DAVE YOST
Ohio Auditor of State

Medicaid Program Integrity
A Detailed Perspective

Presented by: Kristi Erlewine

DAVE YOST
Ohio Auditor of State

www.ohioauditor.gov

1

TOPICS

- Improper Payments in the Medicaid Program
- Ohio's Medicaid Program Integrity Efforts
- Sources of Improper Payments Found by AOS
- Efforts in other states
- Recent Initiatives

2

National Health Expenditures (NHE)

Centers for Medicare and Medicaid Services (CMS) reports that for 2014:

- NHE grew 5.3% to $3.0 trillion
  - $9,523 per person
    - 17.5% of Gross Domestic Product
  - Medicare spending grew 5.5% to $618.7 billion
    - 20 % of total NHE.
  - Medicaid spending grew 11.0% to $495.8 billion
    - 16 % of total NHE.

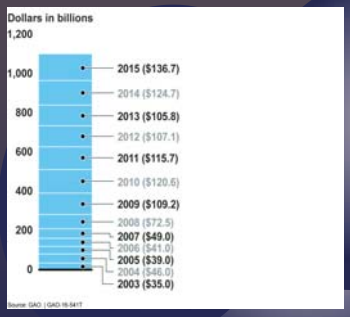
3

Improper Payment Definition

- Improper Payments Elimination and Recovery Improvement Act of 2012
- Any payment that should not have been made or was made in an incorrect amount
- Examples:
  - Duplicate payments;
  - Payments to ineligible recipients;
  - Incorrect amounts paid; and
  - Payments for which insufficient or no documentation was found.

4

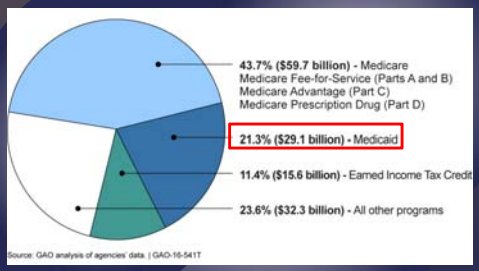
Improper Payments – Current Status



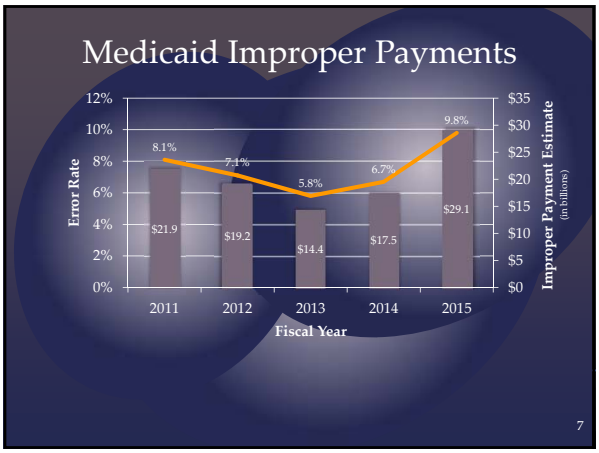
The FFY 2015 government-wide improper payment estimate totaled $136.7 billion, an increase of $12 billion from the prior year.

5

FFY 2015 Government-wide Improper Payment Estimates by Program



6



Medicaid Improper Payment Overview

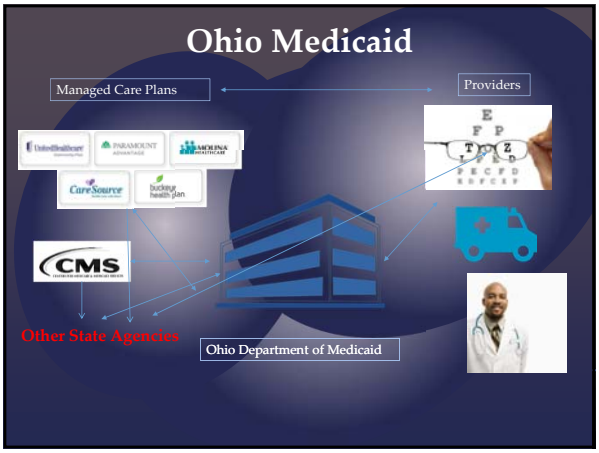
CMS annually estimates the amount of improper payments in Medicaid

- Payment Error Rate Measurement (PERM)

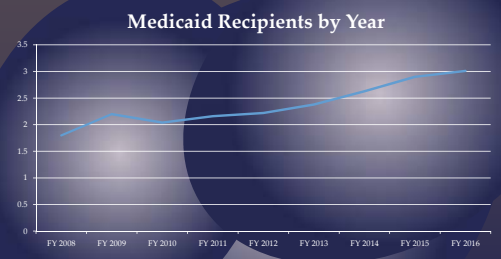
CMS randomly samples a subset of payments for review against federal and state policies

- Average sample size per state : 450 Fee-for-Service & 210 managed care

8

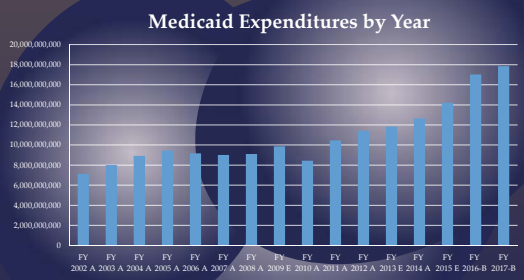


Medicaid in Ohio



10

Medicaid in Ohio



11

Ohio's Program Integrity Groups

- PIG
- MCPIG
- PIGRx,
- PiggyBank
- Charlotte's Web
- O.H.I.O.

12

Definitions of Risk Factors

- Materiality
- Change in Reimbursement
- Complexity
- Strength of Rules
- Recent Rule Changes
- Recent Industry Changes
- Control Factors
- Fraud Risk Factors

13

What is a Cost Report and why use one?

- A cost report payment methodology *"settles"* payments by calculating a final actual rate
- Advantages: provides a mechanism to report certified public expenditures and to evaluate cost trends
- Disadvantages: Time consuming

14

Where can things go wrong?

Under reported statistics

- Claim to not track all services
- Omit contracted services
- Report units in wrong program

15

Additional Risks With Reporting Costs

- Inflating/Shifting costs to federal programs
  - Include unallowable costs
  - Allocation methodology
  - Not include revenue offsets
    - Shared Service Arrangements
    - Acting as fiscal agent for another entity

16

AOS Compliance Examinations

SFY 2012 through SFY 2016

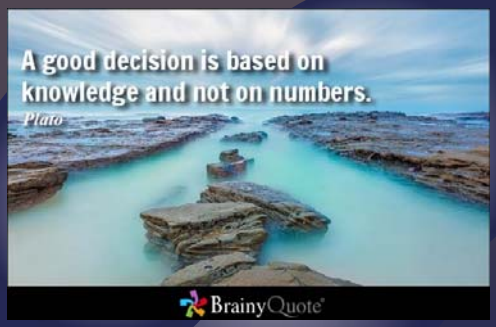
- Released 98 provider examinations
- Findings of over $15.5 million
- Average of $158 K per provider
- Track ROI – average across this timespan - 5:1

17

Methodology in Examinations

- Data analysis to select providers
- Statistical Sampling
- Exception Tests
- On-site review of records
- Verification with external entities
- Extrapolation of findings

18



Before Looking at Claims Data

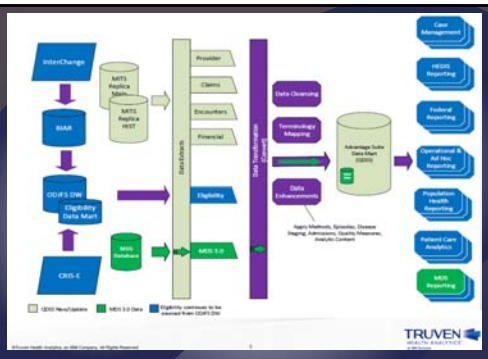
- Provider Type
  - Rules/Laws/Other Applicable Criteria
  - Procedure Codes
  - Procedure Modifiers
  - What constitutes a unit
- Database
  - Where does the data come from, how is the data formatted and what are the field definitions

Data Sources

Medicaid Information Technology System

Data warehouse – in Ohio - Quality Medicaid Decision Support System (QDSS)

Online medical coding service



How Do We Get the Data?

- Paid claims data is extracted from QDSS
  - Template reports in QDSS
  - Easy for auditors to use
- Completeness of Data
  - Annotations Report
  - Data Dictionary

What Do We Do With the Data Once We Have It?

- Use software (IDEA & SAS)
- Reporting – Statistics, Graphing Data
- Patterns in the data –
  - Gap Detection or Potential Duplicates

Rules for Data Analytics

Program Laws, Rules & Regulations

- Establish frequency limits
- Establish pricing/limit payment
- Establish age restrictions
- Detail unallowable services
- Establish authorization requirements

25

What is Clustering?

- Analytics allow relationships to be identified – helps to ID useful clusters
- Clustering identifies and places relevant services into a group
- Enhances the identification of relationships between transactions, individuals and behaviors

26

Analyzing the Data

- Examples of Standard reports
  - Procedure Code/Modifier
  - Date of Service
  - Recipient Date of Service
- Common Analysis
  - Date of Death & Inpatient or care facility

Analyzing the Data

- Risk ranking analysis
- Combining data from different sources
- Complex stratifications, analysis and projections
- Use results to select providers for examination

Red Flags

- Unusual modifiers being billed
- Volume indicators (units, patients)
- Billings compared to peers
- Recipients with high number of services per date of service
- Recipients with same address receiving same type of service on the same date

30

Common Types of Healthcare Fraud

- Billing for services that were never rendered
- Upcoding- billing for a higher-priced treatment than was actually provided
  - o May include worsening of the patient's diagnosis
- Performing medically unnecessary services
  - o Common areas include diagnostic-testing schemes
  - o Recent headlines – cancer treatment, cardiac procedures

31

Common Types of Healthcare Fraud

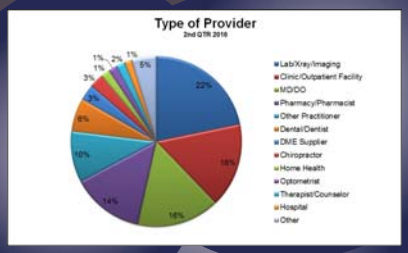
- Misrepresenting non-covered treatments
- Falsifying a patient's diagnosis for procedures that aren't medically necessary
- Unbundling - billing each step of a procedure as if it were a separate procedure
- Accepting kickbacks for patient referrals.

32

NHCAA Data

33

NHCAA Data



34

Sampling Results by Provider Type

Provider Type	# of Samples	Average % of Error
Transportation	30	77.8%
Nurses	18	32.3%
Home Health Agency	17	32.7%
Personal Care Aide	9	50.8%
School Med Program	9	50.2%
Physician (& Group)	7	31.7%
Psychiatric Services	6	32.0%
Psychological Services	3	72.3%
DME & Supplies	2	55.8%
Emergency Res. Sys.	2	27.5%
Podiatry	2	2.5%
Dental	1	31.9%
Total:	**106**	**50.2%**

35

Sources of Improper Payments

- Lack of documentation
- Altered or copied documentation
- Documentation does not support code/rate billed
- Lack of support for elements that drive reimbursement rate

36

Sources of Improper Payments

- Unqualified Providers
  - Services provided by unlicensed individuals
  - Services provided by licensed individual but not directly reimbursable
- No service authorization
  - Authorization for different provider/different services
  - Forms completed by unqualified

37

Sources of Improper Payments

- Repeatedly bill excessive units
  - Bill the impossible day
  - Pattern of large number of units (be aware of false positives)
- Billing rate above usual and customary fee
- Using same or *very similar service* codes to bill for the same service time more than once

38

Sources of Improper Payments

- Billing for services/activities not covered by Medicaid
  - Services after date of death
  - Services while incarcerated
    - Lack of single data source for local jails
  - Home health while in hospital

39

Challenges

- Working with big data
- Difficult to recoup overpayments
- Use of electronic records
- Training staff
- Security

40

Other Midwestern States

Illinois – August 2014 report
All Kids program

- Eligibility – issues with income verification and redeterminations
- Duplicate enrollees
- Poor controls – transportation, optical and dental services – resulted in overpayments

41

Other Midwestern States

Michigan – June 2014 report
Home Help Program

- Found $160 million in overpayments (error rate 17.9%)
  Issues included
  - lack of supporting documentation
  - lack of monitoring
  - ineligible clients &
  - Individuals paid at agency rates

42

Other Midwestern States

Minnesota – March 2015 report
Managed care organizations (MCOs) administrative expenses

- Few restrictions on expenses and lack of adequate guidance to address variations in the MCOs allocation methodologies

43

Other Midwestern States

Wisconsin – findings and recommendations from state FY 14-15 Single Audit

- Identified over $900 million in unallowable costs in the Money Follows the Person program
- Found that allegations of fraud were not consistently being reported to department of justice (houses MFCU unit)

44

Recent Initiative

- Recent discussions involving NSAA & GAO
- Concern over impact of improper payments on state budgets
- Historically – focus was on compliance supplement and single audit
- Growth in managed care is new risk

45

Recent Initiatives

- Issues:
  - Need software to perform data analytics
  - Developing algorithms – ID key indicators
  - Access to managed care data
  - Better coordination with CMS
  - Funding for audit work

46

Recent Ohio Initiatives

Payment reform initiatives

Value Based Payment Model

Moving from fee for service to Incentive Based Payment

47

Thank You

Questions?

48

Contact Information

Kristi Erlewine
Chief Auditor
Auditor of State Dave Yost

(614) 728-7245 Direct
(800) 282-0370 Toll Free
(800) 864-0182 Fax

KSErlewine@ohioauditor.gov
www.ohioauditor.gov

49

Sources:

- http://www.brainyquote.com/quotes/quotes/p/pplato400440.html
- https://ecb.ohio.gov/Print/PrintCBR.aspx?CBR=MCD010004 4
- http://truvenhealth.com/
- http://medicaid.ohio.gov/Portals/0/Resources/Reports/EWIC/PWIC-Report-2014.pdf
- http://www.caseware-analytics.com/products/idea-data-analysis

Ohio Auditor of State
Dave Yost

88 E. Broad St.
Columbus, Ohio 43215
Phone: (800) 282-0370 Fax: (614) 466-4490
Email: ContactUs@OhioAuditor.gov

www.**OhioAuditor**.gov