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$15.6 Billion Returned to the Medicare Trust Fund from all Fraud Audit Recoveries Since Inception in 1997

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The Health Care Fraud and Abuse Control Program (HCFAC) has returned over $15.6 Billion to the Medicare Trust Fund since the inception of the program in 1997.

The Affordable Care Act (ACT) will provide an additional $350 million over the next ten years, beginning in fiscal year 2011. The ACT will coordinate detection and prevention of fraudulent Medicare and Medicaid billing practices and reduction of related payment errors under the newly created CMS Center for Program Integrity. This builds on recent successes of the Department of Justice (DOJ) and Office of Inspector General's (OIG) joint administration of the Health Care Fraud & Abuse Control (HCFAC) Program. The Health Care Fraud Prevention & Enforcement Action Team (HEAT) is responsible for recovering over a billion dollars in Medicare and Medicaid improper payments under the False Claims Act.

HCFAC reported that in fiscal year 2009, $2.51 billion in Medicare and $441 million in Medicaid payments were recovered, a 29% and 28% increase over 2008 respectively. There has been $4 billion in court-ordered fines, penalties, monetary restitution and settlements resulting from OIG investigations and criminal prosecution. CMS estimates that $24.1 billion in Medicare payments, or 7.8% of all Medicare fee-for-service claims, were *improperly* paid.

Similarly, CMS reports that a sample of Medicaid claims in 17 states, (one-third of the country including Alaska, Washington, Oregon, Montana and Hawaii) were audited under its Medicaid Payment Error Rate Measurement (PERM) program. The audit showed that 8.71% claims were improperly paid in fiscal year 2008, compared to a Medicaid payment error rate of 10.5% in fiscal year 2007 for claims audited in 17 other states (including California). CMS' extrapolation of these results estimates $35 billion in improper payments of the federal share of the Medicaid program were made during fiscal years 2007 through 2008.

Medicaid fee-for-service claims audited in fiscal year 2008 showed reported top causes for payment errors were: Insufficient or No Documentation (35%) including non-response to documentation request; Non-Covered Service (17%) including billing unit errors; and Administrative/Data Processing (14%) errors, including ineligible patient or provider, or untimely claim filing.

Recovery Audit Contractors (RAC) and Medicaid Integrity Contractors (MIC) have many differences, according to the Director of Field Operations for the CMS MIG. As an entity, the MIC is more imposing than RAC, but their impact is more likely to be focused on a smaller number of providers while leaving others unscathed. Some of the differences are important. MIC's are not paid based on contingency fee. MIC audits can "Look-Back" at accounts older than three years. The exact "Look-Back" period is state specific. MIC auditors can review accounts that have been previously reviewed by another entity. MIC audits can request unlimited numbers of records, and most troubling

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is that the provider has only two weeks to prepare what could be hundreds of accounts.

In May 2010, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced a new collaborative initiative between the Department of Health and Human Services (OIG) and (DOJ) that expands anti-fraud, waste, abuse and payment recovery enforcement activities. This will include a significant increase of provider post-payment audits, recoupments, civil and criminal actions.

It's no wonder that the Affordable Care Act also authorizes the expansion of the Recovery Audit Contractor (RAC) program to Medicaid, Medicare Part C (Medicare Advantage plans) and Part D (Medicare Prescription Drug program). This will be implemented no later than December 31, 2010. Final rules that detail specific contingency-based audit program requirements for Medicaid, and mandate individual states to contract with one or more RACs by year-end, are expected for release by this Fall. This will be in addition to the currently expanding MIC.

Unfavorable PERM audit trends, mounting budget deficits, and increasing federal pressure to comply with CMS program accountability requirements and reduce Medicaid program costs will be contributing factors to an expected new wave of aggressive program audit and payment recovery activities at the state level. As data mining and analysis technology improves, an auditor will be able to compare provider payment patterns to quickly target abhorrent trends that indicate possible fraudulent billing. The MIC Auditor for the western region states is Health Management Systems (HMS). HMS will be sending out provider audit notification letters, so it is critical that facilities ensure that their point-of-contact information is up to date and designates a centralized coordinator of the compliance audit response team. HMS is still in the process of finalizing its audit rollout procedures and document request requirements for our region in coordination with state officials, but is expected to begin the provider notification process by late summer/early fall.

Donna Herbert is the founder of Financial Consultants of Alaska & Washington (FCAW). Since 1979, she has provided advice and counsel to healthcare providers in Alaska, Washington, Oregon and California concerning all aspects of budget, finance, and preparation of third-party cost reports. She can be reached at fcaw@fcawreimbursement.com.

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