Managing a SIU in a Managed Care World

Chris Horan
VP Corporate Compliance Investigations
WellCare

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

Background
WellCare Health Plans, Inc.
OUR PRESENCE

Served 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
Spearheading efforts to sustain the social safety net:
- 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 as of March 31, 2016
Background

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

National Problem

Health Care Fraud, Waste and Abuse

Estimates show that anywhere from 3 to 10 percent of the nation’s health care spending can be attributed to health care fraud. Some of the most common examples of fraud, waste and abuse include:

- Phantom billing for unnecessary tests or procedures that were never performed
- Upcoding or billing for more expensive supplies or procedures than were actually ordered or performed
- Excessive billing for more than 24 hours of services in a day
- Fake billing companies, such as pharmacy benefits or CMS companies, that disappear after collecting reimbursement

Organizational Structure

Considerations:
- Where does SIU reside within the organization?
- Who has oversight?
- What line(s) of business—Medicaid, Medicare, Commercial or Mix
- Regulatory Requirements

Determine:
- Mission/Vision
- Roles within Organization
- Vendor Needs
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

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

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?
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

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

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"

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

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
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

<table>
<thead>
<tr>
<th>Law</th>
<th>Prohibition</th>
<th>Penalties</th>
<th>Examples</th>
</tr>
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<tbody>
<tr>
<td>Federal Fraud Statutes</td>
<td>• Submission of False Claims</td>
<td>Large criminal fines and penalties</td>
<td>• Submitting a bid package that contains false data in order to receive a higher rate</td>
</tr>
<tr>
<td>False Claims Acts (“FCA”)</td>
<td></td>
<td>• Prison sentences of up to 20 years for individuals</td>
<td>• Certifying to the accuracy of a reconciliation report knowing that the data are inaccurate to avoid having to repay overpayments</td>
</tr>
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<td>Federal Anti-Kickback Statute (AKS)</td>
<td>Prohibits knowingly and willfully soliciting, receiving, offering or paying anything of value for or in return for referral of patients to a health care provider.</td>
<td>Sanctions may be imposed for, among other things:</td>
<td>Fines of up to $25,000 per violation and may be up to 5 years in prison.</td>
</tr>
<tr>
<td></td>
<td>Similarly, prohibits knowingly and willfully soliciting payments to influence referrals.</td>
<td>Medicare regulations provide CMS with the power to impose penalties and sanctions.</td>
<td>Suspension of your Medicare contracts.</td>
</tr>
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<td>Civil Monetary Penalties (CMP) Law</td>
<td>CMPs can also be imposed for violating other health care laws, such as the federal AKS.</td>
<td>An excluded entity or individual must apply for reinstatement if the entity or individual wishes to again participate in any federal health care programs.</td>
<td>The OIG has the authority to deny reinstatement requests.</td>
</tr>
</tbody>
</table>

Infrastructure

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

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

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**Example of a SIU Workflow**

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**SIU Case Prioritization**

- Triage and Prioritize. The SIU team preliminarily assesses the matter and enters 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.
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!

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
  - PBM will adjust claims if needed

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
**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

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**FWA Detection, Prevention, Investigation and Case Management**

- Random Sampling
- Informed Decision-Making
- Scores leads for prioritization
- Flags suspect providers, members, and claims
- Identifies aberrant billing patterns using multivariate analyses
- Includes Potential Exposure reports for analysts and
  - Summarizes and formats findings in investigative
  - Measures potential overpayment against universe
  - Compares providers within peer groups
  - Compares across all claim types
  - Compares billing patterns over time
  - Cross benefit analysis between facility and professional and Rx
  - Combines clear-cut known schemes with Predictive
  - Taylor rules based on your outcomes

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**Lead generation through rules and predictive analytics**

- **Automated Overpayment Identification**
  - Identifies aberrant billing patterns using multivariate
  - High impact providers, members, and claims
  - Scores leads for prioritization

- **High-impact Rules/Algorithms**
  - Identifies case cut benefit schemes with predictive
  - Cross benefit analysis between facility and
t  - Professional and Rx
  - Taylor rules based on your outcomes

- **Claim Comparison Against the “Big Picture”**
  - Compares against all claim types
  - Compares providers within peer groups
  - Measures potential overpayment against universe

- **Comprehensive Reporting**
  - Summarizes and formats findings in investigative
  - Includes potential exposure reports for analysts and
  - Management
**STARS Informant**

- Follow the lead wherever the investigation takes you next
  - 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

STARSInformant is the next generation of STARS

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**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-avoidance units

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**STARS Solutions – Scheme Analysis Example**
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 healthcare 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.

**Resources**

- NHCAA
- HCCA
- OIG
- HFPP
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

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!
Regulatory Reporting

- Externally
  - Timing: Monthly, Quarterly, Annually
  - Recoveries/Cost Avoidance
  - Suspensions
  - Providers Terminated
  - 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
Market Collaboration Meetings

- Regulatory
  - Onsite presence vs. 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 within organization
- Resources/Assistance

Regulatory Challenges

- Approval to refer
- Approval to pursue op
- 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**

Chris Horan  
VP Corporate Compliance Investigations  
WellCare Health Plans, Inc.  
(813) 206-3754  
christopher.horan@wellcare.com

**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

### 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