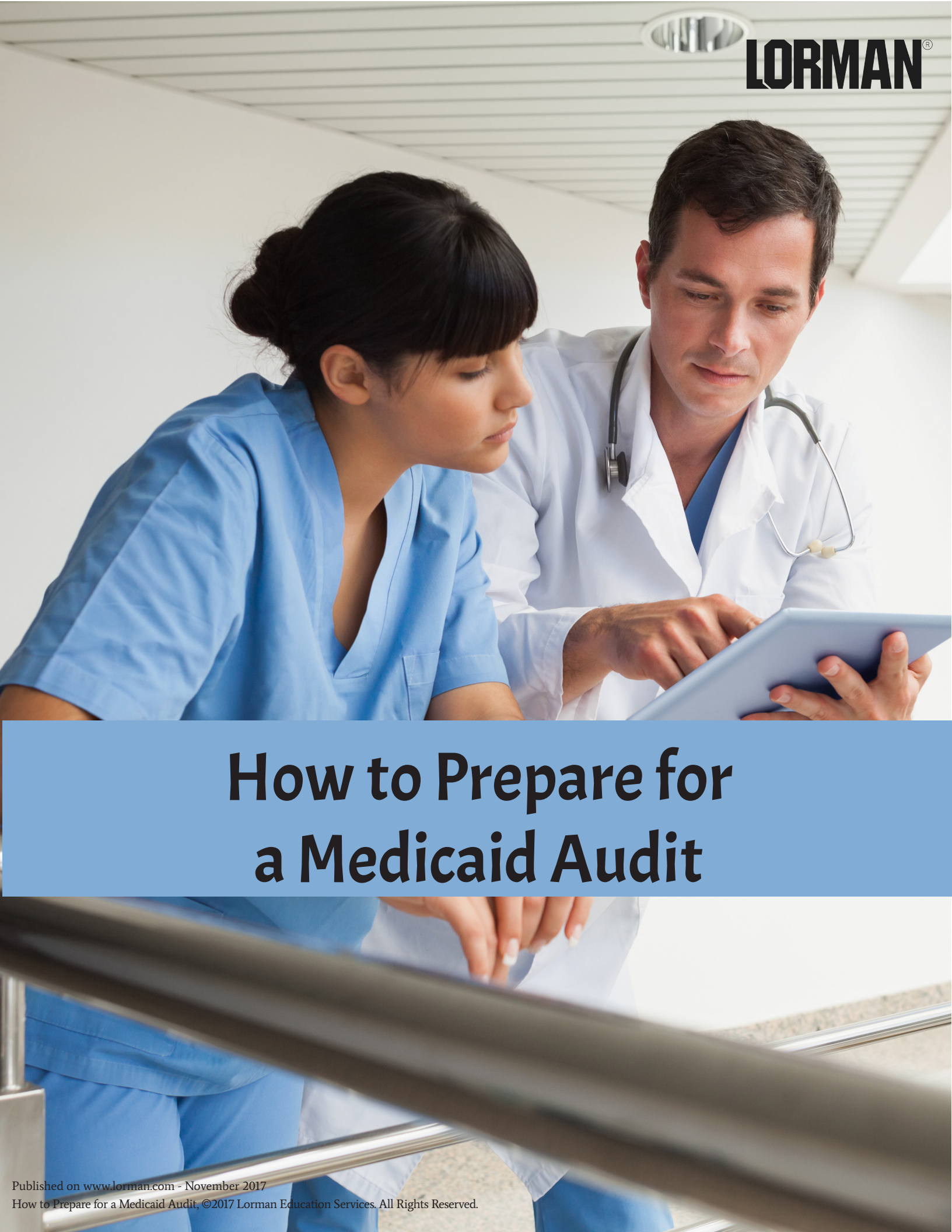

How to Prepare for a Medicaid Audit

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Introduction

The goal of this paper is to help Medicaid providers who work with medical records better understand the increased prevalence of Medicaid audits and how best to prepare for the possibility of being audited. After an explanation of recent issues contributing to increased audit activity, guidance will be offered on proactive steps providers can take to prepare for a Medicaid audit with the confidence and professionalism needed to successfully defend legitimate claims and revenues.

Medicaid Audits as a Deficit-Reduction Measure

The past decade has seen record federal deficits along with unprecedented attempts to reduce spending on key programs such as Medicare and Medicaid as part of deficit-reduction strategies. Although administered and partially funded by individual states, Medicaid programs receive approximately 57 percent of their funding from the federal government. The amount per state can be closer to 50 percent for wealthier states to as much as 75 percent for poorer ones. In real dollars, total Medicaid spending reached $389 billion for fiscal year 2010 and topped $438 billion in 2011, with further increases expected in future. Medicaid's significant cost to individual states and the federal government together with the ongoing federal deficit crisis have motivated the creation of a variety of audit programs charged with identifying waste, fraud and abuse in the Medicaid system and with recovering overpayments.

This increasing use of Medicaid audits has resulted in the need for Medicaid providers to implement policies and procedures to respond proactively to audit notices and to defend their valid, lawful revenues from being disallowed based on reasons such as lack of documented medical necessity or various program compliance issues. For providers on the front lines of the effort to care for the country's most economically vulnerable, a Medicaid audit can represent a significant burden in terms of time, expense and human resources. Within a climate of broadening scope and increasingly severe documentation requirements, auditors analyze data from claims records to identify what they believe are potential abuses and overpayments. The targeted provider often feels placed in the position of having to disprove the preconceived assumptions of audit contractors who have financial incentives to recover funds and identify fraud.

The Real Cause of Increased Medicaid Spending

While identifying fraud, abuse and waste is a legitimate concern, the irony for providers is that Medicaid spending growth in the last decade has been lower than spending growth by private insurers if measured on a per-enrollee basis. A recent Kaiser Family Foundation study, for example, pointed out that, for 2007 through 2010, Medicaid expenditures per enrollee increased at an annual rate of 2.5 percent as compared to 5.5 percent for private health insurance enrollees. The medical care consumer price index, a measure of health care price inflation, was 3.4 percent annually for the same period, which means that Medicaid programs kept their cost increases below typical increases seen in the rest of the healthcare industry. A recent report by Bloomberg Government noted similarly that, after adjusting for inflation and increases in enrollment, state spending on Medicaid changed little between 2002 and 2011. These types of studies support a conclusion already familiar to many Medicaid providers, which is that Medicaid is fundamentally well managed despite the presence of some fraud and abuse within the system.

As most providers know, the primary and overwhelming reason for increased Medicaid spending in recent years is recession-driven increases in enrollment. Reports by USA Today, the Kaiser Family Foundation and others have noted that, between the beginning of the recent recession in December 2007 and June 2010, Medicaid enrollment increased 17.8 percent and exceeded 50 million people for the first time by June 2010. During this period, unemployment nearly doubled from 5 percent to 9.5 percent nationwide. Not surprisingly, the highest increases in enrollment were seen among children and families experiencing recession-driven unemployment. While the rate of new enrollments has subsided somewhat as the impact of the recession softens, providers are nonetheless acutely aware of the coming increase in new enrollments scheduled to occur under the Patient Protection and Affordable Care Act. If left unchanged, this legislation will expand Medicaid coverage to all people, including adults without dependent children, whose incomes are below 133 percent of the federal poverty line. This expansion of Medicaid will result in even greater increases in overall Medicaid spending and provide both federal and state governments with strong motivation to continue to pursue Medicaid audits through various mechanisms established in legislation over the past decade.

Multiple Mechanisms for Identifying an Audit Target

Although the federal Centers for Medicare and Medicaid Services monitors state Medicaid programs and defines basic requirements for eligibility, quality of care, funding and delivery of services, states administer and partially fund their respective programs, resulting in variations from state to state. Prior to 2005, Medicaid anti-fraud and recovery efforts were carried out by individual states, but the Deficit Reduction Act of 2005 changed that by creating the Medicaid Integrity Program. This program provides oversight and support to state anti-fraud efforts and employs a small group of nationwide contractors to identify and perform post-payment audits of Medicaid providers who have been identified through various means such as claims data analysis. In 2010, a further audit mechanism appeared as part of the Patient Protection and Affordable Care Act and required states to create Medicaid Recovery Audit Contractor programs similar to those already in existence for Medicare.

What is concerning for providers is the fact that, amidst these and other mechanisms for going after Medicaid fraud, the data on which auditors rely to detect targets is being called into question in testimony before Congress among other places. Since becoming active, Medicaid Integrity Program contractors have found only a fraction of the expected amount of overpayments and fraud through their audits, and, in carrying out these disappointing efforts, have inadvertently targeted untold numbers of innocent Medicaid providers. Until better methods are implemented to identify true Medicaid abuse, the best that providers can do is to assume the possibility of an audit at any time, no matter how well managed and compliant their records may be.

Preparing for a Medicaid Audit

In all matters related to Medicaid audits, an attitude of utmost professionalism, transparency and compliance is essential. While dedicated providers may feel offended and otherwise upset by the arrival of an audit letter, focus should be channeled before, during and after the audit process towards a successful outcome. A timely and organized response is key to this success and begins well before a provider ever receives an audit notice with the implementation of robust risk management policies and practices. Preparedness further involves keeping abreast of new ways of measuring Medicaid accountability that may be implemented in future.

As a matter of routine practice, all clinical records should be completely legible and entered only at the time services or supplies are provided. Records must be thorough in showing that the nature and level of care were medically necessary and appropriate, and reimbursement codes should be properly entered. Providers should undertake an across-the-board review of all Medicaid compliance requirements with appropriate professional assistance if necessary and implement compliant record-keeping

procedures and software as needed. They should ensure that essential information on licensing, personnel, inventory, ownership and other relevant matters is up to date and readily available. Providers also need to become familiar with the whole range of problems commonly identified during audits and should plan to address these ahead of time within a preparedness plan. Assuming the inevitability of an audit is always a better policy than being caught off guard by it.

Key to successful preparation is to assign a point person and supporting team to manage audit preparedness and response on behalf of a provider organization. Make sure that all employees know how to recognize an audit request letter and that they forward any such letter immediately to the point person so that the team has time to assemble documentation before the deadline. In preparing for the possibility of an audit, the team and its coordinator should conduct internal audits and statistical sampling and adjust policies and practices based on findings. They should plan how records will be made available for onsite audits and how records will be reproduced in appropriate media to satisfy requests for forwarded records. Archived materials can sometimes take several weeks to retrieve, different hospitals may have varied ways of accessing patient records, and care must be taken to forward exactly the information requested rather than entire bodies of patient records. These are examples of the many considerations that must be addressed quickly and with consistency. An audit response coordinator and team will become familiar with what actions need to be taken and will thus ensure a smooth and competently managed response to Medicaid audits.

Conclusion

While attempts to rein in government spending and address the federal deficit are worthwhile and timely, the effort to curb excess monetary waste and fraud in Medicaid programs is hampered by the fact that Medicaid is already cost-efficient on a per-enrollee basis and by reliance on data and other criteria that frequently identify innocent providers for audit. Providers must understand this reality and be familiar with the political, fiscal and administrative contexts in which audits take place. Selection criteria, practices, appeals processes and the general tone and scope of audits can shift over time, and providers need to arm themselves with knowledge, thorough planning and expert guidance to remain successful caregivers within the Medicaid program.