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Auditing Programs: Back to the Drawing Board?

Over the past several months, the Office of the Inspector General (OIG) has released several reports identifying problems with recent fraud and abuse programs created by the Centers for Medicare and Medicaid Services (CMS), pinpointing flaws in some of the methodologies for addressing healthcare fraud.[1] Reports regarding the *Medicaid Integrity Program*, the *Comprehensive Error Rate Testing* (CERT) *Program*, and the *Medicare-Medicaid Data Match* (Medi-Medi) *Program* collectively reflected the potential ineffectiveness of the programs and significant inaccuracies in their results.[2]

Created in 2006, the *Medicaid Integrity Program* was designed to address fraud, abuse, and waste by Medicaid providers.[3] Under the *Program*, CMS is responsible for hiring contractors to review billing activities by Medicaid providers, audit their claims, and identify any overpayments.[4] In its March 2012 report, the OIG assessed the efforts of the *Audit Medicaid Integrity Contractors* (MICs) in order to determine their effectiveness, as well as to identify any issues that existed in distinguishing overpayments.[5] Of 370 audits comprising a potential $80 million in overpayments, the OIG identified 81 percent that were audits in which the MICs were unable or unlikely to discover overpayments to Medicaid providers.[6] The remaining 11 percent of audits accounted for $6.9 million in overpayments, $6.2 million of which were attributed to program areas that had previously been identified (through collaborative audits) as vulnerable to overpayments.[7] The OIG concluded that the MICs' audits were hindered by CMS's selection of poorly identified audit targets, since MICs are not contracted to identify targets, but simply to audit those provided to them by CMS.[8] Audit targets were mistakenly selected based on either incorrect data or the improper application of state policies for identifying audit targets. MICs were further hindered by duplicate efforts due to poor target identification.[9]

In its recommendations, the OIG encouraged CMS to make greater use of collaborative audits where appropriate, as well as to improve its current process for identifying and selecting audit targets, especially where vulnerable program areas are identified.[10] In addition, the OIG recommended that CMS improve both the quality of, and the level of access to, data that MICs have when conducting their audits.[11] In its response, CMS agreed with the OIG's recommendations and stated that it had already encouraged the increased use of collaborative audits and that it has several projects in progress to improve the audit target selection process.[12] CMS also stated it has initiatives in place to improve communication and the quality of data available.[13] However, experts in the industry suggest the problems with MICs may be an indication of performance issues within the *Medicaid Recovery Audit Contractor Program*, as the complex regulations and lack of specific guidelines make it difficult for states to perform audits on Medicaid claims.[14]

The CERT Program was created by CMS in order to measure improper fee-for-service payments, measured by the difference between what Medicare reimbursed a provider and what CMS believes was the proper payment to that provider.[15] CMS uses the results of the CERT Program to provide Congress with an estimate of the annual amount of improper Medicare payments. The OIG suggested in a 2012 report that this estimate does not account for any payment errors that are overturned through the appeals process and may, therefore, inflate the number of improper payments made in a given year.[16] In its review of the error rates for FY 2009 and FY 2010, the OIG determined that based on the number of claim payment denials that were overturned on appeal after the cutoff date for determining the annual error rate, the error rate would have been reduced from 7.8 percent to 7.2 percent for FY 2009, and from 10.5 percent to 9.9 percent for FY 2010.[17] Had these overturned claim payment denials have been included in CMS's error rate calculation, there would have been an approximate $2 billion reduction in the estimated value of reported errors for both FY 2009 and FY 2010.[18] In its recommendations to CMS, the OIG encouraged the agency to develop a reliable method for adjusting the error rate and incorporating the outcome of appealed claim payment denials in order to generate a more accurate report.[19] CMS agreed with the OIG's recommendations and outlined the steps it intends to take in implementing an improved methodology.[20] Industry commentators suggested the OIG's study was a victory for providers, as it demonstrated that claim payment denials can be successfully appealed. The OIG report may also work to counteract the negative public perception that providers continually "*cheat*" the system.[21] Although the OIG's comments generally focus on CERT Program's processes, the agency found one state's program to be ineffective in fraud and abuse reduction.

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The Medi-Medi Program was created to identify areas of potential fraud, abuse, and waste in Medicare and Medicaid billing.[22] Unlike other fraud and abuse programs, state participation in the Medi-Medi Program is voluntary, and states must contribute their own funds.[23] The Medi-Medi Program initially began as a pilot demonstration in one state and expanded significantly over the course of a decade, garnering annual funding of $60 million in recent years.[24] The goal of the Medi-Medi Program was to analyze Medicare and Medicaid claims data collectively in order to identify potentially fraudulent billing activities that might not have been observed when analyzing the two programs' data separately.[25] In its study of Medicare and Medicaid operation in ten states for 2007 and 2008, the OIG found that the Medi-Medi Program "*produced limited results and few fraud referrals.*"[26] The Program's efforts resulted in 66 referrals of potential fraud to enforcement agencies, of which 27 referrals were accepted.[27] Based on the limited gains of the Medi-Medi Program, the OIG recommended that CMS re-evaluate what role, if any, the Program should play in the agency's overall strategy for the integrity of the Medicare and Medicaid programs. CMS agreed with the recommendation, stating that it has already taken steps to improve the Medi-Medi Program's effectiveness.[28] However, the OIG noted that CMS failed to provide any data to support its assertion, and stated that this information was necessary to both Congress's funding decisions and any states considering whether or not to participate in the program.[29]

In each of the programs studied (i.e., the Medicaid Integrity Program; the CERT program; and, the Medi-Medi program), the OIG observed substantial deficiencies, either in the accuracy of each program's results or in the overall lack of success. Though CMS agreed with the OIG's recommendations for improvement, successful implementation of those recommendations may not be imminent or even feasible, leaving many unanswered questions regarding the effectiveness of fraud and abuse monitoring programs going forward.

1 "OIG Uncovers Flaws in CMS Processes, Programs" By James Carroll, HealthLeaders Media, May 17, 2012, http://www.healthleadersmedia.com/content/FIN-280270/OIG-Uncovers-Flaws-in-CMS-Processes-Programs.html (Accessed 5/23/12).
2 Ibid.
3 "Medicaid Integrity Program – General Information" Center for Medicare and Medicaid Services, April 25, 2012, https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/MedicaidIntegrityProgram/ (Accessed 5/23/12).
4 Ibid.
5 "Early Assessment of Audit Medicaid Integrity Contractors" By Daniel R. Levinson, Office of the Inspector General, March 2012, OEI-05-10-00210, p. 1.
6 Ibid, p. 10.
7 Ibid, p. 5, 10.
8 Ibid, p. 11-12.
9 Ibid, p. 12-14.
10 Ibid, p. 17-18.
11 Ibid, p. 18.
12 Ibid, p. 19.
13 Ibid.
14 James Carroll, May 17, 2012.
15 "Comprehensive Error Rate Testing (CERT)" Centers for Medicare and Medicaid Services, May 15, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html?redirect=/CERT/ (Accessed 5/23/12); "Review of CERT Errors Overturned Through the Appeals Process for Fiscal Years 2009 and 2010" By Daniel R. Levinson, Office of the Inspector General, March 2012, A-01-11-00504, p. 1.
16 Daniel R. Levinson, "Review of CERT Errors Overturned Through the Appeals Process for Fiscal Years 2009 and 2010" March 2012, p. 1.
17 Ibid, p. 3.
18 Ibid.
19 Ibid, p. 5.
20 Ibid.
21 James Carroll, May 17, 2012.
22 "The Medicare-Medicaid (Medi-Medi) Data Match Program" By Daniel R. Levinson, Office of the Inspector General, April 2012, OEI-09-08-00370, p. 1.
23 Ibid, p. 17.
24 Ibid, p. 1-2.
25 Ibid, p. 1.
26 Ibid, p. 14.
27 Ibid, p. 17.
28 Ibid, p. 21-22.
29 Ibid, p. 22.

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