U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

August 1, 2014

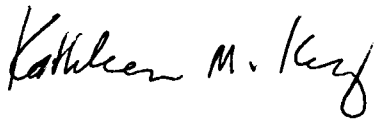
The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

Response to Questions for the Record from June 25, 2014 hearing "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"

Dear Mr. Chairman:

Enclosed please find our response to the questions you asked us regarding your June 25, 2014 hearing, "Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse." If you or your staff have any questions about this response, please contact me at (202) 512-7114 or kingk@gao.gov.

Sincerely yours,



Kathleen M. King
Director, Health Care

Enclosure - I

cc: The Honorable Diana DeGette
Ranking Member

Enclosure I

The Honorable Tim Murphy

1. Are Medicare contractors able to share such information with each other? For instance, if a patient or provider is suspected of fraud and they change plans during open enrollment would the plan a beneficiary is leaving be able to communicate with a plan they are joining about the suspected fraud?

In prior GAO work examining instances of questionable access to prescription drugs in the Medicare program,[1] CMS officials indicated that Medicare Part D plan sponsors are not allowed to share beneficiary information with other plans. GAO is unaware whether CMS applies this policy to Part C health plans.

CMS officials have reported that health plans receive fraud alerts from the agency describing information about reported fraud schemes, and representatives from the health plans are able to meet with CMS, NBI MEDIC, and law enforcement officials in quarterly Medicare Parts C and D Fraud Work Group meetings to share information about specific fraud schemes.

2. Medicare Administrative Contractors, known as "MACs" were created about a decade ago. Today they serve as the primary bill-payers for Medicare claims. Given that the bulk of Medicare reimbursements are processed by MACs, the bulk of improper payments are made by MACs. I know GAO is currently wrapping up work examining the work of the MACs. Do you have any early observations on your work that you can share with the Committee?

We have three research objectives for our current work on MACs: (1) How have the MAC contract costs and scope of responsibilities changed since the implementation of contractor reform?; (2) What alternative or additional contract incentives, if any, could CMS use to improve the operational efficiency and effectiveness of the MACs?; (3) What lessons learned, if any, since CMS implemented contractor reform could be used to increase MAC effectiveness and efficiency or to inform CMS's management of the MACs? We do not have early observations at this point, but expect to issue a report covering these objectives later this year.

3. GAO has conducted work looking at CMS's management of all program integrity contractors. GAO made several interesting findings, including the fact that CMS did not standardize its requirements for all contractors. One of the consistent findings from GAO's work over the years is that CMS will often sign a contract for a program integrity function, but either fail to measure the right functionality and activities from the contractor, or fail to assess progress as the contractor conducts the work. In what ways do you think the current contracting mechanism that CMS uses (which is subject to Federal Acquisition Rules), might hinder CMS's flexibility to manage the program well?

As noted in our work, CMS's requirements for certain contractors and its oversight activities could be improved, providing opportunities for CMS within its current contracting mechanism to improve its management of these contractors. As we reported in July 2013,[2] the differences in

[1]GAO, *Medicare Part D: Instances of Questionable Access to Prescription Drugs,* GAO-11-699 (Washington, D.C.: Sept. 6, 2011).

[2]GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*, GAO-13-522 (Washington, D.C.: July 23, 2013).

CMS's postpayment claims review requirements for four types of contractors may reduce the efficiency and effectiveness of claims reviews by complicating providers' compliance with the requirements. We recommended that CMS examine all postpayment review requirements for contractors to determine whether they could be made more consistent without negative effects on program integrity. We also recommended that CMS reduce differences in those requirements where it can be done without impeding the efficiency of its efforts to reduce improper payments. In our opinion, these recommendations can be implemented in a manner consistent with the Federal Acquisition Regulation, which provides agencies with the flexibility to develop contract requirements that best suit their needs. In commenting on that report, CMS agreed with our recommendations and stated that the agency was beginning to review its requirements for postpayment claims reviews. We are following up on this work with a study reviewing, among other things, whether CMS has strategies for coordinating postpayment review contractors' claims review activities. That report will be issued this summer.

Additionally, in October 2013,[3] GAO reported that CMS lacks information on the timeliness of Zone Program Integrity Contractors' (ZPIC) actions—such as the time it takes between identifying a suspect provider and taking actions to stop that provider from receiving potentially fraudulent Medicare payments—and would benefit from knowing if ZPICs could save more money by acting more quickly. Also, GAO found that CMS's evaluation of measures relating to the quality of ZPIC work, while a best practice, does not connect ZPIC work to agency performance measures. For example, CMS aims to increase the percentage of actions taken against certain high risk Medicare providers—work central to ZPICs—but does not explicitly link ZPICs' work to the agency's progress toward that goal, another best practice that would allow the agency to better assess the ZPICs' support of CMS's fraud prevention efforts. Consequently, GAO recommended that CMS collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions, and develop ZPIC performance measures that explicitly link ZPICs' work to Medicare program integrity performance measures and goals.

4. In other work conducted for Congress, GAO has found two models for managing some offices within HHS (not at CMS, but at FDA). In one approach, individual employees received a portion of their bonuses based on that employee's individual contribution toward stated agency goals. In the other approach, the office had a general commitment to achieving stated agency goals, but the individual employees' contribution toward those goals was not assessed. GAO also found that the latter office significantly failed to advance agency goals in a meaningful way.

In 2012, we issued a descriptive report that provided information on the standards that FDA considers when assessing the performance of its employees.[4] We found that timeliness goals for reviewing medical product applications—including applications to market a new drug or device in the United States—are one aspect that FDA may consider in assessing employee performance. We found that the extent to which these goals are reflected as explicit expectations in employee performance standards varies by an employee's duties, level of responsibility, and organizational component. However, we did not examine the relationship between bonus payments to employees and their contributions to agency goals. In addition, we did not compare different management approaches in determining employees' bonuses or

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[3]GAO, *Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight*, GAO-14-111 (Washington, D.C.: Oct. 25, 2013).

[4]GAO, *Food and Drug Administration: Employee Performance Standards for the Timely Review of Medical Product Applications,* GAO-12-650R (Washington, D.C.: Apr 18, 2012).

assessing employee performance. Accordingly, we did not report on the success or failure of such approaches.

a. Do you think there are any lessons in this management model for CMS's program integrity staff?

We have not conducted relevant work to answer this question.

b. Should the individuals who write or manage the contracts for program integrity contractors at CMS have some portion of their bonus held in reserve to be paid out based on the successfulness of the contractor actually reducing waste, fraud, and abuse?

Members of the CMS acquisition workforce who develop, award, and manage contracts – including program integrity contracts – seek to ensure that the agency obtains the goods and services it needs in a timely manner and at a fair price. They use a number of approaches to achieve that outcome, such as drafting clear requirements, seeking competition, and selecting reliable contractors. Through the use of these approaches, combined with informed contract monitoring, the agency expects that the selected contractor will perform as promised in the contract. For a contract to be successful, both the contractor and the agency do their part. Therefore, because success of a contract depends at least in part on factors outside the control of the agency, we believe it would not be appropriate to assess a monetary penalty against agency personnel merely because a contract within their purview is less than fully successful.

5. The CMS has agreed to postpone awarding the new round of Recovery Audit Contractor contracts until at least Aug. 15 because of pending litigation. This delay comes after numerous administrative changes and delays to the statutorily mandated program. Given the RACs record of recovering hundreds of millions, even billions, of dollars for the Medicare Trust Fund, does GAO have any concerns regarding the impact further administrative or legal delays may have on the effectiveness of the recoveries for the Medicare Trust Fund from the statutorily mandated program?

CMS has instituted a hiatus of the Medicare Fee-For-Service (FFS) Recovery Audit program for the current recovery audit contractors (RAC) as of June 1, 2014. The effect of the hiatus on the Medicare Trust Fund is unknown at this point. CMS has not made an announcement about new contractors. Under the current contractors, the RACs could review claims paid within the prior 3 years. Assuming CMS institutes the same look-back period under the new contracts, the new RACs will be able to review claims during the hiatus period.

6. What do you believe are the top 5 vulnerabilities with regard to the integrity of Medicaid payments?

While not exhaustive, GAO's work on Medicaid program integrity suggests several areas where additional actions could improve oversight of Medicaid payments. These areas include

- holding states accountable for, and providing updated guidance on, effective program integrity practices in Medicaid managed care;[5]

[5]GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014).

- ensuring that states correctly report overpayments identified by federal audits;[6]

- making use of knowledge gained from CMS reviews of states program integrity efforts to better target CMS audit resources towards states that have structural or data-analysis vulnerabilities;[7] and

- taking steps to integrate claims information and improve CMS's ability to detect fraud, waste, and abuse.[8]

The Honorable Tim Murphy

1. What is the likelihood of someone charged with Medicare fraud serving time in prison? What is the likelihood of someone charged with Medicare fraud paying a fine?

2. What is the success rate of Medicare fraud investigations?

We can't answer these questions specifically with respect to Medicare, but a recent GAO report provided some relevant information regarding fraud in Medicare, Medicaid and the Children's Health Insurance Program.[9]

- For criminal health fraud cases, we found that about 85 percent of subjects whose investigations were closed in 2010 were not referred for prosecution. Among those who were pursued by the Department of Justice, over 85 percent were convicted, pled guilty or pled no contest to some or all of the criminal charges against them. Among those found guilty, or who pled guilty or no contest, 60 percent were sentenced to incarceration and 48 percent were required to pay a fine.

- For civil fraud cases, we found that 47 percent of subjects whose investigations were closed in 2010 were pursued by the Department of Justice. The government obtained a favorable judgment or settlement against 55 percent of the subjects who were pursued. Finally, for those subjects with a judgment or settlement, 15 percent were required to pay a fine.

3. What additional data would be valuable to help you prescreen for Medicare fraud?

We think this question was intended for CMS, not GAO, since CMS is responsible for screening through enrollment for Medicare fraud.

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[6]GAO, *Medicaid: CMS Should Ensure That States Clearly Report Overpayments*, GAO-14-25 (Washington, D.C.: Dec. 6, 2013).

[7]GAO, *Medicaid Program Integrity: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, GAO-13-50 (Washington, D.C.: Nov. 13, 2012).

[8]GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

[9]GAO, *Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases*, GAO-12-820 (Washington, D.C.: Sept. 7, 2012).

The Honorable Bill Johnson

1. Are Medicare contractors able to share information with each other? For instance, if a patient or provider is suspected of fraud and they change plans during open enrollment would the plan a beneficiary is leaving be able to communicate with a plan they are joining about the suspected fraud?

In prior GAO work examining instances of questionable access to prescription drugs in the Medicare program,[10] CMS officials indicated that Medicare Part D plan sponsors are not allowed to share beneficiary information with other plans. GAO is unaware whether CMS applies this policy to Part C health plans.
CMS officials have reported that health plans receive fraud alerts from the agency describing information about reported fraud schemes, and representatives from the health plans are able to meet with CMS, NBI MEDIC, and law enforcement officials in quarterly Medicare Parts C and D Fraud Work Group meetings to share information about specific fraud schemes.

The Honorable Billy Long

1. What percentage of the 350,000 cases that will be adjudicated were initially correct and holding the money?

Until those appeals are adjudicated, information will not be available to determine whether the underlying determinations were upheld or overturned.

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[10]GAO, *Medicare Part D: Instances of Questionable Access to Prescription Drugs,* GAO-11-699 (Washington, D.C.: Sept. 6, 2011).