

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS REPORTED COLLECTING JUST
OVER HALF OF THE
\$498 MILLION IN MEDICARE
OVERPAYMENTS IDENTIFIED
BY OIG AUDITS**

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Inspector General**

July 2022
A-04-18-03085

Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: July 2022

Report No. A-04-18-03085

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

The Centers for Medicare & Medicaid Services (CMS) must protect the fiscal integrity of Medicare Trust funds. A previous Office of Inspector General (OIG) audit determined that CMS had not recovered \$332 million of the \$416 million of Medicare overpayments that we had identified in audit reports issued during the 30-month period ended March 31, 2009. Also, we could not verify that CMS collected \$84 million that it reported collecting, and we identified inaccuracies in the reported amounts.

Our current audit was a followup to our previous audit so that we could determine the extent to which CMS recovered Medicare overpayments for a more recent period.

Our objectives were to determine: (1) the extent to which CMS collected sustained Medicare overpayments identified in Department of Health and Human Services (HHS)-OIG audit reports and (2) actions that CMS took in response to the recommendations made in our prior audit report, *Obstacles to Collection of Millions in Medicare Overpayments* (A-04-10-03059).

How OIG Did This Audit

We reviewed 148 Medicare audit reports issued during the 27-month period from October 1, 2014, through December 31, 2016 (audit period). CMS agreed to collect recommended overpayments totaling \$498 million related to those 148 audit reports. We reviewed the relevant OIG clearance documents and CMS's supporting documentation for the 148 audit reports, and we discussed with CMS staff the status of our prior audit recommendations.

CMS Reported Collecting Just Over Half of the \$498 Million in Medicare Overpayments Identified by OIG Audits

What OIG Found

Of the \$498 million in Medicare overpayments identified in HHS-OIG audit reports issued during our audit period that CMS sustained, CMS reported that it had collected only \$272 million (55 percent) and that it had not collected \$226 million (45 percent). Further, CMS provided documentation sufficient to support that it had collected only \$120 million of the \$272 million. CMS did not provide adequate documentation to support that it had collected the remaining \$152 million.

In addition, CMS did not take corrective action in response to all of the recommendations made in our prior audit report, *Obstacles to Collection of Millions in Medicare Overpayments*. In that audit report, issued on May 18, 2012, we made six recommendations (listed in Appendix D) and CMS agreed to implement four of them. Of those four recommendations, CMS implemented two, partially implemented one, and did not implement one.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) continue its efforts to recover any collectible portion of the \$226 million in uncollected overpayments, (2) determine what portion of the \$152 million was collected and recorded in its accounting system, (3) revise 42 CFR section 405.980 and corresponding manual instructions related to the reopening period for claims to be consistent with statutory provisions contained in section 1870 of the Social Security Act, and (4) develop a plan for resolving cost reports applicable to the nine audit reports discussed in this report. We also made other procedural recommendations.

CMS generally did not concur with our findings or recommendations. Of our nine recommendations, CMS concurred with one recommendation, did not concur with seven recommendations, and did not explicitly state that it concurred or did not concur with one recommendation. CMS concurred with our recommendation to continue its efforts to recover any collectible portion of the \$226 million in uncollected overpayments and inform us of any additional collections related to this amount.

On the basis of additional documentation CMS provided us after we had issued our draft report, we revised the total undocumented overpayment collections amount for our recommendation that CMS determine what portion was collected and recorded in its accounting system. We also revised one of our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) must protect the fiscal integrity of Medicare Trust funds. Responsible stewardship that ensures the transparency and accountability of these funds is paramount to making sure that Medicare beneficiaries have access to the services they need. From 2012 to 2020, CMS reported Medicare fee-for-service (FFS) program annual improper payment rates from a low of 6.27 percent (2020) to a high of 12.7 percent (2014) and improper payment amounts from a low of \$25.74 billion (2020) to a high of \$45.8 billion (2014).¹

The mission of the Office of Inspector General (OIG) is to provide independent and objective oversight of Department of Health and Human Services (HHS) programs and to make recommendations to ensure the efficiency and economy of those programs. In keeping with that mission, a previous OIG audit determined that CMS had not recovered \$332 million of the \$416 million of Medicare overpayments that we had identified in audit reports issued during the 30-month period ended March 31, 2009.² Furthermore, we could not verify that CMS collected the \$84 million that it reported collecting, and we identified inaccuracies in the reported amounts.

OIG identifies millions of dollars in potential Medicare overpayments each year. When CMS agrees with the findings, it is imperative that CMS collect those amounts to ensure the integrity of the programs. We performed this current audit to determine the extent to which CMS recovered Medicare overpayments identified in more recently issued audit reports and to determine the actions that CMS has taken to address our previous audit recommendations.

OBJECTIVES

Our objectives were to determine: (1) the extent to which CMS collected sustained Medicare overpayments identified in HHS-OIG audit reports^{3, 4} and (2) the actions that CMS took in response to the recommendations made in our prior audit report, *Obstacles to Collection of Millions in Medicare Overpayments*.

¹ National Comprehensive Error Rate Testing (CERT) Improper Payment Rate by Reporting Year. Available online at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/AdditionalData>. Accessed on September 10, 2021.

² *Obstacles to Collection of Millions in Medicare Overpayments* (A-04-10-03059), issued on May 18, 2012. Available online at <https://oig.hhs.gov/oas/reports/region4/41003059.asp>.

³ We refer to the amount that CMS agreed to collect as the “sustained amount” throughout this report.

⁴ Our audit included OIG-identified overpayments that arose from audits of FFS claims, Medicare cost reports, Medicare Administrative Contractor (MAC) pension plan costs, and MAC administrative costs.

BACKGROUND

Title XVIII of the Social Security Act established Medicare, which provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. CMS administers Medicare. The Office of Management and Budget (OMB) deemed Medicare FFS, Medicare Advantage, and Medicare Prescription Drug to be programs that may be susceptible to significant improper payments for purposes of reporting improper payment rates, corrective action plans, and reduction targets under the Payment Integrity Information Act of 2019 and its predecessors.^{5, 6, 7}

OIG provides independent and objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS operations (e.g., CMS) and programs (e.g., Medicare FFS); and keeps the HHS Secretary and Congress informed about problems and deficiencies in the administration of HHS programs and operations (Inspector General Act of 1978, 5 U.S.C. App. 3 (IG Act)). Under the IG Act, it is the “duty and responsibility” of an Inspector General to conduct audits of agency expenditures. To fulfill this obligation, OIG conducts audits of CMS and its Medicare contractors, as well as of providers, suppliers, and physicians paid by the Medicare program for rendering health care services and providing supplies to Medicare beneficiaries.

Audit Resolution

The Federal Acquisition Streamlining Act of 1994 (FASA),⁸ as amended by the National Defense Authorization Act for Fiscal Year 1996,⁹ provides statutory deadlines for the prompt resolution of audit recommendations. As amended, FASA requires Federal agencies to make management

⁵ The Payment Integrity Information Act of 2019 (PIIA), P.L. No. 115-117, repealed and replaced the Improper Payments Information Act of 2002, P.L. No. 107-300; the Improper Payments Elimination and Recovery Act of 2010, P.L. No. 111-204; and the Improper Payments Elimination and Recovery Improvement Act of 2012, P.L. No. 112-248.

⁶ The PIIA defines “significant improper payments” as the sum of a program’s improper payments and payments whose propriety cannot be determined due to lacking or insufficient documentation that exceeded: (1) \$10 million of all reported program payments made during a fiscal year and 1.5 percent of program outlays or (2) \$100 million.

⁷ Reducing improper payments, such as payments to ineligible recipients or duplicate payments, is critical to safeguarding Federal funds. Improper payments (payments that should not have been made or were made in the incorrect amount) have consistently been a Governmentwide concern despite efforts to reduce them and identify their root causes. In fiscal year (FY) 2019, agencies across the Government made an estimated \$175 billion in improper payments, up from about \$151 billion for FY 2018. Medicare, Medicaid, and the Earned Income Tax Credit accounted for about 69 percent of the \$175 billion total. For example, Medicare’s FFS program paid claims for medically unnecessary services and claims that had insufficient documentation. Available online at <https://www.gao.gov/improper-payments>. Accessed on September 10, 2021.

⁸ P.L. No. 103-355 § 6009.

⁹ P.L. No. 104-106 § 810.

decisions on all findings and recommendations in each Inspector General audit report within 6 months of issuance.¹⁰ FASA also requires Federal agencies to complete a final action on each management decision within 12 months of the issuance of each Inspector General report.¹¹ In addition, section 8(a)(4) of OMB Circular A-50 Revised, *Audit Followup*, requires that agency management maintain accurate records regarding the status of audit report recommendations from resolution through corrective action. As the agency that administers the Medicare program, CMS is tasked with resolving all recommendations arising out of OIG audits of Medicare FFS claims no matter who is the auditee (e.g., CMS, Medicare Administrative Contractor (MAC), hospital, or physician).

CMS's Process for Resolving OIG Audit Report Recommendations

Consistent with the requirements of the FASA, CMS policy states that all audit recommendations in OIG reports should be resolved within 6 months of the report issuance date.^{12, 13} CMS uses the OIG Clearance Document (OCD) to report its management decisions and final actions taken on both monetary and nonmonetary audit recommendations (HHS *Financial Accounting Policy Manual*, section 10-41-V).¹⁴

The OCD lists each audit report recommendation and indicates CMS's concurrence or nonconcurrence with each recommendation. When it concurs with a recommendation, CMS describes the action it has taken or plans to take to address the recommendation. For recommendations to collect overpayments, CMS may concur with the recommendation but elect to sustain an amount that differs from the amount OIG recommends for collection. For example, CMS may sustain an amount that is less than the amount OIG recommends for collection if CMS determines that claims could not be reopened, or if it believes it would not be cost beneficial to reopen and review claims.¹⁵ Whether the OIG-recommended overpayment recovery amount or a different amount, CMS indicates the amount that it agrees to recover as a "sustained amount" on the OCD.

¹⁰ A "management decision" is defined by section 5(f)(5) of the IG Act as the issuance of a final decision by a Federal agency concerning its response to an Inspector General audit report's findings and recommendations.

¹¹ A "final action" is defined by section 5(f)(6) of the IG Act as the completion of all actions, with respect to the findings and recommendations in an audit report, that a Federal agency has concluded are necessary in its management decision.

¹² Consortium for Financial Management and Fee for Service Operations, External Audit Resolution Process, Main Standard Operating Procedure, dated March 1, 2012.

¹³ Consortium for Financial Management and Fee for Service Operations, OIG Clearance Document Standard Operating Procedure, dated April 15, 2016.

¹⁴ The OCD is used only for OIG, Office of Audit Services reports. OCDs are not used for OIG, Office of Evaluation and Inspections reports.

¹⁵ The reopening process is explained in detail on page 6 of this report under the heading, "Limitation on Recovery of an Overpayment."

A CMS “originating official” and an “approving official” sign the OCD to certify that it represents CMS’s official position (HHS *Financial Accounting Policy Manual*, section 10-41-V part 1 G). OIG uses these OCDs to determine the final disposition of OIG audit recommendations and to report information to Congress regarding OIG recommendations in its Semiannual Report to Congress.

CMS policy also states that an OCD can clear and close an audit recommendation. “Cleared” signifies that CMS and the auditee (i.e., CMS, a MAC, or a provider) have established a plan and are taking corrective action to implement a recommendation. An OCD may clear an audit recommendation without closing it. In such instances, CMS withholds closure until all sustained overpayments have been recouped and any operational deficiencies have been corrected. CMS defines “closed” to mean that CMS has verified that a recommendation is implemented and that no further action is required to recoup Medicare overpayments or to correct operational deficiencies.

CMS’s Tracking and Reporting of the Status of Audit Recommendations

CMS categorizes OIG audit reports as either internal or external. Internal reports are issued to the CMS Administrator. External reports are issued to parties other than the CMS Administrator (e.g., contractors, physicians, and hospitals).

During our audit period (October 1, 2014, through December 31, 2016), CMS’s Office of Financial Management (OFM), Financial Services Group (FSG), Division of Financial Services and Debt Management, resolved internal report audit recommendations. CMS’s OFM, Accounting Management Group, Audit Resolution Team, was the audit liaison for internal audits and submitted OCDs to OIG. CMS did not prepare Audit Status Follow-up Reports (ASFRs) for internal audits during our audit period. However, CMS said that it provided updates when significant changes occurred or when requested.

For external reports, CMS tracked the status of the recommendation on the quarterly ASFR that it issues to OIG. CMS’s external audit recommendations were resolved by its Consortium of Financial Management and Fee for Service Operations (CFMFFSO) Boston, Atlanta, Dallas, and Seattle Divisions of Financial Management.¹⁶ CMS’s Audit Management Division (AMD) was the audit liaison for external audits during our audit period and submitted OCDs and ASFRs to OIG.¹⁷

CMS’s OFM/FSG, Division of Medicare Debt Resolution, resolved OIG audit recommendations and prepared OCDs and ASFRs related to Part A Fiscal Intermediary and Part B carrier pension plan audits. CMS’s Office of Acquisition and Grants Management, Customer Relations Group,

¹⁶ After a 2019 CMS reorganization, the CFMFFSO Boston, Atlanta, Dallas, and Seattle Divisions of Financial Management became the Office of Program Operations and Local Engagement, Innovation, and Financial Management Group, Boston, Atlanta, and Dallas Divisions of Financial Management.

¹⁷ After a 2019 CMS reorganization, AMD was renamed the Division of External Audit Management and moved under OFM/FSG.

Division of Financial Services, resolved OIG audit recommendations and prepared OCDs and ASFRs related to MAC pension plan audits.

After CMS submits the initial OCD and OIG accepts it, CMS documents any followup information on cleared recommendations in its quarterly ASFR. CMS uses the ASFR to report and track the status of OIG audit recommendations that have been cleared but not closed. The ASFR identifies audit recommendations as either “cleared” or “pending.” CMS can also label a recommendation “closed” on the ASFR when it determines that corrective actions have been fully implemented and verifies that any overpayments have been collected. CMS obtains overpayment collection information from its MACs and reports that information on its ASFR. A CMS-designated Action Official is required to submit each ASFR to CMS’s AMD. CMS also submits an ASFR to OIG to provide an update on each audit’s current resolution status.

The AMD used the ASFR to make any required updates in CMS’s Strategic Work Information Folder Transfer (SWIFT) audit tracking system.¹⁸ CMS used the SWIFT audits module to monitor the status of OIG recommendations, Corrective Action Plans, and overpayment collections. Periodically, CMS manually entered into SWIFT collections data that it received from MACs and CMS’s regions. The SWIFT audit module generated reports for the administration of the audit resolution process, maintained an audit clearance tracking system, and recorded recovered funds (SWIFT Audits DPRA Process Guide, v 1.3). CMS developed the SWIFT audits module to replace its previous Audit Tracking and Reporting System (ATARS). The SWIFT audits module also generated the mandated Annual Accountability report that CMS produced at the end of each fiscal year. The Annual Accountability report provided the status of OIG reports and summarized the results of actions taken to implement OIG audit recommendations during the reporting period.

Medicare Administrative Contractors

Generally, CMS delegates the responsibility for recovering Medicare overpayments to its MACs.¹⁹ Accordingly, CMS has delegated to MACs the responsibility for reopening and recovering most Medicare overpayments identified in OIG reports. CMS instructs the MACs via Technical Direction Letters (TDLs) to follow applicable recovery rules in Federal regulations and recover OIG-identified overpayments. Providers can appeal when MACs try to recover overpayments, which can delay CMS efforts for years to recover Medicare overpayments identified in OIG reports. For example, one audit report (A-05-14-00046) issued on March 16, 2015, recommended recovery of \$10,855,073, of which CMS had not collected \$2,076,375 as of June 30, 2018, because of an outstanding appeal of a December 31, 2008, cost

¹⁸ Immediately before our exit conference on June 10, 2021, CMS told us that it no longer uses SWIFT for audit resolution. CMS said that it now uses the Audit Management System (AMS) for audit resolution. We did not perform any audit work relative to the new AMS.

¹⁹ Chapters 3 and 4 of the *Medicare Financial Management Manual* provide collection guidance to MACs.

report.²⁰ According to SWIFT, the MAC told CMS that this recommended overpayment was in appeal as of September 2015. As of June 2020, this recommended overpayment had been in appeal for more than 4 years.

Limitation on Recovery of an Overpayment

Section 1870 of the Social Security Act (section 1870) prohibits the recovery of Medicare fee-for-service overpayments if the provider was “without fault” with respect to the overpayment. A provider is presumed to be without fault for Medicare fee-for-service overpayments if the overpayment determination is made by the Medicare program after the fifth year following the year in which notice of such payment was sent to the provider (section 1870 and 42 CFR §§ 405.350(c) and 405.355(b)). Effective January 2, 2013, section 638 of the American Taxpayer Relief Act of 2012 (ATRA), P.L. No. 112-240, had amended section 1870 to extend the recovery period from 3 years following the year payment was made to 5 years following the year payment was made. CMS amended its regulations accordingly (78 Fed. Reg. 74230, 74445–74446) (Dec. 10, 2013).²¹

To recover individual Medicare overpayments, the original payment determination must be reopened (e.g., overpayment determination) (section 1869(b)(1)(G) of the Act and 42 CFR § 405.980(a)). Medicare contractors may reopen Medicare fee-for-service payment determinations: (1) within 1 year from the date of initial determination for any reason, (2) within 4 years from the date of initial determination “for good cause,” and (3) at any time there is reliable evidence that the payment was procured by fraud or similar fault (42 CFR § 405.980(b)). The reopening period runs on a rolling basis beginning on the date of each initial determination (i.e., the date of the overpayment). The 5-year limitation period under section 1870 begins to run on the first day of January of the calendar year following the calendar year in which an overpayment was made. Before ATRA, the 3-year limitation period under section 1870 prevented the Medicare program from reopening claims before the full running of the 4-year reopening period. Presently, the 4-year reopening period bars recovery of certain overpayments that could be recovered under the 5-year section 1870 limitation period.

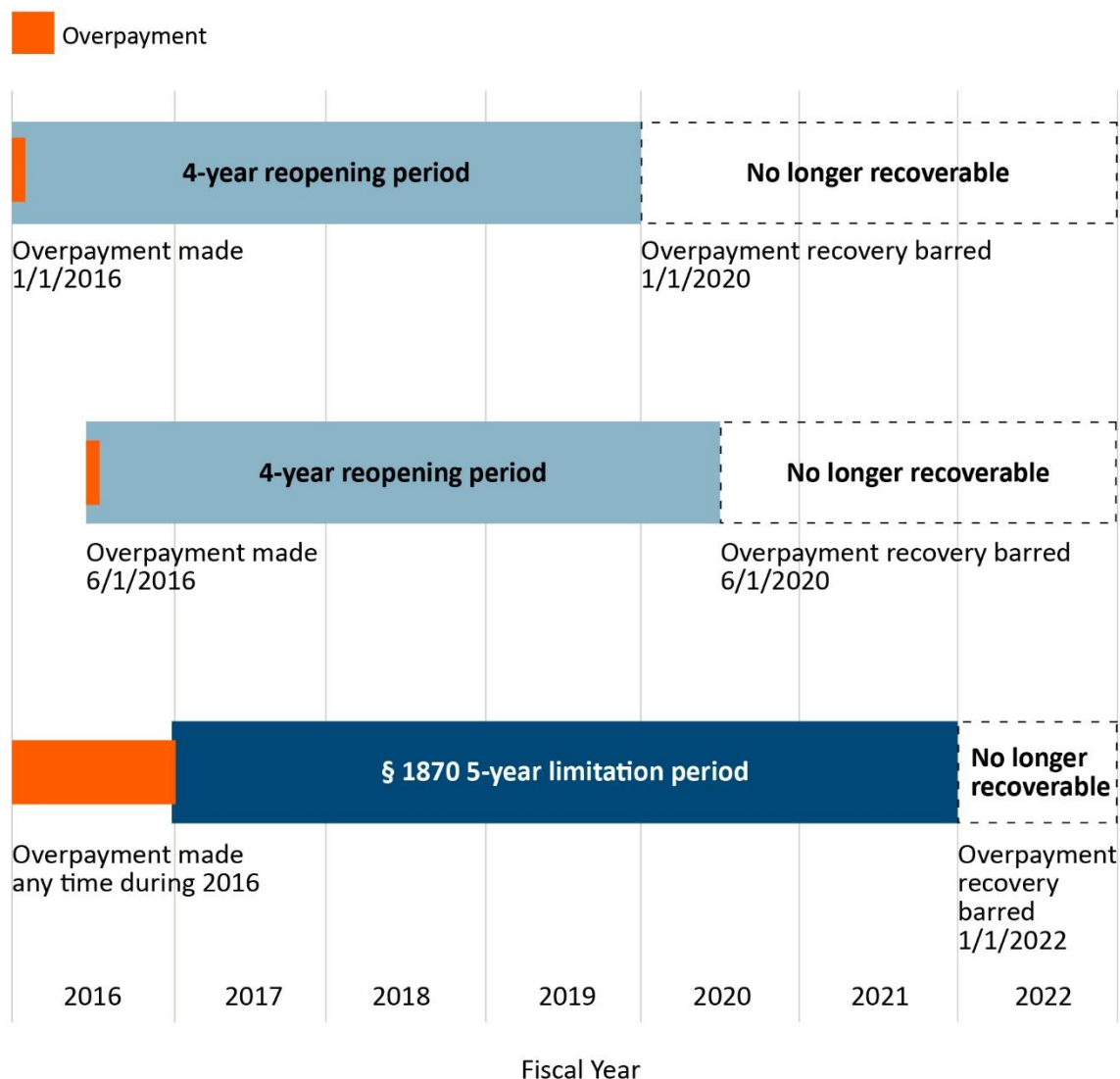
Figure 1 on the following page illustrates this problem. As a result of the 5-year limitation period, the Medicare program may begin collecting overpayments (i.e., determining overpayments) made on January 1, 2016, or June 1, 2016, up through December 31, 2021, from a provider that is not without fault (i.e., claims would be barred on or after January 1, 2022) (section 1870). However, in accordance with the 4-year reopening period, the Medicare program cannot collect an overpayment made on June 1, 2016, as of June 1, 2020, absent fraud or similar fault (42 CFR § 405.980(b)). For an overpayment made on January 1, 2016, the

²⁰ Of the \$10,855,073 that CMS agreed to collect, \$7,437,637 was supported by collection documentation, \$2,076,375 was not collected pending provider appeal, \$735,730 was not supported by collection documentation, and \$605,331 was written off by the MAC or CMS as uncollectible.

²¹ CMS defines “without fault” and provides guidance to Medicare contractors regarding the application of section 1870 in sections 70, 80, and 90 of chapter 3 of the *Medicare Financial Management Manual*.

Medicare program cannot collect the overpayment as of January 1, 2020, absent fraud or similar fault.

Figure 1: 4-Year Reopening Period and Section 1870 Waiver of Liability



HOW WE CONDUCTED THIS AUDIT

We issued 148 Medicare audit reports (10 internal and 138 external) during the 27-month period from October 1, 2014, through December 31, 2016 (audit period), in which CMS fully or partially concurred with the recovery recommendations.²² This audit focuses on the \$498 million recommended for recovery in those 148 reports that CMS agreed to collect

²² We selected our audit period because it included the most current data that would allow CMS an adequate amount of time to take action to collect these overpayments.

(sustained amount) plus an additional \$13 million that CMS reported that it collected in excess of what we recommended.²³

We reviewed the relevant OCDs as of August 3, 2018, to confirm the sustained amounts. We reviewed the supporting documentation that CMS provided to us between August 24, 2018, and June 25, 2020, to determine the collected amounts for the 148 audit reports.²⁴

We reviewed the findings and recommendations in our previous audit report on CMS's recoveries (A-04-10-03059) and CMS's comments on those recommendations. We discussed with CMS officials the actions CMS had taken on the recommendations after we issued our prior audit report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains reasons CMS did not collect all overpayments we recommended for recovery and examples of such uncollected overpayments, Appendix C contains excerpts from the *Standards for Internal Control in the Federal Government* (Green Book), and Appendix D contains our prior audit recommendations from report number A-04-10-03059.

FINDINGS

We verified that CMS collected \$119,680,179 of the \$498,022,527 in sustained Medicare overpayments identified in HHS-OIG audit reports issued during our audit period.²⁵ Of this sustained amount, CMS reported that it had collected \$272,190,370²⁶ (55 percent) and that it had not collected \$225,832,157 (45 percent). CMS officials gave various reasons for not

²³ Actual overpayments that CMS sustained were \$498,022,527.

²⁴ CMS was not always timely in providing the documentation we requested. On July 23, 2018, we initially requested CMS to provide us documentation that supported its claimed overpayment collections for the 148 audits. On June 25, 2020, CMS sent its last batch of documents that it believed supported certain overpayment collections. We requested documentation more than two times in some cases, and on at least two occasions we discussed with CMS the types of documentation needed to support a collection. In some cases, CMS said that it provided documentation, such as copies of checks, but we never received the documentation.

²⁵ After we had issued our draft report, CMS provided documentation that supported \$2,121,441 of overpayment collections. Accordingly, we increased the amount of CMS's reported collections that we verified from \$117,558,738 to \$119,680,179, and we reduced CMS's undocumented collections from \$154,631,632 to \$152,510,191.

²⁶ CMS also reported collecting \$13,247,197 in excess of recommended overpayments.

collecting the \$226 million in sustained overpayments (Table 1 and Appendix B). Of the \$272,190,370 in overpayments that CMS reported that it had collected, CMS provided documentation to support that it had collected \$119,680,179 (See footnote 25). However, CMS did not provide adequate support showing that it had collected the remaining \$152,510,191 (see footnote 25). CMS did not have adequate policies and procedures for obtaining the appropriate documentation needed to support collected overpayments, for properly managing and maintaining documents and records, or for making documents and records readily available for examination.

In addition, CMS did not take corrective action in response to all of the recommendations made in our prior audit report, *Obstacles to Collection of Millions in Medicare Overpayments*. In that audit report, issued on May 18, 2012, we made six recommendations (listed in Appendix D) and CMS agreed to implement four of them. CMS said that it did not implement two of the six prior audit recommendations because they were related to an audit tracking and reporting system that it no longer used. Of the remaining four recommendations, CMS implemented two, partially implemented one, and did not implement one.

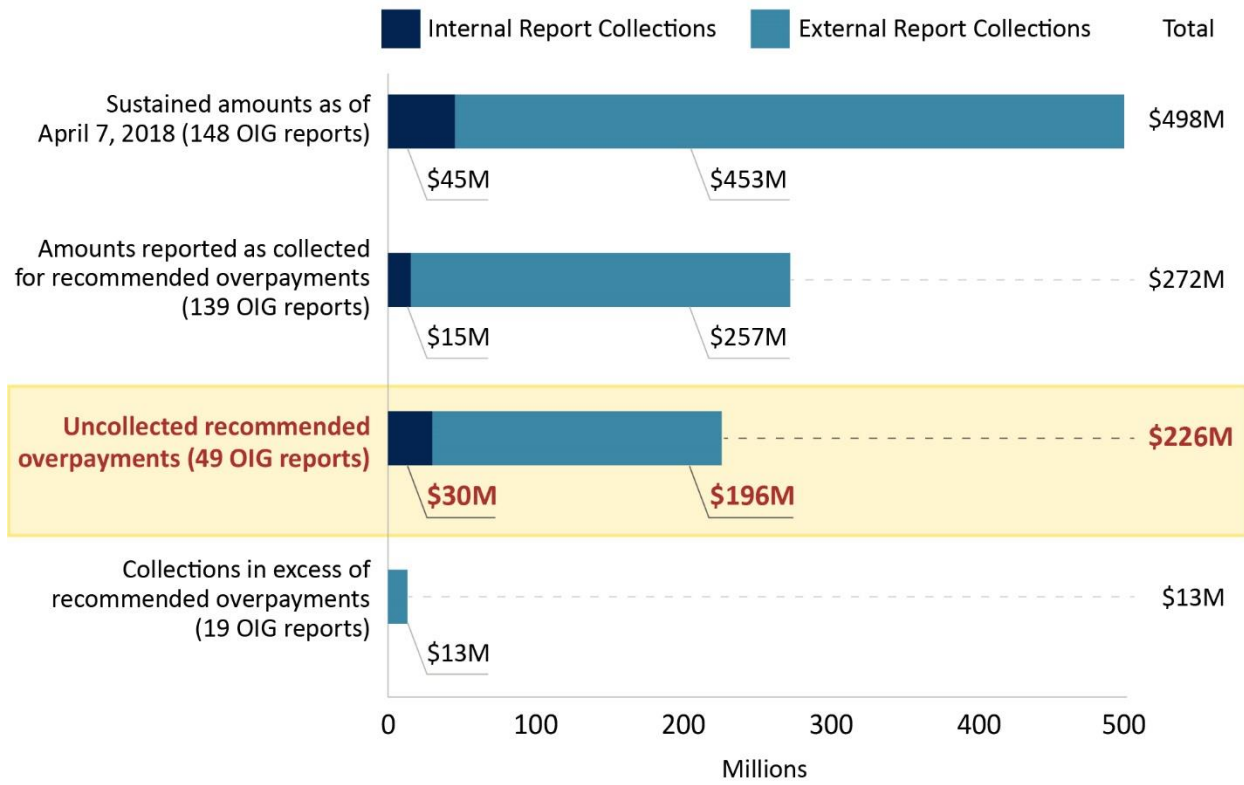
The combination of a substantial balance of uncollected overpayments, inadequate policies and procedures, and unimplemented recommendations increases the risk that CMS will not collect millions of dollars owed to the Medicare Trust funds.

CMS HAS NOT COLLECTED ALL SUSTAINED OVERPAYMENTS IDENTIFIED IN OIG AUDITS

The Presidential Memorandum *Finding and Recapturing Improper Payments* (75 Fed. Reg. 12119 (Mar. 15, 2010)) directs agencies to use every tool available to identify and reclaim the funds associated with improper payments that the Federal Government has made. The memorandum notes that reclaiming these funds is a critical component of the proper stewardship and protection of taxpayer dollars. Federal agencies should take all necessary steps to prevent, detect, and collect improper payments (OMB Circular A-123, Appendix C, “Requirements for Effective Measurement and Remediation of Improper Payments,” part I, section L (2006)).

CMS did not collect all overpayments that we recommended for recovery and that CMS sustained for the 27-month period ended December 31, 2016. In audit reports issued during this 27-month period, we recommended that CMS collect \$647 million in overpayments, and CMS sustained \$498 million of these overpayments. As of June 2020, CMS reported that it had collected \$272 million (55 percent) of the sustained OIG-recommended overpayments and that the remaining \$226 million (45 percent) was uncollected (Figure 2). In addition, CMS reported that it had collected \$13,247,197 in excess of the overpayments we recommended for 19 reports.

Figure 2: Medicare Overpayments—Reported as Collected or Uncollected



For 139 reports, CMS reported collecting all or a portion of the overpayments it sustained; for 49 reports, CMS reported that it had not collected all or a portion of sustained overpayments.²⁷

For 19 of the 139 reports, CMS reported collecting more than the amount that we had specifically recommended for recovery. The \$13 million that CMS reported that it had collected in excess of what OIG recommended consisted of:

- \$8.5 million collected after the MAC expanded its existing edits in the Medicare claims system and reprocessed all applicable claims for the reports’ audit periods,

²⁷ CMS reported that the sustained amounts in 99 reports were fully collected, the sustained amounts in 40 reports were partially collected, and the sustained amounts in 9 reports were not collected, totaling 148 unique reports. Because we included the 40 reports with partially collected overpayments in both the 139 reports with collected overpayments and the 49 reports with uncollected overpayments, the number of reports discussed in Figure 2 is greater than 148.

- \$3.4 million collected after providers refunded overpayments that they identified via the 60-day overpayment recovery rule,²⁸ and
- \$1.3 million collected based on the MAC’s recalculation of our recommended overpayment amount or the MAC reconciled a provider’s cost report.

Approximately 99 percent of the \$225,832,157 in uncollected overpayments was from 1 to 4 years old as of October 24, 2018.²⁹ The table provides a breakdown of the uncollected overpayments by reason and type of report.

Table: Reasons Why Amounts Remained Uncollected*

Reason	Internal Reports	External Reports	Total
NPR [†] on Hold Pending SSI [‡] Factor	\$0	\$78,424,834	\$78,424,834
Pending Cost Report Reconciliation ^{**}	66,338	45,315,952	45,382,290
Provider on a Repayment Plan or Repayment Plan Pending ^{††}	0	33,840,060	33,840,060
Pending Results of Provider Appeal	0	15,898,236	15,898,236
Other ^{††}	1,567,050	11,525,560	13,092,610

²⁸ The 60-day overpayment recovery rule (60-day rule), 42 CFR sections 401.301–401.305, requires providers and suppliers receiving funds under the Medicare program to report and return identified overpayments by the later of: (1) the date 60 days after the date on which the overpayment was identified or (2) the date any corresponding cost report is due, if applicable.

An OIG recommendation that references the 60-day rule in reports covered within our audit period would typically recommend that the auditee “exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day repayment rule.” OIG’s recommendation may contain a specific amount that was paid outside of the recovery period or an estimated overpayment amount. For example, in audit report number A-02-13-01027, we recommended that the provider “exercise reasonable diligence to investigate the potential overpayments outside of the Medicare reopening and recovery periods and work with the Medicare contractor to return any identified overpayments—which we calculate to be as much as \$14,200,773 during our audit period—in accordance with the 60-day repayment rule” The provider subsequently identified and refunded to the Medicare program, overpayments totaling \$15,824,473. For this audit, we classified the \$14,200,773 as a documented collection and classified the remaining \$1,623,700 as a documented collection in excess of what OIG recommended.

²⁹ We calculated the age of the uncollected overpayments using the elapsed time between CMS’s decision to sustain the overpayment (OCD date) and October 24, 2018, our last access to SWIFT. Citing a need to protect proprietary information housed in SWIFT, CMS declined to let us have ongoing, read-only access to SWIFT.

Reason	Internal Reports	External Reports	Total
Overpayment Redetermination ***	443,741	10,575,871	11,019,612
No Reason Provided in OCDs, ASFRs, or SWIFT	27,849,267	325,248	28,174,515
Total	\$29,926,396	\$195,905,761	\$225,832,157

* See Appendix B for a discussion of the reasons CMS did not collect some overpayments.

† Notice of [Medicare] Program Reimbursement (NPR) shows the amount of a provider’s Medicare payment.

‡ Supplemental Security Income (SSI) is a Federal income supplement program funded by general tax revenues and designed to help people who are aged, blind, or disabled and who have little or no income. Annually CMS publishes a ratio called the SSI factor, which providers use to calculate adjustments for low-income patient costs included in cost reports. Without the SSI factor, CMS cannot settle a cost report and issue a provider an NPR.

** CMS uses the cost report reconciliation process to establish final payment amounts to hospitals. Providers must submit cost reports to Medicare contractors within 5 months after the end of a hospital’s fiscal year. The cost reports are based on a hospital’s financial and statistical records. The Medicare contractor reviews the cost report and may audit it before final settlement. After auditing the cost report, the Medicare contractor incorporates necessary adjustments to identify reimbursable amounts and finalize Medicare reimbursements due from or to the hospital. The Medicare contractor then issues an NPR to the hospital. As the final settlement document, the NPR shows whether payment is owed to Medicare or to the hospital.

†† For seven reports totaling \$33,840,060, providers were actively making payments on their repayment plans (three reports), the repayment plan had not started (one report), or we could not determine the status of the repayment plans (three reports).

‡‡ Other reasons CMS did not collect sustained overpayments include: (1) the overpayment was not recoverable under the 60-day rule, (2) the overpayment was accounted for as part of a provider settlement agreement, (3) the provider was no longer in business, (4) the overpayment was written off by CMS or the MAC, or (5) the overpayment was referred to the Department of the Treasury (Treasury) for collection or the Social Security Administration (SSA) for offset. The dollar value of amounts CMS did not collect for audits in each of the “Other” categories represented 1 percent or less of the \$498,022,527 that CMS sustained.

*** Any party to the initial claim determination that is dissatisfied with the decision may request a redetermination. A redetermination is a review of the claim by MAC personnel not involved in the initial claim determination. Available online at <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor>. Accessed on September 10, 2021.

CMS officials gave various reasons for not collecting sustained overpayments, such as provider appeals and CMS/MAC redeterminations of overpayment amounts. Some of the sustained overpayments are no longer collectible, including \$11 million categorized as “overpayment redeterminations” and more than \$5.6 million of the \$13 million that we categorized as

“Other.”³⁰ In other instances, we could not determine whether CMS would be able to collect the overpayment. For example, CMS did not provide a reason for not collecting \$28,174,515 in overpayments we categorized as “No Reason Provided in OCDs, ASFRs, or SWIFT.” Therefore, we could not determine what portion of the \$28,174,515 was collectible.

Although CMS delegated part of its collection responsibilities to the MACs, CMS is ultimately responsible for this function and did not have policies and procedures in place to ensure that the MACs adequately managed their collection efforts. Therefore, we were not able to determine why CMS had not collected some of the almost \$226 million in sustained OIG-recommended recovery amounts. See Appendix B for details.

CMS DID NOT PROVIDE ADEQUATE DOCUMENTATION TO SUPPORT ALL OF ITS REPORTED OVERPAYMENT COLLECTIONS

CMS did not provide adequate documentation to support all of its reported overpayment collections as required by the Green Book.³¹

Of the approximately \$272 million in recommended overpayments that CMS said that it collected, \$120 million (44 percent) was supported by adequate documentation. The remaining \$152 million (56 percent) was not adequately supported. Furthermore, of the \$13 million that CMS said it collected in excess of recommended overpayments, \$9 million (69 percent) was not adequately supported.

Evidence that an overpayment was collected should include documentation that an overpayment occurred, documentation that an overpayment was recorded in CMS’s accounting system, and the source of the recovery amount CMS used to offset the overpayment. Some examples of adequate documentation of a collection include copies of canceled checks, copies of Federal wire monetary transfers, and claim adjustment details that reconcile to CMS’s accounting system which should provide a clear audit trail. A clear audit trail is one in which auditors are able to match monetary adjustments in the accounting system with collections support documentation. In many cases, CMS gave us various documents (e.g., letters, accounting system reports, screen prints of adjusted claims, Excel spreadsheets that contained lists of numbers that CMS said were claim adjustments, and emails) that we could not always associate with a specific overpayment amount or that did not support the claimed collection. In some cases, CMS said that it provided documentation, such as copies of checks, but we never received that documentation.

³⁰ Of the \$13,092,610 we categorized as “Other,” we classified \$5,571,164 as uncollectible because: (1) CMS and the provider agreed to a lesser overpayment amount than OIG recommended, (2) the provider was no longer in business, or (3) CMS determined that the overpayment was uncollectible.

³¹ The Green Book states that management should clearly document all transactions in a manner that allows the documentation to be readily available for examination (Green Book, Attribute 10.03).

The following are some examples of inadequately supported collections:³²

- CMS reported that it collected \$528,730 related to a recommendation in the report for audit A-03-15-00007. CMS provided an Excel worksheet prepared by the MAC to support the collection. However, the worksheet did not provide evidence showing that an overpayment had been recorded and offset by a recovered amount in CMS's accounting system.
- CMS reported that it collected \$1,935,157 related to a recommendation in the report for audit A-09-14-02037. CMS provided us with a spreadsheet prepared by the MAC. The spreadsheet contained claim adjustments related to one of the report's recommendations. From this spreadsheet, we were able to determine that CMS reported a collection of \$1,011,046. CMS did not provide any documentation that showed that it had collected the remaining \$924,111.
- CMS reported that it collected \$1,446,424 related to a recommendation in the report for audit A-01-14-00508. CMS said that it provided us with a copy of a check from the provider for \$1,446,424 in the documentation that it gave to us. However, a copy of the check was not included in the documentation that CMS provided. In October 2021 and after the issuance of our draft report, CMS provided a copy of a check supporting \$1,082,183 of the \$1,446,424. CMS also provided the same documentation it had previously provided for the remaining \$364,241, which did not provide evidence, such as Healthcare Integrated General Ledger Accounting System (HIGLAS) records or a Receivable Balance Detail (RBD) report, that CMS had recorded the collection in its accounting system.³³

The Excel spreadsheets that CMS provided are manually filled tracking sheets containing information with no clear source or link to CMS financial records. To provide a clear audit trail, documentation should include evidence that funds for overpayments were received, recorded in CMS's accounting system, and related to the recommended overpayment. CMS did not provide accounting system screenshots that would have allowed us to match the claims data with the collection amount, thus providing a clear audit trail.

Because CMS did not always provide documentation to support amounts reported as collected, we could not verify that CMS collected \$153 million of the \$272 million it claimed to have collected.

³² Appendix B contains additional details of the various reasons CMS provided for not collecting overpayments and discussions of inadequate documentation to support reported collections.

³³ HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes Federal financial accounting functions for all of CMS's programs.

CMS Did Not Have Specific Policies and Procedures for Documenting Collections Related to External Audit Recommendations

CMS's external audit resolution Standard Operating Procedure (SOP) contained requirements that CMS retain communications received from the MAC.³⁴ However, the procedure did not describe the types of documentation that should be retained to support \$140,664,274 in unsupported external audit report collections. The SOP stated that the audit file should, at a minimum, contain "correspondence related to audit resolution." However, the SOP did not define the types of "correspondence" that should be retained with the audit file.

Of the 148 audit reports included in our audit, 138 were external reports that CMS assigned to various CMS Regional Offices (ROs) for resolution of the audits' recommendations. The SOP described the processes that the ROs should follow in the audit resolution process. However, none of the processes included requirements for documenting collections.

The lack of requirements for documenting collections was reflected in the different types of documentation that CMS obtained from the ROs. We noted inconsistencies in the level of documentation that each RO obtained to support collections. For example, although one RO said that it asked for canceled checks and screen prints to document certain collections, another RO said that the MAC may provide such documentation, but that the RO would not request the documentation if it was not provided. This same RO's staff said that the documentation that they generally obtained to support the MAC's overpayment collection consisted of an Excel tracking spreadsheet that the MAC updated quarterly. Some ROs indicated that they accepted documentation such as screen prints from the MAC, copies of canceled checks the MAC received from the provider, and Excel tracking spreadsheets. Some ROs said that they accepted explanations from the MACs without independently verifying the information received.

CMS Did Not Have Any Policies and Procedures for Documenting Collections Related to Internal Audit Recommendations

For internal reports, CMS did not have any policies and procedures that specified what documentation should be retained to support \$11,845,917 in unsupported internal audit report collections.

CMS officials told us that CMS did not maintain collections documentation at the level of detail that we were seeking. CMS also said that we could obtain more detailed information from the MACs. Even though the MACs may have more detailed information, it is CMS's responsibility to provide documentation to support that it collected an overpayment. Without adequate documentation, CMS is at risk of Medicare overpayment collections not being returned to the Medicare Trust funds.

³⁴ CMS External Audit Resolution Process Standard Operating Procedure outlines the various steps CMS takes to resolve audit recommendations.

CMS Guidance to Medicare Administrative Contractors for Documenting Collections Was Inadequate

CMS did not provide specific guidance to its MACs concerning what would constitute appropriate documentation to support overpayment collections. The Debt Collection Manual and TDLs contain CMS's guidance to MACs that they should recover overpayments. One TDL states that the MAC should "review the [OIG] identified overpayments . . . , adjust the claims and issue demand letters, as appropriate." However, that guidance does not specify the types of documentation required to support overpayment collections. CMS has stated that ROs may, on a case-by-case basis, communicate with the MACs on how to report collections and on reasons for not collecting overpayments. However, CMS did not have a formal policy or procedure that describes what documentation a MAC was expected to provide to CMS to document that it had collected an overpayment.

CMS IMPLEMENTED TWO, PARTIALLY IMPLEMENTED ONE, AND DID NOT IMPLEMENT ONE OF FOUR PRIOR AUDIT RECOMMENDATIONS THAT IT AGREED TO IMPLEMENT

OMB Circular A-50, section 8(a)(4), requires agencies to maintain accurate records regarding the status of audit reports or recommendations through the entire process of resolution and to maintain records of corrective action. Also, the Green Book requires management to complete and document corrective actions it takes to remediate internal control deficiencies on a timely basis. These corrective actions can include resolution of audit findings. The audit resolution process begins when audit or other review results are reported to management and is completed only after action has been taken that: (1) corrects identified deficiencies, (2) produces improvements, or (3) demonstrates that the findings and recommendations do not warrant management action.³⁵

We made six recommendations in our prior audit report (A-04-10-03059) dated May 18, 2012, and CMS agreed to implement four.³⁶ (See Appendix D for our prior audit recommendations and CMS's comments.) Of the four recommendations that CMS agreed to implement, it implemented two, partially implemented one, and did not implement one as of June 2020.

We summarized the recommendations that CMS concurred with (recommendations 1, 2, 3, and 6) and their implementation status below.

³⁵ Principle 17 of the Green Book states that management should remediate identified internal control deficiencies on a timely basis. Attribute 17.06 adds that management complete and document corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings.

³⁶ CMS did not concur with the fourth recommendation in our prior audit report. In that report, we recommended that CMS collect sustained OIG-identified overpayments that providers made after our audit period to the extent allowed under the law. CMS also did not concur with the fifth recommendation that CMS verify that \$84.2 million it reported as collected had actually been collected.

Prior Recommendation: Pursue Legislation To Extend the Statute of Limitations (Implemented)

In our prior report, we recommended that CMS pursue legislation to extend the section 1870 limitation period so that the recovery period exceeds the reopening period for Medicare payments. CMS concurred with this recommendation. Effective January 2, 2013, Congress amended section 1870 to extend the recovery period from 3 to 5 years following the year payment was made.

Although the section 1870 limitation period was extended beyond the reopening period, CMS took no action to revise regulatory and manual instructions to make the reopening period for claims consistent with the 2013 statutory provisions. Current Federal regulations (42 CFR § 405.980) permit contractors to reopen paid claims within 4 years of payment “for good cause.” Unless a claim is reopened within this 4-year window, recovery of overpayments cannot be made, even though the statute allows a 5-year timeframe to begin recovery proceedings. Therefore, the action Congress took in 2013 to extend recovery from 3 to 5 years is effectively limited to 4 years because of the reopening limit.³⁷ OIG typically selects claims for audit within the 4-year reopening limit. However, CMS does not have a mechanism to reopen claims at the start of an OIG audit. CMS usually reopens claims after OIG has issued a final report. This limits OIG’s ability to recommend and CMS’s ability to recover certain overpayments.

Prior Recommendation: Ensure That the Audit Tracking and Reporting System Is Accurate (Not Implemented)

In our prior report, we recommended that CMS ensure that its ATARS was updated to accurately reflect the status of audit report recommendations. CMS concurred with this recommendation.

ATARS was an audit recommendation tracking system that CMS previously used for recording and reporting overpayment recoveries. CMS said that it would ensure that corrective action plans and recoveries were clearly described and reported in ATARS. CMS also stated that it intended to consistently and accurately record overpayment recoveries.

After we issued our prior audit report, CMS developed the SWIFT system to replace the ATARS system. We consider our prior recommendation not implemented because we identified two issues that we identified in ATARS and that were not resolved with CMS’s implementation of SWIFT. Those issues are: (1) not always providing reasons for not collecting an overpayment and (2) not accurately recording overpayment collections.

³⁷ A cost report may be reopened if the MAC receives a written request within 3 years from the date that the NPR was issued. A cost report reopening may be initiated by the provider, MAC, or CMS (42 CFR § 405.1885 and the *Provider Reimbursement Manual*, Part 1, 15-1, chapter 29, sections 2931–2932).

In regard to providing reasons for non-collections in SWIFT, Appendix B of this report shows instances when CMS did not provide a reason for not collecting an overpayment.

In regard to accurately recording collections in SWIFT, CMS recorded total collections of \$1,290,950 for report number A-07-15-01159 but could not provide any documentation to support that it had collected most of this amount. We (OIG) confirmed that CMS collected \$352, but CMS did not confirm that it collected the remaining \$1,290,598. Of the \$1,290,598, CMS referred \$979,169 to SSA for collection, but provided no evidence that it was ever collected; it deemed \$252,614 as uncollectible because the associated beneficiaries were deceased and CMS took no further action; and it recorded the remaining \$58,815 as collected but could not provide any documents to support that it had been collected. Therefore, SWIFT's record of collections was overstated by \$1,290,598 for this one report.

Furthermore, collections associated with one of two recommendations in report number A-07-10-02775 (Recommendation 1 and Recommendation 5 in SWIFT) may have been inaccurate. When we inquired about the amounts reported as collected, CMS said that neither it nor the MAC was able to determine what amount applied to Recommendation 1 and what amount applied to Recommendation 5. The MAC subsequently confirmed that \$830,194 was a collection for Recommendation 5 and that the same \$830,194 was also included in the \$895,814 reported as a collection for Recommendation 1. Because of the duplication, total collections in SWIFT may have been overstated by \$830,194.

The above examples show a continuation of a problem, accurately recording collections, that we identified in our prior audit.

Prior Recommendation: Ensure That CMS Staff Record Collection Information Consistently in ATARS (Implemented)

In our prior report, we recommended that CMS ensure that CMS staff record collection information consistently in ATARS. CMS concurred with this recommendation.

During our current audit, we did not find any issues with CMS inconsistently recording overpayment recoveries.

Prior Recommendation: Provide Specific Guidance to Its MACs Concerning Overpayment Collections (Partially Implemented)

In our prior report, we recommended that CMS provide specific guidance to its MACs concerning: (1) the timeframe in which the MAC must take action to collect an overpayment, (2) how to report collections, (3) the type of documentation that the MAC must maintain to substantiate an overpayment collection, and (4) how to report reasons for not collecting overpayments. CMS concurred with this recommendation.

CMS stated that it:

- had expanded its reporting requirements and provided to MACs additional direction related to closing audit reports,
- was more closely monitoring responses from MACs to ensure that the MACs completed their quarterly reporting timely and accurately and that MACs provided sufficient documentation to substantiate collection amounts,
- had worked with OIG to improve the speed at which CMS receives overpayment data from OIG and that this improvement should allow it to provide OIG-identified overpayment data to the MACs sooner so that the collection process could start, and
- would work to ensure that the MACs provided explanations for overpayments that they could not collect.

In this audit, we identified two issues, one of which we also identified in our prior audit. First, CMS did not more closely monitor responses from MACs to ensure that the MACs provided sufficient documentation to substantiate collection amounts. Specifically, CMS did not provide evidence that it requested documentation from the MACs that was significantly different from the documentation that it requested as part of our prior audit. Second, CMS did not give us evidence to show that it provided its MACs with guidance about the type of documentation that the MAC must maintain to substantiate an overpayment collection.

As previously discussed in this report, CMS continued to rely on collection amounts that MACs reported in emails and recorded on Excel spreadsheets. CMS usually accepted without independent verification whatever form of support a MAC provided. Some CMS regions responsible for collection activities said that they reviewed a MAC's documentation by selecting a number of items on the spreadsheet for verification. However, those regions did not provide evidence for all reported collections that described the extent of that verification.

CONCLUSION

CMS reported that it had collected only \$272 million (55 percent) of the \$498 million in overpayments that it agreed to collect. Further, CMS provided documentation sufficient to support that it had collected only \$120 million (44 percent) of the \$272 million it reported as collected and only \$4 million (32 percent) of the \$13 million it reported as collected in excess of our recommended amounts.

Policies and procedures are one of the primary components of an effective internal control system. Both our current and prior audits showed that CMS did not have adequate policies and procedures to address certain collection issues, especially to support that the collection

occurred. In the absence of adequate policies and procedures, CMS cannot ensure that Medicare overpayments will be collected to the maximum extent possible.

Our current audit also showed that CMS did not take corrective action on all of the recommendations with which it concurred in our prior audit report. As a result, three of the recommendations (4, 5, and 6) that we make in our current audit report parallel two of the recommendations (2 and 6) from our prior report. CMS continues to have issues recording entries accurately in its audit tracking system, providing reasons for not collecting an overpayment, and devising a formal policy or procedure that describes what documentation a MAC is expected to provide to CMS to document that it has collected an overpayment. Unless CMS improves its controls, it will continue to be at risk of not being able to collect millions of dollars owed to the Medicare Trust funds.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- continue its efforts to recover any collectible portion of the \$226 million in uncollected overpayments and inform us of any additional collections related to this amount;
- establish policies that define and require retention of documentation that is needed for independent verification of the collection of overpayments;
- determine what portion of the \$152,510,191 (footnote 25) was collected and recorded in its accounting system based on policies established in response to our recommendation in the previous bullet;
- establish policies and procedures that require staff to clearly describe the reasons for non-collection of an overpayment, maintain any documentation necessary to support those reasons, and obtain approval from an authorized individual not to collect the overpayment;
- ensure that employees follow established policies and procedures for verifying that collection information is accurately and consistently recorded³⁸;
- provide MACs with specific guidance on what documentation is needed to support the collection of an overpayment;
- revise 42 CFR section 405.980 and corresponding manual instructions related to the reopening period for claims to be consistent with statutory provisions contained in

³⁸ On the basis of CMS's comments on our draft report, we modified our recommendation that CMS establish policies and procedures that include specific steps required to verify that collection information is accurately and consistently recorded in SWIFT or any replacement tracking system such as AMS.

section 1870 of the Social Security Act, which allows Medicare contractors to determine whether overpayments were made and to begin to collect them for 5 years following the year payments were made;

- establish a mechanism to reopen claims when OIG starts an audit so that CMS can collect overpayments consistent with the 5-year timeframe contained in section 1870 of the Social Security Act; and
- develop a plan, with milestones, for reconciling cost reports applicable to nine audit reports discussed in Appendix B of this report.

CMS COMMENTS AND OIG RESPONSE

In written comments on our draft report, CMS generally did not concur with our findings or recommendations. Of our nine recommendations, CMS concurred with one recommendation, did not concur with seven recommendations, and did not explicitly state that it concurred or did not concur with one recommendation. CMS concurred with our recommendation to continue its efforts to recover any collectible portion of the \$226 million in uncollected overpayments and inform us of any additional collections related to this amount and stated that it would explore ways that are operationally feasible and cost effective to implement our recommendation to establish a mechanism to reopen claims when OIG starts an audit.

On the basis of additional documentation CMS provided us after we had issued our draft report, we revised the total undocumented overpayment collections amount shown in recommendation 3. (See footnote 25.)

CMS should promptly collect our recommended and sustained overpayments, and when CMS and the MACs do so, they must retain the documentation needed to create an audit trail. This documentation is critical to ensure that the overpaid dollars are in fact collected and returned to the Medicare trust fund.

Below we summarized CMS's comments and our responses to those comments. CMS's comments, excluding its technical comments, are included in their entirety as Appendix E.

RECOMMENDATION 1: CONTINUE EFFORTS TO RECOVER ANY COLLECTIBLE PORTION OF THE \$226 MILLION IN UNCOLLECTED OVERPAYMENTS

CMS Comments

CMS concurred with this recommendation. CMS noted that this recommendation duplicated the recommendations regarding collections in the 148 audit reports that OIG reviewed. CMS further said that it updates OIG on the status of the 148 audits' recommendations via administrative actions. CMS said that it has never stopped collection efforts and continues to recover any collectible portion of the \$226 million, some of which is no longer collectible

because of changes in the sustained amount, provider bankruptcy, and settlements, among other reasons. CMS also said that since the conclusion of OIG’s data collection in June 2020, it had collected more than 75 percent of currently sustained overpayments.

OIG Response

Our audit represented a snapshot in time. As such, it showed the status of overpayments that CMS agreed to collect as of April 7, 2018. As discussed on page 12 of this report, we recognize that about \$17 million of the sustained overpayments are no longer collectible. However, there were other overpayments that may still be collectible, such as the \$78 million that CMS had not collected because the providers’ NPRs were on hold pending the establishment of an SSI factor and the \$45 million that was pending cost report reconciliation.

Thus, consistent with the Green Book, we expect CMS to continue its efforts to recover any collectible portion of the \$226 million in uncollected overpayments and inform us of any additional collections related to this amount.³⁹

Finally, CMS did not provide any documentation to support its statement that it had collected more than 75 percent of currently sustained overpayments since June 2020, nor did it define the term “currently sustained overpayments.” As a result, we cannot confirm CMS’s statement.

RECOMMENDATION 2: ESTABLISH POLICIES THAT DEFINE AND REQUIRE RETENTION OF DOCUMENTATION NEEDED FOR INDEPENDENT VERIFICATION OF COLLECTION OF OVERPAYMENTS

CMS Comments

CMS did not concur with this recommendation, but its comments did not directly address the recommendation. In comments on the related finding (as well as on recommendation 3), CMS said that it had documented performance expectations for the MACs in their Statements of Work, the *Medicare Financial Management Manual*, and TDLs. CMS said that the *Financial Management Manual* requires the MACs to keep detailed records of all collection activities through all stages of the debt collection process.

In its comments on the related finding, CMS said that, in line with the Green Book, it delegates authority to a network of MACs to serve as the primary operational contacts between the Medicare FFS program and health care providers enrolled in the program. In its comments on this recommendation, CMS said that, as part of the OIG audit recommendation resolution process, it receives updates from the MACs on collection amounts, as well as other relevant

³⁹ The Green Book states that management completes and documents corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings. Management, with oversight from the oversight body, monitors the status of remediation efforts so that they are completed on a timely basis (Attribute 17.06).

collection documentation as requested, and regularly reports to OIG on the status of collections. CMS said that some overpayment collections involve thousands of providers and claims; consequently, rather than collecting detailed documentation or screenshots of the thousands of payment transactions that the MACs perform in HIGLAS to collect overpayments, CMS often collects high-level summary updates and HIGLAS extracts, while the MACs maintain the source documentation supporting the summary reports. CMS also said that it seeks to be responsive to OIG's audit needs and to provide all information that OIG requests. Finally, CMS said that, in line with the Green Book, the MACs are able to provide HIGLAS extracts, known as RBD reports, and source documentation for ready examination.

OIG Response

The Green Book states that management should clearly document internal controls and all transactions in a manner that allows the documentation to be readily available for examination. The internal controls requiring documentation may appear in management directives, administrative policies, or operating manuals (Attribute 10.03). CMS did not provide any documentation to show that its performance expectations for the MACs (which CMS said are documented in the Statements of Work, the *Medicare Financial Management Manual*, and TDs) define and require the retention of documentation needed to support overpayment collections.

In addition, for many overpayments, CMS could not readily provide RBD reports from HIGLAS or other source documentation. In many cases, CMS gave us various documents (e.g., letters, emails, accounting system reports, screen prints of adjusted claims, and Excel spreadsheets that contained lists of unverified overpayments and collections) that we could not associate with a specific overpayment amount or that did not support the reported amounts collected.⁴⁰

Some CMS ROs said that they accepted documentation from MACs, such as screen prints, copies of checks that MACs received from providers, and MAC-prepared Excel tracking spreadsheets. Some ROs said that they accepted information from the MACs without independently verifying the information received, including collections information on Excel spreadsheets. Some ROs said that they verified collections information received from the MACs but provided no documentation that showed the extent to which they verified this information. As our prior audit and this audit have shown, the types of documentation provided were not consistent among the various MACs, and documentation was not always readily available to support the reported collections.⁴¹

In many instances, we attempted to use other sources to verify overpayments and collections, such as RBDs from HIGLAS. However, CMS told us that the HIGLAS system underwent a

⁴⁰ Accounting system reports included remittance advices, loan payments, offsets, adjustments, and reports that showed payment activity.

⁴¹ Our prior Audit Report Number is A-04-10-03059 and our current Audit Report Number is A-04-18-03085.

transition during our audit period. Therefore, CMS could not readily provide RBDs for all of the overpayments in our audit period, and some of the RBDs they provided did not include the information needed to determine which audit report the overpayments and collections pertained to.

Even though CMS added the capability to track claims adjustments in HIGLAS by OIG audit report number and instructed the MACs to enter this information, the MACs did not always enter the OIG report number on documentation that CMS provided to us. Without screenshots from HIGLAS or other documentation that showed an overpayment collection specifically related to one of our audits, we could not accept the reported overpayment collection as a documented collection.

CMS is ultimately responsible for functions it outsources and should be able to provide documentation to support a reported overpayment collection and to have the supporting documentation readily available.⁴² Without supporting documentation, robust oversight is not possible, and there is an increased risk of fraud, waste, and abuse. Thus, we continue to believe that CMS should define, in policies and procedures, what documentation the MACs need to retain so that overpayment and collections documentation can be readily obtained for review.

RECOMMENDATION 3: DETERMINE WHAT PORTION OF THE \$152,510,191 WAS COLLECTED AND RECORDED IN CMS'S ACCOUNTING SYSTEM

CMS Comments

CMS did not concur with the recommendation in our draft report that it determine what portion of \$154,631,632 (footnote 25) was collected and recorded in its accounting system, but its comments did not directly address the recommendation. CMS said that, as part of the OIG audit recommendation resolution process, it receives updates from the MACs on collection amounts, as well as other relevant collection documentation as requested, and regularly reports to OIG on the status of collections. CMS said that rather than centrally monitoring and retaining documentation for every transaction, it monitors the effectiveness of established internal controls related to overpayment recoveries, including the work contracted to the MACs, by hiring independent certified public accounting firms to conduct yearly Statement of Standards for Attestation Engagements No. 18 audits (SSAE 18 Audits) and OIG's annual Chief

⁴² The Green Book states that management retains responsibility for monitoring the effectiveness of internal control over the assigned processes performed by service organizations. Management uses ongoing monitoring, separate evaluations, or a combination of the two to obtain reasonable assurance of the operating effectiveness of the service organization's internal controls over the assigned process. Monitoring activities related to service organizations may include the use of work performed by external parties, such as service auditors, and reviewed by management (Green Book Attribute 16.08).

Financial Officer (CFO) audit.⁴³ CMS said that the results of these audits confirm that the MACs' internal controls are operating efficiently and effectively and that CMS has received clean, unmodified audit opinions on the reasonableness of its year-end financial statements from OIG's CFO auditors for the past 23 consecutive fiscal years.

OIG Response

CMS's SSAE 18 audits provide assurance of the MACs' general internal control environment but do not provide assurance that overpayment amounts were collected and appropriately recorded. The SSAE 18 audits test only whether internal controls are in place.

CFO audits do not include in-depth reviews of transactions that would address the specific issues we raised in this report. Rather, the CFO auditors offer an opinion on the quality or integrity of CMS's financial statements. The CFO auditors measure the materiality threshold for CMS's financial statement audits in billions of dollars. For CMS's FY 2020 Financial Report, the CFO auditors considered errors to be material if they were more than \$12.4 billion. This means that the entire \$511 million we reviewed (consisting of \$498 million that CMS sustained and \$13 million that CMS reported that it collected in excess of what we recommended) was significantly below the materiality threshold for CMS's financial statements and would not be specifically addressed in CMS's financial statement audit. In addition, in CMS's 2016 and 2020 Financial Reports, CMS acknowledged that the CFO auditors identified significant deficiencies in internal controls related to CMS's financial reporting systems and information systems controls.⁴⁴

In its comments, CMS stated that it is providing monitoring and oversight. However, its inability to provide documentation or, in some cases, explanation of the documentation it received from its MACs showed that it did not follow Principle 10 in the Green Book, which states that

⁴³ The Chief Financial Officers Act of 1990 (CFO Act), P.L. No. 101-576, established both processes and institutions to address Federal financial management and required executive agencies to prepare annual financial statements. The CFO Act, as amended, requires that agencies develop and maintain financial management systems that comply with applicable accounting principles, standards, and requirements; internal control standards; and requirements of OMB, Treasury, and others. Available online at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c07pdf.pdf>. Accessed on Feb. 4, 2022.

⁴⁴ *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2016*, pages 85, 95, and 105 (A-17-16-02016). Available online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2016_CMS_Financial_Report.pdf. Accessed on May 16, 2022.

Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2020, pages 92, 103, and 110 (A-17-20-53000). Available online at <https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2020.pdf>. Accessed on May 16, 2022.

management should design control activities to achieve objectives and respond to risks.⁴⁵

RECOMMENDATION 4: ESTABLISH POLICIES AND PROCEDURES THAT REQUIRE STAFF TO CLEARLY DESCRIBE REASONS FOR NON-COLLECTION OF AN OVERPAYMENT

CMS COMMENTS

CMS did not concur with this recommendation. CMS said that it has policies and procedures in place for documenting collection activities and that updates are provided to OIG through OCDs or ASFRs after they are signed by an approving official.

In its comments on the related finding and this recommendation, CMS also said that, of the funds that OIG identified as not including reasons for non-collection, 99 percent are related to only two audits. For one of these audits (A-02-12-01008), CMS disagreed with what OIG believes is the audit's sustained amount of \$8.8 million. In its comments on the related finding, CMS said that in this audit we recommended that CMS "consider authorizing Treasury to use its administrative wage garnishment authority to collect delinquent debts, totaling \$8,802,701, associated with 21 individual physicians." CMS also said that it did not sustain any amount for collection because the debts would not be collected by CMS, but rather the Department of the Treasury's (Treasury's) AWG program. CMS said that, therefore, noting a reason for non-collection is not applicable in this instance.

For the second audit (A-01-13-00506), CMS said that it had collected \$6.3 million, which it determined to be sustained overpayments. CMS said that the difference (\$12.7 million) between the OIG-estimated amount (\$19 million) and the amount collected represented overpayments that were: (1) below the recovery threshold, (2) reduced because of favorable appeals, (3) for claims that were previously adjusted, and (4) for claims that were beyond the 4-year reopening period. CMS further noted that the overpayment collections required reviewing more than a million claims and that therefore it would not be administratively feasible for CMS to document the reasons for non-collection of an overpayment for every claim within this audit.

OIG Response

In regard to CMS's comment that updates are provided to OIG through OCDs or ASFRs, our concern is not that CMS did not provide us with OCDs and ASFRs. Our concern is that, in some instances, the OCDs, ASFRs, and CMS's audit tracking system did not contain a reason why an overpayment was not collected, or the reason CMS provided was unclear.

⁴⁵ The Overview section of the Green Book states that the 17 principles support the effective design, implementation, and operation of the associated components and represent requirements necessary to establish an effective internal control system (OV2.05).

Although CMS indicated that the *Medicare Financial Management Manual* requires MACs to keep records of all collection activities through all stages of the debt collection process, the *Manual* does not define and require the retention of documentation needed for independent verification of overpayment collections. Also, the *Manual* does not state that the MACs should provide and document a clear reason why an overpayment could not be collected. OMB Circular No. A-50, 5., Policy, states that agency systems must provide for a complete record of action taken on both monetary and non-monetary findings and recommendations. Circular No. A-50 8.a.4., also states that agency systems must provide for a complete record of action taken on both monetary and non-monetary findings and recommendations.

Regarding the first audit (A-02-12-01008), we disagree with CMS's statement that noting a reason for non-collection of the \$8.8 million is not applicable because the debt was referred to Treasury. In an OCD dated August 27, 2015, CMS concurred with our recommended recovery of \$8.8 million. This OCD also showed that CMS "sustained" the \$8.8 million that we recommended for recovery and established an accounts receivable of \$8.8 million in its accounting system, which indicates that CMS intended to collect the OIG-recommended amount. However, the OCD did not indicate that CMS had referred the overpayments to Treasury for collection. In addition, CMS did not provide documentation supporting that the referral to Treasury had been appropriately approved.

Regarding the second audit (A-01-13-00506), with \$19 million in uncollected overpayments, CMS did not provide any documentation to show that it had collected \$6.3 million of the \$19 million. CMS also did not provide any documentation that showed the difference of \$12.7 million related to overpayments that were: (1) below the recovery threshold, (2) reduced because of favorable appeals, (3) for claims that were previously adjusted, and (4) for claims that were beyond the 4-year reopening period. Although CMS regularly updates OIG on its collections and reasons for uncollected funds via OCDs and ASFRs, CMS did not provide us with an OCD or ASFR that contained reasons for not collecting the \$19 million in overpayments. None of the documentation that CMS provided to us through October 27, 2021, referenced any of the reasons for not collecting the \$19 million that CMS listed in its written comments on our draft report. Moreover, CMS did not offer reasons for not collecting the \$19 million until it had submitted its written comments, even though we requested this information more than once.

We classified the \$28 million (\$19 million and \$8.8 million) in overpayments as "No Reason Provided or Reason Unclear" because CMS has not provided a reason why the amount had not been collected, or the reason provided was unclear. The lack of an explanation or an unclear explanation of the status of the collection process illustrates CMS's inability to adequately track its collection efforts. In addition, CMS's use of Treasury's AWG program to facilitate the collection of Medicare overpayments does not relieve CMS of its responsibility to track and account for Medicare overpayment collections.

CMS may have misinterpreted our recommendation that it establish policies and procedures that require staff to clearly describe reasons for non-collection of an overpayment. At the time of our audit, CMS tracked the status of its overpayment collection efforts through SWIFT. Also,

CMS keeps OIG apprised of the status of its collection efforts through OCDs and its quarterly ASFRs.

Of the \$226 million that CMS reported as not collected, we classified \$28 million as “No Reason Provided in OCDs, ASFRs, or SWIFT.” The \$28 million related to eight audits. Of the eight audits, approximately \$27.8 million related to two audits (\$19 million for A-01-13-00506 and \$8.8 million for A-02-12-01008). Therefore, CMS should not have to review more than a million claims to determine the reasons for not collecting these overpayments. Moreover, CMS did not explain why it would not be administratively feasible for it to document the reasons for not collecting the \$28 million of overpayments discussed in this report. Therefore, we maintain that our recommendation is valid.

RECOMMENDATION 5: ENSURE THAT EMPLOYEES FOLLOW ESTABLISHED POLICIES AND PROCEDURES FOR VERIFYING THAT COLLECTION INFORMATION IS ACCURATELY AND CONSISTENTLY RECORDED

CMS Comments

CMS did not concur with our original recommendation. CMS said that it has made significant improvements in the way recommendations are tracked and noted that we did not find any issues with the consistency of reporting overpayment recoveries. CMS also acknowledged that we noted two instances in which there were issues with CMS’s accuracy in reporting collections. CMS said that updates on overpayment collections are manually entered into its recommendation tracking system, and therefore minor errors in reporting may be present at any given time. CMS also said that the two issues with accuracy of reporting that OIG identified have subsequently been addressed.

OIG Response

On the basis of CMS’s comments on our draft report, we modified our recommendation that CMS establish policies and procedures that include specific steps required to verify that collection information is accurately and consistently recorded. Instead, we are recommending that CMS ensure that employees follow established policies and procedures for verifying that collection information is accurately and consistently recorded.

Although our current audit identified only two instances in which CMS reported inaccurate collections, the issue of inaccurate reporting was also identified during our prior audit. One of the two current instances of inaccurately reported collections related to \$1,290,598 that CMS reported in SWIFT as collected even though it had referred a portion to SSA for collection or deemed another portion uncollectible. The second instance related to CMS reporting the same \$830,194 collection for two different recommendations. This second instance can be attributed to human error.

We agree that minor errors in reporting may have been present in SWIFT at any given time. However, ensuring that established policies and procedures are followed for verifying that collection information is accurately and consistently reported would mitigate the risk that more significant reporting errors will occur in the future. Significant reporting errors could undermine CMS's ability to effectively manage overpayments identified in OIG and other reports.^{46, 47} Therefore, we maintain that our revised recommendation is valid.

RECOMMENDATION 6: PROVIDE MACS WITH SPECIFIC GUIDANCE ON WHAT DOCUMENTATION IS NEEDED TO SUPPORT COLLECTION OF AN OVERPAYMENT

CMS Comments

CMS did not concur with this recommendation. CMS said that it has documented its expectations for the MACs in their Statements of Work, the *Medicare Financial Management Manual*, and TDLs. CMS again cited the *Medicare Financial Management Manual* requirements that: (1) MACs keep records of all collection activities through all stages of the debt collection process and (2) the records be detailed and include all correspondence and conversations with the provider, checks, and any other documents associated with debt collection processes.

OIG Response

CMS's performance expectations for the MACs (documented in the MACs' Statements of Work, the *Medicare Financial Management Manual*, and TDLs) are not substitutes for policies that define and require the retention of documentation needed for independent verification of overpayment collections. CMS should provide MACs with specific guidance on what documentation is needed to support the collection of an overpayment.

Principle 12 of the Green Book states that management should implement control activities through policies. Principle 10 addresses the design of control activities. Attribute 10.03

⁴⁶ Principle 10 of the Green Book states that management should design control activities to achieve objectives and respond to risks. Attribute 10.03 adds that transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. This applies to the entire process or life cycle of a transaction or event from its initiation and authorization through its final classification in summary records. In addition, management designs control activities so that all transactions are completely and accurately recorded.

⁴⁷ Principle 13 of the Green Book states that management should use quality information to achieve the entity's objectives. Attribute 13.02 states that management designs a process that uses the entity's objectives and related risks to identify the information requirements needed to achieve the objectives and address the risks. Information requirements consider the expectations of both internal and external users. Management defines the identified information requirements at the relevant level and requisite specificity for appropriate personnel. Attribute 13.03 states, in part, that management identifies information requirements in an iterative and ongoing process that occurs throughout an effective internal control system. Attribute 13.04 states, in part, that management obtains relevant data from reliable internal and external sources in a timely manner based on the identified information requirements.

provides examples of control activities, including the appropriate documentation of transactions and internal controls.

Without clear instructions for how the MACs should document transactions, CMS risks not being able to substantiate overpayment and collection transactions related to OIG reports. For example, during our current and our prior audit, CMS gave us various documents (e.g., letters, accounting system reports, screen prints of adjusted claims, Excel spreadsheets that contained lists of numbers that CMS said were claim adjustments, and emails) that we could not always associate with a specific overpayment amount or that did not support the claimed collection. As our prior and current audits have shown, the types of documentation that the MACs provided were not consistent across all MACs, and documentation was not always readily available to support the reported collections.

RECOMMENDATION 7: REVISE 42 CFR SECTION 405.980 AND CORRESPONDING MANUAL INSTRUCTIONS RELATED TO THE REOPENING PERIOD FOR CLAIMS TO BE CONSISTENT WITH SECTION 1870 OF THE SOCIAL SECURITY ACT

CMS Comments

CMS did not concur with this recommendation. CMS said that the claim-reopening rules are not dependent on the provisions in section 1870 of the Social Security Act related to overpayment recoveries. CMS also said that section 1870(b) is not a blanket statute of limitation on recovery but rather a rebuttable presumption that a provider is without fault for an overpayment determined after the specified period. CMS quoted section 1870(b): “[S]uch provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary’s determination that more than such correct amount was paid was made subsequent to the fifth year following the year in which notice was sent to such individual that such amount had been paid” CMS said that if there is evidence that the provider or supplier was not without fault, the provider would not get the benefit of the “without fault” presumption, and the overpayment may be recovered beyond the fifth year from the year in which the overpayment was made.

CMS said that, in accordance with 42 CFR § 405.980, claims may be reopened within 1 year for any reason, up to 4 years for good cause, and at any time for fraud or similar fault. CMS also said that, given the discretion contractors have to reopen claims within 4 years of the date of initial determination for good cause, or at any time for fraud or similar fault (as defined in 42 CFR § 405.902), CMS believes that maintaining the existing claim-reopening timeframes will alleviate concerns about an increased burden on providers and their contractors. CMS said that it believes that burdensome changes that are not operationally necessary are unwarranted.

OIG Response

Although not dependent on one-another, the reopening rule and section 1870 are interrelated because both impose time limitations on CMS’s and its contractors’ ability to collect Medicare

overpayments. Although section 1870 is not a blanket statute of limitations, but a rebuttable presumption, absent evidence that a provider is not without fault, section 1870 bars recovery after the fifth year following the year in which notice of such payment was sent to the provider. At the same time, the reopening rule bars Medicare contractors from reopening claims after four years from the date of initial determination absent reliable evidence that the payment was procured by fraud or similar fault. As shown in our report, because claims must be reopened before they can be recovered, the 4-year reopening period functionally bars recovery of certain overpayments that could be recovered under the 5-year section 1870 recovery period.

CMS stated that maintaining existing claim reopening timeframes will alleviate concerns about an increased burden on providers and Medicare contractors. We appreciate that CMS has concerns about making changes to the reopening rule, but our audit shows that CMS and its contractors are not recovering some overpayments and returning those funds to the Medicare Trust because the 4-year reopening period elapses prior to the 5-year limitation period established in statute. Based on our findings and CMS's responsibility to administer and protect the integrity of the Medicare program and Trust, we believe that amending the reopening rule to allow for "good faith" reopening until the running of the statutory 5-year limitation period is necessary and warranted.

RECOMMENDATION 8: ESTABLISH A MECHANISM TO REOPEN CLAIMS WHEN OIG STARTS AN AUDIT SO THAT CMS CAN COLLECT OVERPAYMENTS CONSISTENT WITH THE 5-YEAR TIMEFRAME IN SECTION 1870 OF THE SOCIAL SECURITY ACT

CMS Comments

CMS did not indicate concurrence or nonconcurrence with this recommendation. CMS said that it would explore ways that are operationally feasible and cost effective to establish a mechanism to notify providers concerning the reopening of their claims based on OIG audit work. According to CMS, this provider notification would occur after OIG has identified the specific claims that it intends to sample and audit.

OIG Response

We will work with CMS to explore ways to notify providers concerning the reopening of their claims based on our audit work. Resolving this issue should allow CMS to more effectively resolve audit findings. (See footnote 31.)

RECOMMENDATION 9: DEVELOP A PLAN, WITH MILESTONES, FOR RECONCILING COST REPORTS APPLICABLE TO THE NINE AUDIT REPORTS DISCUSSED IN APPENDIX B

CMS Comments

CMS did not concur with this recommendation. CMS said that it already updates OIG on the status of collections on a regular basis through OCDs and ASFRs. CMS also said that since OIG's

audit period, it has reported to OIG the collection of overpayments from audit A-07-13-02791 after the cost report reconciliation occurred.

OIG Response

CMS's comments were not directly responsive to our recommendation. We based our recommendation on our findings regarding nine audits that contained potential overpayments related to Medicare cost reports. As we discussed in our report, CMS sometimes did not provide a reason for delays in its cost report reconciliations, or the reason that CMS provided was unclear. For example, CMS did not provide a reason for the delay in collecting \$6,802,575 related to five cost reports that were more than 10 years old. For other cost reports, CMS's documentation cited problems with the system it used to process cost report reconciliations as a reason for non-collections. However, none of the OCDs or ASFRs contained a plan or any milestones for resolving the cost reports.

Our recommendation that CMS develop a plan and milestones for resolution of audit findings mirrors Green Book language related to management's completion and documentation of the resolution of audit findings in a timely manner. (See footnote 35.)

For audit A-07-13-02791, we reported that \$279,156 was "Pending Cost Report Reconciliation." Cost reports must be reconciled to be resolved. However, CMS did not provide any of the information we requested on the status of the cost report reconciliations during the course of the audit. CMS did provide a status for the reconciliation of A-07-13-02791 when it provided comments on our draft report. However, CMS did not comment on the status of the cost report reconciliations for the remaining \$45,103,134 that we also classified as pending reconciliation. Therefore, we maintain that our recommendation that CMS develop a plan, with milestones, for reconciling the cost reports applicable to the nine audits discussed in Appendix B remains valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed 149 (10 internal and 139 external) Medicare audit reports issued during the 27-month period from October 1, 2014, through December 31, 2016 (audit period), that included recommendations for the recovery of overpayments totaling \$646,940,425.⁴⁸ CMS concurred with recommendations for the recovery of \$498,022,527 related to 148 of those audit reports. In addition, CMS reported collecting \$13,247,197 in excess of what we recommended for recovery in those reports.

To determine whether CMS recovered the overpayments, we reviewed the relevant OCDs and CMS's supporting documentation for the 148 audit reports.

We met with CMS Central Office staff and CMS regional staff and discussed the status of our prior audit recommendations. We also sent CMS a written request asking for any updates regarding actions it had taken on our prior audit recommendations.

We did not review the overall internal control structure of CMS or the Medicare program. Rather, we reviewed only those internal controls related to our objectives.

We performed our audit from March 2018 through June 2021.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal requirements;
- interviewed CMS officials to gain an understanding of the overpayment recovery process;
- obtained and reviewed CMS policies and procedures for the recovery of overpayments related to our audit recommendations;
- prepared and reviewed information from a list of 149 audit reports issued in the audit period, which had recommended recoveries of \$646,940,425;⁴⁹

⁴⁸ We selected our audit period because it included the most current data that would allow CMS an adequate amount of time to take action to collect these overpayments.

⁴⁹ Relevant information that we obtained for each of the 149 audit reports included the audit Common Identification Number, audit title, final report issued date, recommendation action code (questioned cost, funds put to better use, unable to express an opinion, and provide documentation or make financial adjustment), recommendation code and amount of the recommendation, and management decision date and amount.

- identified sustained overpayments totaling \$498,022,527 that were recommended for recovery in 148 of those audit reports and with which CMS concurred;
- reviewed CMS's ASFRs as of September 2018 to: (1) track CMS's progress in clearing and closing our audit recommendations, (2) identify CMS's actions taken to recover overpayments, and (3) identify the amount of any collected overpayments;
- reviewed the relevant OCDs and supporting documentation applicable to the 148 audit reports to determine the dollar amounts of CMS's concurrences with the overpayment recovery recommendations and the amount CMS said it recovered;
- reviewed our prior audit report (A-04-10-03059) findings and recommendations and CMS's comments on those recommendations;
- discussed with CMS officials the actions CMS had taken on the recommendations after we issued our prior audit report (A-04-10-03059); and
- discussed the results of our current audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: REASONS CMS PROVIDED FOR NOT COLLECTING OVERPAYMENTS

Internal Audits		
Audit Common Identification Number (CIN)*	Uncollected Overpayments	Reason for Not Collecting Overpayment[†]
A-01-13-00506	\$19,000,000	No Reason Provided in OCDs, ASFRs, or SWIFT
A-01-15-00508	492,947	Other
A-02-12-01008	8,802,701	No Reason Provided in OCDs, ASFRs, or SWIFT
A-04-13-06168	77	Other
A-07-15-01159	979,169	Other
A-07-15-01159	252,614	Overpayment Redetermination
A-07-16-05089	46,566	No Reason Provided in OCDs, ASFRs, or SWIFT
A-07-16-05089	191,127	Overpayment Redetermination
A-09-14-02037	42,655	Other
A-09-14-02041	52,202	Other
A-09-14-02041	66,338	Pending Cost Report Reconciliation
8 Reports	\$29,926,396	Subtotal Internal Audits
External Audits		
A-01-13-00502	\$903,583	Overpayment Redetermination
A-02-13-01031	596,699	Provider on a Repayment Plan or Repayment Plan Pending
A-02-13-01031	2,000	No Reason Provided in OCDs, ASFRs, or SWIFT
A-02-13-01031	768,311	Overpayment Redetermination
A-02-14-01005	1,164,416	Provider on a Repayment Plan or Repayment Plan Pending
A-02-14-01005	1,166,960	Other
A-02-14-01005	217,555	Overpayment Redetermination
A-02-14-01027	180,929	Other
A-03-15-00002	3,962	Overpayment Redetermination
A-03-15-00009	92,596	No Reason Provided in OCDs, ASFRs, or SWIFT
A-03-15-00012	112,531	Overpayment Redetermination
A-04-13-04018	1,067,056	Overpayment Redetermination
A-04-13-07039	1,623	Other
A-04-13-07043	11,512,530	Pending Results of Provider Appeal
A-04-14-03077	153,498	Overpayment Redetermination
A-04-14-04023	1,826,464	Pending Results of Provider Appeal
A-04-14-07048	2,345,853	Other

External Audits		
Audit Common Identification Number (CIN)*	Uncollected Overpayments	Reason for Not Collecting Overpayment[†]
A-04-14-07051	423,008	Provider on a Repayment Plan or Repayment Plan Pending
A-04-14-07051	607,069	Other
A-04-14-07052	223,329	Provider on a Repayment Plan or Repayment Plan Pending
A-04-14-07052	679,977	Other
A-04-14-07053	486,932	Other
A-04-14-07053	41,479	Overpayment Redetermination
A-04-15-07054	55,165	Overpayment Redetermination
A-05-11-00016	78,424,834	NPR on Hold Pending SSI Factor
A-05-11-00019	6,345,408	Pending Cost Report Reconciliation
A-05-11-00019	36	No Reason Provided in OCDs, ASFRs, or SWIFT
A-05-11-00023	10,062,599	Pending Cost Report Reconciliation
A-05-12-00057	1,376,489	Provider on a Repayment Plan or Repayment Plan Pending
A-05-13-00019	716,703	Other
A-05-13-00020	667,354	Other
A-05-14-00046	2,076,375	Pending Results of Provider Appeal
A-05-14-00046	605,331	Other
A-05-14-00048	124,895	Overpayment Redetermination
A-05-14-00050	1,387,968	Overpayment Redetermination
A-05-15-00043	284,974	Overpayment Redetermination
A-05-15-00044	564,707	Overpayment Redetermination
A-06-14-00074	19,054	No Reason Provided in OCDs, ASFRs, or SWIFT
A-06-14-00074	667,952	Other
A-06-15-00036	211,562	No Reason Provided in OCDs, ASFRs, or SWIFT
A-07-10-02774	4,890,187	Overpayment Redetermination
A-07-10-02775	25,074,065	Pending Cost Report Reconciliation
A-07-11-02773	1,056,969	Pending Cost Report Reconciliation
A-07-13-02791	279,156	Pending Cost Report Reconciliation
A-07-13-02795	29,963,454	Provider on a Repayment Plan or Repayment Plan Pending
A-07-13-02795	2,978,002	Other

External Audits		
Audit Common Identification Number (CIN)*	Uncollected Overpayments	Reason for Not Collecting Overpayment†
A-07-14-00450	420,875	Other
A-07-16-00487	62,221	Pending Cost Report Reconciliation
A-09-13-02056	311,771	Pending Cost Report Reconciliation
A-09-14-02027	482,867	Pending Results of Provider Appeal
A-09-14-02036	2,123,763	Pending Cost Report Reconciliation
A-09-15-02015	92,665	Provider on a Repayment Plan or Repayment Plan Pending
41 Reports	\$195,905,761	Subtotal External Audits
49 Reports	\$225,832,157	Total
* We assign a separate CIN to each audit report.		
† See explanations of these reasons after the table.		

EXPLANATIONS OF REASONS CMS PROVIDED FOR NOT COLLECTING OVERPAYMENTS AND REASONS CMS'S DOCUMENTATION DID NOT ALWAYS SUPPORT REPORTED COLLECTIONS

CMS provided various reasons for not collecting overpayments. Below is a detailed discussion of those reasons, as well as the reasons the documentation CMS provided did not always support its reported collections.

- **NPR on Hold Pending SSI Factor.**⁵⁰ For one audit report, CMS did not collect overpayments totaling \$78,424,834 because providers appealed the SSI factor that CMS used to calculate Medicare reimbursement. The fiscal year end dates for the four cost reports with SSI factors under appeal were more than 10 years old, with end dates ranging from December 31, 2003, to June 30, 2005. CMS stated that, after the SSI factor appeal is resolved, it would issue new instructions on when these cost reports must be resolved.
- **Pending Cost Report Reconciliation.** For nine audit reports, CMS did not collect overpayments totaling \$45,382,290 because Medicare cost report reconciliations were pending.
 - For audit report number A-07-10-02775 (Recommendation 1; Rec. Code: 004-901-01-1), CMS sustained \$18,883,025 in recommended recoveries as of its

⁵⁰ Annually CMS publishes a ratio called the SSI factor, which is used to calculate adjustments for low-income patient costs included in cost reports. Without the SSI factor, CMS cannot settle a cost report and issue the provider an NPR. The NPR is a notice of the amount the provider will be reimbursed.

September 2, 2015, OCD. The recommended recovery related to six cost reports. Of the \$18,883,025, CMS reported that it had collected \$895,814 for one cost report, but the remaining \$17,987,211 for five cost reports was uncollected because of pending cost report reconciliations. The end dates for the five cost reports were more than 10 years old, ranging from June 30, 2006, to September 30, 2008. On March 21, 2017 (18 months after CMS issued its OCD), CMS provided the MAC approval to perform cost report reconciliations. CMS did not provide a reason for the delay in the reconciliation process. CMS also did not provide a timeframe in which the reconciliation process would be completed.

- For the same audit report (Recommendation 3; Rec. Code: 004-004-03-2), CMS sustained \$29,033,914 in recommended recoveries as of its September 2, 2015, OCD. The recommended recovery related to 13 cost reports. Of the \$29,033,914 amount, CMS reported that it had collected \$22,231,339 for eight cost reports, but the remaining \$6,802,575 for five cost reports was uncollected. The end dates for the five cost reports were more than 10 years old, ranging from September 30, 2004, to June 30, 2007. CMS did not provide a reason for the delay in the collection of the \$6,802,575.
- For audit report number A-05-11-00019, CMS sustained \$9,203,704 in recommended recoveries as of its July 27, 2015, OCD. Of this \$9,203,704, CMS reported that it had collected \$2,858,260. However, CMS provided only an Excel spreadsheet that it received from the MAC to support the collection. The remaining \$6,345,444, which related to seven cost reports, was uncollected because of pending cost report reconciliations (\$6,345,408), or the reason for not collecting was unclear (\$36). CMS did not provide a list of the seven cost reports, nor did it identify the periods the cost reports covered.

On September 29, 2016, 14 months after CMS issued the July 27, 2015, OCD, CMS gave its approval for the MAC to perform the reconciliations. CMS provided additional reasons for delays in the reconciliation process. These reasons included problems with systems used to process cost report reconciliations. CMS did not provide a timeframe in which the reconciliation process would be completed.

For seven of the nine audit reports that were awaiting cost report reconciliation, CMS did not provide a timeframe for collecting the remaining outstanding balance of \$14,247,096.

- **Provider on a Repayment Plan or Repayment Plan Pending.** For seven audit reports, CMS did not collect overpayments totaling \$33,840,060 because the providers were on a repayment plan, or CMS approval of a repayment plan was pending.
- **Pending Results of Provider Appeal.** For four audit reports, CMS did not collect overpayments totaling \$15,898,236 because the collections were pending the results of

provider appeals, or the provider negotiated a lesser overpayment amount. When a provider negotiates a lesser overpayment amount, the difference between the original sustained amount and the negotiated amount is not expected to be recovered.

- **Other.**⁵¹ For 18 audit reports, CMS did not collect overpayments totaling \$13,092,610 that we classified as “Other.”⁵² CMS gave us the following reasons for not collecting the overpayments:
 - For 8 of these 18 audit reports, CMS did not collect overpayments totaling \$6,220,009 because the recommendations were subject to the 60-day rule. For example:
 - CMS concurred with our recommendation in audit report number A-04-14-07048. In accordance with our recommendation, the provider should have reviewed claims outside of the 3-year recovery period and returned any identified overpayments, which were estimated to be \$2,345,853.⁵³ These overpayments were outside of the 3-year recovery period, so return of the overpayments was subject to the 60-day rule.
 - CMS concurred with our recommendation in audit report number A-04-14-07051. In accordance with our recommendation, the provider should have reviewed claims outside of the 3-year recovery period and returned any identified overpayments, which were estimated to be \$607,069. These overpayments were outside the 3-year recovery period, so recovery was subject to the 60-day rule.
 - For 1 of these 18 audit reports, CMS did not recover an overpayment totaling \$2,978,002 because the provider was no longer in business and CMS could not collect the overpayment.

⁵¹ Other reasons CMS did not collect sustained overpayments were: (1) the overpayment was not recoverable under the 60-day rule, (2) the overpayment was accounted for as part of a provider settlement agreement, (3) the provider was no longer in business, (4) the overpayment was written off by CMS or the MAC, or (5) the overpayment was referred to Treasury for collection or SSA for offset. Each of the audit reports in this “Other” category represented 1 percent or less of the \$498,022,527 that CMS sustained.

⁵² Two of the 18 audit reports are included in more than one category that we identified as reasons CMS did not collect all OIG-recommended overpayments.

⁵³ The regulations permit contractors to reopen paid claims within 4 years “for good cause.” On January 2, 2013, section 638 of the American Taxpayer Relief Act of 2012 amended section 1870 of the Social Security Act to extend the recovery period from 3 years following the year payment was made to 5 years following the year payment was made. For example, to be recovered, a claim paid on January 2, 2013, must be reopened by January 1, 2017 (4 years for good cause). However, the same claim (once reopened) can be recovered up until December 31, 2018 (5 years following the year the claim is paid). The claims associated with this recommendation from audit report number A-04-14-07048 were paid before this change in the length of the recovery period.

- For 7 of these 18 audit reports, either CMS or the MAC determined that \$2,172,287 of the overpayments was uncollectible. For example, we recommended that CMS collect an overpayment totaling \$4,778,021 for audit report number A-05-13-00019. CMS negotiated with the provider and collected \$4,061,318. CMS considered the remaining \$716,703 uncollectible.
- For 3 of these 18 audit reports, CMS did not recover overpayments totaling \$1,301,437 that it referred to Treasury for collection or to SSA for offset against the beneficiaries' Social Security payments.
- For 1 of these 18 audit reports, with an overpayment of \$2,069,334, CMS negotiated with the provider and collected \$1,648,459 of the overpayment. It did not collect the remaining \$420,875.
- **Overpayment Redetermination.** For 16 audit reports, CMS did not collect overpayments totaling \$11,019,612 because the overpayment determination was overturned after review by the MAC or an administrative law judge.
- **No Reason Provided in OCDs, ASFRs, or SWIFT.** For eight audit reports, CMS did not provide a reason for not collecting \$28,174,515 in overpayments, or the reason CMS provided was unclear. Examples follow:
 - CMS did not provide a reason for not collecting a \$19 million overpayment that we recommended collecting and that it sustained. Documentation for audit report number A-01-13-00506 in CMS's SWIFT system showed the status of the recommendation as "Closed/Completed" without any collections as of November 13, 2017. CMS officials could not explain to us why the audit was closed without collections. However, CMS said that it collected \$4,785,775 of the \$19 million, but it did not provide any documentation to support the collection.
 - It was not clear, from documentation that CMS provided, whether CMS referred an \$8,802,701 recommended overpayment to Treasury for audit report number A-02-12-01008. In this audit report, we recommended that CMS consider authorizing Treasury to use its AWG authority to collect overpayments, totaling \$8.8 million, associated with 21 individual physicians. In a series of emails dated from January 18, 2017, to January 20, 2017, an OIG auditor assigned to this audit asked CMS to clarify whether Treasury had used its AWG authority to collect the \$8.8 million overpayment. The audit team was concerned because an AWG report that CMS referenced in an OCD did not show, as of March 2016, any wage garnishments for the 21 physicians in question. CMS responded that the 21 providers may have had their debts offset against any Medicare payments they were due. The OIG auditor assigned to this audit told CMS that he did not believe that claim offsets would apply to this recommendation because the Medicare claim payments would be to an entity rather than to an individual and could not be used as an offset to satisfy an

individual debt. The auditor then asked CMS: “[I]f an individual has a delinquent debt, reassigns their benefit to an entity, provides services and the entity receives the payment, . . . would AWG be used to garnish the individual’s wages from the entity to satisfy the individual’s debt?” CMS did not directly answer the auditor’s question. The auditor also asked CMS whether it conducted additional testing or research on the 21 individuals to determine whether Treasury’s AWG reports were accurately reflecting the omission of the 21 individuals. CMS responded that it had not performed any such testing or research.

CMS did not provide any additional documentation, such as correspondence showing that the debt was transferred to Treasury for collection or that Treasury had attempted to collect the debt. Thus, it is unclear whether CMS actually referred the \$8.8 million debt to Treasury for collection.

**APPENDIX C: STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT
(GREEN BOOK EXCERPTS)**

Although there are different ways to present internal control, the *Standards for Internal Control in the Federal Government* (Green Book) approaches internal control through a hierarchical structure of 5 components and 17 principles (Figure 3).

Figure 3: The 5 Components and 17 Principles of Internal Control

<p>Control Environment</p> <ol style="list-style-type: none"> 1. The oversight body and management should demonstrate a commitment to integrity and ethical values. 2. The oversight body should oversee the entity’s internal control system. 3. Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity’s objective. 4. Management should demonstrate a commitment to recruit, develop, and retain competent individuals. 5. Management should evaluate performance and hold individuals accountable for their internal control responsibilities. <p>Risk Assessment</p> <ol style="list-style-type: none"> 6. Management should define objectives clearly to enable the identification of risks and define risk tolerances. 7. Management should identify, analyze, and respond to risks related to achieving the defined objectives. 8. Management should consider the potential for fraud when identifying, analyzing, and responding to risks. 9. Management should identify, analyze, and respond to significant changes that could impact the internal control system. 	<p>Control Activities</p> <ol style="list-style-type: none"> 10. Management should design control activities to achieve objectives and respond to risks. 11. Management should design the entity’s information system and related control activities to achieve objectives and respond to risks. 12. Management should implement control activities through policies. <p>Information and Communication</p> <ol style="list-style-type: none"> 13. Management should use quality information to achieve the entity’s objectives. 14. Management should internally communicate the necessary quality information to achieve the entity’s objectives. 15. Management should externally communicate the necessary quality information to achieve the entity’s objectives. <p>Monitoring</p> <ol style="list-style-type: none"> 16. Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results. 17. Management should remediate identified internal control deficiencies on a timely basis.
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Green Book Components, Principles, and Attributes Cited in This Report

The Green Book Overview, OV2.05, states that the 17 principles support the effective design, implementation, and operation of the associated components and represent requirements necessary to establish an effective internal control system.

The Green Book Overview, OV4.01, states that management may engage external parties to perform certain operational processes for the entity, such as accounting and payroll processing, security services, or health care claims processing. Management, however, retains responsibility for the performance of processes assigned to service organizations. If a component of internal control is not effectively designed, implemented, nor operating effectively, then the internal control system is ineffective.

Green Book Component 3, Design Control Activities, Principle 10.01, states that management should design control activities to achieve objectives and respond to risks.

Green Book Component 3, Control Activities, Accurate and Timely Recording of Transactions, Attribute 10.03, states that transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. This applies to the entire process or life cycle of a transaction or event from its initiation and authorization through its final classification in summary records. In addition, management designs control activities so that all transactions are completely and accurately recorded.

Green Book Component 3, Control Activities, Appropriate Documentation of Transactions and Internal Control, Attribute 10.03, states that management clearly documents internal control and all transactions and other significant events in a manner that allows the documentation to be readily available for examination.

Green Book Component 3, Control Activities, Principle 12, states that management should implement control activities through policies.

Green Book Component 4, Information and Communication, Identification of Information Requirements, Principle 13.01, states that management should use quality information to achieve the entity's objectives.

Green Book Component 4, Information and Communication, Identification of Information Requirements, Attribute 13.02, states that management designs a process that uses the entity's objectives and related risks to identify the information requirements needed to achieve the objectives and address the risks. Information requirements consider the expectations of both internal and external users. Management defines the identified information requirements at the relevant level and requisite specificity for appropriate personnel.

Green Book Component 4, Information and Communication, Identification of Information Requirements, Attribute 13.03, states, in part, that management identifies information

requirements in an iterative and ongoing process that occurs throughout an effective internal control system.

Green Book Component 4, Information and Communication, Identification of Information Requirements, Attribute 13.04, states, in part, that management obtains relevant data from reliable internal and external sources in a timely manner based on the identified information requirements.

Green Book Component 5, Monitoring, Internal Control System Monitoring, Attribute 16.08, states that management retains responsibility for monitoring the effectiveness of internal control over the assigned processes performed by service organizations. Management uses ongoing monitoring, separate evaluations, or a combination of the two to obtain reasonable assurance of the operating effectiveness of the service organization's internal controls over the assigned process. Monitoring activities related to service organizations may include the use of work performed by external parties, such as service auditors, and reviewed by management.

Green Book Component 5, Monitoring, Evaluate Issues and Remediate Deficiencies, Principle 17.01, states that Management should remediate identified internal control deficiencies on a timely basis.

Green Book Component 5, Monitoring, Corrective Actions, Attribute 17.06, states that management completes and documents corrective actions to remediate internal control deficiencies on a timely basis. These corrective actions include resolution of audit findings. Depending on the nature of the deficiency, either the oversight body or management oversees the prompt remediation of deficiencies by communicating the corrective actions to the appropriate level of the organizational structure and delegating authority for completing corrective actions to appropriate personnel. The audit resolution process begins when audit or other review results are reported to management and is completed only after action has been taken that: (1) corrects identified deficiencies, (2) produces improvements, or (3) demonstrates that the findings and recommendations do not warrant management action. Management, with oversight from the oversight body, monitors the status of remediation efforts so that they are completed on a timely basis.

APPENDIX D: PRIOR AUDIT RECOMMENDATIONS
(Report Number A-04-10-03059)

Recommendation 1

“Pursue legislation to extend the statute of limitations so that the recovery period exceeds the reopening period for Medicare payments.”

CMS Response:

“CMS will explore the possibility of legislative proposals that would extend the statute of limitations.”

Recommendation 2

“Ensure its [CMS] Audit Tracking and Reporting System (ATARS) is updated to accurately reflect the status of audit report recommendations.”

CMS Response:

“CMS concurs with this recommendation. CMS has begun a review of its reporting in the ATARS system. We will make necessary changes to reflect the outcomes of the recovery work performed. Going forward CMS will ensure that corrective action plans and recoveries are clearly described and reported.”

Recommendation 3

“Ensure that CMS staff record collection information consistently in ATARS.”

CMS Response:

“CMS concurs with this recommendation. It is CMS’s intent to consistently and accurately record collection efforts. Whenever OIG recommends that CMS collect overpayments, CMS will record the amounts it sustains for collection.”

Recommendation 4

“Collect sustained amounts related to OIG recommendations made after our audit period to the extent allowed under law.”

CMS Response:

CMS partially concurs with this recommendation. CMS will collect only sustained amounts in OIG recommendations that are for claims that can be reopened and

where it is cost beneficial to reopen and review claims. CMS has limited medical review resources and must focus reviews on the most error-prone claims. Due to these resource constraints, CMS must prioritize our review efforts. However, CMS will continue to consider issues identified in OIG reports when developing medical review and recovery audit strategies.

Recommendation 5

“Verify the portion of the \$84,168,502 reported as collected has actually been collected.”

CMS Response:

CMS does not concur with this recommendation. CMS requires Medicare contractors to separately report overpayments related to OIG reports . . . to track this information in Clarity and ATARS. If a contractor reports a collection related to an OIG audit, then CMS considers this proof and uses this information to manually update Clarity and ATARS to indicate that a collection has occurred. Due to the age of the reports, records may no longer be available and thus, it would be extremely difficult to verify this information at this time.

It should be noted that CMS has policies in place to ensure that Medicare contractors accurately account for all overpayment collections, including those from OIG reports. CMS believes that OIG-identified overpayments are accurately accounted for in CMS financial reports. CMS performs bank reconciliations and reviews financial reports to ensure its accuracy and completeness. CMS will continue to improve its tracking and reporting of the collections related to actual sampled overpayment claims. Furthermore, CMS will explore ways to automate the tracking of OIG-related collections in the future.

Recommendation 6

Provide specific guidance to its contractors concerning: (1) the timeframe in which the contractor must take action to collect an overpayment, (2) how to report collections, (3) the type of documentation that the contractor must maintain to substantiate an overpayment collection, and (4) how to report reasons for not collecting overpayments.

CMS Response:

CMS concurs with this recommendation. CMS is reviewing processes to improve the tracking, reporting, and documenting of collection activities for OIG-identified overpayments. CMS has already begun to revise the reporting and tracking processes for OIG recommendations, and timeframes have been

established for closing those recommendations if overpayments are determined to be uncollectible.

CMS has also expanded its reporting requirements and provided additional direction to contractors related to closing audit reports. CMS is more closely monitoring contractors' responses to ensure that quarterly reporting is completed timely and accurately, and that contractors provide sufficient documentation to substantiate collection amounts. CMS will continue to improve its tracking and reporting of the collections related to actual sampled overpayment claims. CMS and OIG have worked to improve the timeliness with which CMS receives data from OIG. This improvement should allow CMS to provide OIG-identified claim overpayments to the contractors sooner . . . to begin the collection process. In addition, CMS will work to ensure that the contractors provide explanations for items that cannot be collected. CMS is currently exploring ways to automate the tracking of collections related to OIG reports . . . to eliminate the manual input process.



APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: November 1, 2021

TO: Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure *Chiquita LaSure*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: The Office of Inspector General (OIG) Draft Report: CMS Reported Collecting Just Over Half of the \$498 Million in Medicare Overpayments Identified by OIG Audits, A-04-18-03085

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the OIG draft report on Medicare overpayment recoveries.

CMS is committed to protecting the fiscal integrity of the Medicare Trust funds and using its resources to collect identified overpayments in a manner that is cost effective and ensures that CMS complies with the statutory and regulatory framework of overpayment collections. Each year CMS receives a number of reports from the OIG that identify findings involving potential improper payments. These reports often involve recommendations to collect overpayments of varying amounts. Some of these are based on actual overpayments identified during OIG's review of a sample of claims, while others are projected overpayments based on extrapolated values estimated by OIG.

CMS reports yearly on the Medicare improper payment rate. CMS has seen this rate decrease significantly over the past seven years from 12.7 percent in 2014 to 6.3 percent in 2020.¹ In line with improvements in the Medicare improper payment rate, OIG's report shows improvements in overpayment collections identified by OIG audits. OIG reported that CMS collected 55 percent of sustained overpayments from their current audit period (October 1, 2014, through December 31, 2016), up from 20 percent in their previous audit period (the 30-month period ending March 31, 2009). Since OIG ended their data collection in June 2020, CMS has continued collections, and to date has collected over 75 percent of currently sustained overpayments.

OIG Finding: CMS Has Not Collected All Sustained Overpayments Identified in OIG Audits

CMS is committed to collecting the currently sustained overpayments identified in OIG audit reports. Based on OIG's findings, 99 percent of uncollected sustained overpayments were four years old or less. OIG noted that they were provided a reason why collections had not yet been made for the vast majority of the funds that were uncollected at the time of their review. For example, 60 percent of the uncollected payments were on hold pending a Supplemental Security Income (SSI) factor appeal, pending other provider appeals, or pending cost report reconciliation. Subsequent to OIG's review, CMS diligently collected funds as determinations were made. Another 15 percent of uncollected payments were from providers on repayment plans that were actively making payments, and five percent were uncollectable based on the provider receiving a favorable overpayment redetermination. As OIG noted, other reasons

¹ CMS, *Improper Payment Rates and Additional Data*. Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/AdditionalData>.

CMS did not collect sustained overpayments include: (1) the overpayment was not recoverable under the 60-day rule, (2) the overpayment was accounted for as part of a provider settlement agreement, (3) the provider was no longer in business, (4) the overpayment was written-off by CMS or the MAC, or (5) the overpayment was referred to the Department of the Treasury (Treasury) for collection or the Social Security Administration (SSA) for offset.

Of the funds that OIG identified as not including reasons for non-collection, 99 percent are related to only two audits. In one of these audits,² OIG recommended that CMS “consider authorizing Treasury to use its administrative wage garnishment authority to collect delinquent debts, totaling \$8,802,701, associated with 21 individual physicians.” The \$8.8 million had been previously referred to Treasury which the OIG confirmed in its audit report. CMS concurred with this recommendation and provided a copy of the Memorandum of Understanding (MOU) with Treasury authorizing use of its administrative wage garnishment (AWG). While OIG considered this amount sustained, CMS determined no funds should be sustained for collection since the previously referred debts would not be collected by CMS through Treasury’s AWG program. Therefore, noting a reason for non-collection is not applicable in this instance. The second audit,³ recommended that CMS “recover, in accordance with CMS policies, the additional \$19 million in potential overpayments related to the services that may have been performed in hospital outpatient locations that [OIG] identified through [their] computer match.” CMS has subsequently collected \$6,343,438 which was determined to be sustained overpayments. The difference between the OIG estimated amount and the amount collected represents overpayments that were below the recovery threshold, favorable appeals, claims that were previously adjusted, and claims that were beyond the four-year reopening period. Of note, the overpayment collections required reviewing over a million claims; therefore, it would not be administratively feasible for CMS to document for OIG the reasons for non-collection of an overpayment for every claim within this audit. CMS regularly provides updates to OIG on collections and reasons for uncollected funds as part of the recommendation follow-up process of individual audits.

OIG Finding: CMS Did Not Provide Adequate Documentation To Support All of Its Reported Overpayment Collections

For those funds already collected, OIG noted that CMS did not provide adequate documentation to support all of its reported overpayment collections as required by the Government Accountability Office’s Standards for Internal Control in the Federal Government (hereafter referred to as the Green Book). CMS does not agree with OIG’s finding relating to collected overpayments. In line with the Green Book, CMS delegates authority to a network of Medicare Administrative Contractors (MACs) to serve as the primary operational contacts between the Medicare Fee-For-Service (FFS) program and health care providers enrolled in the program. The MACs serve more than one million health care providers enrolled in the Medicare FFS program. Each year, the MACs process more than one billion Medicare FFS claims and pay out approximately \$400 billion in Medicare FFS benefits. In addition to processing claims and making payments, the MACs enroll health care providers in the Medicare program and educate them on Medicare billing requirements, handle claims appeals, answer provider inquiries, account for benefit expenditures, recover overpayments, and develop and execute strategies to prevent improper payments.

² OIG, *CMS made Medicare and Medicaid payments totaling \$10.7 million associated with individual physicians who owed the Federal Government more than \$8.8 million. CMS made these payments after referring individual physicians’ Medicare debts to the U.S. Department of the Treasury for collection.* Available at <https://oig.hhs.gov/oas/reports/region2/21201008.pdf>

³ OIG, *Incorrect Place-of-Service Coding Resulted in Potential Medicare Overpayments Costing Millions.* Available at <https://oig.hhs.gov/oas/reports/region1/11300506.pdf>

As the MACs process more than one billion claims annually, CMS does not believe it is operationally efficient or cost-effective to centrally oversee and retain copious source documentation, such as system screenshots, for every claim processed. CMS has documented performance expectations for the MACs in their Statements of Work, the Medicare Financial Management Manual, and Technical Direction Letters (TDLs). In order to monitor the effectiveness of the MACs, CMS uses a rigorous oversight process, known as the Quality Assurance Surveillance Plan (QASP), to ensure MACs fulfill their contract requirements to a high-performance standard. The QASP provides a systematic quality assurance approach for annually evaluating that MACs fulfill their contract functional requirements, such as Claims Processing (CP), Debt Management (DM), and Financial Management (FM), among others. The Debt Management QASP standards measure, which includes several performance standards including overpayment recovery, has seen a 10-percentage point average increase across the MACs from 81 percent to 91 percent between 2018-2020.⁴ In addition to the QASP, CMS uses a mix of both internal evaluation reports/reviews and external independent audits in determining MAC performance and the effectiveness of their internal controls. OIG auditors and other external oversight entities also are able to audit the MACs to verify work and records at any time.

Upon receipt of an OIG report involving overpayments, CMS will review the claims files that OIG provides in the form of excel spreadsheets to CMS and elect to sustain an amount for collection. This amount may differ from the OIG recommended collection amount if CMS identifies errors in the recommendation coding or OIG's overpayment estimation, claims that have exceeded the relevant reopening period and cannot be reopened, or claims that would not be cost beneficial to reopen and review. For example, for one audit recommendation,⁵ OIG recommended that CMS "consider authorizing Treasury to use its administrative wage garnishment authority to collect delinquent debts, totaling \$8,802,701, associated with 21 individual physicians." CMS concurred with this recommendation and provided a copy of the MOU with Treasury authorizing use of its administrative wage garnishment. While OIG considered this amount sustained, CMS did not sustain any amount for collection since the debts would not be collected by CMS through Treasury's AWG program. The sustained amount may change during the course of collections for reasons such as, a provider receives a favorable appeal, enters bankruptcy, or terminates from Medicare. For example, for another audit recommendation,⁶ OIG recommended that the provider "refund \$55,189 to the Federal Government." As a result of a second level appeal decision, the sustained overpayment changed from the extrapolated amount of \$55,189 to the actual amount of \$24 that was subsequently collected from the provider.

When sustained amounts are determined, CMS directs its MACs to reopen and recover the identified overpayments consistent with the Medicare Financial Management Manual and TDLs. The MACs initiate overpayment recovery by sending a demand letter to the provider, requesting repayment. When responding to a demand letter, there are a number of payment options. A provider may make an immediate payment, request immediate recoupment in which overpayments are recovered by offsetting future payments, request standard recoupment through the Overpayment Debt Collection Activities schedule, or request an extended repayment schedule (ERS). Providers may also submit a rebuttal to explain why no recoupment should occur or appeal the overpayment, which may result in an overpayment redetermination. Overpayments that are 120 days delinquent are systematically referred to the Treasury

⁴ CMS, *QASP Debt Management*. Available at <https://www.cms.gov/files/document/qasp-debt-management.pdf>.

⁵ OIG, *CMS made Medicare and Medicaid payments totaling \$10.7 million associated with individual physicians who owed the Federal Government more than \$8.8 million. CMS made these payments after referring individual physicians' Medicare debts to the U.S. Department of the Treasury for collection*. Available at <https://oig.hhs.gov/oas/reports/region2/21201008.pdf>

⁶ OIG, *A Florida physical therapy practice improperly claimed at least \$55,000 in Medicare reimbursement for physical therapy services for calendar years 2012 and 2013*. Available at <https://oig.hhs.gov/oas/reports/region4/41507054.pdf>

for debt collection. Per the Medicare Financial Management Manual, the MACs are required to keep records of all collection activities through all stages of the debt collection process. These records shall be detailed and include all correspondence and conversations with the provider, checks, and any other documents associated with debt collection processes. The Medicare Financial Management Manual also requires the MACs to maintain and make supporting/source documentation readily available for review and audit by both internal and external oversight entities. This must include lead schedules for all amounts used for financial report preparation and detailed documentation, such as demand letters and collections for accounts receivables.

To ensure complete, accurate and timely accounting of Medicare Trust Funds, including relating to overpayment collections, the MACs utilize the Healthcare Integrated General Ledger and Account System (HIGLAS) to track their financial activities. HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting functions for all of CMS' programs. The HIGLAS reduced 50 separate financial accounting systems used by MACs into one system. The main objective of this effort was to increase automation and efficiency, and consistency in reporting, while eliminating redundant and inefficient/ineffective manual processes. The HIGLAS has improved significantly the ability of CMS to perform Medicare financial accounting reporting and tracking of transactions. Some of these improvements include reduced costs due to elimination of redundant individual Medicare financial record keeping systems, improvements in automated Medicare debt collection/referral activities, creation of audit trails for every Medicare transaction/payment/claim reported by CMS, improved internal/external oversight entities' ability to more efficiently and effectively audit CMS and its MACs by providing supporting documentation for audits, and improved capability for CMS to more systematically and efficiently recover identified Medicare overpayments. Moreover, CMS now has better internal financial controls across Medicare contractor operations. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than in a pre-HIGLAS environment. This is a direct result of efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government. To further improve accounting relating to OIG audits, in 2013 CMS added the capability of tracking claims adjustments in HIGLAS by OIG audit report number and instructed the MACs to enter this information.

As part of the OIG audit recommendation resolution process, CMS receives updates from the MACs on collection amounts as well as other relevant collection documentation as requested and reports to OIG the status of collections on a regular basis. Some overpayment collections involve thousands of providers and claims, so rather than CMS collecting detailed documentation or screenshots of the thousands of payment transactions that the MACs perform in HIGLAS to collect overpayments, CMS often collects high-level summary updates and HIGLAS extracts, while the source documentation supporting the summary reports are maintained by the MACs. CMS seeks to be responsive to OIG's audit needs and provide all information requested by the OIG. In line with the Green Book, the MACs are able to provide HIGLAS extracts known as Receivable Balance Detail (RBD) reports and source documentation for ready examination of accounting. Additionally, OIG has access to CMS's National Claims History (NCH) file, providing readily available documentation showing any changes relating to claims, such as claim adjustments and denials. CMS does not believe it is cost-effective or operationally feasible to centrally monitor and retain copious documentation for every transaction which are mainly done systematically. Rather, CMS monitors the effectiveness of established internal controls relating to overpayment recoveries, including the work contracted to the MACs, by hiring independent Certified Public Accounting (CPA) firms to conduct yearly Statement of Standards for Attestation Engagements (SSAE) 18 Audits, and the OIG's annual Chief Financial Officer (CFO) audit. The results from these audits confirm that MACs' internal controls are operating efficiently and effectively, and that the financial data they provide to CMS in HIGLAS is timely, accurate, and complete. CMS has received a clean, unmodified audit opinion on the reasonableness of our year-end financial statements from the OIG/CFO Auditors for the past 23 consecutive fiscal years.

Separate from CMS's automated accounting system, HIGLAS, CMS has a new system for tracking OIG audit recommendations, known as the Audit Management System (AMS). CMS developed AMS in line with OMB Circular A-50, section 8(a)(4) and the Green Book to maintain accurate records on the status of audit recommendations. CMS also solicited input from OIG during the development of the new system and is working with OIG to directly link CMS and OIG audit systems so audit reports, clearance documents, and status updates flow between the two systems, reducing the need for email updates which are not always timely nor accurately documented in either system. With the deployment of its current system, CMS has made significant improvements in the way recommendations are tracked. As noted in their report, OIG did not find any issues with the consistency of reporting overpayment recoveries. OIG did note two instances out of their 148 audits where there were issues with accuracy of collection reporting. While CMS strives to ensure accuracy of all information in its recommendation tracking system, updates on overpayment collections are manually entered as this is not an accounting system. Therefore, minor errors in reporting may be present at any given time. The two issues with accuracy of reporting that OIG identified have subsequently been addressed.

CMS has also worked with OIG to address the time between OIG's review of claims and reporting to CMS. CMS established a workgroup and held several discussions with OIG to determine ways to ensure that the information related to the claims reviewed by OIG is provided to CMS in a timely manner, so that fewer claims fall outside of the reopening period. Reopenings can be conducted by a contractor to revise an initial determination or redetermination. In accordance with § 405.980, claims may be reopened within one year for any reason, up to four years for good cause, and at any time for fraud or similar fault. Under section 1870(b) of the Social Security Act, a provider or supplier is deemed to be without fault, absent evidence to the contrary, if the overpayment is determined after the fifth year following the year in which the original payment was made. This provision creates a rebuttable presumption that does not apply if there is evidence to show the entity should not be deemed without fault. Therefore, if there is evidence to indicate a provider or supplier is responsible for causing the overpayment, then that overpayment may be recovered beyond the fifth year following the year in which the overpayment was made.

The OIG's recommendations and CMS's responses are below.

OIG Recommendation

Continue its efforts to recover any collectible portion of the \$226 million in uncollected overpayments and inform us of any additional collections related to this amount.

CMS Response

CMS concurs with this recommendation. However, CMS notes that this recommendation is duplicative of the recommendations regarding collections in OIG's 148 audit reports reviewed in which CMS already takes administrative action to update OIG on the status. CMS has never stopped collection efforts and continues to recover any collectible portion of the \$226 million, some of which is no longer collectable due to changes in the sustained amount, provider bankruptcy, and settlements, among other reasons. Since OIG ended their data collection in June 2020, CMS has continued collections, and to date has collected over 75 percent of currently sustained overpayments from OIG's selected audits. CMS uses its resources to collect identified actual overpayments in a manner that is cost effective and ensures that CMS complies with the statutory and regulatory framework for Medicare overpayment collections.

As noted above, the OIG was provided a reason why collections had not yet been made for the vast majority of the funds that were uncollected at the time of review. For example, 60 percent of the uncollected payments were on hold pending an SSI factor appeal, pending other provider appeals, or pending cost report reconciliation. Subsequent to OIG's review, CMS diligently collected funds as determinations were made. Another 15 percent of uncollected payments were from providers on

repayment plans that were actively making payments, and five percent were uncollectable based on the provider receiving a favorable overpayment redetermination. As OIG noted, there are several other reasons why CMS did not collect sustained overpayments.

OIG Recommendation

Establish policies that define and require retention of documentation that is needed for independent verification of the collection of overpayments.

CMS Response

CMS non-concurs with this recommendation. CMS has documented performance expectations for the MACs in their Statements of Work, the Medicare Financial Management Manual, and TDLs. Per the Financial Management Manual, the MACs are required to keep records of all collection activities through all stages of the debt collection process. These records shall be detailed and include all correspondence and conversations with the provider, checks, and any other documents associated with debt collection processes. As part of the OIG audit recommendation resolution process, CMS receives updates from the MACs on collection amounts as well as other relevant collection documentation as requested and reports to OIG the status of collections on a regular basis. Some overpayment collections involve thousands of providers and claims, so rather than CMS collecting detailed documentation or screenshots of the thousands of payment transactions that the MACs perform in HIGLAS to collect overpayments, CMS often collects high-level summary updates and HIGLAS extracts, while the source documentation supporting the summary reports are maintained by the MACs. CMS seeks to be responsive to OIG's audit needs and provide all information requested by the OIG. As noted above, the MACs are able to provide HIGLAS extracts known as RBD reports and source documentation for ready examination of accounting.

OIG Recommendation

Determine what portion of the \$154,631,632 was collected and recorded in its accounting system based on policies established in response to our recommendation in the previous bullet.

CMS Response

CMS non-concurs with this recommendation. As the MACs process more than one billion claims annually, CMS does not believe it is operationally efficient or cost-effective to centrally oversee and retain copious documentation, such as system screenshots, for every claim processed and overpayment collected. CMS' internal systems record all transactions. CMS has documented performance expectations for the MACs in their Statements of Work, the Medicare Financial Management Manual, and TDLs. In order to monitor the effectiveness of the MACs, CMS uses a rigorous oversight process, known as the QASP program, to ensure MACs fulfill their contract debt collection requirements to a high-performance standard.

As part of the OIG audit recommendation resolution process, CMS receives updates from the MACs on collection amounts as well as other relevant collection documentation as requested and reports to OIG the status of collections on a regular basis. Some overpayment collections involve thousands of providers and claims, so rather than CMS collecting detailed documentation or screenshots of the thousands of payment transactions that the MACs perform in HIGLAS to collect overpayments, CMS often collects high-level summary updates and HIGLAS extracts from the MACs, while the source documentation supporting the summary reports are maintained by the MACs. CMS does not believe it is cost-effective or operationally feasible to centrally monitor and retain copious documentation for every transaction which are mainly done systematically. Rather, CMS monitors the effectiveness of established internal controls relating to overpayment recoveries, including the work contracted to the MACs, by hiring independent CPA firms to conduct yearly SSAE 18 Audits, and the OIG's annual CFO audit. The results from these audits confirm that MACs' internal controls are operating efficiently and effectively, and that the financial data they provide to CMS in HIGLAS is timely, accurate, and complete. CMS has received a clean, unmodified

audit opinion on the reasonableness of our year-end financial statements from the OIG/CFO Auditors for the past 23 consecutive fiscal years.

OIG Recommendation

Establish policies and procedures that require staff to clearly describe the reasons for non-collection of an overpayment, maintain any documentation necessary to support those reasons, and obtain approval from an authorized individual not to collect the overpayment.

CMS Response

CMS non-concurs with this recommendation. CMS has policies and procedures in place for documenting collections and updates are provided to OIG through an OIG Clearance Document (OCD) or OIG Audit Status Follow Up Reports (ASFR) after being signed by an approving official. CMS also has policies detailing required actions in instances when CMS sustains less than 85 percent of the OIG's recommended amount. Per the Financial Management Manual, the MACs are required to keep records of all collection activities through all stages of the debt collection process. These records shall be detailed and include all correspondence and conversations with the provider, checks, and any other documents associated with debt collection processes. CMS does not believe it is cost-effective or operationally feasible to centrally monitor and retain copious documentation for every transaction made by the MACs. Rather, CMS monitors the effectiveness of established internal controls relating to overpayment recoveries, including the work contracted to the MACs, by hiring independent CPA firms to conduct yearly SSAE 18 Audits, and the OIG's annual CFO audit.

Of the funds that OIG identified as not including reasons for non-collection, 99 percent are related to only two audits. For one of these audits, CMS disagrees with OIG's sustained amount. CMS did not sustain any amount for collection since the debts would not be collected by CMS, but rather Treasury because it would be using its AWG program as an additional method to collect debts that had been previously referred to Treasury. Therefore, noting a reason for non-collection is not applicable in this instance. For the second audit, CMS has collected \$6,343,438 which was determined to be sustained overpayments. The difference between the OIG estimated amount and the amount collected represents overpayments that were below the recovery threshold, favorable appeals, claims that were previously adjusted, and claims that were beyond the four-year reopening period. Of note, the overpayment collections required reviewing over a million claims; therefore, it would not be administratively feasible for CMS to document for OIG the reasons non-collection of an overpayment for every claim within this audit.

OIG Recommendation

Establish policies and procedures that include specific steps required to verify that collection information is accurately and consistently recorded in SWIFT or any replacement tracking system such as AMS.

CMS Response

CMS non-concurs with this recommendation. CMS has made significant improvements in the way recommendations are tracked. As noted in their report, OIG did not find any issues with the consistency of reporting overpayment recoveries. OIG did note two instances out of their 148 audits where there were issues with accuracy of collection reporting. While CMS strives to ensure accuracy of all information in its recommendation tracking system, updates on overpayment collections are manually entered as this is not an accounting system. Therefore, minor errors in reporting may be present at any given time. The two issues with accuracy of reporting that OIG identified have subsequently been addressed.

OIG Recommendation

Provide MACS with specific guidance on what documentation is needed to support the collection of an overpayment.

CMS Response

CMS non-concurs with this recommendation. All claim adjustments/denials and overpayment collection transactions are recorded in CMS' internal systems. CMS has documented expectations for the MACs in their Statements of Work, the Medicare Financial Management Manual, and TDLs. Per the Financial Management Manual, the MACs are required to keep records of all collection activities through all stages of the debt collection process. These records shall be detailed and include all correspondence and conversations with the provider, checks, and any other documents associated with debt collection processes.

OIG Recommendation

Revise 42 CFR section 405.980 and corresponding manual instructions related to the reopening period for claims to be consistent with statutory provisions contained in section 1870 of the Social Security Act, which allows Medicare contractors to determine whether overpayments were made and to begin to collect them for 5 years following the year payments were made.

CMS Response

CMS non-concurs with this recommendation. The claim reopening rules are not dependent on the provisions in section 1870 of the Act related to overpayment recoveries. Further, section 1870(b) is not a blanket statute of limitation on recovery. Rather, it is a rebuttable presumption that a provider is without fault for an overpayment determined after the specified period. “. . .[S]uch provider of services or such other person shall, **in the absence of evidence to the contrary**, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the fifth year following the year in which notice was sent to such individual that such amount had been paid. . .” (Section 1870(b) of the Social Security Act, emphasis added). If there is evidence that the provider or supplier is not without fault, then the provider does not get the benefit of the presumption and the overpayment may be recovered beyond the fifth year from the year in which the overpayment was made.

In accordance with § 405.980, claims may be reopened within one year for any reason, up to four years for good cause, and at any time for fraud or similar fault. Given the discretion contractors have to reopen claims within four years of the date of initial determination for good cause, or at any time for fraud or similar fault (as defined in 42 CFR 405.902), CMS believes that maintaining the existing claim reopening timeframes will alleviate concerns about an increased burden on providers and the contractors. CMS believes that burdensome changes that aren't operationally necessary are unwarranted.

OIG Recommendation

Establish a mechanism to reopen claims when the OIG starts an audit so that CMS can collect overpayments consistent with the 5-year timeframe contained in section 1870 of the Social Security Act.

CMS Response

CMS will explore ways that are operationally feasible and cost-effective to establish a mechanism to notify providers concerning the reopening of their claims based on OIG audit work, once OIG has identified the specific claims that it intends to sample and audit. We note, however, as mentioned above, the claim reopening rules are not dependent on the provisions in section 1870 of the Act.

OIG Recommendation

Develop a plan, with milestones, for resolving cost reports applicable to nine audit reports discussed in Appendix B of this report.

CMS Response

CMS non-concurs with this recommendation. CMS already provides updates to OIG on the status of collections on a regular basis through the OCD and the ASFRs. Since OIG's review period, CMS

reported to OIG the collection of overpayments from audit A-07-13-02791 after the cost report reconciliation occurred.