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MEDICARE ADMINISTRATIVE CONTRACTORS' PERFORMANCE

Daniel R. Levinson
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EXECUTIVE SUMMARY: Medicare Administrative Contractors' Performance OEI-03-11-00740

WHY WE DID THIS STUDY

Given the billions of dollars awarded to Medicare Administrative Contractors (MACs) and the critical role they play in administering the Medicare program, effective oversight of MACs' performance is important to ensure that they are adequately processing claims and performing other assigned tasks.

HOW WE DID THIS STUDY

We collected performance assessment information from the Centers for Medicare & Medicaid Services (CMS) and determined (1) the extent to which MACs met or did not meet performance requirements reviewed by CMS and (2) the extent of CMS's performance assessment and monitoring of MACs. The study included 2 performance periods for 13 MACs. The performance periods began and ended between September 2008 and August 2011.

WHAT WE FOUND

MACs met the majority of quality assurance standards reviewed by CMS. However, MACs did not meet one-quarter of the standards reviewed, and MACs had not resolved issues with 27 percent of these unmet standards as of June 2012. MAC standards have stringent performance requirements; a number of standards require 100-percent performance compliance. CMS did not require action plans for 12 percent of unmet standards, and unmet standards without action plans were almost four times more likely to have issues go unresolved. MACs can earn award fees if their performance exceeds basic requirements, and metrics are included in MACs' award fee plans to encourage improved performance. However, certain areas identified as problematic through quality assurance reviews were not always included as metrics in MACs' award fee plans. Two MACs consistently underperformed across various CMS reviews, and CMS's reviews of MACs, while extensive, were not always completed timely.

WHAT WE RECOMMEND

We recommend that CMS (1) require action plans for all quality assurance standards not met, (2) use the results of quality assurance reviews to help select award fee metrics for review, (3) meet timeframes for completing quality assurance reports, (4) meet timeframes for completing award fee determinations, (5) establish reasonable timeframes for issuing contractor performance reports, and (6) seek legislative change to increase the time between MAC contract competitions to give CMS more flexibility in awarding new contracts when MACs are not meeting CMS requirements. CMS concurred with all six recommendations.

TABLE OF CONTENTS

OBJECTIVES

1. To describe the extent to which Medicare Administrative Contractors (MACs) met or did not meet performance standards reviewed by the Centers for Medicare & Medicaid Services (CMS).
2. To determine the extent to which CMS assessed and monitored MACs' performance.

BACKGROUND

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 required CMS to implement Medicare contracting reform by replacing fiscal intermediaries and carriers with MACs.[1] The MMA required that all MAC contracts be awarded through the Federal Acquisition Regulation (FAR) competitive bidding process. Additionally, the MMA required that MAC contracts be competed not less frequently than once every 5 years. CMS began awarding MAC contracts in 2006 and initially awarded contracts for all 15 Part A and B (A/B) MAC jurisdictions and all 4 Durable Medical Equipment (DME) MAC jurisdictions.[2] However, award protests and consolidation of some jurisdictions have prevented some of the original jurisdictions from becoming operational. As of December 2013, 16 MACs (12 A/B MACs and 4 DME MACs) were operational and all Medicare claims were being processed by MACs. CMS awarded $4.3 billion over a 5-year period for these 16 contracts.[3, 4]

Functions Performed by the MACs

Through statements of work, CMS assigns specific functions to the MACs and outlines performance standards for those functions. The functions performed by the MACs include, but are not limited to, claims processing,

[1] MMA, P.L. 108-173 § 911 (adding section 1874A of the Social Security Act, 42 U.S.C. § 1395kk-1).

[2] CMS originally planned to award 4 MAC contracts for processing home health and hospice claims, in addition to the 15 MAC contracts it awarded for Parts A and B and the 4 it awarded for DME. However, in March 2007, CMS announced that it would consolidate the workloads of the home health and hospice jurisdictions into four of the A/B MAC contracts.

[3] Each MAC contract consists of 1 "base year" (first year) with 4 "option" years. CMS can exercise its option to renew the MAC's contract for each of these 4 years. Effective September 3, 2013, the contracting officer can exercise options only after determining that the "contractor's performance on [the] contract has been acceptable, e.g., received satisfactory ratings." 78 Fed. Reg. 46783, 46788 (Aug. 1, 2013) (adding FAR 17.207(c)(7)).

[4] CMS intends to consolidate 10 of the original A/B MAC jurisdictions into 5 jurisdictions over the next several years. The consolidation will result in a total of 10 A/B MAC jurisdictions and 4 DME MAC jurisdictions.

provider enrollment, provider customer service, medical review, and appeals.[5]

CMS's Oversight of MAC Performance

Several divisions within CMS's Medicare Contractor Management Group are involved in MAC performance assessment, oversight, and monitoring. The Division of Performance Assessment serves as the central point for MAC performance assessment activities. For each MAC contract, this division works with a contract administration team to carry out its performance assessment activities. This team includes a contracting officer, a Contracting Officer's Representative (COR), a contract specialist, MAC program analysts, business function leads, and technical monitors.[6] The team monitors MACs' performance to ensure they are providing the quality of service their contracts require.

CMS oversees MAC performance through a number of internal and external audits as well as by (1) reviewing quality control plans, (2) reviewing Quality Assurance Surveillance Plans (QASPs), (3) determining award fees, (4) monitoring performance, and (5) evaluating MACs through Contractor Performance Assessment Reporting System (CPARS) reviews. According to the *MAC Contract Administration Guide*, if CMS identifies deficient performance through its quality control plan reviews, QASP reviews, or performance monitoring, it requires the MACs to take corrective actions. CMS uses the results of numerous external audits and reviews—such as the 912 system security review, the Chief Financial Officer (CFO) audit, and the Statement on Standards for Attestation Engagements Number 16 (SSAE-16) audit—to assist it in overseeing MAC performance.[7]

Reviewing Quality Control Plans

According to the MAC statement of work, CMS requires each MAC to develop and implement a quality control plan. This plan specifies procedures to ensure that MAC services meet contract performance requirements. For example, a MAC must have in place an inspection and audit system, a mechanism to identify deficiencies in the quality of its services, and a formal system to implement any necessary corrective

[5] The A/B MACs handle enrollment for non-DME providers. DME MACs do not handle enrollment for DME suppliers; instead the National Supplier Clearinghouse handles their enrollment.

[6] CORs were previously known as Contracting Officer's Technical Representatives.

[7] Section 912 of the MMA (adding subsection (e) to section 1874A of the Social Security Act, 42 U.S.C. § 1395kk-1) requires the annual evaluation of, testing of, and reporting on MACs' information security programs. CMS uses the CFO audit to identify operational weaknesses and improve internal controls and financial management. CMS uses the SSAE-16 audit to review MACs' internal controls.

action. The MAC is required to submit its quality control plan to CMS no later than 45 days after the contract is awarded.

CMS policy requires a review of the quality control plan and verification of its implementation to ensure that the MAC is meeting the criteria provided in the statement of work.[8] The business function lead for the quality control plan reviews the plan and recommends either acceptance or rejection of the plan. If the business function lead recommends rejection, he or she provides the COR with a statement of the reason(s) the plan is being rejected along with a recommendation to return the plan to the MAC for revision and resubmission by a specified date. This process continues until CMS deems the plan satisfactory. The COR's acceptance of the MAC's quality control plan is contingent on an onsite validation review. To ensure sufficient review data, this review may be scheduled approximately 3 to 4 months after the date the MAC becomes operational.

The MAC is required to submit an updated version of the quality control plan annually at contract renewal, as well as when substantive changes occur to the plan or when changes occur in the MAC's quality operations. According to CMS staff, when the MAC submits an updated plan after the first contract year, CMS performs a "desk review," i.e.,—a review that does not involve a site visit. CMS performs an additional onsite review only if there is a quality assurance issue that warrants it.

Reviewing Quality Assurance Surveillance Plans

Medicare contracting reform provisions require CMS to adhere to the FAR, which requires agencies to develop QASPs when using performance-based acquisition methods.[9] CMS's QASP for MACs contains specific standards and methods for evaluating MACs' work against the performance requirements in the statement of work. All of the performance requirements are provided to MACs during procurement; however, the MACs do not know which specific standards will be assessed during the QASP review. According to CMS staff, CMS decided in May 2013 to begin providing QASP metrics to all MACs at the beginning of every fiscal year to promote transparency.

CMS performs a QASP review for each MAC at the end of each performance period.[10] CMS reviews standards within a core set of areas

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[8] CMS, *Medicare Administrative Contractor Quality Control Plan Review Protocol*, pp. 1–2, July 2011, and CMS, *MAC Contract Administration Guide,* p. 57, June 2011.

[9] Section 1874A(a)(6) of Social Security Act, 42 U.S.C. § 1395kk-1(a)(6) (requiring adherence to the FAR). 48 CFR § 37.601.

[10] We use the phrase "performance period" to refer to the time period that is being evaluated by CMS. The performance period is typically 1 year and generally corresponds to the contract award date.

for all MACs. For example, within the "provider customer service" area, there are standards regarding the length of time it takes to answer calls and provide responses to inquiries. For each QASP performance standard, CMS determines whether the MAC met the standard.

Within 30 days of the end of the performance period, CMS sends a draft QASP Summary Report to the MAC.[11] This draft report includes each standard reviewed, a determination of whether each standard was met, and narrative support for the determination. The MAC is given 7 days for rebuttal, and CMS then has 14 days to respond to the rebuttal. For each rebuttal submitted, the technical monitor, the business function lead, and the COR must agree whether to accept or reject the rebuttal. CMS makes any necessary revisions to the draft QASP Summary Report, incorporates the MAC's rebuttal and CMS's response, and generates the final QASP Summary Report.

MAC Action Plans. If an action plan is required for an unmet standard, CMS requests it when the final QASP Summary Report is sent to the MAC. CMS tracks the status of action plans through the MACs' monthly status reports. CMS may consider a deficiency identified in an action plan to be corrected on the basis of self-reported or validated information in the monthly status reports, a subsequent review by a technical monitor or business function lead, or a subsequent QASP review.

Determining Award Fees

Medicare contracting reform provisions require CMS to provide MACs with incentives to promote efficiency and quality of services.[12] CMS established MAC contracts as "cost plus award fee" contracts. According to the FAR, such contracts provide a monetary incentive that the MAC may earn in whole or in part on the basis of its performance.[13]

CMS and each MAC negotiate the dollar amount allocated for the MAC's award fee pool—i.e., the amount of the potential award fee. The MAC may earn this award fee amount if it exceeds requirements in the statement of work. The MAC is not guaranteed to earn a minimum amount of its award fee pool; therefore, the MAC may earn none, some, or all of its award fee.

The FAR requires each contract with an award fee to have an award fee plan.[14] This plan outlines (1) a list of metrics that will be reviewed, (2) the

[11] CMS, *Quality Assurance Surveillance Plan, Standard Operating Procedure*, p. 6, May 2011.
[12] Section 1874A(b)(1)(D) of the Social Security Act, 42 U.S.C. § 1395kk-1(b)(1)(D).
[13] 48 CFR § 16.405-2.
[14] 48 CFR § 16.401(e)(3).

distribution of the award fee pool across the metrics, and (3) an explanation of how each metric will be reviewed.

The MAC reviews a draft of the award fee plan that includes the metrics that CMS will use to evaluate performance. CMS can include metrics in MACs' award fee plans on the basis of past performance or other criteria. For example, if an area is deemed to be a critical function or is identified as a problem, an award fee metric can be included to encourage improved performance.[15]

As well as determining which award fee metrics to include in a MAC's award fee plan, CMS determines how to distribute the MAC's award fee pool among metrics. CMS considers a variety of factors when determining how to distribute the award fee pool among metrics, such as a MAC's current and past performance in a given area.

Within 90 days of the end of the performance period, CMS sends the MAC a determination letter containing the amount of award fee earned. The total award fee amount that a MAC earns depends on the amount assigned to each award fee metric and the MAC's performance on each metric. Depending on CMS's assessment of the MAC's performance, MACs may earn none, some, or all of the award fee for each metric.

Beginning in July 2009, CMS included language in each award fee plan stating that a MAC must receive a CPARS rating of satisfactory or higher in all areas to be eligible to earn any award fee.

Monitoring Performance

In addition to reviewing quality control plans and QASPs and determining award fees, CMS policy requires other performance monitoring throughout the MACs' performance period.[16] Members of the contract administration team compile MAC performance information related to their specific areas of Medicare operations. The Division of Performance Assessment maintains the findings of MAC-monitoring activities that are conducted across CMS, such as the CFO financial audit, the Comprehensive Error Rate Testing program, the SSAE-16 and SAS 70 audits, and the section 912 information security reviews.[17] To identify any MAC performance issues, team members also review the monthly status reports that MACs submit to CMS. In addition, CMS may conduct the following types of reviews:

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[15] CMS, *MAC Contract Administration Guide*, p. 61, June 2011.

[16] Ibid., pp. 53–55.

[17] The Comprehensive Error Rate Testing program measures improper payments in the Medicare program. SAS 70 (Statement on Auditing Standards No. 70: Service Organizations) audits review an organization's internal controls.

Onsite Visits and Reviews. According to CMS policy, CMS staff typically visit a MAC for onsite reviews at least once every 2 months and participate in face-to-face meetings with MAC managers.[18] Topics discussed during these meetings may include, but are not limited to, the most recent monthly status report, progress on significant and/or ongoing issues, new issues or concerns, and innovations.

Data Validation Reviews. The MAC is responsible for reporting to CMS certain performance information, such as data on the timeliness of claims and appeals. Occasionally, CMS will validate the data for accuracy and compliance with CMS instructions. The results are forwarded to the Division of Performance Assessment.

Ad Hoc Reviews. CMS may conduct ad hoc reviews. Any irregularity identified through CMS's performance monitoring and data validation may warrant an ad hoc review. Staff within the Division of Performance Assessment or members of the contract administration team can recommend initiation of such a review. However, each ad hoc review must be authorized and approved by the COR.

According to CMS staff, if issues are identified through performance monitoring, staff work with the MAC to resolve the problems immediately. If the issues identified are long-term in nature, the COR may request a plan from the MAC to address the issues. These plans are documented separately from QASP action plans.

Evaluating MACs through CPARS Reviews

At the time of our review, the FAR required the preparation of performance evaluations at the completion of contracts.[19] In addition, it required interim evaluations for contracts with a performance period, including option years, exceeding 1 year.[20] Although the FAR did not specify the timing of these interim evaluations, Department of Health and Human Services (HHS) policy requires that for contracts of 3 years or more, agencies conduct interim assessments at 12-month intervals after the contract is awarded.[21] CMS policy states that all MAC performance

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[18] CMS, *MAC Contract Administration Guide*, p. 101, June 2011.

[19] After our review period, the requirements for contractor performance information at FAR subpart 42.15 were amended, effective September 3, 2013. 78 Fed. Reg. 46783 (Aug. 1, 2013). The amendments include requiring annual performance evaluations, requiring all performance evaluations to be entered electronically into CPARS, requiring award-fee performance ratings to be entered into CPARS, and requiring use of standardized evaluation factors and performance rating categories.

[20] 48 CFR § 42.1502(a).

[21] HHS, Acquisition Policy Memorandum 2009-07, December 23, 2009, p. 5. Accessed at http://www.hhs.gov/asfr/ogapa/acquisition/policies/ on December 14, 2011.

evaluations shall be retained in the CPARS system.[22] CMS monitors its compliance with CPARS reporting requirements on a monthly basis. According to CMS staff, the agency has a very high compliance rate for completing MAC CPARS reports in comparison to the rates for other HHS agencies' completion of CPARS reports. In addition, CMS's Medicare Contractor Management Group has developed and implemented a CPARS template to ensure the consistency of CPARS evaluations across MAC contracts.

For the CPARS evaluation, the COR considers all the different reports, information, and individual experience that he or she has with the MAC and condenses it into the CPARS report format. The COR rates the MAC on a five-point scale from "unsatisfactory" to "exceptional" in areas including quality of services, schedule, cost control, business relations, and management of key personnel. The COR uses various sources of information to rate the MAC's performance. These include, but are not limited to, results from reviews of quality control plans and QASPs, monthly status reports, and performance monitoring information. According to CMS policy, the COR's draft evaluation is due 90 days after the end of a MAC's base year and each option year, but may take longer depending on the availability of necessary information.[23] Once all reviews of the draft report are completed, the contracting officer enters the final report into the CPARS system.

Related Work

In March 2010, the Government Accountability Office (GAO) issued a report that described how CMS assessed MAC performance.[24] According to this report, the MACs' performance improved over time, but did not meet all standards. GAO analyzed CMS's assessment of three MACs for which assessment results were available at the time.

METHODOLOGY

Scope

We collected data for the 13 MACs (9 A/B MACs and 4 DME MACs) that had been operational for at least 2 years as of January 2012. For these 13 MACs, we selected the 2 most recent performance periods for which the required performance reviews had been completed. Across the MACs, the earliest 2-year performance period reviewed was from September 2008

[22] CMS, *MAC Contract Administration Guide*, p. 23, June 2011.

[23] Ibid., p. 114.

[24] GAO, *Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards*, GAO-10-71, March 2010.

to September 2010 and the latest 2-year performance period reviewed was from August 2009 to August 2011. CMS awarded $3.2 billion over a 5-year period for these 13 contracts. Appendix A lists the MACs' coverage areas and performance periods selected.

Data Collection

We requested all data from CMS. We collected the following information on CMS's reviews of the 13 MACs' performance for 2 performance periods:

- information on reviews of quality control plans, reasons for CMS's rejection of any of these plans, and the dates of any onsite validation reviews conducted;
- final QASP Summary Reports; the dates the QASP reviews were conducted; and CMS's determination of whether standards were met, action plans were required, and issues were resolved;
- letters containing award fee determinations and the dates these letters were sent to the MAC;
- information on performance monitoring, such as onsite reviews, ad hoc reviews, and data validation reviews; and
- CPARS evaluation reports and the dates the CPARS reports were finalized.[25]

We followed up by telephone and email to clarify CMS's responses. We collected data from March 2012 through November 2012.

Data Analysis

We reviewed the dates provided by CMS regarding its onsite validation reviews of MACs' quality control plans to determine whether CMS conducted these reviews in the MACs' base years.

We reviewed the final QASP Summary Reports to identify the areas CMS reviewed, determine how many performance standards were evaluated, and calculate the number and percentage of standards that CMS determined were met and not met. We compared the numbers and percentages of standards not met across MACs, performance periods, and performance areas. We analyzed data provided by CMS to calculate the following for each MAC: (1) the time between the end of the performance period and the date CMS sent the draft QASP Summary Report,[26] (2) the

[25] A CPARS evaluation report is considered finalized when the contracting officer enters it into the CPARS system.

[26] We used the end date of the QASP evaluation period in our calculation, but for consistency, we use the phrase "performance period" in our report.

time between the date CMS submitted the draft version of this report and the date it completed the final version, (3) the number of action plans CMS required, (4) and the number and percentage of issues that CMS determined were resolved and not resolved.

We reviewed the award fee determination letters to determine how many and which award fee plan metrics CMS assessed. We calculated (1) the number and percentage of award fee plan metrics for which each MAC earned none, some, or all of its award fee; (2) the total award fee pool and the total amount earned; and, (3) the time between the end of the performance period and the date CMS sent the award fee determination letter to the MAC.[27] We compared the numbers and percentages of metrics for which MACs earned award fees across performance periods and across MACs.

We determined the extent to which CMS conducted performance monitoring throughout the performance periods. We reviewed information on CMS's performance monitoring to determine whether CMS conducted onsite visits, ad hoc reviews, and data validation reviews.

For each MAC, we calculated the time between the end of the performance period and the date CMS finalized the CPARS report. For one CPARS evaluation, CMS was not able to provide the date the final report was entered into CPARS.

To retain MACs' anonymity, we randomly assigned a unique identifier (i.e., a letter) to identify each MAC throughout this report.

Limitations

Although we followed up with CMS to clarify information provided, we did not independently verify CMS's responses regarding its reviews of MACs' performance.

Standards

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

[27] We used the end date of the award fee evaluation period in our calculation, but for consistency, we use the phrase "performance period" in our report.

FINDINGS

MACs did not meet one-quarter of all quality assurance standards reviewed by CMS

There were 1,201 standards included in MACs' QASP reviews for 2 performance periods. Overall, MACs did not meet 26 percent, or 310, of these standards. CMS conducts QASP reviews to ensure that MACs are providing the quality of services required in their contracts. MACs are expected to comply with stringent performance requirements for QASP standards; a number of standards require 100-percent performance compliance.

QASP reviews include standards in eight areas.[28] Each area and examples of standards within each area are listed in Appendix B. For example, QASP reviews evaluate whether MACs' processes meet all CMS requirements in areas such as processing claims, managing appeals, handling claims for which Medicare is the secondary payer, and enrolling providers. The number of QASP standards CMS reviewed varied by MAC and by performance period.

Of the 13 MACs in our review, 7 did not meet 25 percent or more of their QASP standards. The percentage of unmet standards ranged from 13 percent to 48 percent. One MAC did not meet one or more standards in all eight areas.

Most MACs' (10 of 13) performance improved over the two performance periods. Of the 534 standards included in QASP reviews for the first performance period, 158 (30 percent) were not met. Of the 667 standards included in QASP reviews for the second performance period, 152 (23 percent) were not met. However, five MACs (38 percent) still did not meet over one-quarter of their QASP standards reviewed in the second performance period. The percentage of standards not met in the second performance period ranged from 6 percent to 50 percent.

MACs did not meet over 40 percent of QASP standards in three areas

For three of eight QASP performance areas, MACs did not meet over 40 percent of standards. Overall, MACs did not meet 51 percent of standards in the area of provider enrollment. In this area, CMS evaluated MACs' accuracy and timeliness in processing provider enrollment applications and revocations. For example, some MACs did not meet the requirement to accurately process 98 percent of provider applications in

[28] Two of the eight areas—"audit and reimbursement" and "provider enrollment"—are included only in QASP reviews of A/B MACs.

accordance with instructions in CMS's *Medicare Program Integrity Manual*. Additionally, five of nine MACs did not meet one or more standards in this area for two performance periods.[29]

Overall, MACs did not meet 45 percent of the standards in the "Medicare secondary payer" area. In this area, CMS evaluated MACs' timeliness and accuracy in processing claims for which Medicare is not the primary payer. For example, some MACs did not meet the requirement to respond to 95 percent of inquiries regarding Medicare secondary payer claims within 45 days from receipt of the inquiry. Additionally, 12 of 13 MACs did not meet 1 or more standards in this area for 2 performance periods.

Overall, MACs did not meet 43 percent of standards regarding their appeals processes. In this area, CMS evaluated MACs' timeliness and accuracy in managing appeals. For example, some MACs did not send 100 percent of appeal decision notices within 60 days of receipt of appeals as required. Additionally, 12 of 13 MACs did not meet 1 or more standards in this area for 2 performance periods. Table 1 shows the number and percentage of standards MACs did not meet in each area CMS reviewed.

Table 1: Number and Percentage of Unmet QASP Standards in Each Performance Area

Performance Area	Number of Standards Reviewed	Number of Standards Not Met	Percentage of Standards Not Met
Provider Enrollment	90	46	51%
Medicare Secondary Payer	186	84	45%
Appeals	183	79	43%
Audit and Reimbursement	207	36	17%
Medical Review	42	7	17%
Provider Customer Service Program	196	32	16%
Financial Management	178	23	13%
Claims Processing	119	3	3%
Total	**1,201**	**310**	**26%**

Source: OIG analysis of final QASP Summary Reports, 2012.

[29] As noted in the previous footnote, "provider enrollment" is one of the two areas included only in QASP reviews of A/B MACs.

CMS did not always include areas identified as problematic through QASP reviews as metrics in MACs' award fee plans

MAC contracts include an award fee that a MAC may earn if its performance exceeds basic requirements, and metrics can be included in a MAC's award fee plan to encourage improved performance. The purpose of an award fee is, in general, to differentiate performance that is merely satisfactory from performance that demonstrates that a MAC has exceeded the requirements in its statement of work. As a result of changes that CMS made beginning in July 2009, MACs cannot earn any award fee if they do not attain a CPARS rating of satisfactory or higher in all areas. From an overall award fee pool of $39 million across two performance periods, MACs earned two-thirds, or $26 million.

Regarding QASP reviews, MACs did not meet 45 percent of the QASP standards in the "Medicare secondary payer" area. However, CMS did not include any metrics from this area in any MACs' award fee plans. Additionally, although issues with provider enrollment were identified through QASP and other reviews, CMS included provider enrollment metrics in the award fee plan for only one MAC. Moreover, although MACs did not meet 51 percent of QASP standards regarding provider enrollment, metrics in this area made up less than 1 percent of award fee metrics that CMS assessed. Appendix C describes the award fee metrics, the award fees earned by MAC, and the award fees earned by metric.

MACs had not resolved issues with 27 percent of unmet standards

For the 310 QASP standards that MACs did not meet, CMS determined that, as of June 2012, MACs had not resolved issues with 83, or 27 percent, of the unmet standards. MACs had not resolved issues with 18 standards that were not met in the first performance period and issues with 65 standards that were not met in the second. Of the 83 standards not met, over half involved provider enrollment (18), appeals (13), or audit and reimbursement (13).

CMS did not require action plans for 12 percent of unmet standards, and unmet standards without action plans were almost four times more likely to have issues go unresolved

When MACs do not meet a standard, CMS can—but does not always—require the MAC to submit an action plan to resolve issues related to that standard. For example, according to CMS staff, if the MAC had one error that caused it to not meet a standard but the MAC was in compliance for the rest of the performance period, CMS may choose not to require an action plan. Additionally, CMS may not require an action plan if it has

waived a contract requirement because of an issue beyond the MAC's control, such as a CMS system failure.

CMS did not require action plans for 37 of the 310 standards MACs did not meet. When CMS did not require MACs to have action plans for unmet standards, the issues with those standards were almost four times more likely to go unresolved. Of the 37 standards for which CMS did not require action plans, issues with 76 percent were not resolved. In contrast, of the 273 standards for which CMS required action plans, issues with 20 percent were not resolved.

Two MACs consistently underperformed across various CMS reviews

Two MACs, designated as V and Y in this report, consistently underperformed across various CMS reviews. MAC V's quality control plan was initially rejected because the document it submitted was not deemed a quality control plan. Additionally, CMS's onsite validation review of MAC Y's quality control plan uncovered flaws regarding the MAC's inspection and audit system, as well as its procedures for corrective action.

Both MACs did not meet a high percentage of QASP standards. MAC V had the highest percentage of unmet standards (48 percent) and MAC Y had the third-highest percentage of unmet standards (31 percent). For MAC V, over half of the issues identified through its QASP reviews had not been resolved.

CMS awarded the lowest percentage of award fees to these two MACs—35 and 40 percent of their respective award fee pools. For MAC V, CMS reduced the overall percentage of the MAC's award fee earned to 40 percent in one performance period because of its poor performance in key areas. CMS noted MAC V's failure to make system changes; a high volume of complaints regarding its customer service program for providers; and its failure to meet basic performance requirements, such as those regarding appeals processing. Additionally, MACs V and Y were the only two MACs that did not earn any award fee for the contract administration metric during one performance period. This metric evaluates a MAC's overall ability to manage its contract, specifically in areas such as communication, flexibility, staffing, and cost management.

For MAC Y, concerns regarding a backlog in provider enrollment led CMS to increase oversight and monitoring activities, including putting the MAC under an ad hoc review for an entire performance period. As part of this review, the MAC was required to send daily reports of provider enrollment to CMS and to have biweekly update calls with CMS

management. MAC Y received onsite visits nearly twice a month in both performance periods we reviewed.

When the contract for MAC Y's jurisdiction was recompeted, the contract was awarded to a different contractor. As of December 2013, MAC V's contract was still in effect and the recompete for the jurisdiction had not yet been completed.

According to CMS staff, the agency has considered not renewing contract option years for MACs performing at substandard levels. However, it takes approximately 1 year for CMS to solicit and award a new contract. With only 4 option years for each contract, CMS reported that the resources and risk involved in conducting an unforeseen procurement to replace a poorly performing MAC made such a decision impractical.

CMS's performance reviews of MACs, while extensive, were not always completed timely

Overall, CMS conducted extensive activities to review MACs' performance. Because MAC reviews provide important performance information and can be used to support future award decisions, it is important that CMS complete these reviews timely. However, CMS did not always do so.

Quality Control Plan Reviews. CMS policy requires it to conduct an onsite review to determine whether MACs have implemented their quality control plans.[30] This onsite review may be conducted within 3 to 4 months of the date the MAC becomes operational.[31] According to CMS staff, CMS strives to complete the review during the MAC's base year. The performance periods we reviewed included the base year for three MACs. For one of the three, the onsite validation review was conducted in the base year. For the remaining two MACs, there was no onsite validation review in the base year. However, both of these MACs had an onsite validation review in the next year of the contract. According to CMS staff, some onsite validation reviews that should have been conducted in the base year may not have been conducted because of a lack of travel funds or staff.

QASP Reviews. As required, CMS completed a QASP review for each of the 13 MACs' performance periods in our review. CMS's QASP Standard Operating Procedure (SOP) establishes an internal timeframe of 51 days

[30] CMS, *Medicare Administrative Contractor Quality Control Plan Review Protocol,* pp. 1–2, July 2011.
[31] Ibid., p. 2.

for completing final QASP reports.[32] However, none of the QASP reviews met that timeframe. On average, final QASP reports were sent more than 5 months after the end of the QASP performance period.

According to the QASP SOP, the draft QASP Summary Report must be sent to the MAC within 30 days of the end of the performance period. CMS sent draft QASP reports between 34 and 155 days after the end of the performance period, with an average of 99 days after.

The QASP SOP also states that once the draft report has been sent, the MAC has 7 days to provide a rebuttal and CMS has 14 days to respond to the rebuttal and generate the final QASP Summary Report. However, CMS sent 24 of the 26 final QASP Summary Reports more than 21 days after the draft reports were sent. The average number of days between the date of the draft report and the date of the final QASP Summary Report was 62 days.

CMS reported that, to improve timeliness, it revised QASP procedures in July 2012 so that all QASP reviews are begun 30 days before the end of the performance period. In addition, CMS staff reported that in October 2012, the agency instituted a strategy to ensure compliance with internal due dates for QASP reports.

Award Fee Determinations. According to CMS staff, award fee determinations are completed through an extensive process involving numerous staff, including members of the contract administration team, CMS managers, and an award fee determining official. As required, CMS made award fee determinations for each of the 13 MACs' performance periods in our review. According to timeframes set forth in the *MAC Contract Administration Guide*, CMS must send award fee determination letters to MACs within 90 days of the end of the performance period. However, CMS sent only one such letter to a MAC within 90 days. The number of days between the end of the performance period and the date the award-fee determination letter was sent ranged from 89 to 214. On average, award fee determination letters were sent to MACs 135 days after the end of the performance period. According to CMS staff, as of July 2013, CMS was in the process of updating the *MAC Contract Administration Guide* and intended to revise the award fee determination timelines in accordance with best practices.

CPARS Evaluations. As it does with award fee determinations, CMS goes through an extensive process to finalize MACs' CPARS reports. CPARS

[32] CMS must submit the draft QASP Summary Report to the MAC within 30 days of the end of the performance period. The MAC then has 7 days to provide a rebuttal, and CMS has 14 days to respond and generate the final QASP Summary Report.

evaluations provide summaries of CMS's various performance reports and experiences with the MACs. According to CMS guidelines, draft CPARS reports should be submitted for review to the Program Management Division Director within 90 days of the end of the performance period.[33] However, during our review timeframe, CMS did not track the submission date of the draft reports. CMS guidelines for completing CPARS evaluations do not include timeframes for finalizing reports. CMS staff reported that in October 2012, the agency instituted a procedure to track the status of all CPARS evaluations.

If CPARS reports are not completed timely, the information they contain cannot be used to support future award decisions. For the 25 CPARS evaluations that had a final report date in CPARS, the time between the end of the performance period and the date the report was finalized ranged from 8 months to over 2 years. The average amount of time between the end of the performance period and the date the CPARS report was finalized was over 14 months.

[33] CMS, *MAC Contract Administration Guide*, p. 114, June 2011.

CONCLUSION AND RECOMMENDATIONS

Given the billions of dollars awarded to MACs and the critical role they play in administering the Medicare program, effective oversight of these contractors by CMS is important to ensure that they are carrying out their assigned tasks.

Although MACs met the majority of quality assurance standards reviewed by CMS, they did not meet one-quarter of them. Additionally, CMS did not require action plans for some unmet standards, and unmet standards without action plans were almost four times more likely to have issues go unresolved. Moreover, certain areas identified as problematic through QASP reviews were not always included as metrics in MACs' award fee plans.

While CMS's performance reviews of MACs were extensive, they were not always completed timely. If performance reviews are not completed timely, the information they contain may not be available to support future award decisions. Additionally, two MACs consistently underperformed across various CMS reviews. However, the 5-year timeframe under which CMS must recompete MAC contracts limits CMS's ability to solicit and award new contracts when MACs are not meeting the agency's requirements.

It is important that CMS effectively oversee MACs to ensure that it is obtaining the level of performance expected. Therefore, we recommend that CMS:

Require action plans for all unmet QASP standards

Unmet QASP standards that did not have an action plan were almost four times more likely to have issues go unresolved. CMS should require action plans for all QASP standards not met to help ensure that MACs resolve the issues.

Use QASP results to help select award fee metrics for review and to establish award fee metrics for the "Medicare secondary payer" area

CMS should ensure that MACs' QASP performance informs the metrics it selects for MACs' award fee plans. The areas in which the MACs had the greatest percentage of unmet QASP standards were "provider enrollment," "Medicare secondary payer," and "appeals." Although there were award fee metrics for the "provider enrollment" and "appeals" areas, there were no award fee metrics for the "Medicare secondary payer" area. Additionally, provider enrollment metrics were included in only one MAC's award fee plan.

Seek legislative change to increase the time between MAC contract competitions to give CMS more flexibility in awarding new contracts when MACs are not meeting CMS requirements

MAC contracts are awarded for a base year and 4 option years. The current law requires CMS to recompete MAC contracts at least every 5 years. MAC contracts are awarded by jurisdiction, and the periods of performance for MAC contracts are staggered such that MAC contracts do not end at the same time. According to CMS staff, this puts them in a perpetual procurement cycle and makes it impractical to recompete a MAC contract earlier than the mandatory 5-year recompete.

CMS should seek legislative change to allow more time between MAC contract competitions. The intent of this recommendation is not to extend the length of a contract for a poorly performing MAC. Instead, because of the resources, time, and effort it takes to compete a contract, such a change would allow CMS to use its time and resources effectively in soliciting and awarding new contracts. By extending the overall contract term, the time and resources that would have been used for the mandatory 5-year recompete of a well-performing MAC's contract could be used to conduct an unforeseen procurement to replace a poorly performing MAC.

Meet timeframes for completing draft and final QASP summary reports

CMS's procedures for QASP reviews state that the draft QASP Summary Report will be completed within 30 days of the end of the performance period (i.e., evaluation period); however, none of the draft reports in our review were completed within that timeframe. The procedures also state that the final QASP Summary Report should be generated within 21 days from the issuance of the draft report; however, almost none of the final summary reports were issued within that timeframe.

Meet timeframes for completing award fee determinations

CMS's *MAC Contract Administration Guide* states that award fee determination letters will be sent to MACs within 90 days of the end of the performance period (i.e., evaluation period); however, CMS sent only one award fee determination letter within this timeframe.

Establish reasonable timeframes for issuing final CPARS reports

CMS guidelines for completing CPARS evaluations do not include timeframes for submitting the final reports; however, the average amount of time between the end of the performance period and the date of the final CPARS report was 428 days. Without a timely CPARS report, award decisions may be made without comprehensive performance information.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all six of our recommendations. Regarding our first recommendation, CMS stated that effective June 19, 2013, it began requiring action plans for all QASP standards that were not met. However, CMS noted that a request for an action plan may change as the QASP report goes through the rebuttal process. For example, CMS stated that sometimes corrective actions have already been taken after the issue has been identified.

Regarding our second recommendation, CMS stated that it will continue to examine the feasibility of developing award fee metrics for provider enrollment and any other functional areas as warranted. However, CMS added that when basic statement of work standards are not met, as for example, in the case of Medicare secondary payer, it focuses its resources on MACs' achievement of basic standards prior to creating award fee metrics.

Regarding our third recommendation, to increase the time between MAC contract competitions, CMS stated that it will consider this recommendation when it develops the next President's budget proposal.

Regarding our fourth, fifth, and sixth recommendations, CMS stated that effective July 26, 2013, it has revised its timeframes for completing QASP summary reports, award fee determinations, and final CPARS reports. QASP summary reports are now due 60 days after the end of the contract year, award fee determinations are due 150 days after the end of the contract year, and CPARS reports are due 120 days after the end of the contract year. CMS noted that while it agrees with the importance of meeting timeliness goals, it believes that the accuracy and completeness of performance documents take precedence over timeliness. OIG agrees that accuracy and completeness are important, but also stresses the importance of timeliness. If performance reviews are not completed timely, the information they contain may not be available to support future award decisions.

For the full text of CMS's comments, see Appendix D.

APPENDIX A

MACs' Coverage Areas and Performance Periods Reviewed

Table A-1 provides the 13 MACs' coverage areas and the associated performance periods used for this review. These MACs had been operational for at least 2 years as of January 2012. Performance periods ranged from 2008 to 2011.

Table A-1: MACs' Coverage Areas and Performance Periods Reviewed

MAC	MAC Coverage Area	Performance Period 1	Performance Period 2	Base Contract Amount for Two Performance Periods[1]
Palmetto GBA, LLC	Parts A and B for CA, HI, NV	1/25/09 –1/24/10	1/25/10 –1/24/11	$155,753,377
Noridian Healthcare Solutions, LLC (formerly Noridian Administrative Services, LLC)	Parts A and B for AZ, MT, ND, SD, UT, WY	7/31/09 – 7/30/10	7/31/10 – 7/30/11	$79,288,901
TrailBlazer Health Enterprises, LLC	Parts A and B for CO, NM, OK, TX	8/6/09 – 8/5/10	8/6/10 – 8/5/11	$170,778,910
Wisconsin Physicians Services Insurance Company	Parts A and B for IA, KS, MO, NE	9/10/08 – 9/9/09	9/10/09 – 9/9/10	$93,295,705
First Coast Service Options, Inc.	Parts A and B for FL, PR, VI	9/16/08 – 9/15/09	9/16/09 – 9/15/10	$115,227,545
Cahaba Government Benefit Administrators, LLC	Parts A and B for AL, GA, TN	1/12/09 – 1/11/10	1/12/10–1/11/11	$104,328,164
Novitas Solutions, Inc. (formerly Highmark Medicare Services, Inc.)	Parts A and B for DC, DE, MD, NJ, PA	3/01/09 – 2/28/10	3/01/10 – 2/28/11	$196,705,470
National Government Services, Inc.	Parts A and B for CT, NY	3/18/09 – 3/17/10	3/18/10 – 3/17/11	$138,793,917
NHIC, Corp.	Parts A and B for MA, ME, NH, RI, VT; Home Health and Hospice for CT, MA, ME, NH, RI, VT	11/14/08 – 11/13/09	11/14/09 – 11/13/10	$53,550,221
NHIC, Corp.	Durable Medical Equipment for DC, DE, CT, MA, MD, ME, NH, NJ, NY, PA, RI, VT	12/30/08 – 12/29/09	12/30/09 – 12/29/10	$24,389,200
National Government Services, Inc.	Durable Medical Equipment for IL, IN, KY, MI, MN, OH, WI	12/30/08 – 12/29/09	12/30/09 – 12/29/10	$38,102,255
CGS Administrators, LLC (formerly CIGNA Government Services, LLC)	Durable Medical Equipment for AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, PR, TN, SC, VA, TX, WV	12/1/08 – 11/30/09	12/1/09 – 11/30/10	$57,278,148
Noridian Healthcare Solutions, LLC (formerly Noridian Administrative Services, LLC)	Durable Medical Equipment for AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY	12/30/08 – 12/29/09	12/30/09 – 3/31/11	$41,690,071

Source: Documentation collected from CMS on MAC performance periods and contract amounts, 2012.

[1] Base contract amount does not include the MAC's award fee pool.

APPENDIX B

Performance Areas in Quality Assurance Surveillance Plans

Table B-1 provides the QASP performance areas evaluated and a description of selected standards within those areas for the MACs in our review. QASP standards are used to evaluate MACs' performance against statement of work requirements.

Table B-1: QASP Performance Areas Reviewed and Description of Selected Standards

Performance Area	Description of Selected Standards Within Each Area
Appeals	The MAC shall reopen an initial determination or a redetermination to review a decision per regulation, the *Medicare Claims Processing Manual*, and statement of work requirements.
	Administrative Law Judge hearing decisions and Qualified Independent Contractor decisions must be effectuated by the MAC within appropriate timeframes.
	Redeterminations are successful when all redetermination notices are processed and mailed within 60 calendar days.
Audit and Reimbursement	Cost report acceptance is timely if it is completed within 30 days from the receipt date of the provider's cost report.
	Cost reports are settled accurately when a CMS review determines compliance with Medicare payment policy as defined in the *Medicare Provider Reimbursement Manual*.
	Cost reports that do not require an audit are settled timely when the Notice of Program Reimbursement is issued within 12 months of the acceptance of a cost report.
Claims Processing	Claims are processed timely when 95 percent of claims are processed within the claims payment floor and ceiling specified in the *Medicare Claims Processing Manual*. The contractor must meet this standard on a monthly basis.
	Communication is timely when CMS receives notification within 24 hours or within the same business day of identification, if the problem may cause disruption of benefit payments beyond a single provider.
	Medicare Summary Notice (MSN) management is successful when the contractor accurately generates and mails 98 percent of MSNs in accordance with *Medicare Claims Processing Manual* instructions.

Continued on next page

Table B-1: QASP Performance Areas Reviewed and Description of Selected Standards (Continued)

Performance Area	Description of Selected Standards Within Each Area
Financial Management	The contractor's use of trust fund dollars is successful when it will not cause CMS to be cited for financial-management-related deficiencies on the CMS annual CFO audit.
	The contractor's debt referral procedures are successful when its eligible delinquent debt has been referred by the 180th day of delinquency.
	The contractor is able to obtain an unqualified opinion (no material weakness) on annual SAS 70 reviews.
Medical Review	The contractor's medical review strategy is successful when problems targeted in the strategy are addressed during the fiscal year using the Progressive Corrective Action process and the contractor can demonstrate a change in billing behavior.
	The contractor's review is successful when it meets CMS's requirement that demand bills from skilled nursing facilities be processed accurately as referenced in the *Medicare Program Integrity Manual*.
Medicare Secondary Payer	For Medicare secondary payer prepayment, 95 percent of all inquiries regarding Medicare secondary payer claims shall be responded to within 45 calendar days of receipt of the inquiry.
	Upon receipt of an incomplete primary payer notification, the contractor shall send a Medicare secondary payer inquiry or assistance request transaction to the Coordination of Benefits Contractor within 1 business day of processing the claim.
	For Medicare secondary payer postpayment, 95 percent of all Medicare secondary payer supplier inquiries shall be acknowledged or responded to within 45 days of receipt.
	All eligible debts are referred to the Department of the Treasury for cross-servicing when the debt becomes 180 days delinquent.
Provider Customer Service Program	Of all calls monitored for the quarter, the number of customer service representatives scoring as "Achieves Expectations" or higher for Knowledge Skills shall be no less than 93 percent. This standard shall be measured quarterly and shall be cumulative for the quarter.
	Telephone inquiries are successful when the corporate quarterly call completion rate is 95 percent for interactive voice responses and 80 percent for customer service representatives.
	The contractor shall maintain an average speed of answer of 60 seconds or less measured on a quarterly basis.

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Table B-1: QASP Performance Areas Reviewed and Description of Selected Standards (Continued)

Provider Enrollment	The paper enrollment applications described in the statement of work shall be considered timely processed when 80 percent of applications are processed within 60 calendar days of receipt or sooner, 90 percent within 120 calendar days of receipt or sooner, and 99 percent within 180 calendar days of receipt.
	The contractor shall process 100 percent of all revocation actions in full accordance with all revocation instructions in the *Medicare Program Integrity Manual*.
	The contractor shall process 100 percent of all provider enrollment appeals in full accordance with all appeals instructions in the *Medicare Program Integrity Manual*.

Source: OIG's review of MACs' final QASP Summary Reports, 2012.

APPENDIX C

Information on Award Fees

MAC contracts include an award fee that a MAC may earn if its performance exceeds basic requirements, and CMS can include metrics in MACs' award fee plans to encourage MACs to improve their performance. This appendix provides a description of the award fee metrics reviewed, the award fees earned by MAC, and the award fees earned by metric.

Table C-1 shows the types of award fee metrics evaluated for the MACs in our review.

Table C-1: Award Fee Plan Metrics and Description

Metric	Description
Appeals	Measures timeliness in processing and sending 100 percent of redetermination notices within 60 calendar days of receipt. Measures the accuracy of Medicare Redetermination Notices issued by the contractor, fully or partially affirming denials of claims.
Audit Quality	Measures the quality of desk reviews, audits, and/or reopenings.
Beneficiary Inquiries	Measures the timeliness of responses to complex inquiries forwarded from the Beneficiary Contact Center or CMS regional offices.
Claims Processing Timeliness	Measures the timeliness of processing clean electronic claims within the statutorily specified timeframes.
Comprehensive Error Rate Testing	Measures the contractor's ability to reduce its error rate for improper Medicare payments. Measures the contractor's ability to achieve the Government Performance and Results Act goal for Comprehensive Error Rate Testing.
Contract Administration	Measures overall contract management. When evaluating this metric, CMS considers cost, timeliness, staff, flexibility, deliverables, and communication.
Decrease in Paper Remittance	Measures the contractor's ability to decrease the number of paper remittance advices sent to providers in its jurisdiction.
Increase in Electronic Funds Transfer	Measures the contractor's ability to increase the use of electronic funds transfer payments to existing Medicare providers.
Medical Review	Evaluates the probe findings letter sent to the provider/supplier as a result of medical review.
Medicare Provider Satisfaction Survey	Measures the contractor's overall provider satisfaction as calculated by the Medicare Contractor Provider Satisfaction Survey.

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Table C-1: Award Fee Plan Metrics and Description (Continued)

Metric	Description
Program Integrity Support	Measures the timeliness of submitting overpayment information to the Program Safeguard Contractors (PSCs) or Zone Program Integrity Contractors (ZPICs). Measures the contractor's responsiveness to PSC or ZPIC requests for information. Measures the timeliness of adding a new provider to an established payments-suspension flag at the request of the PSC or ZPIC.
Provider Customer Service	Measures the accuracy with which customer service representatives responded to Medicare policy questions. Measures the contractor's ability to actively market and promote the benefits of being a member of the provider listserv(s). Measures the contractor's rating on the Medicare Contractor Website Customer Satisfaction Survey.
Provider Enrollment	Measures timeliness of processing paper applications for provider enrollment. Measures timeliness of processing Web-based applications for provider enrollment.
Qualified Independent Contractor Support	Measures timeliness of Qualified Independent Contractor support.
Systems Security	Measures the contractor's compliance with CMS's system security standards.

Source: OIG's review of MACs' award fee determination letters, 2012.

Award Fees Earned by MACs

From an overall award fee pool of $39 million across two performance periods, MACs earned two-thirds, or $26 million. MACs earned between 35 percent and 86 percent of their respective award fee pools. MACs can earn none, some, or all of the award fee associated with each metric. As shown in Table C-2, of the 314 award fee metrics CMS assessed across 2 performance periods, MACs did not earn any award fee for 22 percent of metrics. MACs earned all of the award fee for 51 percent of metrics and some award fee for 27 percent of metrics.

Table C-2: Award Fees Earned by MAC

MAC[1]	Number of Metrics Assessed	Percentage of Metrics Not Met (No Award Fee Earned)	Percentage of Metrics Partially Met (Some Award Fee Earned)	Percentage of Metrics Fully Met (All Award Fee Earned)
V	27	22%	59%	19%
Y	29	55%	14%	31%
R	31	23%	39%	39%
X	17	29%	29%	41%
Z	17	24%	35%	41%
Q	17	12%	41%	47%
U	26	19%	23%	58%
P	34	24%	18%	59%
T	25	20%	20%	60%
S	18	6%	33%	61%
N	22	14%	23%	64%
W	26	19%	12%	69%
O	25	4%	20%	76%
Total	**314**	**22%**	**27%**	**51%**

Source: OIG analysis of award fee determination letters, 2012.

[1] We randomly assigned a unique identifier (i.e., a letter) to each MAC in our review. Percentages across some rows do not total 100 percent because of rounding.

Amount and Percentage of Award Fees Earned by Metric

As shown in Table C-3, MACs did not earn any award fee for 68 of 314 metrics. Over two performance periods, the award fee pool for metrics ranged from $20,546 to over $14 million. The metrics assessed varied by MAC and performance period (i.e., not all MACs were assessed on every metric). The $39 million total award fee pool represented 3 percent of the $1.3 billion in MAC contracts for the two performance periods reviewed.[34]

The metric associated with systems security represented 25 percent of all metrics (17 of 68) for which MACs earned no award fee. All 13 MACs in our review did not earn any award fee for the systems security metric in at least 1 performance period. Overall, MACs did not earn $2.4 million of the $2.9 million of the available award fee pool for this metric. Appeals represented 22 percent of the metrics (15 of 68) for which MACs earned no award fee. Overall, MACs did not earn $2.4 million of the $4.7 million of the available award fee pool for this metric. Two additional metrics—audit quality and Medicare provider satisfaction survey—had a high percentage of award fees not earned; however, they were reviewed less often and were associated with smaller potential award fees. Audit quality was assessed twice and had an award fee pool of $46,065; MACs did not earn any award fee for this

[34] The $1.3 billion represents the MACs' base contract amounts (i.e., it excludes any award fees).

metric. The metric associated with the Medicare provider satisfaction survey was assessed eight times and had an award fee pool of $357,081; MACs did not earn $299,541 of the available award fee pool for this metric.

The contract administration metric is always included in MACs' award fee plans and represented over one-third of the total award fee pool ($14 million of $39 million) for the performance periods reviewed. Overall, MACs did not earn 31 percent of the available award fee pool for contract administration.

Table C-3: Amount and Percentage of Award Fees Earned by Metric

Metric	Number of Times Metric Assessed	Number of Times Award Fee Not Earned	Award Fee Pool	Award Fee Not Earned	Percentage of Award Fee Earned
Audit Quality	2	2	$46,065	$46,065	0%
Medicare Provider Satisfaction Survey	8	5	$357,081	$299,541	16%
Systems Security	23	17	$2,917,288	$2,441,707	16%
Appeals	43	15	$4,735,906	$2,438,800	49%
Contract Administration	26	2	$14,174,547	$4,326,992	69%
Decrease in Paper Remittance	5	1	$304,808	$92,356	70%
Provider Customer Service	51	10	$6,453,814	$1,864,434	71%
Comprehensive Error Rate Testing	12	4	$750,599	$187,432	75%
Program Integrity Support	47	6	$4,722,686	$733,245	84%
Claims Processing Timeliness	22	0	$1,201,600	$182,850	85%
Beneficiary Inquiries	43	4	$1,670,911	$161,458	90%
Qualified Independent Contractor Support	27	2	$1,375,315	$115,250	92%
Provider Enrollment	2	0	$164,757	$0	100%
Medical Review	1	0	$20,546	$0	100%
Increase in Electronic Funds Transfer	2	0	$128,602	$0	100%
Total	**314**	**68**	**$39,024,523**	**$12,890,130**	**67%**

Source: OIG analysis of award fee determination letters, 2012.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 2 1 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Administrative Contractors' Performance" (OEI-03-11-00740)

Thank you for the opportunity to review and respond on the above subject OIG Draft Report. Given the billions of dollars awarded to Medicare Administrative Contractors (MACs) and the critical role they play in the administration of the Medicare program, effective oversight of these contractors' performance is important to ensure that they are adequately processing claims and performing other assigned tasks.

The OIG recommendations and CMS responses to those recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS require action plans for all unmet QASP standards.

CMS Response

The CMS concurs with the recommendation. Effective June 19, 2013, CMS began requiring action plans for all Quality Assurance Surveillance Plans (QASP) standards that were not met. However, we note that a request for an action plan may change as the QASP report goes through the rebuttal process. For example, sometimes corrective actions have already been taken after the issue has been identified. Moreover, the CMS works closely with the Business Function Leads, Technical Monitors, and the Contracting Officer's Representative to determine if an action plan is needed based on specific circumstances. For example, if the contractor did not meet a 100 percent standard in only one month in a period of performance, an action plan may not be required for that period of performance. In those instances, CMS makes a determination if an action plan is needed.

OIG Recommendation

The OIG recommends that CMS use QASP results to help select award fee metrics for review and to establish award fee metrics for the "Medicare secondary payer" area.

CMS Response

The CMS concurs with the recommendation. In those areas where CMS can establish and create award fee metrics based on QASP results, such action is taken. Furthermore, CMS will continue to examine the feasibility of developing award fee metrics for Provider Enrollment and any other functional areas as warranted. However, when basic statement of work standards are not met (for example, in the case of Medicare Secondary Payer), CMS focuses its resources on achievement of the basic standards prior to creating stretch goals designed to incentivize a MAC with an award fee if it exceeds the statement of work requirements. In addition, CMS also links QASP results and overall MAC performance to the contractor's eligibility for award fee. Specifically, in order to be eligible for award fee, all MACs must achieve at least a satisfactory rating in each area of the MAC's annual performance evaluation that is documented in Contractor Performance Assessment Reporting System (CPARS).

OIG Recommendation

The OIG recommends that CMS seek legislative change to increase the time between MAC contract competitions to give CMS more flexibility in awarding new contracts when MACs are not meeting CMS requirements.

CMS Response

The CMS concurs with the OIG's findings on this issue. CMS will consider the OIG's recommendation when we develop the next President's budget proposal.

OIG Recommendation

The OIG recommends that CMS meet timeframes for completing draft and final QASP summary reports.

CMS Response

The CMS concurs with the recommendation. Effective July 26, 2013, CMS has revised its timeframes so that QASP summary reports are now due 60 days after the end of the contract year. CMS agrees with the importance of meeting timeliness goals; however we believe that the accuracy and completeness of such documents take precedence over timeliness.

OIG Recommendation

The OIG recommends that CMS meet timeframes for completing award fee determinations.

CMS Response

The CMS concurs with the recommendation. Effective July 26, 2013, CMS has revised its timeframes for completing award fee determinations to 150 days after the end of the contract

year. CMS agrees with the importance of meeting timeliness goals; however we believe that the accuracy and completeness of such documents take precedence over timeliness.

OIG Recommendation

The OIG recommends that CMS establish reasonable timeframes for issuing final CPARS reports.

CMS Response

The CMS concurs with the recommendation. While CMS has had a timeframe of completing the final CPARS reports at a minimum on an annual basis since July 6, 2012, effective July 26, 2013, CMS revised its timeframes for completing CPARS reports to 120 days after the end of the contract year. CMS agrees with the importance of meeting timeliness goals; however, we believe that the accuracy and completeness of such documents take precedence over timeliness.

The CMS thanks the OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

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

Tara Bernabe served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Philadelphia regional office who conducted the study include Nancy J. Molyneaux and Sunil Patel. Central office staff who provided support include Scott Manley and Christine Moritz.

Office of Inspector General

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