United States Government Accountability Office

Report to Congressional Addressees

December 2017

MEDICARE AND MEDICAID

CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework
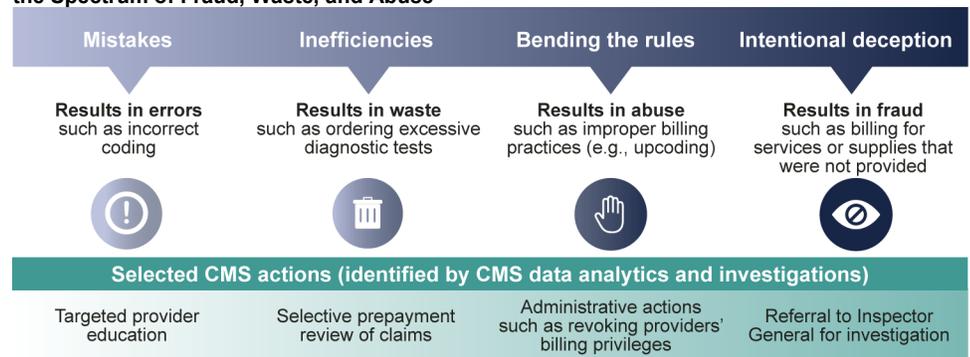
MEDICARE AND MEDICAID

CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework

Why GAO Did This Study

CMS, an agency within the Department of Health and Human Services (HHS), provides health coverage for over 145 million Americans through its four principal programs, with annual outlays of about $1.1 trillion. GAO has designated the two largest programs, Medicare and Medicaid, as high risk partly due to their vulnerability to fraud, waste, and abuse. In fiscal year 2016, improper payment estimates for these programs totaled about $95 billion.

GAO's Fraud Risk Framework and the subsequent enactment of the Fraud Reduction and Data Analytics Act of 2015 have called attention to the importance of federal agencies' antifraud efforts. This report examines (1) CMS's approach for managing fraud risks across its four principal programs, and (2) how CMS's efforts managing fraud risks in Medicare and Medicaid align with the Fraud Risk Framework.

GAO reviewed laws and regulations and HHS and CMS documents, such as program-integrity manuals. It also interviewed CMS officials and a sample of CMS stakeholders, including state officials and contractors. GAO selected states based on fraud risk and other factors, such as geographic diversity. GAO selected contractors based on a mix of companies and geographic areas served.

What GAO Recommends

GAO recommends that CMS (1) provide and require fraud-awareness training to its employees, (2) conduct fraud risk assessments, and (3) create an antifraud strategy for Medicare and Medicaid, including an approach for evaluation. HHS concurred with GAO's recommendations.

View GAO-18-88. For more information, contact Seto Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

What GAO Found

The approach that the Centers for Medicare & Medicaid Services (CMS) has taken for managing fraud risks across its four principal programs—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the health-insurance marketplaces—is incorporated into its broader program-integrity approach. According to CMS officials, this broader program-integrity approach can help the agency develop control activities to address multiple sources of improper payments, including fraud. As the figure below shows, CMS views fraud as part of a spectrum of actions that may result in improper payments.

Centers for Medicare & Medicaid Services (CMS) Description of How the Agency Addresses the Spectrum of Fraud, Waste, and Abuse

Mistakes	Inefficiencies	Bending the rules	Intentional deception
Results in errors such as incorrect coding	**Results in waste** such as ordering excessive diagnostic tests	**Results in abuse** such as improper billing practices (e.g., upcoding)	**Results in fraud** such as billing for services or supplies that were not provided

Selected CMS actions (identified by CMS data analytics and investigations)			
Targeted provider education	Selective prepayment review of claims	Administrative actions such as revoking providers' billing privileges	Referral to Inspector General for investigation

Source: GAO analysis of CMS information. | GAO-18-88

CMS's efforts managing fraud risks in Medicare and Medicaid partially align with GAO's 2015 *A Framework for Managing Fraud Risks in Federal Programs* (Fraud Risk Framework). This framework describes leading practices in four components: *commit*, *assess*, *design and implement*, and *evaluate and adapt*. CMS has shown commitment to combating fraud in part by establishing a dedicated entity—the Center for Program Integrity—to lead antifraud efforts. Furthermore, CMS is offering and requiring antifraud training for stakeholder groups such as providers, beneficiaries, and health-insurance plans. However, CMS does not require fraud-awareness training on a regular basis for employees, a practice that the framework identifies as a way agencies can help create a culture of integrity and compliance. Regarding the *assess* and *design and implement* components, CMS has taken steps to identify fraud risks, such as by designating specific provider types as high risk and developing associated control activities. However, it has not conducted a fraud risk assessment for Medicare or Medicaid, and has not designed and implemented a risk-based antifraud strategy. A fraud risk assessment allows managers to fully consider fraud risks to their programs, analyze their likelihood and impact, and prioritize risks. Managers can then design and implement a strategy with specific control activities to mitigate these fraud risks, as well as an appropriate evaluation approach consistent with the *evaluate and adapt* component. By developing a fraud risk assessment and using that assessment to create an antifraud strategy and evaluation approach, CMS could better ensure that it is addressing the full portfolio of risks and strategically targeting the most-significant fraud risks facing Medicare and Medicaid.

_____ **United States Government Accountability Office**

Contents

Abbreviations

CBO	Congressional Budget Office
CHIP	Children's Health Insurance Program
CM	Center for Medicare
CMCS	Center for Medicaid and CHIP Services
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
DOJ	Department of Justice
FFS	fee-for-service
FPS	Fraud Prevention System
Fraud Risk Framework	*A Framework for Managing Fraud Risks in Federal Programs*
HCFAC	Health Care Fraud and Abuse Control
HFPP	Healthcare Fraud Prevention Partnership
HHS	Department of Health and Human Services
MFCU	Medicaid Fraud Control Unit
OIG	Office of the Inspector General
OMB	Office of Management and Budget
PPACA	Patient Protection and Affordable Care Act of 2010
UPIC	Unified Program Integrity Contractor
ZPIC	Zone Program Integrity Contractor

December 5, 2017

Congressional Addressees

The Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—provides health coverage for over 145 million Americans, but its programs are susceptible to fraud.[1] Instances of fraud in CMS programs have been regularly and widely reported, involving multimillion-dollar scams and false claims. For example, in 2015 a Michigan oncologist was sentenced for submitting $34 million in fraudulent claims to Medicare and private insurance companies for administering medically unnecessary chemotherapy to 553 patients. Every year, the federal government investigates hundreds of fraud cases involving CMS programs and during fiscal year 2016 won or negotiated about $2.5 billion in health-care fraud judgments and settlements as a result of federal investigations and prosecutions.

According to the Congressional Budget Office (CBO), annual mandatory outlays for CMS's four principal programs—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the health-insurance marketplaces[2]—total about $1.1 trillion. Total outlays across these CMS programs are projected to nearly double in the next 10 years. Medicare and Medicaid are the largest CMS programs, covering approximately 129 million individuals in fiscal year 2016, with total outlays of about $1 trillion.

In addition to their size and related expenditures, the complexities of these programs—such as Medicare's four distinct program parts and the variation in states' design and implementation of Medicaid—pose challenges to CMS oversight and present opportunities to be exploited for fraud.[3] We have designated Medicare and Medicaid as high-risk programs due to their size, complexity, and vulnerability to fraud, waste,

---

[1]Fraud involves obtaining something of value through willful misrepresentation.

[2]In this report, we refer to the federally facilitated marketplace and state-based marketplaces as the health-insurance marketplaces.

[3]Within federal requirements, states have significant flexibility to design and implement their Medicaid programs, resulting in over 50 distinct state-based programs. Medicaid programs are jointly administered by CMS and the 50 states, the District of Columbia, and five territories (American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands). In this report, we use the term "states" to refer to the 50 states and the District of Columbia.

and abuse.[4] Although the extent of fraud in Medicare and Medicaid is unknown, given the large size of the programs even a small percentage of fraud poses significant risks to the integrity of these programs.

This report addresses CMS fraud risk management efforts in light of GAO's July 2015 *A Framework for Managing Fraud Risks in Federal Programs* (Fraud Risk Framework), which describes key components and leading practices for agencies to proactively and strategically manage fraud risks.[5] Our objectives were to determine: (1) CMS's approach for managing fraud risks across its four principal programs and (2) how CMS's efforts for managing fraud risks in Medicare and Medicaid align with GAO's Fraud Risk Framework. We performed our work under the authority of the Comptroller General to assist Congress with its oversight.

To address both objectives, we reviewed relevant laws, regulations, and HHS and CMS documents, such as strategic plans, reports to Congress, program-integrity manuals, guidance, and other documents issued from 2011 through 2017.[6] We also reviewed reports by GAO and the HHS Office of the Inspector General (OIG) on antifraud and program-integrity topics across Medicare and Medicaid.

Furthermore, for both objectives, we interviewed CMS officials from the Center for Program Integrity (CPI) as well as officials from other centers and offices within CMS. We interviewed a nongeneralizable sample of CMS stakeholders including states, contractors, private health-insurance plans, federal law-enforcement agencies, as well as industry experts.

For our sample of stakeholders, we selected four states—Florida, Maryland, Michigan, and Oregon—based on health-care fraud risk factors. We selected two states (Florida and Michigan) meeting our high-risk criteria: the presence of Medicare Fraud Strike Force Teams,[7]

---

[4]GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, D.C.: February 2017).

[5]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015).

[6]We selected this period to include CMS's 2011 strategic document describing the agency's new approach to address fraud.

[7]Medicare Fraud Strike Force Teams, a joint Department of Justice (DOJ) and HHS OIG program, consist of investigators and prosecutors who use data-analysis and traditional law-enforcement techniques to identify, investigate, and prosecute potentially fraudulent billing patterns in geographic areas with high rates of health-care fraud.

temporary moratoriums on certain newly enrolling providers and suppliers in specific geographic areas, and a high number of Medicaid fraud investigations. We also selected two states (Maryland and Oregon) that did not meet our high-risk criteria. These four states also represented a mix of Medicaid spending, enrollment in managed care, and geographic variation. For each state, we interviewed state officials from the Medicaid program-integrity unit, Medicaid Fraud Control Unit (MFCU), and state audit organization.[8]

In addition to the states, we interviewed national and regional CMS contractors. We interviewed all national contractors that we identified as most directly involved in CMS's antifraud and program-integrity efforts; there were six such contractors. We also interviewed six regional CMS contractors. We identified six types of regional CMS antifraud and program-integrity contractors, and interviewed one of each type.[9] We selected these contractors to achieve a mix of companies holding each type of regional contract (some companies hold more than one type of contract), and to ensure geographic diversity of the areas they serve. We also interviewed officials from one national and one regional private health-insurance plan. We chose these two plans because they are among larger plans that provide Medicare, Medicaid, and commercial services. We chose one large regional and one national health-insurance plan to obtain a diversity of perspectives.

In addressing our second objective, we evaluated CMS's efforts against the four components of the Fraud Risk Framework: (1) commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management; (2) plan regular fraud risk assessments and assess risks to determine a fraud risk profile; (3) design and implement strategy with specific control activities to mitigate assessed fraud risks and collaborate to help ensure effective implementation; and (4) evaluate outcomes using a risk-based approach and adapt activities to improve fraud risk management. In doing so, we reviewed agency documents and information obtained from interviews

---

[8]MFCUs are responsible for investigating and prosecuting Medicaid fraud; HHS OIG provides funding and oversight for MFCUs, which generally are located in state Attorney General offices. State program-integrity offices refer cases to these units. All states have an MFCU, with the exception of North Dakota.

[9]For example, regional CMS contractors include Zone Program Integrity Contractors (ZPIC), Unified Program Integrity Contractors (UPIC), and Medicare Administrative Contractors, among others.

that enabled us to compare CMS's antifraud efforts against each of these components. We did not evaluate the effectiveness of individual CMS fraud control activities and other antifraud efforts we describe in the report.

We conducted this performance audit from May 2016 to December 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS has four principal programs: Medicare, Medicaid, CHIP, and the health-insurance marketplaces. See table 1 for information about the four programs.

Table 1: Summary of Centers for Medicare & Medicaid Services' (CMS) Four Principal Programs

Program (year established)	Purpose	Features	Number of beneficiaries, fiscal year 2016 estimates (millions)	Mandatory federal outlays, fiscal year 2016 (dollars in billions)
Medicare (Parts A and B: 1965 Part C: 1997 Part D: 2003)	Health insurance for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease	Federally funded with beneficiary cost-sharing. Part A—hospital insurance (fee-for-service [FFS])[a] Part B—outpatient care (FFS) Part C—alternative to Parts A and B through private health-insurance plans, now also known as Medicare Advantage or managed care[b] Part D—voluntary, outpatient prescription-drug coverage through stand-alone drug plans or Medicare Advantage drug plans	57[c]	692[d]
Medicaid (1965)	Health-insurance coverage for low-income and medically needy individuals	Jointly funded by the federal government and the states. States have significant flexibility to design and implement their programs, resulting in over 50 distinct state programs. States can have multiple delivery systems—such as FFS[a] and managed-care[b] arrangements—and states vary considerably in the extent to which they enroll beneficiaries in FFS versus managed care.	72	368

Program (year established)	Purpose	Features	Number of beneficiaries, fiscal year 2016 estimates (millions)	Mandatory federal outlays, fiscal year 2016 (dollars in billions)
Children's Health Insurance Program (CHIP) (1997)	Health insurance for children whose household income exceeds limits for Medicaid eligibility	Jointly funded by the federal government and the states. States may choose to create a separate child-health program, expand Medicaid benefits and services to CHIP-eligible children, or do a combination of both approaches.	9	14
Health-insurance marketplaces (2010)	Health-insurance exchanges (or marketplaces) for eligible individuals who may compare and select among qualified health plans	States may elect to operate their own marketplace, or may rely on the federally facilitated marketplace. Individuals who purchase coverage in the marketplaces may be eligible for financial assistance from the federal government to offset the cost of coverage. CMS and states play a role in overseeing the marketplaces. For example, CMS directly operates the federally facilitated marketplace and establishes minimum standards that all qualified health plans must meet to participate in any marketplace.	11[e]	42[f]

Source: GAO analysis of Congressional Budget Office (CBO), Department of Health and Human Services (HHS), and CMS data. | GAO-18-88

[a]In FFS, providers submit claims for reimbursement after services have been rendered. Under FFS, Medicare (or states in Medicaid) pay providers for each service delivered (e.g., office visit, test, or procedure).

[b]In managed care, managed-care organizations (also known as health-insurance plans) are paid a predetermined, fixed periodic amount per enrollee that does not vary based on number or cost of health-care services an enrollee uses—typically per enrollee per month. These organizations are at financial risk if spending on services and administration exceeds payments from Medicare (or from states, for Medicaid). States may have different types of managed-care arrangements in Medicaid; in this report, we are referring to comprehensive, risk-based managed care, the most-common type of managed-care arrangement.

[c]Medicare projections are for calendar year 2016.

[d]Data include gross spending and exclude the effects of Medicare premiums and other offsetting receipts.

[e]Data reflect the number of individuals who paid their first month's premiums and had active policies as of March 2016.

[f]Data reflect spending to subsidize health insurance purchased through the marketplaces and spending to stabilize premiums for health insurance purchased by individuals and small employers.

As discussed earlier, Medicare and Medicaid are CMS's largest programs and have been growing steadily (see fig. 1). CBO projects that, in 2026, under current law, Medicare spending will reach $1.3 trillion. Medicaid is also expected to continue to grow—program spending is projected to increase 66 percent to over $950 billion by fiscal year 2025, and more than half of the states have chosen to expand their Medicaid programs by covering certain low-income adults not historically eligible for Medicaid

coverage, as authorized under the Patient Protection and Affordable Care Act of 2010 (PPACA).

Figure 1: Federal Spending on Medicare, Medicaid, CHIP, and Health-Insurance Marketplaces Is Projected to Increase

Percentage of gross domestic product
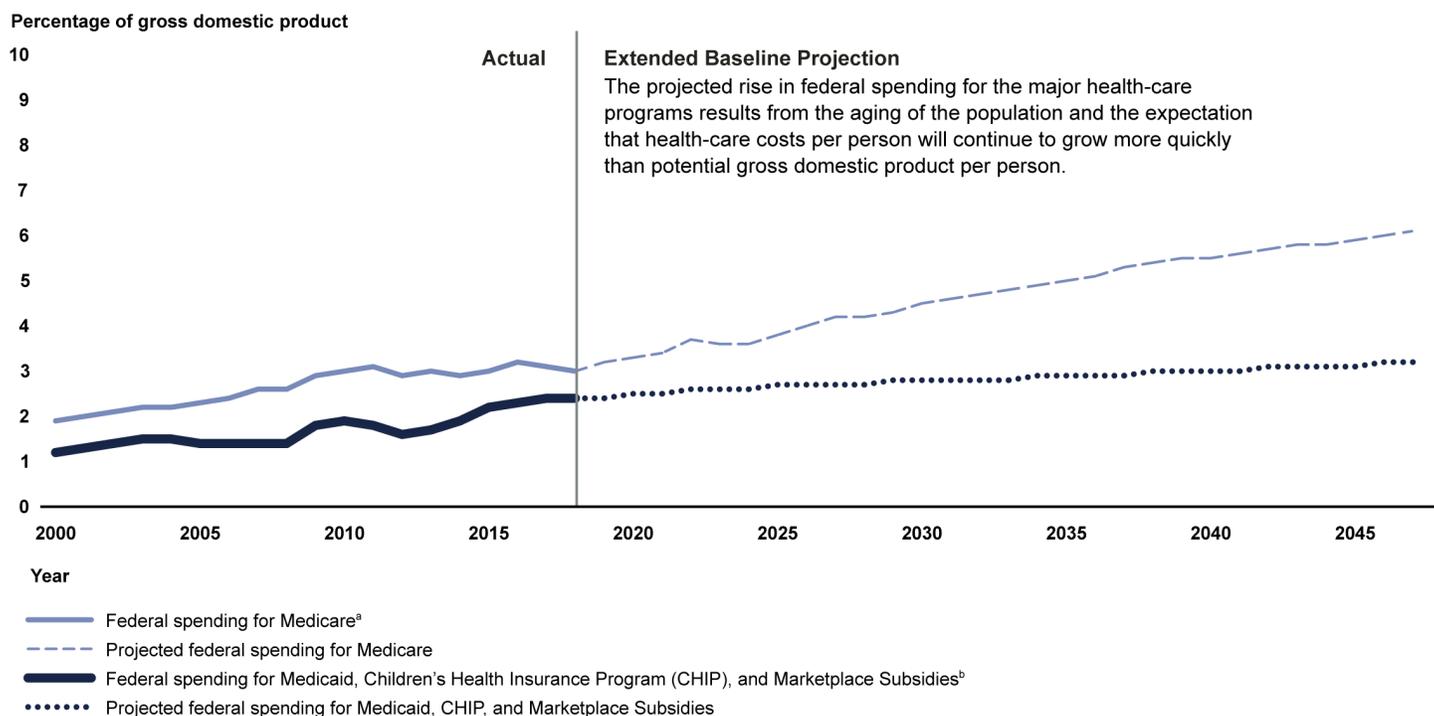
Source: Congressional Budget Office (CBO). | GAO-18-88

[a]Spending for Medicare refers to net spending for Medicare, which accounts for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.

[b]"Marketplace Subsidies" refers to spending to subsidize the health insurance purchased through the marketplaces established under the Patient Protection and Affordable Care Act and spending to stabilize premiums for health insurance purchased by individuals and small employers.

The two programs' use of managed-care delivery systems to provide care has also increased.[10] For example, the number and percentage of

---

[10]In managed care, managed-care organizations (also known as health-insurance plans) are paid a predetermined, fixed periodic amount per enrollee that does not vary based on number or cost of health-care services an enrollee uses—typically per enrollee per month. These organizations are at financial risk if spending on services and administration exceeds payments from Medicare (or from states, for Medicaid). States may have different types of managed-care arrangements in Medicaid; in this report, we are referring to comprehensive, risk-based managed care, the most-common type of managed-care arrangement.

Medicare beneficiaries enrolled in Medicare Part C has grown steadily over the past several years, increasing from 8.7 million (20 percent of all Medicare beneficiaries) in calendar year 2007 to 17.5 million (32 percent of all Medicare beneficiaries) in calendar year 2015.[11] As of July 1, 2015, nearly two-thirds of all Medicaid beneficiaries were enrolled in managed-care plans and about 40 percent of expenditures in fiscal year 2015 were for health-care services delivered through managed care.[12]

CMS Funding to Address Fraud, Waste, and Abuse

CMS receives appropriations to carry out antifraud activities through several funds including the Health Care Fraud and Abuse Control (HCFAC) program and the Medicaid Integrity Program. The HCFAC program was established under the Health Insurance Portability and Accountability Act of 1996 to coordinate federal, state, and local law-enforcement efforts to address health-care fraud and abuse and to conduct investigations and audits, among other things. In fiscal year 2016, CMS received $560 million through the HCFAC program appropriations. The Medicaid Integrity Program, established by the Deficit Reduction Act of 2005, supports contracts to audit and identify overpayments in Medicaid claims, and provides technical assistance for states' program-integrity efforts.[13] According to CMS, it received $75 million every year since fiscal year 2009 through the Medicaid Integrity Program appropriations.[14] According to CMS, in fiscal year 2016, total program-integrity obligations to address fraud, waste, and abuse for Medicare and Medicaid were $1.45 billion.

[11]See The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: 2016).

[12]For enrollment, see Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment and Program Characteristics*, advance copy (Washington, D.C.: 2016). For expenditures, see Centers for Medicare & Medicaid Services, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (Baltimore, Md.: 2016).

[13]CMS also uses the HCFAC program to fund its Medicaid program-integrity activities.

[14]For each fiscal year since 2010, the amount appropriated has been the previous year's appropriation adjusted for inflation.

Fraud Vulnerabilities and Improper Payments in Medicare and Medicaid

As mentioned previously, we designated Medicare and Medicaid as high-risk programs starting in 1990 and 2003, respectively, because their size, scope, and complexity make them vulnerable to fraud, waste, and abuse.[15] Similarly, the Office of Management and Budget (OMB) designated all parts of Medicare as well as Medicaid "high-priority" programs because these programs report $750 million or more in estimated improper payments in a given year. We also highlighted challenges associated with improper payments in Medicare and Medicaid in our annual report on duplication and opportunities for cost savings in federal programs.[16]

Improper payments are a significant risk to the Medicare and Medicaid programs and can include payments made as a result of fraud. Improper payments are payments that are either made in an incorrect amount (overpayments and underpayments) or those that should not be made at all.[17] For example, CMS estimated in fiscal year 2016 that the Medicare fee-for-service (FFS) improper payment rate was 11 percent (approximately $41 billion) and the Medicaid improper payment rate was 10.5 percent (approximately $36 billion).[18] Improper payment measurement does not specifically identify or estimate improper payments due to fraud.

Types of Health-Care Fraud and Fraud Risk

Health-care fraud can take many forms, and a single case can involve more than one scheme. Schemes may include fraudulent billing for services not provided, services provided that were not medically

---

[15]GAO-17-317.

[16]GAO, *2017 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, GAO-17-491SP (Washington, D.C.: April 2017).

[17]An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. OMB guidance also instructs agencies to report as improper payments any payment for which insufficient or no documentation was found.

[18]In fiscal year 2016, the improper payment rate for Medicare Part C was 9.99 percent (approximately $16 billion) and for Medicare Part D was 3.41 percent (approximately $2 billion).

necessary, and services intentionally billed at a higher level than appropriate. These fraud schemes may include compensating providers, beneficiaries, or others for participating in the fraud scheme.[19] Fraud can be regionally focused or can target particular service areas such as home-health services, or durable medical equipment such as wheelchairs. Fraud may also have nonfinancial effects. For example, patients may be subjected to harmful or unnecessary services by fraudulent providers. Fraud can be perpetrated by different actors, such as providers, beneficiaries, health-insurance plans, as well as organized crime.

Fraud and "fraud risk" are distinct concepts. Fraud is challenging to detect because of its deceptive nature. Additionally, once suspected fraud is identified, alleged fraud cases may be prosecuted. If the court determines that fraud took place, then fraudulent spending may be recovered. Fraud risk exists when individuals have an opportunity to engage in fraudulent activity, have an incentive or are under pressure to commit fraud, or are able to rationalize committing fraud. When fraud risks can be identified and mitigated, fraud may be less likely to occur.

Although the occurrence of one or more cases of health-care fraud indicates there is a fraud risk, a fraud risk can exist even if fraud has not yet been identified or occurred. Suspicious billing patterns, certain types of health-care providers, or complexities in program design may indicate a risk of fraud. Information to help identify potential fraud risks may come from various sources, including whistleblowers, agency officials, contractors, law-enforcement agencies, beneficiaries, or providers.

Fraud Risk Management Standards and Guidance

According to federal standards and guidance, executive-branch agency managers are responsible for managing fraud risks and implementing practices for combating those risks. Federal internal control standards call for agency management officials to assess the internal and external risks their entities face as they seek to achieve their objectives. The standards state that as part of this overall assessment, management should consider the potential for fraud when identifying, analyzing, and

---

[19]For additional information about the types of health-care fraud schemes, see GAO, *Health Care Fraud: Information on Most Common Schemes and Likely Effect of Smart Cards*, GAO-16-216 (Washington, D.C.: Jan. 22, 2016).

responding to risks.[20] Risk management is a formal and disciplined practice for addressing risk and reducing it to an acceptable level.[21]

In July 2015, GAO issued the Fraud Risk Framework, which provides a comprehensive set of key components and leading practices that serve as a guide for agency managers to use when developing efforts to combat fraud in a strategic, risk-based way.[22] The Fraud Risk Framework describes leading practices in four components: *commit*, *assess*, *design and implement*, and *evaluate and adapt*, as depicted in figure 2.

---

[20]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

[21]MITRE, *Government-wide Payment Integrity: New approaches and Solutions Needed* (McLean, Va.: February 2016).

[22]GAO-15-593SP.

Figure 2: The Fraud Risk Management Framework

Source: GAO. | GAO-18-88

The Fraud Reduction and Data Analytics Act of 2015, enacted in June 2016, requires OMB to establish guidelines for federal agencies to create controls to identify and assess fraud risks and design and implement antifraud control activities. The act further requires OMB to incorporate the leading practices from the Fraud Risk Framework in the guidelines. In

GAO-18-88 CMS Fraud Risk Management

July 2016, OMB published guidance about enterprise risk management and internal controls in federal executive departments and agencies.[23] Among other things, this guidance affirms that managers should adhere to the leading practices identified in the Fraud Risk Framework. Further, the act requires federal agencies to submit to Congress a progress report each year for 3 consecutive years on the implementation of the controls established under OMB guidelines, among other things.[24]

---

[23]Office of Management and Budget, *Management's Responsibility for Enterprise Risk Management and Internal Control*, Circular No. A-123 (Washington, D.C.: July 15, 2016).

[24]Pub. L. No. 114-186, § 3, 130 Stat. 546 (2016).

CMS Manages Fraud Risks as Part of Its Agency-Wide Program-Integrity Activities and through an Extensive Network of Stakeholders

Fraud Risk Management Is a Part of CMS's Broader Program-Integrity Approach

Tradeoffs for Program-Integrity and Antifraud Approaches

The Fraud Risk Framework recognizes that agencies have flexibility in how they set up their antifraud activities and structures, and fraud risk management activities may be incorporated or aligned with other program risk management activities. Integrating antifraud efforts into a broader program-integrity approach may pose tradeoffs. On one hand, it offers a broad view of potentially aberrant behaviors that could inform the development of control activities that serve multiple program-integrity functions, including fraud risk management. On the other hand, without careful planning, integrating fraud risk management into a larger program-integrity approach could limit the amount of resources and attention focused specifically on fraud prevention, detection, and response. Additionally, fraud's deceptive nature makes it harder to detect than other sources of improper payment, potentially requiring control activities that are specifically designed to prevent and detect criminal intent.
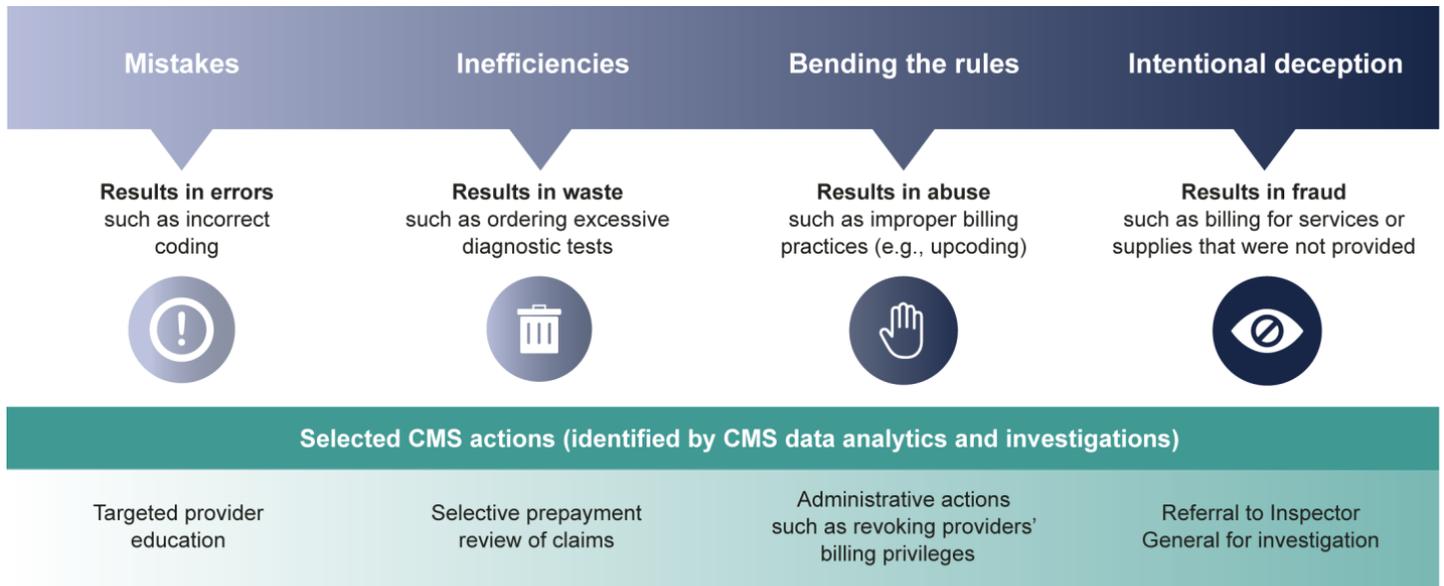
Source: GAO. | GAO-18-88

CMS's antifraud efforts for its four principal programs are part of the agency's broader program-integrity approach to address fraud, waste, and abuse. CMS's Center for Program Integrity (CPI) is the agency's focal point for program integrity across the programs. According to CMS, its approach to program-integrity allows it to "address the whole spectrum of fraud, waste, and abuse." For example, CMS describes its program-integrity activities as addressing unintentional errors resulting from providers being unaware of recent policy changes on one end of the spectrum, through somewhat more-serious patterns of abuse such as billing for a more-expensive service than was performed (known as upcoding), and finally up to serious fraudulent activities, such as billing for services that were not provided. CMS then aims to target its corrective actions to fit the risk. See figure 3 for CMS's description of the spectrum of fraud, waste, and abuse that its program-integrity activities aim to address.

Figure 3: Centers for Medicare & Medicaid Services (CMS) Description of How the Agency Addresses the Spectrum of Fraud, Waste, and Abuse

Mistakes	Inefficiencies	Bending the rules	Intentional deception
Results in errors such as incorrect coding	**Results in waste** such as ordering excessive diagnostic tests	**Results in abuse** such as improper billing practices (e.g., upcoding)	**Results in fraud** such as billing for services or supplies that were not provided

Selected CMS actions (identified by CMS data analytics and investigations)

| Targeted provider education | Selective prepayment review of claims | Administrative actions such as revoking providers' billing privileges | Referral to Inspector General for investigation |

Source: GAO analysis of CMS information. | GAO-18-88

Within its program-integrity activities, CMS has established several control activities that are specific to managing fraud risks, while others serve broader program-integrity purposes.[25] According to CMS officials, the agency's antifraud control activities mainly focus on providers in Medicare FFS. Officials told us that when CPI began operating, its primary focus was developing program integrity for Medicare FFS and, as a result, it is the most "mature" of all of CPI's programs. CMS's specific fraud control activities include, for example, the Fraud Prevention System (FPS), a predictive-analytics system that helps identify potentially fraudulent payments in Medicare FFS, and the Unified Program Integrity Contractors (UPIC), which detect and investigate aberrant provider behavior and potential fraud in Medicare and Medicaid. Other control activities serve broader program-integrity purposes such as to reduce improper payments resulting from error, waste, and abuse in addition to

---

[25]According to federal internal control standards, "control activities" are the policies, procedures, techniques, and mechanisms that enforce management's directives to achieve the entity's objectives and address related risks. In this regard, the Fraud Risk Framework describes examples of control activities—including predictive analytics, document reviews, and investigations, among other things.

preventing or detecting potential fraud. For example, CMS provides education and outreach to Medicare providers and beneficiaries on issues identified through data analyses in order to reduce improper payments and to increase their awareness of fraud.[26]

HHS and CMS department- and agency-wide strategic plans guide CMS's program-integrity activities—including antifraud activities.[27] The program-integrity goals identified in the HHS strategic plan primarily focus on improper payments and are driven by statutory requirements.[28] For example, the HHS strategic plan for fiscal years 2014–2018 includes performance goals of reducing the percentage of improper payments made under Medicare FFS and Medicare Parts C and D. One antifraud-focused goal in the HHS strategic plan is to increase the percentage of Medicare providers and suppliers identified as high risk that receive administrative actions, such as suspending payments to providers or revoking providers' billing privileges.

HHS and CMS department- and agency-wide strategic plans also include an emphasis on fraud prevention and early detection—a leading practice in the Fraud Risk Framework—and moving away from a "pay-and-chase" model.[29] For example, the HHS strategic plan calls for "fostering early detection and prevention of improper payments by focusing on preventing bad actors from enrolling or remaining in Medicare and Medicaid" and to "use public-private partnerships to prevent and detect fraud across the health care industry by sharing fraud-related information and data between the public and private sectors." As a part of this emphasis on prevention, CMS developed FPS in response to the Small Business Jobs

---

[26]We recently reported on Medicare provider education efforts, which CMS cites as an important way to reduce improper payments. See GAO, *Medicare Provider Education: Oversight of Efforts to Reduce Improper Billing Needs Improvement*, GAO-17-290 (Washington, D.C.: Mar. 10, 2017).

[27]Department of Health and Human Services, *HHS Strategic Plan: Strategic Plan FY 2014-2018* (Mar. 10, 2014), and Centers for Medicare & Medicaid Services, *CMS Strategy: The Road Forward 2013-2017* (March 2013).

[28]OMB designated Medicare fee-for-service (FFS), Medicare Part C, Medicare Part D, Medicaid, and CHIP to be at high risk for improper payments. Under the Improper Payments Elimination and Recovery Improvement Act of 2012, CMS must establish annual targets and semiannual or quarterly actions for reducing improper payments.

[29]"Pay-and-chase" refers to the labor-intensive and time-consuming practice of trying to recover overpayments once they have already been made rather than preventing improper payments in the first place.

Act of 2010, which required CMS to implement predictive-analytics technologies. Also, the Patient Protection and Affordable Care Act of 2010 (PPACA) included provisions to strengthen Medicare and Medicaid's provider enrollment standards and procedures, among other program-integrity provisions.[30]

CMS Uses an Extensive Network of Stakeholders to Manage Fraud Risks and Plays Varying Roles in These Relationships

CMS works with an extensive and complex network of stakeholders to manage fraud risks in its four principal programs. In Medicaid and CHIP, CMS partners with and oversees the 50 states and the District of Columbia. Until the Deficit Reduction Act of 2005 expanded CMS's role in Medicaid program integrity to provide effective federal support and assistance to states' efforts to combat fraud, waste, and abuse, states were primarily responsible for Medicaid program integrity.[31] Each state has its own Medicaid program-integrity unit, Medicaid Fraud Control Unit (MFCU), and state audit organization.[32]

CMS also uses numerous contractors to conduct the majority of its program-integrity activities. Since the enactment of Medicare in 1965, contractors have played an integral role in the administration of the program. The original Medicare program was designed so that the federal government contracted with health insurers or similar organizations experienced in handling physician and hospital claims to pay Medicare claims. Later, the Health Insurance Portability and Accountability Act of 1996 required the Secretary of Health and Human Services to enter into contracts to promote the integrity of the Medicare program.[33] According to CMS officials, in fiscal year 2016 contractors received 92 percent of CMS's program-integrity funding. Medicare and Medicaid program-integrity contractors play a variety of roles: (1) processing and reviewing claims, (2) conducting site visits of providers enrolling in Medicare, (3)

---

[30]Pub. L. No. 111-148, § 6401–6411, 124 Stat. 119, 747–775 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

[31]Pub. L. No. 109-171, § 6034, 120 Stat. 4, 74–78 (2006) (codified at 42 U.S.C. § 1396u-6).

[32]As mentioned earlier, North Dakota does not have a MFCU.

[33]Pub. L. No. 111-420, § 4241, 124 Stat. 2504, 2599 (2010) (codified at 42 U.S.C. § 1320a-7m). In response to the Health Insurance Portability and Accountability Act of 1996, CMS created the Program Safeguard Contractors; currently, this role is carried out by the Zone Program Integrity Contractors (ZPIC) and UPICs.

auditing claims and recovering overpayments, (4) performing data analysis, and (5) investigating aberrant claims and provider behaviors, among other things. States also use contractors in many of these roles for managing program integrity.

Additionally, multiple private health-insurance plans in Medicare Parts C and D and over 200 health-insurance plans in Medicaid managed care also carry out program-integrity activities. For the health-insurance marketplaces, CMS is responsible for operating the federally facilitated marketplace and overseeing the state-based marketplaces. CMS also developed the Federal Data Services Hub, which acts as a portal for exchanging information between state-based marketplaces, the federally facilitated marketplace, and state Medicaid agencies, among other entities, as well as other external partners, including other federal agencies, such as the Internal Revenue Service.[34] Finally, law-enforcement groups, including the joint Department of Justice (DOJ) and HHS OIG Medicare Fraud Strike Force Teams, identify, investigate, and prosecute instances of fraud in CMS programs. See figure 4 for a depiction of CMS's stakeholder network for managing fraud risks. This figure illustrates approximate numbers of stakeholders (through the concentration of dots), but not the extent of individual stakeholder roles.

---

[34]CMS uses the Federal Services Data Hub to verify that applicant information necessary to support an eligibility determination is consistent with external data sources. For additional information, see GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, GAO-16-29 (Washington, D.C.: Feb. 23, 2016).

Figure 4: CMS Works with an Extensive Network of Stakeholders to Manage Fraud Risks
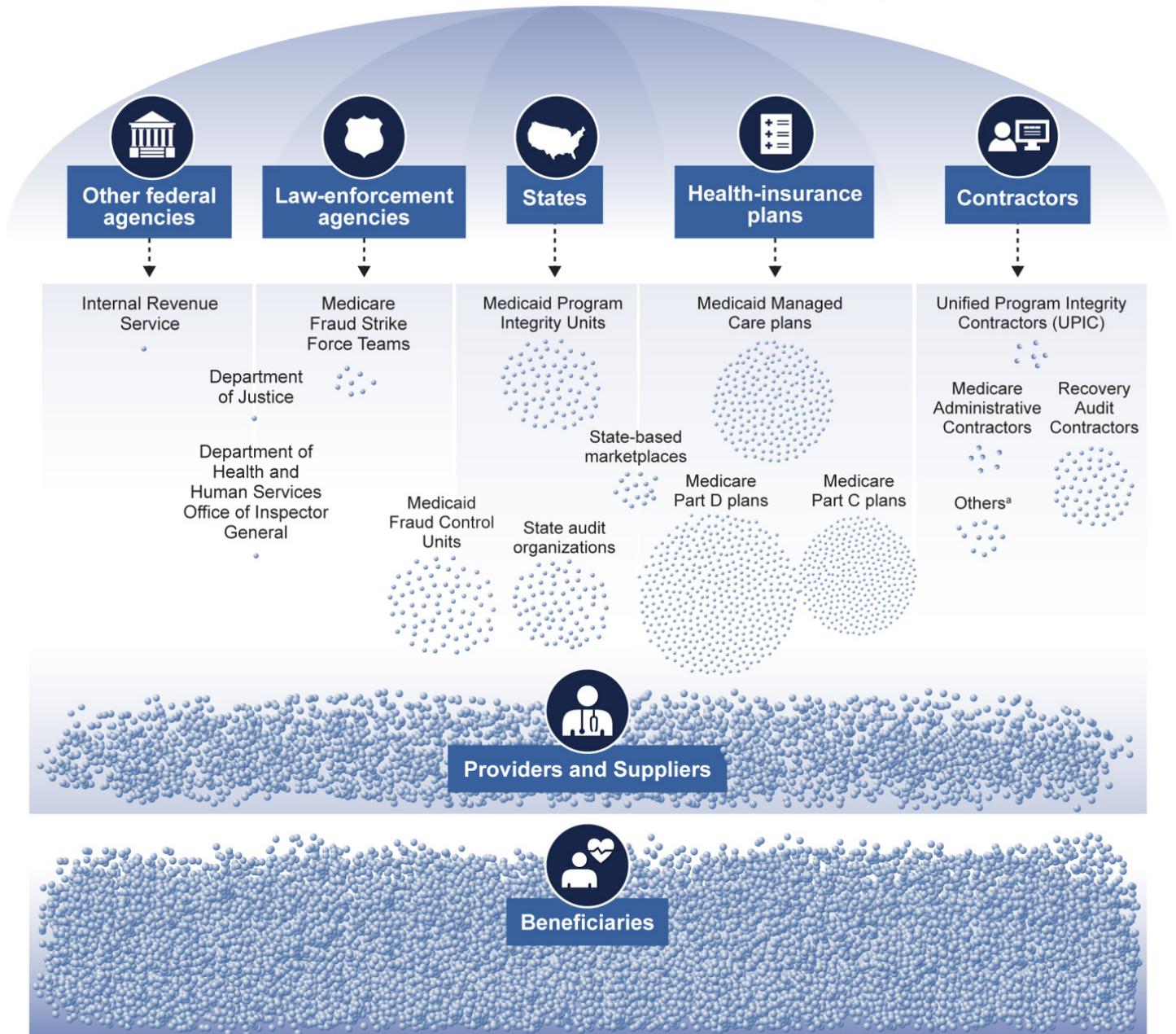
Source: GAO analysis of CMS information. | GAO-18-88

Notes: This figure illustrates approximate numbers of stakeholders (through the concentration of dots), but not the extent of individual stakeholder roles.

Beginning in 2016, CMS began consolidating the data analysis and investigations previously carried out in Medicare by the Zone Program Integrity Contractors and Program Safeguard Contractors, and in Medicaid by the Audit Medicaid Integrity Contractors, into five regional Unified Program Integrity Contractors (UPIC). As of September 2017, two of the five UPICs—the Midwestern and Northeastern—have been implemented.

[a]For example, other CMS program-integrity contractors include the National Site Visit Contractor, Fraud Prevention System contractors, and the Supplemental Medical Review Contractor.

CMS provides oversight to, or partners with, these stakeholders to manage fraud risks. For oversight, CMS creates policies and guidance to direct stakeholders' antifraud efforts, such as Medicare and Medicaid program-integrity manuals and the Medicaid Provider Enrollment Compendium.[35] CMS also provides technical assistance to states in areas such as provider enrollment and data analysis. In areas where CMS does not have a primary role, it acts as a partner by collaborating and coordinating program-integrity and antifraud activities. For example, CMS is directly responsible for Medicare program integrity, but, in Medicaid and CHIP, states are the first line of program-integrity efforts. Similarly, CMS maintains control over Medicare FFS program integrity, but within Medicare managed care, it provides guidance for health-insurance plans to carry out their own program-integrity activities.[36]

In the health-insurance marketplaces, CMS reviews state-based marketplaces' procedures for verifying applicant eligibility for coverage. For example, it conducts annual reviews of the state-based marketplaces, which include a review of states' fraud, waste, and abuse policies.

See figure 5 for a further description of CMS's and various stakeholders' roles and responsibilities in fraud risk management.

---

[35]Centers for Medicare & Medicaid Services, *Medicaid Provider Enrollment Compendium* (Baltimore, Md.: updated Jan. 4, 2017).

[36]Centers for Medicare & Medicaid Services, *Prescription Drug Benefit Manual* "Compliance Program Guidelines," ch. 9, and *Medicare Managed Care Manual* "Compliance Program Guidelines," ch. 21 (revised Jan. 11, 2013).

GAO-18-88 CMS Fraud Risk Management

Figure 5: CMS and Stakeholder Roles and Responsibilities in Managing Fraud Risks for Its Four Principal Programs

Stakeholder	CMS role	Responsibilities	Additional information
States	Provides oversight and technical assistance, Partners	In Medicaid and Children's Health Insurance Program (CHIP), the states administer their programs and day-to-day operations. The Centers for Medicare & Medicaid Services (CMS) is responsible for broad oversight of the program, develops rules and guidance, and conducts audits. CMS and the states partner in pursuing Medicaid and CHIP program integrity. In the health-insurance marketplaces, CMS is responsible for operating the federally facilitated marketplace and overseeing the state-based marketplaces. CMS reviews state-based marketplaces' procedures for verifying applicant eligibility for coverage and conducts annual reviews, including of states' fraud, waste, and abuse policies.	Each state is required to have a Medicaid program-integrity unit to address fraud, waste, and abuse. Additionally, the states establish Medicaid Fraud Control Units (MFCU) to investigate and prosecute fraud, and some state audit organizations perform their own oversight of state Medicaid and CHIP programs. State-based marketplaces and state Medicaid agencies may exchange information in the Federal Data Services Hub (developed by CMS) used to verify that applicant eligibility information necessary to support an eligibility determination is consistent with external data sources.
Contractors	Provides oversight	In Medicare and Medicaid, contractors carry out CMS's antifraud and improper-payment activities including enrolling providers, addressing improper payments, and investigating fraud, among others. Contractors represent CMS to providers and beneficiaries. CMS oversees contractors. In the federally facilitated marketplace, CMS relies on a contractor charged with document processing to report possible instances of fraud.	CMS facilitates information sharing among contractors through joint operating agreements and through recurring meetings.
Health-insurance plans	Provides oversight	In Medicaid managed care and Medicare Parts C and D, private health-insurance plans carry out antifraud responsibilities on behalf of CMS. In Medicare, CMS is responsible for overseeing these health-insurance plans, while in Medicaid, the states oversee these health-insurance plans through contracts and reporting requirements.	CMS requires health-insurance plans to have an effective compliance program in place to mitigate fraud, waste, and abuse and identify fraudulent providers. CMS also requires plans to perform regular risk assessments.
Law-enforcement agencies	Partners	Department of Health and Human Services Office of Inspector General (HHS OIG), the Department of Justice (DOJ), MFCUs, and joint programs, such as the Medicare Fraud Strike Force Teams, investigate and prosecute fraud cases. CMS partners with DOJ on the Medicaid Integrity Institute, which provides training to state Medicaid program-integrity officials.	HHS OIG has two staff members assigned to the Center for Program Integrity (CPI) and it provides funding and oversight to MFCUs. CMS coordinates with law-enforcement agencies to refer and support fraud cases.
Other federal agencies	Partners	CMS is responsible for operating the federally facilitated marketplace, including verifying eligibility for enrollment and determining eligibility for financial assistance available to eligible individuals to offset the cost of coverage. The Internal Revenue Service is responsible for determining the final amount of the premium tax credit, a type of financial assistance that taxpayers are entitled to receive based on information reported on their tax returns.	Marketplaces are required by law to verify applicant eligibility using data sources and methods approved by the Department of Health and Human Services. CMS works with seven federal agencies (and others as mentioned above) on the Federal Data Services Hub (developed by CMS), which is used to verify that applicant information necessary to support an eligibility determination is consistent with external data sources.

Source: GAO analysis of CMS information and interviews with CMS stakeholders. | GAO-18-88

CMS also facilitates collaboration among federal, state, and private entities for managing fraud risks. In 2012, CMS created the Healthcare Fraud Prevention Partnership (HFPP) to share information with public and private stakeholders and to conduct studies related to health-care fraud, waste, and abuse. According to CMS, as of October 2017, the HFPP included 89 public and private partners, including Medicare- and Medicaid-related federal and state agencies, law-enforcement agencies, private health-insurance plans (payers), and antifraud and other health-care organizations. The HFPP has conducted studies that pool and analyze multiple payers' claims data to identify providers with patterns of suspect billing across payers. In a recent report, participants separately told us that the HFPP's studies helped them to identify and take action against potentially fraudulent providers and payment vulnerabilities of which they might not otherwise have been aware, and fostered both formal and informal information sharing.[37]

CMS's relationships with stakeholders were varied in terms of maturity and extent of information sharing, according to stakeholders we interviewed. While some relationships between CMS and stakeholders have been long-standing, some are developing, and others exist on an ad hoc basis. For example, CMS has had a long-standing relationship with state Medicaid program-integrity units, by collaborating through monthly meetings of the Medicaid Fraud and Abuse Technical Advisory Group, sending fraud alerts, and offering courses through the Medicaid Integrity Institute. However, in our interviews with state program-integrity units, and as we recently reported, some state Medicaid agencies shared concerns about the communication, level of policy guidance, and technical support provided by and received from CMS for managing fraud risks in Medicaid.[38] This concern was echoed by state audit officials, with

---

[37]GAO, *Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud*, GAO-17-710 (Washington, D.C.: Aug. 30, 2017).

[38]We have previously made recommendations to CMS to improve collaboration with states. HHS concurred with our recommendations but, as of September 2017, has not implemented them. See GAO, *Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States*, GAO-17-277 (Washington, D.C.: Mar. 15, 2017).

whom CMS recently initiated coordination to build relationships that would facilitate state auditing of Medicaid programs.[39]

CMS also has varying relationships with its law-enforcement partners. For example, the relationship between CMS and DOJ's Health Care Fraud unit, which leads the DOJ and HHS OIG Medicare Fraud Strike Force Teams, has been ad hoc. According to CMS and DOJ officials, the interactions between the agencies have been based on specific fraud cases such as coordination of national takedowns when DOJ provided CMS with the names of providers committing fraud so that CMS could suspend them consistently with the timing of the enforcement efforts. According to CMS officials, they coordinate more with HHS OIG, working together on payment suspensions and revocations for OIG cases, or working with it to take administrative actions against large providers.

CMS's Efforts Managing Fraud Risks in Medicare and Medicaid Are Partially Aligned with the Fraud Risk Framework

CMS's antifraud efforts partially align with the Fraud Risk Framework. Consistent with the framework, CMS has demonstrated commitment to combating fraud by creating a dedicated entity to lead antifraud efforts. It has also taken steps to establish a culture conducive to fraud risk management, although it could expand its antifraud training to include all employees. CMS has taken some steps to identify fraud risks in Medicare and Medicaid; however, it has not conducted a fraud risk assessment or developed a risk-based antifraud strategy for Medicare and Medicaid as defined in the Fraud Risk Framework. CMS has established monitoring and evaluation mechanisms for its program-integrity control activities that, if aligned with a risk-based antifraud strategy, could enhance the effectiveness of fraud risk management in Medicare and Medicaid.

---

[39]In November 2016 and May 2017, CMS and selected state audit officials held meetings to discuss future collaboration as well as specific areas of concern in Medicaid, such as oversight of Medicaid managed care. GAO facilitated the November 2016 meeting, and GAO officials participated in and presented prior audit results at the May 2017 meeting.

CMS Has Shown Commitment to Combating Fraud by Creating an Organizational Structure and Taking Steps to Establish a Culture Conducive to Fraud Risk Management

CMS's Organizational Structure Includes a Dedicated Entity for Program-Integrity and Antifraud Efforts

Fraud Risk Framework Component:

Commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management

Source: GAO. | GAO-18-88

The *commit* component of the Fraud Risk Framework calls for an agency to commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management. This component includes establishing a dedicated entity to lead fraud risk management activities.[40]

Within CMS, the Center for Program Integrity (CPI) serves as the dedicated entity for fraud, waste, and abuse issues in Medicare and Medicaid, which is consistent with the Fraud Risk Framework. CPI was established in 2010, in response to a November 2009 Executive Order on reducing improper payments and eliminating waste in federal programs.[41] This formalized role, according to CMS officials, elevated the status of program-integrity efforts, which previously were carried out by other parts of CMS.

As an executive-level Center—on the same level with five other executive-level Centers at CMS, such as the Center for Medicare and the Center for Medicaid and CHIP Services—CPI has a direct reporting line to executive-level management at CMS. The Fraud Risk Framework identifies a direct reporting line to senior-level managers within the agency as a leading practice. According to CMS officials, this elevated organizational status offers CPI heightened visibility across CMS, attention by CMS executive leadership, and involvement in executive-level conversations.

Additionally, in 2014, CMS established a Program Integrity Board that has brought together senior officials across CMS Centers on a monthly basis to coordinate on fraud and program-integrity vulnerabilities. According to

---

[40]GAO-15-593SP.

[41]*Reducing Improper Payments*, Exec. Order No. 13520, 74 Fed. Reg. 226 (Nov. 20, 2009).

CPI officials, the board is one of the mechanisms through which CPI engages other executive-level offices at CMS. CPI chairs the meetings and typically develops meeting agendas to solicit information from and disseminate information to other CMS units or stakeholders. Further, the board may establish small working groups, known as integrated project teams, to address specific vulnerabilities. For example, according to CMS officials, in 2016 the board established a Marketplace integrated project team to resolve potential fraud eligibility and enrollment issues in the federally facilitated marketplace using the Fraud Risk Framework.

CPI has further demonstrated commitment to addressing fraud, waste, and abuse through several organizational changes with the goal of improving coordination and communication of program-integrity activities across Medicare and Medicaid. Most recently, in 2014, CPI reorganized its structure to align functional areas across Medicare and Medicaid, where possible. Previously, separate units within CPI administered their own program-integrity activities for Medicare and Medicaid programs. For example, CPI established a Provider Enrollment and Oversight Group, responsible for provider screening and enrollment functions in both Medicare and Medicaid. According to CMS officials, if CPI employees identify an issue in provider enrollment in Medicare, the same CPI employees also consider how this issue applies to Medicaid. According to CMS officials, the reorganization has helped CPI to look at vulnerabilities in a crosscutting way and to facilitate communication across programs.

Similarly, since 2016, CPI began shifting contracting functions from separate Medicare and Medicaid regional contractors that identify and investigate cases of potential fraud and conduct audits to five regional UPICs responsible for a range of program-integrity and fraud-specific activities in both Medicare FFS and Medicaid. According to CMS, the purpose of the UPICs is to coordinate provider investigations across Medicare and Medicaid, improve collaboration with states by providing a mutually beneficial service, and increase contractor accountability through coordinated oversight. CMS officials told us that UPIC integration is a cornerstone of CMS's contract management strategy and would help to ensure communication and coordination across Medicare and Medicaid program-integrity efforts. CMS plans to award all the UPIC contracts by the end of 2017, ultimately phasing out the ZPICs and Medicaid Integrity Contractors.

CMS Has Taken Steps to Create a Culture Conducive to Fraud Risk Management but Could Enhance Antifraud Training for Employees

Fraud Risk Framework Component:
Commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management

Source: GAO. | GAO-18-88

The *commit* component of the Fraud Risk Framework also includes creating an organizational culture to combat fraud at all levels of the agency.

Consistent with the Fraud Risk Framework, CMS has promoted an antifraud culture by demonstrating a senior-level commitment to combating fraud through public statements, increased resource levels, and internal and external coordination.

In addition to HHS and CMS strategic documents discussed earlier, CMS and CPI leaders have testified publicly about CMS's commitment to preventing fraud and protecting taxpayers and beneficiaries. For example, CPI's former Director testified in May 2016 before the House Committee on Energy and Commerce's Subcommittee on Oversight and Investigations that "CMS is deeply committed to our efforts to prevent waste, fraud and abuse in Medicare and Medicaid programs, protecting both taxpayers and the beneficiaries that we serve."[42] More recently, CMS's new Administrator testified in her February 2017 confirmation hearing regarding her intent to prioritize efforts around preventing fraud and abuse.[43]

CPI's budget and resources have increased over time to support its ongoing program-integrity mission. According to CMS, program-integrity obligations for Medicare and Medicaid increased from about $1.02 billion in fiscal year 2010 to $1.45 billion in fiscal year 2016. According to CMS officials, the Health Care Fraud and Abuse Control (HCFAC) account, one of the primary sources of CPI funding, has never received a funding reduction. Additionally, in 2015, CPI received additional funding based on a discretionary cap adjustment to HCFAC.[44] Similarly, CPI staff resources

---

[42]Dr. Shantanu Agrawal, Deputy Administrator, and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, *Medicare and Medicaid Program Integrity: Combating Improper Payments and Ineligible Providers*, testimony before the House Committee on Energy and Commerce, Subcommittee on Oversight & Investigations, 114th Cong., 2nd sess., May 24, 2016. As of the writing of this report, the CPI Director position was unfilled.

[43]Seema Verma, Nominee to be Administrator of the Centers for Medicare & Medicaid Services, Department of Health and Human Services, statement before the Senate Committee on Finance, 115 Cong., 1st sess., February 16, 2017.

[44]The Budget Control Act of 2011 created a discretionary allocation cap adjustment for HCFAC funding for 10 years, from fiscal year 2012 to fiscal year 2021. The passage of the Consolidated and Further Continuing Appropriations Act of fiscal year 2015 was the first time the HCFAC cap adjustment was appropriated.

have increased over time. According to CMS, CPI's full-time equivalent positions increased from 177 in 2011 to 419 in 2017.[45]

Consistent with leading practices in the Fraud Risk Framework to involve all levels of the agency in setting an antifraud tone, CPI has also worked collaboratively with other CMS Centers. In addition to engaging executive-level officials of other CMS Centers through the Program Integrity Board, CPI has worked collaboratively with other Centers within CMS to incorporate antifraud features into new program design or policy development and established regular communication at the staff level. For example:

- Center for Medicare and Medicaid Innovation (CMMI). When developing the Medicare Diabetes Prevention Program, CMMI officials told us they worked with CPI's Provider Enrollment and Oversight Group and Governance Management Group to develop risk-based screening procedures for entities that would enroll in Medicare to provide diabetes-prevention services, among other activities. The program was expanded nationally in 2016, and CMS determined that an entity may enroll in Medicare as a program supplier if it satisfies enrollment requirements, including that the supplier must pass existing high categorical risk-level screening requirements.[46]

- Center for Medicaid and CHIP Services (CMCS). CMCS officials told us they worked closely with CPI to issue Medicaid guidance and best practices to states on home and community-based services that incorporate program-integrity provisions.[47] A senior CMCS official told us that, to address fraud, CMS has requested that states include provider information on claims to determine whether providers are meeting eligibility criteria.

---

[45]Full-time equivalent allocations are as of January 1 of each year.

[46]82 Fed. Reg. 52,976 (Nov. 15, 2017) (codified at 42 C.F.R. Parts 405, 410, 414, 424, and 425). For additional information about CMS provider-enrollment activities for Medicare, see GAO, *Medicare: Initial Results of Revised Process to Screen Providers and Suppliers, and Need for Objectives and Performance Measures*, GAO-17-42 (Washington, D.C.: Nov. 15, 2016).

[47]Home and community-based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups, such as people with cognitive, physical, or mental disabilities.

- Center for Medicare (CM). In addition to building safeguards into programs and developing policies, CM officials told us that there are several standing meetings, on monthly, biweekly, and weekly bases, between groups within CM and CPI that discuss issues related to provider enrollment, FFS operations, and contractor management. A senior CM official also told us that there are ad hoc meetings taking place between CM and CPI: "We interact multiple times daily at different levels of the organization. Working closely is just a regular part of our business."

CMS has also demonstrated its commitment to addressing fraud, waste, and abuse to its stakeholders. Representatives of CMS's extensive stakeholder network whom we interviewed—state officials, contractors, and officials from public and private entities—generally recognized the agency's commitment to combating fraud. In our interviews with stakeholders, officials observed CMS's increased commitment over time to address fraud, waste, and abuse and cited examples of specific CMS actions. State officials, for example, told us that the Medicaid Integrity Institute, a training center coordinated jointly by CMS and DOJ, has been a helpful resource for states to build capacity to address fraud and program integrity.[48] CMS contractors told us that CMS's commitment to combating fraud is incorporated into contractual requirements, such as requiring (1) data analysis for potential fraud leads and (2) fraud-awareness training for providers. Officials from entities that are members of the HFPP, specifically, a health-insurance plan and the National Health Care Anti-Fraud Association, added that CMS's effort to establish the HFPP and its ongoing collaboration and information sharing reflect CMS's commitment to combat fraud in Medicare and Medicaid.

The Fraud Risk Framework identifies training as one way of demonstrating an agency's commitment to combating fraud. Training and education intended to increase fraud awareness among stakeholders, managers, and employees, serves as a preventive measure to help create a culture of integrity and compliance within the agency. The Fraud Risk Framework discusses requiring all employees to attend training upon hiring and on an ongoing basis thereafter.

---

[48]The Medicaid Integrity Institute has offered fraud-related training courses such as basic and specialized skills and techniques in Medicaid fraud detection. We recently reported that the Medicaid Integrity Institute is an important training resource, but states' demand for its courses frequently exceeded the institute's capacity. See GAO-17-277.

To increase awareness of fraud risks in Medicare and Medicaid, CMS offers and requires training for stakeholder groups such as providers, beneficiaries, and health-insurance plans. Specifically, through its National Training Program and Medicare Learning Network, CMS makes available training materials on combating Medicare and Medicaid fraud, waste, and abuse.[49] These materials help to identify and report fraud, waste, and abuse in CMS programs and are geared toward providers, beneficiaries, as well as trainers and other stakeholders. Separately, CMS requires health-insurance plans working with CMS to provide annual fraud, waste, and abuse training to their employees.[50]

However, CMS does not offer or require similar fraud-awareness training for the majority of its workforce. For a relatively small portion of its overall workforce—specifically, contracting officer representatives who are responsible for certain aspects of the acquisition function—CMS requires completion of fraud and abuse prevention training every 2 years. According to CMS, 638 of its contracting officer representatives (or about 10 percent of its overall workforce) completed such training in 2016 and 2017. Although CMS offers fraud-awareness training to others, the agency does not require fraud-awareness training for new hires or on a regular basis for all employees because the agency has focused on providing process-based internal controls training for its employees.

While fraud-awareness training for contracting officer representatives is an important step in helping to promote fraud risk management, fraud-awareness training specific to CMS programs would be beneficial for all employees. Such training would not only be consistent with what CMS offers to or requires of its stakeholders and some of its employees, but would also help to keep the agency's entire workforce continuously aware of fraud risks and examples of known fraud schemes, such as those identified in successful OIG investigations. Such training would also keep employees informed as they administer CMS programs or develop agency policies and procedures. Considering the vulnerability of Medicare and Medicaid programs to fraud, waste, and abuse, without regular

---

[49]The CMS National Training Program provides support for partners and stakeholders, not-for-profit professionals and volunteers who work with seniors and people with disabilities, and others who help people make informed health-care decisions. The program offers an online training library with materials to conduct outreach and education sessions. The Medicare Learning Network provides free educational materials for health-care professionals on CMS programs, policies, and initiatives.

[50]For example, 42 C.F.R. § 422.503(b)(4)(vi)(C).

required training CMS cannot be assured that its workforce of over 6,000 employees is continuously aware of risks facing its programs.

Although CMS has shown commitment to combating fraud, at times CPI's efforts to combat fraud compete with other mission priorities, such as (1) ensuring beneficiary access to health-care services and (2) limiting provider burden. CPI leadership has been aware of this inherent challenge. For example, at a congressional hearing in May 2016, CPI's Director stated that "our efforts strike an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers and suppliers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse."[51]

Beneficiary access to care. In accordance with its mission statement, providing and improving beneficiaries' access to health care is a CMS priority. CMS's commitment to providing access to high-quality care and coverage is reflected in the agency's mission statement and is one of its four strategic goals. As a result, before taking administrative actions against a Medicare Part A provider, such as a hospice, or providers in rural areas, CMS officials told us that they first look at whether there is a sufficient number of providers in an area by running a provider search by provider county and adjacent counties and considering how heavily populated an area is with Medicare beneficiaries. According to these officials, rather than taking an administrative action against a provider that would limit beneficiaries' access to services, the agency may enter into a corrective action plan with the provider. CMS officials told us that revoking a provider's enrollment in Medicare, an option available to CMS in cases of provider noncompliance or misconduct, is rare.[52]

Administrative burden on providers. According to CMS documents and officials, concern over placing undue burden on providers—the majority of whom are presumed to be honest—provides a counterforce to implementing program-integrity control activities. CMS's web page entitled Reducing Provider Burden states: "CMS is committed to reducing improper payments but must be mindful of provider burden because

---

[51]Dr. Shantanu Agrawal, *Medicare and Medicaid Program Integrity: Combating Improper Payments and Ineligible Providers*.

[52]42 C.F.R. § 424.535.

medical review[53] is a resource-intensive process for both the healthcare provider and the Medicare review contractor."[54] Two CMS contractors told us that they scaled back or did not pursue audits of providers' documentation because of provider burden or sensitivity considerations. One contractor removed providers from audit samples after some providers opposed having to supply multiple medical records. CPI officials told us that they want to reduce provider burden in a logical manner. For example, according to CMS officials, in the Medicare FFS Recovery Audit Program, CMS established limits on Additional Documentation Requests, which are requests for medical documentation supporting a claim being reviewed. CMS requires such documentation adjustments so that they align with a providers' claim denial rates. Providers with low denial rates will have lower documentation requirements, while providers with high denial rates will have higher documentation requirements, thus adjusting provider burden based on demonstrated compliance.

---

[53]A medical review is the manual review of Medicare FFS claims and related medical records by trained clinicians and coders to ensure that the claims are consistent with Medicare coverage, payment, and coding policies. Many improper claims can be identified by manually reviewing associated medical records and a beneficiary's claim history, and exercising clinical judgement to determine whether a service is reasonable and necessary. Less than 1 percent of claims undergo manual reviews. See GAO, *Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data*, GAO-16-394 (Washington, D.C.: Apr. 13, 2016).

[54]See Centers for Medicare & Medicaid Services, *Reducing Provider Burden*, accessed August 15, 2017, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/ReducingProviderBurden.html.

CMS Has Taken Steps to Identify Program Fraud Risks but Has Not Conducted a Fraud Risk Assessment for Medicare or Medicaid

CMS Has Taken Steps to Identify Some Fraud Risks for Medicare and Medicaid

Fraud Risk Framework Component:

Plan regular fraud risk assessments and assess risks to determine a fraud risk profile

Source: GAO. | GAO-18-88

The *assess* component of the Fraud Risk Framework calls for federal managers to plan regular fraud risk assessments and to assess risks to determine a fraud risk profile.[55] Identifying fraud risks is one of the steps included in the Fraud Risk Framework for assessing risks to determine a fraud risk profile.

CMS has taken steps to identify some fraud risks through several control activities that target areas the agency has designated as higher risk within Medicare and Medicaid, including specific provider types, such as home health agencies, and specific geographic locations. As discussed earlier, CMS officials told us that CPI initially focused on developing control activities for Medicare FFS and considers these activities to be the most mature of all CPI efforts to address fraud risks. CMS has identified fraud risks in the following selected examples, which are not an exhaustive list of its control activities.

Data analytics to assist investigations in Medicare FFS. In 2011, CMS implemented FPS, a data-analytic system that screens all Medicare FFS claims to identify health-care providers with suspect billing patterns for further investigation. Medicare FFS contractors—ZPICs and UPICs— have used FPS to identify and prioritize leads for investigations of potential fraud by high-risk Medicare FFS providers.[56] Contractors told us that FPS allows them to quickly identify and triage leads. CMS's guidance requires contractors to prioritize investigations with the greatest program

---

[55]According to the Fraud Risk Framework, a fraud risk profile documents the findings from a fraud risk assessment. We discuss this concept later in the report.

[56]We recently reported that about 20 percent of ZPIC investigations in fiscal years 2015 and 2016 were initiated based on FPS leads. The proportion of investigations based on FPS is poised to increase as CMS transitions the ZPICs to the UPICs, with 45 percent of new investigations coming from FPS. According to ZPIC officials, this new requirement should allow the UPICs flexibility to focus their reviews on the FPS leads that are most applicable to their geographic region. See GAO-17-710.

impact or urgency and identifies required criteria for prioritizing investigations, such as patient abuse or harm, multistate fraud, and high dollar amount of potential overpayments. One contractor we interviewed developed a risk-prioritization model that incorporated CMS's required criteria, such as patient harm, as well as additional criteria, such as provider spikes in billing, into a tool that automatically creates a provider risk score to help the contractor focus and prioritize investigative resources.

Prior authorization for Medicare FFS services or supplies. CMS published a final rule in December 2015 that identifies a master list of durable medical equipment, prosthetics, orthotics, and supplies for which CMS can require prior authorization before suppliers submit a Medicare FFS claim. In this rule, CMS identified 135 items that are frequently subject to unnecessary utilization and stated that the agency expects the final rule to result in savings in the form of reduced unnecessary utilization, fraud, waste, and abuse. Under this program, prior authorization is a condition of payment for claims. CMS can choose which items on the master list to subject to prior authorization. For example, in March 2017, it began requiring prior authorization for selected power wheelchairs in four states and expanded the prior authorization program for these items to all states in July 2017.

CMS also began to test the use of prior authorization on a voluntary basis through a series of fixed-length demonstrations for items and services that have been associated with high levels of improper payments, including high incidences of fraud in some cases, and unnecessary utilization in certain geographic areas. For example, CMS began implementing a voluntary prior authorization demonstration in September 2012 for other power mobility devices, such as power scooters, in seven states where historically there has been extensive evidence of fraud and improper payments.[57] CMS expanded the demonstration to an additional 12 states in October 2014, for a total of 19 states. According to the initial Federal Register notice, CMS planned to use the demonstration to develop improved methods for investigation and prosecution of fraud to protect federal funds from fraudulent actions and the resulting improper

---

[57]In the Federal Register notice announcing the power mobility demonstration, CMS cited Medicare Fraud Strike Force Teams' data as part of the basis for the demonstration. CMS has additional prior authorization models, for example, a 3-year demonstration for nonemergent hyperbaric oxygen therapy, which began in March 2015.

payments.[58] Under the demonstration, providers and suppliers are encouraged—but not required—to submit a request for prior authorization for certain items before they provide the item to the beneficiary and submit a claim for payment.[59]

Revised provider screening and enrollment processes for Medicare FFS and Medicaid FFS. In response to PPACA, in 2011 CMS implemented a revised screening process for providers and suppliers who enroll in Medicare and Medicaid based on identified provider risk categories.[60] CMS placed all Medicare provider and supplier types into one of three risk categories—limited, moderate, or high—based on its assessment of the potential risk of fraud, waste, and abuse each provider and supplier type poses. For example, CMS designated prospective (newly enrolling) home health agencies and prospective suppliers of durable medical equipment, prosthetics, orthotics, and supplies in the high-risk category. According to the final rule and our interviews with CMS officials, CMS developed these risk-based categories based on its review and synthesis of various information sources about the fraud risks posed by each provider and supplier type, including (1) the agency's experience with claims data used to identify potentially fraudulent billing practices, (2) expertise of contractors responsible for investigating and identifying Medicare fraud, and (3) GAO and OIG reports.[61] CMS designated specific screening activities for each risk category, with increased requirements

---

[58]77 Fed. Reg. 46,439 (Aug. 3, 2012). In 2015, the Director of CPI testified that before implementation of this demonstration, CMS's work found that over 80 percent of claims for power mobility devices did not meet Medicare coverage requirements. See Dr. Shantanu Agrawal, Deputy Administrator, and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, testimony before the House Committee on Oversight and Government Reform, 114th Cong., 1st sess., February 11, 2015.

[59]Claims submitted without a prior-authorization decision are to undergo prepayment review and are subject to a 25 percent reduction in payment if they are determined payable.

[60]76 Fed. Reg. 5,862 (Feb. 2, 2011) (codified at 42 C.F.R. Parts 405, 424, 447, 455, 457, and 498).

[61]Medicaid provider types that also exist in Medicare must be assigned to the same or higher risk category applicable to Medicare. For Medicaid-only providers, CMS guidance requires the state Medicaid agency to assign such providers to an appropriate risk level and recommends that the state Medicaid agency assess provider risk using similar considerations to those that CMS used to assess risk in Medicare provider and supplier types, including GAO or OIG reports, insight of law-enforcement partners, and level of administrative enforcement actions, among others. See CMS, *Medicaid Provider Enrollment Compendium*.

for moderate- and high-risk provider and supplier types. For example, moderate- and high-risk providers and suppliers must receive preenrollment site visits, and high-risk providers and suppliers also are subject to fingerprint-based criminal-background checks.[62] As part of the revised screening process, beginning in September 2011, CMS also undertook its first program-wide effort to rescreen, or revalidate, the enrollment records of about 1.5 million existing Medicare FFS providers and suppliers, to determine whether they remain eligible to bill Medicare.[63]

Temporary provider enrollment moratoriums for certain providers and geographic areas for Medicare FFS and Medicaid FFS. CMS identified certain provider types and geographic areas as high risk for fraud and used its authority under PPACA to implement temporary moratoriums to suspend enrollment of such Medicare and Medicaid providers in those areas. For example, in July 2016, CMS extended temporary moratoriums statewide on the enrollment of new Medicare Part B nonemergency ambulance suppliers and Medicare home health agencies statewide in six states, as applicable. The statewide moratoriums also apply to Medicaid.[64] According to the Federal Register notice, CMS imposed the

---

[62]Our prior work indicated that this requirement may address some of the potentially fraudulent or improper payments. See GAO, *Medicaid: CMS Has Taken Steps, but Further Efforts Are Needed to Control Improper Payments*, GAO-17-386T (Washington, D.C.: Jan. 31, 2017). In addition, CMS has implemented some modifications to its screening procedures since March 2011, such as increased site visits for limited-risk providers and continuous criminal monitoring reports. The act also allows for some movement of individual providers from the limited- or moderate-risk categories to the high-risk category, for reasons such as having Medicare billing privileges revoked at any time within the past 10 years. See GAO-17-42. Additionally, CMS officials also told us the agency began a special project that uses data analytics to identify high-risk Medicare FFS providers in Florida for additional screening. According to a 2016 report, from July 1, 2015, through September 30, 2016, a contractor covering Florida had conducted 9,891 site visits to verify providers' and suppliers' operational status, deactivated 422 practice locations, and revoked or denied 1,157 providers.

[63]This program-wide revalidation effort was implemented in three phases, from September 2011 through March 2015. CMS began the second program-wide (Medicare FFS) revalidation effort in March 2016. See GAO-17-42. For Medicaid, states must also revalidate the enrollment of all Medicaid providers at least every 5 years.

[64]In addition to Medicare and Medicaid, the statewide moratoriums also apply to CHIP. These statewide moratoriums have been extended in 6-month increments, with the most-recent extension announced in July 2017. 82 Fed. Reg. 35,122 (July 28, 2017) (codified at 42 C.F.R. Part 424).

temporary moratoriums based on qualitative and quantitative factors suggesting a high risk of fraud, waste, or abuse, such as law-enforcement expertise with emerging fraud trends and investigations. CMS's data analysis also confirmed the agency's determination of a high risk of fraud, waste, and abuse for these provider and supplier types within certain geographic areas, according to the notice.[65]

Medicaid state program integrity reviews and desk reviews. CMS tailored state Medicaid program-integrity reviews to areas it identified as high risk for improper payments, such as personal care services, which may also be at high risk for fraud.[66] In March 2017, we reported that, from fiscal years 2014 through 2016, CMS conducted focused reviews of state program-integrity efforts in 31 states, reviewing 10 or 11 states annually.[67] For each state, CMS tailored its focused reviews to the state's managed care plans and relevant other high-risk areas, including provider enrollment and screening, nonemergency medical transportation, and personal care services. CMS and state officials we spoke with as part of that work told us that the tailored oversight had been beneficial and helped identify areas for improvement. CMS has also initiated desk reviews of state program-integrity efforts. According to CMS, these desk reviews allow the agency to provide states with customized program-integrity oversight.

Vulnerability tracking system for Medicare. CPI recently initiated an effort to centralize and formalize a vulnerability tracking process for Medicare, which could support identification of specific fraud risks, both in Medicare and possibly Medicaid.[68] As described by CPI officials, the process aims

---

[65]81 Fed. Reg. 51,120 (Aug. 3, 2016) (codified at 42 C.F.R. Parts 424 and 455).

[66]HHS OIG testified in May 2017 that persistent vulnerabilities in personal care services contribute to significant fraud and place beneficiaries at risk for abuse and neglect. See Christi A. Grimm, Chief of Staff, Office of Inspector General, Department of Health and Human Services, *Combating Waste, Fraud, and Abuse in Medicaid's Personal Care Services Program*, testimony before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, 115th Cong., 1st sess., May 2, 2017. We have also testified on the risks of this Medicaid benefit, including instances where services for which the state was billed were not provided. See GAO, *Medicaid Personal Care Services: More Harmonized Program Requirements and Better Data Are Needed*, GAO-17-598T (Washington, D.C.: May 2, 2017).

[67]GAO-17-277.

[68]We did not evaluate the effectiveness of this effort as, at the time of our review, CMS's work to establish a vulnerability tracking process was ongoing.

to collect information on fraud-related vulnerabilities from CMS employees, contractors, and other sources, such as GAO and HHS OIG reports.

CMS Has Not Conducted a Fraud Risk Assessment for Medicare or Medicaid

Fraud Risk Framework Component:

Plan regular fraud risk assessments and assess risks to determine a fraud risk profile

Source: GAO. | GAO-18-88

The *assess* component of the Fraud Risk Framework calls for federal managers to plan regular fraud risk assessments and assess risks to determine a fraud risk profile. Furthermore, federal internal control standards call for agency management to assess the internal and external risks their entities face as they seek to achieve their objectives. The standards state that, as part of this overall assessment, management should consider the potential for fraud when identifying, analyzing, and responding to risks.[69]
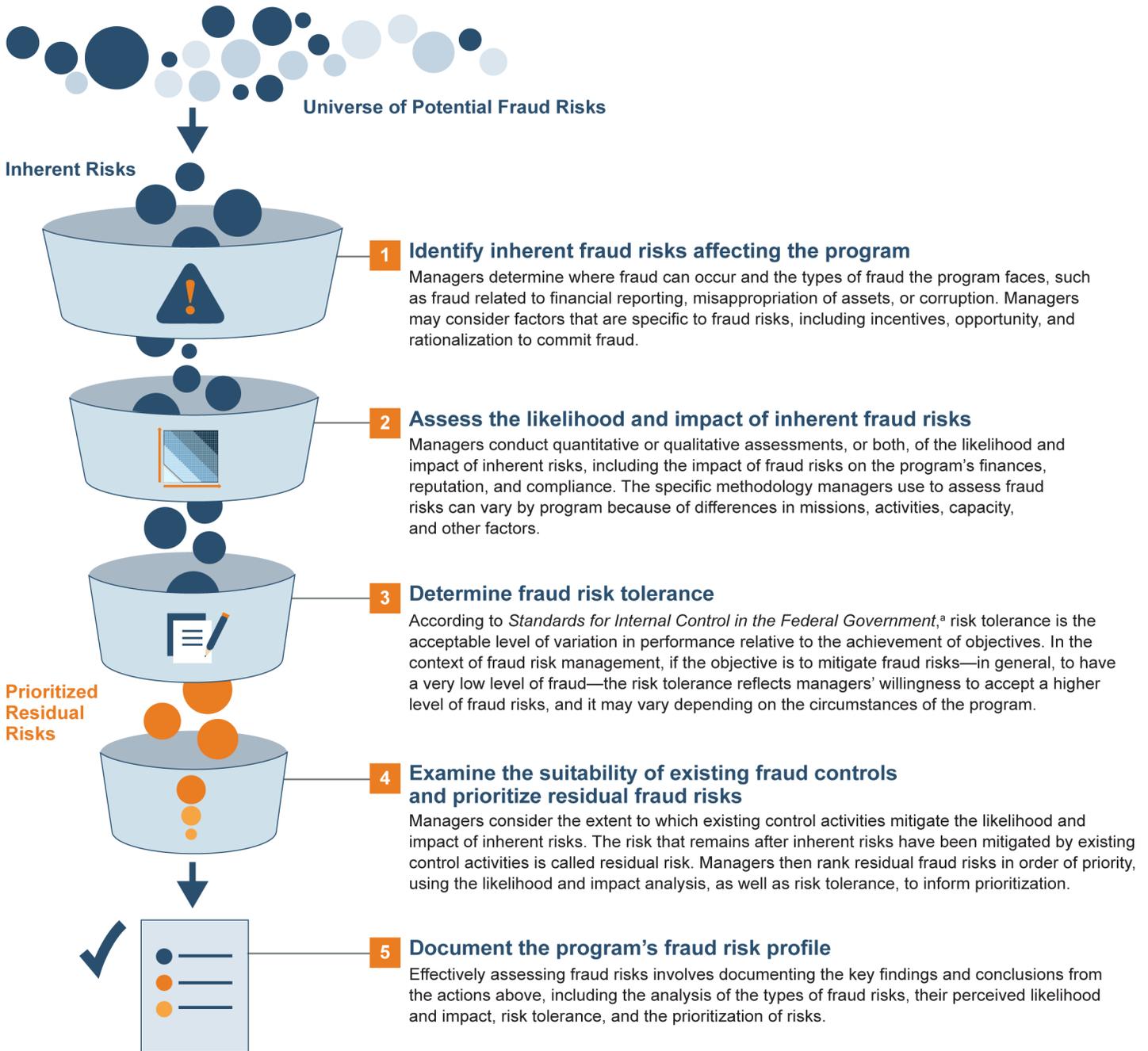
The Fraud Risk Framework states that, in planning the fraud risk assessment, effective managers tailor the fraud risk assessment to the program by, among other things, identifying appropriate tools, methods, and sources for gathering information about fraud risks and involving relevant stakeholders in the assessment process. Fraud risk assessments that align with the Fraud Risk Framework involve (1) identifying inherent fraud risks affecting the program, (2) assessing the likelihood and impact of those fraud risks, (3) determining fraud risk tolerance, (4) examining the suitability of existing fraud controls and prioritizing residual fraud risks, and (5) documenting the results. (See fig. 6.)

Although, as discussed earlier, CMS has identified some fraud risks posed by providers in Medicare FFS and, to a lesser degree, Medicaid FFS, the agency has not conducted a fraud risk assessment for either the Medicare or Medicaid program. Such a risk assessment would provide the detailed information and insights needed to create a fraud risk profile, which, in turn, is the basis for creating an antifraud strategy.

---

[69]GAO-14-704G.

Figure 6: Key Elements of the Fraud Risk Assessment Process

Universe of Potential Fraud Risks

Inherent Risks

1 **Identify inherent fraud risks affecting the program**

Managers determine where fraud can occur and the types of fraud the program faces, such as fraud related to financial reporting, misappropriation of assets, or corruption. Managers may consider factors that are specific to fraud risks, including incentives, opportunity, and rationalization to commit fraud.

2 **Assess the likelihood and impact of inherent fraud risks**

Managers conduct quantitative or qualitative assessments, or both, of the likelihood and impact of inherent risks, including the impact of fraud risks on the program's finances, reputation, and compliance. The specific methodology managers use to assess fraud risks can vary by program because of differences in missions, activities, capacity, and other factors.

3 **Determine fraud risk tolerance**

According to *Standards for Internal Control in the Federal Government*,[a] risk tolerance is the acceptable level of variation in performance relative to the achievement of objectives. In the context of fraud risk management, if the objective is to mitigate fraud risks—in general, to have a very low level of fraud—the risk tolerance reflects managers' willingness to accept a higher level of fraud risks, and it may vary depending on the circumstances of the program.

Prioritized Residual Risks

4 **Examine the suitability of existing fraud controls and prioritize residual fraud risks**

Managers consider the extent to which existing control activities mitigate the likelihood and impact of inherent risks. The risk that remains after inherent risks have been mitigated by existing control activities is called residual risk. Managers then rank residual fraud risks in order of priority, using the likelihood and impact analysis, as well as risk tolerance, to inform prioritization.

5 **Document the program's fraud risk profile**

Effectively assessing fraud risks involves documenting the key findings and conclusions from the actions above, including the analysis of the types of fraud risks, their perceived likelihood and impact, risk tolerance, and the prioritization of risks.

Source: GAO. | GAO-18-88

[a]GAO, Standards for Internal Control in the Federal Government, GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

According to CMS officials, CMS has not conducted a fraud risk assessment for Medicare or Medicaid because, within CPI's broader approach of preventing and eliminating improper payments, its focus has been on addressing specific vulnerabilities among provider groups that have shown themselves particularly prone to fraud, waste, and abuse. With this approach, however, it is unlikely that CMS will be able to design and implement the most-appropriate control activities to respond to the full portfolio of fraud risks.

A fraud risk assessment consists of discrete activities that build upon each other. Specifically:

- *Identifying inherent fraud risks affecting the program*. As discussed earlier, CMS has taken steps to identify fraud risks. However, CMS has not used a process to identify inherent fraud risks from the universe of potential vulnerabilities facing Medicare and Medicaid programs, including threats from various sources. According to CPI officials, most of the agency's fraud control activities are focused on fraud risks posed by providers. The Fraud Risk Framework discusses fully considering inherent fraud risks from internal and external sources in light of fraud risk factors such as incentives, opportunities, and rationalization to commit fraud. For example, according to CMS officials, the inherent design of the Medicare Part C program may pose fraud risks that are challenging to detect.[70] A fraud risk assessment would help CMS identify all sources of fraudulent behaviors, beyond threats posed by providers, such as those posed by health-insurance plans, contractors, or employees.

- *Assessing the likelihood and impact of fraud risks and determining fraud risk tolerance*. CMS has taken steps to prioritize fraud risks in some areas, but it has not assessed the likelihood or impact of fraud risks or determined fraud risk tolerance across all parts of Medicare and Medicaid. Assessing the likelihood and impact of inherent fraud risks would involve consideration of the impact of fraud risks on program finances, reputation, and compliance. Without assessing the likelihood and impact of risks in Medicare or Medicaid or internally determining which fraud risks may fall under the tolerance threshold,

---

[70]In Medicare Part C, health-insurance plans may pose a fraud risk, as shown by recent legal settlement. See Freedom Health case, Department of Justice, *Medicare Advantage Organization and Former Chief Operating Officer to Pay $32.5 Million to Settle False Claims Act Allegations,* accessed May 31, 2017, https://www.justice.gov/opa/pr/medicare-advantage-organization-and-former-chief-operating-officer-pay-325-million-settle.

GAO-18-88 CMS Fraud Risk Management

CMS cannot be certain that it is aware of the most-significant fraud risks facing these programs and what risks it is willing to tolerate based on the programs' size and complexity.

- *Examining the suitability of existing fraud controls and prioritizing residual fraud risks*. CMS has not assessed existing control activities or prioritized residual fraud risks. According to the Fraud Risk Framework, managers may consider the extent to which existing control activities—whether focused on prevention, detection, or response—mitigate the likelihood and impact of inherent risks and whether the remaining risks exceed managers' tolerance. This analysis would help CMS to prioritize residual risks and to determine mitigation approaches. For example, CMS has not established preventive fraud control activities in Medicare Part C. Using a fraud risk assessment for Medicare Part C and closely examining existing fraud control activities and residual risks, CMS could be better positioned to address fraud risks facing this growing program and develop preventive control activities. Further, without assessing existing fraud control activities and prioritizing residual fraud risks, CMS cannot be assured that its current control activities are addressing the most-significant risks. Such analysis would also help CMS determine whether additional, preferably preventive, fraud controls are needed to mitigate residual risks, make adjustments to existing control activities, and potentially scale back or remove control activities that are addressing tolerable fraud risks.

- *Documenting the risk-assessment results in a fraud risk profile*. CMS has not developed a fraud risk profile that documents key findings and conclusions of the fraud risk assessment. According to the Fraud Risk Framework, the risk profile can also help agencies decide how to allocate resources to respond to residual fraud risks. Given the large size and complexity of Medicare and Medicaid, a documented fraud risk profile could support CMS's resource-allocation decisions as well as facilitate the transfer of knowledge and continuity across CMS staff and changing administrations.

Senior CPI officials told us that the agency plans to start a fraud risk assessment for Medicare and Medicaid after it completes a separate fraud risk assessment of the federally facilitated marketplace. This fraud risk assessment for the federally facilitated marketplace eligibility and enrollment process is being conducted in response to a recommendation we made in February 2016.[71] In April 2017, CPI officials told us that this

---

[71]GAO-16-29.

fraud risk assessment was largely completed, although in September 2017 CPI officials told us that the assessment was undergoing agency review. CPI officials told us that they have informed CM and CMCS officials that there will be future fraud risk assessments for Medicare and Medicaid; however, they could not provide estimated timelines or plans for conducting such assessments, such as the order or programmatic scope of the assessments.

Once completed, CMS could use the federally facilitated marketplace fraud risk assessment and apply any lessons learned when planning for and designing fraud risk assessments for Medicare and Medicaid. According to the Fraud Risk Framework, factors such as size, resources, maturity of the agency or program, and experience in managing risks can influence how the entity plans the fraud risk assessment. Additionally, effective managers tailor the fraud risk assessment to the program when planning for it. The large scale and complexity of Medicare and Medicaid as well as time and resources involved in conducting a fraud risk assessment underscore the importance of a well-planned and tailored approach to identifying the assessment's programmatic scope. Planning and tailoring may involve decisions to conduct a fraud risk assessment for Medicare and Medicaid programs as a whole or divided into several subassessments to reflect their various component parts (e.g., Medicare FFS, Medicaid managed care) as well as determining the timing and order of assessments (e.g., concurrently or consecutively for Medicare and Medicaid).

CMS's existing fraud risk identification efforts as well as communication channels with stakeholders could serve as a foundation for developing a fraud risk assessment for Medicare and Medicaid. The leading practices identified in the Fraud Risk Framework discuss the importance of identifying appropriate tools, methods, and sources for gathering information about fraud risks and involving relevant stakeholders in the assessment process. CMS's fraud risk identification efforts discussed earlier could provide key information about fraud risks and their likelihood and impact. Further, existing relationships and communication channels across CMS and its extensive network of stakeholders could support building a comprehensive understanding of known and potential fraud risks for the purposes of a fraud risk assessment. For example, the fraud vulnerabilities identified through data analysis and information sharing with states, health-insurance plans, law-enforcement organizations, and contractors through the HFPP could inform a fraud risk assessment. CPI's Command Center missions—facilitated collaboration sessions that bring together experts from various disciplines to improve the processes

for fraud prevention in Medicare and Medicaid[72]—could bring together experts to identify potential or emerging fraud vulnerabilities or to brainstorm approaches to mitigate residual fraud risks.

As CMS makes plans to move forward with a fraud risk assessment for Medicare and Medicaid, it will be important to consider the frequency with which the fraud risk assessment would need to be updated. While, according to the Fraud Risk Framework, the time intervals between updates can vary based on the programmatic and operating environment, assessing fraud risks on an ongoing basis is important to ensure that control activities are continuously addressing fraud risks. The constantly evolving fraud schemes, the size of the programs in terms of beneficiaries and expenditures, as well as continual changes in Medicare and Medicaid programs—such as development of innovative payment models and increasing managed-care enrollment—call for constant vigilance and regular updates to the fraud risk assessment.

---

[72]According to CMS, the Command Center opened in July 2012 and provides an opportunity for Medicare and Medicaid policy experts, law-enforcement officials from OIG and the Federal Bureau of Investigation, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads in real time. In fiscal year 2015, CMS conducted 41 Command Center missions.

CMS Has Not Developed a Risk-Based Antifraud Strategy for Medicare and Medicaid, Which Would Include Plans for Monitoring and Evaluation

CMS Has Not Developed a Risk-Based Antifraud Strategy

Fraud Risk Framework Component:

Design and implement a strategy with specific control activities to mitigate assessed fraud risks and collaborate to help ensure effective implementation

Source: GAO. | GAO-18-88

The *design and implement* component of the Fraud Risk Framework calls for federal managers to design and implement a strategy with specific control activities to mitigate assessed fraud risks and collaborate to help ensure effective implementation.

According to the Fraud Risk Framework, effective managers develop and document an antifraud strategy that describes the program's approach for addressing the prioritized fraud risks identified during the fraud risk assessment, also referred to as a risk-based antifraud strategy. A risk-based antifraud strategy describes existing fraud control activities as well as any new fraud control activities a program may adopt to address residual fraud risks. In developing a strategy and antifraud control activities, effective managers focus on fraud prevention over detection, develop a plan for responding to identified instances of fraud, establish collaborative relationships with stakeholders, and create incentives to help effectively implement the strategy. Additionally, as part of a documented strategy, management identifies roles and responsibilities of those involved in fraud risk management activities; describes control activities as well as plans for monitoring and evaluation, creates timelines, and communicates the antifraud strategy to employees and stakeholders, among other things.

As discussed earlier, CMS has some control activities in place to identify fraud risk in Medicare and Medicaid, particularly in the FFS program.[73] However, CMS has not developed and documented a risk-based antifraud strategy to guide its design and implementation of new antifraud activities and to better align and coordinate its existing activities to ensure it is targeting and mitigating the most-significant fraud risks.

---

[73]The individual CMS fraud control activities and other antifraud efforts we describe in the report serve as examples of CMS activities; we did not evaluate the effectiveness of these efforts.

Antifraud strategy. CMS officials told us that CPI does not have a documented risk-based antifraud strategy. Although CMS has developed several documents that describe efforts to address fraud,[74] the agency has not developed a risk-based antifraud strategy for Medicare and Medicaid because, as discussed earlier, it has not conducted a fraud risk assessment that would serve as a foundation for such strategy.

In 2016, CPI identified five strategic objectives for program integrity, which include antifraud elements and an emphasis on prevention.[75] However, according to CMS officials, these objectives were identified from discussions with CMS leadership and various stakeholders and not through a fraud risk assessment process to identify inherent fraud risks from the universe of potential vulnerabilities, as described earlier and called for in the leading practices. These strategic objectives were presented at an antifraud conference in 2016,[76] but were not announced publicly until the release of the *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2015* in June 2017.

Stakeholder relationships and communication. CMS has established relationships and communicated with stakeholders, but, without an antifraud strategy, stakeholders we spoke with lacked a common understanding of CMS's strategic approach. Prior work on practices that can help federal agencies collaborate effectively calls for a strategy that is shared with stakeholders to promote trust and understanding.[77] Once an antifraud strategy is developed, the Fraud Risk Framework calls for managers to collaborate to ensure effective implementation. Although

---

[74]Centers for Medicare & Medicaid Services, *New Strategic Direction and Key Antifraud Activities* (Nov. 3, 2011); *Comprehensive Medicaid Integrity Plan: Fiscal Years 2014-2018*; *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2015*; *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Years 2013 and 2014*; *CMS Medicare and Medicaid Program Integrity Strategy* (Mar. 3, 2013).

[75]The five strategic objectives are: (1) address the full spectrum of fraud, waste, and abuse; (2) proactively manage provider screening and enrollment; (3) continue to build states' capacity to protect Medicaid; (4) extend work in Medicare Parts C and D, Medicaid managed care, and the Marketplace; and (5) provide greater transparency into program-integrity issues.

[76]National Health Care Anti-Fraud Association conference in Atlanta, Georgia, November 15–18, 2016.

[77]GAO, *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, GAO-03-669 (Washington, D.C.: July 2, 2003).

some CMS stakeholders were able to describe various CMS program-integrity priorities and activities, such as home health being a fraud risk priority, the stakeholders could not communicate, articulate, or cite a common CMS strategic approach to address fraud risks in its programs.

Incentives. The Fraud Risk Framework discusses creating incentives to help ensure effective implementation of the antifraud strategy once it is developed. Currently, some incentives within stakeholder relationships may complicate CMS's antifraud efforts. As discussed earlier, CMS is a partner and provides oversight to states' program-integrity functions. Officials from one state told us that they were reluctant to share their program vulnerabilities because CMS would use this information to later audit the state. Among contractors, CMS encourages information sharing through conferences and workshops; however, competition for CMS business among contractors can be a disincentive to information sharing. CMS officials acknowledged this concern and said that they expect contractors to share information related to fraud schemes, outcomes of investigations, and tips for addressing fraud, but not proprietary information such as algorithms to risk-score providers.

Without developing and documenting an antifraud strategy based on a fraud risk assessment, as called for in the *design and implement* component of the Fraud Risk Framework, CMS cannot ensure that it has a coordinated approach to address the range of fraud risks and to appropriately target and allocate resources for the most-significant risks. Considering fraud risks to which the Medicare and Medicaid programs are most vulnerable, in light of the malicious intent of those who aim to exploit the programs, would help CMS to examine its current control activities and potentially design new ones with recognition of fraudulent behavior it aims to prevent. This focus on fraud is distinct from a broader view of program integrity and improper payments by considering the intentions and incentives of those who aim to deceive rather than well-intentioned providers who make mistakes. Also, continued growth of the programs, such as growth of Medicare Part C and Medicaid managed care, call for consideration of preventive fraud control activities across the entire network of entities involved.

Further, considering the large size and complexity of Medicare and Medicaid and the extensive stakeholder network involved in managing fraud in the programs, a strategic approach to managing fraud risks within the programs is essential to ensure that a number of existing control activities and numerous stakeholder relationships and incentives are being aligned to produce desired results. Once developed, an antifraud

strategy that is clearly articulated to various CMS stakeholders would help CMS to address fraud risks in a more coordinated and deliberate fashion. Thinking strategically about existing control activities, resources, tools, and information systems could help CMS to leverage resources while continuing to integrate Medicare and Medicaid program-integrity efforts along functional lines. A strategic approach grounded in a comprehensive assessment of fraud risks could also help CMS to identify future enhancements for existing control activities, such as new preventive capabilities for FPS or additional fraud factors in provider enrollment and revalidation, such as provider risk scoring, to stay in step with evolving fraud risks.

CMS Has Established Monitoring and Evaluation Mechanisms That Could Inform a Risk-Based Antifraud Strategy for Medicare and Medicaid

Fraud Risk Framework Component:
Evaluate outcomes using a risk-based approach and adapt activities to improve fraud risk management

Source: GAO. | GAO-18-88

The *evaluate and adapt* component of the Fraud Risk Framework calls for federal managers to evaluate outcomes using a risk-based approach and adapt activities to improve fraud risk management. Furthermore, according to federal internal control standards, managers should establish and operate monitoring activities to monitor the internal control system and evaluate the results, which may be compared against an established baseline.[78] Ongoing monitoring and periodic evaluations provide assurances to managers that they are effectively preventing, detecting, and responding to potential fraud.

CMS has established monitoring and evaluation mechanisms for its program-integrity activities that it could incorporate into an antifraud strategy.

In Medicare, CMS has taken steps to measure the rate of fraud in a particular service area. We have previously reported that agencies may face challenges measuring outcomes of fraud risk management activities in a reliable way. These challenges include the difficulty of measuring the extent of deterred fraud, isolating potential fraud from legitimate activity or other forms of improper payments, and determining the amount of undetected fraud.[79] Despite these challenges, CMS has taken steps to estimate a fraud baseline—meaning the rate of probable fraud—in the home health benefit. In fiscal year 2016, CMS conducted a pretest in the Miami-Dade area of Florida to evaluate its potential measurement approach that could later be used in a nationwide study of probable fraud among home health agencies. The pretest was not a random sample and

---

[78]GAO-14-704G.

[79]GAO-15-593SP.

was not intended to produce a rate of fraud, but instead was intended to test the interview instruments and data-collection methodology CMS might use in a study nationwide. CMS and its contractor collected information from home health agencies, the attending providers, and Medicare beneficiaries in the Miami-Dade area in order to test these interview instruments. CMS completed this pretest, but, according to CMS officials, the agency does not yet have plans to roll out a nationwide study that would estimate a probable fraud rate for the Medicare FFS home health benefit.

In its 2015 annual report to Congress, CMS stated that "documenting the baseline amount of fraud in Medicare is of critical importance, as it allows officials to evaluate the success of ongoing fraud prevention activities."[80] CMS officials working on the pilot told us that having an estimate of the rate of fraud in home health benefits would allow CMS to reliably assess its efforts at eliminating or reducing fraud. Without a baseline, officials said, the agency cannot know whether its antifraud efforts are as effective as they could be. We previously reported that the lack of a baseline for the amount of health-care fraud that exists limits CMS's ability to determine whether its activities are effectively reducing health care fraud and abuse.[81] A baseline estimate could provide an understanding of the extent of fraud and, with additional information on program activities, could help to inform decision making related to allocation of resources to combat health-care fraud.

As described in the Fraud Risk Framework, in the absence of a fraud baseline, agencies can gather additional information on the short-term or intermediate outcomes of some antifraud initiatives, which may be more readily measured. For example, CMS has developed some performance measures to provide a basis for monitoring its progress towards meeting the program-integrity goals set in the HHS Strategic Plan and Annual Performance Plan. Specifically, CMS measures whether it is meeting its goal of "increasing the percentage of Medicare FFS providers and

---

[80]Centers for Medicare & Medicaid Services, *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2015.*

[81]GAO, *Health Care Fraud and Abuse Control Program: Indicators Provide Information on Program Accomplishments, but Assessing Program Effectiveness is Difficult*, GAO-13-746 (Washington, D.C.: Sept. 30, 2013).

suppliers identified as high risk that receive an administrative action."[82] CMS does not set specific antifraud goals for other parts of Medicare or Medicaid; other CMS performance measures relate to measuring or reducing improper payments in CHIP, Medicaid, and the various parts of Medicare.

CMS uses return-on-investment and savings estimates to measure the effectiveness of its Medicare program-integrity activities and FPS.[83] For example, CMS uses return-on-investment to measure the effectiveness of FPS[84] and, in response to a recommendation we made in 2012, CMS developed outcome-based performance targets and milestones for FPS.[85] CMS has also conducted individual evaluations of its program-integrity activities, such as an interim evaluation of the prior-authorization demonstration for power mobility devices that began in 2012 and is currently implemented in 19 states.

Commensurate with greater maturity of control activities in Medicare FFS compared to other parts of Medicare and Medicaid, monitoring and evaluation activities for Medicare Parts C and D and Medicaid are more limited. For example, CMS calculates savings for its program-integrity activities in Medicare Parts C and D, but not a full return-on-investment. CMS officials told us that calculating costs for specific activities is challenging because of overlapping activities among contractors. CMS officials said they continue to refine methods and develop new savings estimates for additional program-integrity activities.

---

[82]This performance metric refers to providers identified by FPS whose behavior is aberrant and potentially fraudulent. CMS can take a variety of administrative actions against those providers, from payment suspensions to revoking providers' billing privileges. CMS has met this goal from 2013 to 2015; the 2016 data are pending at the time of the writing of this report.

[83]We previously found flaws with CMS's return-on-investment calculation and made two recommendations regarding the methodology. CMS has implemented both of the recommendations. See GAO, *Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness*, GAO-11-592 (Washington, D.C.: July 29, 2011).

[84]HHS OIG has reviewed CMS's methodology and calculations and certified the use of adjusted savings, which in 2014 yielded the FPS return-on-investment of approximately 3 to 1.

[85]GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

According to the Fraud Risk Framework, effective managers develop a strategy and evaluate outcomes using a risk-based approach. In developing an effective strategy and antifraud activities, managers consider the benefits and costs of control activities. Ongoing monitoring and periodic evaluations provide reasonable assurance to managers that they are effectively preventing, detecting, and responding to potential fraud. Monitoring and evaluation activities can also support managers' decisions about allocating resources, and help them to demonstrate their continued commitment to effectively managing fraud risks.

As CMS takes steps to develop an antifraud strategy, it could include plans for refining and building on existing methods such as return-on-investment or savings measures, and setting appropriate targets to evaluate the effectiveness of all of CMS's antifraud efforts. Such a strategy would help CMS to efficiently allocate program-integrity resources and to ensure that the agency is effectively preventing, detecting, and responding to potential fraud. For example, while doing so would involve challenges, CMS's strategy could detail plans to advance efforts to measure a potential fraud rate through baseline and periodic measures. Fraud rate measurement efforts could also inform risk assessment activities, identify currently unknown fraud risks, align resources to priority risks, and develop effective outcome metrics for antifraud controls. Such a strategy would also help CMS ensure that it has effective performance measures in place to assess its antifraud efforts beyond those related to providers in Medicare FFS, and establish appropriate targets to measure the agency's progress in addressing fraud risks.

As CMS makes plans to move forward with a strategy and to further develop evaluation and monitoring mechanisms, it will be important to share its efforts with stakeholders. The Fraud Risk Framework states that effective managers communicate lessons learned from fraud risk management activities to stakeholders. For example, CMS could be a leader to states in measuring the effectiveness of program-integrity efforts. Officials in three of the four states we spoke with expressed interest in receiving CMS guidance on how to measure the effectiveness of their Medicaid program-integrity efforts, such as by providing models for how to calculate return-on-investment.

Conclusions

Medicare and Medicaid provide health insurance to over 129 million Americans, but the size—in terms of number of beneficiaries and amount of expenditures—as well as complexity of these programs make them

inherently susceptible to fraud and improper payments. CMS currently manages these risks across its programs as part of a broader approach to identifying and controlling for multiple sources of improper payments and by developing relationships with an extensive network of stakeholders. In Medicare and Medicaid specifically, we note that CMS has taken many important steps toward implementing a strategic approach for managing fraud. However, the agency could benefit by more fully aligning its efforts with the four components of the Fraud Risk Framework.

CMS is well positioned to leverage its fraud risk management efforts—such as demonstrated leadership for combating fraud, existing control activities, and stakeholder relationships—to provide additional antifraud training, as well as to develop an antifraud strategy based on fraud risk assessments for Medicare and Medicaid. We recognize that the effort may be challenging, given the size and complexity of Medicare and Medicaid, and the need to balance antifraud activities with CMS's other mission priorities. However, by not employing the actions identified in the Fraud Risk Framework and incorporating them in its approach to managing fraud risks, CMS is missing a significant opportunity to better ensure employee vigilance against fraud, and to organize and focus its many antifraud and program-integrity activities and related resources into a comprehensive strategy. Such a strategy would (1) provide reasonable assurance that CMS is targeting the most-significant fraud risks in its programs and (2) help protect the government's substantial and growing investments in these programs.

Recommendations for Executive Action

We are making the following three recommendations to CMS:

- The Administrator of CMS should provide fraud-awareness training relevant to risks facing CMS programs and require new hires to undergo such training and all employees to undergo training on a recurring basis. (Recommendation 1)

- The Administrator of CMS should conduct fraud risk assessments for Medicare and Medicaid to include respective fraud risk profiles and plans for regularly updating the assessments and profiles. (Recommendation 2)

- The Administrator of CMS should, using the results of the fraud risk assessments for Medicare and Medicaid, create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks. This strategy should

include an approach for monitoring and evaluation. (Recommendation 3)

Agency Comments

We provided a draft of this report to HHS and DOJ for comment. HHS provided written comments, which are reprinted in appendix I. DOJ did not have comments. HHS and DOJ also provided technical comments, which we incorporated as appropriate.

In commenting on this report, HHS agreed with our three recommendations. Specifically, in response to our first recommendation to provide required fraud-awareness training to all employees, HHS stated that it will develop and implement a fraud-awareness training plan to ensure all CMS employees receive training.

Regarding our second recommendation to conduct fraud risk assessments for Medicare and Medicaid, HHS stated that it is currently conducting a fraud risk assessment on the federally facilitated marketplace and, when this assessment is complete, will apply the lessons learned in assessing this program to fraud risk assessments of Medicare and Medicaid.

In response to our third recommendation to create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks, HHS stated that it will develop respective risk-based antifraud strategies after completing fraud risk assessments for Medicare and Medicaid.

We are sending copies of this report to the Acting Secretary of Health and Human Services, the Administrator of CMS, the Assistant Attorney General for Administration at DOJ, as well as appropriate congressional committees and other interested parties. In addition, this report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found

on the last page of this report. GAO staff who made contributions to this report are listed in appendix II.
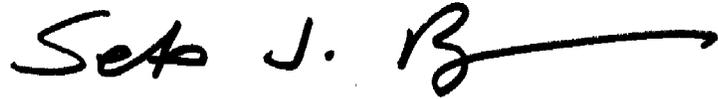
Seto J. Bagdoyan
Director of Audits
Forensic Audits and Investigative Service

List of Addressees

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Claire McCaskill
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Pat Tiberi
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Vern Buchanan
Chairman
Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Tom Cole
Chairman
Subcommittee on Labor, Health and Human Services, Education and
  Related Agencies
Committee on Appropriations
House of Representatives

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 1 3 2017

Seto Bagdoyan
Director, Forensic Audit & Investigative Service
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"Medicare and Medicaid: CMS Needs to Fully Align Its Efforts with Fraud Risk Framework"* (GAO-18-88).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED: MEDICARE AND MEDICAID: CMS NEEDS TO FULLY ALIGN
ITS EFFORTS WITH FRAUD RISK FRAMEWORK (GAO-18-88)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and
comment on this draft report. HHS takes seriously its commitment to safeguarding taxpayer
dollars and ensuring program integrity in the programs it administers.

As recommended by the Government Accountability Office (GAO), HHS is conducting a fraud
risk assessment on the federally facilitated exchanges, leveraging GAO's Fraud Risk
Framework. HHS is using this framework to identify and prioritize key areas for potential fraud
risk in the federally facilitated exchanges. As GAO notes in its report, HHS has taken many steps
to implement the four leading practices in GAO's Fraud Risk Framework. HHS is committed to
combating fraud by creating an organizational culture and structure conducive to fraud risk
management. In 2010, HHS established the Center for Program Integrity, an executive-level
center that serves as the dedicated entity for fraud, waste, and abuse issues for Centers for
Medicare and Medicaid Services (CMS) programs. In 2014, CMS established the Program
Integrity Board to help senior leadership across CMS coordinate on identifying and addressing
program integrity vulnerabilities. HHS has also steadily increased resources devoted to program
integrity, from $1.02 billion in 2010 to $1.45 billion in 2016.

HHS continuously works to ensure its stakeholders have effective support and assistance necessary
to combat fraud. HHS offers substantive training, technical assistance, and support to states in a
structured learning environment through the Medicaid Integrity Institute, which trains state
Medicaid program integrity employees on the fundamentals of program integrity activities and
emerging program integrity issues. To improve efficiency and coordination of federal data
analysis, audits, and investigations, HHS is consolidating multiple contractors that work on
program integrity issues in Medicare and Medicaid into Unified Program Integrity Contractors.
In 2012, HHS established a voluntary public-private partnership between the federal
government, state agencies, law enforcement, private health insurance plans, and healthcare anti-
fraud associations, called the Healthcare Fraud Prevention Partnership. This partnership fosters a
proactive approach to detecting and preventing healthcare fraud through cross-payer studies and
information sharing.

HHS also identifies and assesses program integrity vulnerabilities in Medicare and Medicaid,
and designs and implements strategies to mitigate those risks. HHS monitors improper payment
rates in Medicare and Medicaid, and develops and implements corrective actions for high-
priority programs. Corrective actions can include service- or provider-specific edits, prepayment
or post-payment medical review of claims, and provider education. HHS has incorporated
program integrity designs in the development of new programs focusing on quality payment and
alternative payment methods and is working on a variety of risk assessments and risk profiles to
develop program-specific risk mitigation strategies and overall risk reduction.

In Medicare, HHS has implemented categorical risk-based screening of newly enrolling
Medicare providers and suppliers. Due to these efforts, HHS avoided $2.4 billion in Medicare
payments to ineligible providers and suppliers from March 2011 to May 2015. HHS' Fraud
Prevention System, a sophisticated predictive analytics technology designed to prevent and
detect fraud, waste, and abuse in the Medicare Fee-for-Service program, has helped identify or
prevent $1.47 billion in inappropriate payments since it was implemented in 2011. HHS has also

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED: MEDICARE AND MEDICAID: CMS NEEDS TO FULLY ALIGN
ITS EFFORTS WITH FRAUD RISK FRAMEWORK (GAO-18-88)

implemented prior authorization models and demonstrations for certain services at high risk of
improper payments, including fraud, and temporary provider enrollment moratoria for certain
provider and supplier types in specified geographic areas in order to prevent and combat fraud,
waste, and abuse.

In Medicaid, HHS is supporting states' efforts to implement categorical risk-based screening of
newly enrolling Medicaid providers. HHS published and continues to update the Medicaid
Provider Enrollment Compendium to help states in implementing various provider enrollment
requirements including provider site visit and fingerprint-based criminal background check
requirements. State program integrity reviews help HHS provide effective support and assistance
to states in their efforts to combat fraud, waste, and abuse. Through these reviews, HHS assesses
the effectiveness of states' program integrity efforts. Beginning in 2016, HHS also initiated desk
reviews of program integrity efforts in 41 states and the District of Columbia. Desk reviews
allow HHS to increase the number of states that receive customized program integrity oversight.
Medicaid Integrity Contractor audits also contribute to HHS's oversight of State Medicaid
programs. From fiscal years 2012-2015, audits through the Medicaid Integrity Contractor
identified more than $147 million in potential overpayments.

HHS evaluates the outcomes of its program integrity activities and adapts those activities based
on the results. HHS monitors improper payment rates in Medicare and Medicaid, and
continuously adjusts the corrective actions it takes in response to those improper payment rates.
HHS also calculates savings from its provider enrollment activities and the Fraud Prevention
System, as well as from the work of Zone Program Integrity Contractors, Medicaid Integrity
Contractors, Unified Program Integrity Contractors, and the Medicare Drug Integrity Contractor.
In addition, HHS continuously monitors and evaluates prior authorization models and
demonstrations, as well as temporary provider enrollment moratoria, to ensure they are
implemented effectively. State program integrity reviews, desk reviews, and Medicaid Integrity
Contractor audits help HHS evaluate outcomes of program integrity activities in the Medicaid
program and implement corrective actions for identified vulnerabilities.

GAO's recommendations and HHS' responses are below.

GAO Recommendation
Provide required fraud-awareness training relevant to risks facing CMS programs for new hires
and all employees on an ongoing basis.

HHS Response
HHS concurs with GAO's recommendation. HHS will develop and implement a fraud awareness
training plan to ensure all CMS employees receive training.

GAO Recommendation
Conduct fraud risk assessments for Medicare and Medicaid to include respective fraud risk
profiles and plans for regularly updating the assessments and profiles.

2

<u>**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED: MEDICARE AND MEDICAID: CMS NEEDS TO FULLY ALIGN
ITS EFFORTS WITH FRAUD RISK FRAMEWORK (GAO-18-88)**</u>

<u>**HHS Response**</u>
HHS concurs with GAO's recommendation. HHS is currently conducting a fraud risk assessment
on the federally facilitated exchanges. When this assessment is complete, HHS will apply the
lessons learned in assessing this program to fraud risk assessments of Medicare and Medicaid.

<u>**GAO Recommendation**</u>
Create, document, implement, and communicate an antifraud strategy that is aligned with and
responsive to regularly assessed fraud risks. This strategy should include an approach for
monitoring and evaluation.

<u>**HHS Response**</u>
HHS concurs with GAO's recommendation. After completing fraud risk assessments for Medicare
and Medicaid, HHS will develop respective risk-based antifraud strategies.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and
other issues in the future.

3

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Seto J. Bagdoyan, (202) 512-6722 or bagdoyans@gao.gov

Staff Acknowledgments

In addition to the contact named above, Tonita Gillich (Assistant Director), Irina Carnevale (Analyst-in-Charge), Michael Duane, Laura Sutton Elsberg, and Catrin Jones made key contributions to this report. Also contributing to the report were Lori Achman, James Ashley, Colin Fallon, Leslie V. Gordon, Maria McMullen, Sabrina Streagle, and Shana Wallace.