DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 2 1207

FEB 1 1 2000

The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
U.S.House of Representatives
Washington, DC 205 15-6 115

The Honorable Fred Upton
Chairman, Subcommittee on Oversight
and Investigations

The Honorable Joe Barton
Chairman, Subcommittee on Energy
and Power

Dear Chairman Bliley:

In response to your August 3 request that the Health Care Financing Administration (HCFA) submit quarterly reports to the Committee summarizing Medicare contractor program integrity improvement efforts, we sent the first of these reports on October 27, 1999. We surveyed our contractors and extracted information from our management reporting systems in order to address each of the eight areas specified by the Committee. This letter and its enclosures constitute the second of these reports. Since these reports were to be submitted on a quarterly basis for the remainder of the first session of Congress, this would also be the final report.

Based on a September 9 conversation between Charles M. Clapton, Committee Counsel, with HCFA's Office of Legislation, it is our understanding that this subsequent quarterly report is to contain concise summaries for items l-6 and that if there are no changes from the previous quarter, a simple note of that fact would be sufficient. Since you had requested both summary information and an enumeration of contractor-specific data, we have included the total numbers and summary information for each of the areas. Detailed descriptions of activities and contractor-specific totals are contained in spreadsheets and enclosures appended to this letter.

Although we have removed individual provider identifiers in the enclosure listing program vulnerabilities, we would request that you limit release of and access to this particular enclosure since it describes vulnerabilities of the Medicare program which could be breached.

Following are updates to HCFA's October 27, 1999 responses to each of the eight topics cited in the Committee's request:

1. **Identify, in a concise summary, all new efforts and initiatives that contractors and HCFA are pursuing to identify fraud or abuse within the Medicare program.**

Here are the following new initiatives:

Operation Restore Trust (ORT) – FY 2000: For Fiscal Year 2000, HCFA has committed funding in the amount of $1 million for contractor special projects. These ORT special projects will focus on the prevention and detection of fraud, waste and abuse (FWA) in the Medicare program and will continue to strengthen HCFA's relationship with its ORT partners in the Department of Health & Human Services (e.g., Office of Inspector General and the Administration on Aging), the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). To date, twenty-five contractors have been approved for a total of forty projects. The approved projects involve the following:

- Education of Medicare providers, beneficiaries and local advocacy groups in the detection and prevention of FWA;
- Verification of services rendered and the determination of medical necessity for various service types; and
- Review of specific provider types, which appear to be problematic, based on analysis of billing patterns.

McNeil Project: Surveying, testing, and implementing rapidly emerging technology is critical to keeping HCFA at the forefront of the battle against Medicare FWA. In recent years, HCFA has successfully expanded its arsenal of detection capabilities by increasing investment in FWA detection tools. Many of HCFA's contractors currently use these types of products in their program integrity efforts. Because HCFA and Medicare contractors receive numerous unsolicited proposals describing new FWA detection products, it has become increasingly challenging for them to evaluate these products, quantify potential benefits, and determine if and how they complement existing efforts. To help meet the clear need for a coordinated, ongoing process for assessing and implementing FWA detection technology, HCFA contracted with an information technology firm to conduct a market survey to identify and catalog the functionality of commercially available FWA detection products. Efforts are focused on capturing information on products that offer advanced analytical functionality, such as fuzzy logic and neural networking, in addition to data mining features.

HCFA expects to announce the upcoming market survey shortly to the vendor community through announcements on the HCFA Website and in Commerce Business Daily inviting vendors to complete this survey electronically. Responses will constitute the basis for a "virtual" catalog of FWA detection products that will be constantly updated by annually inviting vendors to refresh prior submissions.

Program Safeguard Contractors (PSCs): As of November 24, 1999, all of the first six PSC task orders were awarded. Ten out of the thirteen PSCs bid on at least one of these six task orders and seven out of the ten entities that bid were awarded at least one PSC task order. Following is a list of the PSCs task orders and the respective contract awardee(s):

Perform Millennium-Related National Data Analysis and Provider On-Site Reviews: The purpose of this task order is to conduct national data analysis to minimize the potential risk of increased fraud and abuse during the millennium critical months. The PSC will also be required to conduct Coordinated Comprehensive Provider Reviews on providers determined to be a potential fraud risk. Awardee: Computer Sciences Corporation

Establish a Part A Benefit Integrity Support Center in New England: This task order will focus on doing Part A data analysis and supporting fraud unit activities in New England. All New England Medicare fraud units will maintain their current staffing levels, and will continue to perform the fraud related functions which they are currently performing. Awardee: California Medical Review, Inc.

Conduct On-Site Community Mental Health Center (CMHC) Reviews: The purpose of this project is for qualified mental health professionals to conduct uniform, professional and unannounced visits to CMHCs. These site visits will serve as a tool for screening applicants and enrollees in the Medicare program. Awardee: Electronic Data Systems

Review Providers for Compliance with Office of the Inspector General (OIG) Corporate Integrity Agreements (CIAs): Under this task order, the PSCs will perform on-site reviews of providers that are subject to CIAs as part of a settlement with the OIG. The PSC will review the providers' CIA obligations and conduct a statistically valid random sample of claims to ascertain if the provider is meeting all of their CIA commitments. Awardee: TriCenturion, LLC

Develop a Nationally-Focused Medicare Integrity Plan Provider Education Plan: The PSC will conduct a national education needs assessment and then develop a comprehensive Medicare Integrity Program educational plan. The needs assessment will involve surveying our current contractors, providers, and medical and professional groups. Awardee: Aspen Systems Cornoration

Conduct Home Office Cost Report Audits of Large Chain Facilities: This task order will supplement the efforts of Medicare fiscal intermediaries by conducting up to 5 field audits on Home Office Chains. We will focus on large chains from across the country. Awardees: United Government Services, Aspen Systems Corporation, and Science Applications International Corporation

Additionally, this past quarter, another PSC task order Statement of Work was released for the Statistical Analysis Contractor. Bids for this task order were due to be submitted to HCFA from the PSCs on January 20,200O. The panel to evaluate the proposals will meet during the month of February 2000.

Therapy Services: We briefed HCFA Deputy Administrator Mike Hash and the HHS Deputy Secretary Kevin Thurm on Comprehensive Outpatient Rehabilitation Facilities & Outpatient Rehabilitation Facilities issues. A multi-faceted action plan was initiated, including the development of a new PSC task order for therapies.

2. **Identify the number of potential cases of fraud or abuse that each contractor has proactively developed, especially through the use of information management techniques such as utilization review or claims validation.**

HCFA's Fraud Investigation Database reports provide the following summary numbers for proactive cases that resulted in referrals to the OIG:

	CY 1998	**CY 1999 (through 9/30/99)**
Total Proactive Cases	246	374
Proactive Cases as Percent of Total Referrals	30%	45%

The CY 1999 figure includes 40 additional cases since the last report.
[Enclosure I – entitled 'Fraud Unit Referrals to Law Enforcement" contain detailed reports of this information by contractor for the time period September 27-30, 1999. CY 1999 data contained in October 27, I999 report was actually through 9/26/99 extraction date, not 8/31/99;additional 40 cases in this report are only for the four-day period Sept. 2 7-30, I999.]

3. **Identify the number of potential fraud or abuse cases referred by each contractor to the Department of Health and Human Services' Office of Inspector General (OIG) or Department of Justice for further investigation or prosecution. If known, please also note how cases previously referred to either the OIG or the Department of Justice have been resolved.**

Medicare contractors referred a total of 822 cases to law enforcement in Calendar Year 1998, of which 246 were proactive cases and a total of 824 cases to law enforcement in the first 9 months of Calendar Year 1999, of which 374 were proactive cases. Disposition of cases referred to the OIG or the DOJ is not provided in this letter since that information is directly related to and dependant upon the investigations conducted by the OIG and DOJ.

CY 1999 figures include 68 additional cases since the last report. *[Enclosure- entitled "Fraud Unit Referrals to Law Enforcement" contain breakouts by contractor of these figures for the time period September 27-30, 1999. CY 1999 data contained in October 27, I999 report was actually through 9/26/99 extraction date, not 8/31/99; the additional 68 cases in this report are only for the four-day period Sept. 27-30, 1999.]*

4. Identify the number of program vulnerabilities identified by each contractor and if applicable, what steps have been taken to address such vulnerabilities.

For the first three-quarters of FY 1999 (Oct. 98-June 99), Medicare contractors identified 273 program vulnerabilities; during the 4th Quarter FY 1999, they identified 53 additional vulnerabilities for a total of *326* **in FY 1999.** *[Enclosure 2 – entitled "HCFA Program Vulnerabilities Identified by Contractor" identify the total numbers of vulnerabilities by each contractor for the 4th Quarter FY 1999 (July 1999-Sept. 1999). Enclosure 3 - entitled "HCFA Program Vulnerability Detail Sheet for the 4th Quarter of FY 1999 (July 1999-Sept. 1999)" identify the specific vulnerabilities identified by each contractor and actions taken.]*

As reflected in the OIG report, contractors define and report program vulnerabilities in different ways. HCFA has developed and provided more guidance for contractors on what should be reported as program vulnerabilities and how Regional Office staff should use and respond to that information. For example, some contractors report specific problems with specific providers; some include complaints about responsiveness of the OIG, General Counsel, or Regional Offices; some focus on systems or policies which invite abuse. HCFA is pursuing improvements in the reporting of program vulnerabilities to focus on this latter category.

5. Describe the dollar amounts either identified or recovered as a result of the program integrity efforts of each Medicare contractor.

In the third quarter of FY 1999 (April 1999-June 1999), Medicare intermediaries and Regional Home Health Intermediaries (RHHIs) reported a total of $1,326.3 million in Part A Medicare Integrity Program (MIP) savings, which included $185.1 million in medical review (MR) savings, $78 1.6 million in Medicare Secondary Payer (MSP) savings and $359.6 million in Audit savings.

In the third quarter of FY 1999 (April 1999-June 1999), Medicare carriers and DMERCs reported a total of $1,135.1 million in Part B MIP savings, which include $848.7 million in MR savings, $210.7 million in MSP savings, and $75.7 million in Correct Coding Initiative (CCI) and Contractor Off-the-Shelf Software (COTS) savings (a.k.a. HBOC edits).

In the fourth quarter of FY 1999 (July 1999-Sept 1999), Fraud Unit overpayments totaled $54.57 million.

Note: Third quarter FY 1999 Audit savings are through 5/99 because of reporting requirements for this system. MSP savings vary from the semiannual report to Congress because of updates made by contractors. Because of systems problems, MR savings for Texas include some prior period savings amounts. *[Enclosure 4 - entitled "HCFA Medicare Integrity Program Savings – Part A and Part B" for the 4th Quarter FY 1999 (July 1999-Sept. 1999) contain the MIP savings information {reported in millions) by contractor for that timeframe, excluding Fraud and Abuse. Enclosure 5 - entitled "HCFA Fraud Unit Overpayments by Contractor" for the 4th Quarter FY I999 (July 1999-Sept. 1999) include breakouts of contractor Fraud Unit Overpayments for that time period.*

6. **Identify what steps each contractor has taken to ensure that Medicare is not paying claims that should be paid by other insurers, including the use of data matches with other federal information systems, processing claims through the HCFA Common Working File and pursuing retroactive recoveries of improper payments.**

Our October 27, 1999 report outlined in detail a number of Medicare as Secondary Payer (MSP) prepay and postpay activities which assist contractors in paying secondary claims (or denying claims, where appropriate) which included the following: (1) Initial Enrollment Questionnaire (IEQ); (2) First Claim Development; (3) Trauma Code Development; (4) MSP Litigation Settlement; (5) Internal Revenue Service (IRS)/Social Security Administration (S SA)/HCFA Data Match; (6) Voluntary Insurer/Employer Reporting for MSP; (7) Hospital Admissions Procedures Review; (8) Medicare Claims Submission Instructions; (9) Unsolicited contact from a beneficiary, beneficiary's representative, or other source often provides information about a beneficiary's MSP situation; and (10) Coordination of Benefits Contract. Following is an update on the last item:

Coordination of Benefits (COB) Contract: This contract, which was awarded to GHI on November 1, 1999, will consolidate many pre-payment MSP activities under one contract. The activities will be phased-in at the contractor, GHI, over the first few years of this 5-year contract. The IEQ and Data Match activities will become operational under the new COB Contract effective April 4, 2000. Later implementations will move First Claim Development, Trauma Code Development, investigations of MSP leads from the claims process, and unsolicited contacts to the COB Contractor. Awarding this contract to a single contractor is aimed at eliminating existing overlap and redundancies inherent in the current multiple contractor environment. It will also allow the new contractor to focus its efforts entirely on coordination of benefits, with MSP as a primary area of activity. As a result, it is anticipated that this contractor will substantially increase the Medicare secondary payer savings currently realized annually.

Information developed through the above-described MSP prepay and postpay activities is used: 1) to prevent improper payment; and 2) to develop and pursue recovery of mistaken payments (for example, payments where a beneficiary's group health plan coverage should have paid primary) as well as conditional payments which are now recoverable (for example, conditional payments which are recoverable due to the beneficiary's receipt of a liability settlement).

In addition to the specific activities described above, Medicare contractors' educational and outreach activities also support MSP identification and recovery. Presentations to providers and suppliers include information on correct billing procedures for all types of situations, including MSP. Presentations to beneficiary groups or specialized audiences such as liability attorneys include MSP information, as appropriate, ranging from questions about Medicare coverage when the beneficiary is working and receiving group health plan coverage to a specialized discussion of Medicare's MSP liability and no-fault recovery rights. *[Enclosure 6 - A 3-page narrative document entitled 'Medicare as Secondary Payer (MSP) Savings "provides detailed descriptions of the sources and categories of MSP savings.*]

7. Identify what steps HCFA has taken to educate contractors and their fraud unit staffs about best practices to improve their fraud fighting efforts.

National Contractor Fraud Unit Training: In October, we reported on the joint 3-day HCFA/OIG/DOJ/FBI training sessions held between May and July 1999 for all Medicare contractor fraud units in four sites across the country to facilitate timely and appropriate case referrals to law enforcement. Similar to the Benefit Integrity conferences held during FY 1999, HCFA is currently planning two conferences to be held in the third quarter of FY 2000. HCFA has solicited agenda topics from the Medicare contractors, Department of Health & Human Services - Office of Inspector General, the Department of Justice and the Federal Bureau of Investigation. It is expected that the agenda will be finalized by the end of January 2000. The conferences will be similar in structure to the FY 1999 conferences. However, the FY 2000 topic list will be modified to give greater attention to achieve increased audience participation and subject matter depth through more detailed discussions and "hands-on" training sessions.

Medicare Fraud Information Specialists (MFISs): Medicare Fraud Information Specialists located at select contractors have overall coordination responsibility for ensuring that fraud-related information is shared with appropriate parties across contractor jurisdictions. In addition to sharing information with each other and Medicare contractors on newly emerging scams and disseminating positive practices and innovative or new investigative and analytical techniques, MFISs are responsible for disseminating information and networking with HCFA's partners. To maximize the efficiency of the position, HCFA has convened a Workgroup of MFISs, HCFA Central Office (CO) and Regional Office (RO) staff with the following goals:

- Clarify the MFIS role, with an eye toward improved functions;
- Adjust and distribute workload more equitably, in light of the consolidation of some contractor markets; and
- Achieve Medicare Program Integrity goals.

The Workgroup expects to achieve the first two goals by May 2000.

Fraud Alerts, Significant Investigation Reports and Vulnerability Reports: HCFA issues National Medicare Fraud Alerts to Regional Offices; Medicare Contractor Fraud Units, Peer Review Organizations, Medicaid Fraud Control Units, the Office of the Inspector General, the Department of Justice, the Federal Bureau of Investigation, and U.S. Attorney Offices. Fraud Alerts notify our contracting community and law enforcement partners of newly identified scams, explain how the fraud is perpetrated and recommend steps to detect this type of activity in their jurisdictions. MFISs also issue Fraud Alerts to apprise HCFA, Medicare contractors and law enforcement of newly emerging scams. *[Enclosure 7 – Medicare Fraud Alerts is a listing of the 2 National Medicare Fraud Alerts since our October 27 report.]*

MFIS Teleconferences: Monthly MFIS conference calls are conducted as a tool for the MFISs to update each other and report on current activities (fraud cases, outreach events, meetings, fraud alerts, etc.). CO staff attend these calls and are available for questions on the Fraud Investigation Database (FID), Incentive Reward Program (IRP), fraud alerts, etc.

Contractor Fraud Unit Teleconferences: Monthly conference calls have been initiated by HCFA with Regional Office Benefit Integrity and Medicare contractor Fraud Unit staff to increase HCFA's direct contact with contractors. These calls facilitate three-way information sharing and educate contractors and their fraud unit staffs about best practices to improve their fraud fighting efforts.

MSP Liability Teleconferences: The MSP liability staff hold bi-weekly teleconferences with the appropriate Department of Justice and HHS Office of General Counsel staff and HCFA's designated lead contractors who handle large product liability recoveries. HCFA believes the use of lead contractors in large recoveries is more efficient and results in uniformity in recovery action.

8. **Identify what steps are being taken to ensure that the evaluation of contractors by HCFA Regional Offices is consistent, including the adoption and use of clearly defined, outcome focused performance standards, oversight of Regional Office reviews, and efforts to disseminate information regarding best practices among all HCFA Regional Offices.**

Contractor Oversight: In early FY 1999, prior to the GAO report, HCFA began its own initiative to strengthen the management and conduct of its contractor oversight activities. GAO's report recommendations reinforced many of the actions HCFA had already begun and confirmed the need for additional actions that HCFA had planned for the remainder of FY 1999 and for the FY 2000 evaluation cycle. Among the most important steps HCFA has taken to strengthen our contractor oversight is to restructure the contractor management function within HCFA. In November 1998, responsibility for contractor management within the Agency was consolidated in the newly established position of Deputy Director for Medicare Contractor Management within the Center for Beneficiary Services. This position is also responsible for evaluating the effectiveness of Regional Office oversight of contractors.

As described in our response to the referenced GAO report, HCFA has developed a multi-faceted plan for strengthening contractor oversight, including the development of clear and measurable contractor performance standards. In FY 1999, work was begun to develop consistent evaluation protocols, standardize reporting requirements, and improve the consistency of reviews by developing national teams. We also began the process of analyzing how other federal and state agencies and several private sector companies manage and evaluate performance of contractors from which they obtain goods and services. This continuing analysis will provide valuable benchmarking information and identify strategies for the CPE process. We initiated a Continuous Improvement Program for CPE that is evaluating the current process, identifying best practices, and beginning development of outcome-oriented, measurable performance standards. We will continue to increase the consistency of the CPE process and strengthen review of internal management controls. Actions that have been undertaken, as well as those that are planned for the current FY, are summarized below:

Continuously Improving CPE: In September 1999, HCFA retained an outside consultant, PriceWaterhouseCoopers, to assist in developing a Continuous Improvement Program for CPE systems and processes. Included in the tasks is an evaluation of HCFA-conducted analysis, documentation of the performance oversight cycle, recommendations for process improvements, and assistance with developing new and innovative tools including well-defined and measurable contractor performance standards, review protocols, and data validation methods. The contract will run through December 2000.

Risk Assessment: In FY 1999, our overall approach for selecting contractors for more intensive review was based on a national risk assessment which considered such factors as claims volume, administrative costs, benefit payments, integrity issues, and past performance. For FY 2000, we developed a structured risk assessment protocol to be used at both the national and regional level to set priorities and commit resources. During the first quarter of FY 2000, the protocol was tested by the Regional Offices and we intend to use this for identifying CPE reviews in FY 2000. PriceWaterhouse-Coopers will work with us to further refine the protocol for use in FY 200 1.

Another important risk assessment tool is the Pulse System. The Pulse System was designed as an initial post Y2K monitoring and early warning system, but it could have long term utility as a contractor workload and risk management tool. Specifically, the system identifies variances and monitors system performance as close to real-time as possible. Workload statistics from each Medicare contractor is collected and sent to HCFA on a daily basis. The system tabulates the data, compares it to calculated norms, and groups it to quickly identify potential problems as well as whether potential problems are isolated or common to all contractors.

Strengthening CPE Consistency: To promote greater consistency in FY 1999, we developed and used standardized review protocols to evaluate contractor performance in a number of key business functions: Medical Review, Fraud and Abuse, Medicare Secondary Payer, Provider Audit, Accounts Receivable, the Home Health Interim Payment System, and implementation of HCFA instructions. The National review teams utilized these protocols. In FY 2000, we are developing more standardized review protocols, as well as instructions on timeframes for notifying contractors of reviews and additional guidance on review samples and documentation.

In FY 1999, HCFA established a number of national review teams composed of Central Office and Regional Office staff. The FY 1999 national teams reviewed the Durable Medical Equipment Regional Carriers, Regional Home Health Intermediaries, Mutual of Omaha (an intermediary that deals with providers in 48 States), and other contractors with significant workload. These national teams utilized the standardized review protocols; all other HCFA reviewers were instructed to use these protocols for reviews scheduled after their release. CPE training, which included the policies and procedures for reviews as well as the standardized protocols, was conducted for many of the members of the national teams. Some review activity, such as the quality of intermediary audits of provider cost reports, was evaluated using a standard review protocol through contracts with accounting firms. In FY 2000, we will expand the use of national review teams and the number of standardized protocols.

In FY 1999, HCFA introduced greater consistency to the CPE process by requiring use of standard definitions of adverse CPE findings ("program deficiency" and "program vulnerability") and issuing clear instructions on when to require a Performance Improvement Plan. Regional Office staff were trained in the use of the new reports and report definitions. Reviewers are now required to adhere to stricter timeliness requirements for completing performance evaluation reports which are issued to contractors by Associate Regional Administrators. Further, Central Office staff reviewed a sample of CPE Reports on individual business functions for consistency with report preparation guidelines and provided feedback to the Regional Offices (RO). In FY 2000, training and feedback to HCFA reviewers will continue.

In FY 1999, we also implemented standard CPE management tracking reports which include summary reports of current and historical CPE findings for each contractor. In FY 2000, we will build a database to facilitate better tracking and analysis of contractor performance information.

Evaluating CPE Implementation: As indicated in the GAO report, evaluation of the RO CPE process is a critical component toward development of uniform contractor performance standards. In FY 1999, we began training of RO staff to ensure consistent application of rules and policies. Selected reports have been reviewed and feedback was given to each Regional Office. This review will continue in FY 2000. In FY 2000, HCFA will work with PriceWaterhouseCoopers to design a formal evaluation process for RO performance in implementing contractor oversight policies and procedures. This plan will be implemented in FY 2001.

Sharing Lessons Learned/Best Practices: Central Office staff is continuously reviewing Regional Office staff prepared reports and providing ongoing feedback. We will hold a joint Central/Regional Office conference in mid February 2000 to provide national and regional consortia review team members the opportunity to share experiences and best practice information face-to-face and to build improvements into our FY 2000 and FY 2001 CPE reviews. This type of conference will be incorporated into the annual CPE process.

Environmental Scanning: In FY 1999, HCFA's Office of Strategic Planning conducted an analysis of how other government agencies and private sector companies manage the contractors from whom they contract for goods and services. This project identified strategies that might assist HCFA in its oversight of the Medicare contractors; compared HCFA's contractor oversight efforts to those of other organizations in terms of strength, depth, and innovation; and, promoted creative thinking about future contractor oversight activities. Major findings of this analysis included:

- No single entity studied was comparable to fee-for-service Medicare in terms of claims volume and geographic dispersion of enrollees and contractors.
- A performance evaluation program is most effective when accompanied by a competitive contracting process, strong operational and financial audit, and a contractor payment methodology that neutralized incentives for mediocre performance or fraud.

In FY 2000, this analysis will be the basis for the further benchmarking and development of program design recommendations for a reengineered CPE system by PriceWaterhouseCoopers.

In addition, HCFA is participating in the Council for Excellence in Government's Fellows Program in which a group of HCFA managers will benchmark private sector organization management of third party contractors.

Comprehensive Error Rate Testing Program (CERT): During the past quarter, we have been presenting our vision of the CERT program to staff and management across the agency. The CERT methodology is designed to meet HCFA's need to measure precise, timely subnational estimates of payment errors in order to manage the Medicare program more effectively. CERT is based upon a modified sampling protocol originally developed by the Lewin Group. An optimal subnational estimate should include: contractor, provider type, and benefit service categories; be adaptable to meet

program management demands and changing budget situations; and provide a robust source of information for identification of potential fraud, waste, and abuse. The CERT methodology includes all of these components.

Conference Calls: In addition to the conference calls cited previously, HCFA's Program Integrity staff convene or attend a variety of conference calls to oversee Regional Office and contractor activities, disseminate best practice information, and increase consistency in implementation of operational guidelines.

1. Program Integrity Group Regional Office Conference Call: The Program Integrity Group holds a conference call with PI staff from the 10 Regional Offices on the first Tuesday of every month to share information/concerns and answer questions. Agenda items are solicited from all RO and CO PI staff. Three agenda items appear every month: (1) RO Fraud Review - Opportunity for ROs to discuss fraud schemes that are occurring in their region; (2) Program Memoranda Review - CO discusses program memoranda that have been or will be issued and invites the regional offices to share their comments and concerns; and (3) MR Regional Office Questions (ROQs) - Once a month, CO's Contractor Management Branch compiles and answers all RO MR questions received during the previous month in the ROQ. This document is discussed during the PI RO Conference call.

2. Contractor MR Managers' Conference Calls: HCFA hosts separate monthly conference calls with Part A and Part B MR Managers to directly communicate with contractor staff, obtain their input and feedback, discuss draft program guidelines, memoranda, Budget Performance Requirements, etc., and give consistent program guidance. RO PI staff also attend the calls. Separate DMERC and RHHI calls deal with MR issues among others.

3. MSP RO Conference Calls: HCFA convenes monthly calls with all MSP Regional Office staff to discuss issues, disseminate best practices and information in a timely manner and address specific Regional Office concerns.

We appreciate this opportunity to report to you on our program integrity activities. If you have any questions regarding this report, please do not hesitate to contact me on (410) 786-5704.

Sincerely,

Penny R. Thompson

Penny Thompson
Director
Program Integrity Group

Enclosures:
1. Fraud Unit Referrals to Law Enforcement
2. HCFA Program Vulnerabilities Identified by Contractor
3. HCFA Program Vulnerability Detail Sheet for 4th Quarter FY 1999
4. HCFA MIP Savings Part A & B – April 1999- June 1999
5. HCFA Fraud Unit Overpayments by Contractor for 4th Quarter FY 1999 – July 1999 – September 1999
6. Medicare as Secondary Payer (MSP) Savings - Narrative Information on Source and Categories of MSP Savings.
7. Medicare Fraud Alerts

cc: The Honorable John D. Dingell
Ranking Member, Committee on Commerce

The Honorable Ron Klink