

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS'S PROCESSING OF
COMPLAINTS RECEIVED
THROUGH THE 1-800-HHS-TIPS
HOTLINE**



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E X E C U T I V E S U M M A R Y

OBJECTIVE

To assess the Centers for Medicare & Medicaid Services' (CMS) processing of complaints received through the 1-800-HHS-TIPS hotline.

BACKGROUND

Many Offices of Inspector General (OIG) operate hotlines to respond to citizen and employee allegations of fraud, waste, or abuse in Federal programs. The Department of Health & Human Services (HHS) OIG maintains such a hotline (1-800-HHS-TIPS), for individuals to provide information that may assist in combating fraud, waste, or abuse in HHS programs (e.g., Medicare, Medicaid, child support enforcement, and Head Start). Individuals may call the hotline or send their written concerns by email, postal mail, or fax.

We obtained a copy of the hotline complaint data in CMS's information system as of March 2009. We identified 1,427 complaints that OIG forwarded to CMS in the first 6 months of 2008. From these, we selected a simple random sample of 120 complaints. We telephoned staff at each contractor assigned to the sampled complaints to inquire about what initial research the contractor performed to validate each complaint; how and when the contractor contacted the complainant; and what outcomes (e.g., recouping an overpayment from the provider) resulted from the contractor's actions on the complaint. We also conducted structured telephone interviews with contractor staff, CMS central office staff, and CMS regional office staff about the complaint process. Finally, to check the status of complaints 1 year after we initially received the hotline complaint data, in March 2010 we obtained a copy of the hotline complaint data in CMS's information system.

FINDINGS

At least 1 year after receiving complaints through the 1-800-HHS-TIPS hotline, CMS had resolved the majority of them, but 12 percent remained unresolved. CMS has no requirements regarding the length of time within which contractors should resolve complaints. Our period of review allowed at least 1 year to elapse after CMS received the complaints from OIG. As of March 2010, interviews with contractors and a review of data in CMS's information system confirmed that CMS resolved or closed administratively 88 percent of complaints received during the first 6 months of 2008. (Complaints are

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closed administratively if they are below the dollar-amount threshold required for research or if the information in the complaint is insufficient to conduct further work.) Overall, 32 percent of complaints were confirmed as services billed in error. Eleven percent of complaints involved allegations of fraud. Contractors closed 11 percent of complaints administratively. For another 32 percent, contractors researched complaints and found no problems. Two percent of complaints were referred to another agency. CMS had not resolved 12 percent of the complaints it received during our period of review.

Long timeframes and inefficient processes delay starting work on complaints. For 58 percent of complaints, contractors reported starting work within 30 days of CMS's receipt of the complaints from OIG, but for 29 percent of complaints, contractors took more than 4 months to start work. Included in the latter group are complaints that contractors were unaware had been assigned to them (22 percent of all complaints). Only following our inquiry did the contractors begin work on these complaints. CMS and contractor staff described processes that contribute to delays in transmitting complaints from the CMS central office to contractor staff. Such delays add to the time that it takes to resolve complaints.

Lack of guidance and an inadequate information system hinder complaint processing. Some CMS and contractor staff reported the need for written guidance defining their roles and responsibilities for processing hotline complaints. Although CMS provides some guidance to contractors, some CMS and contractor staff stated that guidance is lacking for processing complaints from receipt through resolution. No written procedures for processing complaints exist at the level of the CMS central office; however, staff from two CMS regional offices reported developing standard operating procedures for handling complaints. Most contractors have developed internal policies and procedures for handling complaints; however, some contractors desired guidance from CMS. In addition, the status of complaints cannot be tracked in CMS's information system.

RECOMMENDATIONS

The 1-800-HHS-TIPS hotline is widely publicized as an avenue that individuals can use to provide information that may assist in combating fraud, waste, or abuse in Federal health care programs. While the extent of health care fraud is unknown, it is estimated to be in the billions of dollars each year. HHS emphasizes that Medicare beneficiaries are the front line of defense in detecting Medicare fraud because they have firsthand knowledge of the health care services they have received. When researched and resolved, hotline complaints can lead to recovering overpayments and identifying fraud. Therefore, it is important for CMS to have a clear and consistent approach to process hotline complaints.

We recommend that CMS:

Issue written guidance for processing hotline complaints. CMS should issue guidance defining the roles and responsibilities of CMS and contractor staff and timeframes for assigning, researching, and resolving complaints.

Upgrade its information system for processing hotline complaints. CMS should ensure that its information system tracks user activity on each complaint and alerts CMS when a complaint has not been assigned to a contractor.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the draft report, CMS concurred with our recommendations. In response to our first recommendation, CMS stated that it will create written guidance that defines the specific roles and responsibilities for CMS and its contractor staff to achieve greater clarity in administration of its database (i.e., its information system). Where they are not already established, CMS will establish timeframes for assigning, researching, and resolving complaints. CMS stated that it is revising its national contractor list to include contact names and contract numbers associated with the contractors. In response to our second recommendation, CMS stated that it is upgrading and updating its database with the following features: auditing mechanisms to track user activity, contractor assignments, and status of complaints; and the capacity to alert CMS when complaints have not been assigned. CMS

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stated that it will work with OIG to establish an electronic method to deliver hardcopy evidence received from complainants concurrently with the electronic complaint.



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OBJECTIVE

To assess the Centers for Medicare & Medicaid Services' (CMS) processing of complaints received through the 1-800-HHS-TIPS hotline.

BACKGROUND

Many Offices of Inspectors General (OIG) operate hotlines to respond to citizen and employee allegations of fraud, waste, or abuse in Federal programs. The Department of Health & Human Services (HHS) OIG maintains such a hotline (1-800-HHS-TIPS), which individuals can use to provide information that may assist in combating fraud, waste, or abuse in HHS programs (e.g., Medicare, Medicaid, child support enforcement, and Head Start). Individuals may call the hotline or send their written concerns by email, postal mail, or fax.

The availability of the hotline is widely publicized on the Internet and in various publications, such as the CMS *Medicare & You* handbook distributed annually to Medicare beneficiaries. These media strongly encourage individuals to report suspicious activity, emphasizing that they can help stop fraud in HHS programs. The CMS Web site states that it is in the best interest of beneficiaries and of all citizens to report suspected fraud, as fraud increases health care costs. In addition, HHS emphasizes that Medicare beneficiaries are the front line of defense in detecting Medicare fraud because they have firsthand knowledge of the health care services they have received. Given the hotline's prominence, it is vital that information reported to the hotline be thoroughly reviewed and appropriately addressed in a timely fashion.

Written Procedures and Guidance

Three groups process hotline complaints related to CMS programs: OIG hotline staff, CMS central and regional office staff, and contractor staff. OIG has developed two written guidance documents pertaining to the handling of hotline calls: *OIG Hotline Program Orientation* and *OIG Hotline Screening Protocols*. The CMS central office has not issued written procedures or guidance for processing hotline complaints.

In the absence of written procedures or guidance from CMS, the information in this report regarding CMS's complaint processing is based primarily on information that OIG obtained through verbal contacts made during this evaluation. For a flowchart of complaint processing as explained to and observed by OIG, see Appendix A.

OIG Hotline Complaint Processing

In 2008, the OIG hotline received approximately 124,000 telephone calls and 15,000 pieces of written correspondence. However, most contacts to the hotline do not result in complaints logged into the OIG hotline database. Using OIG's written procedures, customer service representatives (CSR) determine whether an issue rises to the level of a complaint and whether it falls within OIG's jurisdiction. For issues that fall outside OIG's jurisdiction or that do not rise to the level of a complaint, CSRs provide individuals contacting the hotline with, whenever possible, another avenue to seek assistance, such as calling their State health and human services agencies or 1-800-MEDICARE. For example, if callers inquire about terminology on a Medicare Summary Notice (MSN), CSRs refer them to 1-800-MEDICARE. If callers have complaints involving Medicaid eligibility, CSRs refer the callers to State Medicaid agencies. In contrast, if a caller alleges that a Medicare beneficiary was billed for services not received, the CSR logs a complaint.

When CSRs determine that a written or telephone contact rises to the level of a complaint, they enter information—including beneficiary contact information, provider contact information, and a summary of the complaint—into the OIG hotline database. The database automatically assigns a number to identify the complaint. When taking telephone complaints, CSRs do not conduct detailed inquiries with callers or call complainants back for followup. CSRs also do not update complainants on the disposition of individual complaints.

Forwarding complaints for resolution. In 2008, hotline calls and correspondence resulted in approximately 6,200 complaints. OIG hotline staff forward complaints to either an OIG field office or the appropriate HHS staff division or operating division (e.g., CMS) or other Federal agency for resolution. OIG forwarded approximately 2,400 complaints to field offices for followup, forwarded more than 3,000 complaints to CMS, and distributed the balance of the complaints among other HHS operating divisions and other Federal agencies.

An OIG analyst reviews the CSR's data entry for quality control and prints a cover sheet that includes the complaint number, beneficiary and provider contact information, and a summary of the complaint. If any hardcopy documents (e.g., letters or MSNs) accompany the complaint, the analyst attaches them to the cover sheet. OIG staff package the cover sheets and documents and mail them in batches to

CMS. OIG also sends an electronic file containing complaint information to an information technology (IT) staff member at the CMS central office.

CMS Complaint Processing

Staff in CMS's central and regional offices, as well as staff at Medicare claims processing contractors (hereinafter referred to as claims processing contractors), process complaints referred to CMS by OIG. CMS staff and claims processing contractors use an information system (a Microsoft Access database) to assign, research, and resolve OIG-referred complaints. The database includes each complaint's unique identifier, date of intake by OIG, date of entry into CMS's information system, date of the complaint's assignment to a CMS regional office and to a claims processing contractor, closure date, and resolution code (if applicable).

Assigning complaints. An IT staff member at the CMS central office receives the electronic file from the OIG hotline and uploads it to the CMS information system. Using the provider address information in the complaint, the information system electronically assigns the complaint to the appropriate CMS regional office.¹

When a batch of new complaints is pending in the database, an IT staff member concurrently sends an electronic notice to alert CMS regional office staff and claims processing contractors to assign complaints. After receiving the notice, claims processing contractors review the complaints. Typically, a claims processing contractor assigns to itself any complaints involving claims that it originally paid, a process known as "self-assigning." Any complaints not self-assigned in this manner are assigned electronically among the contractors by the CMS regional office staff.

Staff in the CMS central office mail the hardcopy complaint packages to the appropriate regional offices. Regional office staff then mail the packages to the appropriate claims processing contractors.

Researching and resolving complaints. Claims processing contractors conduct initial research on each complaint to determine such things as the amount paid for the claim and patterns of complaints related to an

¹ If the complaint is related to durable medical equipment (DME) or the provider address is not available, the complaint is assigned to the CMS regional office that corresponds geographically to the beneficiary address.

individual provider. CMS requires claims processing contractors to research complaints for services with a claim paid amount of \$100 or greater. Complaints for services of less than \$100 must be retained and tracked for 1 year. If a claims processing contractor receives three complaints on the same provider within 1 year, the contractor is required to conduct an in-depth review of all related complaints.²

CMS directs claims processing contractors to, within certain timeframes, (1) review complaint documentation and (2) determine whether fraud and/or abuse is suspected.³ If claims processing contractors suspect fraud and/or abuse, they must forward the complaint to the Program Safeguard Contractor or Zone Program Integrity Contractor (hereinafter referred to as program integrity contractors) within 45 business days of receipt of the complaint or within 30 business days of receiving medical records, whichever is later.⁴

To resolve complaints, claims processing contractors use a variety of research techniques, such as calling the beneficiary or provider and reviewing the claims history.⁵ Although claims processing contractors may begin working on complaints as soon as they are electronically assigned, any hardcopy documents associated with a complaint may not be available for several weeks because of processing and mailing time. CMS does not specify a timeframe within which contractors must resolve complaints.

Updating complaint status. When a complaint is resolved, claims processing contractors or program integrity contractors update the status of the complaint to “closed” in the CMS database. After this update, no further action is taken on a complaint. Some claims processing and program integrity contractors notify the complainant of the resolution by letter; however, this is not a CMS requirement. Periodically, a CMS IT staff member provides OIG with an electronic file of the complaint information in CMS’s information system. An OIG

² *CMS Program Integrity Manual*, ch. 4, § 6.2.

³ *CMS Program Integrity Manual*, ch. 4, § 6.2.

⁴ A provider has 45 days to submit medical records to the contractor.

⁵ We use the term “resolve” to indicate that Medicare contractors have completed the actions that they are able to take on complaints. For some complaints, these actions may be limited, especially if the contractors are unable to contact complainants.

staff member uploads this information to the OIG hotline database, thereby updating the status of complaints in OIG's records.

METHODOLOGY

Scope

This evaluation includes a sample of complaints received through 1-800-HHS-TIPS during the first 6 months of 2008 that OIG referred to CMS. This evaluation excludes complaints that OIG forwarded to its field offices, other HHS operating divisions, and other Federal agencies, as well as complaints that CMS received from sources other than 1-800-HHS-TIPS. We did not evaluate OIG hotline processes, including its intake process, nor did we evaluate the accuracy of the process of forwarding the complaints.

Sample and Data Sources

We obtained a copy of the complaint data in CMS's information system as of March 2009. We identified 1,427 complaints that OIG forwarded to CMS from January 1 to June 30, 2008. From these, we selected a simple random sample of 120 complaints. One year later, in March 2010, we obtained a copy of CMS's information system to check the status of complaints at the completion of our data collection. Our period of review allowed at least 1 year to elapse after CMS received the complaints.

Data Collection

Contractor staff. We telephoned staff at each claims processing and program integrity contractor (hereinafter referred to as contractor) assigned to the sampled complaint(s) to inquire about the initial research that the contractor performed on the complaint. We asked contractors how and when they contacted the complainant and what outcomes (e.g., recouping an overpayment from the provider) resulted from the contractors' actions on complaints. At the same time that we contacted contractors about sampled complaints, we conducted structured telephone interviews with them about the complaint process. We asked about any challenges they had encountered, any circumstances that had impeded timely resolution of complaints, and any suggested solutions. We interviewed staff from 24 contractors (14 claims processing contractors and 10 program integrity contractors).

CMS central and regional office staff. Upon completing our interviews with contractors, we conducted structured interviews with CMS central office staff and staff involved in complaint processing from each of the 10 CMS

regional offices.⁶ We asked CMS staff whether they had encountered any challenges when processing complaints, whether any processing changes were anticipated or underway, and how feasible the solutions that contractors suggested were.

Analysis

We analyzed contractors' responses to determine the actions they reported taking to resolve the sampled complaints. To ensure that our analysis included the most up-to-date information, we used the March 2010 version of CMS's information system to determine the reported status of sampled complaints.

Using data from contractor interviews and data in CMS's information system, we projected the amount of time that elapsed between CMS's receipt of complaints and contractors' receipt of complaints.

Limitations

Using data from CMS's information system, we contacted the contractor assigned to the sampled complaint. In many instances, the contractor stated that the complaint had been transferred to another contractor, but the contractor to which it had been transferred reported that it had no record of the complaint. For this reason, we could not determine which contractor researched and/or resolved 16 of the complaints (13 percent). Therefore, the information about these 16 complaints is limited to data in CMS's information system. We note that the timeframe of our fieldwork intersected with the transition from legacy claims processing contractors to Medicare Administrative Contractors (MAC), which may have made it more complex for OIG and CMS to determine which contractor was responsible for a complaint.⁷

Standards

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

⁶ One CMS regional staff member has responsibility for complaint processing in two regions.

⁷ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires that CMS replace fiscal intermediary and carrier contracts (legacy claims processing contractors) with competitively procured contracts that conform to the Federal Acquisition Regulation. P.L. 108-173 § 911, Social Security Act, § 1874A, 42 U.S.C. 1395kk-1. CMS was given 6 years (between 2005 and 2011) to complete the transfer of claims processing activities to MACs.

F I N D I N G S

At least 1 year after receiving complaints through the 1-800-HHS-TIPS hotline, CMS had resolved the majority of them, but 12 percent remained unresolved

As of March 2010, interviews with contractors and a review of data in CMS's information system confirmed that CMS had resolved or closed administratively

88 percent of complaints. However, CMS had not resolved 12 percent of complaints received during the first 6 months of 2008.⁸ CMS has no requirements regarding the length of time within which contractors should resolve complaints. Our period of review allowed at least 1 year to elapse after CMS received the complaints.

Of the 15 unresolved complaints, 6 were allegations of fraudulent Medicare billing, 6 were complaints of services not rendered, 2 were allegations of unlicensed providers, and 1 was a complaint regarding unsafe conditions at a clinic. One complaint of services not rendered alleged that a hospice provider visited a beneficiary's home once, but the beneficiary decided not to "sign up with their program." The beneficiary received a MSN stating that Medicare paid the provider more than \$10,000.

CMS resolved 88 percent of complaints received during the first 6 months of 2008

Overall, 32 percent of complaints were confirmed as services billed in error, such as rental charges that continued after the supplier picked up a hospital bed from the beneficiary's home. Contractors collected \$35,487.60 in overpayments based on these sampled complaints. Eleven percent of complaints involved allegations of fraud, such as medical studies and tests billed using stolen Medicare identification numbers. Outcomes of these complaints included an arrest of a provider, termination of a provider from Medicare, seizure of a provider's bank account, and a large monetary settlement with a provider. Contractors closed 11 percent of complaints administratively (i.e., the complaint was below the \$100 threshold, or the information in the complaint was not sufficient to conduct further work). For another 32 percent, contractors researched complaints and found no problems. Two percent of complaints were referred to another agency. Table 1 describes the resolutions of sampled complaints as reported by contractors.

⁸ Appendix B presents the point estimates and confidence intervals for all statistics.

Table 1: Resolutions of Complaints as Reported by Contractors

Description of Resolution	Number of Sampled Complaints (n=120)	Percentage of Complaints
Allegations researched; no problems found	38	31.7%
Service(s) billed in error	38	31.7%
Allegations involved fraud	13	10.8%
Allegations involved services with claim paid amounts of less than \$100; complaints closed and retained for provider tracking	7	5.8%
Information in allegations insufficient; complaints closed with no action	6	5.0%
Complaints referred to another agency	3	2.5%
Subtotal, resolved complaints	105	87.5%
Unresolved	15	12.5%
Total	120	100.0%
Source: OIG analysis of contractor interviews and March 2010 version of CMS's information system, 2010.		

Complaint research and resolution. Contractors used a variety of methods to research and resolve complaints. For the sampled complaints, this included reviewing medical records or other documentation requested from the provider, reviewing data in the contractor's internal systems, and interviewing complainants or providers by telephone.

Some complainants submitted hardcopy documents (e.g., MSNs, photographs, letters) in support of their allegations. Staff from 17 of the 24 contractors reported problems with receiving such documents. Contractors reported seeing notes in the database saying that complainants had submitted hardcopy documents but not receiving the documents for 30 to 90 days after complaint assignment, if at all. Not receiving the documents can impede resolution of a complaint or cause the contractor to request the same documents from the complainant. Staff from 2 of the 24 contractors stated that they received hardcopy documents after a complaint had been closed and that they had to reopen the complaint to evaluate whether the documents changed the resolution. In addition to contractors, staff from all 10 CMS regional

offices reported challenges with handling hardcopy documents, including not receiving them in a timely manner and the potential for them to be lost.

Complainant contact. Contractors contacted complainants by telephone or postal mail for 45 complaints.⁹ The reasons for contacting complainants included acknowledging that a complaint was received (9 complaints), interviewing complainants to gain information (14 complaints), and notifying complainants of resolution (26 complaints).

Not all contractors notify complainants of the outcomes, and CMS does not require them to do so. For a complaint that results in the contractor's adjustment of the provider claim payment (e.g., a complaint resolved as "service(s) billed in error"), the beneficiary receives a revised MSN indicating the amount of the adjustment. Some contractors consider the revised MSN as a notice to the beneficiary (who may or may not be the complainant) of the complaint's resolution. In addition, upon receiving a revised MSN, some beneficiaries place another call to the hotline because they misinterpret the information on the revised MSN as meaning that the provider received an additional payment for services.

Long timeframes and inefficient processes delay starting work on complaints

For a complaint to be resolved, it must be assigned to and acknowledged by the contractor that paid the claim for the service

in question. Inefficient processes contribute to the delay in assigning complaints to contractors, thereby adding to the time it takes to resolve complaints.

For 58 percent of complaints, contractors reported starting work within 30 days of CMS's receipt of the complaints from OIG, but for 29 percent of complaints, contractors took more than 4 months to start work

The number of days between the date that a complaint was uploaded to CMS's information system and the date that the contractor reported starting work on it ranged from 0 (i.e., uploaded and work started on the same day) to 660 days, with an average of 163 days. On average,

⁹ Contractors contacted some complainants for more than one reason.

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more than 5 months elapsed between CMS's receiving complaints from OIG and contractors' starting work on them.

Table 2 provides an overview of the time it took for contractors to start work on complaints after they were uploaded to CMS's information system. Contractors took more than 120 days to start work on 29.1 percent of complaints. The bulk of the complaints in this category—22 percent of all complaints—are those that contractors were unaware had been assigned to them. Only following our inquiry did the contractors start work on these complaints. During our interview with one contractor, OIG staff assisted the contractor staff in identifying complaints assigned to them by walking them through certain fields in the database. The contractor had been looking only for complaints listed under one region, but the contractor was in fact assigned to complaints from multiple regions.

Table 2: Timeframes for Contractors To Start Work on Complaints

Timeframes for Contractors To Start Work on Complaints After Upload to CMS Information System	Number of Sampled Complaints (n=117)	Percentage of Complaints
Same day–30 days	68	58.1%
31–120 days	15	12.8%
Greater than 120 days	34	29.1%
Source: OIG analysis of contractor interviews and March 2010 version of CMS's information system, 2010.		

CMS's processes for transmitting complaints to contractors are ad hoc and inefficient

The processing, distribution, and assignment of complaints described by CMS and contractors contribute to delays in transmitting complaints from the CMS central office to contractors. Such delays add to the time it takes to resolve complaints.

- *Batch processing*—Complaints are not immediately available to contractors when OIG sends the complaints to CMS. An IT staff member at the CMS central office must first upload the batch of complaints to CMS's information system; this may add days or weeks to the date that the complaints are available to contractors to research and resolve.

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- *Incomplete distribution list*—After uploading the complaints, an IT staff member sends electronic notices to the CMS regional office staff and to the MACs for which the IT staff member has email addresses. However, a CMS IT staff member stated that CMS's electronic distribution list for sending notice of new complaints does not contain all contractors. Staff from only 5 of 14 claims processing contractors reported that they receive electronic notices of pending complaints. Staff from the remaining nine contractors reported that they check the information system daily or weekly to determine whether new complaints have been assigned to them.
- *Inconsistent timing of complaint assignment*—Staff from the 10 CMS regional offices electronically assign any remaining complaints that contractors did not self-assign. Staff from two CMS regional offices said that the timing of their assignment of complaints is determined by their workload. Staff at a third regional office said that they assign complaints within 10 days of the electronic notice. Staff from four CMS regional offices indicated that they are unsure how long they should wait (to give contractors a chance to self-assign complaints) between receiving the electronic notice of new complaints and assigning unassigned complaints.

Lack of guidance and an inadequate information system hinder complaint processing

Long timeframes and inefficient processes contribute to delays in contractors' starting work on complaints, whereas a lack of

guidance and an inadequate information system hinder complaint processing. Some CMS and contractor staff reported the need for written guidance defining their roles and responsibilities for processing hotline complaints. Although CMS provides some guidance to contractors, some CMS and contractor staff stated that guidance is lacking for processing complaints from receipt through resolution. In addition, the status of complaints cannot be tracked in CMS's information system. Because there is little written guidance to inform CMS and contractor staff on their roles and responsibilities for processing complaints and an inadequate information system, CMS and contractor staff use inconsistent processes to handle complaints.

CMS and contractor staff lack written guidance defining staff roles and responsibilities for processing complaints

CMS staff. Staff from 8 of 10 CMS regional offices reported that they have not received written guidance defining their responsibilities with respect to hotline complaints. These staff told us they believed that written guidance would improve their work and would ensure consistent processes across regions. Staff from one regional office remarked, “It’s hard to determine exactly what we’re supposed to do. It’s not all cut and dried.” Staff from the other two CMS regional offices told us that the guidance they were following had been developed by their regional offices as a standard operating procedure; it was not established or disseminated by the CMS central office.

Staff from only three CMS regional offices reported receiving training in handling complaints. These individuals reported that the training was conducted by their predecessors or other regional staff. Absent written guidance and training, many regional staff reported relying on their colleagues in other regions for direction and advice. As staff from one regional office stated, a typical interaction with a colleague in another region might be “to discuss how a particular complaint should be handled, since the procedures to resolve [complaints] are not set in stone.”

Regional staff mentioned specific content areas that should be covered in the written guidance, such as how to determine to which line of business (e.g., Medicare Parts A, B, C, or D, or Medicaid) a complaint refers and how to transfer complaints to other contractors when they are misassigned or require handling by a program integrity contractor. Although staff from all 10 CMS regional offices reported having a contact list for contractors, they reported that these lists were self-developed and not national in scope. Without written guidance, it is difficult for CMS regional staff to assign complaints to the correct contractor.

Contractor staff. Nearly all contractors identified the *Program Integrity Manual* and their internally developed policies and procedures as sources of written guidance. However, one-third of contractors reported that further guidance on contractor responsibilities could improve their operations. For example, staff from one contractor stated, “We are unsure about all of our responsibilities. We would like to know what CMS explicitly expects us to do.” Staff from another contractor remarked, “[We would like] procedures on how CMS would like to see

complaints handled, to ensure we are in compliance with what CMS wants.” Staff from two CMS regional offices echoed the need for clearer guidance to contractors.

Challenges with CMS’s information system hinder complaint processing

Staff from each of the 10 CMS regional offices and staff from 15 of the 24 contractors responded that they have encountered challenges working with CMS’s information system. Those most frequently mentioned were the inability to track the status of the complaint and the inability to determine which contractor is assigned to the complaint, as a complaint can be transferred from one contractor to another. This affects the ability of CMS and contractor staff to determine what work has been done on the complaint and the status of any transfers of the complaint to another contractor. As staff from one contractor summarized, “We need to be able to know which complaints are actually assigned to us and what the status is of each complaint.” Also, when a complaint involves more than one provider type (e.g., a physician and a DME provider), the information system is unable to indicate that more than one contractor is assigned.

We encountered similar challenges when attempting to identify which contractors had been assigned to the sampled complaints. When we selected the sample of complaints for review in April 2009, CMS’s information system identified no contractor for 24 percent of the sample. We used other information in the system to attempt to identify the assigned contractor, but for 13 percent of the sampled complaints we were unable to do so.

Contractors reported that they do not use the information system to track activities on complaints during their review of allegations; rather, they use their internal databases for this purpose. Staff from six contractors reported that the CMS information system has inadequate fields to store information.

Staff from four regional CMS offices reported maintaining a record of hotline complaints (e.g., an Excel spreadsheet) separate from CMS’s information system. These staff reported using such a record for a variety of purposes, such as tracking hotline complaint numbers, dates of contractor assignment, and dates that hardcopy documentation arrives in the regional office and is sent to the contractor. Staff from one CMS regional office stated that the information system needs to be changed so that for each complaint, it would track which contractor took

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action, when the action occurred, and why the action was taken, so that staff will not have to maintain separate records for these purposes.



R E C O M M E N D A T I O N S

CMS widely publicizes the 1-800-HHS-TIPS hotline as an avenue that individuals may use to provide information that may assist in combating fraud, waste, or abuse in Federal health care programs. Health care fraud is estimated to be in the billions of dollars each year. HHS emphasizes that Medicare beneficiaries are the front line of defense in detecting Medicare fraud because they have firsthand knowledge of the health care services they have received.

At least 1 year after receiving complaints through the 1-800-HHS-TIPS hotline, CMS had resolved the majority of them, but 12 percent remained unresolved. Long timeframes and inefficient processes delay starting work on complaints. Additionally, lack of guidance and an inadequate information system hinder complaint processing.

When researched and resolved, hotline complaints can lead to recovering overpayments and identifying fraud. Therefore, it is important for CMS to have a clear and consistent approach in place to process hotline complaints.

To address these findings, we recommend that CMS:

Issue written guidance for processing hotline complaints

CMS should issue guidance defining the roles and responsibilities of CMS and contractor staff and timeframes for assigning, researching, and resolving complaints. If applicable, CMS may need to amend appropriate contracts to reflect any new contractor requirements, responsibilities, and/or timeframes. As part of the guidance, CMS should create and maintain a national contact list of contractors, including staff names, contact information, and contract numbers associated with each contractor. Such a list would assist CMS and contractor staff in accurately assigning and transferring complaints to contractors.

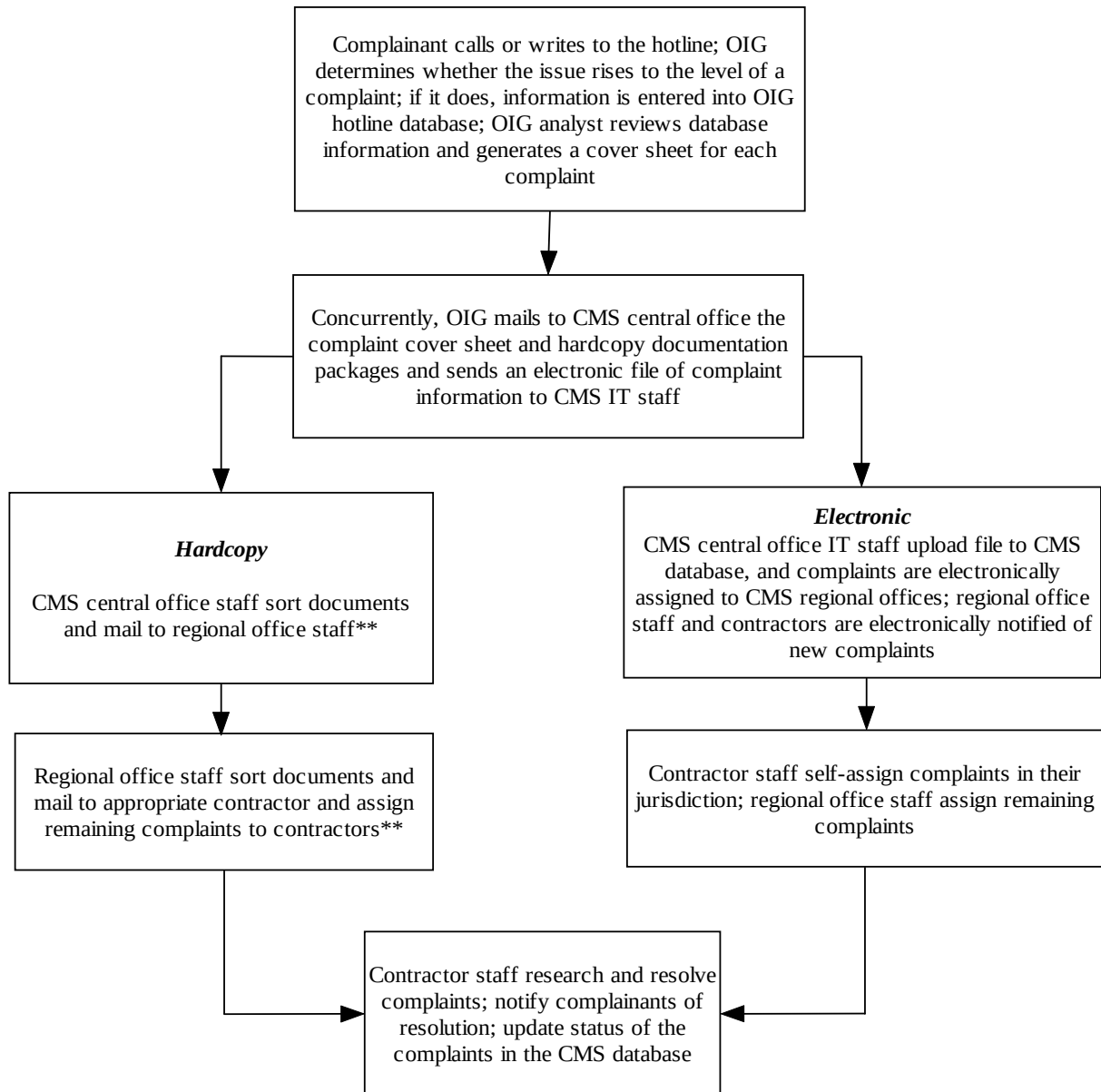
Upgrade its information system for processing hotline complaints

CMS should ensure that its information system tracks user activity on each complaint and that the system can handle complaints that have multiple provider types and contractors. It should alert CMS when complaints have not been assigned. CMS should establish an electronic method to deliver hardcopy documents submitted by complainants so they are received at the same time as the complaints.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the draft report, CMS concurred with our recommendations. In response to our first recommendation, CMS stated that it will create written guidance that defines the specific roles and responsibilities for CMS and its contractor staff to achieve greater clarity in administration of its database (i.e., its information system). Where they are not already established, CMS will establish timeframes for assigning, researching, and resolving complaints. CMS stated that it is revising its national contractor list to include contact names and contract numbers associated with the contractors. As appropriate, CMS will amend contracts to reflect any new contractor requirements, responsibilities, or timeframes. In response to our second recommendation, CMS stated that it is upgrading and updating the database with the following features: auditing mechanisms to track user activity, contractor assignments, and status of complaints; the ability to handle complaints that have multiple provider types and contractors; and the capacity to alert CMS when complaints have not been assigned. CMS stated that it will work with OIG to establish an electronic method to deliver hardcopy evidence received from complainants along with the electronic complaint. We did not make any changes to the report based on CMS's comments. The full text of CMS's comments on the draft report can be found in Appendix C.

Flowchart of Processing of Complaints Received Through the 1-800-HHS-TIPS Hotline and Referred to the Centers for Medicare & Medicaid Services*



*CMS.

**Sorting and mailing often occur after electronic notice.

Source: Office of Inspector General (OIG) interviews, 2009.

► A P P E N D I X ~ B

Table B-1: Point Estimates and Confidence Intervals

Statistic	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of complaints not resolved by the Centers for Medicare & Medicaid Services (CMS)	120	12.5%	7.8%–19.5%
Percentage of complaints resolved by CMS	120	87.5%	80.5%–92.2%
Percentage of complaints with allegations researched and no problems found	120	31.7%	24.2%–40.2%
Percentage of complaints confirmed as services billed in error	120	31.7%	24.2%–40.2%
Percentage of complaints confirmed as illegal activity	120	10.8%	6.5%–17.5%
Percentage of complaints with allegations involving services with claim paid amounts of less than \$100; complaints closed and retained for provider tracking	120	5.8%	2.9%–11.5%
Percentage of complaints with insufficient allegation information; complaints closed with no action	120	5.0%	2.3%–10.5%
Percentage of complaints referred to another agency	120	2.5%	0.8%–7.2%
Average number of days between the date that complaints were uploaded to CMS's information system and the date that contractors reported starting work on them	117	163.2 days	121.2 days–205.3 days
Percentage of complaints that contractors were unaware had been assigned to them	120	21.7%	15.4%–29.7%
Percentage of complaints on which contractors started work the same day to 30 days after CMS uploaded them to its information system	117	58.1%	49.3%–66.5%
Percentage of complaints on which contractors started work between 31 days and 120 days after CMS uploaded them to its information system	117	12.8%	8.0%–19.9%
Percentage of complaints on which contractors started work more than 120 days after CMS uploaded them to its information system	117	29.1%	21.8%–37.6%

Source: Office of Inspector General (OIG) analysis of simple random sample of 120 complaints forwarded from OIG to CMS, 2010.



A P P E N D I X ~ C

AGENCY COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: JAN 19 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. /SI/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "CMS' Processing of Complaints Received Through the 1-800-HHS-TIPS Hotline" (OEI-07-09-00020)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report entitled "CMS' Processing of Complaints Received through the 1-800-HHS-TIPS Hotline." The purpose of this report was to evaluate complaints received through the 1-800-HHS-TIPS Hotline, which individuals may use to provide information that may assist in combating fraud, waste, and abuse in the Department of Health and Human Services programs (i.e., Medicare, Medicaid, Head Start and child support enforcement).

The CMS takes complaints received from the 1-800-HHS-TIPS Hotline and from other sources seriously. These complaints play an important role in helping CMS and OIG in reducing and fighting fraud, waste, and abuse in the Medicare Program. Some complaints lead to new investigations and/or are incorporated into existing investigations. These complaints are also used to support revocation, deactivation, and/or suspension actions taken against providers and suppliers.

The report accurately reflects the current process by which CMS and its contractors handle these referrals and in identifying the areas where improvement is needed. CMS has already begun working to update, standardize, and improve the current internal handling and oversight monitoring procedures to address a number of the concerns expressed in the report. Additional system changes are in development that will allow more effective screening, tracking of user activity, contractor assignments, and complaint status. We are working with OIG on many of these changes.

We appreciate the OIG's efforts in working with CMS to assist in the complaints process. Our response to each of the OIG recommendations follows.

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OIG Recommendation

The OIG recommends that CMS issue written guidance on processing hotline complaints. This guidance should define the roles and responsibilities of both CMS and contractor staff and timeframes for assigning, researching, and resolving complaints.

CMS Response

The CMS concurs with this recommendation. CMS will create written guidance that defines the specific roles and responsibilities for both CMS and its contractor staff for greater clarity in administration of the database. CMS will also establish timeframes for assigning, researching, and resolving complaints (where not already established) and will also, in the near future, have the benefit of audit mechanisms of an updated information system to aid in ensuring accountability regarding these timeframes. As applicable, CMS will amend appropriate contracts to reflect any new contractor requirements, responsibilities, or timeframes. Although CMS already has a national contact list of contractors, CMS is in the process of revising the list to more accurately reflect those individuals who are actively engaged with the database. Additionally, information such as contract numbers associated with contractors are going to be included as part of updating the database. CMS agrees that such a list will aid both CMS and its contractors in accurately assigning and transferring complaints to contractors.

OIG Recommendation

The OIG recommends that CMS upgrade its information system for processing hotline complaints. This upgrade should have the ability to track user activity on each complaint and alert CMS of unassigned complaints.

CMS Response

The CMS concurs with this recommendation. Presently, CMS is upgrading and updating the database to include auditing mechanisms that will enable CMS to track user activity, contractor assignments, and status of complaints and to handle complaints that have multiple provider types and contractors. The upgraded database will have the capacity to alert CMS when complaints have not been assigned. CMS will work with OIG to establish an electronic method of delivering hardcopy evidence received from complainants to ensure that the evidence is received concurrently with the electronic complaint.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Deborah K. Walden, Deputy Regional Inspector General.

Tricia Fields served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include LCDR Mike Garner and Dennis Tharp; central office staff who contributed include Robert Gibbons, Scott Manley, Megan Ruhnke, and Arianne Spaccarelli.

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