Learning Objectives

- Provide overview of risks and vulnerabilities to fraud, waste, and abuse in Medicaid managed care programs
- Develop workflow of risk management, compliance review, and fraud surveillance activity
- Apply logic model framework to consider inputs and analysis methods in risk assessment, decision making strategies, and possible corrective actions
- Explore lessons learned from over a decade of work with Medicaid fee-for-service and managed care programs
Introduction

Background

- I serve as Vice President of Analytics at Integrity Management Services (IMS)
- IMS is a subsidiary of Strategic Management Systems (SMS)
- Parent company (SMS) was founded in 1992 by Richard Kusserow, former Inspector General, DHHS
- My consulting work with Medicare, Medicaid, and managed care began in 1999
- IMS Program Integrity work began in 2007 with the expansion of our government division
- SMS and IMS are Veteran-Owned Small Businesses
- SMS and IMS have headquarters in Alexandria, VA with staff associates nationwide
- IMS’s focus is helping government agencies improve program efficiency and effectiveness
What is Medicaid managed care fraud?

Medicaid Managed Care Fraud is any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.


Why are we interested in Medicaid managed care fraud?

- According to the IOM we waste $75 billion on health care fraud, waste, and abuse per year in Medicare and Medicaid.
- According to a recent RAND study, Medicare and Medicaid fraud and abuse cost as much as $98 billion per year. Waste and inefficiency may cost another $304 billion. See http://www.rand.org/pubs/external_publications/EP201200117.html
- Medicare expenditures totalled $554.3 billion in 2011 according to CMS.
- Consequently, fraud and abuse alone is about 10% of spending for Medicare and Medicaid and the situation is expected to get worse. http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America/Press_Release.aspx
- In 2011 74% of Medicaid beneficiaries were enrolled in managed care and the number is growing.
Costs are Trending Upward

Top 40 Service Categories CMS-64 Report 2011

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Total (Federal Share)</th>
<th>State Share</th>
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<tr>
<td>Medicaid</td>
<td>$62,275,480,789</td>
<td>$55,001,522,817</td>
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<td>Other Care Services</td>
<td>$49,031,462,966</td>
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<td>Home &amp; Community-Based Services</td>
<td>$31,076,865,370</td>
<td>$25,421,564,841</td>
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<td>Prescribed Drugs</td>
<td>$19,042,826,860</td>
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<td>Nursing Facility Services - Reg Payments</td>
<td>$17,995,380,109</td>
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<td>Nursing Home Services - Reg Payments</td>
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<tr>
<td>Home Health Services</td>
<td>$13,572,951,108</td>
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<td>Outpatient Hospital Services - Reg Payments</td>
<td>$12,978,106,220</td>
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<td>Personal Care Services</td>
<td>$12,060,906,220</td>
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<td>Physician &amp; Surgical Services</td>
<td>$11,318,800,379</td>
<td>$7,981,108,281</td>
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<td>Other Practitioners Services</td>
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<td>Intermediate Care Facility - Public</td>
<td>$6,415,385,153</td>
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<td>Dental Services</td>
<td>$5,980,678,725</td>
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<td>Intermediate Care - Private</td>
<td>$5,837,704,897</td>
<td>$4,389,469,836</td>
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<tr>
<td>Home Health Services</td>
<td>$4,986,615,194</td>
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<td>Outpatient Hospital Services - Sup Payments</td>
<td>$4,622,663,523</td>
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<tr>
<td>General Hospital Services</td>
<td>$4,555,267,935</td>
<td>$3,319,580,897</td>
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<td>Emergency Services</td>
<td>$4,312,795,623</td>
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<td>Federally-Qualified Health Center</td>
<td>$3,512,795,623</td>
<td>$2,117,507,973</td>
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<td>Mental Health Facility</td>
<td>$2,952,707,519</td>
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<td>Rehabilitation Services - Non-school Based</td>
<td>$2,653,009,086</td>
<td>$1,613,517,713</td>
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<td>Hospice Benefits</td>
<td>$2,277,513,230</td>
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<td>Other Practitioners Services - Reg Payments</td>
<td>$2,182,253,523</td>
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<td>Emergency Services for Uninsured/Indigent</td>
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<td>School Based Services</td>
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<td>Nursing Facility Services - Sup Payments</td>
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<td>Other Care Services</td>
<td>$1,888,018,803</td>
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<td>Psychiatric Services</td>
<td>$1,798,785,392</td>
<td>$1,070,745,967</td>
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<td>Diabetes Screening</td>
<td>$1,749,390,140</td>
<td>$1,057,651,839</td>
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<td>Non-Emergency Medical Transportation</td>
<td>$1,677,629,166</td>
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<td>Internal Health Services</td>
<td>$1,377,195,068</td>
<td>$791,678,657</td>
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<td>Emergency Room Visits</td>
<td>$1,305,557,782</td>
<td>$715,999,991</td>
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<tr>
<td>All-Inclusive Care Plan</td>
<td>$1,204,363,634</td>
<td>$691,986,897</td>
</tr>
</tbody>
</table>

Medicaid Managed Care Penetration

- States allowed to adopt mandatory enrollment in managed care plans except for Children with Special Health Care Needs (CSHCN), dual eligibles, and Native Americans
- New initiatives under ACA encourage states to develop fully integrated managed care for dual eligibles
- As states look to managed care to control costs, managed care penetration is trending upward in most states
- States may choose capitated or fee-for-service (FFS) arrangements to reimburse managed care plans
- Managed care plans may choose capitated or FFS arrangements to reimburse providers
Who may commit Medicaid managed care fraud?

- Managed care organization (MCO)
- Contractor (of the MCO or government entity)
- Subcontractor (e.g., behavioral health or pharmacy benefit management organization)
- Health care provider, pharmacy, or supplier
- Government employee
- Medicaid beneficiary or managed care plan member
- Organized crime
Examples of Types of Fraud and Abuse

- Specific to Managed Care
  - Bid rigging in procurement
  - Marketing, enrollment, and disenrollment fraud
    (e.g., cherry picking and lemon dropping)
  - Underutilization
- Fee-for-Service and Managed Care
  - False claims submission
  - Overbilling
    (e.g., upcoding and unbundling)
  - Antitrust violations and kickbacks
  - Embezzlement and theft

Recent Examples of Managed Care Fraud

<table>
<thead>
<tr>
<th>Settlement Amount</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>$319.85 million</td>
<td>MCO rates for long-term-care certified (LTC) patients that were over the legal ceiling set by State statute and regulations</td>
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<tr>
<td>$137.5 million</td>
<td>Violated the false claims act, engaged in sales and marketing abuses, including “cherrypicking” of healthy patients to avoid future costs</td>
</tr>
<tr>
<td>CMP of $325,000</td>
<td>Failed to comply with CMS requirements governing the processing of Part C and D grievances, organization/coverage determinations, and Part C and Part D appeal</td>
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<tr>
<td>$26 million</td>
<td>Knowingly failed to provide required screening, assessment and case management for adults, and children with special health care needs. Also, submitted false data to the State.</td>
</tr>
<tr>
<td>$35 Million</td>
<td>Settlement with State Attorney General, compensated marketing representatives based on productivity</td>
</tr>
</tbody>
</table>
Risk Areas

- Procurement and contracting
- Marketing and enrollment
- Inadequate provider networks
- Underutilization and barriers to access
- Claims submission and billing procedures
- Fee-for-service and capitated reimbursement of providers
- Theft and embezzlement including diversion of funds for unallowable costs
- Cost accounting and rate setting
- Falsification of data or quality and outcome measures
- Rebates, drug pricing, and formulary issues for pharmacy benefit management
- New initiatives such as certain provisions of the Affordable Care Act
  - Medicaid expansion, incentive payments, ACOs, and special programs
Eligibility and Enrollment Systems & Expansion

- Note: eligibility and enrollment systems are being revamped under the ACA to better handle Medicaid expansions and coordinate enrollments with insurance benefit exchanges. New eligibility categories in 2014 include:
  - Adult Group (new)
  - Parents
  - Pregnant Women
  - Children under Age 19

- New eligibility and enrollment systems utilize web-based electronic applications with data matching to SSA for verification.

- States can expand to 138% FPL but not required due to Supreme Court ruling.

See: [http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf)

Demonstrations

- CMS Center for Medicare and Medicaid Innovation (CMMI) is charged with developing new demonstration programs under the ACA to produce better quality and improved health at a lower cost.

- Accountable Care Organizations (ACOs)
Managed Care for Dual Eligibles

- ACA directs CMS to develop integrated care innovative programs for dual eligibles.
- CMS has established a Medicare-Medicaid Coordination Office and Integrated Care Resource Center to this end
- CMS has solicited proposals from states to set up demonstration programs to align care for dual eligibles
- Managed care organizations may enter into 3-way contracts with states and CMS to establish Fully Integrated Dual Advantage (FIDA) plans
- Alignment can be achieved through either fully capitated managed care or fee-for-service (FFS) models.
  For example: NY has responded and established a demonstration program applying both models.


Medicare Advantage Special Needs Plans

- Under provisions of the MMA, the Medicare Advantage program (Part C), health plan organizations may work with CMS and states to set up Dual eligible Special Needs Plans (D-SNPs) to provide managed care and pharmacy using blended funding from both the Medicare and Medicaid
- While less than 25% of dual eligibles are enrolled in Medicare Advantage plans, enrollment is growing
- States are seeing the potential of these programs to provide higher quality coordinated care at a lower cost

http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html
Long-term Care Plans

- Focus on candidates for nursing home placement
- Continuum of long-term care (LTC) includes home health, assisted living, basic nursing facilities, skilled nursing facilities, and institutional care
- Incentivize placement in lower levels of care
- LTC eligibility limited by assets as well as income. 5 year look back helps limit people transferring assets to family members to gain eligibility. Spousal residence exception
- Vulnerable to gaming capitation rates, recruiting ineligible patients (cherry picking), and selective admission (lemon dropping)

Outside Threats

- Cyber-terrorism
- International organized crime
- Provider and patient recruiting
- Identity theft
- Drug diversion
- Human trafficking
- Enrollment fraud in Medicaid and State- and Federally-based Exchanges under the ACA
Key Components of Managed Care Fraud Control

Medicaid Managed Care Functional Areas

- Surveillance and Utilization Review (SURS)
- IT Systems and Data Analysis
- Payment Processing
- Provider Network
- Enrollment & Member Services
- Contracting and Financial Management
- Human Resources
- Pharmacy Benefit Management
- Program, Policy, and Quality
- Special Investigations Unit (SIU)

FWA Control Touches All Functional Areas
Surveillance and Utilization Review

• Surveillance and Utilization Review System (SURS) is a component of each state’s MMIS
• MCOs should consider establishing a similar unit
• SURS:
  • staff utilize business intelligence and statistical software to monitor Medicaid utilization patterns for potential fraud, waste, and abuse
  • units vary widely in their sophistication in use of detection tools and in their effectiveness
• Potential fraud cases should be referred to the MCO’s SIU for investigation

Medical Review

• Medical review:
  • may be housed within the SURS unit
  • includes pre-payment and post-payment review
• Methods:
  • Reviews may consider a probe or comprehensive sample of claims
  • Claims are compared to medical records and evaluated against coverage policies
  • Reviewers should be training to look for evidence of fraud such as forged signatures, repetitive patterns in service notes, and use of unqualified staff
IT Systems and Data Analysis

- MCOs are adopting “big data” approaches to fraud surveillance including data warehousing and software detection tools
- Effective systems combine sophisticated algorithms with expert clinical judgment (domain expertise) to rule out false positives
- Data mining may utilize a quality improvement life-cycle approach such as CRISP-DM* and champion and challenger predictive models
- Data security is also a critical component, to prevent system intrusions, denial of service attacks, and identity theft
- IT and data analysis staff should work closely with other units, for example to implement sophisticated prepayment edits and provider vetting methods

Data Analysis Methods

- Rule-based algorithms
- Normative comparisons
- Anomaly detection and clustering
- Predictive modeling
- Link and geospatial analysis
- Complaint and social media monitoring using text mining
- Sampling and extrapolation
- Encounter data validation

cumentation/14/UserManual/CRISP-DM.pdf
Payment Processing

• FFS and capitated payment processing my MCOs can build in many of the same fraud controls as in Medicaid FFS:
  o Prepayment edits including risk scoring that incorporates claims history, provider, and member characteristics
  o Auto-denials and claims payment suspensions that are provider specific
  o Preauthorization
  o Continuous monitoring for billing spikes and other anomalies

Provider Network

• Controlling the gate to enter the provider network also helps reduce improper payments and fraud. Control methods include:
  o Screening and credentialing
  o Background checks
  o Matching against state, federal, and commercial insurance exclusion and sanction lists, including other states
  o Provider audits
  o Site visits
  o Provider education and feedback
  o Surveys of provider satisfaction
Marketing, Enrollment, and Member Services

- Close attention to members also limits fraud. Control methods include:
  - Enrollment monitoring
  - Marketing surveillance
  - Education and training
  - Call center and complaint monitoring
  - Member satisfaction surveys

Contracting, Financial Management, and HEOR

- Build fraud and abuse controls into contract language including ability to audit and recoup overpayments
- Monitor components of medical loss ratio, administrative costs, and related party transactions
- Engage in health economics and outcome research (HEOR), and cost effectiveness monitoring to provide essential feedback for program and process improvement and help eliminate waste
Human Resources

- Train all staff in FWA control processes, business ethics, and corporate compliance
- Publicize whistleblower processes
- Offer staff incentives to reduce waste and suggest quality improvements

Pharmacy Benefit Management

- Drug utilization review applied to prescribers, pharmacies, and members
- Control and monitor
  - Rebates
  - Drug pricing
  - Formulary
  - Retail dispensing
  - Outsourced PBM and specialty pharmacies
- Screen and vet pharmacies
- Conduct pharmacy audits using team approach
- Provide data-based feedback
- Promote mail order prescription use
Program, Policy, and Quality

- Case management and care management
- Compliance program assessment
  - Monitor performance in all functional areas, not just a checklist
- Regulatory analysis
- Continuous quality improvement
  Note: fraud and poor quality often go hand-in-hand

Special Investigations Unit

- Works closely with other functional units
- Combines subject matter knowledge, clinical expertise, data and systems knowledge, cost accounting, and policy analysis using a team approach
- Collaborates with other SIUs and the state
- Shares data and case information as appropriate
- Utilizes FWA case tracking system integrated with data warehouse and fraud detection systems
- Ready to support hearings and appeals including expert witnesses from your team
Fraud Surveillance Workflow
Tried and True Approaches

MCP Tried and True Approaches

- Anomaly detection, rule-based algorithms, and predictive modeling applied on a pre-pay and post-pay basis
- Prepay edits and provider and beneficiary restrictions
- Data matching and cross-claims analysis
- Provider vetting and credentialing
- Staff training
- Provider education
- Self-assessments and self-audits
- Revise/update fraud and abuse policies and procedures
State-based Approaches

- Compliance reviews and audits
- Whistleblower incentives
- Medical loss ratio evaluation
- Encounter data mining and data validation
- Monitoring marketing practices
- RACs (optional for managed care)
- Work with CMS and federal contractors (MIC and Medi-Medi)
- System hardware and software upgrades
- Revise fraud and abuse surveillance plans
- RACs

New Approaches
New Approaches

- Contracting with strong fraud compliance and recoupment provisions
- Collaboration across plan organizations, payers, FFS, states, and CMS
- Bidding systems that incentivize savings
- Feedback to plan organizations and providers
- Developing a corporate compliance culture

Lessons Learned
Lessons Learned

- Simple fraud detection methods may perform as well as sophisticated predictive models – use both
- Software can’t do it all – combine data-based methods with expert clinical judgment and business knowledge
- Prevention is more effective than pay and chase
- Engage in networking and collaboration
- Monitor third party transactions and coordinate benefits
- Prioritize - conduct risk assessments and risk management
- Fraud cases often start with complaints, tips, or whistle blowers
- Follow through - fraud cases are often overturned on appeal

Suggested Reading
Suggested Reading


Question and Answer Discussion
Contact Us

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