Data Analytics and Improper Payments

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Office of Inspector General

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Public Law

- Improper Payments Information Act of 2002 (IPIA) (P.L. No. 107-300) as amended
- Improper Payments Elimination and Recovery Act of 2010 (P.L. No. 111-204) and
- Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) (P.L. No. 112-248)

IPIA as amended

- To improve accountability of federal agencies' administration of funds, the IPIA as amended requires agencies, including HHS, to annually report to the President and Congress on the agencies' improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either overpayments or underpayments).

IPIA as amended

- The head of each agency shall, in accordance with guidance prescribed by the Director of the Office of Management and Budget, periodically review all programs and activities that the relevant agency head administers and identify all programs and activities that may be susceptible to significant improper payments.

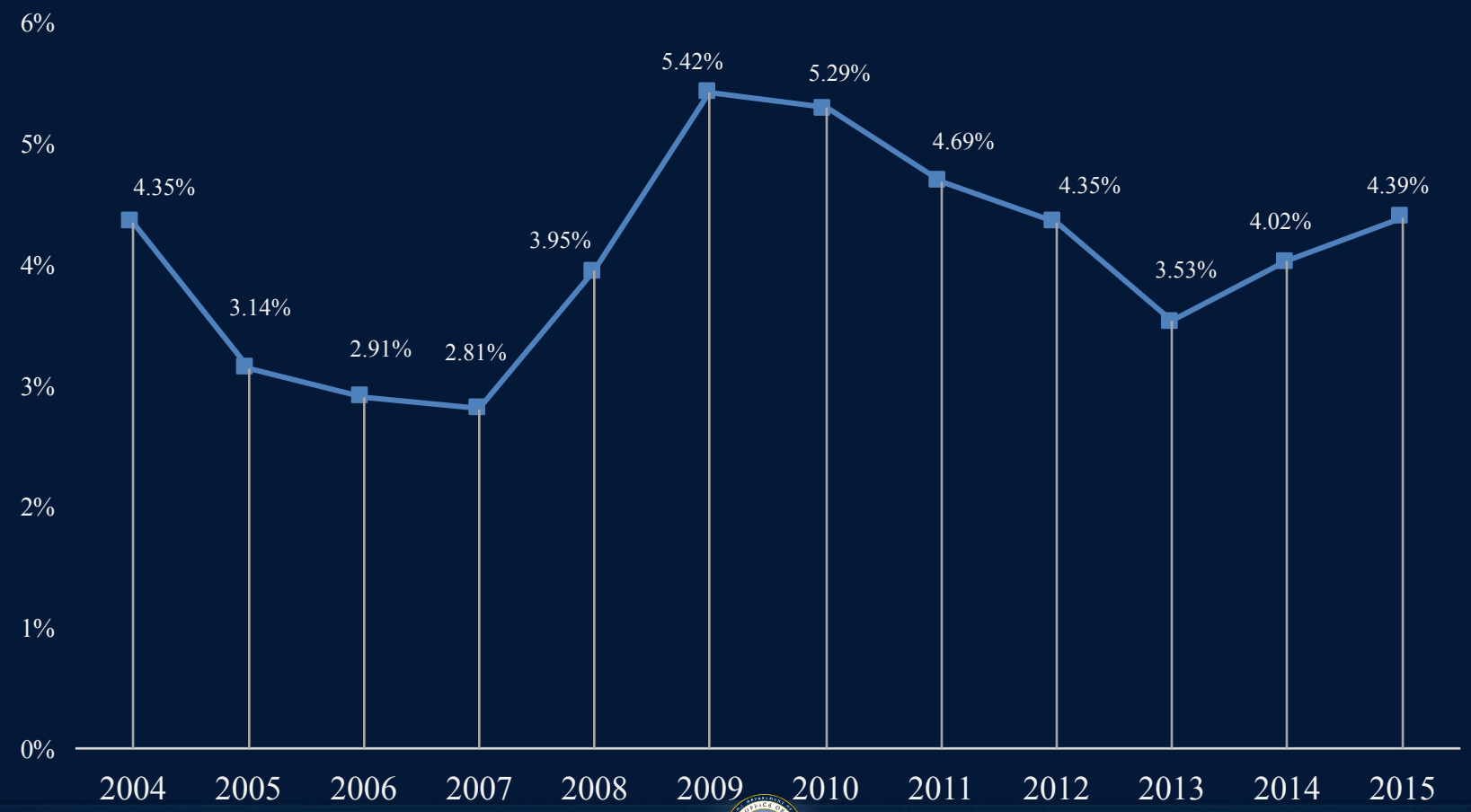
Public Law

- Disaster Relief Appropriations Act of 2013 (DRAA) states that all funds received under the law are deemed "susceptible to significant improper payments" for the purposes of IPIA, as amended, which requires HHS to develop and report improper payment estimates of Superstorm Sandy funding

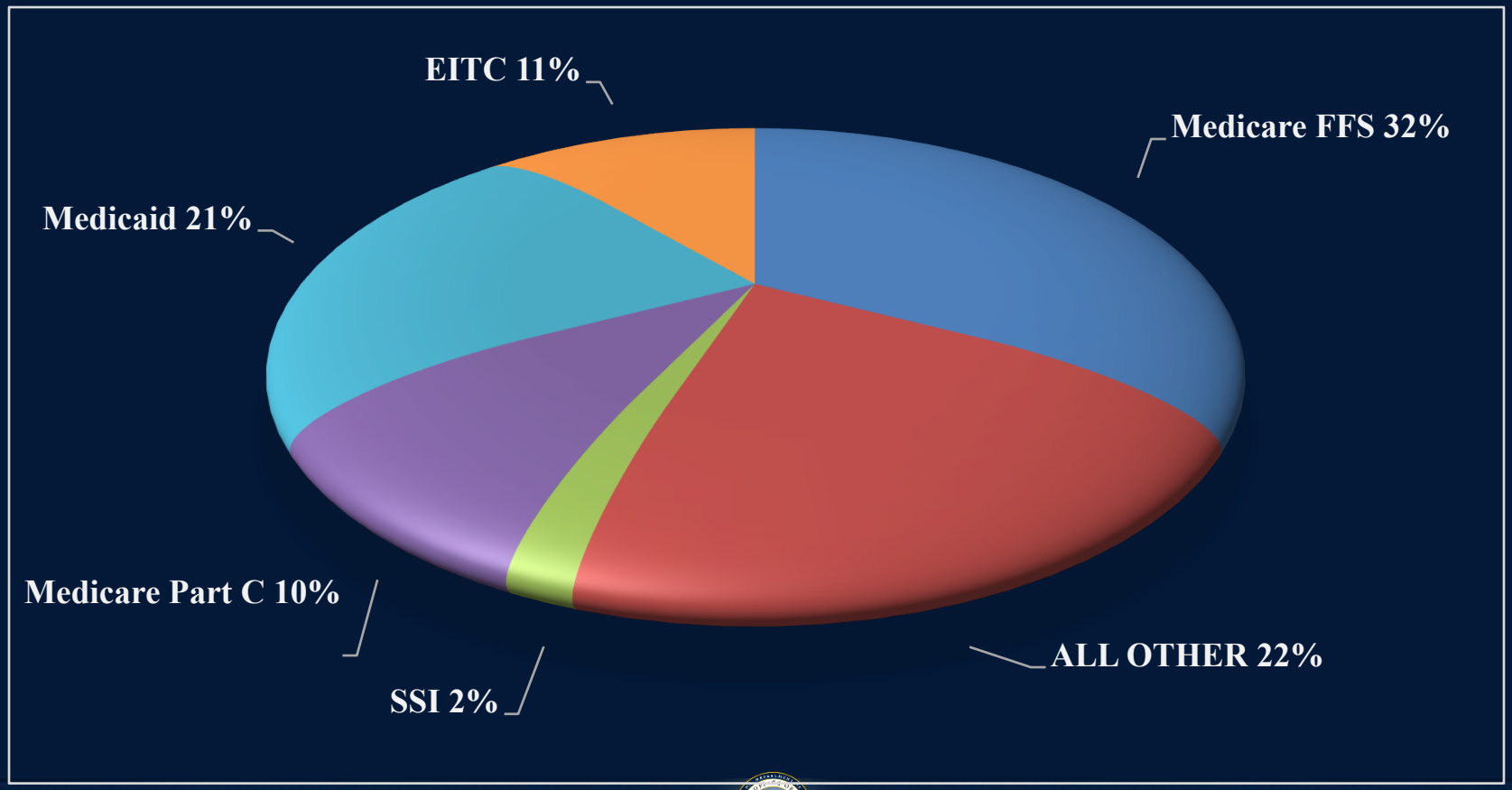
What's an Error

- An improper payment can be a payment made to an ineligible recipient, a payment made in the wrong amount, a payment made without proper documentation, duplicate payments, or payments for services not rendered;
- Not all improper payments constitute fraud, and high improper payment rates do not necessarily indicate a high rate of fraud. While fraud may be one cause, improper payments are not always the result of fraud or payments that should not have been made; and
- Many improper payments may actually be corrected if the documentation was properly maintained and provided upon request.

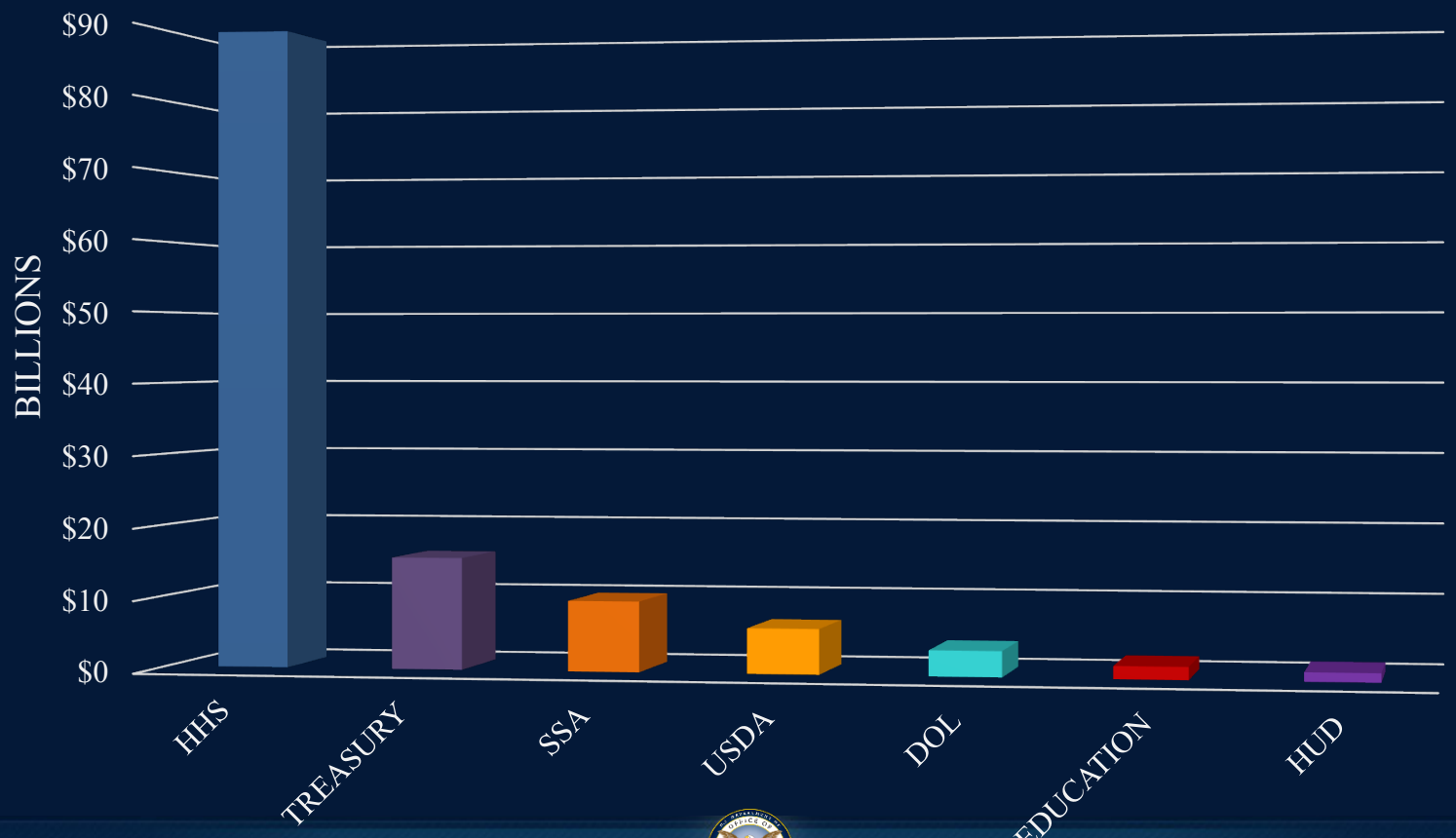
Government Wide



Percentage Distribution



By Agency


BILLIONS
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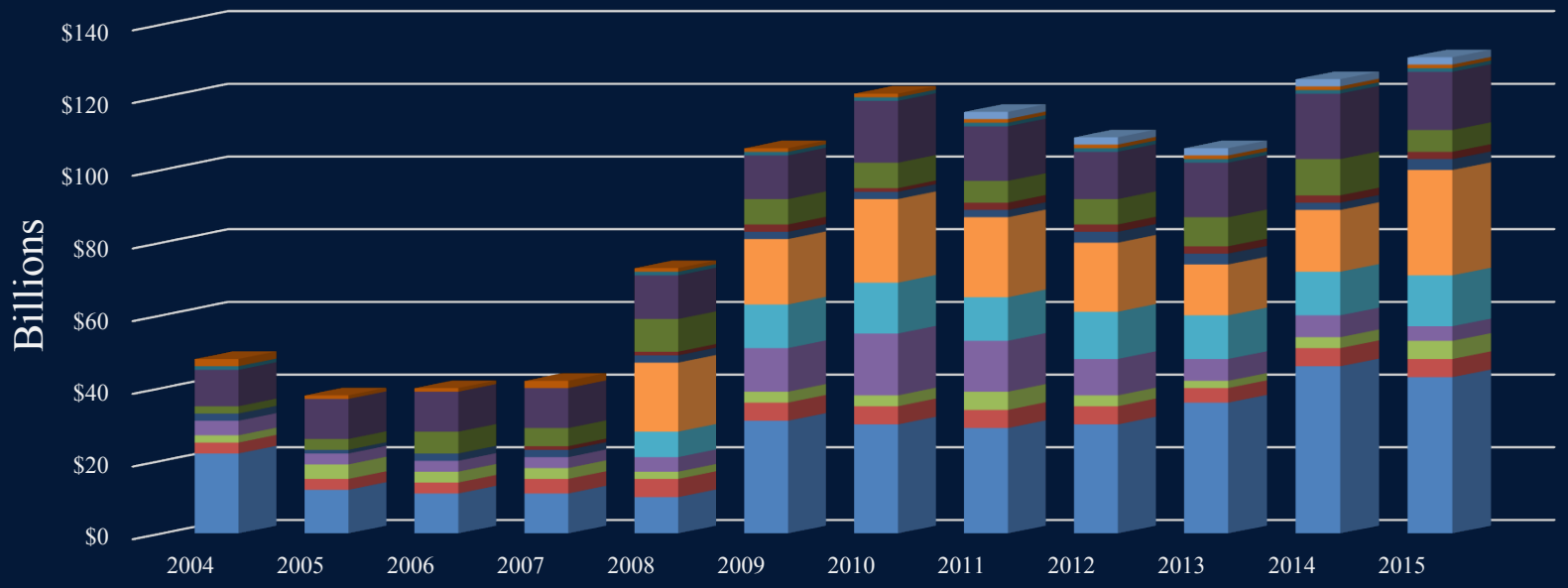
HHS
TREASURY
SSA
USDA
DOL
EDUCATION
HUD

Improper Payment Amounts



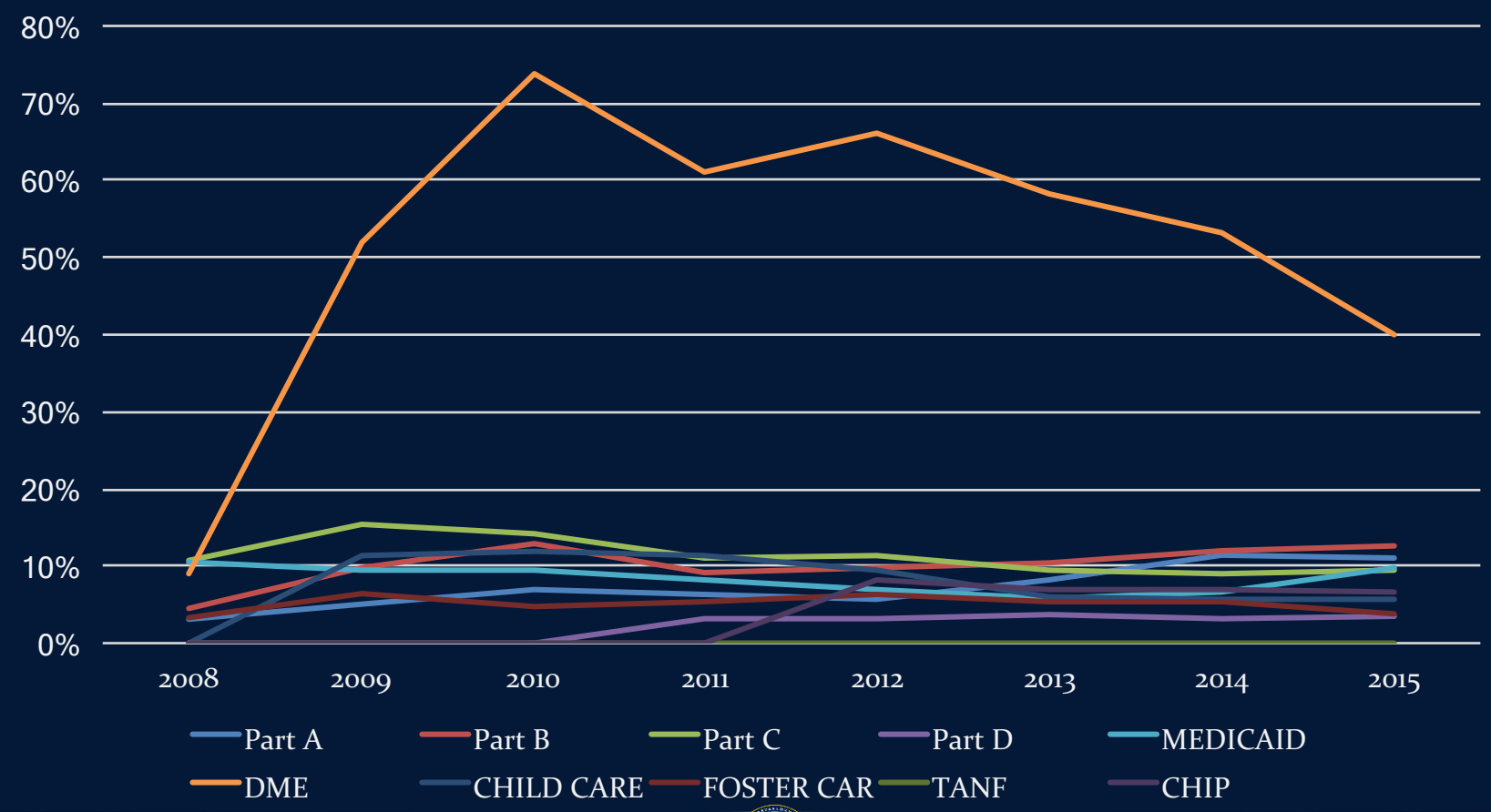
Improper Payment Oversight

- **In FY 2015, HHS reported $89.8 billion in improper payments**

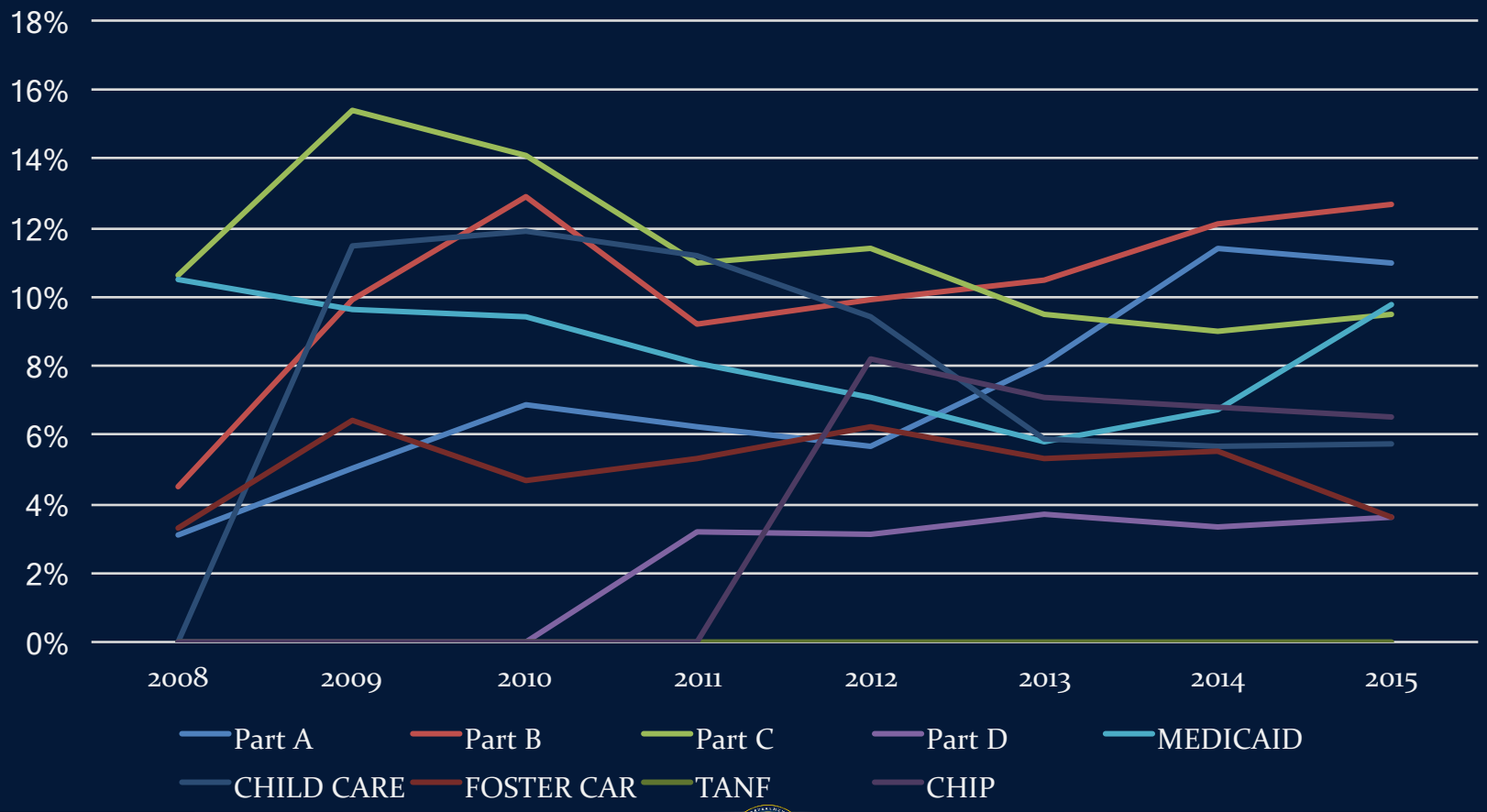
Programs Susceptible to Significant Improper Payments

Program	FY2015 Improper Payment Estimate Dollars (in millions)
Medicare FFS	$43,326
Medicare Advantage	$14,117
Medicare Prescription Drug Benefit	$2,234
Medicaid	$29,125
Children's Health Insurance Program (CHIP)	$632
Temporary Assistance for Needy Families (TANF)	N/A
Foster Care	$30.7
Child Care and Development Fund (CCDF)	$311.1
Disaster Relief Appropriation Act Programs (DRAA)	$1.4

HHS Error Rates



HHS Error Rates

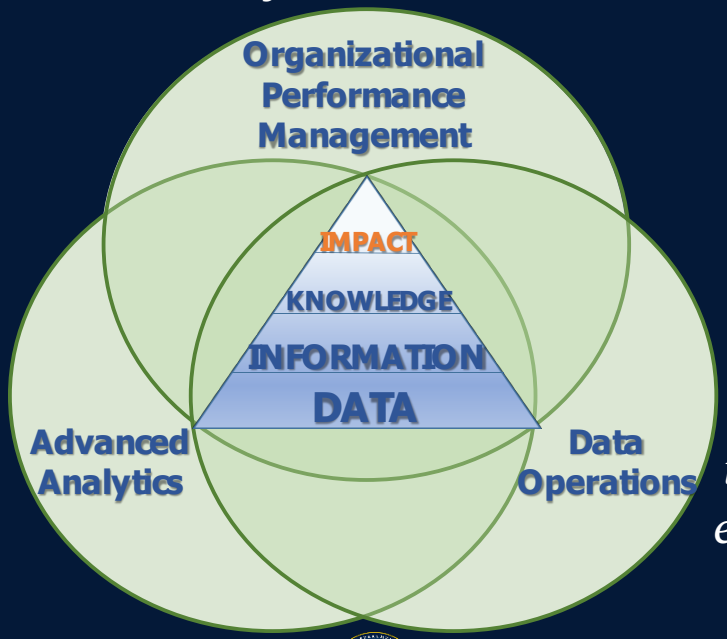


Office of the Chief Data Officer

Provide more and better access to data and analytics to support OIG's mission

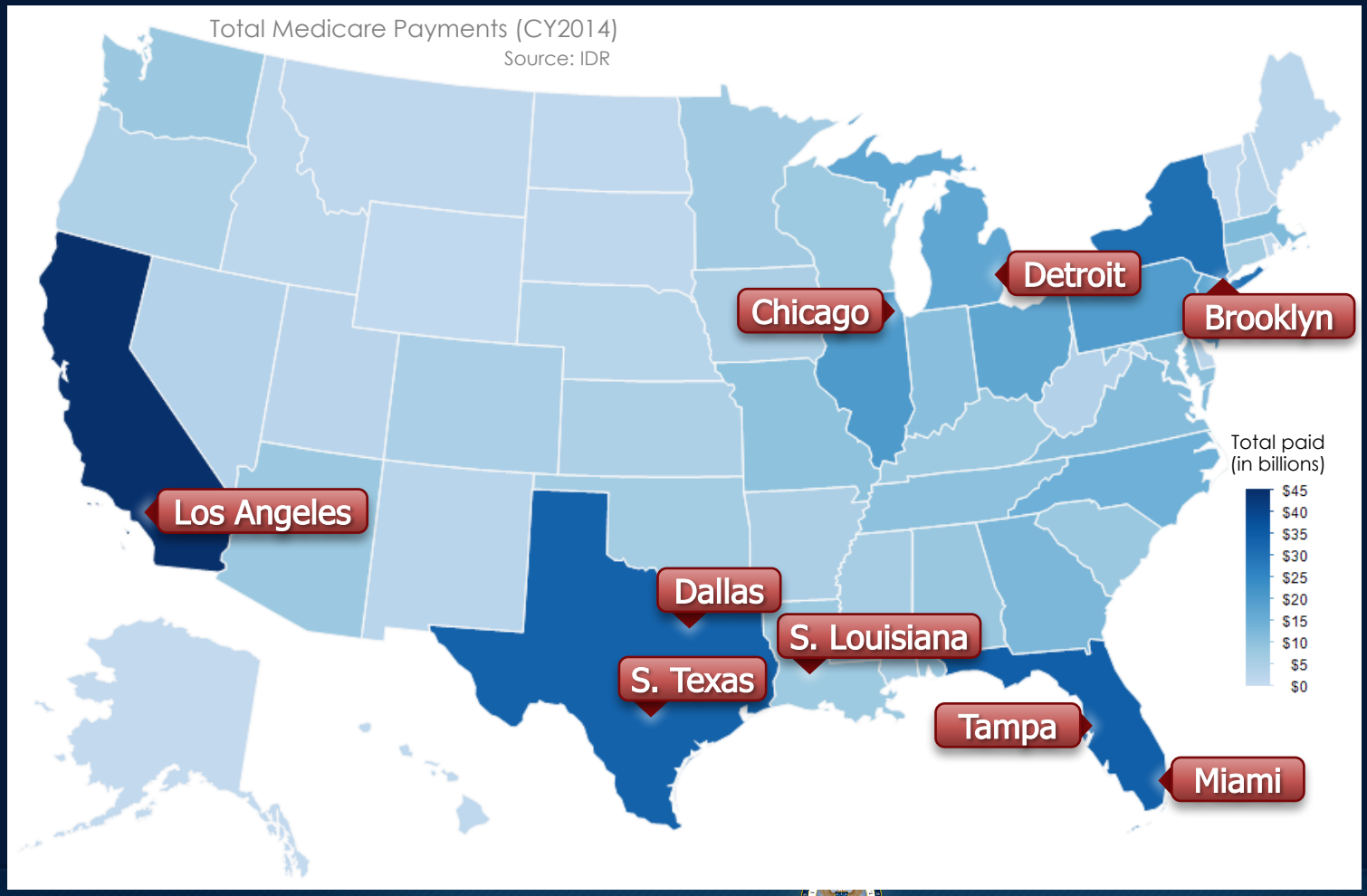
Enhance our use of data to make more informed decisions

Accelerate data analytics for use in audits, investigations, and evaluations



Improve access to internal and external data

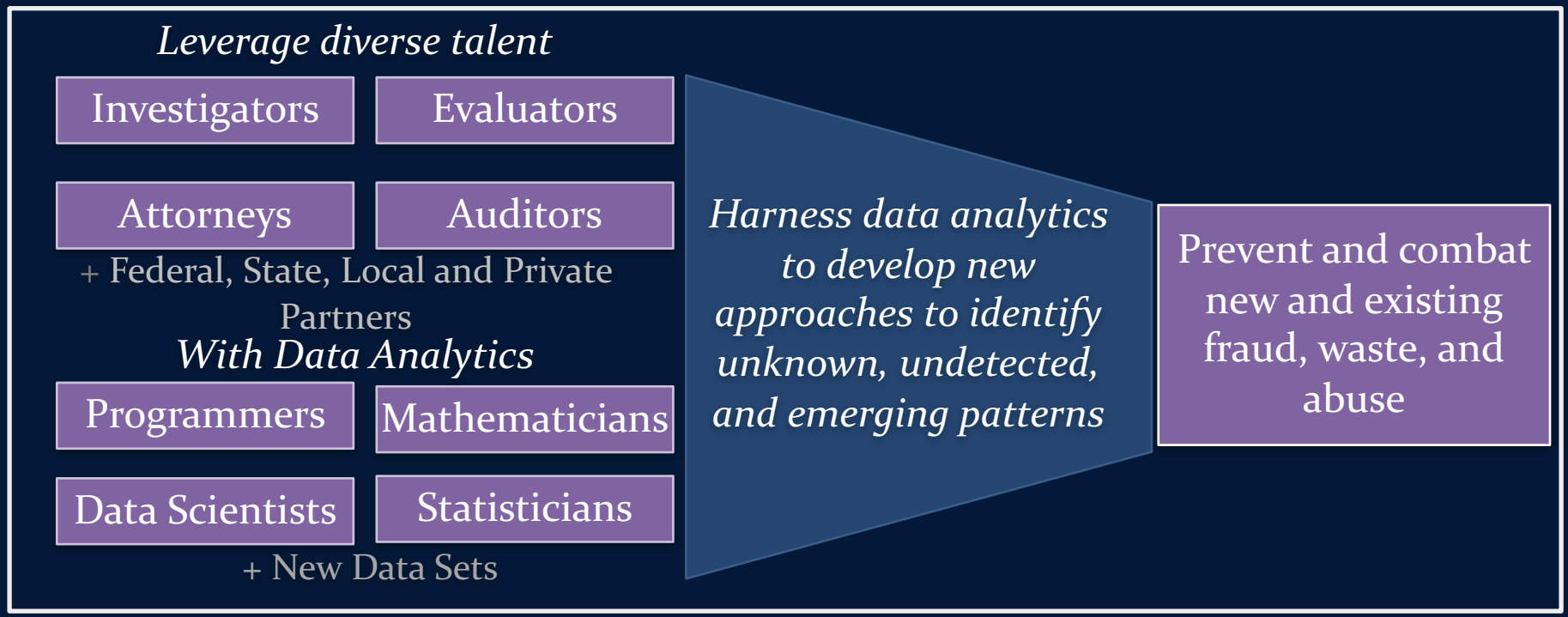
Medicare Payments



California	$44.8B
Florida	$34.3B
Texas	$33.6B
New York	$30.6B
Illinois	$20.3B
Pennsylvania	$19.8B
Ohio	$17.2B
Michigan	$17.1B
New Jersey	$17.0B
North Carolina	$14.5B

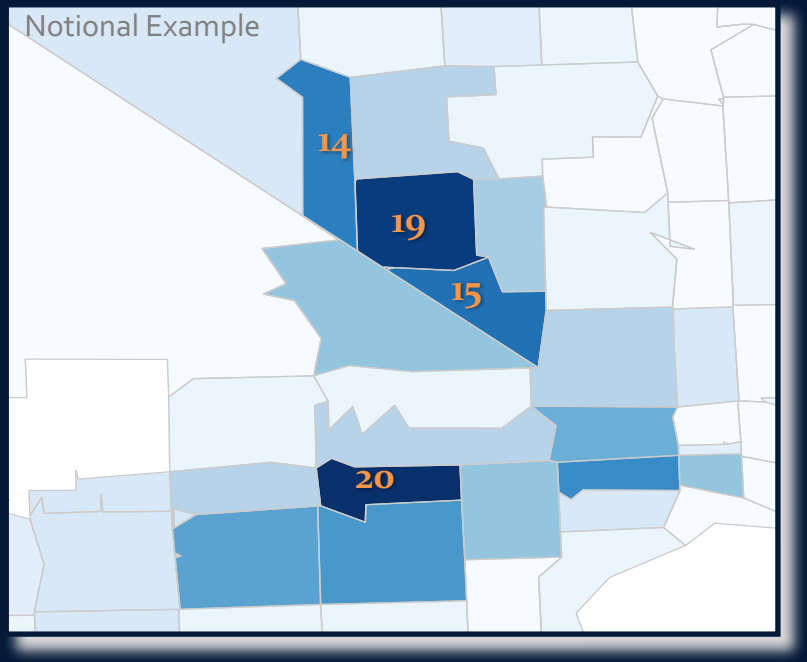
How the OCDO will help OIG be even more efficient and effective

Using data analytics



Bring skills, authorities and tools together in a team approach to take a fresh look at the problem and capitalize on innovative ways of looking at data

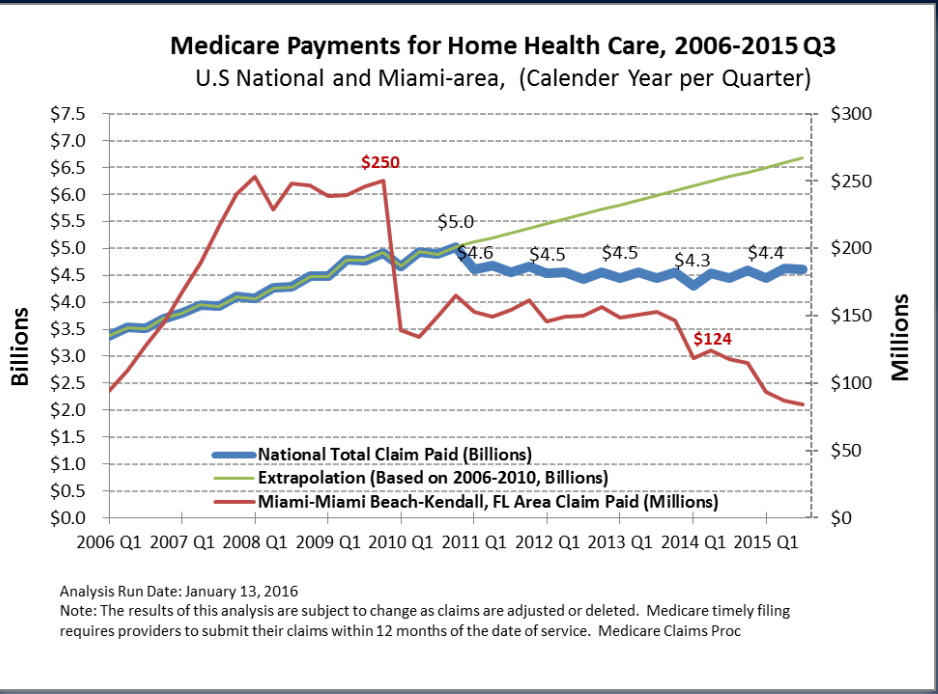
Fraud Models: Risk Measures

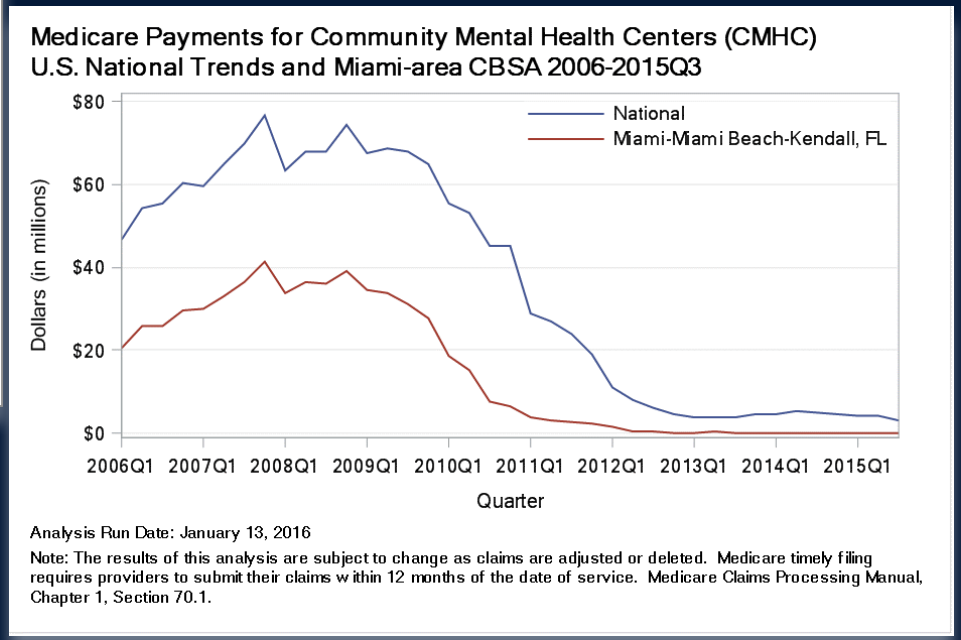


- Developing statistical models to calculate "risk scores" for providers who may be defrauding Medicare
- Mapping of high-risk provider locations
- Leverage access to new data sources to add richness to the models

Actionable Advanced Analytics Means High-Quality Lead Generation

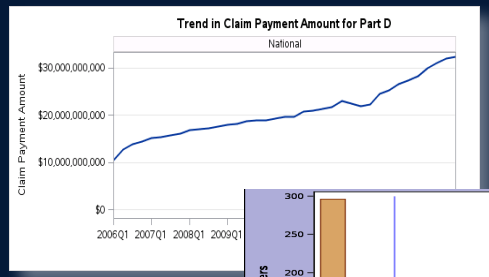
Using Analysis to Show Impact

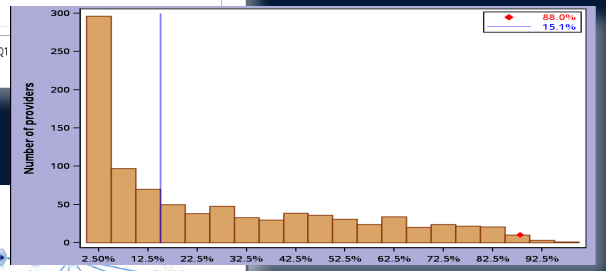


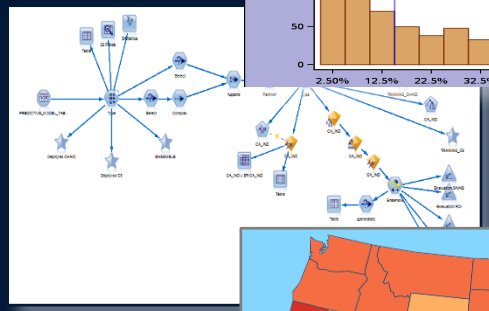


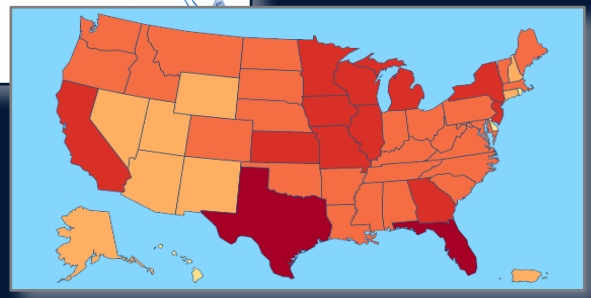
Analytic Tools

- Trend Tool
- Peer comparison generator
- Link analysis (Pharmacy, Provider)
- Payments by Geographic Area
- Dashboards (Administrative data)





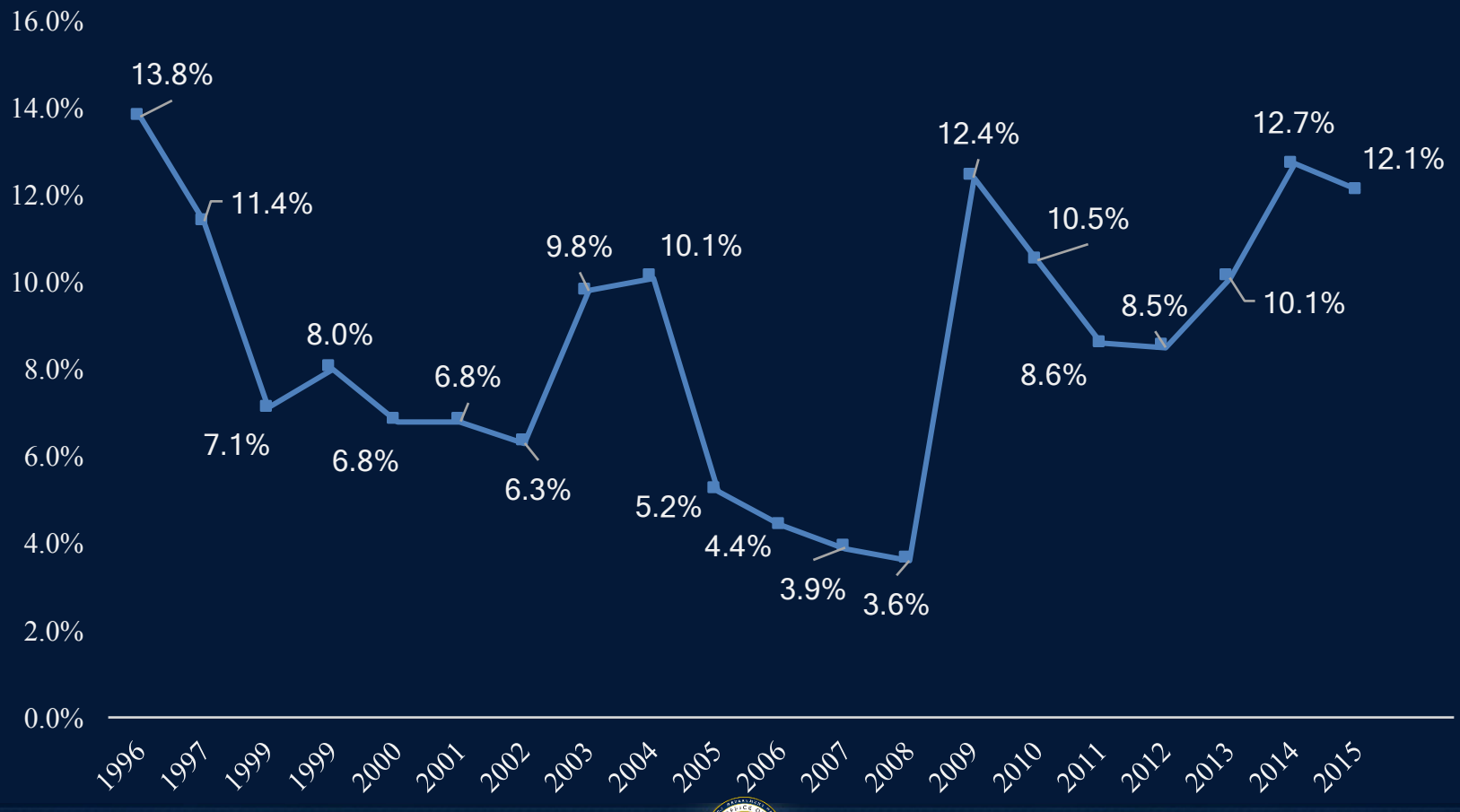




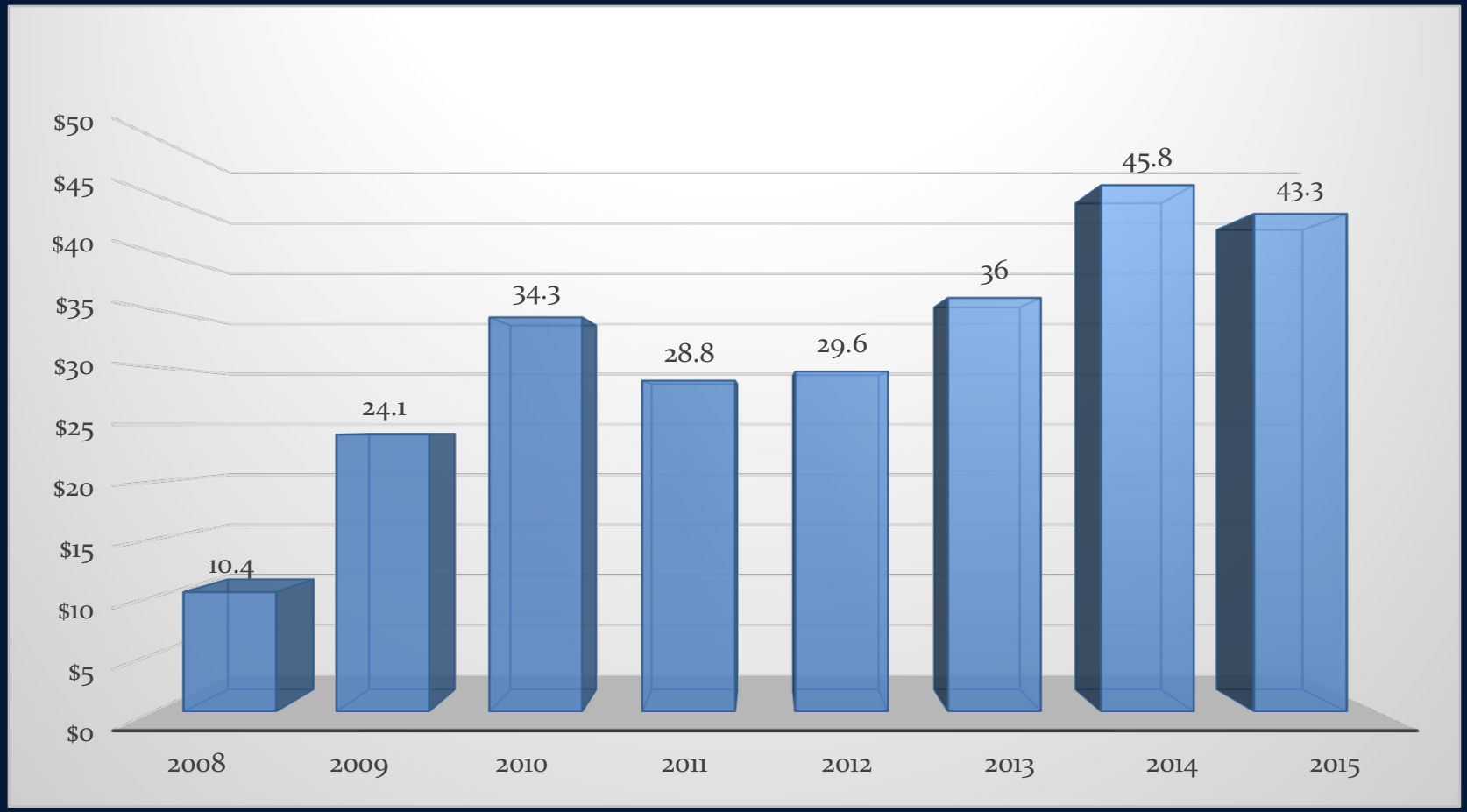
Using Analysis to Inform Decisions

- Consider how customers are going to use the results
- Create analytic products and processes that best facilitate the decision that needs to be made
- Socialize the team's work and impact for positive change
- Conduct timely and relevant analysis to support decision-making, using the best available data, models, and results

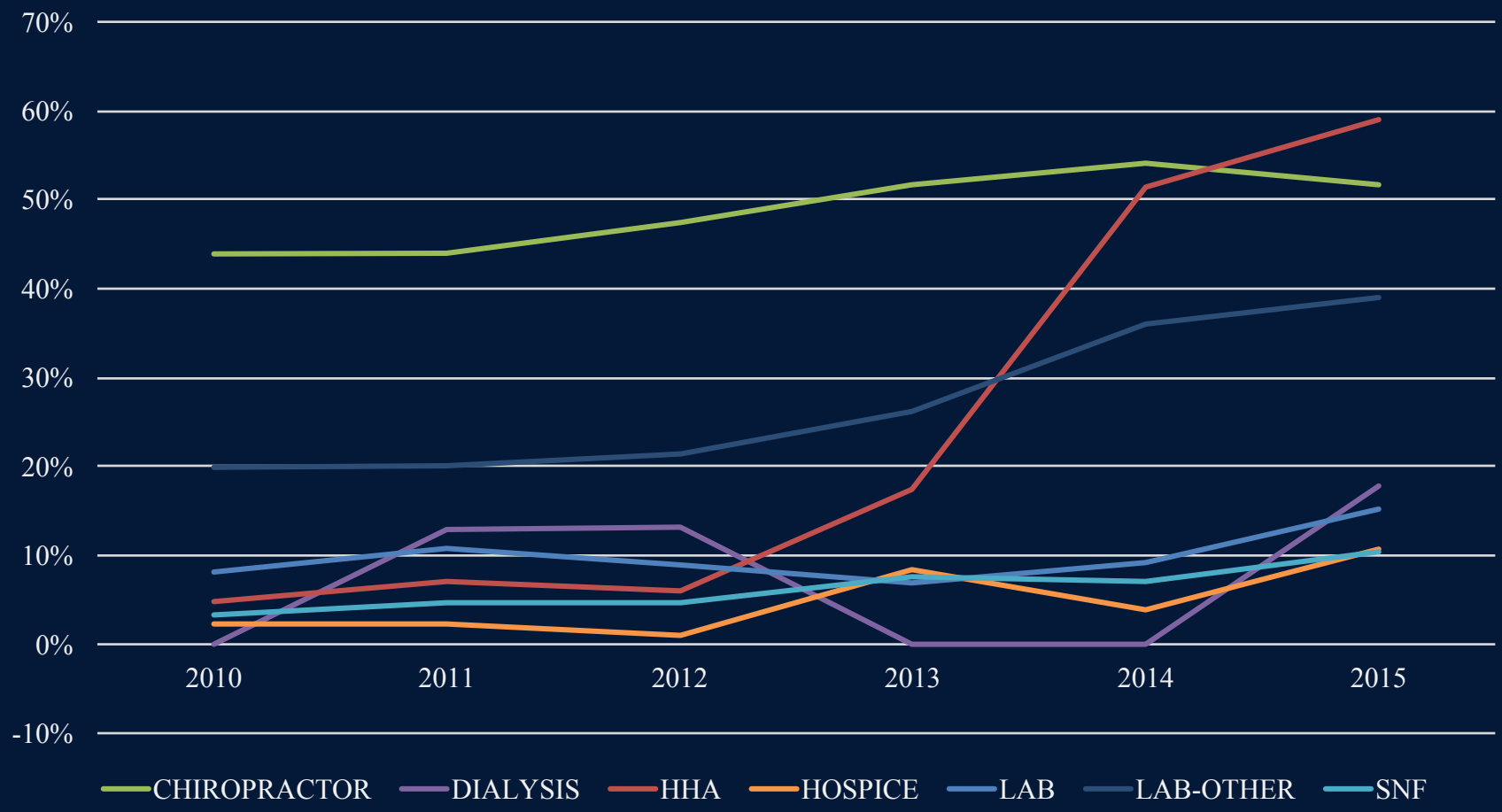
Medicare Error Rate



Medicare Improper Payments



By Service Type



Drives Healthcare Workplan

- Nationwide Compliance Initiatives
  - HHA
  - Hospice
  - Lab
- SNF
- Chiropractor
- Dialysis

Drives Healthcare Law Enforcement

- HHA
- Hospice
- Lab
- SNF

Home Health

- Christian Home Health Inc.
  - $34 million in fraudulent billing
  - Used elderly and disabled Medicare recipients in New Orleans and adjacent communities to bill Medicare for unnecessary home health care services.

- Willsand Home Health Agency Inc. ,JEM Home Health Care LLC (JEM) and Healthy Choice Home Services Inc.
  - $57 million in fraudulent billing
  - purported to provide home health services to Medicare beneficiaries in the Miami area, which were not medically necessary and often were never even provided and paid kickbacks to doctors, patient recruiters and staffing groups, which, in exchange, referred beneficiaries.

Hospice

- Community Health United Home Care, LLC
  - $9.8 million settlement arising from a self-disclosure.
  - Submitted false claims for hospice services without certifications of terminal illness.
- Serenity Hospice and Palliative Care
  - $2.2 million settlement.
  - Allegations that Serenity submitted false claims to Medicare for hospice patients who were not eligible to be admitted.
- Alive Hospice, Inc.
  - $1.5 million settlement.
  - Allegations that Alive billed for services provided to patients who did not qualify for general inpatient hospice care.

Labs

- Millennium Health
  - $256 million settlement
  - Billed for unnecessary urine drug tests and genetic tests, including for unnecessary confirmation tests on samples that produced normal results
  - Free testing cups in exchange for referrals
- Physicians Group Services, P.A.
  - $7.4 million settlement
  - Maintains a clinical laboratory as part of its practice.
  - Billed for medically unnecessary quantitative urine drug testing services.

Skilled Nursing Facilities

- Rehabcare - $125 million settlement - presumptively placed patients in highest therapy reimbursement level
  - Increased therapy during assessment reference periods only
  - Shifted therapy among disciplines to ensure targeted reimbursement levels
  - Provided high amounts of therapy at end of measurement period to reach minimum time threshold

OIG Objectives

1. Determine whether HHS complied with the IPIA for FY 2015 in accordance with OMB guidance

2. Evaluate HHS' assessment of the level of risk and the quality of the improper payment estimates and methodology for high-priority programs

3. Assess HHS' performance in reducing and recapturing improper payments

Specific Requirements Measured

- Issues that must be reported to ensure IPIA compliance:
  - Appropriate publishing of AFRs ✓
  - Conducting program-specific risk assessments ✗
  - Developing improper payment estimates for programs and activities identified as risk- susceptible ✗
  - Publishing corrective action plans (CAPs) ✗
  - Establishing and meeting annual reduction targets for risk-susceptible programs ✗
  - Reporting gross improper payment rates of less than 10% ✗

In FY 2015, HHS Failed To

1. Perform risk assessments of payments to employees and charge card payments
2. Publish an improper payment estimate for TANF that OMB determined to be susceptible to improper payments
3. Publish a CAP for TANF
4. Meet reduction targets for four of the seven programs for which HHS reported reduction targets in the FY 2014 AFR
5. Report an improper payment rate of less than 10 percent for Medicare FFS

Other Issues

- Medicare FFS program has not achieved a improper payment rate of less than 10 percent for 3 consecutive years

- HHS has not published an improper payment estimate and other required information for TANF for 5 consecutive years

OIG Recommendations

1. Develop and establish an improper payment estimate for TANF

2. Reduce improper payment rates to below 10 percent and achieve established improper payment target rates

3. Conduct risk assessments of payments to employees and charge card payments