Program Integrity: Fraud Prevention, Detection & Correction

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Health Care Fraud

FRAUD. WASTE. ABUSE.

THE PROBLEM

Fraud creates:
- Higher premiums
- Higher out-of-pocket expenses
- Health and quality of care risks

TENS OF BILLION$

Financial losses due to health care fraud each year

FRAUD AFFECTS EVERYONE
Health Care Fraud

An owner of a Florida pharmacy sentenced to 15 years in prison & ordered to pay $54.5 million for a prescription drug fraud scheme.

Two co-conspirators connected with clinics in Brooklyn, NY, were sentenced for their role in a $48.5 million healthcare fraud scheme.

Health Care Fraud

Auditor "shocked" by massive billing schemes at rural hospitals

Rural hospitals across the country are closing at the highest rates in decades. Since 2010, 83 have shuttered. Desperate to stay open, some hospitals got caught up in dubious billing schemes. In March, CBS News investigated questionable billing at rural hospitals in Georgia and Florida.

Agenda

- Program Integrity
- Anti-FWA Compliance Programs
- Prevention, Detection & Correction – Examples
- Collaborating with Government Entities

It’s the right thing to do
Protects members, providers and the public from harm

Regulatory & compliance obligations
Required by law to have mechanisms in place to prevent, detect, and correct FWA

Good business practice
Being good stewards of health care dollars

Compliance plays a key role!
Anti-FWA Compliance Program
**Program Integrity**

Program Integrity consists of activities that focus on prevention, detection, and correction activities undertaken to minimize or prevent overpayments due to fraud.

<table>
<thead>
<tr>
<th>PREVENTION</th>
<th>DETECTION</th>
<th>CORRECTION</th>
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<tbody>
<tr>
<td>• Fraud prevention programs</td>
<td>• Investigations</td>
<td>• Corrective action</td>
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<tr>
<td>• Claims edits</td>
<td>• Post-payment reviews</td>
<td>• Provider education</td>
</tr>
<tr>
<td>• Data analytics</td>
<td>• Pharmacy &amp; provider audits</td>
<td>• Retrospective recovery</td>
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<tr>
<td>• Aberrant billing pattern analysis</td>
<td>• Data analytics</td>
<td>• Reporting and referral</td>
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<tr>
<td>• Verification of excluded individuals &amp; entities</td>
<td>• Machine learning &amp; Artificial intelligence</td>
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<tr>
<td>• Drug utilization review</td>
<td>• Provider education</td>
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Ongoing feedback loop
# Anti-FWA Compliance Programs

1. Based on the 7 elements of an effective compliance program,
2. Align with the company’s Compliance Program, and
3. Meet any other applicable requirements.

<table>
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<tr>
<th>7 ELEMENTS</th>
<th>OTHER REQUIREMENTS</th>
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<tbody>
<tr>
<td>• Written standards &amp; policies</td>
<td>• Reporting of overpayments</td>
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<td>• High level oversight - governance</td>
<td>• Verification of services</td>
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<tr>
<td>• Training &amp; education</td>
<td>• Referral of potential FWA</td>
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<td>• Effective lines of communications / reporting</td>
<td>• Suspension of payments</td>
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<td>• Enforcement &amp; disciplinary standards</td>
<td>• Notification of provider circumstances due to potential FWA (e.g., contract termination)</td>
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<td>• Auditing, monitoring &amp; identification of compliance risks</td>
<td>• Eligibility verification</td>
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<td>• Prompt response to identified issues</td>
<td>• Policies &amp; procedures</td>
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*This is not a comprehensive list. Requirements vary based on type of business and contract.*

# Regulatory Landscape

- **CMS** (Centers for Medicare & Medicaid Services)
- **State Agencies**
- **MEDICARE MEDICAID COMMERCIAL**
- **Employer Groups**
- **Departments of Insurance**
**Program Integrity**

**The UnitedHealthcare Compliance Program** is the formal structure established by the organization to fulfill its legal obligations to the state and federal government and regulatory agencies. It is:

- Required by state and federal law and regulation
- A strategy implemented across all UHC lines of business that includes a system of individuals, structures and processes
- The process by which the organization operationalizes and demonstrates its legal and regulatory responsibilities and commitments

As part of our Compliance Program, our **Anti-Fraud, Waste and Abuse program** focuses on prevention, detection, and correction activities undertaken to minimize or prevent overpayments due to fraud, waste or abuse.

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**Program Integrity Partners**

- **Prevents, detects and corrects** fraudulent, wasteful and abusive healthcare-related activities and compliance violations through effective investigative operational strategies.
- **Provides a framework and supports** strategic development and implementation of an effective Anti-FWA Compliance Program.
- **Operations designed to prevent** improper payments: to ensure the right amount is paid to legitimate providers, for covered, correctly coded, correctly billed services, provided to eligible members.
- **Provides focused interpretation and guidance** regarding legislation and regulations to advance the growth, innovation, brand reputation and performance goals.
Program Integrity
Special Investigations Unit

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>PHARMACY</th>
<th>DATA</th>
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<tbody>
<tr>
<td>Investigations centralized around medical and/or ancillary benefits. Investigations are: • Retrospective</td>
<td>Investigations centralized around pharmacy benefits and network. Investigations are: • Retrospective • Preventative</td>
<td>Performs sophisticated analytics and data manipulation. Creates powerful graph data visualizations. Develops databases and manages big data.</td>
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</tbody>
</table>

**MISSION**

• **Protecting the ethical and fiscal integrity** of the company and its employees, members, providers, government programs, and the general public.

• **Safeguarding the health and well-being** of our members.

• **Preventing, detecting, and correcting** fraudulent, wasteful, and abusive activities and compliance violations through effective investigative operational strategies.
Prevent, Detect, Correct

**PREVENTION**

- Fraud prevention programs
- Claims edits
- Pre-payment data analytics
- Aberrant billing pattern analysis
- Verification of excluded individuals & entities
- Drug utilization review (DUR)
- Opioid overutilization prevention
- Training & Education
- Code of conduct

**SPOTLIGHT ON**

**Fraud Prevention Programs:**
- Independent Pharmacy Enhanced Credentialing (IPEC)
- Independent Verification Program (IVP)

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Pharmacy Investigations

**Focus on Prevention**

**Independent Pharmacy Enhanced Credentialing ("IPEC")**

A preventative fraud credentialing program in which the standard pharmacy credentialing process is enhanced with additional validation activities performed by trained SIU investigators.

**Jurisdiction & Scope**

Independent Retail Pharmacies
Located in Health Care Fraud Prevention and Enforcement Action Team (HEAT) areas:

- Miami-Dade, Florida
- Tampa Bay, Florida
- Brooklyn, New York
- Houston, Texas
- Dallas, Texas
- Chicago, Illinois
- Detroit, Michigan
- Los Angeles, California

**FACTS**

- Program started in 2014
- Key elements include:
  - Onsite inspections
  - Inventory reconciliation
  - Background checks
### Pharmacy Investigations
#### Case Examples - IPEC

**Pharmacy A** investigated as a part of IPEC located in Florida.

- Pharmacy was found in violation of at least 9 requirements.
- No drug inventory but processing claims.

**Pharmacy B** investigated as a part of IPEC located in New York.

- **Sanitary Issues**
  - Expired Drugs
  - PHI

**Attempted to process $40K worth of claims**
Laboratory Investigations
Focus on Prevention

Independent Verification Program (IVP) – Enhanced verification process for independent laboratories located within high risk states, who expressed an interest or intent to bill UHC for laboratory services.

Investigative activities
• Provider verification (case lead)
• Background investigation
• Claims data review
• Unannounced onsite inspection
• Findings and recommendations

FACTS

☐ Program started in June 2017
☐ Over 40 laboratories inspected
☐ Actions taken may include full denial of incoming claims or a request to review records before paying claims

Laboratory Investigations
Case Examples - IPV

Laboratory “E”

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Prevent, Detect, Correct

DETECTION
- Investigations
- Scheme specific investigations
- Post-payment reviews
- Controlled substance drug diversion program
- Lock-in program
- Pharmacy & provider audits
- Advanced Analytics
- Machine Learning & Artificial Intelligence
- Provider education

SPOTLIGHT ON
Special Investigations:
- Medical Investigations
- Addressing Abusive Laboratory Billing Practices

Medical Investigations
Focus on Detection

Scope
- Performs retrospective investigations of credible suspicions of fraud.
- Responsible for conducting investigative activities and has knowledge and experience in intelligence led investigative practices and relevant legislation.

Jurisdiction
In and out of network providers, including:
- Professional and facility
- Durable medical equipment (DME)
- Dental
- Vision

FACTS

Investigative steps include:
- Member & provider interviews
- Review evidence
- Medical records reviews
- Onsite inspections
Medical Investigations
Case Examples – Orthosis

Provider A investigated as a part of a (national) durable medical equipment scheme with ties to telemedicine issues.

- Identified via member complaints and data analytics; member & provider interviews conducted
- Often referred to as “mummy scheme”
- **Provider A** referred and accepted by Office of Insurance Fraud Prosecutor

Prevent, Detect, Correct

In addition to detection, investigation, payment prevention and recovery efforts, corrective action is taken when fraud, waste or abuse is discovered. Corrective actions vary based on the nature of the issue.

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<thead>
<tr>
<th>CORRECTION</th>
<th>Referral to law enforcement, state agencies, boards</th>
<th>Disciplinary action</th>
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**Laboratory Investigations**
**Addressing Abusive Billing Practices**

**Dallas men to plead guilty to roles in two massive health care kickback cases**

Two key figures who prosecutors say played a role in multiple medical kickback schemes in Dallas in which doctors were paid to steer patients to certain hospitals have agreed to plead guilty in two cases, court records show.

Andrew Hillman, 42, and Semyon Narosov, 54, owned the Next Health network of pharmacies and testing labs that gave people $50 gift cards to urinate in cups at Whataburger bathrooms.

The specimens were sent to the Next Health labs for a battery of unnecessary and expensive tests under the guise of a wellness study, court records say, and doctors were paid kickbacks for referring patients.

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**Relationships & Collaboration**

UnitedHealthcare

[Logos of CMS, DOJ, FTC, TDI, Texas Department of Insurance]
The Fight Against Health Care Fraud

- We all play a part
- Compliance plays a key role
- Relationships matter

Q&A
Appendix