

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**EARLY ASSESSMENT OF
AUDIT MEDICAID INTEGRITY
CONTRACTORS**



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EXECUTIVE SUMMARY: EARLY ASSESSMENT OF AUDIT MEDICAID INTEGRITY CONTRACTORS

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WHY WE DID THIS STUDY

This study presents an early assessment of the efforts of Audit Medicaid Integrity Contractors (Audit MIC) to identify overpayments in Medicaid. The combination of this study and a companion study, *Early Assessment of Review Medicaid Integrity Contractors* (Review MIC), offers insights into the overall effectiveness of Medicaid integrity contractors and the Medicaid Integrity Program. Our objectives were: (1) to determine the extent to which Audit MICs identified overpayments and (2) to describe any issues or barriers that hindered the identification of overpayments.

HOW WE DID THIS STUDY

This study focused on Audit MICs' results for audits assigned between January 1 and June 30, 2010. We reviewed audit assignment data from the Centers for Medicare & Medicaid Services' (CMS) Database Audit Report Tracking System and resulting audit reports. We interviewed staff from CMS, Audit MICs, and State Medicaid oversight agencies.

WHAT WE FOUND

Eighty-one percent of audits either did not or are unlikely to identify overpayments. Only 11 percent of assigned audits were completed with findings of \$6.9 million in overpayments, \$6.2 million of which resulted from seven completed collaborative audits involving Audit MICs, Review MICs, States, and CMS. The remaining audits had not progressed enough to draw conclusions about likely outcomes.

Problems with the data used and analyses conducted by Review MICs and CMS to identify audit targets hindered Audit MICs' performance. However, collaborative audits appear to have improved the selection of audit targets and the efficiency of the audit process, leading to better results.

WHAT WE RECOMMEND

We recommend that CMS: (1) increase the use of collaborative audits and (2) improve audit target selection in States that choose not to be involved in collaborative audits.

CMS concurred with both recommendations. CMS stated that it has redesigned its approach to audit assignments, instructing Audit MICs to focus on collaborative projects. With respect to our second recommendation, CMS stated that several initiatives are underway to improve audit target selection. First, CMS noted that it is facilitating improved communication among Audit MICs, Review MICs, and States. In addition, CMS is internally evaluating options related to consolidating certain tasks and requirements of Audit and Review MICs. Finally, CMS has efforts underway to improve the quality of data that MICs can access for conducting data analysis.

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OBJECTIVES

1. To determine the extent to which Audit Medicaid Integrity Contractors (Audit MICs) identified overpayments.
2. To describe any issues or barriers that hindered the identification of overpayments.

BACKGROUND

Medicaid is jointly funded by States and the Federal Government to provide certain health-related services to categorically and medically needy populations. Medicaid spending in fiscal year (FY) 2010 totaled an estimated \$404.9 billion, of which the Federal share was estimated at \$271.4 billion.¹ Medicaid spending is projected to increase as Medicaid enrollment increases, further straining already burdened State and Federal budgets.²

Fraud, waste, and abuse unnecessarily add to Medicaid program costs for States and the Federal Government. The Office of Inspector General (OIG), the Government Accountability Office, CMS, the Department of Justice, and State Medicaid oversight agencies have uncovered millions of dollars in overpayments and fraudulent billing for services covered under Medicaid. For example, CMS projected \$22.5 billion in improper payments for FY 2010 through its Medicaid Payment Error Rate Measurement.³

The Medicaid Integrity Program

The Deficit Reduction Act (DRA) of 2005 established the Medicaid Integrity Program as the first comprehensive effort by CMS to fight fraud, waste, and abuse within Medicaid.⁴ The DRA requires CMS to fight fraud, waste, and abuse by contracting with entities to identify overpayments to providers and to educate providers, managed care organizations, and beneficiaries on program integrity issues.⁵ CMS created the Medicaid Program Integrity Group to administer the Medicaid Integrity Program and oversee contracted entities.

¹ Centers for Medicare & Medicaid Services (CMS), *2010 Actuarial Report on the Financial Outlook for Medicaid*. Accessed at <http://www.cms.gov> on June 15, 2011.

² Ibid.

³ U.S. Department of Health and Human Services, *FY 2010 Agency Financial Report*. Accessed at <http://www.hhs.gov> on August 8, 2011.

⁴ DRA of 2005, P.L. 109-171 § 6034, Social Security Act, § 1936, 42 U.S.C. § 1396u-6.

⁵ DRA of 2005, P.L. 109-171 § 6034(a)(2), Social Security Act, § 1936, 42 U.S.C. § 1396u-6.

CMS defined three types of MICs to perform the program integrity activities mandated in the DRA and to identify fraud, waste, and abuse: Review MICs, Audit MICs, and Education MICs. Review MICs review State Medicaid claims data and identify potential overpayments. Audit MICs audit specific providers and identify overpayments. Education MICs educate providers and beneficiaries on program integrity issues.

Audit MICs

CMS began awarding annual Audit MIC task orders in 2008. For FY 2010, three firms, Health Management Systems/IntegriGuard (HMS), Health Integrity, and Island Peer Review Organization, were awarded five task orders covering geographic areas that correspond to the 10 CMS regions across the country.⁶ CMS spent approximately \$30.5 million on Review and Audit MICs in FY 2010, \$17.2 million of which went to Audit MICs.

Identification of Overpayments

Review MICs are contracted to identify, and Audit MICs are contracted to audit, providers who potentially received Medicaid overpayments. Review MICs conduct analysis to identify providers who potentially received overpayments. CMS selects certain providers as audit targets from the information provided by the Review MICs and assigns them to Audit MICs. Audit MICs then conduct audits to determine whether potential overpayments associated with the audit target (i.e., provider) were overpayments.

Review MICs Identify Potential Overpayments. CMS makes monthly assignments to Review MICs to identify potential overpayments. For each data analysis assignment, CMS specifies the State, type of Medicaid claims data, and range of service dates that Review MICs are to review. CMS also specifies the algorithm (i.e., data analysis model) that Review MICs are to use to perform data analysis assignments.⁷ CMS expects Review MICs to consider any relevant State or Federal policies, such as maximum quantity limits for drugs, in their analyses. Review MICs analyze claims submitted for reimbursement over a 5-year period (5-year audit window), which is the period most States require providers to keep records.

⁶ HMS was awarded task orders for Regions VI and VIII (South and Mountain West) in September 2008 and for Regions IX and X (West and Northwest) in May 2009. HMS's contract for Regions VI and VIII was not renewed for FY 2012. Health Integrity was awarded task orders for Regions III, IV, V, and VII (East, Southeast, and Midwest) in July 2009. Island Peer Review Organization was awarded a task order for Regions I and II (Northeast) in July 2009.

⁷ Algorithms target specific types of potential overpayment, such as pharmacy billing errors, excessive amounts of service, or duplicate claims that appear to be for the same service. CMS and all Review MICs are responsible for developing algorithms.

In a recent study, OIG found that, from assignments made during a 6-month period, Review MICs provided CMS with lists that included 113,378 unique providers, ranked by the amount of their potential overpayments.⁸

That study also found that Review MICs' ability to accurately complete assignments was hindered because data were missing or inaccurate. Review MICs use the Medicaid Statistical Information System (MSIS) to identify potential overpayments. The MSIS is a nationwide Medicaid eligibility and claims data source containing a subset of data elements from State data systems that States report quarterly to CMS.⁹ OIG found that MSIS was missing provider identification information, adjustments that corrected payments, and service and beneficiary descriptions. Because these data were missing or inaccurate, Review MICs incorrectly identified potential overpayments.¹⁰ To address these issues, CMS is making efforts to replace MSIS with an upgraded version, called Transformed MSIS (T-MSIS), which will include new data fields and should be updated more frequently than MSIS.¹¹

Once Review MICs identify potential overpayments as part of their analyses, they send selected samples of those potential overpayments to the appropriate States for validation. States determine whether the sampled overpayments are valid using their State data systems. If States invalidate more than half of sampled overpayments, CMS requires Review MICs to reanalyze their data.

CMS Selects Audit Targets. Using the lists of providers created by Review MICs, CMS conducts the analysis necessary to select audit targets. CMS conducts a quality assurance review before accepting Review MIC assignments as complete. CMS's quality assurance review includes an analysis of State policies, a review of the algorithms used by the Review MICs, and a verification of Review MICs' calculations of potential overpayments. After selecting audit targets from the lists of providers submitted in Review MIC assignments, CMS screens the audit targets with States or with other Federal entities to ensure that they are not

⁸ OIG, *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012.

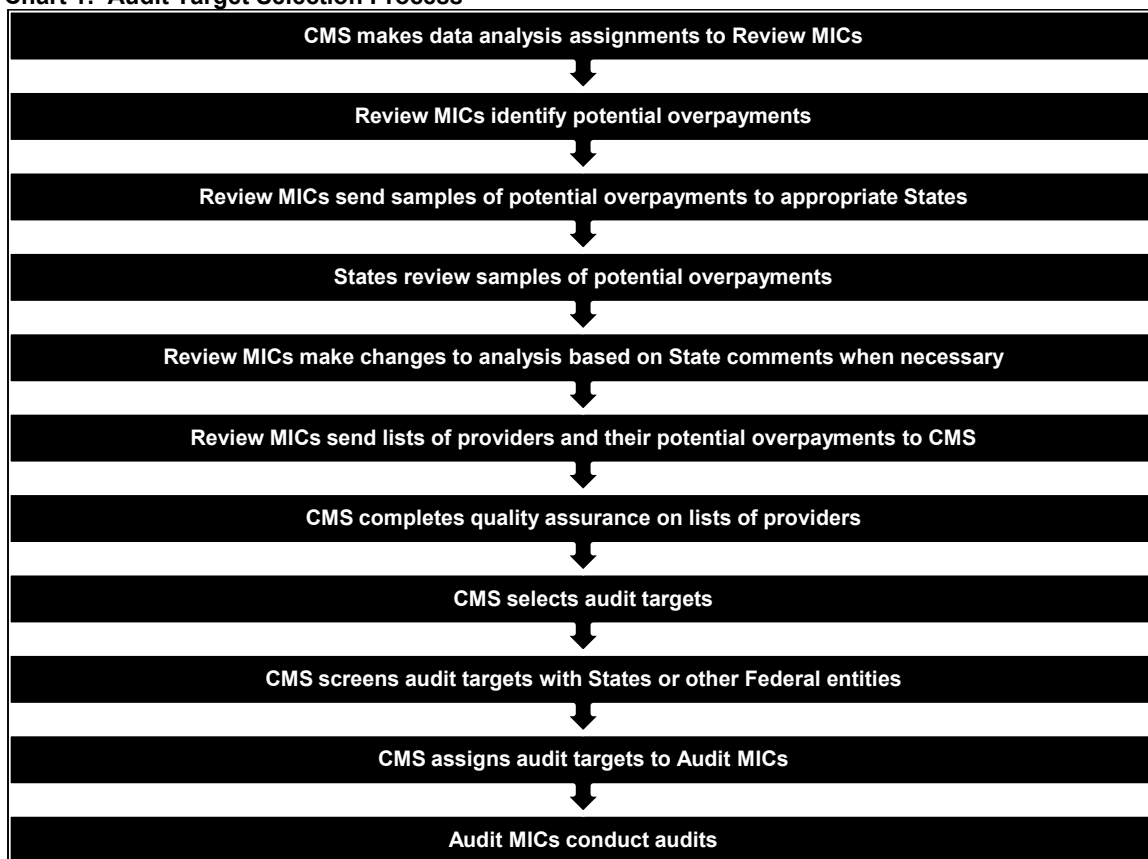
⁹ MSIS data are a specified subset of fields extracted from each State's unique Medicaid Management Information System (MMIS). States use MMIS to process claims and monitor use of services. MSIS includes files of eligible Medicaid enrollees and four Medicaid claims files: (1) inpatient care, (2) long-term care, (3) prescription drugs, and (4) all other claims. CMS, *Medicaid Statistical Information System (MSIS) File Specifications & Data Dictionary*. Accessed at <http://www.cms.gov> on March 22, 2011.

¹⁰ OIG, *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012.

¹¹ CMS, *Annual Report to Congress on the Medicaid Integrity Program for Fiscal Year 2010*. Accessed at <http://www.cms.gov> on August 22, 2011.

already being audited or investigated. Chart 1 shows the process for identifying audit targets.

Chart 1: Audit Target Selection Process



Source: OIG analysis of interviews with CMS, November 2011.

For the 6-month review period in a recent study, CMS filtered the full lists of 113,378 providers identified by Review MICs and selected 244 as audit targets with \$39.8 million in potential overpayments.¹²

Audit MICs Identify Overpayments. After selecting the audit targets, CMS assigns them to the Audit MICs. Audit MICs may request additional information from the State, CMS, or Review MICs for their reviews. The Audit MICs then draft audit plans for CMS approval, notify the providers, and start the audits.

If Audit MICs detect potential fraud during an audit, they refer the cases to OIG for investigation. The Audit MICs continue to conduct the audits, but must receive clearance from OIG to report audit results to providers.

¹² Ibid.

When an audit identifies no recoverable overpayments, Audit MICs submit a Low-No-Findings Report to CMS. These audits either identify no overpayments or conclude that the amount of overpayments is too small to warrant recovery by CMS.

When Audit MICs find overpayments, they submit Draft Audit Reports to CMS followed by Final Audit Reports. CMS conducts quality assurance reviews for Draft Audit Report findings and submits them to the appropriate State and provider for comment. After receiving comments from the State and provider on Draft Audit Report findings, Audit MICs make any necessary revisions to the reports and submit Final Audit Reports for CMS approval. See Appendix A for a flowchart of the Audit MIC audit process.

Collaborative Audits

When States are willing to participate, CMS may assign collaborative audits. Collaborative audit targets are selected with the involvement of Audit and Review MICs, States, and CMS. The States provide input on program areas that are vulnerable to overpayments and the State policies that apply to those program areas. MICs, CMS, and the States then jointly develop data analysis models to identify potential overpayments. Instead of using MSIS, collaborative audits identify potential overpayments using data available in each State's MMIS.¹³ All parties then determine which providers identified with potential overpayments should be audited. CMS screens the audit targets with State and other Federal entities to ensure they are not already being audited or investigated and then assigns targets to Audit MICs for auditing.

Collection of Overpayments

States are responsible for collecting overpayments from providers as determined in Final Audit Reports and returning the Federal share to CMS within 1 year.¹⁴ Should a provider appeal audit findings, Audit MICs provide support to States during hearings and appeals.

Related Work

As previously mentioned, OIG conducted a companion study, *Early Assessment of Review Medicaid Integrity Contractors*, which focused on the early results of Review MICs.¹⁵ That evaluation determined the extent to which Review MICs completed assignments, recommended audit leads, and identified potential fraud. It also described barriers Review MICs encountered.

¹³ States that participate in collaborative audits agree to share data, and in many cases States provide MICs with an extract from their MMIS database of the claims necessary for the collaborative audit.

¹⁴ Social Security Act, § 1903(d)(2)(C), 42 U.S.C. § 1396b(d)(2)(C).

¹⁵ OIG, *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012.

In addition, a 2009 OIG report addressed the usefulness of MSIS data in detecting fraud, waste, and abuse. OIG found that MSIS did not capture all data elements that can assist in the detection of Medicaid fraud, waste, and abuse. Missing data elements include provider identifiers; procedure, product, and service descriptions; billing information; beneficiary identification information that indicates whether a beneficiary is dually eligible;¹⁶ and Medicaid eligibility information.¹⁷

METHODOLOGY

Scope

This study focuses on Audit MICs' program integrity activities for audits assigned between January 1 and June 30, 2010. Because the last contracts were awarded in July 2009, we requested data on Audit MIC audits assigned by CMS between January 1 and June 30, 2010. We selected this period because during this time, each Audit MIC had sufficient time to begin its activities; also, we wanted a 6-month assignment period upon which to base our findings. We collected data through June 1, 2011, on the audits assigned during this 6-month period because by that date, Audit MICs had had nearly 1 year to conduct their audits and report results.¹⁸

The audit targets in this report are not the same as the 244 audit targets identified in the report *Early Assessment of Review Medicaid Integrity Contractors*.¹⁹ Instead, this report focuses on 370 different audit targets.

Data Sources

Data Collection. We collected data from CMS concerning Audit MICs' audit activities for targets assigned between January 1 and June 30, 2010. For purposes of this report, we refer to audits that originated with Review MICs or CMS analysis as regular audits and audits that originated through MICs, CMS, and State collaboration as collaborative audits.

Specifically, we collected:

- Audit data from CMS's Database Audit Report Tracking System (DART). CMS maintains DART to track the assignment, progress, and results of Audit MICs' audits. DART contains information necessary to track audit status and identifies overpayment amounts, as well as comments on issues that arise during audits. DART is updated

¹⁶ Dually eligible beneficiaries are low-income seniors and severely disabled individuals who are covered by both Medicare and Medicaid.

¹⁷ OIG, *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse*, OEI-04-07-00240, August 2009. Accessed at <http://oig.hhs.gov> on March 11, 2011.

¹⁸ Audit MIC contracts allow for a 60-day transition period after contracts are awarded.

¹⁹ OIG, *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012.

weekly by Audit MICs. The weekly update includes estimates of overpayments as audits progress.

- Audit reports associated with the audits conducted during our review period: Low-No-Findings Reports, Draft Audit Reports, and Final Audit Reports. Audit reports include descriptions of the providers and services being audited, the State policies that affect audit findings, the specific claims that were audited and determinations regarding whether they were paid for appropriately, and the amount of overpayments identified by Audit MICs. Audit reports also included barriers encountered while the Audit MICs were conducting the audits.

Interviews. We conducted structured interviews with staff from each of the three Audit MICs and from CMS to identify audit processes that Audit MICs followed and barriers they encountered when conducting audits. These interviews also included questions about Audit MIC results, the process for discontinuing audits, identification of overpayments, and issues that caused audits to result in Low-No-Findings Reports.

We also conducted interviews with seven selected State Medicaid oversight agencies to gather States' perspectives on the effectiveness of MICs. These interviews included questions about Audit MIC results, communication between Audit MICs and States, and the impact that the Medicaid Integrity Program has on State Medicaid program integrity agencies.

Data Analysis

DART System. Using DART, we analyzed 388 audit assignments that Audit MICs received between January 1 and June 30, 2010. These assignments covered 27 States plus the District of Columbia. We analyzed the status of assignments to determine whether each assignment was completed, ongoing, discontinued, or placed on hold by CMS as of June 1, 2011. For the purposes of this report, we consider audits to be complete if they resulted in a Low-No-Findings Report, a Draft Audit Report, or a Final Audit Report or were discontinued by CMS.

We also analyzed DART's comments field to determine the reasons Audit MICs reported for why some assigned audits identified no overpayments. We created categories for the reasons Audit MICs provided based on common elements.

Our findings are based on 370 assigned audits. We dropped 18 canceled audits from our analysis. CMS canceled these audits because the assigned Audit MIC's contract was not renewed and the Audit MIC had not started the audits.

For the purposes of this report, we use the term “potential overpayments” to mean the amount of overpayments in claims initially assigned by CMS to Audit MICs for audit and the term “overpayments” to mean the amount of overpayments discovered by Audit MICs as a result of their audits. We also refer to all audits that did not identify recoverable overpayments, including all audits that resulted in Low-No-Findings Reports, as having no overpayments.

We determined the amount of potential overpayments using the “Overpayments in Data Engine” field. This is the value of claims Review MICs identified as potential overpayments that was then passed on to Audit MICs.

We determined the amount of overpayments primarily using the “Overpayments in Initial DAR (Draft Audit Report)” field. “Overpayments in Initial DAR” is a uniform point in the audit process when Audit MICs have completed their audits and determined whether payments were overpayments. In a few cases where there was not an entry in the “Overpayments in Initial DAR” field, we used the “Estimated Overpayments” field. The “Estimated Overpayments” field is the most recent amount of overpayments identified and may reflect adjustments to the overpayment amount after States and providers comment on the initial audit findings.

To determine which ongoing audits were unlikely to identify overpayments, we compared ongoing audits’ targets with completed audits’ targets. Specifically, we compared the methods used to select audit targets for ongoing audits with completed audits that primarily identified no overpayments. When the methods were the same, we determined it was likely that the ongoing audits would also identify no overpayments. In most cases, the methods used to select the audit targets for the ongoing audits had been used for multiple audits that identified no overpayments.

In addition to comparing audit target selection methods, we determined that those audits that did not have any overpayments in the “Estimated Overpayments” field in DART were also unlikely to identify overpayments.

Audit Reports. When completed audits resulted in Low-No-Findings Reports, Draft Audit Reports, or Final Audit Reports, we analyzed the reports to confirm and give context to information gathered from DART. We also reviewed these reports to determine what, if any, barriers or issues Audit MICs encountered during the audits. We created categories of barriers, when applicable, based on common elements.

Interviews. We analyzed the results of structured interviews with staff from each Audit MIC and from CMS to determine whether any commonalities existed in the barriers they stated Audit MICs confront when auditing.

We analyzed the results of structured interviews with State Medicaid oversight agencies to identify any State concerns with the Medicaid Integrity Program's audits. We also analyzed these structured interviews to determine whether selected States felt the audits assigned to Audit MICs were appropriate and effective for identifying overpayments.

Data Limitations

Because this study did not assess the results of Audit MIC activities for audits assigned outside the 6-month period between January 1 and June 30, 2010, we cannot describe the collection of overpayments or the results of Audit MIC activities during the entirety of their contracts with CMS. However, Audit MICs were assigned 370 audits during our 6-month review period, or 62 audits per month, from which we can draw conclusions about the results of Audit MICs' program integrity activities.

Because most audits had not been issued as Final Audit Reports by the time we completed data collection, the dollars we report as identified overpayments are from the Draft Audit Report stage. Downward adjustments may occur between the Draft and Final Audit Reports as States and providers respond to the audits with supporting documentation that shows potential overpayment was appropriate. Therefore, the actual overpayment amounts reported in Final Audit Reports may be lower than the overpayment amounts in this report.

Standards

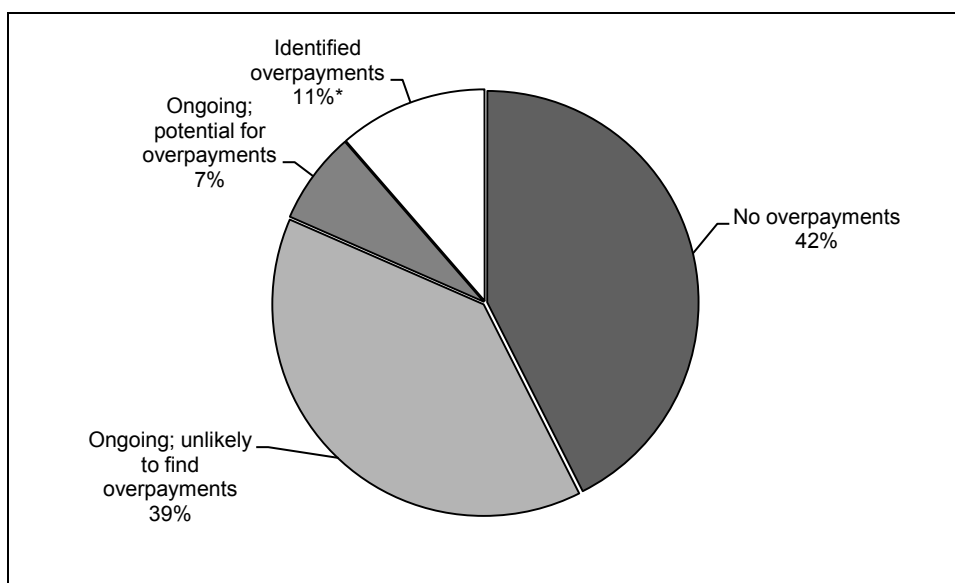
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Eighty-one percent of Medicaid Integrity audits either did not or are unlikely to identify overpayments

Between January and June 2010, CMS assigned Audit MICs 370 audits with \$80 million in potential overpayments. Only 11 percent identified overpayments, totaling \$6.9 million. Eighty-one percent of the audits were either completed with findings of no overpayments (42 percent) or remained ongoing as of June 2011 and are unlikely to identify overpayments (39 percent). The remaining audits were ongoing as of June 2011; however, there was not enough information about these audits to draw conclusions about their likely outcomes. See Chart 2 for a breakdown of the status of audits as of June 2011.

Chart 2:
Status of 370 Audits,
June 2011



Source: OIG analysis of Audit MIC assignments, July 2011.

*Percentages do not add up to 100 percent because of rounding.

Forty-two percent of audits identified no overpayments

Forty-two percent of audits either were completed with findings of no overpayments or were discontinued by CMS. Audit MICs found no overpayments for 85 audits. An additional 72 audits had no overpayments because they were discontinued by CMS after the Audit MICs determined that finding overpayments was unlikely, making further audit activities unnecessary.

Thirty-nine percent of Medicaid Integrity audits are ongoing and are unlikely to identify overpayments

Of the 370 audits in our review period, 144 are ongoing and are unlikely to result in findings of overpayments. On average, these 144 audits have been ongoing for over 1 year; evidence from other audits and from progress updates in CMS's DART suggests that they will not identify overpayments.

Specifically, 109 of the 144 ongoing audits are unlikely to identify overpayments because the methods used to select the audit targets have already proven unsuccessful. The 109 audit targets were selected using the same algorithms in the same States as other completed audits that primarily had findings of no overpayments. In fact, 1 Audit MIC confirmed that the review process for 23 of the 109 audits is complete and that staff found no overpayments for any audit; the Audit MIC was in the process of drafting Low-No-Findings Reports. Additionally, CMS's DART, which tracks weekly progress updates, showed no estimated overpayments in weekly updates for another 48 of these 109 audits as of June 2011.

Preliminary evidence for the remaining 35 of the 144 ongoing audits suggests that these audits are also unlikely to result in findings of overpayments. As of June 2011, DART showed no estimated overpayments for these 35 audits in the weekly updates. Additionally, the same Audit MIC as above confirmed that the review process for 2 of these 35 audits is complete and that staff found no overpayments for either audit. The Audit MIC was in the process of drafting Low-No-Findings Reports.

Eleven percent of audits identified \$6.9 million in overpayments

Audit MICs completed 42 audits with findings of overpayments totaling \$6.9 million. Audit MICs identified \$6.2 million of the \$6.9 million in overpayments through seven completed collaborative audits. The remaining \$700,000 in overpayments was identified through 35 regular audits. See Appendix B for a description of these audits.

Audit MICs' performance was hindered because audit targets were poorly identified

Audit MICs' ability to find overpayments were hindered because the audit targets they were provided were poorly identified. Based on their contracts with CMS, Audit MICs are responsible for identifying overpayments among audit targets provided to them by CMS. They are

not responsible for selecting the audit targets. CMS selects the audit targets from the lists of providers and their potential overpayments supplied by the Review MICs.

For 111 of the 157 audits with no overpayments, Audit MICs discovered they had inappropriate audit targets. These audit targets were misidentified because of problems with the MSIS claims data used to identify potential overpayments or the interpretation of the claims data in light of each State’s specific Medicaid program policies. See Table 1 for a breakdown of the reasons 157 audits were completed with findings of no overpayments.

Table 1: Reasons Audit MICs Reported That 157 Audits Had Findings of No Overpayments

Reason	Number of Audits	Percentage
There was an MSIS data issue	57	36%
Program policy was misinterpreted	54	34%
Payment was appropriate (no error)	30	19%
Review MIC analysis was missing	14	9%
No reason given	2	1%
Total	157	99%*

Source: OIG analysis of DART and Low-No-Findings Reports, August 2011.

*Percentages do not add up to 100 percent because of rounding.

Audit targets were misidentified because of data problems

Audit MICs discovered that 36 percent of the audit targets that resulted in audits with no overpayments were mistakenly selected based on conclusions drawn from erroneous MSIS data. For some of these misidentified audit targets, MSIS claims data incorrectly identified the place of service. These audit targets were identified through an algorithm intended to identify overpayments for inpatient claims. While MSIS data identified the claims for these audit targets as inpatient claims, Audit MIC staff reported that the claims were in fact outpatient claims.

Other audit targets had claims that were mistakenly identified as overpayments because the services appeared to occur after beneficiaries died, but the beneficiaries’ dates of death were incorrect.

Additionally, 13 audit targets were misidentified because MSIS data for their claims were outdated. These claims were mistakenly identified as overpayments because MSIS showed overpayments, but further research showed that the problems had already been corrected by the States and the changes were not reflected in MSIS.

Audit targets were misidentified because State program policies were applied incorrectly

Audit MICs discovered that 34 percent of audit targets with no overpayments were misidentified because Review MICs applied State Medicaid program policies incorrectly. Forty-four audit targets were selected because of misidentified duplicate payments for services provided to dually eligible beneficiaries (i.e., beneficiaries enrolled in both Medicaid and Medicare). In these cases, Medicaid made two payments for each beneficiary's hospital stay, but both payments were appropriate. One payment covered all inpatient services and the second payment covered the coinsurance for ancillary services billed to Medicare during the hospital stay. The State Medicaid agency is required to pay for the Medicare coinsurance for dually eligible beneficiaries.²⁰

Audit MICs discovered another 10 audit targets with claims that were inappropriately identified as overpayments because of a misapplication of policy. These audit targets had claims that violated the Correct Coding Initiative, a national policy on medical coding edits designed to prevent improper billing. However, the States these audit targets were located in had not adopted the Correct Coding Initiative and the claims were allowable under those States' Medicaid policies.²¹

In addition, five of the seven State Medicaid oversight agencies interviewed stated that the audit targets assigned by CMS were often inappropriate. Staff from one State Medicaid oversight agency stated that a Review MIC mistakenly identified drug claims as potential overpayments because it believed the drug was not covered when, in fact, the drug was covered in that State. Staff from another State Medicaid oversight agency commented that Review MICs and CMS did not correctly apply the State's payment methodologies when analyzing State Medicaid claims.

Identifying improper payments in Medicaid requires indepth knowledge of each State's Medicaid program policies and data. Medicaid is administered by States and each State's Medicaid program is unique. States also process and store their own claims data, which contain variables unique to each State.²²

²⁰ Social Security Act, §§ 1902(a)(10)(E) and 1905(p), 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p). States may differ in the policies that determine how Medicare and Medicaid claims for dually eligible beneficiaries are submitted and recorded.

²¹ Social Security Act, § 1903(r)(1)(B)(iv), 42 U.S.C. 1396b(r)(1)(B)(iv). The Patient Protection and Affordable Care Act made the National Correct Coding Initiative (NCCI) mandatory in all States for Medicaid claims filed on or after October 1, 2010. However, the NCCI is not legally required for audit assignments made during our review because the claims associated with these audits were filed before October 1, 2010.

²² Ibid.

Audit MICs reported that problematic audit targets caused them to duplicate efforts

Audit MICs reported spending significant preaudit time evaluating algorithms, reanalyzing MSIS data, and ensuring the accurate application of State policies during audit target selection. According to CMS's DART, an average of 3 months elapsed between the date CMS assigned audits to Audit MICs and the date when Audit MICs began the audits. Audit MICs stated that they needed to duplicate previous work during this time because of the problems they discovered with many of the audit targets.

Additionally, Audit MICs stated that they felt compelled to duplicate Review MIC analyses because they could not easily communicate with Review MICs or States. At the time of our review, all communications between Audit MICs and Review MICs were channeled through CMS. When an Audit MIC had questions for a Review MIC concerning the data analysis associated with audits it was conducting, the Audit MIC first had to send its questions to CMS. CMS would then either contact the Review MIC or schedule a meeting between the Audit MIC and Review MIC. Questions for States about policies and procedures were similarly directed first to CMS before the Audit MIC was allowed to contact the State.

More recently, CMS began to allow more direct communication among Audit MICs, Review MICs, and States. In late 2010, CMS began facilitating monthly conference calls between Audit and Review MICs to address issues arising during audits that relate to Review MIC data analysis. In addition, CMS is allowing direct communication between Audit MICs and States. Audit MICs notify CMS of communication with the State only when the issue significantly affects the audit.

Audit MICs also reported rescreening audit targets that were previously screened by CMS with States and other Federal agencies. Audit MICs stated that they started this practice after CMS assigned some audit targets during our review that were already under State review. In one instance, by the time CMS assigned the audit target to the Audit MIC, the State had already conducted an audit and collected the overpayments.

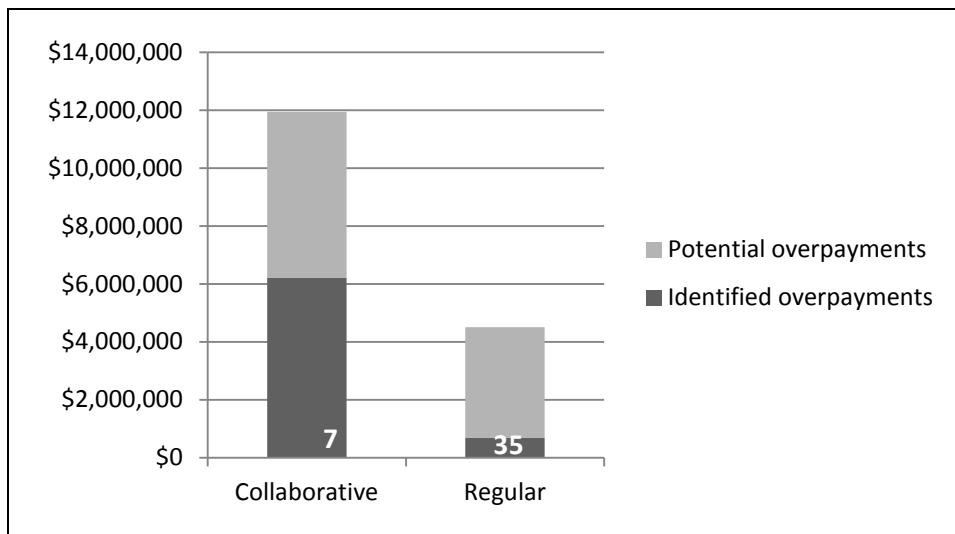
Collaborative audits generated 90 percent of the \$6.9 million in overpayments that Audit MICs identified

Audit MICs, Review MICs, States, and CMS worked collaboratively on eight audits, seven of which identified overpayments, between January and June 2010. Although only 7 of the 42 audits that identified

overpayments were collaborative audits, they accounted for \$6.2 million of the identified overpayments, compared with only \$700,000 for the 35 regular audits. Eighty-eight percent of completed collaborative audits had findings of overpayments compared with only 18 percent of completed regular audits.

Audit MICs also found that collaborative audits resulted in a higher proportion of overpayments to potential overpayments than regular audits. Specifically, 52 percent of the potential overpayments identified during the collaborative audit process were found to be overpayments. By comparison, Audit MICs found that only 16 percent of potential overpayments identified by Review MICs and CMS for regular audits were, in fact, overpayments. See Chart 3 for a breakdown of potential overpayments versus overpayments for 7 completed collaborative audits compared to the 35 completed regular audits with findings of overpayments.

Chart 3:
Potential
Overpayments Versus
Overpayments for
Audits With Findings
of Overpayments



Source: OIG analysis of audits completed with findings of overpayments, June 2011.

Collaboration may have improved the selection of audit targets and efficiency of the audit process, leading to better results

Collaboration among Audit MICs, Review MICs, States, and CMS may have improved audit target selection by making more accurate data available, improving access to State data systems and knowledge of State-specific Medicaid policies, and decreasing duplication of effort. Audit MICs completed collaborative audits an average of 2.5 months faster than regular audits.

Collaboration with State Medicaid agency staff provided Audit MICs with access to States’ MMIS for claims analysis rather than using the MSIS

data used to conduct claims analysis for regular audits. MMIS data include adjustments and more up-to-date data than MSIS, thus eliminating some of the data problems that occur when using MSIS.

Collaboration with State Medicaid agency staff also gave Audit and Review MICs a chance to gain familiarity with State-specific Medicaid policies and regulations, leading to improved audit target selection. As staff from one Audit MIC explained, working closely with a State helps Audit MICs identify services and providers that are more likely to abuse the Medicaid program in that particular State. Another Audit MIC's staff commented that collaboration with States prior to the start of audit activities resulted in fewer problematic audit targets, yielding higher overpayment findings.

Finally, collaboration may eliminate the duplication of effort that occurs during regular audits, making the entire audit process more efficient. While Audit MICs often felt compelled to duplicate Review MIC and CMS analysis for regular audit targets, collaborative audits involved Audit MICs in original data analysis and target selection. In fact, CMS's DART indicated that an average of 1 month elapsed between the date CMS assigned collaborative audits to Audit MICs and the date when Audit MICs began the audits. For regular audits, an average of 3 months elapsed before Audit MICs began the audits. Furthermore, collaborative audit targets were screened only once, immediately preceding the start of the audit. This reduces the burden on States of multiple screenings of possible audit targets and makes it unlikely that the Audit MIC and the State would conduct simultaneous audits.

CONCLUSION AND RECOMMENDATIONS

Few of the audits assigned to Audit MICs from January through June 2010 identified overpayments. Of the 370 audits assigned to Audit MICs, 81 percent either did not identify overpayments or are unlikely to identify overpayments. Only 11 percent of assigned audits were completed with findings of \$6.9 million in overpayments, \$6.2 million of which resulted from seven completed collaborative audits. Additionally, this recoverable overpayment total may be lowered as audit reports are finalized.

While mixed audit results were expected, the extensive analysis used to identify audit targets should have yielded better overall results. The majority of audit targets were identified through Review MIC and CMS analysis, were selected by CMS as audit targets, and were screened by CMS with the appropriate States and Federal entities. Yet most completed audits from our review period had findings of no overpayments.

Problems with the data and with the analyses conducted by Review MICs and CMS to identify audit targets hindered Audit MICs' performance. Poor audit target selection also led to duplication of effort as Audit MICs chose to verify the accuracy of the analyses and rescreen selected audit targets. However, collaboration among Audit MICs, Review MICs, States, and CMS during collaborative audits appears to have improved the selection of audit targets and the efficiency of the audit process, leading to better results.

Because Audit MICs are only one part of the process to identify Medicaid overpayments, the results of this study reflect the efforts of Review and Audit MICs, as well as CMS. The quality of audits conducted by Audit MICs depends on the quality of the audit targets selected by CMS, and audit target quality depends on the quality of data analyses conducted by Review MICs. Thus, when combined with the companion study, *Early Assessment of Review Medicaid Integrity Contractors*, this study provides recommendations to improve the effectiveness of the entire process for identifying Medicaid overpayments.²³

CMS Should Increase the Use of Collaborative Audits

We recommend that CMS encourage collaborative audits where appropriate. We recognize that not all States will be interested in or capable of partnering with CMS in this way. However, increasing the number of collaborative audits assigned to Audit MICs will capitalize on the benefits of the collaborative audit model, with potential to identify greater overpayments more efficiently. Collaborative audits use more

²³ OIG, *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012.

complete, updated State MMIS data and knowledge of State-specific Medicaid policies to more accurately identify potential overpayments and select audit targets. Additionally, increased collaboration among Audit and Review MICs, CMS, and States would eliminate the duplication of efforts and support recent requirements to coordinate auditing efforts.²⁴

CMS Should Improve Audit Target Selection in States That Choose Not To Be Involved in Collaborative Audits

Given that not all States will want to partner with CMS using the collaborative model approach, we recommend that CMS work to improve the current method of identifying and selecting audit targets. One reason audit targets were misidentified was misapplication of State Medicaid policy. Therefore, CMS should work to improve the ability of Review MICs to properly analyze Medicaid data in light of State-specific policies. One way to do this would be to create better communication among Audit MICs, Review MICs, and States. Audit MICs discovered numerous audit targets that were misidentified because of misapplication of State policy. Review MICs could benefit from this better communication as they strive to build more indepth knowledge of each State's Medicaid program and policies.

Although CMS has made some strides to improve the communication between Audit and Review MICs, we believe even more could be done. For example, interaction between Audit and Review MICs could be improved by combining their responsibilities and tasks under one Medicaid integrity contractor. This would eliminate duplication of effort and reduce the burden that States face in interacting with multiple contractors throughout the audit process.

To address errors in audit targeting caused by data problems, CMS needs to improve the quality of data MICs can access to conduct data analysis. We made this recommendation in the companion report, *Early Assessment of Review Medicaid Integrity Contractors*.²⁵ We recommend that CMS devote the resources necessary to implement T-MSIS to make it available to the Review and Audit MICs, especially in States that choose not to participate in collaborative audits. One of the reasons collaborative audits outperformed regular audits is that they had access to better data. Collaboration with the State Medicaid agency staff provided access to the States' MMIS for claims analysis rather than MSIS. MMIS is more complete and is updated more often than MSIS.

²⁴ Patient Protection and Affordable Care Act, P.L. 111-148 § 6411(a)(1)(C), amending Social Security Act § 1902(a)(42), 42 U.S.C. § 1932a(a)(42).

²⁵ OIG, *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012.

AGENCY COMMENTS

CMS concurred with both recommendations. CMS stated that it has redesigned its approach to audit assignments, instructing Audit MICs to focus on collaborative projects. While CMS assigned only 8 collaborative audits during the first 6 months of 2010, it stated it has assigned 83 collaborative audits in the 18 months since our review. These collaborative audits allow Audit MICs to work with States and obtain up-to-date claims data from each State's MMIS.

With respect to our second recommendation, to improve audit target selection in States that choose not to be involved in collaborative audits, CMS stated that it has several initiatives underway to improve audit target selection. First, CMS is working to clarify MICs' understanding of State Medicaid programs and policies by arranging for direct communication between Audit MICs and States. In addition, CMS is working to improve communication between Audit and Review MICs while internally evaluating options for consolidating certain MIC tasks and requirements.

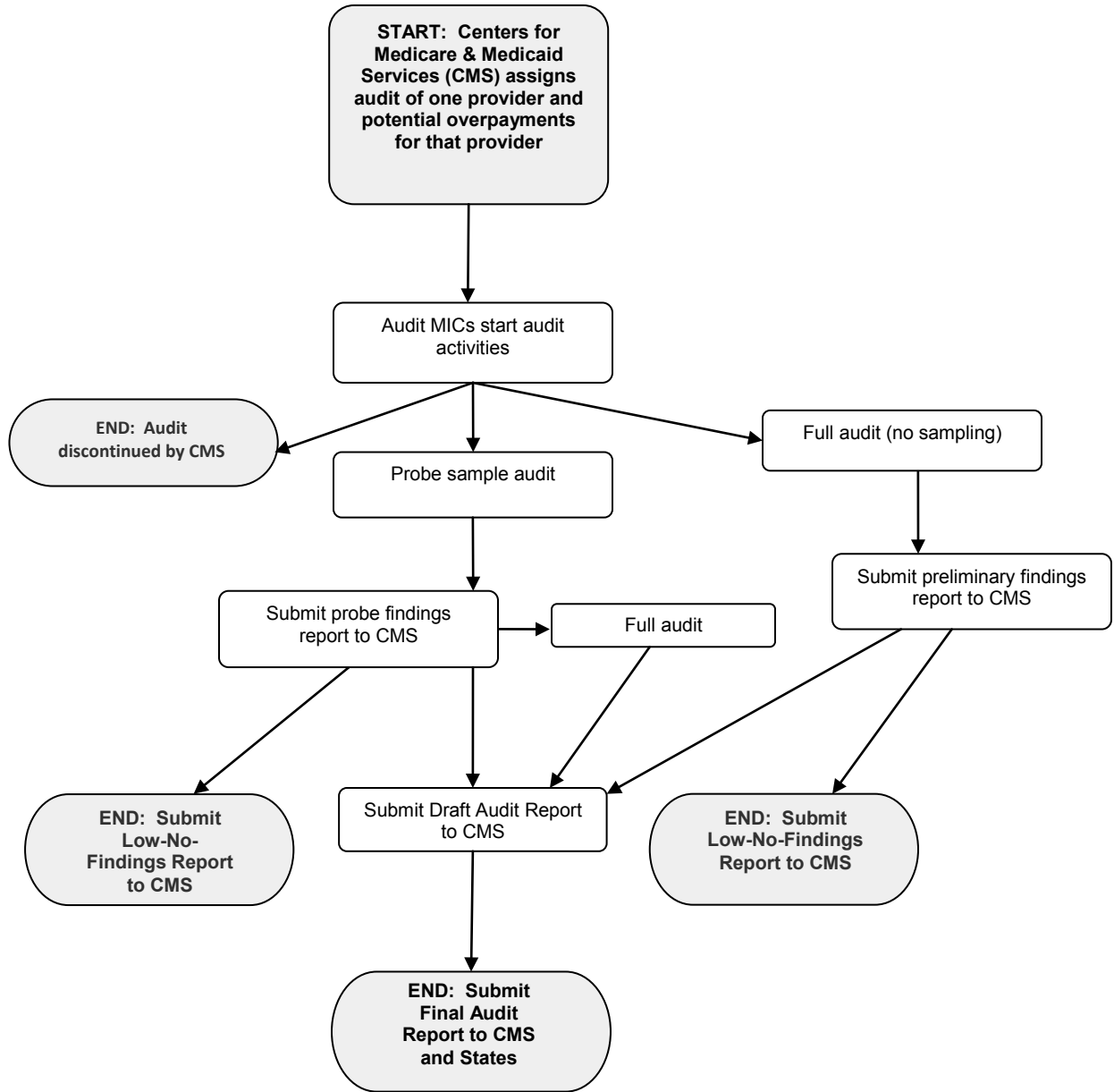
Finally, CMS reiterated that several initiatives are underway to improve the quality of data that MICs can access for conducting data analysis. CMS continues to work toward improving the data available in MSIS through a 10-State pilot project testing the expanded T-MSIS data set. In the interim, CMS is working directly with States to obtain MMIS data extracts for specific provider types and is leveraging data from the Medicare-Medicaid Data Match program.

We made revisions to the report based on CMS's technical comments.

For the full text of CMS's comments, see Appendix C.

APPENDIX A

Audit Process²⁶



Source: Office of Inspector General analysis of interviews with CMS, June 2011.

²⁶ Audit Medicaid Integrity Contractors (MIC) either conduct a probe audit or immediately audit the entire universe of questionable claims associated with the assigned audit target, as directed by CMS.

APPENDIX B

Audit Results for Audits That Found Overpayments

Audit Number	Provider Type	Issue	Potential Overpayments	Overpayments
1	Hospital	Inappropriate Service Setting	\$29,649	\$1,921
2	Hospital	Inappropriate Service Setting	\$31,644	\$2,507
3	Hospital	Inappropriate Service Setting	\$41,845	\$2,626
4	Hospital	Inappropriate Service Setting	\$200,437	\$2,733
5	Hospital	Inappropriate Service Setting	\$10,173	\$2,908
6	Behavioral Health	Upcoding	\$15,792	\$3,825
7	Hospital	Inappropriate Service Setting	\$9,796	\$3,983
8	Hospital	Inappropriate Service Setting	\$16,297	\$5,561
9	Hospital	Inappropriate Service Setting	\$2,948,137	\$6,012
10	Home Health	Inappropriate Service Setting	\$7,000	\$7,000
11	Mental Health Clinic	Upcoding	\$10,375	\$8,000
12	Hospital	Inappropriate Service Setting	\$11,587	\$9,016
13	Hospital	Inappropriate Service Setting	\$26,689	\$9,699
14	Mental Health Clinic	Upcoding	\$9,343	\$9,800
15	Hospital	Inappropriate Service Setting	\$20,807	\$10,435
16	Mental Health Clinic	Upcoding	\$12,539	\$10,909
17	Pharmacy	Pharmacy Error	\$23,304	\$11,304
18	Hospital	Inappropriate Service Setting	\$52,977	\$11,517
19	Hospital	Inappropriate Service Setting	\$72,767	\$14,268
20	Hospital	Inappropriate Service Setting	\$8,581	\$16,764
21	Hospital	Inappropriate Service Setting	\$212,296	\$21,027
22	Hospital	Inappropriate Service Setting	\$47,642	\$23,450
23	Hospital	Duplicate Billings	\$98,223	\$25,165
24	Pharmacy	Early Refill	\$36,522	\$27,450
25	Pharmacy	Early Refill	\$80,170	\$27,583
26	Pharmacy	Early Refill	\$31,831	\$30,470
27	Hospital	Inappropriate Service Setting	\$56,818	\$30,472
28	Pharmacy	Early Refill	\$80,997	\$32,406
29	Pharmacy	Early Refill	\$94,202	\$33,747
30	Pharmacy	Pharmacy Error	\$46,759	\$34,374
31	Hospital	Inappropriate Service Setting	\$14,064	\$37,041
32	Pharmacy	Pharmacy Error	\$3,686	\$40,932
33	Hospital	Inappropriate Service Setting	\$45,811	\$45,811
34	Hospital	Inappropriate Service Setting	\$40,658	\$49,622
35	Hospital	Duplicate Billings	\$104,114	\$90,466
36	Long-Term Care	Hospice Services	\$1,600,000	\$218,758
37	Pharmacy	Pharmacy Services	\$240,333	\$240,333
38	Hospice	Hospice Services	\$821,842	\$284,645
39	Hospice	Hospice Services	\$723,678	\$487,430
40	Hospice	Hospice Services	\$2,038,482	\$575,808
41	Hospital	Hospice Services	\$1,420,613	\$1,367,218
42	Long-Term Care	Hospice Services	\$5,095,317	\$3,045,748

Source: Office of Inspector General analysis of the Database Audit Report Tracking System, 2011.

APPENDIX C

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB 08 2012

TO: Daniel R. Levinson
Inspector-General

FROM: ~~Marilyn Tavenner~~ /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Early Assessment of Audit Medicaid Integrity Contractors" (OEI-05-10-00210)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on this subject OIG draft report. The objectives of the report were: 1) to determine the extent to which Audit Medicaid Integrity Contractors (MIC) identified overpayments and 2) to describe any issues or barriers that hindered the identification of overpayments. OIG's recommendations offer important strategies for improving the effectiveness of contractors' efforts to identify fraud, waste, and abuse in the Medicaid program that are consistent with our own assessments.

In fiscal year 2010, CMS initiated a redesign of the Medicaid Integrity Program's National Audit Program. Through this redesign, CMS is engaging Audit and Review MICs and the States more extensively to improve MIC audit targets as well as improve the quality of data accessible to MICs. So far, these redesign efforts have been successful. For example, whereas OIG reported eight collaborative audits assigned during its study period from January 1 to June 30, 2010, CMS has since assigned 83 collaborative audits to Audit MICs in 10 States during the subsequent 18-month period. Currently, CMS is engaged in discussions with 13 additional States to develop new collaborative audit projects.

The collaborative audit efforts also involved progress in improving the quality of data accessible to MICs. The collaborative audits include up-to-date claims data from each State's respective Medicaid Management Information System (MMIS). In addition to working directly with States to obtain MMIS data for collaborative audits, CMS is leveraging data from the Medicare-Medicaid Data Match program, as well as obtaining extracts of MMIS data from several States for projects focused on pharmacy and other specific provider types. In addition, CMS has taken steps to improve communication among Audit MICs, Review MICs, and State Medicaid agencies to meet the challenges of conducting Federal audits of State claims, bound by a wide variety of State policies.

Our response to each of the OIG recommendations follows.

OIG Recommendation

The CMS should increase the use of collaborative audits.

CMS Response

The CMS concurs with this recommendation and has dramatically increased the number of collaborative audits assigned to Audit MICs since the period of OIG’s study. We have observed the same striking difference in the success of collaborative versus traditional audits and have re-designed the National Audit Program to focus the Audit MICs’ efforts more closely on collaborative projects with States, as described in the “Annual Report to Congress on the Medicaid Integrity Program for Fiscal Year 2010.” Whereas OIG reported 8 collaborative audits assigned during its study period from January 1 to June 30, 2010, CMS has since assigned 83 collaborative audits to Audit MICs in 10 States during the subsequent 18-month period. In addition, CMS is engaged in discussions with 13 additional States to develop new collaborative audit projects. As OIG has noted, an important key to the success of collaborative audits is the ability to work with States to obtain up-to-date MMIS data. CMS will continue to work to expand the scope of collaborative audit projects with a wider range of States as part of our multi-faceted approach to reducing the impact of improper payments on the Medicaid program.

OIG Recommendation

The CMS should improve audit target selection in States that choose not to be involved in collaborative audits.

CMS Response

The CMS concurs with this recommendation. OIG suggested that audit target selection for traditional audits could be improved by facilitating communication among Audit MICs, Review MICs, and States, and we appreciate that OIG recognized that CMS has already taken steps to permit more direct communication. CMS began facilitating monthly conference calls between Audit and Review MICs in late 2010 and has arranged for direct communication between Audit MICs and States to help clarify State policy issues. OIG also suggested that Audit and Review MIC interaction could be improved by combining the responsibilities and tasks of Audit and Review MICs under one Medicaid integrity contractor. CMS is internally evaluating options for awarding new contracts to include consolidating certain tasks and requirements for each regional program.

The OIG also concluded that audit target selection for traditional audits would benefit from improving the quality of data that MICs can access for conducting data analysis, which was the focus of the first recommendation in OIG’s companion report, “Early Assessment of Review Medicaid Integrity Contractors” (OEI-05-10-00200). CMS’ strategy for improving the quality of Medicaid claims data accessible to MICs is described at length in CMS’ response to the companion OIG report. In addition to working directly with States to obtain MMIS data for collaborative audits, CMS is leveraging data from the Medicare-Medicaid Data Match program,

as well as obtaining extracts of MMIS data from several States for projects focused on pharmacy and other specific provider types.

The CMS is also working to improve the quality of data in the Medicaid Statistical Information System (MSIS). MSIS is the database of nationwide Medicaid claims and beneficiary eligibility information that serves as the primary source of Medicaid claims data available for use by MICs. CMS has proposed additional data elements to expand the MSIS data set, called Transformed-MSIS (T-MSIS), and is currently introducing the expanded T-MSIS data set for pilot testing. This 10-State pilot project involves Medicaid data which represent approximately 40 percent of the nation's Medicaid expenditures. After assessment of the quality and utility of the T-MSIS data, the results and lessons learned from the multi-State pilot project will then be used as the basis for national implementation. As OIG has indicated, the implementation of T-MSIS will improve the quality of data available to the MICs and enhance audit target selection, especially in those States that choose not to participate in collaborative audits.

The CMS would like to thank OIG for its efforts in assessing the results of Audit MICs' program integrity activities and identifying the barriers that Audit MICs have encountered in performing those activities. We look forward to working with OIG on this and other issues in the future.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office; Thomas F. Komaniecki, Deputy Regional Inspector General; and Laura Kordish, Deputy Regional Inspector General.

Mark Stiglitz and Benjamin Dieterich served as project leaders for this study and Cassandra Yarbrough served as analyst. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Leigh Pylman; other central office staff who contributed include Kevin Manley and Andrew VanLandingham.

Office of Inspector General

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