INDIANA - FRAUD AND ABUSE DETECTION SYSTEM
2016 ANNUAL BUSINESS PLAN

Indiana Medicaid

Fraud and Abuse Detection System

2016 Annual Business Plan

V.1.5

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Revision History

Version	Date	Author	Action / Summary of Changes
1.0	12/01/2015	Mary Diaz-Przybyl	Draft Plan submitted to FSSA – Program Integrity
1.1	02/03/2016	Ray Lawson	Updated figures to reflect final totals from December.
1.2	03/01/2016	Lindsey Phelps; Zac Charlson	Added Algorithm Details and risk assessment totals; Modified Encounter Validation section
1.3	03/22/2016	Mary Diaz-Przybyl	Updated Pay for Performance Metrics and added Return on Investment information.
1.4	3/23/2016	Ray Lawson	Finalize format and add links.
1.5	5/11/2016	Ray Lawson	Updated descriptions for two policy recommendations on page 24: Dental Tooth Surface Procedure Code Table Dentist Signatures Also added these items to list of policies on page 8.

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A. INTRODUCTION AND SUMMARY

This document serves as the Annual Business Plan update for the Indiana Fraud and Abuse Detection System (FADS) for 2016, the sixth contract year and the fifth full year of FADS operations. This Annual Plan update has several purposes:

- Present detailed plans for 2016 activities in the three key Benefit Integrity functions – Data Analysis, Audit and Investigation, and Case Disposition.
- Provide a high level overview of processes and procedures that have been established for the Benefit Integrity program, which is the consulting component of the FADS, as well as the operations of the FADS.
- Outline the Pay for Performance metrics that will be used to assess results under the Pay for Performance incentive program. These will be included when finalized by Indiana Family and Social Services Administration (FSSA), Program Integrity. For brevity, we will refer to FSSA Program Integrity as FSSA PI throughout the remainder of this document.
- Summarize the goals and deliverables of the Managed Care Encounter Data Validation Project, which will bridge the transformation of Program Integrity oversight from primarily Fee for Service (FFS) claims to Managed Care claims and provide a roadmap for ongoing program integrity activities.

Both Truven Health Analytics and FSSA PI acknowledge that this document is intended to provide guidance to direct the FADS activities, yet it must be flexible enough to adapt to changes in focus and priorities that occur from year to year during the project.

The FADS project is supported by a host of Truven Health Analytics staff and subcontractors, located in Indianapolis and elsewhere, and are led by the Benefit Integrity Manager. The Data Analysis Team Lead supervises the analytic consultants. The Audit Team Lead oversees the case disposition staff, the audit subcontractor Myers and Stauffer (MSLC), and coordinates with subcontractor HMS as the Recovery Audit Contractor (RAC).

B. 2015 ACCOMPLISHMENTS

Indiana FADS Contract
Report (as of 11/27/2015 with noted exceptions) of 2015 Accomplishments

The following are the highlight of the IN FADS 2015 accomplishments, as of November 27.

- Recovered $ 6.24 million in overpayments as of December 31 versus the goal of $ 3.0 million (excludes RAC recoveries).

- Successfully implemented the data source change from Milliman to the FSSA Electronic Data Warehouse (EDW), while providing analytic consulting to help the State identify and correct data problems to improve the integrity of the EDW.
- Delivered 27 Algorithms vs. the goal of 25 as of December 31st.
    - Significant algorithms with either large realized or potential overpayment recoveries:
        - Outpatient Revenue Codes Paying at Manually-Priced Procedure Rate
        - Duplicate Claims (Re-Run)
        - Outpatient Services within Three Day of Inpatient Stay
        - Unbundled Dialysis (2015)
        - Duplicate Drug Billing
        - Multiple Treatment Rooms
        - Ambulatory Surgical Centers (ASC) Billing Crossover and Paper Claims
        - Trips to Nowhere
    - Algorithms which identified a need for select risk assessments:
        - J-SURS – J9310 Utilization & Provider Risk Assessment Referral (1 risk assessment)
        - Pain Management (9 risk assessments)
        - Infusion Provider Dashboard (5 risk assessments)
        - CPT 96152 Health and Behavior Intervention (2 risk assessments)
        - Upcoded/Unbundled Dental Restorations (2 risk assessments)
        - Psychotherapy with E/M Outliers (1 risk assessment)
        - Procedure Code Analysis (5 risk assessments)
    - Algorithms which identified claims processing problems or edit recommendations:
        - Outpatient Services within Three Day of Inpatient Stay
        - Outpatient Revenue Codes Paying at Manually-Priced Procedure Rate
        - Multiple Treatment Rooms
    - Algorithms recommending prior authorization or policy modifications
        - Spinal Fusions
        - Therapeutic Shoes/Inserts
        - Knee Orthoses
    - Recurrent algorithms for general surveillance and utilization review:
        - Questionable Prescriber Dashboard
        - Questionable Retail Pharmacy Dashboard
        - Procedure Code Analysis
    - Thirty-three (33) providers identified for referrals based upon algorithm results:
        - 25 providers referred for risk assessments
        - Eight referred to Medicaid Fraud Control Unit (MFCU)
    - Ad hoc projects requested by FSSA PI:
        - P.O. Box Providers

- Audit Activity (excludes RAC)
  - 379 Provider Audits initiated
  - MSLC (Desk audits unless further noted) 50
    - Two Day In-Patient Stay 23
    - CMHC (On-Site) 4
    - Transportation 3
    - High Dollar In-Patient Claims (2015) (5 Self Audit) 11
    - H. Bradley (On-Site) 1
    - Foster Children Psychotropic Drug (1 provider but 3 locations) 1
    - Multiple IV Administration 1
    - Dentists 5
    - Admiral Medical Supply 1
  - Algorithm-Driven Audits – (DAFs and Self-Audits) 329
    - UB Outpatient Manual Pricing 85
    - Duplicate Claims 66
    - Outpatient Services with 3 Days of Inpatient Admit. 25
    - Trips to Nowhere 5
    - Therapeutic Shoes and Inserts 9
    - Unbundled Dialysis Supplies 79
    - Duplicate Drug Billing 33
    - ASC Crossover Claim Double Billing 2015 27
  - 594 Other Audit Letters mailed to providers:
    - 62 Draft Audit Findings letters after initial audit notification or medical record request
      - Psychiatric Therapeutic Procedures 2
      - Two Day Inpatient Stays 18
      - High Level NICU 1
      - CMHC 4
      - Transportation 1
      - Advanced Respiratory 1
      - B. Houston 1
      - Lending A Helping Hand 1
      - Multiple Initial IV Administration 1
      - Dentists 4
      - Wheelycare 1
      - Admiral Medical Supply 1
      - Hospital Transfers (2104) 1
      - Hospital Readmissions 1
      - Outpatient Services within 3 Days of Inpatient Admit 24
    - 407 Final Calculation of Overpayment letters
    - 22 Final Audit Findings letters
    - Review and research completed on 14 Requests for Administrative Reconsideration

- 89 Demand and Offset Notification Letters Mailed
- FSSA PI Referrals and Audit Support:
    - Participated in monthly calls with Medicaid Integrity Contractors (MICs).
        - Provided claims data for next set of hospice providers
    - Supported FSSA PI during OIG Pediatric Dental Audit and Herceptin Audits
    - Completed 33 Risk Assessments.
    - Developed Repricing Tools for both inpatient and outpatient claims to compute identified overpayment amounts. Worked with FSSA PI and Reimbursement to verify assumptions and placed tool in production.

- Process Improvements
    - Refined and documented processes surrounding SUR lockbox, accounts receivables, entering SUR recoveries in i-Sight Case Management System, and coordination of financial procedures between Truven Health Analytics and the FSSA Finance Team.

- Medicaid RAC:
    - Credit balance audits: Continued quarterly review cycles for large hospital networks and an annual review for small to medium sized hospitals.
        - 117 Audit notifications mailed
        - 87 DAFS mailed
        - 79 FCOs mailed
        - 38 No Findings
        - 6 Demand letters mailed
        - $1.5 M overpayments recovered,
    - Long Term Care (LTC) audit program
        - 125 audit notifications mailed
        - 151 DAFS mailed
        - 358 FCOs mailed
        - 50 No Findings
        - 18 Demand letters mailed
        - $2.4M overpayments recovered

- Surveillance and Utilization Review System
    - Produced Q1 and Q2 Provider Profiles to assure FSSA PI access to updated information while FSSA-PI Super User position remained open.
    - Enhanced Non-Emergency Transportation and Behavioral Health provider profiles.

- FSSA Program Integrity Support
    - Delivered recommendation for policy changes or amend conflicting direction between IHCP Provider Manuals and the Indiana Administrative Code (IAC) on the following topics:
        - Inpatient Spinal Fusions-recommendation to follow Medicare guidelines
        - Transportation Driver Name: recommend methodology and documentation to clearly identify driver who provided transportation services especially driver's typically use initials.
        - Transportation Additional Documentation Requirements: maintain daily log of driver –vehicle assignments, driver license insurance records and require annual vehicle inspections
        - Criminal Background Checks: conduct criminal background checks for Medicaid providers and develop provisions for providers who are convicted of felonies in which they are considered violent offenders
        - Lower Limb Orthotics and Spinal Orthoses- recommend Prior Authorization following the more specific Medicare guidelines.
        - Durable Medical Equipment: require DME providers maintain an invoice or similar documentation to support proof of delivery.
        - Dental Root Planing and Scaling: require tooth numbers be documented within medical record when root planning and scaling services are performed.
        - Dental Tooth Surface Procedure Code Table: recommend moving D2394 from procedure codes that require a minimum of three tooth surface codes to procedure codes that require a minimum of four tooth surface codes per the CDT code book.
        - Dentist Signatures: recommend the IHCP consider revising the Provider Manual and IAC to state, when applicable, physicians, limited license practitioners (LLP), and/or non-physician practitioners (NPP) be required to sign medical documentation, specifically each entry in a member's medical record.

- Web-based Case Management System (i-Sight) and Reporting (Yellowfin)
    - Continued development of the library of self-serve reports.
    - Submitted detailed claims information for identified and/or recovered overpayments each quarter to FSSA Finance to support CMS-64 reporting.
    - Following the FSSA Finance approved process, submitted detailed historical CMS-64 information for the backlog of provider initiated adjustments to support Finance making a PeopleSoft journal entry to properly capture RAC recoveries.
    - Continued the disciplined monthly reporting schedule for all audit entities including a review of exception reports to maintain a high degree of data integrity with the audit information.

- Project Management
    - CORE Day One Readiness
        - Initiated project to identify changes in CORE that will impact IN FADS processes and procedures by function as well as impact to i-Sight.
        - Connected with HP to determine available training and documentation resources

C. DATA ANALYTICS

1. Algorithm Development Plan

Data analysis supports the Fraud and Abuse Detection System (FADS) by providing a comprehensive view into Indiana Medicaid claims data. The data mining, analytics, and tracking tools allow development of customized fraud, waste, and abuse detection algorithms to enhance the State's ability to analytically survey various provider types.

On an annual basis, Truven Health Analytics and FSSA PI meet to discuss and agree upon algorithms to be included on the following year's Annual Analytic Work Plan. Requirements of FSSA PI, output from the previous year, provider type risk/focus, economic impact, hot topics, and strength of Indiana policy, overall complexity, are among the considerations and factors used in developing the plan.

Based on the Indiana FADS contract, the Truven Health Analytics Data Analysis team will also set expectations for the quantity of algorithms per year. To ensure an even annual workload for Truven, MSLC, and for provider types, these projects will be scheduled per calendar-year quarter. Using the list of 36 ideas as a guideline, Truven Health Analytics will complete 25 algorithms to the point of a formal algorithm write-up document for the 2016 calendar year. Algorithms reaching the formal write-up stage may result in letters to providers (Draft Audit Findings or Self Audit Letters), referrals to other departments/teams, provider education, or simply no results. The majority of the 25 completed algorithms will surface from the following list; however, ad-hoc requests made throughout the year may take priority according to FSSA PI business needs, priorities, or newly acquired information.

Multiple sources were used, such as the Office of the Inspector General, National Health Care Anti-Fraud Association, Indiana Administrative Code Regulations, IHCP Provider Manuals, Truven Health Analytics Algorithm Library, as well as the knowledge and experience of the FADS staff to build a list of possible algorithms. Algorithms that showed a high potential for overpayments, focused on different provider types, and were likely to result in a mix of results (Draft Audit Findings, Self-Audits, Referrals, etc.) were selected. Do note that algorithms which would potentially result in a Draft Audit Finding are scheduled in the first two quarters to increase the likelihood of recovery before the end of the calendar year.

The following is a breakdown of the algorithms by provider type (sorted by total number of algorithms in descending order):

Provider Type	Total Algorithms*
Physicians (Individual Providers)	11
Dentists	6
DME	6
Hospitals	6
Laboratories	6
Pharmacies	6
Clinics	5
HME	5
Transportation	4
Hospice	3
Managed Care	3
Recipients	2
Specialty: Pain Management	2
Specialty: Physical Therapists	2
Specialty: Anesthesiologists	1
Specialty: Chiropractors	1
Specialty: Ophthalmologists	1
Specialty: Otolaryngologists	1
Specialty: Podiatrists	1
Long Term Care	1

*Note: The sum of Total Algorithms does not equal 36 because some algorithms involve multiple provider types.

The 2016 Data Analysis Plan can be found in the appendix and on the FADS SharePoint site at the following link:

2016 Data Analysis Plan

2. Enhancing J-SURS Utilization to Increase Referrals

The 3.5 upgrade of the J-SURS application along with the additional information in the Electronic Data Warehouse (EDW) claims extract, strengthens the application functionality and enhances the ability of the J-SURS user community to identify outlying and potentially aberrant providers.

The following highlights summarize enhancements included in the version 3.5 May upgrade:

- Report Generator Wizard
- Enhanced System Monitoring
- Export J-SURS Standard Reports to Excel
- DD1 View Names More Identifiable
- Enhanced Advanced Drilldown Processing Information
- Standardization of Wizards in Viewer

The J-SURS extract has been optimized for the EDW data set. New fields such as tooth surface have been added to J-SURS along with new data such as encounter data.

Truven has scheduled J-SURS training at the end of January for all FSSA PI staff who expect to use the application, and is committed to provide training and support resources throughout the year to raise the level of FSSA PI staff to" expert" levels to support FSSA PI's goals to increase referrals to MFCU.

3. Additional Data Analysis Topics

Throughout the year, the Data Analysis Team Lead maintains a list of report ideas and/or requests. These additional data analysis topics may be directly requested, discovered through conversations, or identified in the results of other data analysis projects.

These topics will be explored with FSSA PI, and may be added to the Analytic Work Plan. Some of these topics may be one-time reports, while others may be re-run on a periodic basis. The frequency of the reporting depends upon the needs of FSSA PI and the level of success in terms of recoveries, based on the data analysis. Prioritization and identification of whether the topic becomes an annual focus or an ad-hoc request is discussed below.

4. Ad Hoc Requests from Stakeholders

Some data requests may be more urgent or may not require processing a full algorithm. These requests are considered "ad hoc" and are addressed more quickly. While it is a goal to have these formally requested through the use of a standard request form, ad hoc requests often come verbally or through email to a FADS manager.

Whatever the request method, they are compiled and documented by the Data Analysis Team Lead and discussed during the bi-weekly FADS Data Analytic Meeting. Prioritization of these requests is discussed below.

5. Work Flow and Prioritization

Due to the potentially high number of requests and backlog of annual data analysis work plan topics, prioritization is increasingly important. On a regular bi-weekly basis, the Data Analysis Team meets with the FSSA PI team and discusses the priority of annual data analysis plan items, additional data topics, and ad-hoc requests. Discussions include the impact on planned algorithm delivery dates as a result of adding additional data topics or ad hoc requests. The FSSA PI team makes the final prioritization decisions for the analytic agenda, based on their business needs.

Also during the regular bi-weekly meetings with FSSA PI, the Data Analysis Team discusses algorithms in process and presents the final reports and algorithm write-ups. In addition, the Data Analysis Team updates FSSA PI regarding which reports and algorithms are in the pipeline and discusses any questions, concerns, or clarifications on previously-delivered reports.

D. PROVIDER PROFILING

1. Surveillance and Utilization Review

Using the Truven Health Analytics J-SURS tool, Truven Health Analytics developed a set of provider profile reports which should be run regularly over a 12-month period by provider type. In the initial stage of the contract, Truven Health staff assumed the responsibility to run the profiles because FSSA PI did not have a trained J-SURS user who had the statistical and analytical background to create and understand the reports. In 2013, FSSA PI acquired and developed a resource with these capabilities and, as a result, assumed the responsibility of running the profiles described above until this FSSA PI position was again vacant in 2014. Truven Health has delivered the profiles since 2014 to help the State meet CMS's SUR requirement; FSSA PI is slated to resume running profiles in early 2016.

Truven Health retains the responsibility to update the J-SURS system with the latest available full set of claims history each month.

Truven Health will continue to share provider profile ideas and best practices with FSSA PI along with providing annual training to all FSSA PI staff.

E. AUDITS

1. Introduction

The Audit and Investigation Team is led by the Truven Health Analytics Audit Team Lead, who provides oversight of audit and case disposition staff as well as subcontractors Myers and Stauffer and HMS. Myers and Stauffer (MSLC) perform risk assessments, desk audits, and field investigations under the Surveillance and Utilization Review (SUR) component of the FADS contract. HMS is the Indiana Medicaid Recovery Audit Contractor (RAC) and operates in compliance with the federal regulations found at 42 CFR Part 455 for state RAC programs.

The Audit and Investigation Team meets on a regular basis at the bi-weekly Audit Committee meetings and in working sessions with FSSA PI to discuss progress on active cases and receive referrals for new cases. The various sources of referrals are discussed in more detail below.

2. Audit Plan

The audit process includes input and activities from various groups, including FSSA PI, the Medicaid Fraud Control Unit (MFCU), Truven Health Analytics, Myers and Stauffer, and other interested parties (e.g., legislature, Office of General Counsel, other FSSA divisions, etc.). The annual audit goals may require additional refinement based on requests for other services, the types of referrals received, the types of audits, legislation, project events, and other unforeseen situations.

The goal is to complete 40 self, desk, or on-site audits in 2016 and finalize 40 audits (further definition and details available in the 2016 Audit Plan in the appendix or at the link below). Many of the audits are ad-hoc, determined by new referrals from FSSA units, MFCU, members, and providers, often crossing multiple provider types. However, as in previous years the Audit and Investigation Team will also target areas which require medical records review and clinical expertise. The first three target areas are a continuation of the High Level Neonatal Intensive Care Unit (NICU) audits, the Two-Day Inpatient Hospital Stay audits, and the OIG High Dollar Hospital audits. We will initiate new Transportation audits focusing on inappropriate payments for emergency transportation services including advanced life support (ALS) and basic life support (BLS) services. And of course, we will complete or finalize all 2015 audits including the Community Mental Health Center (CMHC)/ Medicaid Rehabilitation Option (MRO) Provider Audits and Transportation Audits. In addition to planned audit focus areas, we will continue to perform risk assessments on providers who have surfaced from various algorithms and dashboards in the following areas: High Utilization Procedure Codes, Home Health Providers (skilled vs non-skilled services), Pharmacy, Distance between Provider and Recipient, Eyeglass Reimbursement Frequency, and audit where appropriate.

As Indiana migrates to a managed care model for IHCP members, IN FADS will support FSSA PI in designing an effective managed care oversight model including developing audit protocols for CY 2016 and beyond.

Audit Plan link

3. Referrals from Data Analysis

Data analysis performed by Truven Health Analytics is a major source of referrals to the Audit and Investigation Team. This may include algorithms, special projects, or other ad-hoc requests that identify potential fraud or abuse and require further review. All data analysis projects require the approval of FSSA PI. In the case of algorithms, they are also shared with the Audit Committee.

There are two potential paths for a data analysis referral: claims investigation or formal audit. Cases that require claims investigation are generally retained internally by the Audit and Investigation Team, although these may be referred to MSLC if their expertise is needed. These types of cases typically involve some level of policy review, comparison of claims in the data analysis report to the Indiana*AIM* system, and conclusion about whether the results of the data analysis are valid or whether there are some exceptional circumstances that need to be considered before moving to recovery or closing the case.

When data analysis and claims investigation identify overpayments that are clearly supported by policy, Truven Health Analytics sends providers Draft Audit Findings letters or Self-Audit letters, as decided by FSSA PI. The letters and attached claims listings are produced using automated processes to pull the appropriate claims and provider information from the Data Probe database. When a provider agrees with the audit findings, and requests a final determination of overpayment, Truven Health Analytics calculates the interest owed on the overpayment and returns a Final Calculation of Overpayment letter to inform the provider of the total amount owed.

Cases that require formal audit are those instances in which a review of the claims data is not sufficient to demonstrate whether the provider has perpetrated fraud or abuse, so a review of medical records, and potentially an on-site audit, is necessary. These cases are generally referred to MSLC, although the Truven Health Analytics Audit and Investigation Team may retain responsibility for some provider self-audits. Formal audits performed through MSLC and any subsequent recommendations must be approved by the Audit Committee.

In addition, the Audit Committee determines whether any other state departments or FSSA divisions need to be involved in the review of results from data analysis or audits, and coordinates accordingly.

4. Referrals from FSSA PI

In addition to referrals from Data Analysis, the Truven Health Analytics team may receive direct referrals from FSSA PI. Truven Health works closely with FSSA PI to coordinate investigation of referrals, whether they are received through the Fraud and Abuse hotline, the SUR Customer Service line, or from other FSSA departments or divisions.

Referrals are presented at the Audit Committee meetings, where a determination is made regarding how to proceed with the referral. Any further action is taken as a result of the Audit Committee recommendation. Urgent referrals may be communicated via email or the i-Sight Case Management System and then discussed at the next scheduled Audit Committee meeting.

5. Work Flow and Prioritization

Truven Health Analytics and MSLC receive referrals and investigation requests through the Audit Committee. Discussion of the referrals occurs during the regular meetings and determination is made by the team members on how to proceed with further investigation or action. The Audit Committee determines if MSLC should pursue completion of a risk assessment to determine the level of risk for the provider(s) in question. The risk score aids the team in developing its recommendation on how to proceed. Potential next steps include a request for provider self-audit, draft audit findings, desk audit, on-site audit, provider education, or a determination that no further action needs to be taken.

After the claims review and audit research and determinations have been made, a summary of the audit findings is compiled and incorporated into a Draft Audit Findings letter that is sent to the provider. The audit process includes an opportunity for providers to submit a Request for Administrative Reconsideration in response to the Draft Audit Findings summary letter for each audit case. Through this process, providers can present results of their research, additional information, or a statement of issues to address any findings contained in the Draft Audit Findings summary letter. With the goal of coming to an agreement on the audit findings and, consequently, to minimize provider appeals, the administrative reconsideration process allows for a series of correspondence and information exchange between the providers and Truven Health or MSLC.

Throughout the audit and investigation process, the team works with the goal of close coordination between FSSA PI, Truven Health Analytics, MSLC, and other FSSA departments or agencies. The Medicaid Fraud Control Unit (MFCU) is copied on all relevant findings and may be asked to give final approval on specific recommended actions. Prioritization of all open cases is determined by FSSA PI at the Audit Committee meetings.

6. Coordination with External Audits

The Truven Health Analytics Audit and Investigation Team also works with FSSA PI to provide assistance with external audit requests. These may include the federal Department of Health and Human Services, Office of Inspector General (DHHS-OIG), the Indiana OIG, the federal Audit MIC (Health Integrity), and other entities. Many of these entities rely on review and feedback from the State on Medicaid policy questions, or may request analysis of individual claims in order to perform their activities.

FSSA PI is the lead agency responsible for communication and coordination with these entities. Depending on the nature of the request, the Data Analysis Team or the Audit and Investigations Team may be involved in drafting a response to the external audit entity. Upon review of the draft response, FSSA PI facilitates the official communication back to the requesting entity.

7. Recovery Audit Contractor

As part of the FADS solution, Truven Health Analytics has included a Recovery Audit Contractor (RAC). This component of the solution is subcontracted to HMS. According to federal requirements at 42 CFR 455, Subpart F, Medicaid RACs are contractors, working for States, that audit payments made to healthcare providers to identify Medicaid payments that may have been underpaid or overpaid, and recover overpayments or correct underpayments, similar to the RAC program in Medicare.

The following is a summary of the key activities of the RAC:

- Identify providers with substantial credit balances and perform audits to determine whether overpayments exist and should be recovered.
- Perform data mining activities and run algorithms to identify additional targets for audits. All algorithm and data mining is coordinated with the Truven Health Analytics team to ensure that no duplication occurs.
- Perform audits of providers to determine whether an overpayment exists. Audits may include on-site audits, desk audits, complex audits, and automated audits.
- Identify and report any underpayments identified during the audit process.
- Address any requests for reconsideration prior to issuing the final overpayment notice to the provider.
- Coordinate the recovery process with providers and instruct them on how to submit their checks for overpayments to the FSSA PI.
- Provide detailed claims listings for disposition in the Indiana*AIM* system, as necessary.

In order to ensure coordination between the RAC and the Truven Health Analytics FADS team, the RAC uses the i-Sight Case Management System to log all of its case activities. This includes the provider information, reason for the audit, results of the audit, detailed claims listings, and copies of any relevant correspondence. The Truven Health Analytics FADS team has full access to view all RAC cases and can report RAC results in a consistent manner as other FADS outcomes.

Truven Health Analytics and FSSA PI approve the RAC's audit plan prior to any providers being contacted. In 2012, the Indiana RAC initiated programs with Credit Balance Audits (CBA), Complex Reviews with DRG Validation, and Long Term Care (LTC) Auditing. Each of these initiatives involved outreach and awareness to the affected provider community as well as system and start-up implementation efforts amongst partners, HMS, Truven Health Analytics and the State of Indiana. At present, both Credit Balance and LTC audits are fully operational. LTC audits, which are on a 2 year cycle, are coordinated with the LTC compliance reviews of nursing facilities which provide care for Medicaid recipients. The LTC audits are wrapping up. No new LTC audits will be initiated in 2016. The DRG Validation Pilot audit did not yield expected results and no further expansion of that audit type is planned. . The RAC will explore expanding their reviews to other provider types, and will present specific proposals to FSSA PI, throughout the year.

Finally, HMS expects to leverage its expertise in Medicare claims payments by comparing IN Medicaid payments against the Medicare Crossover files (COBA: Coordination of Benefits Agreement) to identify Medicaid overpayments. HMS is testing the viability of COBA based audits, and will present their

results and potential audits for FSSA PI approval in 2016. The 2016 RAC Audit Plan can be found in the appendix and on the FADS SharePoint site at the following link:

RAC Audit Plan

F. AUDIT SUPPORT

1. Case Disposition Overview

The Truven Health Analytics Audit and Investigation Team executes the steps necessary to complete the final disposition of each case, respond to provider inquiries, review written responses, and perform provider education and outreach. The Audit and Investigation Team routinely monitors case activity and completes all steps necessary to correctly apply refunded dollars to outstanding accounts receivables and to disposition claims associated with each recovery. This team works closely with the FSSA Finance team to apply all dollars recovered to the appropriate outstanding provider case and report dollars recovered on a regular basis to the FSSA PI Director. The Audit and Investigation team works closely with FSSA PI and FSSA Finance to prioritize the cases on an "as-needed" basis.

The Audit and Investigation Team also serves in a supporting role with any provider inquiries that are received through the Surveillance and Utilization Review (SUR) Customer Service line. The SUR customer service representatives may escalate calls to a Case Disposition Specialist within the Audit and Investigation Team if assistance is needed in answering detailed information regarding audit findings and associated recoveries.

The Audit and Investigation staff also assists with provider education efforts as requested by the FSSA PI Director. Such efforts include drafting individualized provider education letters following an audit and/or recovery. Other activities may include targeted provider education to a group of providers based on the results of data analysis and or an audit project case, and general education to a large provider audience that may be based on data analysis but is not necessarily related to an audit or a project case. Some of the tools used for provider education opportunities include provider bulletins, newsletters, provider workshops, association meetings, and individual on-site meetings at the provider's office or facility

2. Case Disposition and Audit Coordination Goals

The work of the Truven Health Analytics Audit and Investigation Team is influenced and impacted by changing priorities in FSSA, changes in Indiana State and Federal (CMS) legislation and regulations, system changes, and primarily FSSA PI goals and objectives. Within this dynamic environment, the following are the 2016 operational goals for the Audit and Investigation Team:

Transition from MMIS *AIM* to MMIS CORE

FSSA anticipates a major conversion of its MMIS system from *AIM* to a newer, more modern MMIS system called CORE. Because many of the IN FADS processes and procedures are tied to *AIM* including data structures and file names, this change will impact many aspects of our operations.

- Continue to identify changes in CORE and their impact by function and staff deliverables

- Train staff for day 1 readiness
- Update processes, procedures and documentation

Audit Coordination and Support

- Continue to support the State in reaching the goal of increased recoveries through the generation and mailing of audit letters, the conducting of administrative reconsideration reviews, and the processes of tracking recoveries.
- Offer continued support to FSSA PI through facilitation of the Audit Committee meetings and participation in the RAC Status meetings.
- Continue to work closely with MSLC, HMS, and the Truven Health Data Analysis Team to ensure there is no overlap in auditing efforts. Monitor progress and ensure proper tracking and reporting accuracy for all auditing entities.

Development of Policies and Procedures

- Support FSSA PI in identification of areas of vulnerability, with regard to policy, that prevent the program from pursuing certain recoveries. Work with FSSA PI to make recommendations and compile documentation for presentation of recommended changes.
- Further define and document business processes for the case tracking and case disposition functions, both in i-Sight and throughout the audit and recovery cycle. SUR Financial Tracking
- Continue the disposition of checks in the MMIS, sending providers demand letters for unrecovered outstanding balances of identified overpayments and creating ARs to initiate offsets for aged outstanding balances.
- Continue coordination of meetings between Truven Health Analytics Audit and Investigation Team and the FSSA Finance Team to facilitate communication and address questions or any areas of concern identified throughout the audit recovery and case disposition process.

Support SUR Related System Changes

- Design and implement enhancements to the i-Sight Case Management System to streamline workflow, increase efficiency, and continue to improve data integrity.
- Evaluate and respond to changes flowing from conversion to CORE which will impact case disposition and CMS-64 Reporting.

Provider Education

- Assist in education of the provider community with regard to guidelines for provider self-disclosures. Identify any needed policy or procedure changes as the current guidelines are implemented.
- Support FSSA PI as needed with provider education efforts and communication of audit and recovery processes.

G. ENCOUNTER DATA VALIDATION PILOT

To support the goal of FSSA PI to Enhance Managed Care oversight, Truven will commence and deliver a data validation project, reviewed and initially approved by FSSA PI in 2015 (modified as requested by FSSA in 2016). The project will address the CMS Corrective Action Plan by enhancing MCE oversight and help define the ongoing cost of a major component of MCE PI oversight to help the State plan appropriately to ensure the successful growth and expansion of Indiana's HIP 2.0 program.

The encounter data validation project will validate the quality and completeness of MCE encounter data for calendar years 2014 and 2015. There are five major components to the project. Components 1-4 are part of this project and component 5 is an optional, additional service to be performed when the encounter data accuracy and completeness has been assessed. The components are:

1. Understand and document the data flow and delegated vendors of all three MCEs.
2. Reconcile the EDW encounter data to the MCEs - accounting and/or payment system(s).
3. Compare encounter data to data obtained directly from the MCEs data warehouse.
4. Compare the encounter data, or the previously obtained MCE data to data from Anthem, MHS, and MDwise claims adjudicators (i.e., payers) collected by the plan.
5. Perform an optional audit of a random sample of claims (including outpatient, professional, and inpatient claims) to verify claims are being accurately submitted by providers to claims adjudicators.

Calendar years 2014 and 2015 will be reviewed to highlight pre and post HIP2.0 data.

This entire project will be performed collaboratively with Optum as they transition the flow of the encounter data directly into the EDW, bypassing the MMIS. The results of this data validation project will positively impact the data transition project by providing additional intelligence and guidance on potential issues. We are honored that FSSA invited the IN FADS Team to participate with Optum in this innovative project.

To accomplish the project, Truven will collect data directly from all of the MCE's claims adjudicators (i.e. payers) and evaluate the quality of the adjudicated claims. We will evaluate the MCE's encounter data for the same period, then compare the data sets received from the payers to the encounters in the MMIS. If FSSA approves the optional audit component of the project, we propose to use the MCEs adjudicated claims and the cash disbursement file for select providers as a basis for an audit to verify appropriateness/accuracy of billing and as well as data completeness as captured by the plan and the MMIS.

H. OTHER PROGRAM INTEGRITY ACTIVITIES

1. An effective Medicaid Program Integrity operation extends beyond building algorithms and conducting audits. To achieve the ultimate goal of payment integrity, "Making the ***correct payment*** for the ***correct member*** for the ***correct service*** to the ***correct provider***," ongoing efforts to review and strengthen policies and procedures as well as continually educate providers, builds a solid foundation for program integrity. The INFADS team through algorithms and audits will identify edits needed in the MMIS and will identify changes or improvement to policies or other changes to the IHCP Provider Manual to support FSSA PI efforts.

2. In this world of instant news, working with FSSA PI, the INFADS team will design a process to support a rapid, data-driven response to news clips and information alerts regarding potentially aberrant IHCP providers.

I. PRODUCT SUPPORT AND ENHANCEMENTS

1. Claims Data Source

At the direction and support of FSSA PI, Truven Health Analytics launched the data source conversion project in March 2014, to replace the Milliman extract with data from the FSSA Electronic Data Warehouse - EDW. Truven worked closely with Optum, the EDW vendor, and commenced using the new extracts in DataProbe in July 2015. The new data source was fully operational by the J-SURS application in December. However, the conversion from *AIM* MMIS to CORE MMIS has impacted the data structures especially those pertaining to provider identification, provider groupings and service locations and more significantly claim numbers. We are working with Optum to identify all the changes, and restructure and rebuild DataProbe based on the new data extract.

2. SharePoint

The IN FADS Support Team reorganized and updated the FADS SharePoint site in the Fall of 2015. We will train all users on the revised map of files and folders.

3. i-Sight and Yellowfin Reporting

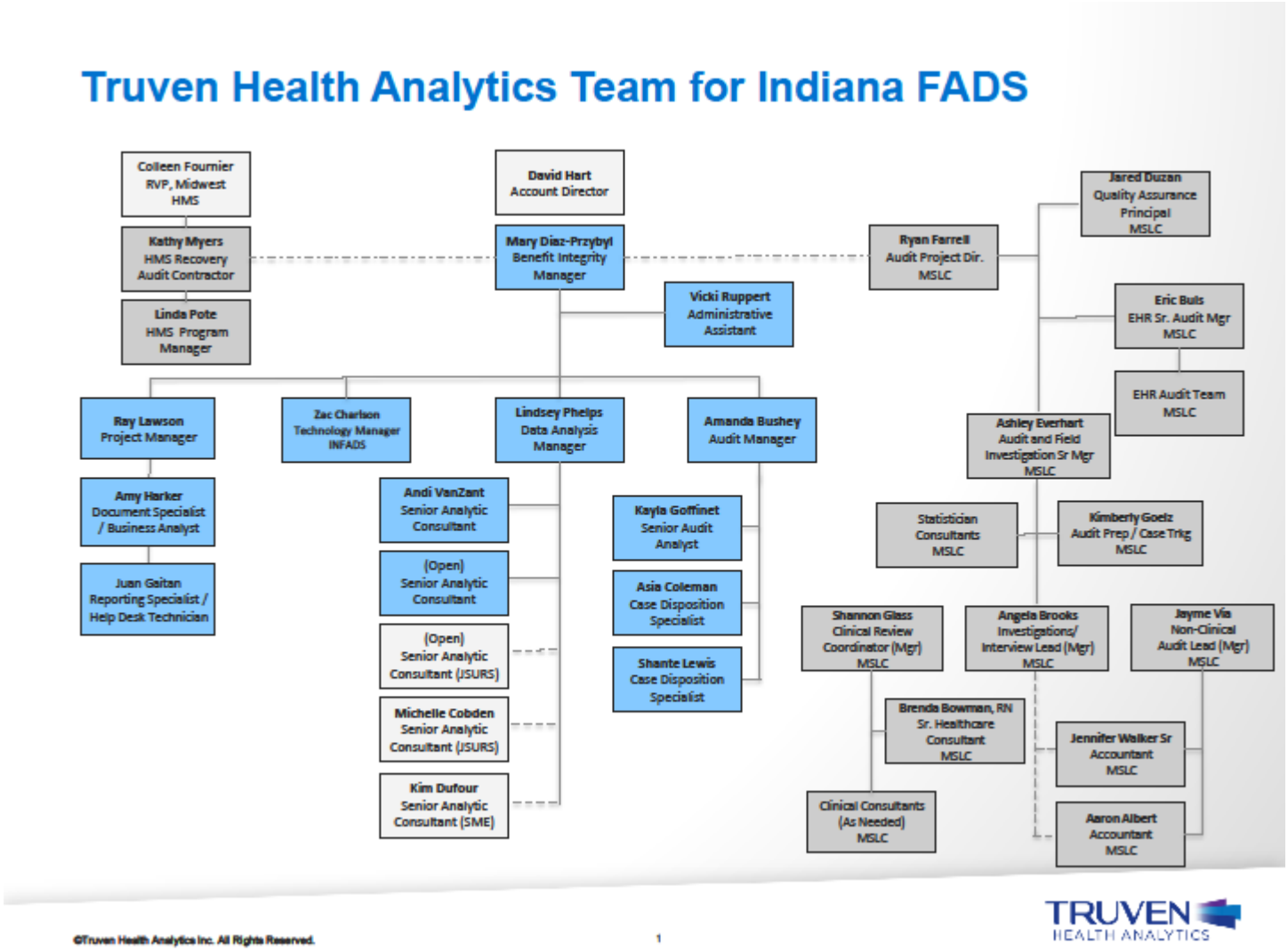
Iteration #3 of the Phase 2 i-Sight Enhancements was implemented in 2013, but additional enhancement opportunities have been identified, both in the i-Sight Case Management System and in the Yellowfin reporting tool. Additional changes are now required to adapt to CORE MMIS changes in 2016, Truven Health Analytics will work with FSSA PI staff to prioritize the list of desired and critical enhancements, to formalize the requirements, and to fund the changes to the system, which may include some of the following:

- Enhancements to Increase Efficiency and Effectiveness:
    - Enhancements and processes to improve monitoring and avoid system downtime.
    - Enhancements to streamline data entry screens to reduce likelihood of user error.
    - Ability to view all file attachments for a particular case in one screen, regardless of which screen was used to perform the attachment.
    - Enhancements to the Provider Portal to enable effective paperless communications with providers.
- Enhancements to Improve Compliance with State and Federal Guidelines:
    - Additional security role for system-wide read-only auditor access.
    - File import functionality to update, not just append to, existing claim records.
    - Additional fields in, and linkages between, the claim data and the payment data

J. ORGANIZATION

The most recent IN FADS organization chart can be found in the IN FADS SharePoint site through the following link.

Organization Chart



K. PRELIMINARY 2015 PAY FOR PERFORMANCE RESULTS

1. Recoveries/Recoupment (4%)

The Recoveries and Recoupment metric represents 4% of the withhold payment. These are broken down into three components:

1. Recover $3.0M from provider submitted checks and money orders, claims adjustments or voids, or through credits or offsets against a provider's future claim payments (3%)

   Recoveries as of December 31, 2015 are $6.24 M.

2. Develop 25 algorithms. (1%)

   Delivered 27 algorithms as of December 31, 2015.

2. Cost Avoidance (4%)

In addition to overpayments recovered, performance is also measured by costs avoided. This metric represents 4% of the withhold payment. In early 2015 FFSA PI and Truven Health Analytics agreed on the following measures under the umbrella of Cost Avoidance:

1. Identify $4.0M overpayments (FCOs)

   Identified $13.5M as of December 31, 2015

2. Propose and prepare for submission six policy change recommendations or other changes to the Provider Manual which would result in cost avoidance over time or enable more productive audits.

   Submitted the following nine recommendations:

   1. Inpatient Spinal Fusions-recommendation to follow Medicare guidelines
   2. Transportation Driver Name: recommend methodology and documentation to clearly identify driver who provided transportation services especially driver's typically use initials.
   3. Transportation Additional Documentation Requirements: maintain daily log of driver – vehicle assignments, driver license insurance records and require annual vehicle inspections
   4. Criminal Background Checks: conduct criminal background checks for Medicaid providers and develop provision s for providers who are convicted of felonies in which they are considered violent offenders
   5. Lower Limb Orthotics and Spinal Orthoses- recommend Prior Authorization following the more specific Medicare guidelines.

6. Durable Medical Equipment: require DME providers maintain an invoice or similar documentation to support proof of delivery.
7. Dental Root Planing and Scaling: require teeth numbers be documented within medical record when root planning and scaling services are performed.
8. Dental Tooth Surface Procedure Code Table: recommend moving D2394 from procedure codes that require a minimum of three tooth surface codes to procedure codes that require a minimum of four tooth surface codes per the CDT code book.
9. Dentist Signatures: recommend the IHCP consider revising the Provider Manual and IAC to state, when applicable, physicians, limited license practitioners (LLP), and/or non-physician practitioners (NPP) be required to sign medical documentation, specifically each entry in a member's medical record.

3. Appeals/Appeal Overturns (Persistence of Recovery) (2%)

This metric represents 2% of the withhold payment.

Truven Health Analytics will maintain upheld appeal cases, with a target of less than 10% of the appeals resulting in reversals of the decision/overpayment assessment.

CONTRACT-TO-DATE as of 12/31/2015		
Total Number of Appeals*		97
Appeals Dismissed	60	
Appeals in which FSSA Prevailed	2	
Appeals Currently Open	35	
Appeals Resulting in Reversal of Overpayment	0	
FCO Letters Sent (contract-to-date, including RAC)		2,280
Appeal Rate (Appeals Resulting in Reversal of Overpayment / FCO Letters Sent)		0%
Annual Target (Targeted to remain at or below this threshold)		10%

**Does not include interest-only appeals.*

The IN FADS Team has continued to meet this metric.

L. 2016 PAY FOR PERFORMANCE METRICS

1. Recoveries/Recoupment (4%)

The Recoveries and Recoupment metric represents 4% of the withhold payment. This is broken down into two components:

1. Recover $5.0M from provider submitted checks and money orders, claims adjustments or voids, or through credits or offsets against a provider's future claim payments. (3%)
2. Develop 25 algorithms. (1%)

2. Cost Avoidance (4%)

The Cost Avoidance metric represents 4% of the withhold payment. This is broken down into two components:

1. Identify and notify providers of $10.0M in provider overpayments. (2%)
2. Propose and prepare for submission six (6) policy change recommendations or other changes to the Provider Manual which would result in cost avoidance over time or enable more productive audits. Each recommendation would achieve 1/6 of the deliverable. (2%)

3. Appeals/Appeal Overturns (Persistence of Recovery) (2%)

Truven Health Analytics will maintain upheld appeal cases, with a target of less than 10% of the appeals resulting in reversals of the principal overpayment assessment. (2%)

M. RETURN ON INVESTMENT

We are pleased to report that the collective efforts of Truven Health Analytics, Myers and Stauffer and HMS provided a cumulative 98% return on the State's investment in the IN FADS contract. Contract to date savings include $24.4 million in cash recoveries and claims adjustments, $12.8 million in identified overpayments not yet collected, and cost avoidance of $15.7 million through December 31, 2015. With each ensuing year of the contract as our knowledge of the Indiana Health Coverage Programs deepens, not only are we are initiating and completing more audits but the audits are resulting in larger identified overpayments and greater recoveries. In addition under the direction and guidance of FSSA PI, we continue to work collaboratively with the Office of Medicaid Policy and Planning (OMPP) Policy and Reimbursement staff to clarify information in the Provider Manual for more accurate claims submissions, and identify MMIS edits that were inadvertently turned off or potentially needed. This teamwork may not have an immediate quantifiable value but does impact the quality of the Medicaid program. Providers can rely on good information and predictable, consistent adjudication of their claims.

We thank the FSSA PI team for all their help and support. The continued productivity of the IN FADS contract relies on the leadership and strong working partnership with FSSA PI management. We appreciate the opportunity to serve FSSA and the State of Indiana.

N. APPENDICES

Appendix 1 – 2016 Data Analysis Plan

Appendix 2 – 2016 Draft Audit Plan

Appendix 3 – 2016 RAC Audit Plan

Appendix 4 – 2015 Monthly Status Reports (January through December)

The 2015 IN FADS Monthly Status Reports, along with the reports from prior years, can be found on the FADS SharePoint site under" Contract Deliverables" through the following link:

Contract Deliverables 2015 Monthly Status Reports