Senate Special Committee on Aging
Roundtable: "Improving Audits: How We Can Strengthen the Medicare Program for Future Generations"
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Steve Stang, CPA
National Partner-in-Charge Healthcare Assurance Services
CliftonLarsonAllen LLP

Thank you Mr. Chairman, Ranking Member, and members of the Special Committee, my name is Steve Stang. I'm a Certified Public Accountant and a Partner at CliftonLarsonAllen where I lead our firm's healthcare assurance practice, as well as a member of the AICPA's Health Care Expert Panel. Thank you for this opportunity to discuss future improvements to the Medicare RAC program in order to eliminate improper payments.

First, I'd like to contrast aspects of the current Recovery Audit program to the requirements in Government Auditing Standards.

Most CMS program integrity audits are similar to government financial statement audits and follow Government Auditing Standards. In contrast, while the Recovery Auditors don't follow Government Auditing Standards, there are many similarities in how they plan and execute their audits. However, there are four significant differences with Government Auditing Standards, including independence, understanding the provider's internal controls, assessing risk, and required auditor communications to providers.

Independence is critical under Government Auditing Standards and is the foundation that allows the auditor to be objective, maintain professional skepticism, and have the ability to act fairly to both the provider and the users of the audited information. I believe the current requirement that Recovery Auditors receive contingent fees for their audit services inherently compromises the Recovery Auditor's independence.

The Introduction to GAOs Standards for Internal Control in the Federal Government states, *"Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud."* Understanding a provider's internal control environment and assessing risks are required under Government Auditing Standards. One of the required risks to assess is inherent risk, the risk that all providers have due to the nature of their business, or types of transactions. Recovery Auditors assess inherent risk through the CERT analysis. A second required risk assessment it control risk, a risk that is specific to each provider's internal control environment. It does not appear that Recovery Auditors specifically consider control risks at each individual provider when designing their audits.

Government Auditing Standards also require the communication of findings and recommendations for improvement of the internal control environment. These comments are intended to educate the provider, and assist them in strengthening internal controls to reduce the likelihood of future errors. In contrast, CMSs statement of work with the Recovery Auditors expressly prohibits them from providing provider education.

Finally, all audits have an inherent level of variability that cannot be eliminated by the application of additional auditing procedures. In essence, it's very difficult to "build in quality on the back-end". I believe increasing the volume of Medicare audit activity at providers will likely not significantly lower the rate of improper payment errors.

Provider education is critical to eliminating errors on the front-end – before they happen. I believe CMSs current organizational structure may reduce the effectiveness of provider education. The Recovery Auditors statement of work expressly prohibits provider education to each individual provider. Instead, CMS has implemented communication channels, including routine conference calls and meetings, to transfer educational knowledge first, from the Recovery Auditors and ZPICs to CMS and MACs, and next to the providers in the region – often

at a higher, more summarized level. Inherently, this “circle of knowledge” significantly diminishes the value of the information once it ultimately reaches the individual providers. I believe allowing Recovery Auditor’s to communicate their “boots on the ground” knowledge directly to the individual providers, as well as sharing best practices they observe at other providers, could significantly improve the controls over the provider’s billing process.

A recent OIG report on MAC performance indicated CMSs current payment structure and evaluation process result in virtually no financial incentive for the MACs to enhance provider education. I believe these factors may contribute to ineffective provider education, as evidenced by the recent AHA RACTrac survey that reported 76% of hospitals didn’t receive (or didn’t know if they received) recent education from CMS or its contractors, and of those that received education, only 51% scored its effectiveness as Good or Excellent.

In closing, In preparing for today’s session I read, or reread, several recent CMS, OIG and GAO reports on CMSs program integrity efforts. I was struck by how each of the reports seemed to focus almost exclusively on “recovered savings” or “ROI”, and provided very little information on the level of efforts to help the providers “prevent errors on the front-end”. As an independent CPA, I work with numerous providers every day and I see their concern and focus to do what’s right. Consideration should be given to Enhance CMSs evaluation and reporting on the effectiveness of provider education programs, including the % of expenditures each program spends on provider education, and the methods of delivering the education directly to individual providers.

Thank you.