

## Office of Health Transformation **Fight Medicaid Fraud and Abuse**

### **Governor Kasich's Budget:**

- *Invests in new, stronger measures to fight Medicaid fraud and abuse.*

### **Background:**

Ohio Medicaid remains committed to combating Medicaid provider fraud, waste, and abuse that diverts money from needy children, the elderly, and people with disabilities. The majority of providers and their billings are honest and accurate. However, one dishonest provider can take thousands of dollars over time by billing for services not rendered or medically necessary, or through organized crime take hundreds of thousands of dollars illegally.

The size and scope of Ohio's Medicaid program requires strong financial stewardship. Ohio Medicaid employs auditors, analysts, and fraud examiners, as well as private-sector experts and other professionals to identify, recover, and prevent overpayments. In partnership with Ohio Medicaid, the Ohio Attorney General has become a national leader in convicting and indicting Medicaid fraud, waste, and abuse.

In addition to prosecuting fraud cases and chasing down overpayments, Medicaid program integrity is about promoting a policy environment in which expectations and incentives are aligned to promote efficiency and quality, and prevent misuse of services. It also includes effective program management and ongoing monitoring. These efforts create a culture that drives better health outcomes and common-sense ways to eliminate fraud, waste, and abuse.

### **First Four Years:**

Governor Kasich's first budget (enacted in 2011) created Ohio Medicaid, which previously was organized as a division within the Ohio Department of Job and Family Services, as a stand-alone agency with full accountability to administer Ohio's Medicaid program. The new department is responsible for deterring and detecting fraud, waste, and abuse. Over the past four years, Ohio Medicaid launched several new initiatives to actively fight fraud, waste, and abuse:

- ***Established a new Bureau of Program Integrity.*** In 2014, Ohio Medicaid created a new Bureau of Program Integrity to coordinate program integrity activities with the state's five Medicaid managed care plans.
- ***Provided leadership as a member of Ohio's Program Integrity Group.*** The Program Integrity Group (PIG) relies on information sharing and constant innovation to combat deceptive and improper billing practices. In conjunction with the Office of the Ohio

Attorney General's Medicaid Fraud Control Unit, the Auditor of State, and federal contractors, the PIG has earned national recognition for its success in catching instances of fraud, waste and abuse. In 2013, the AG's Medicaid Fraud Control Unit ranked first nationally for fraud indictments or charges and fraud criminal convictions.

- **Reined in hospital utilization.** Ohio Medicaid contracted with Permedion to perform pre- and post-payment reviews of hospital services and to provide technical advice regarding utilization management policies.
- **Involved providers in third-party recoveries.** Ohio Medicaid is the payer of last resort and contracts with a vendor to recover Medicaid payments when the beneficiary has other insurance coverage that should cover all or part of the medical expenses. In some cases, the other insurance pays better than Medicaid, so the provider has an incentive to seek payment from the other insurance, not Medicaid. Ohio Medicaid now works with these providers to identify Medicaid overpayments and, rather than Medicaid billing the third party, providers recover claims directly from the third party.
- **Streamlined nursing facility claims review.** The FY14/15 Executive budget aligned the Medicaid claims review process for nursing facilities to match other provider types, streamlining the process and allowing nursing homes to resolve payment more quickly.
- **Required enrollment of ordering, referring and prescribing (ORP) providers.** Formal enrollment of ORP providers allows Medicaid to track occurrences of fraud down to the originating prescription or order of service.
- **Required providers to be revalidated every five years.** Providers must be re-screened by Ohio Medicaid at least every five years to ensure that they are eligible to serve individuals covered by Medicaid. The five-year revalidation is a federal requirement and assists in identifying and eliminating fraudulent providers.
- **Implemented provider site visits.** Ohio Medicaid contracted with Public Consulting Group (PCG) to conduct on-site surveys of provider types that have been identified as being at heightened risk for Medicaid fraud.

### Executive Budget Proposal and Impact:

The Executive Budget includes several new Medicaid program integrity initiatives that, after an initial investment, are expected to generate significant savings over time. Ohio Medicaid will:

- **Use advanced analytics to mine existing data for indications of fraud.** Ohio Medicaid has access to terabytes of data that should be leveraged to further program integrity efforts. The department will initiate the procurement of a robust, state-of-the-art advanced data analytics system for pre-payment and post-payment review. Such a

system can prove vital in detecting billing patterns tied to potential fraud, waste, or abuse. The new system will require an initial investment of \$14 million (\$3.5 million state share) in 2016, but that will be offset by \$5 million in savings, and by the second year the program will pay for itself through additional savings.

*The following initiatives also contribute to program integrity and together are estimated to save Ohio taxpayers \$90 million over the next two years. These savings are counted in other sections related to hospital, physician, and nursing facility payment reforms.*

- **Procure a new Recovery Audit Contractor to ensure accuracy in payment.** Ohio Medicaid will competitively contract with one or more Recovery Audit Contractors (RACs) to identify payment inaccuracies and recoup overpayments. RACs are reimbursed on a contingency fee basis, incenting them to root out fraud, waste, and abuse. The RAC will be required to employ trained medical professionals, including a full time medical director, and work with Ohio Medicaid to develop and implement an education and outreach program around audit policies and procedures. The RAC also will be required to conduct customer service activities to alleviate unnecessary provider burden, but the focus will be to refer suspected cases of fraud, waste, or abuse to Ohio Medicaid.
- **Reduce potentially preventable hospital readmissions.** Across Ohio, the statewide average for inpatient hospital potentially preventable readmission (PPR) is 9.2 percent. While Ohio Medicaid currently targets claims related to readmissions at the same hospital within 30 days, the state's utilization review process and policies do not focus on readmissions that occur *among* hospitals. The Executive Budget will require the implementation of PPR software that analyzes clinically-related readmissions across hospital providers. By incorporating this critical tool, the statewide average PPR rate is expected to decrease by 1 percent annually and save \$42.4 million (\$15.9 million state share) over two years. The State will also implement a one-percent penalty on hospitals whose PPR rate exceeds an acceptable benchmark, saving an additional \$3.2 million (\$1.2 million state share) over two years.
- **Implement correct coding standards to hospital claims processing.** The National Correct Coding Initiative (NCCI) was introduced to promote national correct coding methodologies that reduce instances of improper coding which may potentially result in inappropriate payments of Medicaid claims. Ohio Medicaid has aligned necessary edits within the Medicaid Information Technology System (MITS) to properly process outpatient Medicaid claims in accordance with federal regulations. The department will activate the NCCI edits in MITS not later than January 1, 2016. This will save approximately \$15 million (\$5.6 million state share) over two years.
- **Recoups certain physician payments.** Hospital claims are currently subject to retrospective review for medical necessity. Under the policy, hospitals can be issued a technical denial and their payment may be taken back by Ohio Medicaid. The Executive

Budget extends this recoupment policy to any physician claim associated with a technical denial received by a hospital. This provision saves \$76,000 over two years.

- ***Reduces reimbursement for low acuity residents of nursing facilities.*** Governor Kasich's first budget implemented a reduced rate for low-acuity individuals. The Executive Budget takes the next step in aligning payments across delivery systems based on the care needs of the beneficiary. The daily rate paid for the lowest acuity individuals in Ohio's nursing facilities will be reduced from \$130 per resident day to \$91.70 per resident day, more in line with what it would cost to serve these individuals in a community setting. This provision will save \$23.5 million (\$8.8 state share) in 2017.
- ***Implements an Electronic Visit Verification (EVV) system for home health.*** To combat potentially fraudulent home health providers, the Executive Budget requires Ohio Medicaid to implement an EVV system to validate service delivery to eligible individuals by authorized service providers. Similar systems are currently being implemented in states across the country. An EVV system may rely on various technology solutions, including telephony, GPS tracking, and biometrics to authenticate the presence of service providers. Additionally, these systems enable the individual receiving the services to verify that they are receiving care at the precise time of service delivery. An EVV system will significantly reduce the risk of improper claims being paid by Ohio Medicaid, as well as reduce certain administrative burdens associated with identifying fraud, waste, and abuse. Ohio Medicaid will implement EVV system by July 1, 2016. This provision will save \$9.5 million (\$1.9 million state share) over two years.
- ***Transition to a home health care agency model.*** In order to improve programmatic oversight, decrease fraud and abuse, and improve health outcomes for individuals, a majority of states – and the federal Medicare program – only do business through Medicaid with home health care agencies, not independent providers. The Executive Budget requires Ohio Medicaid to eliminate the “independent service provider” option as a strategy to improve the administrative oversight of the program, decrease programmatic fraud and abuse, and improve health outcomes for individuals. Ohio Medicaid will not take any new independent service providers after July 1, 2016 and by July 1, 2019 only accept claims submitted through home health agencies. Ohio Medicaid and the related agencies will work with stakeholders to make the transition to the agency only model as smooth as possible for Ohio's direct care workforce.

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