Finding and Fighting Fraud, Waste and Abuse within Managed Care Programs:

Strategies to Develop an Effective and Robust FWA Program Within Your Health Plan while Ensuring Compliance with Federal and State Regulations

Session P6
Sunday, February 11, 2018
2:15pm – 3:45pm

StrategicManagement

Introductions

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Presentation Highlights

- Federal & State Requirements for SIUs
- Compare and Contrast Different Models of Special Investigations Units
- Methods of Proactively Identifying FWA
- Effective Reporting & Oversight

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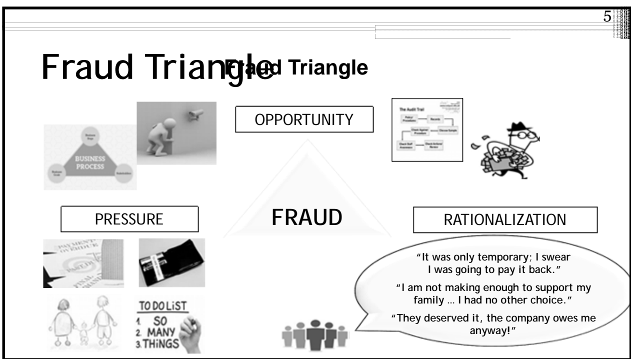
Why do people in engage in unethical behavior?
The Hippocratic Oath
FIRST, DO NO HARM.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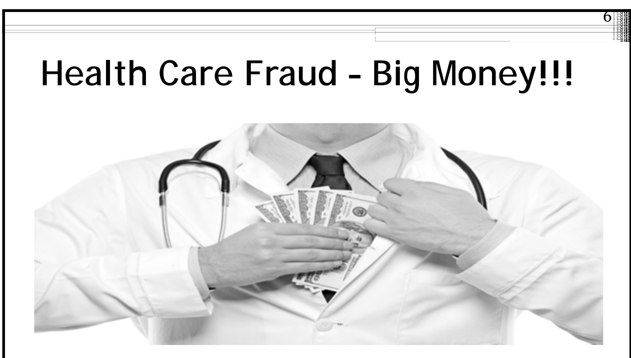
Fraud Triangle
Fraud Triangle
OPPORTUNITY
PRESSURE
FRAUD
RATIONALIZATION
"It was only temporary; I swear I was going to pay it back."
"I am not making enough to support my family ... I had no other choice."
"They deserved it, the company owes me anyway!"
TO DO LIST
1. SO
2. MANY
3. THINGS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Health Care Fraud - Big Money!!!

Healthcare FWA Statistics

- How much money does our Country spend on an annual basis on healthcare?

  $3.5 Trillion

- What % is attributed to health care fraud?

  3% - 10% or $350 Billion

- How much of that figure is lost per minute, hour?

  $570,777 per minute $34,246,575 per hour

Medicaid Managed Care in Illinois

- CountyCare is a Medicaid-only Managed Care Community Network ("MCCN") plan offered by Cook County Health and Hospital System operating in Cook County, Illinois
- Designed to transform CCHHS into a patient-centered continuum of care.
- CountyCare provides coverage for any Cook County Medicaid eligible beneficiaries (ACA Adults, FHP, and SPD).
- Rapid Growth—expected enrollment in 2018: 422,000 members.
- Facilitated through CCHHS internal CountyCare staff and its various subcontractors.

- Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC) is the largest customer-owned health insurer in the United States and fourth largest overall, operating through our health insurance Plans in Illinois, Montana, New Mexico, Oklahoma and Texas.
- HCSC affiliates and subsidiaries such as Dearborn National, TMG Health and Medecision, offer group life, disability and dental solutions, as well as a range of other individual solutions.
- HCSC has multiple government programs products serving approximately 1.5 million Medicare and Medicare Supplemental and 500,000 Medicaid members in 5 states.

State	Medicaid	Duals	MA-PD	PDP	Med Sup
IL	X	X	X	X	X
MT			X	X	X
NM	X	X	X	X	X
OK			X	X	X
TX	X	X	X	X	X

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Elements of Effective Compliance Program

1. Oversight and management of the Compliance Program
2. Written compliance guidance
3. Education and training
4. Effective lines of communication
5. Enforcement of written standards
6. **Auditing and monitoring**
7. Response to detected offenses and corrective action

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SIU Requirements – Medicaid Plans

- State Medicaid Agency Fraud Detection and Investigation Program Requirements
  - 42 CFR §455.12 – §455.23
- MCO Fraud Waste & Abuse (FWA) Program Integrity Requirements
  - 42 CFR § 438.608
- Medicaid MCO Contracts with your state
  - SIU program requirements vary largely across state contracts. No one specific structure is required.

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Ex: Illinois MCO SIU Requirements

5.35 **Fraud, Waste, and Abuse procedures**

5.35.1 Contractor shall have an affirmative duty to report to the OIG in a timely way, as provided in section 9.1.29, suspected Fraud, Waste, Abuse, or financial misconduct in the HFS Medical Program by Enrollees, Providers, Contractor's employees, or Department employees. Contractor shall:

5.35.1.1 have a designated Special Investigations Unit (SIU) to oversee Fraud, Waste and Abuse investigations.

5.35.1.2 under the purview of the Compliance Officer, employ Fraud, Waste, and Abuse Investigators at a minimum ratio of one (1) Investigator to every one hundred thousand (100,000) Enrollees.

5.35.1.3 develop and document in writing policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements under this Contract and all applicable Federal and State requirements, including 42 CFR §438 Part H.

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SIU Requirements – Medicare

- Medicare Advantage and Part D Sponsor regulations only require the establishment and implementation of an "*effective system for routine monitoring and identification of compliance risks*," which must include internal and external monitoring and audits.
  - Medicare Advantage – See 42 CFR §422.503(b)(4)(vi)(F)
  - Part D Sponsors – See 42 CFR §423.504(b)(4)(vi)(F)
- CMS SIU Definition for Medicare Managed Care:
  - "*An internal investigation unit responsible for conducting investigations of potential FWA.*"

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CMS Medicare SIU Guidance

50.6.10 – Special Investigation Units (SIUs)
(Chapter 21 - Rev. 109, Issued: 07-27-12, Effective: 07-20-12; Implementation: 07-20-12)
(Chapter 9 - Rev. 15, Issued: 07-27-12, Effective: 07-20-12; Implementation: 07-20-12)

42 C.F.R. §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F)

An effective program to control FWA includes policies and procedures to identify and address FWA at both the sponsor and FDR levels in the delivery of Parts C and D benefits. An SIU is an internal investigation unit, often separate from the compliance department, responsible for conducting surveillance, interviews, and other methods of investigation relating to potential FWA. Depending upon the size of and resources available within the organization, sponsors must either establish a specific SIU or ensure that responsibilities generally conducted by an SIU are conducted by the compliance department. Sponsors are not expected to perform law enforcement activities and may refer all matters indicative of FWA to the NBI MEDIC or law enforcement.

See Chapter 9/21 of the Medicare Managed Care Manual and the Prescription Drug Benefit Manual – Section 50.6.10.

CMS Medicare SIU Guidance

- Medicare SIU responsibilities should include:
  - Reducing or eliminating Medicare Part C/D benefit costs due to FWA;
  - Reducing or eliminating fraudulent or abusive claims paid for with federal dollars;
  - Preventing illegal activities;
  - Identifying enrollees with overutilization issues;
  - Identifying and recommending providers for exclusion, including those who have defrauded or abused the system;
  - Referring suspected, detected or reported cases of illegal drug activity, including drug diversion, to the NBI MEDIC and/or law enforcement and conducting case development and support activities for NBI MEDIC and law enforcement investigations; and
  - Assisting law enforcement by providing information needed to develop successful prosecution.

See Chapter 9/21 of the Medicare Managed Care Manual and the Prescription Drug Benefit Manual – Section 50.6.10.

CMS Medicare SIU Guidance

- The SIU must be accessible through multiple channels such as via phone, email, Internet message submission, and mail.
- Any suspicions of FWA must be able to be reported anonymously to the SIU.
- The SIU and compliance department must communicate and coordinate closely to ensure that the Medicare Part C/D benefits are protected from fraudulent, abusive and wasteful schemes throughout the administration and delivery of benefits, both at the sponsor and FDR levels.

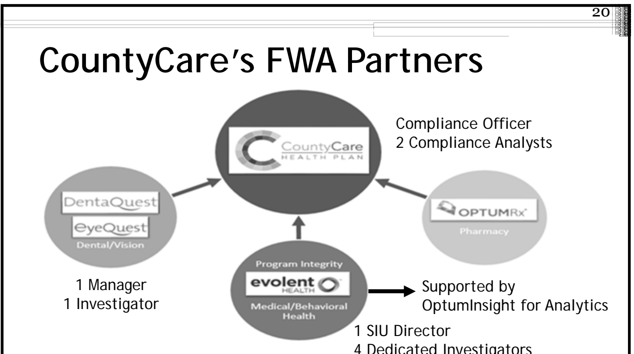
See Chapter 9/21 of the Medicare Managed Care Manual and the Prescription Drug Benefit Manual – Section 50.6.10.

DIFFERENT MODELS OF SPECIAL INVESTIGATIONS UNITS

SIU Description

- Investigates instances of fraud, waste, and abuse from CountyCare's hotline, internal reporting, HFS-OIG requests and tips, and partner organization investigations and tips.
- Detects aberrant billing patterns, high usage of modifiers, and outliers by using algorithms.
- Reports trends, patterns, and results of algorithms.
- SIU functions are largely delegated.
- Oversight of SIU operations is performed by the CountyCare Compliance Officer, with help from analyst staff.

CountyCare's FWA Partners



CountyCare - Evolent's Partnership with OptumInsight

Data Sharing/Availability is Key

Solution Scope

- **Determine Risk Earlier**: Predictive analytics by Service Type and DRG, very specific:
  - **Algorithms/predictive modeling**
- **Outlier-based:** Ability to compare peers from larger pool of providers
- **Other clients:** identification of information
- **Link analysis**

Why Optum?

- Serves 150 health plans
- Represents over 50 million lives
- Identifies recoveries in excess of $1 billion per year on just fraud and abuse
- Optum is represented in all 50 states
- Many State Medicaid agencies have Optum as their vendor

Tips for Managing an External SIU

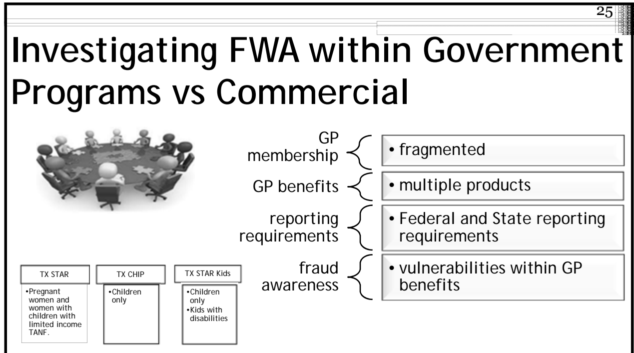
- Expectation Setting
  - Priorities for Health Plan
  - Reporting
  - Communication
  - Turnaround times
- Transparency is key – ensure you have all case documentation readily available
- Training on health plan and programs
- Location of investigation staff
- Pricing Considerations

HCSC Special Investigations Department

- Government Programs Compliance (GPC), SID, Audit report to the Chief Compliance Officer, outside of the Government Programs Division.
- GPC maintains and implements the Compliance Program and related policies and procedures; Coordinates CMS Program Audit.
- SID reviews and investigates potential FWA and conducts investigations; On point for FWA related portions of CMS Program Audit.

Internal SID Structure

SID Staff:
- Medical Directors, Nurses, Professional Coders, former Law Enforcement, Institutional knowledge.
- Director designated to oversee FWA investigations within Government Programs and compliance requirements associated with Government Programs FWA work.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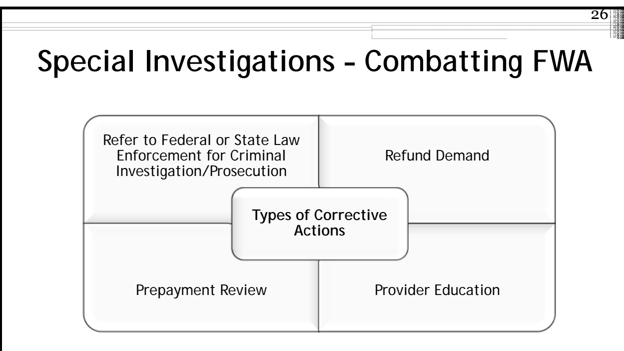
Investigating FWA within Government Programs vs Commercial
GP membership
• fragmented
GP benefits
• multiple products
reporting requirements
• Federal and State reporting requirements
fraud awareness
• vulnerabilities within GP benefits
TX STAR
•Pregnant women and women with children with limited income TANF.
TX CHIP
•Children only
TX STAR Kids
•Children only
•Kids with disabilities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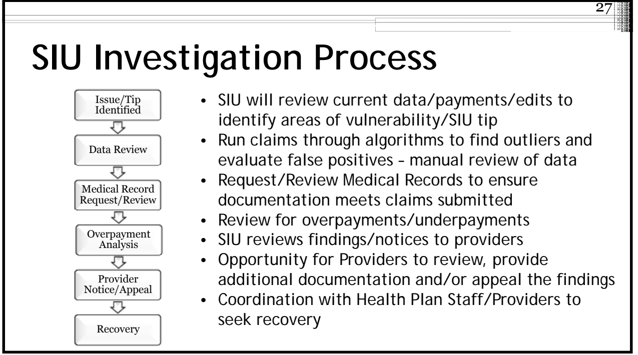
Special Investigations – Combatting FWA
Refer to Federal or State Law Enforcement for Criminal Investigation/Prosecution
Refund Demand
Types of Corrective Actions
Prepayment Review
Provider Education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SIU Investigation Process
Issue/Tip Identified
Data Review
Medical Record Request/Review
Overpayment Analysis
Provider Notice/Appeal
Recovery
• SIU will review current data/payments/edits to identify areas of vulnerability/SIU tip
• Run claims through algorithms to find outliers and evaluate false positives – manual review of data
• Request/Review Medical Records to ensure documentation meets claims submitted
• Review for overpayments/underpayments
• SIU reviews findings/notices to providers
• Opportunity for Providers to review, provide additional documentation and/or appeal the findings
• Coordination with Health Plan Staff/Providers to seek recovery

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Schemes We've Seen

- Nursing Homes: Upcoding, PT/OT/ST
- Member Related: Identity Theft, card sharing
- Laboratory: Genetic testing, experimental
- Durable Medical Equipment (DME)
- Opioid prescriptions with no corresponding medical visit
- Ghost office billings
- High utilization of certain Dental Codes

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Schemes We've Seen

- Wellness Benefits fraud

Wellness Check
- Member tells MCO he had the required wellness checks to be eligible for a Walmart gift card.

Wellness Benefit
- Member's mailing address deleted from the system by the fraudster.

Fraudster receives the Wellness Benefit
- Fraudster receives the gift card.

METHODS FOR PROACTIVELY IDENTIFYING FWA

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Internal Sources and Partners

- Data Intelligence Unit
- Benefits Managers – i.e., Pharmacy, Dental, Transportation, etc.
- Managed care personnel who have contact with members and are in a position to identify potential fraud, waste or abuse.
  - Prepayment Service
  - Management Staff
  - Operations
  - Member Services
  - Behavioral Health
  - Care Coordinators
  - Pharmacy
  - Quality Dept. & Clinical Care
- Review Unit - Stop suspect claims before they are paid.
- Claims Recovery Unit - utilizes data mining techniques to recover claim overpayments from multiple providers with the same problematic billing issue.
- Audit Team –internal and external.
- Third Party Liability/Reimbursement/Subrogation - recovers payments for claims that are the legal responsibility of other payer (e.g. auto insurers).

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External Sources and Partners

- National Health Care Anti-Fraud Association (NHCAA)
- National Anti-Fraud Advisory Board (NAAB)
- Health Care Fraud Prevention Partnership (HFPP)
- National Insurance Crime Bureau (NICB)
- Local HCF Task Forces such as the Midwest Anti-Fraud Insurance Association (MAIA)
- NAMPI (National Association for Medicaid Program Integrity)
- Federal and State Law Enforcement

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FWA Collaboration

Best Practices

Internal FWA Referral Form	Shared SID mailbox per Internal Partner	Monthly FWA meetings with Internal Partner	Provide FWA training to Internal Partners throughout the year	Publicize SID 24/7 Hotline	Index every FWA lead via administrative files in case management system that can be tracked for reporting purposes.

Data Mining & Algorithms

- DIU supports ongoing investigations by:
  - Comparing provider to peers
  - Identifying group exposure
  - Identifying patients to investigate/interview
  - Calculating overpayments
  - Responding to subpoenas from law enforcement
  - Producing graphical output
  - Testifying
- SIU Develops Leads by Consulting:
  - HFS OIG
  - Other Health Plans
  - NHCAA SIRIS
  - corporationwiki.com
  - healthratings.com
  - Social media
  - Licensing Boards
  - PLATO
  - NPI website
  - Accurint (as needed)
  - Google

Data Mining Algorithms Used

- Lag Time: Identifies providers with a high volume of claims with a substantial lag time between service being rendered and submitted for reimbursement
- Peer Comparison Analysis
- Procedure/Diagnosis Utilization Patterns
- Member-Filed Claims: Identifies members with high dollar member-filed and member-paid claims
- Spike Billing: Identifies procedures, diagnoses and providers with a month-to-month spike in billing
- Provider Time/Distance Summary: Compares provider and peer average hours/patient and patient/provider distance for each diagnosis and procedure category

Data Mining Sample: ER Abusers

- ER Hoppers/Abusers—Identifies members with high utilization of the emergency room to obtain controlled substance prescriptions.
  - "Heat map" of a member's ER visits by county.
  - Color corresponds to total ER visits in two-year period.
  - Member pled guilty to fraudulently obtaining controlled drugs, sentenced to probation.

Investigating Voluminous Claims

- Statistical Random Sample (SRS)
  - A true sampling of claims or patients that are considered to be a true representation of an entire universe or claims or patients
  - Identified through a court approved statistical formula.
- RAT-STATs – created by US HHS
  - Strong foundation for analytics should case go to trial
  - Underlying methodology has been challenged and upheld by courts of law
  - Selecting claims/patient records for review
  - Damage calculations based on results of review
- To achieve a relevant SRS, the investigator must define a Universe:
  - What he/she wants to prove; and
  - Identify the elements of the fraud scheme (i.e., Dates for scheme, CPT codes, NPIs, Employer Groups, ICD 9/10)

Statistical Random Sample

- Probe Sample (selected by the investigator)
- Patient interviews
- Medical record review
- Claims analysis for suspect billing patterns
- Medical Director input is advisable if fraud/abusive billing is not clear cut.
- If fraud scheme involves medical necessity, are there conflicting medical authorities?
- Will Medical Director fully support the investigation given his personal and professional experience?

Pilot Sample
10% of Random Sample
(10 patients)

Random Sample
Statistically Appropriate
30% of Universe
(90 patients)

Universe
(300 patients)

EFFECTIVE REPORTING AND OVERSIGHT

Internal/External Reporting

- **Internal reporting** structures will vary based on organization build and requirements outlined in the Medicare and Medicaid contract.
- Where SIU responsibilities are **delegated** to other organizations, **adequate oversight** of these entities will be essential to ensure reporting is accurate.
- Contracts may also require that an SIU and/or Compliance Department report the findings of their investigative efforts to **external agencies/departments**.

Internal Reporting Responsibilities

- Heath System Board of Directors
- Health System Audit and Compliance Committee
- CountyCare Health Plan Compliance Committee
- FWA Workgroup

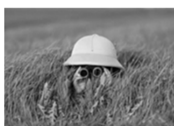
CountyCare HEALTH PLAN

HCSC

- Corporate Compliance Committee
- HCSC Board
- HCSC Board Audit Committee
- Subsidiary Boards
- Government Programs Compliance Committee

Tips on Reporting to Stakeholders

- Be sure to provide enough background information to ensure that Board Members understand FWA program
- But don't get lost in the weeds!
- Provide examples of schemes/cases as necessary
- Utilizing and providing a Work Plan to the Board may help to demonstrate an understanding of risk areas affecting your health plan and allow the Board to see how you are addressing them within the SIU operations.



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2018 High Risk Areas

1. Opioid/Suboxone
2. Transportation
3. Long Term Services and Supports (Personal Assistants, Homemakers)
4. Services Billed for Members while Incarcerated
5. Nursing Home

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External Reporting Responsibilities

- Medicaid Plans:
  - Monthly Medicaid Agency Task Force
  - Quarterly Report to State Medicaid Agency
  - Ad-hoc requests from Medicaid Agency and State Police
  - Medicaid Fraud Control Unit (MFCU)
- Medicare Plans:
  - CMS – Program Integrity Audit
  - NBI MEDIC

WRAP UP & QUESTIONS

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