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

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
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.

Improper Payment Definition

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

Improper Payments – Current Status

FFY 2015 Government-wide Improper Payment Estimates by Program

- Medicare
- Medicaid Fee-for-Service (Parts A and B)
- Medicare Advantage (Part C)
- Medicare Prescription Drug (Part D)
- Earned Income Tax Credit
- Other programs
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
Medicaid in Ohio

Medicaid Recipients by Year

Medicaid in Ohio

Medicaid Expenditures by Year

Ohio’s Program Integrity Groups

• PIG
• MCPIG
• PIGRx,
• PiggyBank
• Charlotte's Web
• O.H.I.O.
Definitions of Risk Factors

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

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

Where can things go wrong?

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

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

Methodology in Examinations

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

- Provider Type
- Rules/Laws/Others 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

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

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
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

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.

NHCAA Data
### NHCAA Data

![NHCAA Data Chart]

### Sampling Results by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th># of Samples</th>
<th>Average % of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>30</td>
<td>77.8%</td>
</tr>
<tr>
<td>Nurses</td>
<td>18</td>
<td>32.3%</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>17</td>
<td>38.2%</td>
</tr>
<tr>
<td>Personal Care Aide</td>
<td>9</td>
<td>50.8%</td>
</tr>
<tr>
<td>School Med Program</td>
<td>9</td>
<td>53.2%</td>
</tr>
<tr>
<td>Physician &amp; Group</td>
<td>7</td>
<td>31.7%</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>6</td>
<td>52.0%</td>
</tr>
<tr>
<td>Psychological Services</td>
<td>3</td>
<td>72.3%</td>
</tr>
<tr>
<td>DME &amp; Supplies</td>
<td>2</td>
<td>55.8%</td>
</tr>
<tr>
<td>Emergency Res. Sys.</td>
<td>2</td>
<td>27.3%</td>
</tr>
<tr>
<td>Podiatry</td>
<td>2</td>
<td>2.5%</td>
</tr>
<tr>
<td>Dental</td>
<td>1</td>
<td>31.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>106</strong></td>
<td><strong>50.2%</strong></td>
</tr>
</tbody>
</table>

### 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
Sources of Improper Payments

• Unqualified Providers
  o Services provided by unlicensed individuals
  o Services provided by licensed individual but not directly reimbursable

• No service authorization
  o Authorization for different provider/different services
  o Forms completed by unqualified

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

Sources of Improper Payments

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

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

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

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
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

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)

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
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

Recent Ohio Initiatives

Payment reform initiatives

Value Based Payment Model

Moving from fee for service to Incentive Based Payment

Thank You

Questions?
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