

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**EARLY ASSESSMENT OF  
REVIEW MEDICAID  
INTEGRITY CONTRACTORS**



**Daniel R. Levinson**  
Inspector General

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## **Executive Summary: Early Assessment of Review Medicaid Integrity Contractors**

**OEI-05-10-00200**

### **WHY WE DID THIS STUDY**

This study presents an early assessment of the efforts of Review Medicaid Integrity Contractors (Review MIC) to conduct data analysis to identify potential overpayments and provide or recommend audit leads to the Centers for Medicare & Medicaid Services (CMS). Our objectives were: (1) to determine the extent to which Review MICs completed assignments, recommended audit leads, and identified potential fraud; and (2) to describe barriers that Review MICs encountered in their program integrity activities.

### **HOW WE DID THIS STUDY**

This study focused on Review MICs' results for assignments made between January 1 and June 30, 2010. We analyzed the results of Review MIC assignments, reviewed assignment data from CMS's Algorithm Tracking Database, and interviewed CMS and Review MIC staff. We did not determine whether Review MIC activities resulted in the recovery of actual overpayments.

### **WHAT WE FOUND**

Review MICs completed 81 percent of their assignments; however, they had limited involvement in recommending specific audit leads and identifying potential fraud. Review MICs did not recommend specific audit leads; instead, CMS required Review MICs to submit lists of providers ranked by the amount of their potential overpayments. Review MIC assignments resulted in 114 accepted reports, which identified 113,378 unique providers. CMS filtered this list of unique providers, selecting 244 audit targets. Review MICs did not identify any potential fraud leads from their assignments.

Because data were missing or inaccurate, Review MICs were hindered in their ability to accurately complete data analysis assignments. States invalidated more than one-third of sampled potential overpayments from assignments, mainly because data were missing or inaccurate. As a result, some of Review MICs' data analyses may not lead to recoveries.

### **WHAT WE RECOMMEND**

We recommend that CMS: (1) improve the quality of data that Review MICs can access for conducting data analysis and (2) require Review MICs to recommend specific audit leads.

CMS concurred with both recommendations. CMS stated that to improve the quality of data that Review MICs can access for conducting data analysis, it has several initiatives underway. CMS is expanding the Medicaid Statistical Information System to include additional data elements important for detecting Medicaid fraud, waste, and abuse. CMS is also working directly with States to obtain State Medicaid data. With respect to our second recommendation, CMS stated that it will direct Review MICs to include specific recommendations in their data analysis reports for followup as potential audit targets.

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## OBJECTIVES

1. To determine the extent to which Review Medicaid Integrity Contractors (Review MIC) completed data analysis assignments, recommended audit leads, and identified potential fraud.
2. To describe barriers that Review MICs encountered in their program integrity activities.

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## BACKGROUND

Medicaid is jointly funded by States and the Federal Government to provide certain basic 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.<sup>1</sup> According to the Centers for Medicare & Medicaid Services (CMS), Medicaid spending is projected to grow because of anticipated increases in Medicaid enrollment.<sup>2</sup> These projected costs will strain already-burdened State and Federal budgets.

Fraud, waste, and abuse of Medicaid unnecessarily add to 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 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.<sup>3</sup>

### **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.<sup>4</sup> 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,<sup>5</sup> and beneficiaries regarding program integrity issues.<sup>6</sup> The Medicaid Program Integrity Group within CMS is responsible for

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<sup>1</sup> 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.

<sup>2</sup> CMS, *2010 Actuarial Report on the Financial Outlook for Medicaid*. Accessed at <http://www.cms.gov> on June 15, 2011.

<sup>3</sup> Department of Health and Human Services, *FY 2010 Agency Financial Report*. Accessed at <http://www.hhs.gov> on August 22, 2011.

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

<sup>5</sup> Managed care organizations contract with States to provide Medicaid services.

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

administering the Medicaid Integrity Program and overseeing the contracted entities.

CMS defined three types of Medicaid Integrity Contractors (MIC) to perform the program integrity activities listed 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 conduct audits of providers and identify actual overpayments. Education MICs educate providers and beneficiaries on program integrity issues.

### **Review MICs' Task Orders**

In 2008, CMS began awarding Review MIC task orders to two firms. These two firms, Thomson Reuters and AdvanceMed, were awarded five task orders covering geographic areas that correspond to the 10 CMS regions across the country.<sup>7</sup> Task orders in effect for FY 2010 allowed Review MICs to earn a maximum of approximately \$15 million depending on costs they incurred in fulfilling their task orders. CMS spent approximately \$13.3 million on Review MICs in FY 2010.

Within each task order, CMS defines the primary functions that Review MICs are tasked to perform, as follows:

1. conducting data analysis and data modeling, and performing risk assessments of Medicaid data;
2. providing or recommending leads for Audit MICs to determine whether any Medicaid claims identified by Review MIC data analysis were paid inappropriately; and
3. detecting or preventing Medicaid fraud, waste, and abuse by individuals or entities furnishing items or services under Medicaid.<sup>8</sup>

### **Review MIC Identification of Potential Overpayments**

*Review MIC assignments.* 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

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<sup>7</sup> Thomson Reuters was awarded task orders for Regions III and IV (East and Southeast) in April 2008 and for Regions I and II (Northeast) in August 2009. AdvanceMed was awarded task orders for Regions VI and VIII (South and Mountain West) in September 2008, for Regions V and VII (Midwest) in May 2009, and for Regions IX and X (West and Northwest) in September 2009. CMS established a 60-day transition period for Review MICs after awarding each task order.

<sup>8</sup> CMS, *Review of Medicaid Provider Task Orders*.

use to perform assignments.<sup>9</sup> CMS expects Review MICs to consider any relevant State or Federal policies, such as maximum quantity limits for certain drugs, to complete their assignments. CMS generally allows Review MICs 60 days to complete them.

Review MICs use data sources stored within a CMS data repository known as the Information Technology Infrastructure (ITI) to complete their assignments. The ITI contains several sources of data; the primary source is the Medicaid Statistical Information System (MSIS). 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.<sup>10,11</sup> The ITI also contains files to assist Review MICs in the analysis of MSIS data, such as the Social Security Administration's Death Master File, medical coding files, commercial drug data files, and the National Provider Identifier file.<sup>12</sup>

Generally, Review MICs send selected samples of potential overpayments to the appropriate States for validation. States determine whether the sampled potential overpayments are valid—i.e., whether they are in fact overpayments—using their State data systems. States provide an explanation for their validation or invalidation of the sampled potential overpayments to Review MICs. If States invalidate more than half of sampled potential overpayments, CMS requires Review MICs to adjust their data review.

*Review MIC submission of assignment results.* Once Review MICs finish their assignments, they enter their results into the ITI and generally submit Algorithm Findings Reports to CMS. In these reports, Review MICs describe the purpose of the assignments, provide background information on State policies, list the potential overpayments identified by claim and provider, detail States' responses to sampled claims, and indicate whether any adjustments were made as a result of States' responses. Algorithm Findings Reports also give Review MICs an opportunity to provide

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<sup>9</sup> Algorithms target specific types of potential overpayments, such as services provided after a beneficiary's date of death or duplicate claims that appear to be for the same service. CMS and Review MICs are each responsible for developing algorithms.

<sup>10</sup> MSIS data are a specified subset of fields extracted from each State's Medicaid Management Information System (MMIS). MMIS enables States to process claims and monitor use of services.

<sup>11</sup> MSIS includes four Medicaid claims files: (1) inpatient care; (2) long-term care; (3) prescription drugs; and (4) all other claims, along with files of eligible Medicaid enrollees. CMS, *Medicaid Statistical Information System (MSIS) File Specs & Data Dictionary*. Accessed at <http://www.cms.gov> on March 11, 2011.

<sup>12</sup> The Social Security Administration's Death Master File includes information reported by State Governments, funeral homes, and friends and family on the deaths of individuals registered with the Social Security Administration.

recommendations for further action and identify specific audit leads, with an optional section to list any potential fraud.<sup>13</sup>

CMS has also periodically assigned special projects that do not require Review MICs to submit Algorithm Findings Reports. In some cases, CMS has assigned special projects to identify overpayments that would result in letters requesting repayment from the States rather than audits of providers.

CMS requires Review MICs to store lists of all providers identified by completed assignments, including special projects, in the ITI. These lists sum the number of claims that each provider was potentially overpaid and rank providers by the amount of the potential overpayment.

### **CMS Review of Completed Assignments**

CMS considers data analysis assignments complete once it accepts Review MIC results following CMS's quality assurance review. This review includes an analysis of State policies, a review of the algorithms used by Review MICs, and verification of Review MICs' calculation of potential overpayments. If an assignment fails this quality assurance review, CMS does not consider the assignment complete. For such assignments, CMS generally requires Review MICs to conduct further data analysis and to resubmit the results, including Algorithm Findings Reports.

### **Related Work**

OIG is conducting a companion study that focuses on early results for audits assigned to Audit MICs between January 1 and June 30, 2010. That study will also identify any barriers Audit MICs encountered in conducting audits of Medicaid providers and identifying actual overpayments.

In addition, OIG published a report in 2009 addressing the usefulness of MSIS data in detecting fraud, waste, and abuse in Medicaid. OIG found that MSIS did not capture all data elements that can assist in the detection of fraud, waste, and abuse, including those that CMS had identified as necessary for such detection. Data were missing from provider identifiers; procedure, product, and service descriptions; billing information; and beneficiary and eligibility information.<sup>14</sup>

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<sup>13</sup> The section on fraud became a required section of the Algorithm Findings Report in December 2010, which was after the period reviewed by this study.

<sup>14</sup> OIG, *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse*, OEI-04-07-00240, August 2009.

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## METHODOLOGY

### Scope

This study is an early assessment of the results of Review MICs' program integrity activities and barriers that Review MICs encountered when performing those activities. This study focused on Review MICs' program integrity activities conducted between January 1 and June 30, 2010. We selected January 1, 2010, as the beginning of our review period to allow all Review MICs to have completed the 60-day transition periods for their task orders. We selected June 30, 2010, as the end of our review period to create a 6-month review period upon which to base our findings.

This study did not evaluate the effectiveness of the Medicaid Integrity Program overall, nor did it evaluate the effectiveness of CMS's policies and procedures concerning Review MIC assignments and CMS's selection of audit targets. Instead, we focused on the results of Review MICs' program integrity activities and any barriers that Review MICs encountered when performing them.

In addition, we did not determine whether Review MICs' activities to identify fraud, waste, and abuse resulted in the recovery of overpayments. Because of the amount of time required for Audit MICs to conduct audits, few—if any—assignments made during our review period would have resulted in final audits or recoveries by the end of our data collection.

### Data Sources

*Data collection.* We collected data from CMS concerning Review MICs' data analysis assignments made between January 1 and June 30, 2010. We collected these data between November and December 2010, which allowed enough time for the completion of all data analysis, given the typical 60-day deadline for completing assignments. Specifically, we collected:

- Assignment data from CMS's Algorithm Tracking Database. This database contains the algorithm, the responsible Review MIC, the State under review, milestone dates, status of assignments, and summary overpayment results for each assignment. CMS maintains the Algorithm Tracking Database to track the progress and results of Review MIC assignments. There were 361 assignments from our review period listed in this database.
- ITI files for completed assignments. The ITI contains lists of providers and potential overpayment data identified by completed assignments. These files include the unique provider identification number and the amount of potential overpayment for each provider identified in each completed assignment. There were 274 completed assignments with

data files in the ITI. Seventeen completed assignments did not have files in the ITI because they had no or low findings.

- Algorithm Findings Reports for completed assignments. These reports include descriptions of the problems identified, the number of providers and amount of potential overpayments identified, results from States' validation of sampled potential overpayments, any audit leads recommended, and any identified potential fraud leads. There were 114 completed assignments that resulted in Algorithm Findings Reports.<sup>15</sup>
- Audit targets selected from completed assignments. Audit targets are identified by their unique provider identification numbers and include the assignments in which they were identified as well as the amount of potential overpayments to be audited. CMS selected 244 audit targets.

*Interviews.* We conducted structured interviews with staff from each Review MIC and from CMS to identify barriers that Review MICs encountered when conducting program integrity activities. These interviews also included questions about Review MIC results, including the identification of audit leads and the identification of potential fraud leads.

## **Data Analysis**

*Algorithm Tracking Database.* Using the Algorithm Tracking Database, we analyzed assignments that Review MICs received between January 1 and June 30, 2010. We determined whether each assignment was complete, ongoing, placed on hold by CMS, or rejected by CMS as of November 1, 2010.

*ITI.* We analyzed data files in the ITI that Review MICs submitted for completed assignments identifying providers and their potential overpayments. Because some providers were identified in multiple assignments, we determined the unique providers identified by Review MICs across all data files. We calculated each unique provider's total potential overpayment amount across all completed assignments.

In the case of some regular assignments with algorithms intended to identify services provided after a beneficiary's date of death, CMS reassigned the algorithms with new ranges of service dates for Review MICs to analyze as part of a nationwide special project. For providers identified in both regular assignments and special project assignments, we counted only the potential overpayments identified by Review MICs in the regular assignments.

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<sup>15</sup> We received Algorithm Findings Reports for 113 assignments. One additional assignment resulted in an Algorithm Findings Report, but the report was not provided to OIG. However, for this assignment, we did receive the results and sufficient evidence that an Algorithm Findings Report had been submitted to CMS.

*Algorithm Findings Reports.* For completed assignments that resulted in final Algorithm Findings Reports, we analyzed the reports to determine whether Review MICs recommended specific audit leads or identified potential fraud leads to CMS. We also reviewed final Algorithm Findings Reports to determine which algorithms CMS defined as identifying potentially improper or fraudulent billing patterns. Further, we calculated the percentage of sampled claims that States invalidated as potential overpayments.

*Audit targets.* We analyzed the providers that CMS selected as audit targets by December 2010. These audit targets were selected from the lists Review MICs provided in Algorithm Findings Reports for assignments made between January 1 and June 30, 2010. Because some providers were selected from multiple Algorithm Findings Reports, we identified the unique audit targets selected by CMS across all Algorithm Findings Reports. We then calculated the amount of potential overpayments CMS selected to be audited for each unique audit target.

*Interviews.* We analyzed the results of structured interviews with staff from each Review MIC and CMS to determine whether the two Review MICs encountered the same obstacles when conducting program integrity activities. We also analyzed these structured interviews to determine whether Review MICs recommended audit leads or identified potential fraud leads.

## **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.

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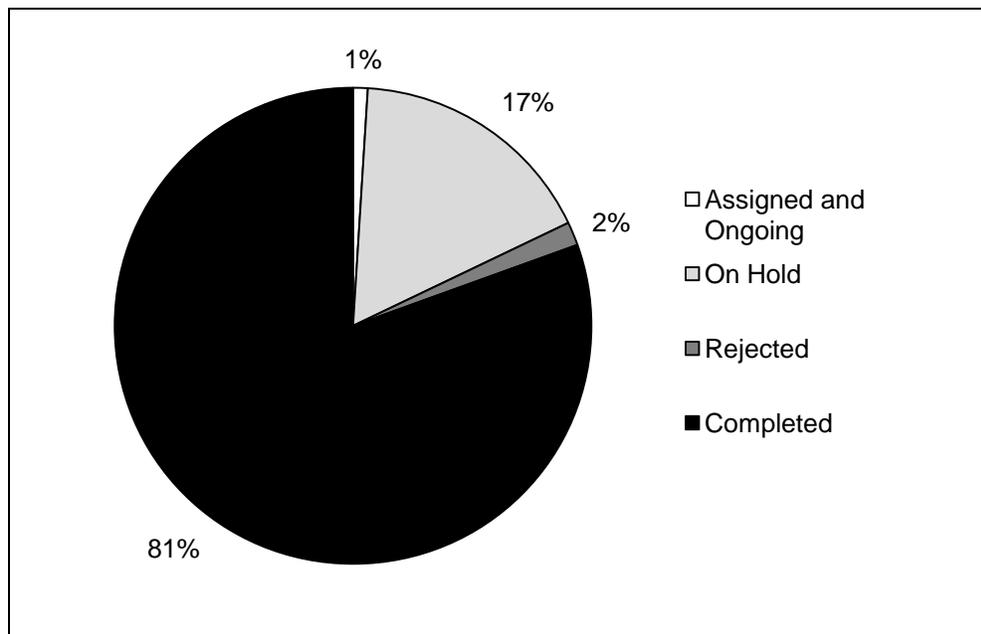
## FINDINGS

### **Review MICs completed 81 percent of their assignments; however, they had limited involvement in recommending specific audit leads and identifying potential fraud**

Review MICs were tasked with 361 data analysis assignments by CMS between January 1 and June 30, 2010. The 361 assignments covered every State plus the District of Columbia and used 31 distinct algorithms. Sixty-two percent of assignments used algorithms intended to identify services provided after a beneficiary's date of death. Other assignments used algorithms intended to identify duplicate billing, pharmacy errors, and excessive amounts of services. See Appendix A for additional detail on Review MIC assignments.

Review MICs completed 81 percent of assignments (either regular or special project assignments). Nearly all completed assignments were completed within the assigned timeframes. Seventeen percent of assignments were placed on hold by CMS. The remaining 3 percent were ongoing and had passed the assigned completion dates or were rejected by CMS. See Chart 1 for a breakdown of the status of assignments as of November 2010.

**Chart 1:  
Status of Review  
MIC Assignments  
as of November  
2011\***



Source: OIG analysis of Review MIC assignments, 2011.

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

The 291 completed assignments fall into 3 categories. Forty percent, or one hundred fourteen assignments, were completed assignments that resulted in Algorithm Findings Reports. An additional 172 completed assignments were for a special project to identify services billed after beneficiaries' date of deaths. These special project assignments were not expected to lead to Algorithm Findings Reports or audit leads. The remaining five completed assignments were other special project assignments.

**Review MICs did not recommend specific audit leads; instead, CMS required Review MICs to submit lists of providers ranked by the amount of their potential overpayments**

For the 114 data analysis assignments that resulted in Algorithm Findings Reports, Review MICs ran the assigned algorithms and provided CMS with the results. The results consisted of lists of providers ranked by the amount of their potential overpayments. Fifty-two percent of the Algorithm Findings Reports also contained a separate list of top providers ranked by the amount of potential overpayments. None contained specific recommendations for audit leads.

The Algorithm Findings Reports contained 113,378 unique providers with \$282 million in potential overpayments. The number of providers ranged from zero to nearly 86,000. The \$282 million in potential overpayments were generated by approximately 1 million claims for services covered under Medicaid.

Although the amount of potential overpayments for each provider varied, most potential overpayments were modest. Eighty-nine percent of providers included in the ranked lists each had less than \$1,000 in potential overpayments, including 107 providers with \$0 in potential overpayments. At the high end of the range, one provider had more than \$3.6 million in potential overpayments.

The specific providers included in the separate lists of top providers do not appear to be recommended audit leads. For example, one Algorithm Findings Report in Rhode Island had a top provider list on which the top provider had \$69,000 in potential overpayments and the last 5 providers all had under \$1,000 in potential overpayments. An Algorithm Findings Report in Utah listed all 7 providers identified by the assignment in the top provider list, including a provider with \$992 in potential overpayments and a provider with only \$20 in potential overpayments.

**Instead of requiring Review MICs to provide specific audit leads, CMS selected 244 audit targets from the full lists of 113,378 providers**

CMS selected 244 audit targets with \$39.8 million in potential overpayments, covering a retrospective 5-year audit period established by CMS.<sup>16</sup> Of the 244 audit targets, 133 were in the top 10 providers identified by Review MICs in any given assignment. Forty-nine of the 244 audit targets had total potential overpayments of over \$100,000 each for the 5-year audit period. The majority of audit targets, or 182 audit targets, had between \$10,000 and \$100,000 in potential overpayments. See Table 1 for a breakdown of the potential overpayments of providers selected as audit targets.

**Table 1: Providers Selected by CMS for Audits as of December 2010**

Amount of Potential Overpayment	Number of Providers Identified by Review MICs	Number of Providers Selected by CMS for Audits	Total Potential Overpayments Selected for Audits
\$1 million to \$3.6 million	32	7	\$17.7 million
\$100,000 to \$999,999	475	42	\$15 million
\$10,000 to \$99,999	905	182	\$7.1 million
\$1,000 to \$9,999	10,725	8	\$39,000
\$1 to \$999	101,134	5	\$2,000
\$0	107	0	NA
<b>Total</b>	<b>113,378</b>	<b>244</b>	<b>\$39.8 million</b>

Source: OIG analysis of Review MIC assignments, 2011.

CMS took multiple steps to select the 244 audit targets to pass on to Audit MICs. The first step was to conduct quality assurance reviews on all submitted Algorithm Findings Reports. This resulted in the acceptance of 114 reports, which identified 113,378 unique providers. The quality assurance reviews included analyzing State policies, which Review MICs are expected to consider when completing their assignments. The quality assurance reviews also included reviewing the algorithms used by Review MICs and verifying Review MICs' calculation of potential overpayments. CMS categorized assignments as complete once they passed its quality assurance review.

After categorizing the 114 Algorithm Findings Reports as complete, CMS had to filter the 113,378 unique providers to determine which of the audit leads would make suitable audit targets. CMS considered all 113,378 unique providers listed by Review MICs to be audit leads. Of the

<sup>16</sup> CMS established a 5-year audit period because most States require providers to maintain records for at least 5 years.

244 audit targets selected from the ranked lists of providers, 111 were not in the top 10 providers identified by Review MICs for any given assignment.

In selecting audit targets, CMS considered a variety of factors. For example, CMS officials reported that they considered the number of ongoing audits in the relevant State and the number of audits assigned to the responsible Audit MIC when selecting the 244 audit targets. CMS then screened the audit targets to ensure that they were not being audited or were not under investigation by States or by other Federal entities, such as OIG and the Department of Justice.

For more than half of the 244 audit targets, CMS also had to adjust the potential overpayments reported by Review MICs. CMS removed potential overpayments reported by Review MICs that occurred beyond the 5-year audit period. Ultimately, CMS removed more than \$5.6 million from the \$45.5 million in potential overpayments that Review MICs attributed to the 244 audit targets, leaving \$39.8 million in potential overpayments.

#### **Review MICs did not identify any potential fraud leads**

Both a review of Algorithm Findings Reports and interviews with Review MIC and CMS staff revealed that Review MICs did not identify any potential fraud leads to CMS from assignments made between January 1 and June 30, 2010. However, for 20 assignments, Review MICs were assigned algorithms that CMS described as identifying potentially improper or fraudulent billing patterns. For these 20 assignments, all of which were completed, Review MICs listed 11,097 unique providers in their results.

CMS officials stated that they have formalized the process for Review MICs to identify potential fraud leads. In December 2010, CMS began requiring Review MICs to include a section in the Algorithm Findings Reports for identifying any potential fraud leads. In this section, Review MICs can identify those providers that the Review MIC feels should be investigated by CMS in more detail for potential referral to law enforcement.

## **Because data were missing or inaccurate, Review MICs were hindered in their ability to accurately complete data analysis assignments**

Review MICs identified problems with data that limited their ability to accurately complete their data analysis assignments. During interviews, staff from Review MICs and CMS identified data elements missing from the MSIS data used by Review MICs that are important for conducting program integrity activities. For example, MSIS data lack provider identification and are missing adjustments that corrected payments.<sup>17</sup> OIG also identified these data elements, as well as service descriptions and beneficiary information, as missing from MSIS and vital to program integrity activities.<sup>18</sup>

Recognizing MSIS's shortcomings and needing to implement changes required by the Patient Protection and Affordable Care Act of 2010, CMS is making efforts to upgrade MSIS.<sup>19</sup> CMS intends to replace MSIS with an expansion known as Transformed MSIS (T-MSIS), which will include new data and should be updated more frequently than MSIS.<sup>20</sup> According to CMS staff, the effort to upgrade the system began in 2007 and a pilot project of T-MSIS began in 10 States during late summer 2011. CMS anticipates that T-MSIS will be operational in 2014.

## **States invalidated more than one-third of sampled potential overpayments from assignments, mainly because data were missing or inaccurate**

Of the potential overpayments that Review MICs submitted, States asserted—after comparing the Review MIC-provided information with information in their State data systems—that 34 percent were not overpayments. For many of their completed data analysis assignments, Review MICs selected a sample of individual claims that they identified as potential overpayments and submitted them to States for validation.

States invalidated results from Review MIC assignments because the results did not match information in the States' data systems. State data systems are more up to date than MSIS and contain data elements missing from MSIS, which is an extract of State data systems. Data from State systems are not available to Review MICs because they are not loaded into the ITI, which CMS requires Review MICs to use for data analysis.

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<sup>17</sup> Adjustments may be made to claims data that affects payment of those claims. If adjustments are made after States submit data for MSIS, those adjustments would not be reflected in the data Review MICs can access.

<sup>18</sup> OIG, *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse*, OEI-04-07-00240, August 2009.

<sup>19</sup> Patient Protection and Affordable Care Act of 2010, P.L. 111-148 § 6504(a), 42 U.S.C. 1396b(r)(1)(F).

<sup>20</sup> CMS, *Annual Report to Congress on the Medicaid Integrity Program for Fiscal Year 2010*. Accessed at <http://www.cms.gov> on August 22, 2011.

Of all of the Review MIC-identified potential overpayments that Review MICs submitted to States for review, the assignment type that resulted in the highest percentage of invalidated potential overpayments was for assignments intended to identify services provided after a beneficiary's date of death. For the 37 completed regular assignments intended to identify such services during our review period, States invalidated an average of 67 percent of the potential overpayments submitted by Review MICs. In many cases, States invalidated potential overpayments because Review MICs had identified them using MSIS data that had not been adjusted to reflect final payment information. Another reason why States invalidated potential overpayments was that State files showed different dates for beneficiaries' deaths than did the Social Security Administration's Death Master File used by Review MICs.

**Because data were missing or inaccurate, CMS invalidated a special project identifying services provided after beneficiaries' deaths**

A nationwide special project performed by Review MICs to identify services provided after a beneficiary's date of death will not yield any recoveries for States or the Federal Government. The special project consisted of 172 assignments that identified \$113 million in potential overpayments. The special project was a nationwide expansion of the 37 completed regular data analysis assignments intended to identify services provided after a beneficiary's date of death. The \$113 million in potential overpayments was in addition to the potential overpayments identified in the 37 completed regular assignments. The goal of the special project was to identify overpayments for immediate collection from States.

CMS decided to invalidate the special project after reassessing the MSIS data used by Review MICs. An OIG audit assessing the same types of potential overpayments in California found \$273,000 in overpayments, a lower amount than that found by Review MICs during the special project.<sup>21</sup> After reassessing the results of the special project and holding discussions with OIG staff, CMS determined that the MSIS data used by Review MICs did not include payment and billing adjustments and other variables that potentially invalidated some of the overpayments identified by Review MICs. In contrast, the State data used by OIG contained the payment and billing adjustments and other variables missing from MSIS.

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<sup>21</sup> OIG, *Review of Medicaid Payments for Services Claimed for Deceased Beneficiaries in California*, A-09-09-00110, June 2010.

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## RECOMMENDATIONS

Review MICs' task orders with CMS state that Review MICs are to: (1) conduct data analysis, (2) provide or recommend audit leads, and (3) detect and prevent Medicaid fraud. However, during our review period, Review MICs only conducted data analysis and provided lists of providers ranked by the amount of their corresponding potential overpayments. Review MICs did not single out any individual providers on their lists either as specific audit leads or as providers having potentially fraudulent billing patterns.

Further, the fact that data were missing or inaccurate compromised Review MICs' ability to accurately perform data analysis. Because States and CMS determined that Review MICs incorrectly identified some potential overpayments, some of the Review MICs' assignments may not lead to recoveries.

This study was an early assessment of the results of Review MICs activities; therefore, our recommendations focus on increasing Review MICs' contribution to protecting the integrity of Medicaid payments. We make the following recommendations to CMS:

### **Improve the quality of data that Review MICs can access for conducting data analysis**

Because data were missing or inaccurate, Review MICs inaccurately identified potential overpayments and may have overlooked some potential overpayments. Review MICs' ability to accurately identify overpayments that result in actual recoveries for States and the Federal Government depends on accurate data.

One option for CMS to improve the quality of data available to Review MICs is to facilitate their access to States' Medicaid data systems. As the responsible parties for administering their Medicaid programs, States use their Medicaid data systems to process and monitor claims. These systems contain more timely information than MSIS and contain adjustments that are not included in MSIS because it is a quarterly extract of State Medicaid data systems. Using State systems to conduct analysis should enable Review MICs to improve the accuracy of their results. Along these lines, CMS has already initiated a project in which a Review MIC is using Louisiana's Medicaid data system.

Another option for CMS to improve the quality of data that Review MICs can access is to implement T-MSIS. T-MSIS should improve the accuracy of Review MICs' identification of potential overpayments because it is intended to contain more data elements and will be updated more

frequently than MSIS. However, T-MSIS will still be an extract of State Medicaid data systems.

### **Require Review MICs to recommend specific audit leads**

CMS should require Review MICs to conduct the analysis necessary to recommend specific audit leads to CMS that have the best potential for recoveries of State and Federal overpayments. Beyond ranking providers by potential overpayments, Review MICs did little to filter the lists of providers generated from their data analysis assignments. As a result, Review MICs provided CMS with 113,378 unique providers, from which CMS selected 244 audit targets.

Requiring Review MICs to recommend specific audit leads would help CMS improve upon the value of the Review MIC's contribution to the Medicaid Integrity Program. CMS could focus less of its resources on filtering audit leads and more on screening and assigning audit targets, tasks Review MICs are not in a position to accomplish.

This recommendation is another step in line with those CMS has already taken to improve the Medicaid Integrity Program. CMS has already strengthened fraud identification and reporting by clarifying the process for Review MICs and requiring that all Algorithm Findings Reports have a section identifying any potential fraud leads. Increasing the expectations for Review MICs to conduct more sophisticated filtering of providers, beyond ranking them by the amount of potential overpayments, would similarly improve the effectiveness of the Medicaid Integrity Program. It would also align with one of CMS's five strategic goals for program integrity: to use advanced technology and data analysis to prevent and detect fraud, waste, and abuse.<sup>22</sup>

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## **AGENCY COMMENTS**

CMS concurred with both recommendations. CMS stated that to improve the quality of data that Review MICs can access for conducting data analysis, it has several initiatives underway. CMS has established the Medicaid and Children's Health Insurance Program Business Information and Solutions governance body to oversee the development and deployment of improved data systems for Medicaid program integrity and oversight. The development of improved data systems includes expanding the MSIS dataset to include data elements important for detecting Medicaid fraud, waste, and abuse.

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

In addition to expanding MSIS, CMS is working directly with States to obtain Medicaid data from MMIS. Further, CMS indicated that it plans to load State MMIS data for Texas, Oklahoma, and Colorado into the ITI by 2012. These data would then be available for Review MICs to analyze.

With respect to our second recommendation, to require Review MICs to recommend specific audit leads, CMS stated that it will direct Review MICs to include specific recommendations in their data analysis reports for followup as potential audit targets. CMS stated that it began in December 2010 to provide Review MICs with more explicit directions on recommending next steps and will extend this to include specific recommendations for potential audit targets.

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

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

## APPENDIX A

### Review Medicaid Integrity Contractor\* Assignments From the Centers for Medicare & Medicaid Services\*\*

Table A-1: Breakdown of Algorithms Assigned To Review MICs by Algorithm Model

Algorithm	Service Type	Billing Issue Reviewed	Algorithm Source	Frequency Assigned	Number of Providers Identified	Amount of Potential Overpayment
1	Adult day health care	Inappropriate service setting	Review MIC	3	162	\$381,491
2	Ambulance services	Inappropriate service setting	Review MIC	1	186	\$250,084
3	Dental services	Excessive services	Review MIC	1	172	\$28,129
4	Durable medical equipment	Excessive equipment rental	CMS	1	193	\$3,049,847
5	Hospice services	Inappropriate service setting	CMS	1	0	\$0
6	Inpatient services	Duplicate billings	CMS	8	15	\$718,548
7	Inpatient services	Duplicate billings	Review MIC	1	0	\$0
8	Inpatient services	Duplicate billings	CMS	8	506	\$42,824,192
9	Inpatient services	Inappropriate service setting	CMS	1	0	\$0
10	Inpatient services	Inappropriate service setting	CMS	3	1,410	\$175,757,413
11	Inpatient services	Inappropriate service setting	CMS	6	90	\$11,431,554
12	Inpatient services	Services after death	CMS	56	637	\$5,244,583
13	Long-term-care services	Duplicate billings	CMS	10	1	\$5,880
14	Long-term-care services	Services after death	CMS	54	2,095	\$18,809,573
15	Outpatient services	Duplicate billings	CMS	2	81	\$47,790
16	Outpatient services	Inappropriate service setting	CMS	8	2,356	\$5,092,533
17	Outpatient services	Medically unlikely	CMS	4	584	\$4,450,428
18	Outpatient services	Services after death	CMS	59	38,531	\$83,850,039
19	Outpatient services	Upcoding	Review MIC	11	3,994	\$4,398,115
20	Personal care services	Inappropriate service setting	Review MIC	9	87,031	\$28,387,694
21	Pharmacy services	Duplicate billings	CMS	6	1,573	\$1,950,520
22	Pharmacy services	Early refill	CMS	5	1,783	\$479,936
23	Pharmacy services	Early refill	CMS	5	5,603	\$7,207,701
24	Pharmacy services	Early refill	CMS	9	3,617	\$6,616,698
25	Pharmacy services	Inaccurate quantity	CMS	8	109	\$971,130

\*Review MIC.

\*\*CMS.

*continued on next page*

**Table A-1: Breakdown of Algorithms Assigned To Review MICs by Algorithm Model (continued)**

<b>Algorithm</b>	<b>Service Type</b>	<b>Billing Issue Reviewed</b>	<b>Algorithm Source</b>	<b>Frequency Assigned</b>	<b>Number of Providers Identified</b>	<b>Amount of Potential Overpayment</b>
26	Pharmacy services	Overprescribed	CMS	12	977	\$1,555,820
27	Pharmacy services	Overprescribed	CMS	8	6,096	\$720,663
28	Pharmacy services	Overprescribed	Review MIC	3	21	\$1,212,489
29	Pharmacy services	Services after death	CMS	55	10,544	\$10,618,722
30	Psychotherapy services	Excessive time	Review MIC	2	7	\$91,678
31	Therapy services	Ineligible billing	Review MIC	1	166	\$2,516,189

Source: Office of Inspector General analysis of Review MIC assignments, 2011.

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## APPENDIX B

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** NOV 02 2011

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** ~~Donald M. Berwick~~ /S/ Donald M. Berwick, M.D.  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Early Assessment of Review Medicaid Integrity Contractors" (OEI-05-10-00200)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on this subject Office of Inspector General (OIG) draft report. The objectives of the report were: 1) to determine the extent to which Review Medicaid Integrity Contractors (Review MICs) completed assignments, recommended audit leads, and identified potential fraud and 2) to describe barriers that Review MICs encountered in their program integrity activities.

The OIG found that Review MICs completed 81 percent of their assignments, but had limited involvement in recommending specific audit leads and identifying potential fraud. OIG also found that missing or inaccurate data hindered Review MICs' ability to accurately complete assignments.

We appreciate OIG's efforts in working with CMS to assess the results of Review MICs' program integrity activities and identifying the barriers that Review MICs have encountered in performing those activities. Our response to each of the OIG recommendations follows.

#### **OIG Recommendation**

The CMS should improve the quality of data that Review MICs can access for conducting data analysis.

#### **CMS Response**

The CMS concurs that improving the quality of Medicaid claims data accessible to Review MICs would significantly increase the accuracy of identifying potential overpayments. CMS has several initiatives underway to improve the quality of data available for program integrity efforts, and we will continue to work to provide program integrity contractors with access to better quality Medicaid data.

To meet the challenge of improving the quality of Medicaid claims data available for combating fraud, waste, and abuse, CMS has established the Medicaid and Children’s Health Insurance Program Business Information and Solutions (MACBIS) governance body. The MACBIS Council provides leadership for the development and deployment of enterprise-wide improvements in the accuracy and availability of data for Medicaid program integrity and program oversight.

The CMS’ long-term strategy is to improve the quality of data collected from States in the Medicaid Statistical Information System (MSIS). MSIS is a subset of the data in States’ Medicaid Management Information Systems (MMIS), and is currently the only database of nationwide Medicaid claims and beneficiary eligibility information. For this reason, the MSIS data set has served as the primary source of Medicaid claims data available for use by Review MICs. The MSIS data set was designed primarily for administrative purposes and lacks many data elements important for the detection of Medicaid fraud, waste, and abuse. To address these limitations, the MACBIS Council has proposed additional data elements to expand the MSIS data set, called Transformed-MSIS (T-MSIS). CMS is currently introducing the expanded T-MSIS data set for testing in a pilot project involving Medicaid data from 10 States, which represent approximately 40 percent of the nation’s Medicaid expenditures. After intensive assessment of the quality and utility of the T-MSIS data, the results and lessons learned from these 10 States will then be used as the basis for national implementation.

In the near term, CMS is working to improve access to better quality Medicaid data by leveraging the data available through the Medicare/Medicaid Data Match Expansion Project (Medi-Medi) and its participating States, as well as working directly with States to obtain Medicaid data for specific collaborative projects. For example, as a part of a three-State pilot project using data from the Medi-Medi program, State data from the MMIS of Texas, Oklahoma, and Colorado will be loaded into a program integrity focused system, the Information Technology Infrastructure, and will be available for use in the first quarter of fiscal year 2012. In addition, as a result of CMS’ collaborative work with States, extracts of MMIS data from several States have been loaded into the Information Technology Infrastructure and are currently being used in a number of projects. Examples include:

- pharmacy MMIS extract from Florida, initially focusing on Part D duplicate claims
- provider MMIS extract from Kansas for identifying potential overpayments
- pharmacy MMIS extracts from five States for targeted prescriber education

#### **OIG Recommendation**

The CMS should require Review MICs to recommend specific audit leads.

#### **CMS Response**

The CMS concurs with the recommendation to require Review MICs to extend their analyses to recommend to CMS specific audit leads that have the best potential for recovery of overpayments. CMS will direct Review MICs to include specific recommendations in their data analysis reports for follow-up as potential audit targets.

In the beginning years of the National Audit Program, CMS has exercised enhanced oversight of Medicaid Integrity Contractors to coordinate the activity of Review MICs and Audit MICs with State Medicaid agencies and to provide quality assurance. CMS developed many of the algorithms that Review MICs employ and pioneered their implementation on the Information Technology Infrastructure. Selection of promising audit targets requires additional analyses that take into account the pattern of results across multiple types of algorithms. In light of our experience with algorithm development and with the data quality challenges of coordinating Federal audits of non-Federal claims data, we believe that CMS has exercised responsible oversight in initially limiting the role of Review MICs in recommending specific audit targets.

With the successful performance of the Review MICs over these initial years, CMS agrees that this work should now be extended to include specific recommendations for potential audit targets. In December 2010, CMS revised the template for Review MICs' Algorithm Findings Reports to include more explicit directions to recommend next steps to recover potential overpayments and improve future algorithms, as well as to identify potential fraud leads. As a result, Review MICs have used Algorithm Findings Reports to provide a summary of recommended audit leads based on the findings from a specific algorithm.

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

Attachment

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## 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 served as the team leader for this study and Benjamin Dieterich served as lead analyst. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Leigh Pylman and Cassandra Yarbrough; central office staff who contributed include Kevin Manley, Antigone Potamianos, and Andrew VanLandingham.

# Office of Inspector General

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