



Improper Payments and Data Analytics

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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)
- 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.





IPIA as amended

- The Office of Management and Budget requires the head of each agency to:
 - 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.





Disaster Relief Act

- The Disaster Relief Appropriations Act of 2013 deemed all programs and activities receiving funds under the Act to be “susceptible to significant improper payments,” as defined by the IPIA. The Act funded Hurricane Sandy disaster relief.





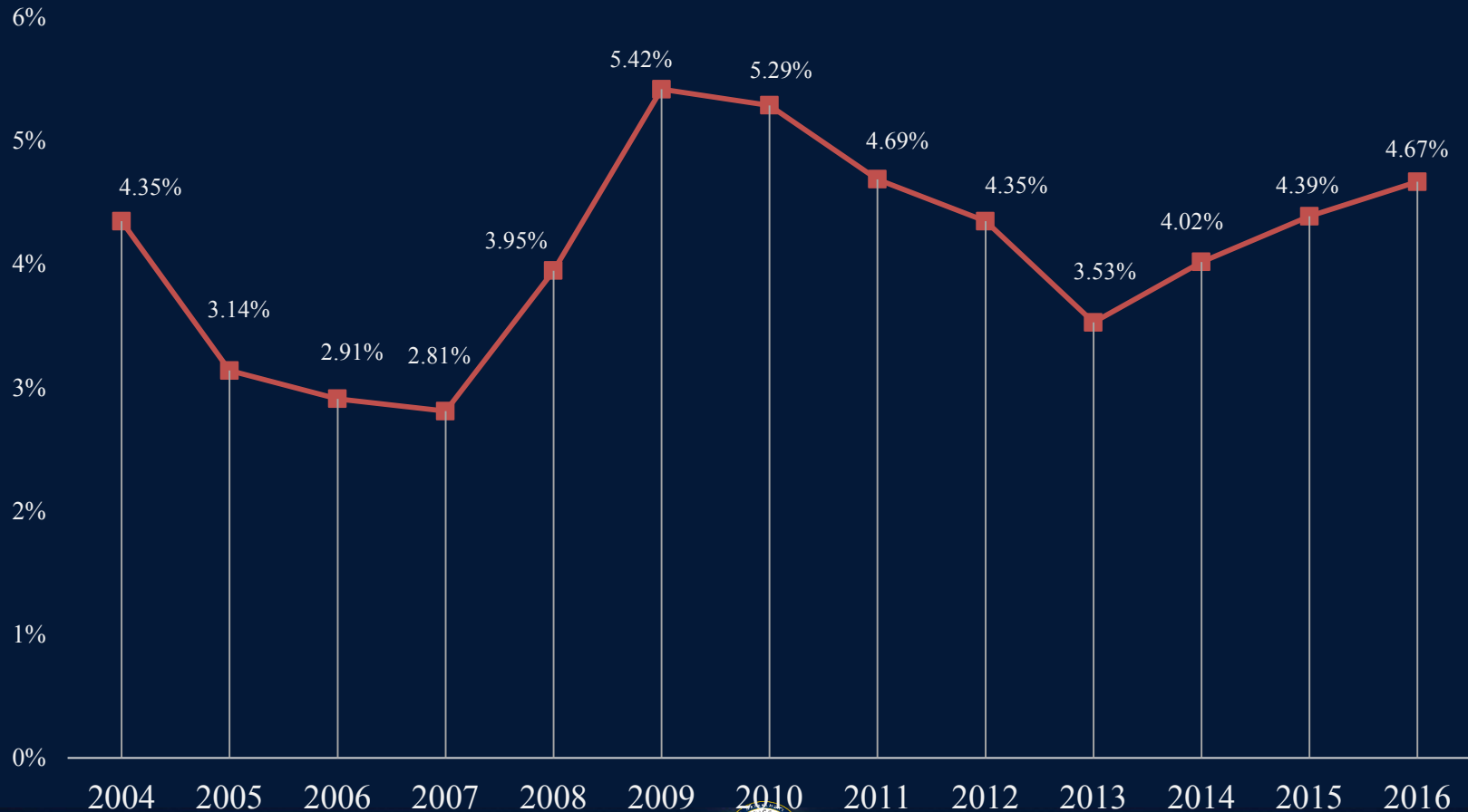
What's an Error?

- An improper payment is a payment made to an ineligible recipient, a payment made in the wrong amount, a payment made without proper documentation, a duplicate payment, or a payment for services not rendered.
 - Not all improper payments are 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.



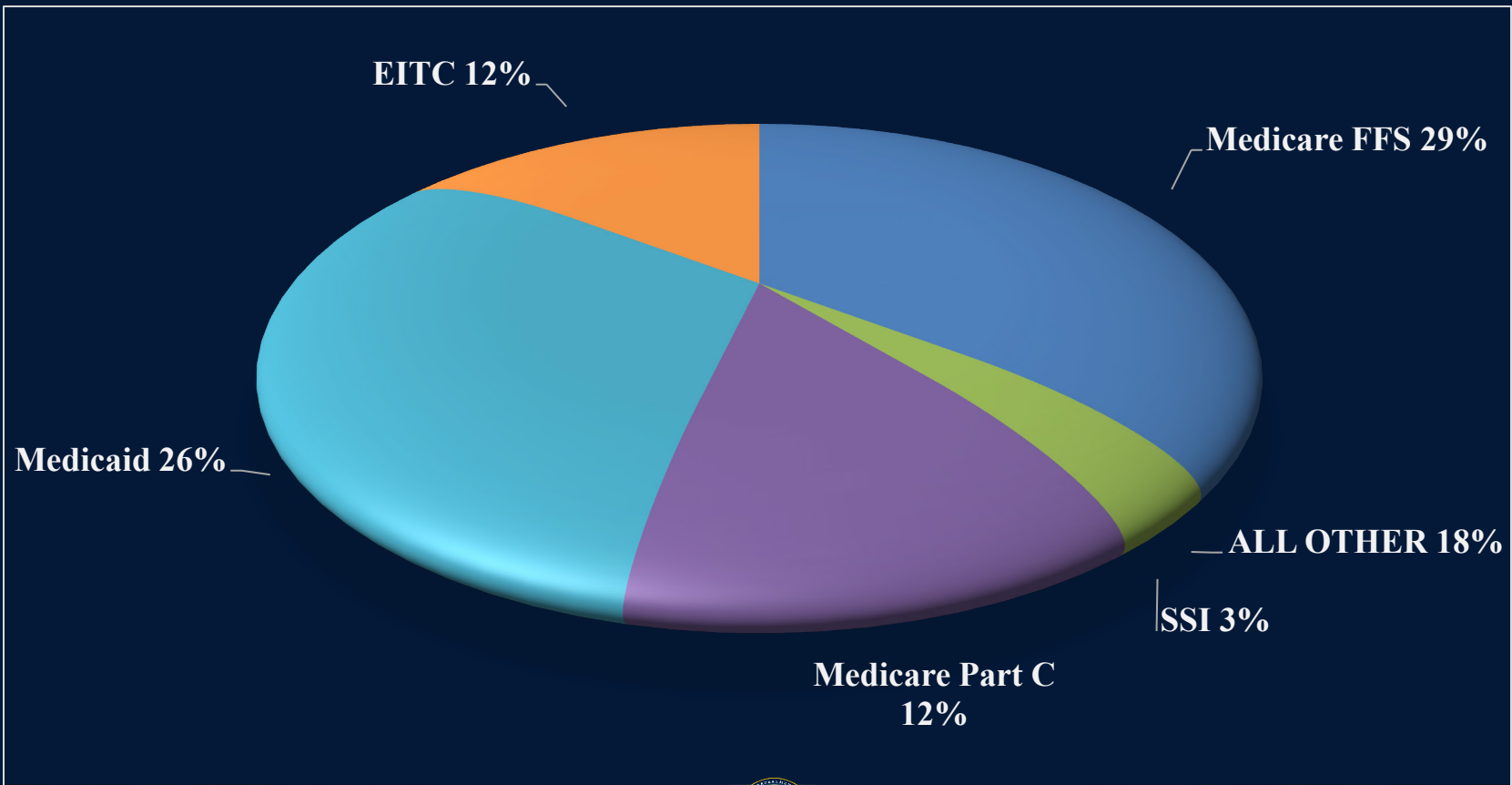


Government Wide



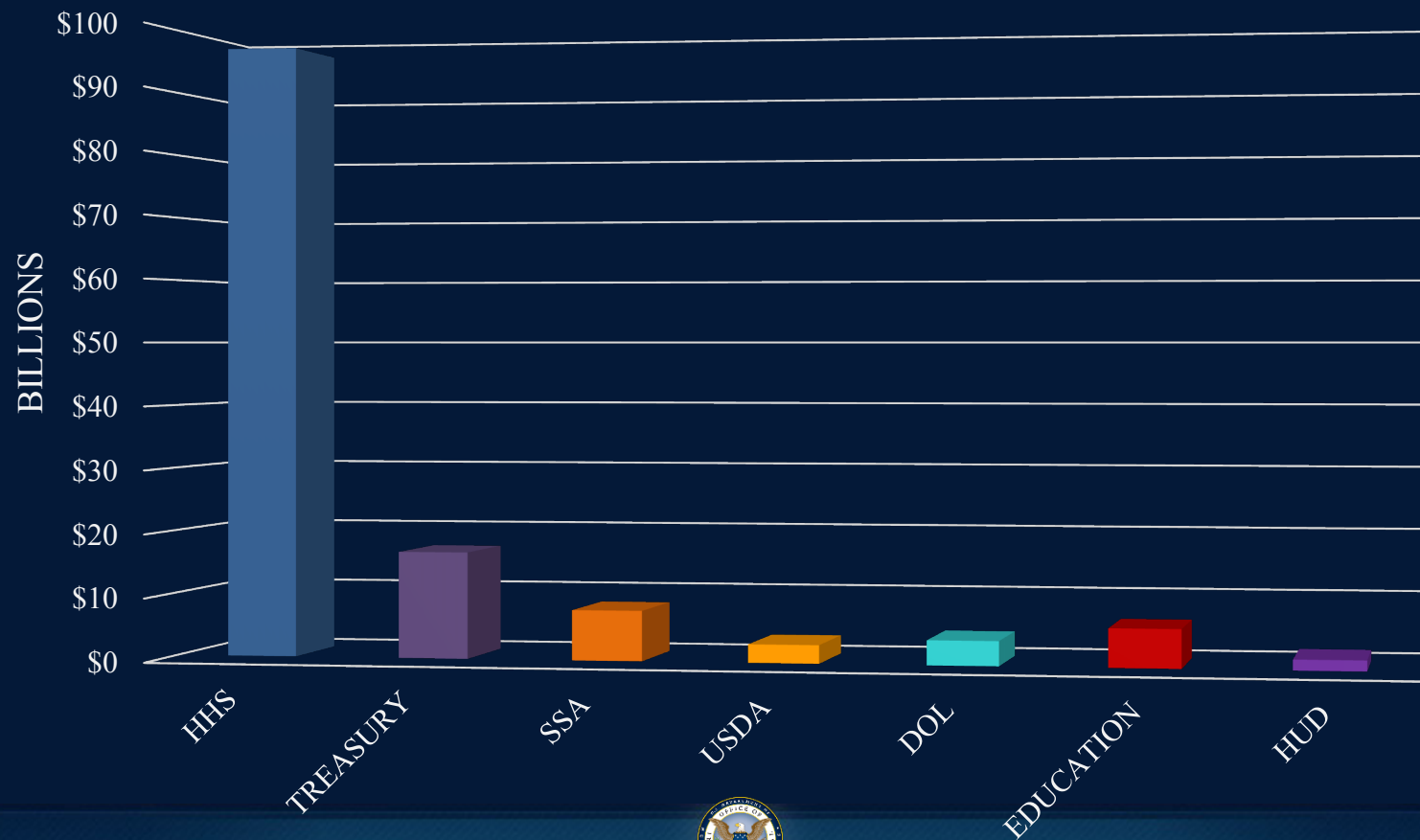


Percentage Distribution



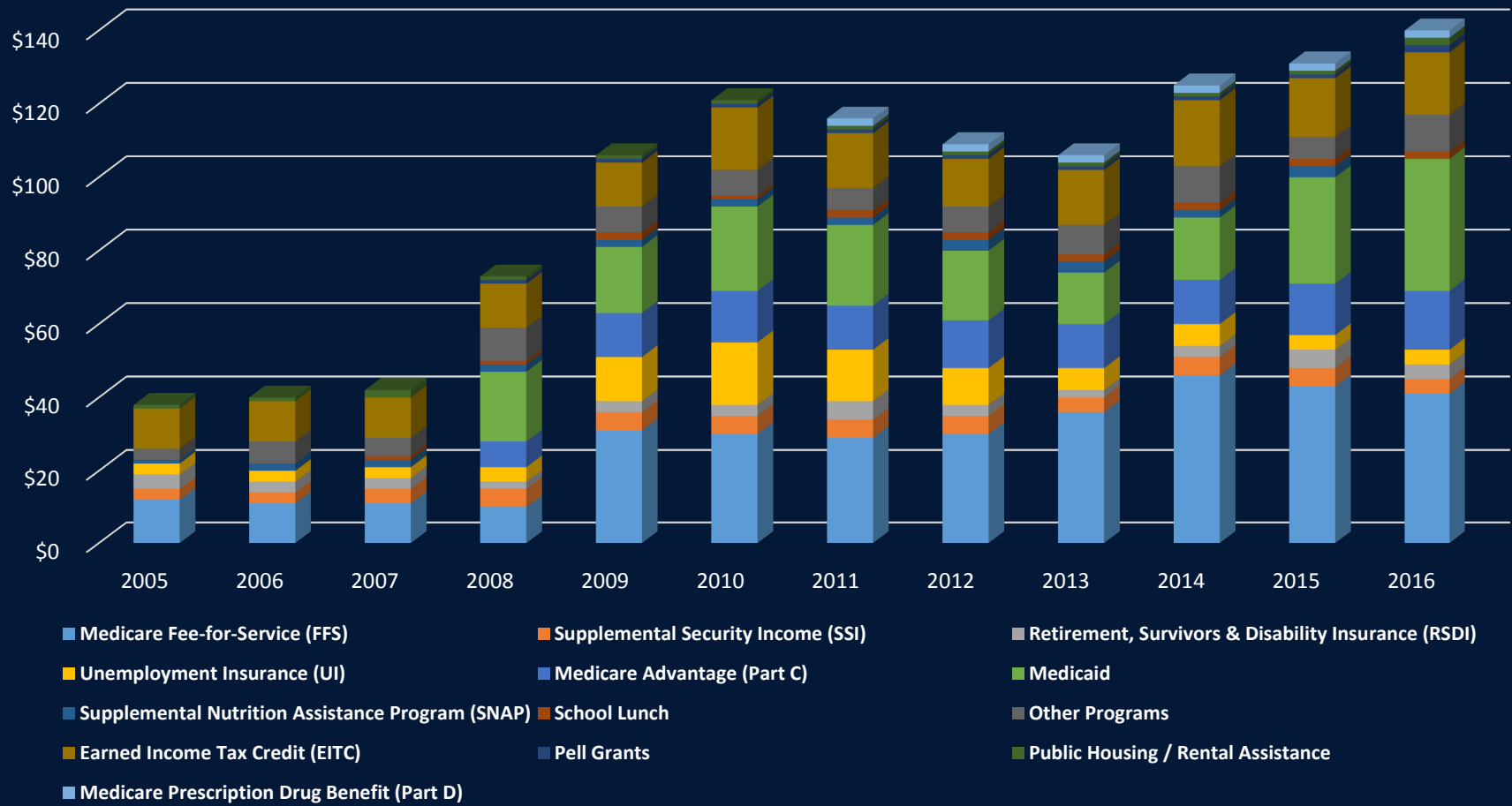


By Agency





Improper Payment Amounts





Improper Payment Oversight

**In FY 2016, HHS reported \$96.9 billion
in improper payments**





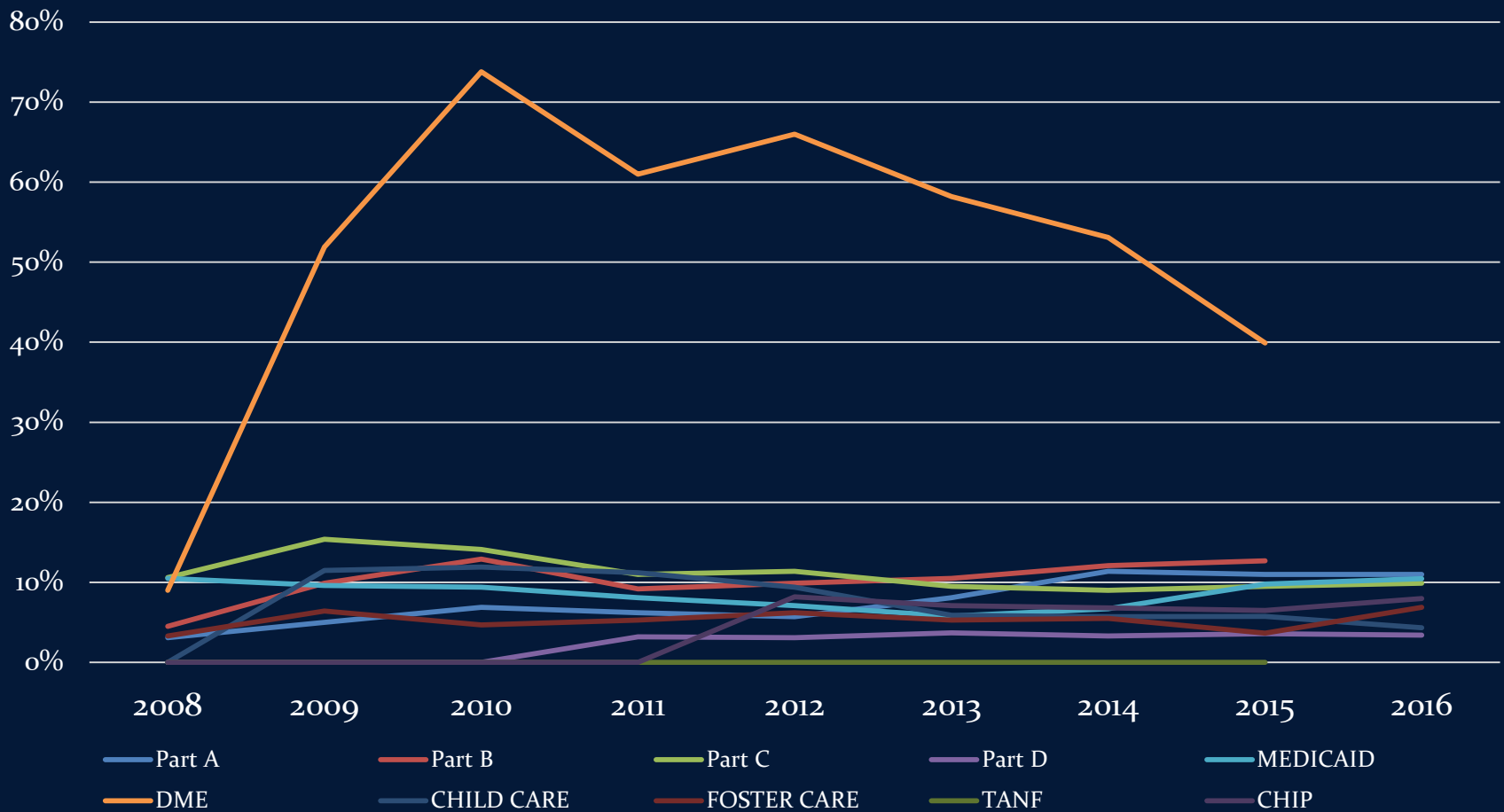
Programs Susceptible to Significant Improper Payments

Program	FY2016 Improper Payment Estimate Dollars (in millions)
Medicare FFS	\$41,085
Medicare Advantage	\$16,183
Medicare Prescription Drug Benefit	\$2,394
Medicaid	\$36,253
Children's Health Insurance Program (CHIP)	\$738
Temporary Assistance for Needy Families (TANF)	N/A
Foster Care	\$47.7
Child Care and Development Fund (CCDF)	\$240.7
Disaster Relief Appropriation Act Programs	\$1.4



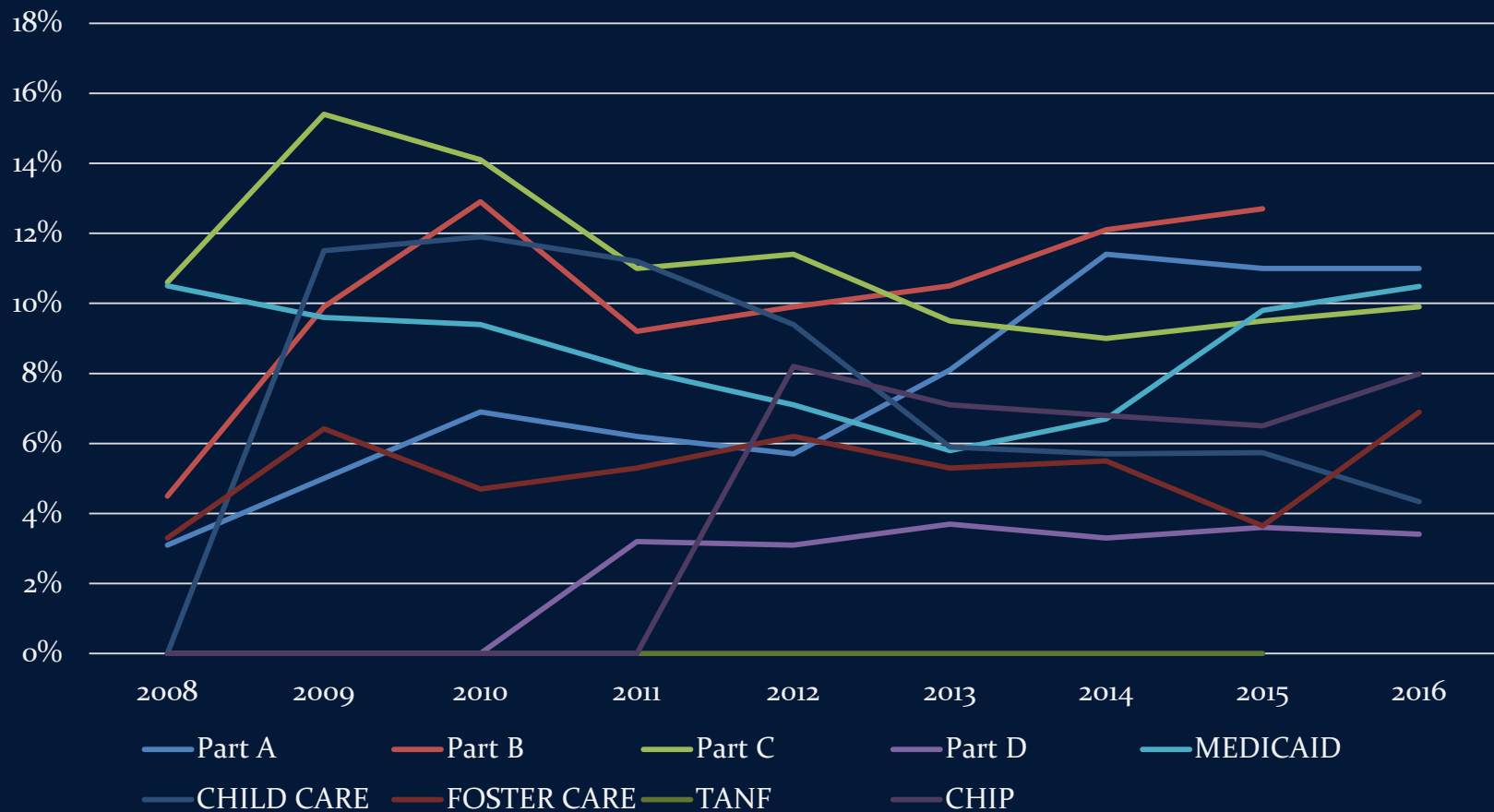


HHS Error Rates





HHS Error Rates



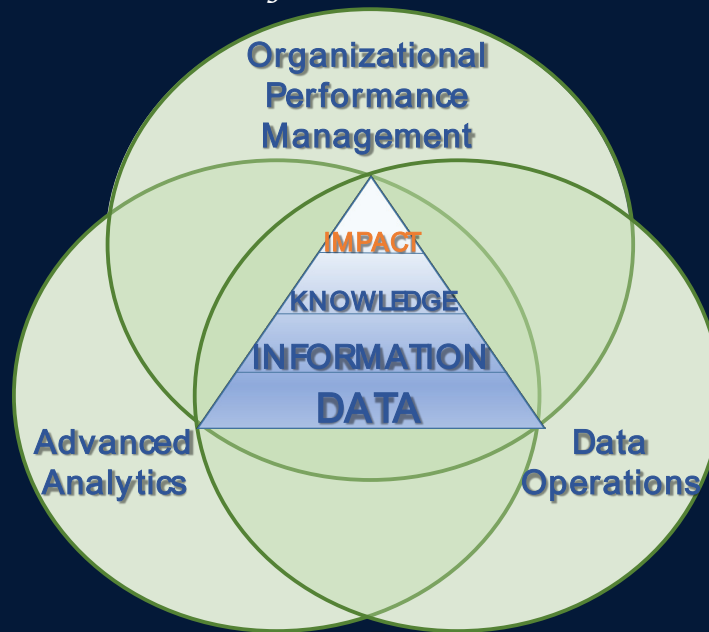


Office of the Chief Data Officer

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

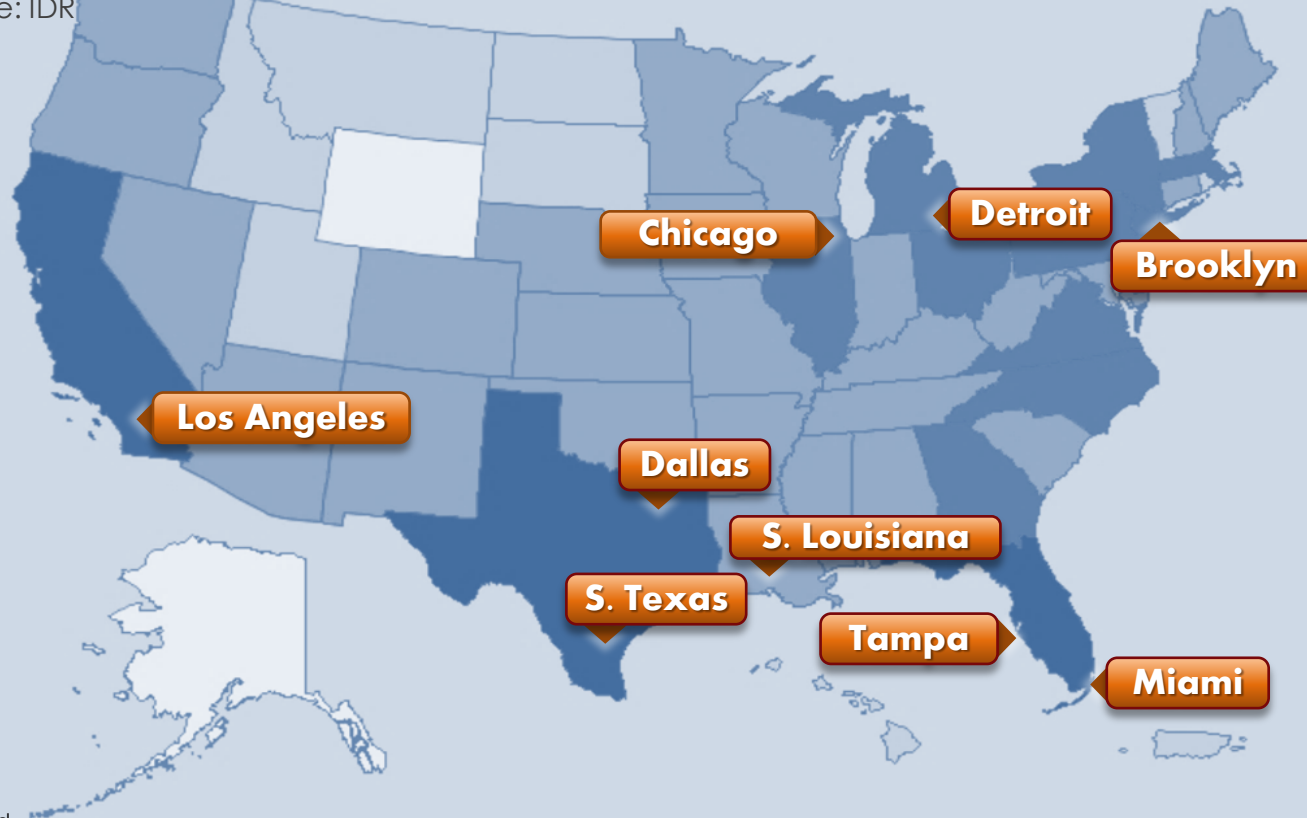




Medicare Payments

Total Medicare Payments (Parts A, B, and D for CY2015)

Source: IDR



California	\$48.3B
Florida	\$36.1B
Texas	\$35.3B
New York	\$32.7B
Pennsylvania	\$21.2B
Illinois	\$20.7B
New Jersey	\$18.1B
Michigan	\$17.9B
Ohio	\$17.6B
North Carolina	\$15.6B

Total Paid

KEY

\$819,067,043 - \$1,027,087,745

\$1,027,087,746 - \$2,515,751,120

\$2,515,751,121 - \$11,629,536,019

\$11,629,536,020 - \$35,293,954,753

\$35,293,954,754 - \$48,393,598,260

Indicates Strike Force Location





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

performance-management
data-mining
dashboards
data-access
data-quality
data-governance
geospatial-analysis
develop-models
analytic-tools
predictive-analytics
data-visualization
facilitate-discussion-and-decision-making
key-performance-indicators
strategic-planning





Using data analytics

Leverage diverse talent

Investigators

Evaluators

Attorneys

Auditors

+ Federal, State, Local and Private
Partners

With Data Analytics

Programmers

Mathematicians

Data Scientists

Statisticians

+ New Data Sets

*Harness data analytics
to develop new
approaches to identify
unknown, undetected,
and emerging patterns*

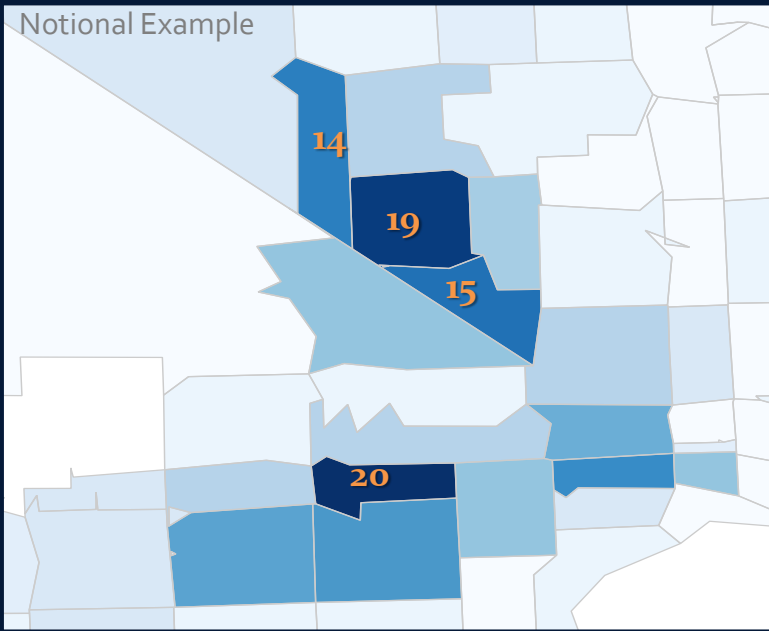
Prevent and combat
new and existing
fraud, waste, and
abuse

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

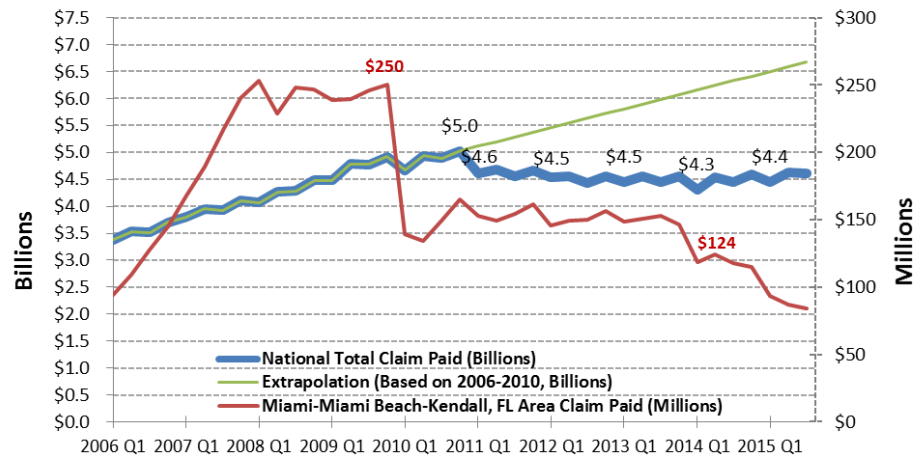
**Actionable Advanced Analytics Means
High-Quality Lead Generation**





Using Analysis to Show Impact

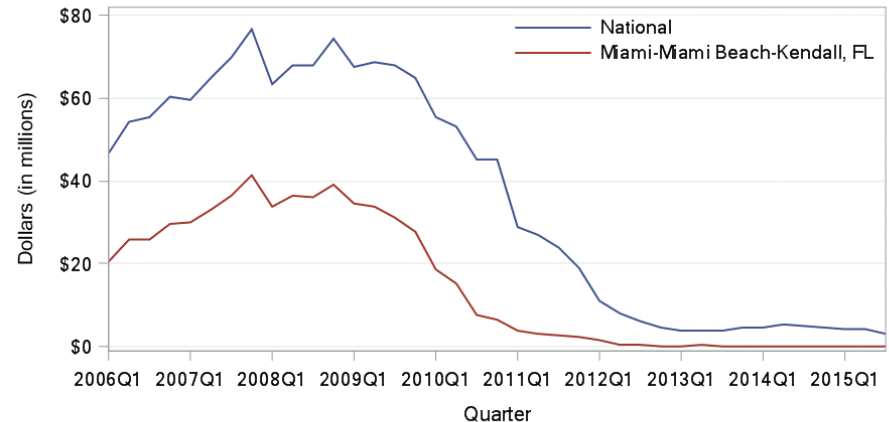
Medicare Payments for Home Health Care, 2006-2015 Q3
U.S. National and Miami-area, (Calendar Year per Quarter)



Analysis Run Date: January 13, 2016

Note: The results of this analysis are subject to change as claims are adjusted or deleted. Medicare timely filing requires providers to submit their claims within 12 months of the date of service. Medicare Claims Proc

Medicare Payments for Community Mental Health Centers (CMHC)
U.S. National Trends and Miami-area CBSA 2006-2015Q3



Analysis Run Date: January 13, 2016

Note: The results of this analysis are subject to change as claims are adjusted or deleted. Medicare timely filing requires providers to submit their claims within 12 months of the date of service. Medicare Claims Processing Manual, Chapter 1, Section 70.1.





- 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



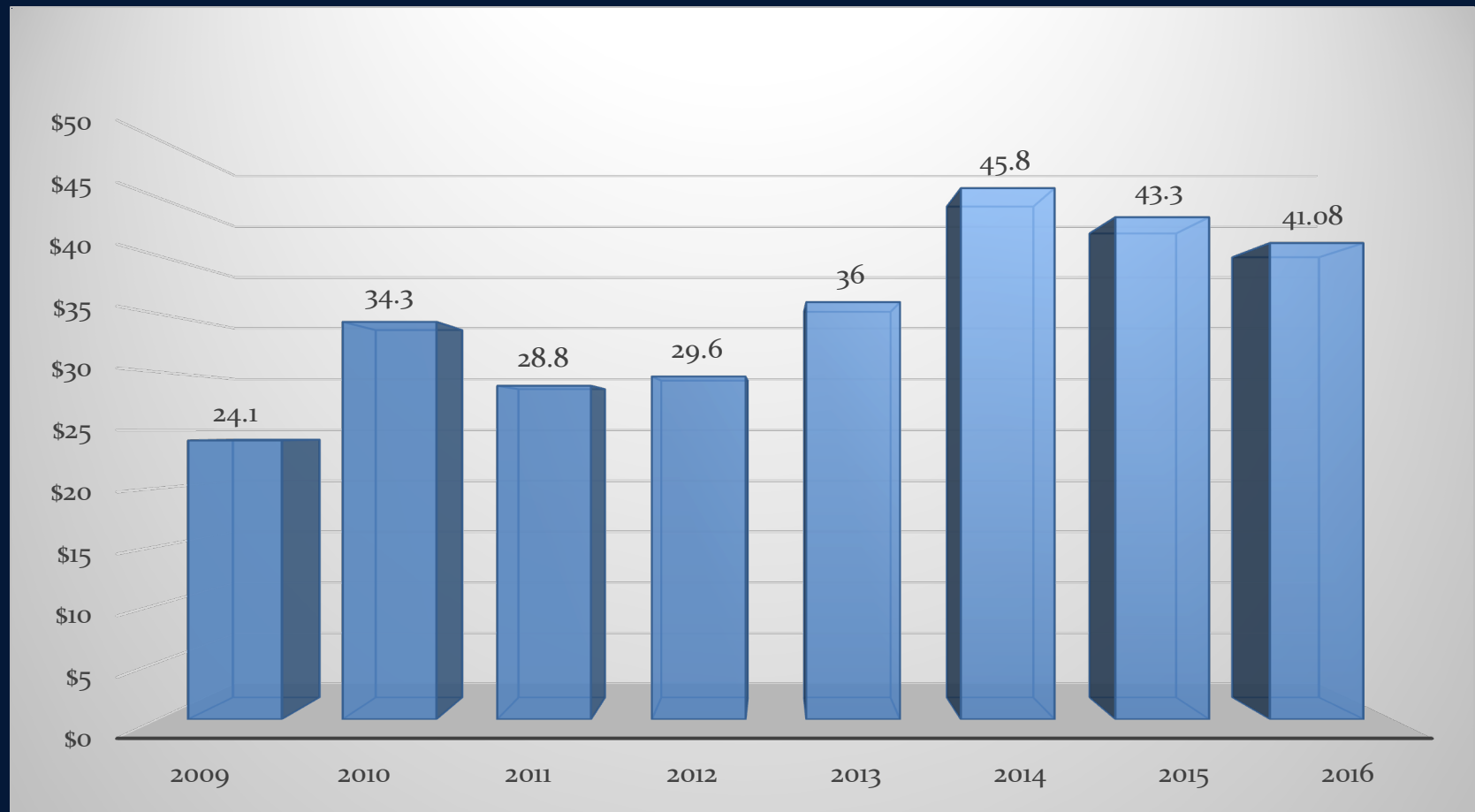


Medicare Error Rate



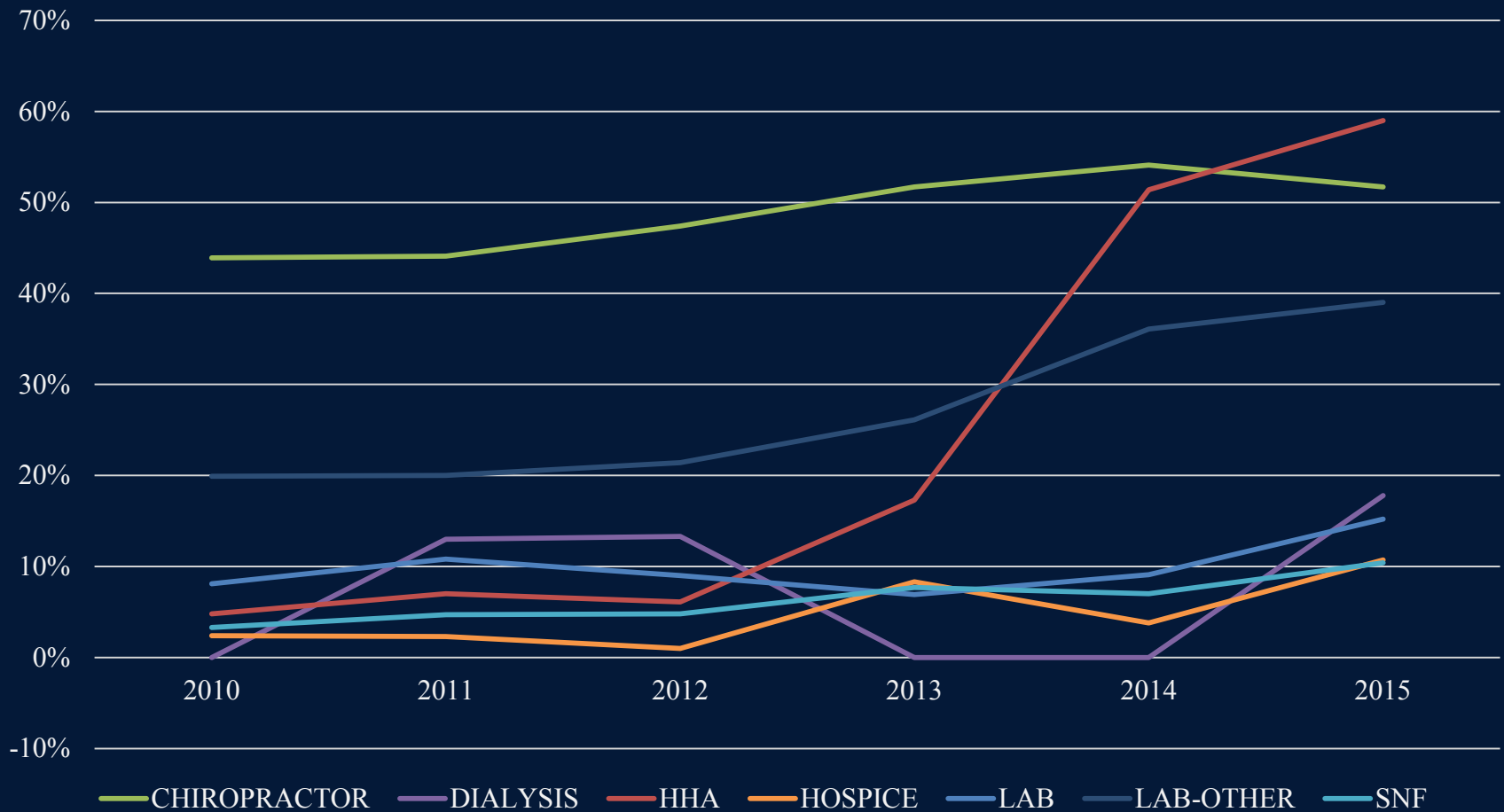


Medicare Improper Payments





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 2016 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.
4. Evaluate the accuracy and completeness of HHS's improper payment reporting.





Specific Requirements Measured

- Issues that must be reported to ensure IPIA compliance:
 - Appropriate publishing & posting of the AFR ✓
 - 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 2016, HHS Failed To

1. Publish an improper payment estimate for the TANF program, that OMB determined to be susceptible to improper payments.
2. Publish a CAP for TANF.
3. Meet reduction targets for three of the seven programs for which HHS reported reduction targets in the FY 2015 AFR.
4. Report an improper payment rate of less than 10% for the Medicare FFS and Medicaid programs.





Other Issues

- Medicare FFS program has not achieved a improper payment rate of less than 10% since FY 2012 (8.5 percent).
- HHS has not published an improper payment estimate and other required information for TANF for 6 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. Continue efforts to identify a Recovery Audit Contractor for the Medicare Advantage program.





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