



Testimony

Before the Subcommittee on Federal Financial Management,
Government Information, Federal Services, and
International Security, Committee on Homeland Security
and Governmental Affairs, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
June 14, 2012

NATIONAL MEDICAID AUDIT PROGRAM

CMS Should Improve Reporting and Focus on Audit Collaboration with States

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G A O

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Chairman Carper, Ranking Member Brown, and Members of the Subcommittee:

I am pleased to be here today to discuss the National Medicaid Audit Program. Until recently, Medicaid program integrity had been primarily a state responsibility. Specifically, states have been responsible for ensuring the qualifications of the providers who bill the program, detecting improper payments, recovering overpayments, and referring suspected cases of fraud and abuse to law enforcement authorities.¹ At the federal level, however, the Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program to oversee and support state program integrity efforts, and, among other actions, directed the Centers for Medicare & Medicaid Services (CMS) to hire contractors to review and audit state Medicaid claims data.² CMS established the Medicaid Integrity Group (MIG) to implement and oversee the National Medicaid Audit Program (NMAP).³

My statement will highlight key findings from a report prepared at your request.⁴ This report focuses on: (1) the effectiveness of the MIG's implementation of NMAP and (2) the MIG's efforts to redesign NMAP. To conduct this work, we analyzed NMAP data provided by the MIG and interviewed MIG officials. In addition, we reviewed reports submitted by the MIG's review and audit contractors and interviewed representatives of

¹An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note). The Centers for Medicare & Medicaid Services estimated that \$21.9 billion (8 percent) of Medicaid's federal expenditures of \$270 billion in fiscal year 2011 involved improper payments, the second highest amount reported by any federal program.

²Pub. L. No. 109-171, § 6034, 120 Stat. 3, 74-78 (2006) (codified at 42 U.S.C. § 1396u-6). CMS is the federal agency within the Department of Health and Human Services that oversees Medicaid.

³See GAO, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States*, [GAO-12-288T](#) (Washington, D.C.: Dec. 7, 2011).

⁴See GAO, *National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States*, [GAO-12-627](#) (Washington, D.C.: June 14, 2012).

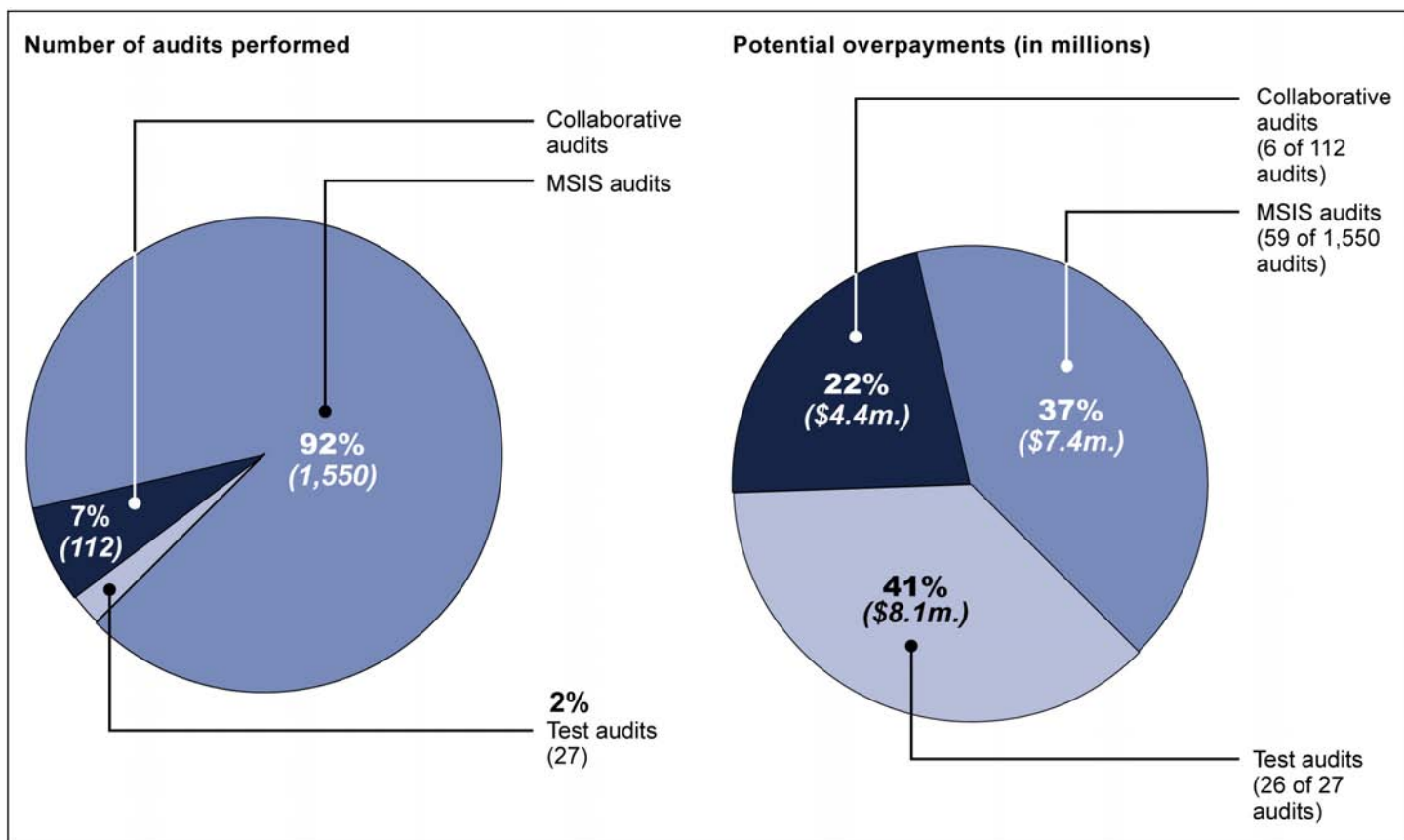
each type of contractor. We also interviewed program integrity officials in 11 states to obtain their perspectives on NMAP, and collected additional information from 8 states where the MIG has recently implemented changes to NMAP.⁵ We reviewed relevant Department of Health and Human Services Office of the Inspector General (HHS-OIG) reports, and interviewed HHS-OIG officials involved in early assessments of the MIG's review and audit contractors. More information on our scope and methodology is provided in the full report. We performed our work from July 2011 to June 2012 in accordance with generally accepted government auditing standards.

We found that, compared to the initial test audits and the more recent collaborative audits, the majority of the MIG audits conducted under NMAP were less effective because they used Medicaid Statistical Information System (MSIS) data.⁶ MSIS is an extract of states' claims data and is missing key elements, such as provider names, that are necessary for identifying audit targets. Since fiscal year 2008, a small fraction (4 percent) of the 1,550 MSIS audits identified \$7.4 million in potential overpayments, over two-thirds did not identify overpayments, and the remaining audits (27 percent) were ongoing. In contrast, 26 test audits and 6 collaborative audits—which used states' more robust Medicaid Management Information System (MMIS) claims data and allowed states to select the audit targets—together identified more than \$12 million in potential overpayments. (See fig. 1.) Furthermore, the typical amount of the potential overpayment for MSIS audits (\$16,000) was smaller than the amounts identified through test and collaborative audits—\$140,000 and \$600,000—respectively.

⁵CMS had implemented changes to NMAP in nine states; however, eight responded to our questions on the changes to the program. We selected these 11 states because of their geographic diversity and because together they accounted for more than half of Medicaid spending and beneficiaries.

⁶For this statement, we refer to audits that used MSIS data as MSIS audits. The other two types of NMAP audits (test audits and collaborative audits) used state claims data.

Figure 1: Number of Audits and Total Potential Overpayments Identified and Sent to States for Recoupment (in millions of dollars) by Audit Approach, through February 2012



Source: GAO analysis of CMS data.

Notes: Test audits were conducted from 2007 through 2010. MSIS audits began in 2008 and are ongoing. Collaborative audits began in 2010 as part of the redesign of the NMAP and are also ongoing. Dollar amounts shown are potential overpayments in final audit reports sent to states for recovery. They do not reflect the amounts in draft audit reports or the amounts actually recovered by the states. Percentages may not total 100 because of rounding.

The MIG reported that it is redesigning NMAP, but has not provided Congress with key details about the changes it is making to the program, including why it changed to collaborative audits, new analytical roles for its contractors, and its plans to monitor and evaluate the redesign. Early results showed that this collaborative approach may enhance state program integrity activities by allowing states to leverage the MIG's resources to augment their own program integrity capacity. However, the lack of a published plan detailing how the MIG will monitor and evaluate

NMAP raises concerns about the MIG's ability to effectively manage the program. Given that NMAP has accounted for more than 40 percent of MIG expenditures, transparent communications and a strategy to monitor and continuously improve NMAP are essential components of any plan seeking to demonstrate the MIG's effective stewardship of the resources provided by Congress.

Our report includes recommendations that the Acting Administrator of CMS ensure that the MIG's (1) planned update of its comprehensive plan provides key details about NMAP, including its expenditures and audit outcomes, program improvements, and plans for effectively monitoring the program; (2) future annual reports to Congress clearly address the strengths and weaknesses of the audit program and its effectiveness; and (3) use of NMAP contractors supports and expands states' own program integrity efforts through collaborative audits. In commenting on a draft of our report, HHS partially concurred with our first recommendation but believed that CMS's annual report to Congress was a more appropriate vehicle for reporting NMAP results than its comprehensive plan. HHS concurred with the other two recommendations.

Chairman Carper, Ranking Member Brown, and members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

For questions about this statement, please contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Walter Ochinko, Assistant Director; Sean DeBlieck; Leslie V. Gordon; and Drew Long.

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