Testimony of:
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Introduction

Good morning, Chairman Carper, Ranking Member Brown, and other distinguished Members of the Subcommittee. I am Ann Maxwell, Regional Inspector General for Evaluation and Inspections of the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG). I appreciate the opportunity to appear before you to discuss OIG's recent work focused on Medicaid program integrity.

My testimony today is based on several evaluations recently issued by OIG that focused on two national Medicaid integrity programs intended to augment States' efforts to protect Medicaid from fraud, waste, and abuse.[1] This body of work offers insights into the effectiveness of the Centers for Medicare & Medicaid's (CMS) National Medicaid Audit Program and the Medicare-Medicaid Data Match Program (Medi-Medi Program).

OIG's work reveals that these programs are not effectively accomplishing their missions. A primary objective for both programs is to identify improper payments for recovery. However, both programs had low findings of actual overpayments and, as a result, yielded negative returns on investment. These programs also delivered very few referrals of potential fraud to OIG and our law enforcement partners. In many ways, these programs resemble a funnel through which significant Federal and State resources are being poured in and limited results are trickling out.

In evaluating these programs, we found a variety of challenges that limited their potential to successfully identify Medicaid overpayments and potential fraud. Most fundamentally, there are significant shortcomings in the data available to conduct efficient, national Medicaid program integrity oversight through data analysis and data mining. In addition, variation in State Medicaid policies presented significant learning curves for integrity contractors, which had difficulty accurately applying the policies unique to each State. These problems led Medicaid Integrity Contractors (MIC) to misidentify potential overpayments and the Medi-Medi Program to identify fewer overpayments and fewer cases of potential fraud for Medicaid than it did for Medicare.

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[1] OIG evaluations that serve as the basis for this testimony are: (1) *Early Assessment of Review Medicaid Integrity Contractors*, OEI-05-10-00200, February 2012; (2) *Early Assessment of Audit Medicaid Integrity Contractors*, OEI-05-10-00210, March 2012; (3) *Status of 244 Provider Audit Targets Identified Using Review Medicaid Integrity Contractor Analysis*, OEI-05-10-00201, April 2012; and *The Medicare-Medicaid (Medi-Medi) Data Match Program*, OEI-09-08-00370, April 2012.

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The potential of these programs to safeguard Medicaid may also have been diminished by the way that CMS administered them. While the National Medicaid Audit Program appeared to suffer from too much CMS involvement, the Medi-Medi Program experienced the opposite problem: a lack of involvement by all of the relevant staff at the Federal level. In addition, CMS did not always hold the contractors operating these programs accountable for performing their contracted tasks.

Federal Medicaid Integrity Programs Were Created To Augment States' Efforts

The task of ensuring Medicaid program integrity has historically fallen primarily on States; the Federal Government has provided support and oversight. States have their own program integrity or inspector general offices dedicated to Medicaid. In addition, OIG supports the Medicaid Fraud Control Units (MFCU), which handle the majority of Medicaid fraud cases.

Only recently, legislation has led to a greatly expanded role in Medicaid program integrity for CMS. The Deficit Reduction Act (DRA) of 2005 established the Medicaid Integrity Program to fight fraud, waste, and abuse. The DRA requires CMS to contract with entities to identify overpayments to Medicaid providers. CMS contracted with two types of MICs—Review MICs and Audit MICs—to identify such overpayments. Together, their efforts are known as the National Medicaid Audit Program.[2]

In general, Review MICs conduct data mining on Medicaid claims, and Audit MICs conduct audits of specific providers. More specifically, Review MICs use Medicaid claims data made nationally available through CMS's Medicaid Statistical Information System (MSIS) to identify providers that potentially received overpayments. Audit MICs then audit selected providers to determine whether they had received actual overpayments that should be recouped by the State. This is what we refer to as the "traditional process."

In addition, CMS established a "collaborative process," in which CMS assigned collaborative audits when States were willing to participate. 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 mining models to identify potential overpayments. Instead of using MSIS, collaborative audits identify potential overpayments using data available in each State's Medicaid Management Information System (MMIS). All parties then determine which providers identified with potential overpayments should be audited.

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[2] A third contractor type, Education MICs, was also created by the DRA, but they are not involved in the audit program.

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The DRA also funded an expansion of the Medi-Medi Program. The Medi-Medi Program enables CMS and participating State and Federal agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse. Participation by State Medicaid agencies and other Federal agencies is optional, and States must contribute their own resources to participate. The purpose of analyzing Medicare and Medicaid claims data collectively is to detect billing patterns that indicate possible overpayments or fraud that may not be evident when analyzing the data separately.

CMS requires Medicare integrity contractors, known as Program Safeguard Contractors (PSC), to perform mandated Medi-Medi Program integrity tasks, which consist of:

- identifying program vulnerabilities by using computer algorithms to look for payment anomalies that may indicate improper payments or potential fraud;

- coordinating State and Federal actions to protect Medicare and Medicaid expenditures; and

- increasing the effectiveness and efficiency of Medicare and Medicaid prepayment denials and recovery of fraudulent, wasteful, or abusive expenditures.[3]

Federal Program Integrity Efforts Show Limited Results in Protecting Medicaid From Fraud and Abuse

As CMS took on a more active role in Medicaid program integrity at the Federal level, OIG assessed those efforts. Our evaluations assessed the results of the National Medicaid Audit Program, operated by CMS and the MICs, and the Medi-Medi Program, operated by the PSCs. These evaluations also sought to identify barriers that might be limiting the efficiency and effectiveness of these programs' integrity efforts.[4]

Federal Program Integrity Efforts Were Limited in Their Ability To Identify Medicaid Overpayments

The National Medicaid Audit Program had limited results during the time of our review. Audits of providers selected using the traditional process had particularly limited results. As Chart 1 demonstrates, during our review period, Review MICs initially identified 113,378 providers with potential overpayments of $282 million, but after performing audits, the Audit MICs eventually

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[3] CMS is transitioning program integrity work from PSCs to Zone Program Integrity Contractors (ZPIC). The chief difference between PSCs and ZPICs is that ZPICs cover broader geographical areas and multiple parts of the Medicare program, whereas PSCs cover more limited areas and scopes.

[4] OIG's three evaluations of the National Medicaid Audit program are an early assessment of the program. These evaluations focused on program integrity activities conducted as the result of assignments CMS made to MICs between January 1 and June 30, 2010. CMS completed the process of awarding MIC task orders to cover all regions of the country in the fall of 2009. Our evaluation of the Medi-Medi Program focused on 2007 and 2008.

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found that only 25 of these providers had overpayments, which totaled $285,629. The remaining 102 completed audits found no overpayments.

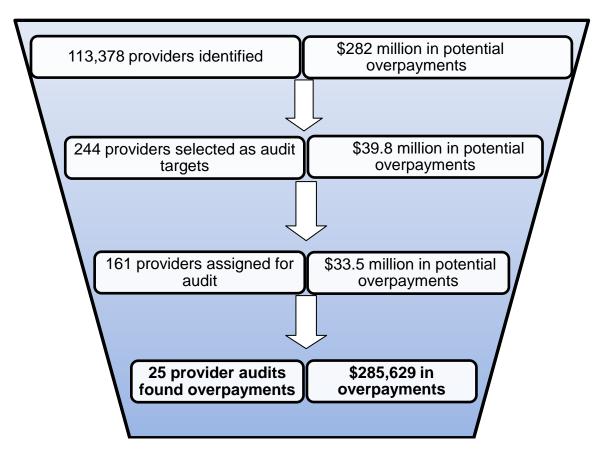Chart 1 shows the process that resulted in the identification of $285,629 in actual overpayments.

Chart 1: Identification of Overpayments From Review MIC Analysis

113,378 providers identified	$282 million in potential overpayments
244 providers selected as audit targets	$39.8 million in potential overpayments
161 providers assigned for audit	$33.5 million in potential overpayments
25 provider audits found overpayments	**$285,629 in overpayments**

A separate evaluation of audits assigned to Audit MICs also found few completed audits with findings of overpayments. OIG found that 81percent of these 370 audits either did not or are unlikely to identify overpayments. At the time of our review, only 11 percent of assigned audits were completed with findings, totaling $6.9 million in overpayments. The remaining audits had not progressed enough to draw conclusions about likely outcomes.

Most of the overpayment findings ($6.2 million) resulted from seven completed audits that used the collaborative approach. The remaining $700,000 in overpayments was identified by 35 audits that used the traditional approach.

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The Medi-Medi Program also had limited results, recovering few funds for the Medicaid program. Between 2007 and 2008, the Medi-Medi Program recovered $11.3 million for Medicaid. During the same time period, Medi-Medi recovered more than three times that amount – $34.9 million – for Medicare. While the amount recovered for Medicaid increased from $3.5 million in 2007 to $7.8 million in 2008, the total amount was still low compared to expenditures on the program.

Only 5 of the 10 participating States as of 2008 recovered Medicaid overpayments during our period of review.[5] Two of the participating States ultimately withdrew from the program, finding that it offered them minimal benefits. One of the two States that withdrew reported that it invested $250,000 of its own resources in the program, but recovered only $2,000 over a 5-year period (which included 2007 and 2008). However, during 2007 and 2008, that State also administered its own Medicaid integrity program, which recovered $28.9 million.

Identified Overpayments Yielded a Negative Return on Investment
The National Medicaid Audit Program did not identify overpayments commensurate with the investment CMS made in the program. In fiscal year (FY) 2010, CMS paid Review and Audit MICs approximately $32.1 million. Audit MICs identified $6.9 million in overpayments for assignments made in the first 6 months of calendar year 2010. Although we did not collect data for the other 6 months of the fiscal year, we have no information that would lead us to expect significantly different results. Projecting the 6-month results over a full year would yield less than $14 million, well below the annual expenditures. Further, these overpayment totals represent expected recoveries, not actual recoveries, and therefore may not all materialize as providers are given the chance to appeal the findings.

The Medi-Medi Program also had a poor return on investment. Although the Medi-Medi Program had better results for Medicare than for Medicaid, it was still not enough to achieve a positive return on investment during the time period we reviewed. In 2007 and 2008, Medicare and Medicaid expenditures recovered were $46.2 million and expenditures avoided were $11.6 million, bringing the program total to $57.8 million. However, CMS spent $60 million on the program during this same period.

Federal Program Integrity Contractors Made Few Medicaid Fraud Referrals
The National Medicaid Audit Program generated limited law enforcement referrals. During the time of our review, Review MICs did not identify any potential Medicaid fraud leads from their data mining efforts for CMS to review. CMS officials stated that they have now formalized the process for Review MICs to identify potential fraud leads. Audit MICs, however, have referred a limited number of fraud referrals to law enforcement over the course of the program.

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[5] After 2008, 7 additional States joined the Medi-Medi Program, resulting in a total of 15 participating States. As a result of the transition to ZPICs, the seven additional States joined the Medi-Medi Program as part of three geographic areas.

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The Medi-Medi Program also produced a small number of Medicaid law enforcement referrals. Over the 2 years we reviewed, the Medi-Medi Program produced 10 law enforcement referrals for Medicaid among the 10 participating States. Results for Medicare were better, although still limited, with 56 fraud referrals in this time period. Further, the vast majority of all referrals were in just 1 State, accounting for 41 percent (27 of 66) of the total referrals.

Poor Quality of Data Hindered National Medicaid Program Integrity Work

The poor quality of the Medicaid data on which these programs rely hindered their ability to efficiently detect suspicious trends in Medicaid claims for further auditing or investigation.

Review MICs use MSIS claims data to identify potential overpayments, the only national database of Medicaid claims and beneficiary eligibility information. However, OIG has found that the MSIS data are not current, available, complete, and accurate.[6] Further, MSIS does not capture all data elements that can assist in the detection of fraud, waste, and abuse.

Unlike the MICs, PSCs obtain Medicaid claims data directly from each participating State's MMIS to match them to Medicare data. These data are typically more complete and accurate. However, each State's MMIS data set is unique, rendering it difficult to match it to other States' MMIS data or to Medicare data.

The inaccuracies in and incompleteness of the MSIS data led Review MICs to misidentify providers with potential overpayments. One of the primary reasons audits resulted in no findings of overpayments was that the MSIS data used to pinpoint an audit target were inaccurate. In some instances, the reason that audits resulted in no findings of overpayments was that claims for outpatient services appeared as inpatient claims in MSIS, making the claims appear suspicious when they were, in fact, legitimate. In other cases, the State adjustments to claims were not reflected in MSIS, leading Review MICs to conclude that the State had overpaid a provider for a service when it had not.

The Medi-Medi Program faced different challenges attempting to use existing Medicaid data to fulfill its program integrity goals, mainly, efficiently matching State Medicaid data to Medicare data. The Integrated Data Repository was designed to automate the process of matching Medicaid to Medicare data. The repository contains data from Medicare Parts A, B, and D. However, as of the date of this testimony, Medicaid data are not yet included in the repository and are not projected to be available for use by the Medi-Medi Program until at least 2015.

According to CMS, Medicaid data in their current form would not be appropriate to integrate into the Integrated Data Repository. MSIS data lack many of the standardized data elements needed for program integrity work and often lack consistency across States. Similarly, States' MMISs do not

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[6] *OIG, MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse,* OEI-04-07-00240, August 2009.

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allow for efficient matching to Medicare data because the data are structured to meet State-specific needs, containing variables and data definitions unique to each.

Medicaid Contractors Had Difficulty Accurately Applying State Medicaid Program Policies

Both the National Medicaid Audit Program and the Medi-Medi Program encountered problems when contractors incorrectly applied State Medicaid policies in their analyses of Medicaid data. Knowledge of State Medicaid policies is critical to correctly interpreting the data.

MICs misidentified audit targets because they lacked the appropriate knowledge of each State's Medicaid program policies. Five of the seven State Medicaid oversight agencies interviewed stated that the audit targets were often inappropriate because of misinterpretation of State policy. For example, 44 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 in this instance, both payments were appropriate.[7, 8]

The Medi-Medi program also encountered these same issues with interpreting and analyzing Medicaid claims data. Four of the ten participating State Medicaid program integrity agencies said that the Medicare program integrity contractors administering the program do not understand Medicaid and that as a result they primarily analyze Medicare claims data.

Poor Program Administration Diminished the Potential of These Program Integrity Efforts

Our evaluations also reveal that poor administration of the National Medicaid Audit Program and the Medi-Medi Program appears to have limited their effectiveness. In addition, CMS did not always hold contractors accountable for the tasks outlined in their contracts. These are issues OIG has identified in the administration and oversight of Medicare integrity contractors for the past decade.

Basic Program Design Limited Efficiency and Effectiveness
Both the National Medicaid Audit Program and the Medi-Medi Program were constrained by elements of their program design. The National Medicaid Audit Program appears to have been constrained by the lack of communication among the contractors and States. At the time of our review, all communication, whether between Review and Audit MICs, between MICs and States,

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[7] 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.

[8] 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.

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or between MICs and different divisions within CMS, went through a multistep process controlled by CMS. According to the MICs, this served to slow the flow of information and delayed work. Audit MICs stated that they felt compelled to duplicate Review MIC analyses because they could not easily communicate with Review MICs or States. The inability to communicate freely also meant MICs could not take full advantage of States' knowledge of State Medicaid policies.

CMS stated in response to our report that it considered its involvement to be responsible oversight in establishing a new program. Now that the program has been in existence for several years, CMS is allowing freer communication among all the parties involved in the National Medicaid Audit Program.

While the National Medicaid Audit Program appeared to suffer from too much CMS involvement, the Medi-Medi Program experienced the opposite problem: a lack of involvement by all of the appropriate CMS staff. Federal Medicaid program integrity staff were not incorporated into the administration of the program. Rather, the Medi-Medi Program was administered entirely by the Medicare Program Integrity Group. Both States and Medi-Medi contractors indicated that this resulted in a deemphasis on Medicaid program integrity within the program, leaving the majority of Medi-Medi activities focused on Medicare claims analysis. In response to our evaluation, CMS stated that it is assessing ways to increase the involvement of Medicaid program integrity staff.

CMS Did Not Hold Contractors Fully Accountable
MICs were not held accountable for completing all of their contracted tasks. Review MICs' task orders with CMS state that Review MICs are to provide or recommend audit leads, among other tasks. However, during our review period, CMS stated that it expected Review MICs only to conduct data analysis and provide lists of providers ranked by the amount of their corresponding potential overpayments and did not expect them to recommend audit leads. As a result, Review MICs did not single out any individual providers on their lists as specific audit leads. Rather, Review MICs provided lists containing a total of more than 113,000 providers to CMS for its review. CMS selected only 244 of these providers as audit targets, suggesting that CMS did a significant amount of work to screen the provider lists. Thus, it appears that CMS staff completed much of the Review MICs' contracted tasks themselves.

Similarly, CMS did not hold PSCs fully accountable for their administration of the Medi-Medi Program. Although CMS conducts annual assessments of PSCs, CMS did not formally evaluate the PSCs on each of the contracted Medi-Medi tasks. OIG found CMS's documentation of PSC performance to be insufficient for drawing conclusions about their effectiveness in completing Medi-Medi tasks.

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OIG Recommends Improvements to Medicaid Data and Program Administration

To improve the efficiency and effectiveness of these programs, we recommend that CMS:

- Devote the resources necessary to improve the quality of the Medicaid data available to conduct national Medicaid program integrity data analysis and mining.

- Improve the ability of contractors to properly analyze Medicaid data in light of State-specific policies.

- Evaluate the goals, design, and operations of both programs to determine what aspects of these programs should be part of a national Medicaid program integrity strategy. For the National Medicaid Audit Program, CMS should consider increasing the use of collaborative audits. Collaboration among Audit MICs, Review MICs, States, and CMS during audits appears to have improved the selection of audit targets and the efficiency of the audit process, leading to better results.

- Hold contractors accountable for all of the tasks outlined in their contracts by establishing clear expectations that align with the contracts and evaluating all tasks during the annual assessments.

In response, CMS stated that it has an initiative underway, called Transformed MSIS, to improve the quality of national Medicaid data. Additionally, CMS stated that it has redesigned its approach to audit assignments, instructing Audit MICs to focus on collaborative projects. In fact, CMS stated that it assigned more audits through the collaborative process than through the traditional process in 2011. CMS has also stated it has made significant strides in enhancing the effectiveness of the Medi-Medi Program. However, evidence of this has not been made available.

Conclusion: More Needs To Be Done To Protect the Integrity of Medicaid Payments

OIG's body of work raises questions about the overall effectiveness of the National Medicaid Audit Program and the Medi-Medi Program in protecting Medicaid from fraud, waste, and abuse. OIG's work reveals that neither program produced results commensurate with the investments made in them.

Given the size of current Federal and State outlays for Medicaid and the potential for increased outlays as the beneficiary population expands, a robust national approach to Medicaid program integrity is imperative.

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While we are encouraged by the changes that CMS has made, more must be done to improve these programs and ensure the economical investment of Federal and State dollars. Critically, CMS needs to improve data available to each program to enable them to efficiently and effectively identify potential overpayments and possible fraud.

Thank you for your interest in this important issue and for the opportunity to be a part of this discussion about better protecting Medicaid funds from fraud, waste, and abuse.

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