Managed Care Fraud Enforcement and Compliance

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Overview

• Understanding and Developing an SIU in a Managed Care Environment

• Understanding Regulatory Challenges for a Managed Care Environment

• Managed Care SIU and Law Enforcement-Same Goals But How To Get There

WellCare Health Plans, Inc.

Company Snapshot

OUR PRESENCE

WellCare in the States, Inc.

• Serves 3.7 million members nationwide
• 365,000 contracted health care providers
• 68,000 contracted pharmacies
• Serving 2.4 million Medicaid members, including:
  • Aged, Blind and Disabled (ABD)
  • Children’s Health Insurance Program (CHIP)
  • Family Health Plus (FHP)
  • Supplemental Security Income (SSI)
  • Temporary Assistance for Needy Families (TANF)
• Serving 1.4 million Medicare members, including:
  • 326,000 Medicare Advantage members
  • 1 million Prescription Drug Plan (PDP)
• Spearheading efforts to sustain the social safety net:
  • The WellCare Community Foundation
  • WellCare Associate Volunteer Efforts (WAVE)
  • Advocacy Programs
• Significant contributor to the national economy:
  • A FORTUNE 500 and Barron’s 500 company
  • 7,000 associates nationwide
  • Offices in all states where the company provides managed care

All numbers are approximations and are as of March 31, 2016
WellCare Health Plans, Inc.

At WellCare, our members are our reason for being. We help those eligible for government-sponsored health care plans live better, healthier lives.

Emphasis on lower income populations and value-focused benefit design
Communication among members and providers to improve outcomes
Focus on preventive care including regular doctor visits
Community-based solutions to close gaps in the social safety net

Mission/Vision

Ensure development of Mission/Vision Statements and ensure communicated and understood by associates not just in SIU but across the company.

Mission: To identify, investigate and correct fraud, waste and abuse (FWA) committed against the plan and its stakeholders, by anyone, including, providers, employees, and members.

What an SIU does:
• Detect and deter fraudulent claims
• Identify and remedy provider overutilization
• Terminate providers who have defrauded or abused the system
• Refer for regulatory inquiry and criminal prosecution those who defraud the system
• Work with our pharmacy benefit manager to identify and remedy pharmacy fraud
• Provide fraud awareness training to employees, vendors and providers

Fraud, Waste, and Abuse Definitions

Fraud
• Fraud is an intentional deception, misrepresentation, or omission made by someone with knowledge that may result in benefit or financial gain.

Abuse
• Abuse is sometimes defined as a practice that is inconsistent with accepted business or medical practices or standards and that results in unnecessary cost.
• There is no “bright line” distinction between fraud and “abuse.” “Abuse” can be thought of as potential fraud, where the intent of the person or entity may have been unclear.
• Key Question: Does the conduct result in excessive or undue reimbursement or benefit?

Waste
• Waste includes any practice that results in an unnecessary use or consumption of financial or medical resources.
• Waste does not necessarily generate financial gain, but almost always reflects poor management decisions or practices or ineffective or lax controls.
Member Fraud Examples

Doctor Shopping
• A member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotics or other prescription drugs

   Doctor shopping may be indicative of an underlying scheme, such as stockpiling or resale on the black market/street

Theft of ID/Services
• An unauthorized individual uses a member’s Medicare/Medicaid card to receive medical care, supplies, pharmacy scripts, or equipment; it’s often a family member or acquaintance

Provider Fraud Examples

Billing for Services not Rendered
• Billing for individual therapy, where only group therapy was performed
• Billing for Durable Medical Equipment (“DME”) supplies never delivered
• Billing for “phantom” supplies or services never rendered
   • For example, billing for a practitioner’s visit to a nursing home for services rendered to all or nearly all residents, even though the practitioner did not provide services to all residents.

Fraudulently Justifying Payment
• Misrepresenting a diagnosis in order to justify payment
• Falsifying documents such as certificates of medical necessity, plans of treatment and medical records to justify payment

Kickbacks
• Referring patients for diagnostic tests in exchange for money
• Using a specific wheelchair manufacturer because the individual selecting the wheelchair received an “incentive” payment for the selection
Provider Fraud Examples

Rendering and Billing for Non-medically Necessary Services

- Performing Magnetic Resonance Imaging with contrast despite the contrast not being indicated or medically necessary
- Ordering higher-reimbursed, complete blood lab tests for every patient although more specific or limited tests are indicated

Provider Fraud Examples

Upcoding - Billing a Higher Level Service than Provided

- Reporting CPT code 99245 (High Level Office Consultation); yet, services provided only warranted use of CPT code 99243 (Mid level Office Consultation)
- Reporting CPT code 99233 (High Level Subsequent Hospital Care); yet, services provided only warranted use of CPT code 99231 (Lower Level Subsequent Hospital Care)

Provider Fraud Examples

Unbundling - Separate Pricing of Goods and Services to Increase Revenue

- Billing separately for a post-operative visit; however it is included in a global billing code
- Billing a series of tests individually instead of billing for a global or “panel” code

Billing for Non-Covered Services

- Billing for non-covered services as covered services (e.g., billing a rhinoplasty as deviated-septum repair)
### Provider Fraud Examples

**Provider Prescription Drug Fraud**

- Operating a “pill mill” by overprescribing opioids and high-cost drugs to be sold illegally, with the prescribing provider receiving a share of the profits
- Diluting or illegally importing drugs from other countries (e.g., cancer drugs)
- Falsifying information in order to justify coverage for higher-cost medications

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**More Provider Fraud Examples**

**Pharmacy Fraud**

- Pharmacy increases the number of refills on a prescription without the prescriber’s permission
- Pharmacy dispenses expired drugs
- Pharmacy processes services not covered under the Over-the-Counter (OTC) benefit
- Pharmacy splits prescriptions, such as splitting a 30-day prescription into four 7-day prescriptions to get additional copays and dispensing fees
- Pharmacy bills for prescriptions which are never picked up
- Pharmacy re-dispenses unused medications which have been returned without crediting the return

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**Provider Fraud Examples**

**Overbilling or Duplicate Billing**

- Billing a patient more than the co-pay amount for pre-paid services or services paid in full by the benefit plan under the terms of a managed care contract
- Waiving patient co-pays or deductibles and overbilling the insurance carrier or benefit plan
- Billing Medicare or Medicaid as well as the member or private insurance for the same service
Real Life Example

December 18, 2014, Jennan Comprehensive Medical, P.C. (Jennan) - a medical group practice in New York and its owner, Henry Chen, M.D., entered into a $694,887.02 settlement agreement with the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services. Between May 15, 2008 to December 31, 2013, Jennan and Dr. Chen knowingly submitted or caused to be submitted false and/or fraudulent claims to Medicare for physical therapy services.

Specifically, OIG alleged these claims were false and/or fraudulent for one or more of the following reasons:
1. Physical therapy services were not provided or supervised by the rendering provider;
2. Group services were billed as one-on-one provider-patient physical therapy services;
3. Services were performed by unqualified individuals; and/or
4. Claims for time-based physical therapy services did not accurately reflect the actual time spent performing the services.

Sources of Regulation - Medicare

There are multiple sources of laws and regulations which include but not limited to:

- Federal statutes and regulations governing Medicare Advantage Plans (42 C.F.R. Part 422)
- The Medicaid Managed Care Manual
- The Medicare Managed Care Manual
- State Contracts, Amendments, P&P Manuals
- State Statutes and Regulations
- CMS guidance documents and directives, such as
  - Guidance documents issued through the Health Plan Management System ("HPMS")
  - Directives and guidelines on Medicare Reporting Requirements
  - Annual call letter requirements for bid submissions

Laws Regarding FWA (Cont’d)

- Civil Monetary Penalties Law (CMP) which imposes administrative fines or CMPs for many types of illegal or unethical conduct. CMPs can also be imposed for violating healthcare laws such as the Anti-Kickback Statute and the False Claims Act in addition to the penalties found in those laws.
- Beneficiary Inducement Statute which prohibits remuneration or inducements to beneficiaries which the benefactor knows or should know is likely to influence the beneficiary’s choice of a provider or plan
Laws Regarding FWA (Cont’d)

- Deficit Reduction Act was designed to eliminate fraud, waste and abuse in federal healthcare programs by granting states the flexibility to modify their Medicaid programs to make reforms. It also established the Medicaid Integrity Program and expanded the False Claims Act to the states.

Penalties for Non-Compliance

Each of these laws carry their own individual provisions for failure to comply. Provisions which may be multiplied depending on the nature of the violation.

Other consequences for non-compliance include sanctions and exclusion from healthcare programs.

To help you understand these penalties and the consequences of non-compliance - the next few slides summarize the requirements, prohibitions, and the penalties for non-compliance (examples included).

<table>
<thead>
<tr>
<th>Law</th>
<th>Prohibitions</th>
<th>Penalties</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Fraud Statutes</td>
<td>- Submission of False Claims</td>
<td>Large criminal fines and prison sentences for individuals</td>
<td>Making false submissions to a state for Kick payments</td>
</tr>
<tr>
<td></td>
<td>- Mail Fraud</td>
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<td>Falsifying reports of costs submitted to states to increase premium payments</td>
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<td></td>
<td>- Wire Fraud</td>
<td></td>
<td>Up-coding encounter data for higher risk adjusted member premiums</td>
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<td></td>
<td>- Health Care Fraud</td>
<td></td>
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<td></td>
<td>- Obstruction of Justice</td>
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<tr>
<td></td>
<td>Knowing and willful compliance violations, depending on their severity, may cause your company to violate several general criminal statutes that make it a felony to defraud Medicare and Medicaid.</td>
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<td>The fraud can be punished differently and the penalties will vary depending on whether the fraud is committed:</td>
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<td>- By submitting false data or making false statements to the government;</td>
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<td></td>
<td>- Through the mail, phone or over the Internet; or</td>
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<td>- By trying to conceal illegal facts from being learned by government investigators.</td>
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<td>False Claims Acts (“FCA”)</td>
<td>Prohibit the knowing submission of false or fraudulent claims to the government for payment or the knowing concealment of a repayment obligation, such as an overpayment.</td>
<td>Damages of up to 3 times the amount of damages sustained by the government because of the fraud.</td>
<td>Small business; the fraud is not material to the business; the offender is under 50 years of age; the government is an unincorporated government or a political subdivision of a state.</td>
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<td>Allow “whistleblowers” to bring suits on behalf of the government in exchange for a portion of the fraud recovery.</td>
<td>An additional penalty of between $5,500 and $11,000 per false claim submitted (federal).</td>
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<td>State penalties vary</td>
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## Penalties for Non-Compliance

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<td><strong>Exclusion from Medicare or Medicaid</strong></td>
<td>- If an employee, officer, contractor or any other person or entity enrolled in a Medicare Part B or Medicaid program</td>
<td>- Suspension of your Medicare or Medicaid enrollment for one year.</td>
<td>- Your company is barred from participating in Medicare or Medicaid programs.</td>
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<td>- Monetary fines of up to $50,000 per violation.</td>
<td>- Your company is barred from participating in Medicare or Medicaid programs.</td>
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<td>- Treble damages (3 times the value of each bribe, in the case of a kickback)</td>
<td>- Your company is barred from participating in Medicare or Medicaid programs.</td>
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<td>- Criminal penalties of up to 5 years in prison.</td>
<td>- Your company is barred from participating in Medicare or Medicaid programs.</td>
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<td></td>
<td>- Civil penalties of up to $25,000 per violation.</td>
<td>- Your company is barred from participating in Medicare or Medicaid programs.</td>
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### SIU Structure-Things to Consider
- What kind of staff?
  - Experience (degree or equivalent, health care, managed care)
  - Certifications (required or preferred; which ones-ACFEE, AHFI)
- Who does what portions?
  - Recovery
  - Operations
  - Pharmacy
  - Vendors
- How will the SIU execute?
  - Anti-Fraud Plans
- ARPs
- What kind of reporting is needed internally and externally?
  - Case Management System
  - What to report; how and to whom in the organization
  - Flexibility; Systems capability
  - State reporting metrics
  - Definitions
  - Timing Variances (monthly, quarterly, annual, ad hoc)
Special Investigations Unit (SIU)

- Primarily responsible for identifying, investigating and reporting FWA
- Key components of the SIU Team:
  - Management: Strategy; day-to-day guidance; supervision of SIU staff
  - Investigators: Resolve FWA allegations (with coding auditors and nurse)
  - Senior Analyst: Proactively identifies FWA utilizing data analysis software
  - Medical Coders/Reviewers: Review and analyze medical records and coding
  - Case Information Coordinators and Business Analysts: Case referrals; case management system; anti-fraud hotline; reporting responsibilities
  - Medical Directors / Other SMEs: Consult on investigations
  - Regulatory Affairs: Anti-fraud regulatory and contractual requirements

*** Regulatory impacts in state; FTE; X staff per YY Memberships ***

Internal Partnerships

- Provider Relations
- Provider Contracting-state; cap v non-cap; records allowance
- Legal
- Finance
- Regulatory/Markets
- Government Affairs
- Claims/Encounters
- Recovery Department
- Pharmacy—include Lock In Programs
- Vendor Relations
- UM/CM/Medical Directors

Training/Education

Internal
- Training for SIU Staff (Onboarding; Continuing Education)
- FWA Training (At new hire/Annually)
  - All Staff
  - Contractors
  - FDR
- False Claims Act; Deficit Reduction Act; Anti-Kickback Statute
- Program Integrity/Compliance (States blending)

Externally
- False Claims Act; Deficit Reduction Act; Anti-Kickback Statute
- Providers
- Vendors
Communication

Internal
  • Branding
  • Webpage
  • Homepage

External
  • Member Handbooks
  • Provider Handbooks
  • Websites
  • Letters/Communications (EOMBs)

Hotline (in-house vs outsourcing)
  • Recommend Outsourcing—Anonymous, 7/24/365; Web-capability
  • Reporting/Tracking
    ****Ensure everyone knows how to report*****

Market Collaboration Meetings

  • Regulatory
    – Onsite presence v corporate site; challenges managing WFH; offsites vs. onsite collaboration
    – Capability to conduct onsites
    – Capability to meet with regulators
    – Shifting culture to broaden “Program Integrity”
  • RFPs/Contracts/Amendments
  • SVI
  • Purpose/Value- Two-way street; buy-in; transparency; collaboration; sensitive/confidential info Identified

Conflict Points-
  • FWA vs. Key Contracted Provider
  • Competing savings recorded w/in organization
  • Resources/Assistance

SIU Process

  • An SIU should use a multi-faceted approach to identify and pursue potential FWA to include, but not limit to:
    • An education and awareness training program to maximize employee, business partner, and downstream entity referrals to develop tips regarding possible FWA;
    • Investigating referrals from anyone, including employees, business partners, law enforcement agencies and providers; and
    • Utilize a combination of analytical tools, clinical expertise, and investigative knowledge to identify potential FWA.
    • Establish baseline data to enhance efforts to recognize unusual trends or changes in utilization patterns.
  • The SIU will commence an inquiry within X days of the referral of the matter to the SIU.
  • Document matters into a secure case management system.
Failing to Timely Report Provider Fraud & Abuse

- Medicaid health plans are required by many state laws and state health plan contracts to report to respective state Medicaid agencies any fraud and/or abuse by healthcare providers. This is true even if the fraud and/or abuse could not have any adverse financial impact on the state Medicaid program.

- For example, Florida law requires Medicaid managed care plans to:

**409.91212 Medicaid managed care fraud.**

(1) Each managed care plan shall adopt an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud relating to the provision of and payment for Medicaid services and submit the plan to the Office of Medicaid Program Integrity within the agency for approval.

(5) Each managed care plan shall report all suspected or confirmed instances of provider or recipient fraud or abuse within 15 calendar days after detection to the Office of Medicaid Program Integrity within the agency. As a criteria, the report must contain the name of the provider or recipient, the Medicaid billing number or tax identification number, and a description of the fraudulent or abusive act. The Office of Medicaid Program Integrity in the agency shall forward the report of suspected overpayment, abuse, or fraud to the appropriate investigative unit, including, but not limited to, the Bureau of Medicaid program integrity, the Medicaid fraud control unit, the Division of Public Assistance Fraud, the Division of Investigative and Forensic Services, or the Department of Law Enforcement.

Failing to Timely Report Provider Fraud & Abuse, cont.

- **Florida Agency for Health Care Administration v. Humana Medical Plan, Inc., DOAH Case No. 11-6451MPI (AHCA Final Order Entered June 12, 2012).**

  - Florida’s Bureau of Medicaid Program Integrity (MPI) discovered that Humana did not report to MPI “all suspected or confirmed instance of provider or recipient fraud or abuse” within 15 days after detection. The alleged untimeliness ranged from 33 days late to 536 days late.

  - MPI issued two adverse action letters to Humana on August 9, 2011:
    - The first letter alleged a statutory violation and imposed a statutory fine of $1,000 per calendar day for each violation, which MPI alleged amounted to $2,732,000.
    - The second letter alleged a contractual breach and imposed a contractual civil monetary penalty of $200 per day for each violation, which MPI alleged amounted to $660,400.

Humana settled and agreed to pay $3,225,000!
SIU Allegation Sources

Reactive complaints
- Anonymous
- Members
- Providers
- Regulators
- SIU FWA Hotline
- Associate referrals

Proactive data analysis
- Data Analysis Tool
- Articles/News
- HealthCare Fraud Sources
  - NHCAA; ACFE; HCCA; HFPP
  - OIG Workplan
  - CMS
- Industry – AHIP, CMS, etc.

Intake Sources
- Hotline- tied to MEOBs; Provider/Member documents
- Internal Reporting chains (email, in-person etc.)
- PBM
- Triage (7s when/what to advance)
- Tie into Case Management System
- Case Management System-Functionality
  - Reporting
  - Monitoring
  - Repository
  - Security
  - Controls for access

SIU Case Prioritization

- Triage and Prioritize. The SIU team preliminarily assesses the matter and enter the case priority in our case tracking system in order to pursue the cases with the highest impact of potential FWA.

- Examples of prioritization:
  - High – Cases/allegations having the greatest program impact which would include: patient abuse or harm, multi-state fraud, high dollar impact of potential overpayment, likelihood for an increase in the amount of fraud or enlargement of a pattern, cases with an active payment suspension, etc.
  - Medium – Cases/allegations not at the level of a high priority, may be a case active with law enforcement or regulatory agency and SIU told to stand down, cases in recovery status, multiple complaints against subject but lower dollars involved, etc.
  - Low – Cases/allegations not at the level of a high or medium priority, may be low dollars involved and had no or few prior complaints, etc. All cases being prepared for closure should be a low priority.
### Allegation – Medical

**Medical Case - Investigative Actions**

- Contact Referral Source/Complainant
- Complete referral to State – Note: State requirements differ
- Research prior complaints against subject
- Conduct internal research regarding subject/managing employees, background information, provider/facility
- Search for Subject on the HHS-OIG exclusions list
- Review NPI Registry for provider
- Research claims system for provider/member effective date and/or termination date, and credentialing
- Run claims data in claims system and/or data analytics tool
- Send records for coder and/or nurse review
- Calculate and issue overpayment notice

### Allegation – Pharmacy

**Pharmacy Case - Investigative Actions**

- Contact Referral Source/Complainant
- Complete referral to State – Note: State requirements differ; If Medicare and “suspected” fraud, complete referral to MEDIC
- Research prior complaints against pharmacy and/or recipient
- Identify if recipient qualifies for pharmacy “Lock-Out” program
- Conduct internal research regarding subject/managing employees, background information, provider/facility
- Search for provider on the HHS-OIG exclusion list
- Review NPI Registry for provider
- Review pharmacy/member claim billings report to identify case allegation and/or billing trends and patterns and/or run in data analytics tool
- Send member service verification letter
- PBM will adjust claims if needed

### SIU Investigative Actions

- The SIU should pursue reactive and proactive investigations to either corroborate the allegations or determine them unfounded. The actions should include but not be limited to:
  - Data analysis to identify outlier billing patterns
  - Public record reviews – state licensure, state disciplinary actions, corporation records, etc.
  - Partnership systems search – National Healthcare Anti-fraud Association SIRIS, Healthcare Fraud Prevention Partnership
  - Pull a valid random sample based on the allegation (i.e., top code billed, claims with excessive codes, etc.)
  - Internal systems review - credentialing file, provider contract, prior authorizations, etc.
  - Conduct member interviews
  - Provider onsite audit
  - Request and review medical records by coder, nurse, and/or medical director
- The SIU should timely report suspected FWA. Once a determination has been made that the target party has engaged in FWA, appropriate remedial action should be pursued, which depends upon the misconduct at issue. Also timeliness for reporting varies by state. Document, Document, Document!
Reactive FWA Investigations

- Inquiries typically commence within 14 days of referral to the SIU
- Initial investigative actions include obtaining sample of relevant records
- Examples of records pulled by investigators
  - Provider top CPT/ICD 9 codes
  - Charts, Trending analyses, drug profiles, medical records and prescriptions
  - Payment records
  - Provider-ID, Vendor ID, credentialing, Member-ID (incl. address and contact information), eligibility span, PBM prescription data
  - Copy of provider’s license of state of issue, registered Disciplinary actions, NPI (National Provider ID)
  - NHCAA/SIRIS search and reporting
  - Division of Corporation listing
  - Provider and Vendor contracts

Proactive Investigations

- SIU should use a variety of proactive investigative measures to identify and pursue potential FWA
- Information sharing regarding schemes detected in the industry
  - Review of law enforcement reports or other publicly reported information
  - Partnerships with State and Federal agencies
  - Member of the National Health Care Anti-Fraud Association (NHCAA)
  - Member of the Healthcare Fraud Prevention Partnership (HFPP)
- Targeted claims queries to identify suspicious activity or unusual patterns
  - Examples: Visit trend analysis, provider up-code checker, hospital stay with no professional services bill curve analysis, abnormal utilization
  - Results: Up-coding, unbundling, misuse of modifiers; unusual CPT codes; double billing; unreasonable service time billed in a day
- If suspicious activity identified, expanded investigation is initiated
- Recently purchased STARSSolutions (predictive algorithm)

Data Mining

Examples of areas to conduct data drill down:
- Outliers
- Upcoding
- Time Bandits
- Service Profiles
- Unusual Patterns
- Doctor Shopping
- Follow the Money
- Peer Comparisons
- Duplicate Payments
- Inappropriate Code Combinations
- Top Controlled Substance Prescribers
Cases Documentation
• Workflow Management
• Workload Balancing
• Financial & Case Reporting

Post-Pay Detection
Expert Services
Pre-Pay Analysis
Pre-Pay Detection
• Post and Pre Payment Review Services
• Consulting: Audit Prep, etc.

FWA Prevention
Investigation Analysis
Case & Workflow Management

Lead Generation
• High Impact Rules and Algorithms
• Bank on the Big Picture
• Automated Detection of Suspect Behavior

• Informed Decision Making
• Trend Analysis
• Random Sampling
• Statistical Aggregations

• Lead Generation
• High Impact rules and predictions
• Automated detection of suspect behavior

• Post-Pay | FWA Prevention | Post-Pay Detection
• Pre-Pay | FWA Prevention | Pre-Pay Detection

Investigation Analysis
Case & Workflow Management

Lead generation through rules and predictive analytics
• Automated Overpayment Identification
  • Identifies aberrant billing patterns using multivariate analyses
  • Flags suspect providers, members, and claims
  • Scores leads for prioritization

• High-Impact Rules/Algorithms
  • Compares claim payment schemes with Prediction
  • Cross benefit analysis between facility and professional Rx
  • Taylor rules based on your outcomes

• Claim Comparison Against the “Big Picture”
  • Compares billing patterns over time
  • Compares providers within peer groups
  • Identifies potential overpayment against universe of payments

• Comprehensive Reporting
  • Summarizes and formats findings in investigative templates
  • Includes potential exposure reports for analysts and management

Follow the lead wherever the investigation takes you next
• After the lead is generated by STARS|Sentinel or received from another source
  • Use STARS|Informant to explore the allegation
  • Conduct ad hoc data analysis
  • Collect data and reports to support the investigation
  • Generate random samples

• Fill law enforcement data requests
  • Empowers analysts as they probe for:
    • Validation
    • Investigation
    • Research
STARS|Informant is the next generation of STARS™
• Put all suspects (from internal and external sources) under inventory control
• Assign (and re-assign) workload to staff members
• Monitor timeliness, generate alerts, follow progress
• Measure dollars at risk, overpayment demands, recoveries, the cost of case development
• Reinforce the value of SIU, Audit, and other cost-recover cost-avoidance units

STARSCommander
Command Center for Fraud Investigation Case Management

- Collect, organize, and inventory all caseload and
- Gain new perspectives
- Assign (and re-assign) workload to staff members
- Monitor timeliness, generate alerts, follow progress
- Measure dollars at risk, overpayment demands, recoveries, the cost of case development
- Reinforce the value of SIU, Audit, and other cost-recover cost-avoidance units

STARSolutions – Scheme Analysis
Example

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<th>Scheme Name</th>
<th>Scheme Type</th>
<th>Scheme Description</th>
</tr>
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<tbody>
<tr>
<td>001</td>
<td>123</td>
<td>Medicare</td>
<td>Primary</td>
<td>Scheme for Medicare</td>
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<tr>
<td>002</td>
<td>456</td>
<td>Medicaid</td>
<td>Secondary</td>
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STARSolutions – Submission Analysis
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<td>002</td>
<td>456</td>
<td>Medicaid</td>
<td>Claim</td>
<td>Medicaid submission</td>
</tr>
</tbody>
</table>
HFPP

• In July 2012, the Secretary of HHS and the Attorney General announced a historic partnership to exchange facts and information between the public and private sectors in order to detect and prevent health care fraud.

• The Healthcare Fraud Prevention Partnership (HFPP) currently has 45 partner organizations from the public and private sectors, law enforcement and associations.

• In 2013 and 2014, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions, including payment suspensions, system edits and revocation of Medicare billing privileges.
Regulatory Challenges

- Approval to refer
- Approval to pursue o/p
- Approval to recover
- Timing for each of above
- Limited ability to show ROI if can’t pursue
- Law Enforcement interaction
- Compliance=FWA/SIU=Program Integrity
- Meetings- in-person vs. phone; level of detail; transitioning to more data sharing;
  - State (all MCOs; MCO-specific)
  - MFU
  - Federal Task force meetings
  - Bring Something to the Table

Examples of Contract Language

- Statutory language requiring MCOs to report suspected fraud and abuse within 10 calendar days of discovery
- Requirements for specific, designated staff as well as general adequacy requirements
- Contract language requires the MCO’s to submit to a NOI if they suspect fraud or abuse
- Contract language requires the MCO to report recoveries to a monthly basis and quarterly
- Statutory and contract language requiring quarterly and annual activity reports
- Liquidated damages

Regulatory Reporting

- Externally
  - Timing: Monthly, Quarterly, Annually
  - Recoveries/Cost Avoidance
  - Suspensions
  - Providers Termined
  - Exclusions/Sanctions Checks
  - Actual v Tip
  - Summary
  - Audits Performed
  - Referrals Made
  - Overpayments Identified
  - Overpayments Recovered
  - New PI Actions
  - List of Involuntary Terminations
  - List of Recipients Referred to OIG
- RFIs
Enforcement Focus: Integrity of Data Submissions

- Medicare Advantage health plans and Medicaid managed care programs must routinely submit data to the government. Some of the data submissions can impact the amount of premium payments the government pays the plans.

- Government auditors are becoming more sophisticated in their ability to detect inaccurate data submissions.

- In its 2016 Mid-Year Work Plan Report*, the HHS-OIG indicates that it is reviewing CMS's oversight of data integrity for Medicare Advantage plans' encounter data submissions and is reviewing the sufficiency of documentation submitted by Medicare Advantage plans to support risk adjustment diagnoses.


Enforcement Focus: Integrity of Data Submissions, cont.

  - CMS calculates the payment for Medicare Advantage enrollees based in part on various “risk adjustment data” relating to each enrollee’s health status and other demographic profile information. Some plans conduct record reviews retrospectively to determine whether the risk adjustment data previously filed with CMS is accurate.
  - The federal regulations require Medicare Advantage organizations must certify that the risk adjustment data they submit are accurate, complete and truthful.
  - Here, Relator alleged that certain Medicare Advantage plans designed their retrospective member records intentionally to identify only opportunities for payment increases rather than decreases. How did they allegedly do that?

• They allegedly retained coding companies or purchased specialized software to perform retrospective reviews of the medical charts of tens of thousands of their patients with severe illnesses but “concealed from the coders the diagnosis codes that had been previously submitted to the Government.” Consequently, “the results of the coding reviews did not identify the diagnosis codes unsupported by properly documented clinical charts that had been previously submitted to the Government.”
  - One plan allegedly instructed its medical providers to review the medical charts of selected patients to determine whether those charts supported specific diagnoses that had not previously been reported to CMS. The medical providers reported the additional diagnosis codes supported by the records “but made no attempt to determine or report those previously reported diagnosis codes that were unsupported by properly documented medical charts that were reviewed.”
  - The plans allegedly used a template to report the results of their retrospective reviews to CMS that allowed coders to enter any additional diagnosis codes identified by the reviews but “did not permit the entry of information indicating what previously submitted diagnosis codes should be withdrawn.”
  - Several plans allegedly “had RADV audit error rates well in excess of 20%, reflecting that more than 20% of [their] diagnosis codes submitted to CMS were not supported by properly documented medical charts.” Relator alleges the over-reporting error rates found in these audits of representative medical records placed the defendants on notice that the risk adjustment data they more broadly submitted to CMS also contained significant over-reporting errors.
Enforcement Focus: Integrity of Data Submissions, cont.

• After the District Court dismissed his Fourth Amended Complaint with prejudice, the 9th Circuit revived it by holding that:
  – “When, as alleged here, Medicare Advantage organizations design retrospective reviews of enrollees’ medical records deliberately to avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence, they can no longer certify, based on best knowledge, information and belief, the accuracy, completeness and truthfulness of the data submitted to CMS. This is especially true, when, as alleged here, they were on notice of erroneously reported diagnosis codes.”

• The 9th Circuit found that at least some of the plans were “on notice” of erroneously reported codes by virtue of certain RADV audits with error rates of 20 percent or more.

Enforcement Focus: Integrity of Data Submissions, cont.

• The 9th Circuit distinguished the allegations here from a situation involving a health plan that “passively forwarded to CMS unsupported diagnosis codes they received from their medical providers. That type of conduct would not necessarily result in false … certifications.”
  – The 9th Circuit also pointed out that in a 2000 preamble, CMS stated that MA plans “cannot reasonably be expected to know that every piece of data is correct, nor is the standard that [CMS and the Department of Justice] believe is reasonable to enforce. [Simple mistakes will not result in sanctions].”
  – However, the 9th Circuit believed that the allegations here amount to more than “simple mistakes” and instead to “affirmative steps to generate and report skewed data.”

• “If Medicare Advantage organizations acquire the codes identified by retrospective coders, compare them to the codes previously submitted to the CMS, identifying both under- and over-reporting errors, but withhold information about the over-reporting errors from CMS, this would result in a false certification.”

Examples of Referral Packets

Completed Referral Packet submitted should contain the following:
• Identifying Information for Provider, including name, NPI and other known ID #s
• Contract(s) with Health Plan
• Credentialing Information
• Disclosure(s)
• Provider Education; including that specific to activity under review
• Fee Schedule (in Excel format)
• Audits/Communication
• Information on Pre-pay; including Reason(s), Status and History
• Health Plan’s Policy on
• Provider participation history & status (MS Word or PDF format)
• Records reviewed
• MCE Coders Report
• Other pertinent Information or data
** Varies by State
**SIU Remedial Action Taken**

- Once an investigation is completed, the resolution of the case may result in the allegation being unfounded.

- Cases that are founded may result in one or more of the following:
  - Provider / Member education
  - Payment suspension
  - Overpayment
  - Referral to government entities
  - Provider / Member termination
  - Referral to member pharmacy lock-in program
  - Settlement or litigation

**Other Overpayment Activities**

- Other MCO potential overpayments may be attributable to:
  - Retroactive member termination
  - Inappropriate coding
  - Payment duplication
  - Payment for unauthorized services

- Scope / time limitations of recovery efforts
  - Professional Claims (CMS-1500): 12 months from DOS
  - Institutional Claims (UB-04): 30 months from DOS
    - Exception for retrospective disenrollment, where institutional claims are also limited to 12 months from DOS

**Tracking Success**

- $ Recoveries-Identified vs Recovered
- In house
  - Who records recoveries?
    - Regulatory requirements tied to encounters
- $ Recoveries via External Stakeholders (OIG, State; MFCU, etc…)
- $ Saved/Cost Avoidance
  - What to track
    - How & for how long (12 mo. Vs. perpetuity)
    - Who will track; validation
    - When to track
- Pre-Pay Savings (FWA; Operational Savings)
- Other value
  - Meetings
  - Reports
  - Surveys/Audits
Keys

- Transparency
- Provide expectations; clarify roles
- Solid Relationships
- Communicate, communicate (joint assistance-MFCU)
- Document, document
- Collaborate w/key partners
  - Internally (i.e. provider relations)
  - Externally (i.e. Other SIUs)
- Data-Integrity of data
- No surprises
- Reevaluate/Assess-outside firms review
- ROI $ saved per $ spent

Wrap Up/Questions

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