigative referrals. Our review determined that Palmetto's returned provider remittances and Medicare summary notices (MSNs) were not being referred to the benefit integrity unit for follow-up action. While Palmetto officials indicated that benefit integrity referrals should be an option for returned mailings; CMS procedure did not require their referral.

We determined that Palmetto receives significant volumes of returned mail classified as "do not forward" for both Railroad Medicare providers and beneficiaries. During the five month period from October 2013 through February 2014, Palmetto's undeliverable returned mail volume included 3,586 beneficiary MSNs and 2,707 provider remittances.

Palmetto's process for handling returned mail consisted of:

- determining if a different address is provided on the MAC Provider Enrollment, Chain and Ownership System record;
- forwarding the returned mail to a new address; or
- flagging the record as do not forward if a new address isn't found.

Since Palmetto's returned remittances and MSNs were not referred to the benefit integrity unit, opportunities for the identification of fictitious providers or practice locations could be missed. Similarly, the beneficiary can't review their claims for improper or fraudulent charges.

In response to our concerns, Palmetto officials stated that they would proactively modify their returned mail work instructions to process future remittance and MSN investigative referrals.

Recommendation

11. We recommend that the Office of Programs ensure that Palmetto modifies their returned mail process to include benefit integrity referrals.

Management's Response to Recommendation No. 11

The Office of Programs concurred with our recommendation. The Office of Programs stated that the Office of Programs would work with Palmetto to modify the returned mail process to incorporate referrals to the Benefit Integrity unit.

Corrective Actions Have Increased but Significant Recommendations Remain Open

Railroad Medicare recommendations for corrective action was not always addressed in a timely manner. The Office of Programs and Palmetto completed corrective actions addressing 18 of the 22 recommendations issued by our office since 2009. However, the Office of Administration has not introduced any form of corrective action addressing 23 recommendations issued since September 2011.⁴ According to the Office of Administration, this occurred because higher priority projects prevented an in-depth review of Palmetto's new SMAC contract.

The Office of Management and Budget requires agencies to assign a high priority to the resolution of audit recommendations and to corrective action. Systems for resolution and corrective action must meet the following standard:

Require prompt resolution and corrective actions on audit recommendations. Resolution shall be made within a maximum of six months after issuance of a final report or, in the case of audits performed by non-Federal auditors, 6 months after receipt of the report by the Federal Government. Corrective action should proceed as rapidly as possible.⁵

⁴ Since 2009, our office conducted six Railroad Medicare audits and issued 54 recommendations to the RRB and Palmetto. Of the 54 recommendations, 6 were rejected by the Office of Programs, 2 were rejected by Palmetto, and 1 was rejected by the Office of Administration. As of May 2014, there were 27 open recommendations directed toward Railroad Medicare program improvements.

⁵ OMB Circular No. A-50 Revised, *Audit Followup*, September 29, 1982.

Implementing recommendations is a Congressional concern. The Committee on Oversight and Government Reform oversees and supports the work of the Federal inspectors general (IG) and is positioned to hold agencies accountable that choose to ignore or otherwise fail to implement cost saving measures. In its March 2013 report, *Open and Unimplemented IG Recommendations Could Save Taxpayers \$67 Billion*, the committee reported that the backlog for implementing IG recommendations has reached an all-time high, and the volume of recommendations that remain unimplemented continues to increase every year. The report suggests that if evidence continues to mount that the government is dismissive of the work of the IG community, Congress should aggressively incorporate unimplemented recommendations into legislative actions.

Recommendation

12. We recommend that the Office of Administration re-evaluate its audit follow-up process to ensure that open recommendations are closed in a timely manner.

Management's Response to Recommendation No. 12

The Office of Administration concurred with our recommendation. The Office of Administration stated that they were working aggressively to provide much needed human capital resources, depleted by separations, in the acquisition management area and will move to begin addressing the open recommendations.

Proposed Changes in Medicare Program Structure Will Require Advanced Planning

Palmetto had not received sufficient planning information detailing the upcoming transition to Unified Program Integrity Contractors (UPIC) and the impact on Railroad Medicare operations.⁶ Information concerning the UPIC transition is limited because the program is in the development phase.

The UPIC transition will likely pose both an opportunity and a challenge for Palmetto. For example, Medicare is subject to frequent program changes, system updates, and security enhancements. Palmetto officials stated many of these modifications require Palmetto to modify its work instructions and processes. While the UPIC program will integrate the program integrity functions across Medicare and Medicaid, it may also affect Palmetto's operational processes.

⁶ The UPIC program will support the Center for Program Integrity's national priorities for both Medicare and Medicaid. The scope of the UPICs will encompass functions performed by several contractors, including: ZPICs, Medicare-Medicaid Data Match, the former Program Safeguard Contractors, and the Medicaid Integrity Contractors. UPICs will operate based on regional jurisdictions, with a single contractor conducting Medicare and Medicaid program integrity audits and investigations. An implementation schedule for the UPIC program is to be established.

If Palmetto does not receive timely information, Railroad Medicare may not receive adequate representation in the UPIC program or have adequate response time.

Recommendation

13. We recommend that the Office of Programs work with Palmetto to acquire UPIC program information in a timely manner and determine its impact on Railroad Medicare.

Management's Response to Recommendation No. 13

The Office of Programs concurred with our recommendation. The Office of Programs stated that as outlined in the CMS FY 2015 Justification of Estimates for Appropriations Committees report, the UPIC program is still in the planning stages, with implementation expected to start in FY 2015. Any Railroad Medicare involvement in the UPIC program would need to be issued via the CMS Change Management process, i.e. Change Request or Technical Direction Letter. This process notifies all MACs, including the RRB SMAC, on proposed changes to the Medicare program. This enables the RRB SMAC to determine its impact on Railroad Medicare prior to going final. As of June 30, 2014, no proposed changes regarding UPIC have been issued.



MEMORANDUM

JUL 16 2014

TO: Patricia A. Conliss
Acting Assistant Inspector General for Audits

FROM: Micheal Pawlak *Micheal Pawlak*
Director of Unemployment and Programs Support Division

THROUGH: Martha Barringer *Martha M Barringer*
Director of Programs

SUBJECT: Draft Management Information Report - Railroad Medicare Progress and Challenges

Overall comments After reviewing the draft management information report, we found some inaccuracies in the draft report that are stated below.

- Page 2 – Palmetto completed their transition in FY 13 and began their option year in FY 14.
- Page 4, 3rd paragraph - CERT is not a system; it is a program.
- Page 4, 2nd paragraph, last line- Palmetto did not agree with the CERT national error being the best estimate.
- Page 9 – The 6,500 provider remittances is not an annual estimate; the estimate given was for a 5 month period only.
- Page 9 - Third bullet is not correct. Palmetto records are flagged as do not forward (DNF). No payments are issued to that provider until they contact Palmetto.

Recommendation #1 We recommend that the Office of Programs works with Palmetto to establish a system of communication and information sharing with the ZPICS.

OP Response #1 We concur. The Centers for Medicare and Medicaid Services (CMS) contacted Palmetto and the RRB in 2013 to discuss developing a partnership with the Zone Program Integrity Contractor (ZPIC) to ensure that Medicare overpayments are pursued for RRB beneficiaries. CMS is currently working on a joint operating agreement between the RRB Specialty Medicare Administrative Contractor (SMAC) and the ZPIC. The completion date is incumbent on CMS' target date.

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| Recommendation #2 | We recommend that the Office of Programs works with Palmetto to determine if Railroad Medicare inquiries and referrals can be directly assigned to a ZPIC. |
| OP Response #2 | We do not concur with this recommendation. The RRB SMAC performs its own benefit integrity activities. Similar to the ZPICs, the RRB SMAC identifies and investigates program vulnerabilities and determines patterns of fraud. The RRB SMAC also examines Medicare claims and other data to support investigations and search for fraudulent transactions and improper payments. The RRB SMAC follows CMS' guidelines found in the Internet-Only Manual (IOM) Publication 100-08, Chapter 4, Section 4.18.1.1. |
| Recommendation #3 | We recommend that the Office of Programs requests that Palmetto issues an appeal to CMS for inclusion in the CERT program, stressing the impact on oversight of the Railroad Medicare program. |
| OP Response #3 | We concur. CMS has already agreed to review and coordinate with the RRB how and when the CMS Comprehensive Error Rate Testing (CERT) program will apply to the RRB SMAC. The completion date is incumbent on CMS' target date. |
| Recommendation #4 | We recommend that the Office of Programs requests that Palmetto apply CERT national error rates of comparable claim types during medical review and benefit integrity process, to identify additional improper payments. |
| OP Response #4 | <p>We do not concur with this recommendation. As stated on page 4 of the study, "Palmetto does not find participation feasible with applying the CERT national error rate for comparable services in the RRB SMAC program." The OIG further explains the reasons that Palmetto disagrees with using the CERT error rate; referencing the inclusion of Local Coverage Determinations in a MAC's CERT error rate and the differences in claims processing volumes and sample sizes between the MAC and the RRB SMAC.</p> <p>Although we do not concur with this recommendation, we will have Palmetto use the National CERT report for analysis and, if applicable, incorporate those findings into their Medical Review Strategy. We will have Palmetto continue this process until such time that the RRB SMAC is approved for participation in the CERT program.</p> |
| Recommendation #5 | We recommend that the Office of Programs ensures that Palmetto periodically conducts meetings and training with key fraud and abuse units including provider enrollment, medical review, benefit integrity and Medicare secondary payer. |
| OP Response #5 | We concur. Palmetto's Railroad Medicare Benefit Integrity unit (BI) will work with their corporate training department to expand the current technology based training activities. Training classes and discussions will be conducted for key ancillary units to promote fraud and abuse awareness and highlight potential problem areas of fraud within the Medicare program. The expanded training program will begin by March 31, 2015. |

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| Recommendation #6 | We recommend that the Office of Programs works with Palmetto to develop and implement a comprehensive fraud training plan for the nurse clinician staff that addresses medical procedures with an inherent risk of fraud. |
| OP Response #6 | We concur. The Medical Review manager has extensive experience in the field of fraud and abuse investigation and will work in collaboration with the BI manager. Together they will provide the clinical staff with information gathered from the annual CMS MR Operational Meeting as well as the annual National Health Care Anti-Fraud Association conference. The training will be conducted within 90 days after each conference. |
| Recommendation #7 | We recommend that the Office of Programs works with Palmetto to evaluate the current nurse clinician staff's medical experience during the recruitment process and determine how specialized nurse clinician experience could be used to minimize improper payments. |
| OP Response #7 | We do not concur with this recommendation. The RRB SMAC Medical Review clinical staff has an extensive range of clinical experience, covering multiple specialties and clinical areas. Palmetto hires clinical staff according to the direction supplied in the IOM Publication 100-08, Chapter 3, Section 3.3.1.1. While it is impossible to predict where the latest focus for fraud will originate; the wide variety of experience held by Palmetto's clinical staff makes it possible to cover the spectrum of multiple areas of vulnerability. |
| Recommendation #8 | We recommend that the Office of Programs works with Palmetto and CMS to expedite the implementation of the HIGLAS for Railroad Medicare. |
| OP Response #8 | We concur with this recommendation. A tentative time frame has been established with CMS on the Health Integrated General Ledger Accounting System (HIGLAS) implementation. CMS has agreed that the RRB SMAC would migrate to HIGLAS once the Affordable Care Act changes were completed and the Durable Medical Equipment Medicare Administrative Contractors MACs were migrated to HIGLAS. The estimated time of migration is targeted for FY 2016 or FY 2017. |
| Recommendation #9 | We recommend that the Office of Programs works with Palmetto to establish a process for identifying providers who are frequently involved in MSP recoveries and referring these providers to the provider education and benefit integrity units for monitoring and follow-up action. |
| OP Response #9 | We do not concur with this recommendation. CMS' purpose to centralize the Benefits Coordination and Recovery Center contractor (BCRC) operation was to ensure the integrity of the Medicare Trust funds. CMS assigned responsibility to the BCRC for Medicare Secondary Payer recoveries resulting from liability claims. All MACs as well as Palmetto have been instructed to refer all inquiries related to the collection of debts related to Auto, No Fault, Workers Compensation, or Liability to the BCRC to be researched. The BCRC will take the appropriate action based on the outcome of the research for each scenario previously listed. |

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| Recommendation #10 | We recommend that the Office of Programs and Palmetto conduct a cost benefit analysis to determine the optimal budgetary resources needed for MSAD data analysis directed toward minimizing fraud and improper payments. |
| OP Response #10 | We do not concur with this recommendation. We would like further clarification on this recommendation. Presently, the recommendation does not accurately describe Palmetto's utilization of Medicare Statistical Analysis Department (MSAD) resources or the effectiveness of the services they provide to the Railroad Medicare operation. The budget that was requested by Palmetto and approved by the RRB for option year 1 for MSAD services has allowed Palmetto to implement a successful, data-driven medical review program. MSAD reports are highly relied upon to assist with identifying potential vulnerabilities within the Railroad Medicare program. |
| Recommendation #11 | We recommend that the Office of Programs ensures that Palmetto modifies their returned mail process to include benefit integrity referrals. |
| OP Response #11 | We concur. The Office of Programs will work with Palmetto to modify the returned mail process to incorporate referrals to the BIU. We anticipate a target completion date of March 31, 2015. |
| Recommendation #12 | We recommend that the Office of Administration reevaluate its audit follow-up process to ensure that open recommendations are closed in a timely manner. |
| OP Response #12 | Office of Administration to respond. |
| Recommendation #13 | We recommend that RRB officials work with Palmetto to acquire UPIC program information in a timely manner and determine its impact on Railroad Medicare. |
| OP Response #13 | We concur with this recommendation. As outlined in the CMS FY 2015 Justification of Estimates for Appropriations Committees report, the Unified Program Integrity Contractors (UPIC) program is still in the planning stages, with implementation expected to start in FY 2015. Any Railroad Medicare involvement in the UPIC program would need to be issued via the CMS Change Management process, i.e. Change Request or Technical Direction Letter. This process notifies all MACs, including the RRB SMAC, on proposed changes to the Medicare program. This enables the RRB SMAC to determine its impact on Railroad Medicare prior to going final. As of June 30, 2014, no proposed changes regarding UPIC have been issued. |



UNITED STATES GOVERNMENT

MEMORANDUM

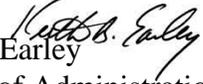
Appendix II

FORM G-115f (1-92)

RAILROAD RETIREMENT BOARD

June 24, 2014

TO : Patricia A. Conliss, Acting Assistant Inspector General for Audit

FROM : Keith B. Earley 
Director of Administration

SUBJECT: Draft Management Information Report-Railroad Medicare
Progress and Challenges

This is in response to your memorandum titled above and dated June 20, 2014. I concur with your recommendation that “the Office of Administration reevaluate its audit follow-up process to ensure that open recommendations are closed in a timely manner.” We are working aggressively to provide much needed human capital resources, depleted by separations, in the Acquisition Management area and will move to begin addressing the open recommendations.

Thank you for the opportunity to review the draft.

cc: Director of Programs
Contracting Officer