

# Medicaid Fraud Trends & Best Practices for Reporting and Partnering with State Medicaid Regulators

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## AGENDA

Medicaid Fraud Risks / Areas of Interest to Managed Care Professionals

About Kaiser Permanente Medicaid

Medicaid Fraud Reporting

Medicaid Audits

Q & A

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# HHS OIG

## OIG's Approach to Health Care Fraud



- All Hands on Deck!

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# Collaboration

### Law Enforcement

- Federal
- State
- Local

### Public Health

- HHS Public Health Service
- CDC
- State Health Agencies

### Payers

- Public
- Private

### Industry

- Advisory Opinions
- Compliance Monitoring
- Provider Groups

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# Data Analytics

## Resource Allocation

- Trend Analysis
- Geographic Distribution
- Emerging Schemes

## Lead Generation

- Predictive Models
- Free Text Analysis
- Self-service tools

## Data Sharing

- Law Enforcement Partners
- Payors
- Public Health
- Toolkit
- Data Briefs

## Measuring Impact

- Financial
- Patient migration
- Billing behavior

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# Mission Focus

## ARPO

- Opioid prescription and treatment fraud

## Brace Yourself

- Durable Medical Equipment

## Genetic Testing

- Cancer Screening

## Emerging

- Foot baths
- Telemedicine
- Home Health
- Hospice
- Part C, Medicare and Medicaid Advantage
- COVID-19!!!

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## The Right Tool at the Right Time

### Criminal

- Restitution
- Fines
- Penalties
- Prison

### Civil

- Restitution
- Fines
- Penalties
- Corporate Integrity Agreement

### Admin

- Education
- Payment Suspension
- Revocation
- Reimbursement rules

### Exclusion

- Mandatory
- Permissive

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## Focus on Impact

### Taxpayers

- Recoveries
- Confidence

### Programs

- Returning program dollars
- Improving efficiency of program delivery

### Deterrence

- Holding wrongdoers accountable
- Changing behavior

### Patients

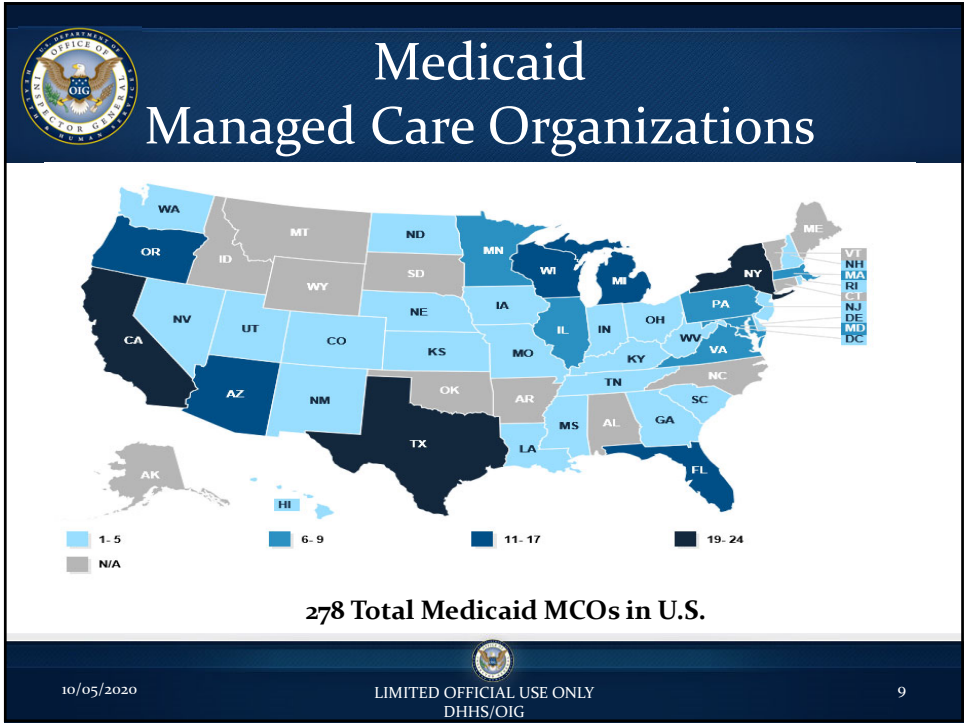
- Improving care delivery
- Connecting patients to quality care
- Protecting from harm

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**Medicaid Program Integrity Units**

The duties of Program Integrity include:

- Prevention
- Investigation
- Education
- Audit
- Recovery of improper payments
- Cooperation with MFCU and other federal/local law enforcement agencies.

**Program Integrity** encompasses a range of activities to target the causes of improper and fraudulent payments.

Mistakes → Inefficiencies → Bending the rules → Intentional Deception

Error → Waste → Abuse → Fraud

Examples:

- Incorrect coding
- Inappropriate use and overutilization
- Medically unnecessary services
- Billing for services or supplies that were not provided

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## Medicaid Fraud Control Units

- Fraud in 1970's (Congressional Hearings)
  - NY 1<sup>st</sup> MFCU (dedicated unit/team)
- 48 of the 53 are located within Offices of States Attorneys General
- Some are LEO, Non-LEO, Hybrid LEO
- **Puerto Rico, Virgin Islands, North Dakota**
  - **Newly certified MFCUs**



More information on MFCUs available at:

<https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/>



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## Medicaid Fraud Control Units

- Investigate Medicaid provider fraud
- Investigate abuse and neglect of patients in healthcare facilities
- Authority to
  - Review original records required of providers with or without notice
  - Subpoena additional material
  - Make an arrest
  - Civilly or criminally prosecute providers

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# MFCU Case Types

- Medicaid Provider Fraud
- Patient Abuse/Neglect
- Long Term Care Facilities/Nursing Homes (Cost Reporting Cases)
- Financial Exploitation of Vulnerable Adults (Misappropriation)
- Investigate fraud in the administration of Medicaid
- Physician Services
- Home Health Care Agencies/Individual Home Health Providers
- Ambulette/Ambulance Services
- Dental Providers
- Psychiatric Services
- Durable Medical Equipment (DME)
- Pharmacy

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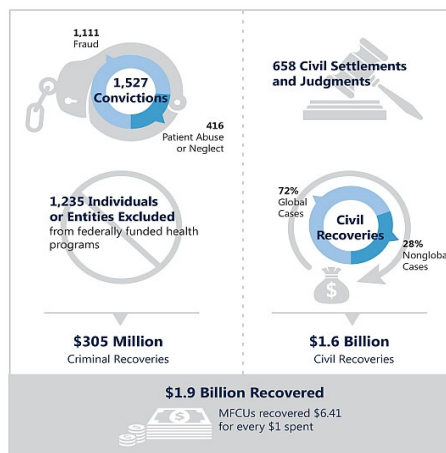


# MFCU Annual Report

## Medicaid Fraud Control Units Fiscal Year 2019 Annual Report

- Case Outcomes
- OIG Priority Outcome – Maximizing MFCU Effectiveness
- Beneficial Practices

<https://oig.hhs.gov/oei/reports/oei-09-20-0010.asp>



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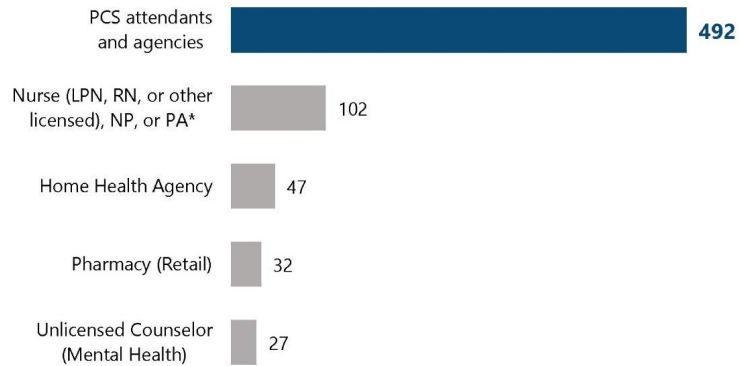
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## MFCU Case Types



\*LPN = Licensed Practical Nurse; RN = Registered Nurse; NP = Nurse Practitioner; PA = Physician Assistant

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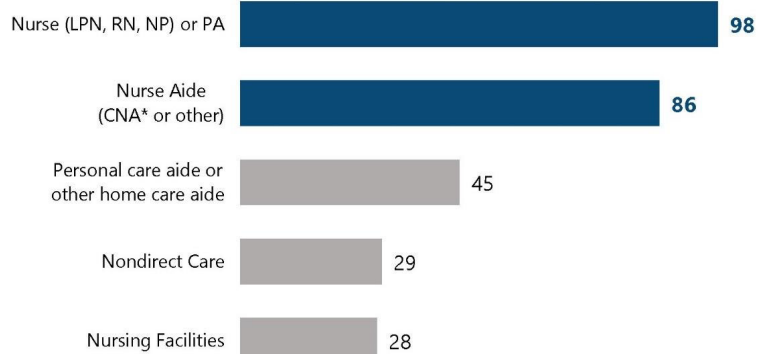
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## Patient Abuse and Neglect



\*CNA = Certified Nurse Aide

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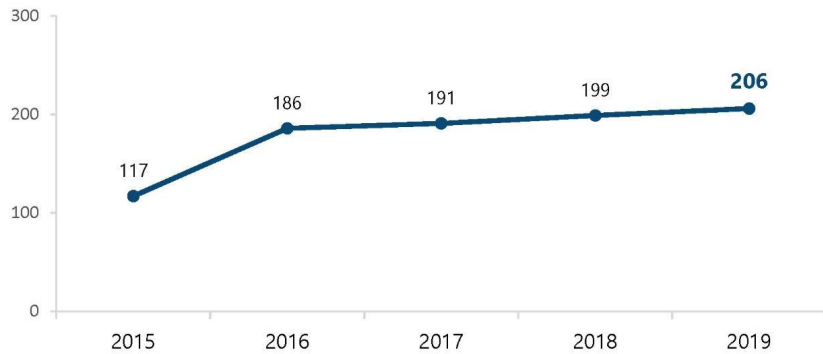
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## Opioid Diversion Cases



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## Health Care Fraud Trends

- Home and Community Based Services – HHA, Hospice, PCS
- Pharmacies/Drug Diversion
- Behavioral Health
- Dental
- Non-Controlled Drug Diversion/Specialty Drugs
- Medical Identity Theft
- Telemedicine
- **DME**
- **Genetic Testing**

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## COVID-19 Fraud Schemes



- Respiratory Pathogen Panel (“RPP”) Testing
- Identity Theft
- Telemedicine
- Part D
- Fake Testing Kits



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## Major Case Coordination (MCC)



- Implemented: April 2018
- Stakeholders: OIG, DOJ, UPICS and all components of CPI
- Purpose: Maximize efforts to identify, investigate, and pursue providers who might otherwise endanger the program
- Goal: Right tool, right case, right time, and right order

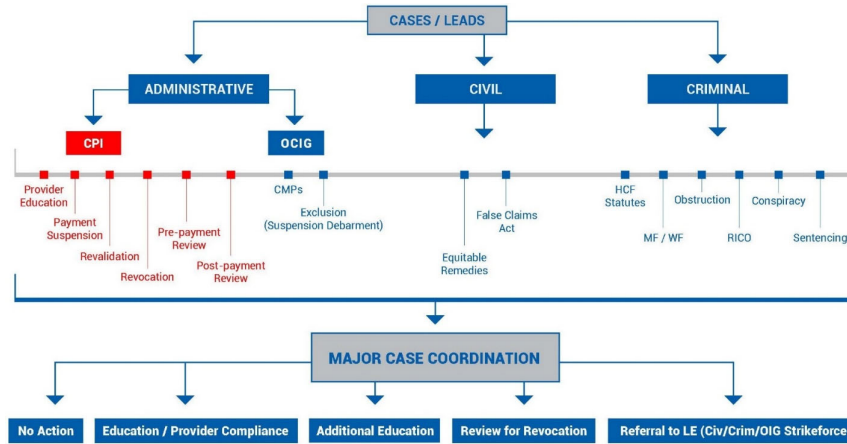


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# MCC Enforcement Continuum



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# MCC Results

## Results Since April 2018:

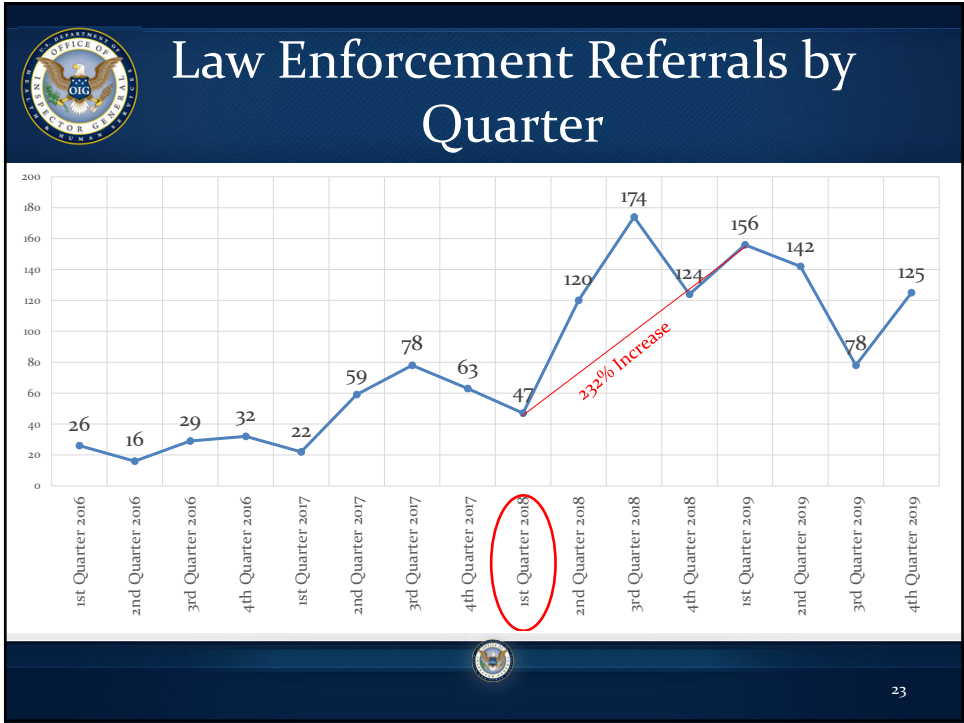
- 1500+ Unique Case Reviews
- 900+ Law Enforcement Referrals
- 350+ Revocations
- 700+ Payment Suspension

Increase in number and quality of law enforcement referrals



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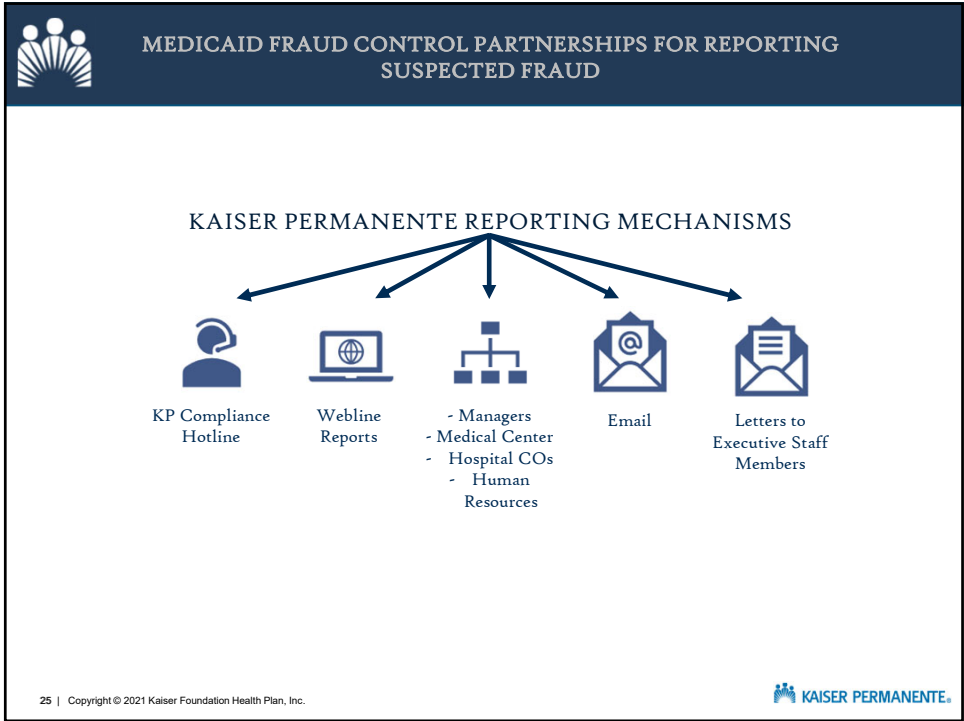
**ABOUT KAISER PERMANENTE**

<b>Regions</b> 8 including D.C.	<b>Members</b> 12.2M	<b>Employees</b> 217,173
<b>Hospitals &amp; Medical Offices</b> Hospitals: 39 Medical Offices: 690	<b>Annual Prescriptions Filled</b> 78.3M	<b>Nurses and Physicians</b> Nurses: 58,345 Physicians: 22,013

Source: 2019 Annual Report

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## MEDICAID FRAUD CONTROL PARTNERSHIPS FOR REPORTING SUSPECTED FRAUD



# ETHICS & COMPLIANCE INVESTIGATIONS



### Investigation Procedures 2

- Read the allegation
- Determine the investigation steps
- If applicable, investigators send referrals depending upon **member type** and reporting criteria





### Quarterly Quality Review 3

#### Manual

- Case documentation quarterly random sampling
- Check member type
- Attach referral


#### Scheduled reporting

- Cross check selected case member type against the member database (pilot in 2020)
- If applicable, update the case member type and reassess if reporting is required

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## EMERGING MEDICAID FRAUD RISKS AND AREAS OF INTEREST TO MANAGED CARE PROFESSIONALS

### Incident Regulatory Reporting Instructions




- Medicaid Contact
  - Who?
- Reporting Due Date
  - When?
- Criteria for Reporting: Member and/or Provider
  - What triggers notification?
- Review and Approvals
  - Who?
  - Does Legal want to provide additional language?
- Reporting Instructions
  - What?
  - How?
- Inform
  - Who?

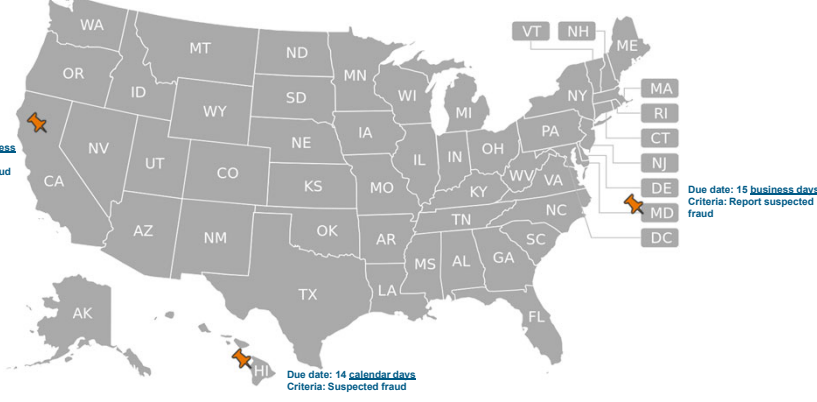
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## REPORTING SUSPECTED FRAUD



**Due date: 10 business days**  
Criteria: Report fraud upon discovery of incident


**Due date: 14 calendar days**  
Criteria: Suspected fraud

**Due date: 15 business days**  
Criteria: Report suspected fraud

**Kaiser Permanente had over 928,787 Medicaid members in 2019.**

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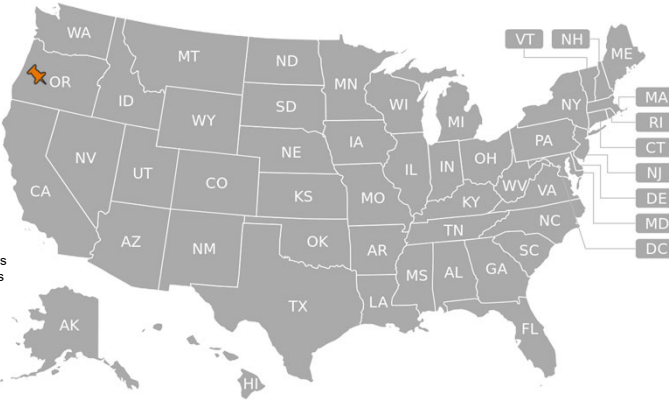
## SCHEDULED REPORTING

**Sample Contract Deliverables from the State of Oregon**

Report	Due Date
Annual FWA Referrals and Investigations	January 31


**Scheduled Regulatory Reporting Instructions**

- Medicaid Contact
- Reporting Due Date
- Criteria for Reporting
- Review and Approvals
- Reporting Instructions
- Inform





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## RESPOND TO MEDICAID AUDITS







**The Strategy:** Review and assess the audit request to create a plan to gather all requested documents and data, monitor our document production and tracer progress.




**Engage your crucial partners:** Other compliance teams, business operations teams such as claims administration, provider contracting, pharmacy benefits managers, finance, risk, internal audit, and your legal department.




**Update the reference library:** All requested documents and data.




**Lessons learned:** Having a “change mindset” as you perform your post-audit plus-delta analysis will help you become even better prepared to respond to future audits



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Questions  
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## THANK YOU



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