Managing a SIU in a Managed Care World

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WellCare

Agenda

- Background
- Organizational Structure
- SIU Staffing
- Budgeting
- Training
- Regulatory Touchpoints
- Infrastructure
- Reporting
- Collaboration
- Wrap Up

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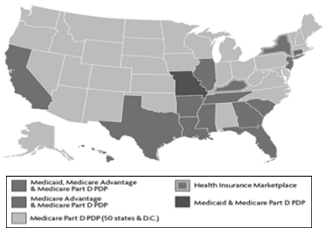
Background

WellCare Health Plans, Inc.

OUR PRESENCE



Founded in 1985 in Tampa, Fla.:
- Serving 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) members

Serving the full spectrum of member needs:
- Dual-eligible populations (Medicare and Medicaid)
- Health Care Marketplace plans
- Managed Long Term Care (MLTC)

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

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Background

- 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

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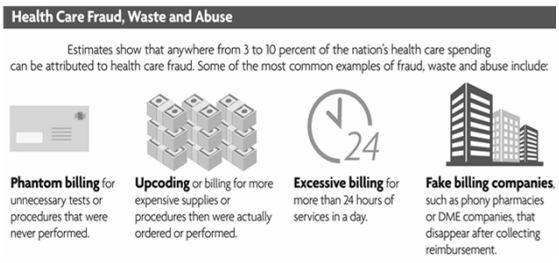
National Problem



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Organizational Structure

- Considerations:
  - Where does SIU reside within organization?
  - Who has oversight?
  - What line(s) of business---Medicaid, Medicare, Commercial or Mix
  - Regulatory Requirements
- Determine:
  - Mission/Vision
  - Roles within Organization
  - Vendor Needs

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Staffing

- Regulatory Requirements
  - In-State
  - Full-Time Equivalent
  - X Investigators/Coders/Nurse per XX Membership
    - -- New Jersey: Requires 1 investigator per 60,000 enrollees (not in-state)
    - -- Nebraska: Requires state-based Program Integrity Officer and a minimum of 1 investigator for every 50,000 members

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Staffing

- Staffing Mix/Job Descriptions
  - Management/Oversight
  - Medical Director
  - Investigators-Certifications (ACFE, AHFI); Exp-H/C, MCO, Law Enf.
  - Coders/Nurses- RNs/Behavioral Health/Certified Professional Coders
  - Analysts-**Data**, Financial, Intake
  - Consider Progressions-Level I, II, III; Senior; Leads
- Pharmacy Factors
  - PBM
  - Pharmacist

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Staffing

- Corporate-based; Field-based, Mix
  - Contractual Requirements
  - Work From Home (WFH)/ Field Office-Based
  - Costs (space, locale-cost of living adjustments, travel budget etc..)
  - Accessibility
    - Internal Meetings
    - External Meetings (Regulators/Law Enforcement)
    - To Conduct Provider Audits
    - Data-connectivity
  - Oversight
  - Security
  - Role-Based (i.e. investigators only)
  - How deep is Talent Pool? Number of Competitors?

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Budgeting

- Salaries
- Vendor Services
  - Background Checks
  - Hotline
  - Data Analytics Tool
- Training
  - Certifications
  - Licensing
  - Internal/External
- Travel
- Miscellaneous (Postage, Medical Records, Member Associations)
- Legal/Consulting Costs
- SG&A

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Training-Internal

- Training for SIU Staff (Onboarding; Continuing Education)
- FWA Training (At new hire/Annually)
  - All Staff
  - Contractors/FDRs
- False Claims Act; Deficit Reduction Act; Anti-Kickback Statute
- Program Integrity/Compliance (States blending)
- Continuous via Newsletters, Intranet, Posters
- Set up Department-specific (Specific Examples)
- Reporting Mechanisms-Hotlines, Email

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Internal Partnerships

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

Communications

- 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 *******

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Training-External

- Contractual Requirements
- False Claims Act
- Deficit Reduction Act
- Anti-Kickback Statute
- Providers-FWA Provisions
- Vendors- Delegated or Otherwise
- Sources- Communications (Member/Provider Manuals, Websites, Other communications)
- Tracking/Monitoring (Are they effective)
- Reporting Mechanisms-Hotlines, Email

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Sources of Regulation

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

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Examples-Contract Language

- Statutory language requiring MCOs to report suspected fraud and abuse within 15 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

Regulations

- **Penalties for Non-Compliance-**

Each of the 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 summarizes the requirements, prohibitions, and the penalties for non-compliance (examples included).

Penalties for Non-Compliance

Law	Prohibition	Penalties	Examples
Criminal Fraud Statutes • Submission of False Claims • Mail Fraud • Wire Fraud • Health Care Fraud • Obstruction of Justice	• 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. • The fraud can be punished differently and the penalties will vary depending on whether the fraud is committed: – By submitting false data or making false statement to the government; – Through the mail, phone or over the Internet; or – By trying to conceal illegal facts from being learned by government investigators.	• Large criminal fines and penalties • Prison sentences of up to 20 years for individuals	• Making false submissions to a state for Kick payments • Falsifying reports of costs submitted to states to increase premium payments for members • Up-coding encounter data for higher risk adjusted member premiums
False Claims Acts ("FCA") • Federal • State	• These are general fraud statutes that aid federal and state governments in combating and recovering losses they suffer due to fraud in Medicare and Medicaid programs. • 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. • Allow "whistleblowers" to bring suits on behalf of the government in exchange for a portion of the fraud recovery.	• Damages of up to 3 times the amount of damages sustained by the government because of the fraud • An additional penalty of between $5,500 and $11,000 per false claim submitted (federal) • State penalties vary	• Submitting a bid package that contains false data in order to receive a higher rate • Certifying to the accuracy of a reconciliation report knowing that the data are inaccurate to avoid having to repay overpayments

Penalties for Non-Compliance

Law	Prohibition	Penalties	Examples
CMS Intermediate Sanctions	• Medicare regulations provide CMS with the power to impose penalties and sanctions if your company does not comply with all laws, regulations and contract requirements that apply to its Medicare plans. • Sanctions may be imposed for, among other things: – Misrepresenting information that it furnishes to CMS, to an enrollee, or to a provider; – Failing to provide medically necessary items and services to members; – Discriminating among enrollees on the basis of their health status; and – Violating marketing rules.	• Suspension of your company's ability to enroll beneficiaries in its Medicare plans • Monetary fines • Termination of your Medicare contracts	• Purposely disenrolling members from a plan based on health status • Purposely denying covered health services for members
Anti-Kickback Statute ("AKS") • Federal • State: states have their own Anti-Kickback Statutes	• Prohibits knowingly and willfully soliciting, receiving, offering or paying anything of value (also called "remuneration") in return for, or to induce someone to: – refer patients for services or for the purchase of items reimbursed by any federal health care program; or – arrange, recommend, or order any item or service reimbursed by any federal health care program. • "Safe harbors" apply that immunize certain arrangements from criminal and civil prosecution. • If you have specific questions about whether a business activity complies with the AKS, please call your Compliance Hotline or the Legal Department.	• Fines of up to $25,000 per violation • Felony conviction and up to 5 years in prison • Additional civil penalties of up to $50,000 for each violation *plus* up to three times the total amount of remuneration • Exclusion	• Providing gifts or cash incentives to members in exchange for enrollment • Paying physician offices for enrolling patients in your health plans • Accepting payments from vendors in exchange for using services

Penalties for Non-Compliance

Law	Prohibition	Penalties	Examples
Exclusion from Federal/state Health Care Programs	• If an associate, officer, contractor or agent is convicted of violating federal or state health care laws, the government can bar your company from participating in federal health care programs. • Offenses that can lead to exclusion include: – Felony convictions related to the delivery of an item or service under federal or state health care programs; – Felony convictions relating to health care; – Violations of the CIA; and/or – A conviction related to the obstruction of an investigation. • An excluded entity or individual must apply for reinstatement if the entity or individual wishes to again participate in any federal health care programs. The OIG has the authority to deny reinstatement requests.	• Suspension of your company's ability to bill or receive any reimbursement from Medicare and Medicaid • If your company has discovered that an Associate is excluded, the Associate's employment should be terminated	• An Associate's conviction for health care fraud requires the OIG to exclude that Associate from participating in federal health care programs • Determine if your company will terminate the Associate once he or she is excluded
Civil Monetary Penalties ("CMP") Law	• The government, through the OIG, may impose administrative fines, referred to as CMPs, on your company for many types of illegal or unethical conduct, such as: – Making payments to induce Medicare or state health care program beneficiaries to select your company as their plan; – Submitting a claim to the government for a service not rendered or for members not enrolled in a plan; and – Failing to promptly return a known overpayment in the reconciliation process. • CMPs can also be imposed for violating other health care laws, such as the federal AKS and the Federal False Claims Act, **in addition to** the fines and penalties found in those laws.	• Fines of up to $50,000 per violation • Treble Damages (3 times the amount claimed under each false claim, or 3 times the value of each bribe, in the case of a kickback)	• Refusing to enroll a Medicare recipient due to the individual's health status • Hiring an Associate who has previously been excluded from participating in federal health care programs

Infrastructure

- ➢ Develop Anti-Fraud Plan
- ➢ Identify Case Management System
  - Homegrown vs. Vendor Product
- ➢ Develop Policies and Procedures
  - Case Intake
  - Triage/Case Prioritization
  - Case Referrals to Regulators-time requirements
  - Conducting Reactive/Proactive Investigations
  - Proactive Data Analysis/Monitoring
  - Case Referrals to Regulators/Law Enforcement
  - Remedial Actions
  - Reporting

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Intake

Sources

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

Example of a SIU Workflow

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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.

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SIU Investigative Actions

- SIU actions to either corroborate the allegations or determine them unfounded should include but not be limited to:
  - Conduct 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!

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Allegation – Medical

- **Medical Case - Investigative Actions**
  - Contact Referral Source/Complainant
  - Complete referral to State – Note: State requirements differ
  - Research prior complaints against subject
  - Research corporation records, state licensure, and disciplinary issues
  - Conduct internet research regarding subject/managing employees, background information, provider/facility reviews, map of the location
  - 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 member service verification letter
  - Complete and mail medical record request letter
  - Send records for coder and/or nurse review
  - Calculate and issue overpayment notice

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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 recipients qualifies for pharmacy "Lock-Out" program
  - Research corporate records, state licensure, and disciplinary issues
  - Conduct internet research regarding subject/managing employees, background information, provider/facility reviews, map of location
  - 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
  - Complete and mail medical record request letter
  - PBM will adjust claims if needed

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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

STARS*Solutions*

FWA Detection, Prevention, Investigation and Case Management

- Lead Generation
- High Impact rules and Predictive Analytics
- Examine the big Picture
- Automated Detection of Suspect Behavior

- Post and Pre Payment Review Services
- Consulting: P&P, Best Practices, Audit Prep, etc.

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

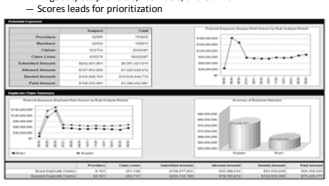
- Pre-Payment Intervention
- Integrated with post-payment review
- Targeted prepayment review for a more effective program

- Case Documentation
- Workflow Management
- Workload Balancing
- Financial & Case Reporting

STARS*Sentinel*

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**
  - Combines clear-cut known schemes with Predictive Analytics
  - Cross benefit analysis between facility and professional and professional and Rx
  - Taylor rules based on your outcomes
- **Claim Comparison Against the "Big Picture"**
  - Compares billing patterns over time
  - Compares across all claim types
  - Compares providers within peer groups
  - Measures potential overpayment against universe of payment
- **Comprehensive Reporting**
  - Summarizes and formats findings in investigative templates
  - Includes Potential Exposure reports for analysts and management

STARS*Informant*

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 to:
    - Validate
    - Investigate
    - Research

STARS*Informant* is the next generation of STARS®

STARS*Commander*

Command Center for Fraud Investigation Case Management

- 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

Case Management to Collect, organize, and inventory all caseload and gain new perspectives

STARSSolutions – Scheme Analysis Example

Sentinel Provider ID: 1720042252
Sentinel Name: FALASCO NORBERT M
Specialty: PEDIATRICS (PED)
Sentinel Specialty: Pediatric medicine (37)
Rule Analysis Period:
Current: 06/2015 - 11/2015
History: 06/2014 - 05/2015

Tax ID: 132442515
DEA Number:
License Number:
Address: 25 W KALEY ST, STE 300A,ORLANDO, FL 32806
Region: Florida (FL)

	Duplicate Analysis	Scheme Analysis	Submission Analysis
Total Score	0.00	0.34	0.00
Claims	0	352	0
Claim Lines	0	352	0
Patient Count	0	219	0
Submitted Amount	$0	$70,600	$0
Allowed Amount	$0	$18,198	$0
Denied Amount	$0	$52,402	$0
Paid Amount	$0	$18,198	$0

Case Number:
Investigator:
Status:
Recoveries:
Comments:

Analysis Type	Scheme/Analysis Class	Rule / Pattern	Scored Variance
Scheme Analysis - Professional	EM Procedures	Excessive average complex EMs per day	2.06

Provider 1720042252 FALASCO NORBERT M
Statistical Results:
Rules
1. Rule EXCESSIVE AVERAGE COMPLEX E&MS PER DAY revealed the provider billed 352 complex E&Ms for 94 days (3.74 complex E&Ms per day) resulting in a paid amount of $18,198

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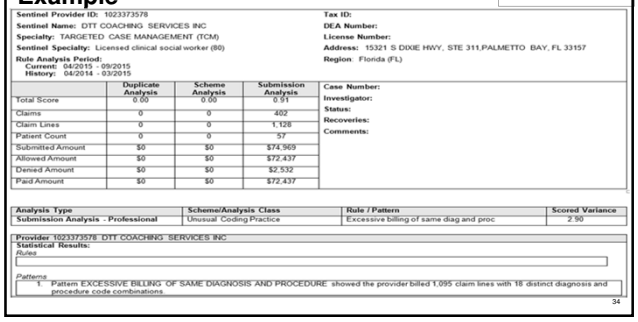
STARSSolutions – Submission Analysis Example



Sentinel Provider ID: 1023373578
Sentinel Name: DTT COACHING SERVICES INC
Specialty: TARGETED CASE MANAGEMENT (TCM)
Sentinel Specialty: Licensed clinical social worker (80)
Rule Analysis Period:
Current: 04/2015 - 09/2015
History: 04/2014 - 03/2015

Tax ID:
DEA Number:
License Number:
Address: 15321 S DIXIE HWY, STE 311,PALMETTO BAY, FL 33157
Region: Florida (FL)

	Duplicate Analysis	Scheme Analysis	Submission Analysis
Total Score	0.00	0.00	0.91
Claims	0	0	402
Claim Lines	0	0	1,128
Patient Count	0	0	57
Submitted Amount	$0	$0	$74,969
Allowed Amount	$0	$0	$72,437
Denied Amount	$0	$0	$2,532
Paid Amount	$0	$0	$72,437

Case Number:
Investigator:
Status:
Recoveries:
Comments:

Analysis Type	Scheme/Analysis Class	Rule / Pattern	Scored Variance
Submission Analysis - Professional	Unusual Coding Practice	Excessive billing of same diag and proc	2.90

Provider 1023373578 DTT COACHING SERVICES INC
Statistical Results:
Rules
Patterns
1. Pattern EXCESSIVE BILLING OF SAME DIAGNOSIS AND PROCEDURE showed the provider billed 1,095 claim lines with 18 distinct diagnosis and procedure code combinations.

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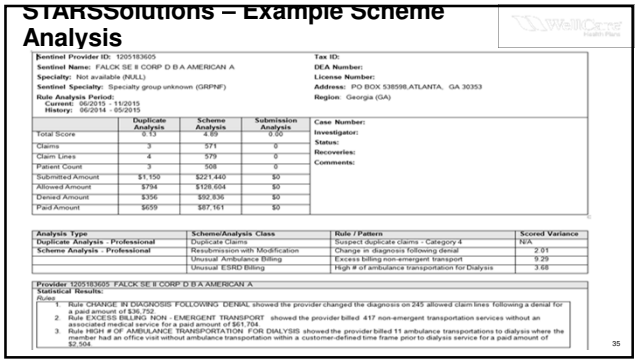
STARSSolutions – Example Scheme Analysis



Sentinel Provider ID: 1205183605
Sentinel Name: FALCK SE II CORP D B A AMERICAN A
Specialty: Not available (NULL)
Sentinel Specialty: Specialty group unknown (GRPNF)
Rule Analysis Period:
Current: 06/2015 - 11/2015
History: 06/2014 - 05/2015

Tax ID:
DEA Number:
License Number:
Address: PO BOX 538598,ATLANTA, GA 30353
Region: Georgia (GA)

	Duplicate Analysis	Scheme Analysis	Submission Analysis
Total Score	0.13	4.69	0.00
Claims	3	571	0
Claim Lines	4	579	0
Patient Count	3	508	0
Submitted Amount	$1,150	$221,440	$0
Allowed Amount	$794	$128,604	$0
Denied Amount	$356	$92,836	$0
Paid Amount	$659	$87,161	$0

Case Number:
Investigator:
Status:
Recoveries:
Comments:

Analysis Type	Scheme/Analysis Class	Rule / Pattern	Scored Variance
Duplicate Analysis - Professional	Duplicate Claims	Suspect duplicate claims - Category 4	N/A
Scheme Analysis - Professional	Resubmission with Modification	Change in diagnosis following denial	2.01
	Unusual Ambulance Billing	Excess billing non-emergent transport	9.29
	Unusual ESRD Billing	High # of ambulance transportation for Dialysis	3.68

Provider 1205183605 FALCK SE II CORP D B A AMERICAN A
Statistical Results:
Rules
1. Rule CHANGE IN DIAGNOSIS FOLLOWING DENIAL showed the provider changed the diagnosis on 245 allowed claim lines following a denial for a paid amount of $36,752.
2. Rule EXCESS BILLING NON - EMERGENT TRANSPORT showed the provider billed 417 non-emergent transportation services without an associated medical service for a paid amount of $61,704.
3. Rule HIGH # OF AMBULANCE TRANSPORTATION FOR DIALYSIS showed the provider billed 11 ambulance transportations to dialysis where the member had an office visit without ambulance transportation within a customer-defined time frame prior to dialysis service for a paid amount of $2,504.

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Resources

- NHCAA
- HCCA
- OIG
- 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.

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

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Referrals

- 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**

Law Enforcement

- Provide complete, thorough referrals
- Provide continuous coordination and support with law enforcement
- Participate in Task Force meetings
- Ensure staff are responsive and timely
- **Be a Resource!**

Office of Inspector General

Attorney General's Office

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Attorney General Pam Bondi News Release

April 19, 2016
Contact: Whitney Ray
Phone: (850) 245-0150

Two More Arrested in Fraud Scheme Involving Student Identity Information, One Still at Large

TALLAHASSEE, Fla.—Attorney General Pam Bondi's Medicaid Fraud Control Unit, with the assistance of the Orlando Police Department, today arrested two individuals for participati in a scheme to defraud the Medicaid program using teenagers' personal identity information. Wendy Leiba of Longwood, 53, and Bobby Lyons of Winter Garden, 50, allegedly assiste Orlando-based companies to fraudulently bill Medicaid more than $500,000 for services not rendered. An additional participant in this scheme, Brian Craig of Sanford, 40, is at large.

A MFCU investigation into the false and fraudulent billing by Revive Athletics, Divine Consulting and Durden Consulting, led to the recent two arrests. These companies provided Medicaid for behavioral health services primarily in the Orlando area. According to the investigation, Craig and Leiba, both case management supervisors at Divine Consulting, billed for services not provided and not medically necessary. Lyons, who runs the Young Men of Promise program through the Orange County School system, allegedly sold high school students' identity information to Divine Consulting and Revive Athletics. The companies allegedly billed Medicaid for services to these students, but the students never received the services.

MFCU previously arrested five other individuals in connection to this case. For more information on the previous arrests, click here.

Leiba faces one count of organized scheme to defraud, a third degree felony. If convicted, Leiba faces up to five years in prison and $5,000 in fines. Lyons faces one count of Medicaid provider fraud, a first-degree felony, one count of criminal use of personal identification information, a first-degree felony, and one count of organized scheme to defraud, a third degree felony. If convicted, Lyons faces up to 55 years in prison, with a minimum mandatory sentence of at least five years.

Wellcare Health Plans, the U.S. Trustee Program's Orlando Office, the Agency for Health Care Administration's Office of Medicaid Program Integrity and the Orange County Public Schools School Police Uni assisted the Medicaid Fraud Control Unit in the investigation. The State Attorney's Office for the Ninth Judicial Circuit will prosecute the case.

The Attorney General's MFCU investigates and prosecutes providers that intentionally defraud the state's Medicaid program through fraudulent billing practices. Medicaid fraud essentially steals from Florida's taxpayers. From Jan. 2011 to the present, Attorney General Bondi's MFCU has obtained more than $600 million in settlements and judgments. Additionally, the MFCU investigates allegations of patient abuse, neglect, and exploitation in facilities receiving payments under the Medicaid program.

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Regulatory Reporting

- Externally
  - Timing: Monthly, Quarterly, Annually
  - Recoveries/Cost Avoidance
  - Suspensions
  - Providers Termed
  - Exclusions/Sanctions Checks
  - Actual vs Tips
  - Summary
  - Audits Performed
  - Referrals Made
  - Overpayments Identified
  - Overpayments Recovered
  - New PI Actions
  - List of Involuntary Terminations
  - List of Recipients Referred to OIG
- RFIs

Quarter/Year
MCO--
Program Integrity Quarterly:

Recoveries	Q1 Recoveries		Q2 Recoveries		Q3 Recoveries		Q4 Recoveries		YTD Recoveries	
	Identified $	Recovered $	Identified $	Recovered $	Identified $	Recovered $	Identified $	Recovered $	Identified $	Recovered $
MFA Recoveries	$	$	$	$	$	$	$	$	$	$
Non-SIU Waste Recoveries (and unsolicited refunds)	N/A	$	N/A	$	N/A	$	N/A	$	N/A	$
Total	$	$	$	$	$	$	$	$	$	$
Cost Avoidance	Q1 Cost Avoidance		Q2 Cost Avoidance		Q3 Cost Avoidance		Q4 Cost Avoidance		YTD Cost Avoidance	
SIU FWA Cost Avoidance	$		$		$		$		$	
SIU FWA Pre-Pay	$		$		$		$		$	
Other Cost Avoidance (i.e. COB/TPL; Subrogation; Other)	$		$		$		$		$	
Total	$		$		$		$		$	
Type	Q1 Summary Information		Q2 Summary Information		Q3 Summary Information		Q4 Summary Information		YTD Summary Information	
SIU FWA Providers Suspended	#		#		#		#		#	
SIU FWA Cases Opened	#		#		#		#		#	
SIU FWA Cases Active (includes Opened)	#		#		#		#		Not Applicable	
SIU Referrals to SCDHHS	#		#		#		#		#	
SIU Provider Education	#		#		#		#		#	
MCO Providers Termed for Cause	#		#		#		#		#	
MCO Providers Denied Cred.	#		#		#		#		#	
MCO Exclusions	#		#		#		#		#	

Instructions:
The Financial Summary section captures expenses identified, recovered and/or avoided due to fraud, waste and abuse prevention and investigation efforts by both the MCO and contrated Vendors for FA.

Market Collaboration Meetings

- Regulatory
  - Onsite presence v corporate site; challenges managing WFH; offsite vs. onsite collaboration
  - Capability to conduct onsite visits
  - Capability to meet with regulators
  - Shifting culture to broaden "Program Integrity"
- RFPs/Contracts/Amendments
- Purpose/Value- two-way street; buy-in; transparency; collaboration; sensitive/confidential info discussed
- FWA vs. Key Contracted Provider
- Competing savings recorded w/in organization
- Resources/Assistance

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)
  - MFCU
  - Federal Task force meetings
  - **Bring Something to the Table**

Tracking Success

- $ Recoveries-Identified vs Recovered
- 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 methodology
- Pre-Pay Savings (FWA; Operational Savings)
- Other value
  - Meetings
  - Reports
  - Surveys/Audits

Keys

- **Communication & Collaboration w/Internal and External Stakeholders**
- Documentation!
- Ensure Data Integrity- Data Analytics, Reporting
- ROI ($ saved per $ spent)
- Stay Current
- Transparency
- Periodically re-evaluate/assess
  - Independent Third Party
  - Seek Best Practices

Wrap Up/Questions

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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.

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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.

Provider Fraud Examples

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

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

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