Medicaid Enterprise Program Integrity Insights

Presented September 11, 2013
At the Medicaid Enterprise Systems Conference
Charleston, South Carolina
By Dale Posont & Rusty Simmons
Guarding against a past scam

Approx 15 lbs Assorted Victorinox Knives #12020

The Commonwealth of Pennsylvania Sale of TSA Property
You are bidding on:
Approx 15 lbs Assorted Victorinox Knives #12020
The Lot consists of the following:
Various Sizes and Styles
Various Conditions
Various Manufacturers
Approximate Shipping Weight: 16 lbs
**NAMES OR BRANDS ARE LISTED AS MARKED OR AS THEY MAY
**ALL ITEMS ARE BEING SOLD AS-IS WHERE IS**
BUYER'S FINAL AUCTION COST:
About CSG Government Solutions

- Government Operations Consulting
- National, specialized HHS, Project Assurance Services, and Unemployment Insurance Practices

Healthcare and Human Services Thought Leadership
- Project Assurance Services tailored to HHS priorities
- Established Centers of Excellence
- Industry participation and partnership
- CSG REALize™ Maturity Models and Best Practices

Expertise

Innovation

Results

Strategy & Planning
- Enterprise IT Strategy
- Planning & Requirements
- Enterprise Technical Architecture
- Procurement Support

Project Assurance
- Project Management / PMO
- Independent Verification & Validation (IV&V)
- Quality Assurance
- User Acceptance Testing

Technology Design and Implementation
- Technical System Design
- Business Process Design
- Software Development and Testing
- Deployment and Training

© 2013 CSG Government Solutions
Program Integrity

- Set of programs
  - Controlling Waste, Fraud, & Abuse
  - Contain costs
  - Enforce rules
  - Recover unwarranted expenditures

- Stakeholders
  - State Medicaid Agencies
  - CMS
  - Members
  - Taxpayers
“The United States spends more than $2.5 trillion on health care annually, and rough estimates indicate that anywhere from 3 to 10 percent of all health care expenditures are attributed to fraud.”

— FBI Special Agent David Welker (May 2012)

$75 B - $250 B annually
Medicaid Expenditures

- 2011 – $410 Billion *(Kaiser Foundation)*
  - $12B to $41B in F&A *(Agent Welker’s estimate)*

Medicaid recoveries

- 2010 – $1.9 Billion
- 2011 – $1.7 Billion
- 2012 – $2.9 Billion
Providers

- Traditional Fee-For-Service claims
  - Providing unnecessary services
  - Overstating services rendered
  - Improper procedure coding

- Managed care plans
  - Not providing covered services
  - Using substandard materials and techniques
  - Undetected provider F&A activities

- Pharmacies
  - Prescription shorting
  - Prescription diversion

- System or staff errors
Types of Activities Targeted

- **Members**
  - Fraudulent eligibility
  - Sharing of credentials
  - Accepting unnecessary services

- **Provider and Agency Employees**
  - Fake provider enrollments
  - Altered provider information
  - Fake claims
CMS PI Activities

- **SURS**
  - Early approach to Program Integrity
- **Post-payment audits of providers**
  - Medicaid Integrity Contractors (MIC)
  - Recovery Audit Contractors (RAC)
- **National Correct Coding Initiative**
  - Policies and edits for proper procedure code usage
CMS PI Activities

- Program Integrity Reviews
  - Assessments of state PI activity
- MITA Business Architecture
  - Performance Management business processes
- Business Results Condition
  - Accurate adjudication of claims
- Medicaid Fraud Control Units
  - Operated by HHS OIG, State AG/IG
State Responsibilities – Planning and Control

- Regulation
  - Adherence to guidance
  - Establish policies
  - Periodic review and update

- Organization
  - Program Integrity units
  - Staff training and certification
  - Collaboration with MFCU

- Implementation
  - Controls in System and Business Processes
State Responsibilities – Prevention

- **Provider screening**
  - Data verification
  - Social analysis
  - Interagency collaboration
  - Use of exclusion lists

- **Education**
  - Providers
  - Members
  - Staff and contractors

- **Deterrence**
  - High likelihood of detection
  - Significant penalties
State Responsibilities – Detection

- Post-payment
  - Traditional *pay and chase*
  - Relies on data collection & aggregation, static and ad hoc reports, tips
  - Ineffective against *hit and run*
  - Collections more difficult as time goes by

- Predictive / pre-emptive
  - Include analytics in claim adjudication
  - Hold questionable claims for manual review
  - Relies on large volumes of data, analytical models, integration with claims engine
  - Not as useful for MC encounters
State Responsibilities

- **Investigation**
  - Case Management
    - Multi agency cooperation
    - Full case lifecycle including archives
  - Evidence capture
    - Cataloging existing evidence
    - Alerts on new related activity

- **Prosecution**
  - Program sanctions
    - Exclusion lists
  - Civil and/or criminal penalties
  - Recovery
Pre-emptive Fraud and Abuse Detection

Date 9/10/2013  Time 7:25 pm
Reg#  Cashier  Trans#  Store
4      356419  397636  168

Voicemail
Name: 64-4864
Date: 7:35 PM
Location: IN
Time: 9:05 PM
Potential Changes in the PI World

- Expanded use of online systems
  - Medical Identify Theft
  - Phishing and fraudulent web sites
- New eligibility rules
  - More opportunity for human or system errors
- Growth in Medicaid population
  - More opportunity for F&A
  - More unsuspecting / vulnerable members
Potential Changes in the PI World

- **Move to Managed Care**
  - Does not relieve SME responsibilities
  - Encounter data supplements claim data
  - MCOs have own opportunities for F&A
  - Providers and members continue their F&A

- **Health care an easy target**
  - Expanded organized crime activities
  - Globalization of criminal activities and scams
Calculating future incident volumes

- **O** = Occurrences of fraud last year
- **E** = total Medicaid Expenditure
- **R** = number of Recipients
- **M** = Growth Multiple over next 5 years

How many fraud cases can you expect in the future?

MORE
Considerations Moving Forward

- **Enabling technologies**
  - More data and analytics
    - Predictive and social modeling
    - Geospatial analysis
    - Pre-emptive detection
  - Case management
  - Evidence management
Considerations Moving Forward

- Interagency cooperation
  - Updated policies
  - Appropriate staffing levels and skill sets
  - Data sharing with collaborative governance
    - Providers
    - Sanctions
    - Claims and encounters
  - System integration
Considerations Moving Forward

- Educating providers and the public
  - Awareness of rules
  - Vigilance against fraud
  - Likelihood and cost of getting caught
Agenda

- Integrity Flavors
- PI Approaches
- Architectural Implications
- State PI Viewpoint
- Future of State PI Initiatives
Recent Medicaid Fraud Example

Alleged Fraud in Illinois Consumer-Directed Program Brings Calls for Legislative Action

September 5, 2013

In Illinois, 25 people have been indicted for committing fraud in the Home Services Program, the state’s Medicaid consumer-directed care program which serves individuals with severe disabilities up to age 60 and employs approximately 28,000 personal care assistants.

Following two waves of indictments that took place on May 24 and July 11, a total of 18 personal care assistants and 11 consumers were indicted by Stephen Wigginton, United States Attorney for the Southern District of Illinois, for receiving Medicaid funds to which they were not entitled.

The charges carry a maximum penalty of 10 years of imprisonment, a $250,000 fine, and up to 3 years of supervised release, according to a press release issued by Wigginton’s office.

After receiving “numerous complaints” about the Home Services Program, an investigation was initiated to root out fraud, the release explains, and uncovered these abuses in the Home Services Program:

- Services were being billed, but not performed, because the personal care aide was in jail or out of town.
- The client was residing in a hospital, a nursing home, or out of town at the time the services were supposedly rendered in the home.
- Some personal care aides and clients were receiving the Medicaid payments for services not rendered and split the paychecks.
Guarding against improper information modification or destruction and includes ensuring information nonrepudiation and authenticity.

Integrity is perhaps the most complex and misunderstood characteristic of information.

Some texts define integrity as "assets (which) can only be modified by authorized parties." Such a definition unnecessarily confines the concept to one of access control.

Data integrity calls for a comprehensive set of functions to promote accuracy and completeness as well as security.
PI Approaches

- Agency Specific
  - Siloed ... Typical approach of recent years that is isolated to state Medicaid agency

- Enterprise Solutions and Programs
  - Multi-Agency (Single Department within the State)
  - Multi-Departmental
    - Architectural differences
    - Data governance
    - Enterprise decision support
      - Case management
      - Multi-agency alerts
    - Funding
    - State staff resources

**Bottom Line:** The move to a wide spanning enterprise Program Integrity approach can be beneficial, but requires extra coordination and considerations.
# Architecture – Conceptual Integrity

## Systems Architecture

<table>
<thead>
<tr>
<th>Principle or Property</th>
<th>The ability of an architecture to . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Versatility</td>
<td>... offer “good enough” mechanisms to address a variety of problems with an economy of expression.</td>
</tr>
<tr>
<td>Conceptual Integrity</td>
<td>... offer a single, optimal, nonredundant way for expressing the solution of a set of similar problems.</td>
</tr>
<tr>
<td>Independently Changeable</td>
<td>... keep its elements isolated so to minimize the number of changes required to accommodate changes.</td>
</tr>
<tr>
<td>Automatic Propagation</td>
<td>... maintain consistency and correctness, by propagating changes in data or behavior across modules.</td>
</tr>
<tr>
<td>Buildability</td>
<td>... guide the software’s consistent and correct construction.</td>
</tr>
<tr>
<td>Growth Accommodation</td>
<td>... cater for likely growth.</td>
</tr>
<tr>
<td>Entropy Resistance</td>
<td>... maintain order by accommodating, constraining, and isolating the effects of changes.</td>
</tr>
</tbody>
</table>
Conceptual Integrity

- A set of abstractions and the rules for using them throughout the system as simply as possible
- Consistencies in things such as decomposition, criteria, application of design patterns, and data formats

**Bottom Line:** A good system architecture exhibits conceptual integrity; that is, it comes equipped with a set of design rules that aid in reducing complexity and that can be used as guidance in detailed design and in system verification.
Home Services Program Architecture

Node Connectivity Diagram
Home Services Program

Legend
- Need Line
- Node
- State
- Contractor

Table:
- **Description**: Client contacts the client to check the legitimacy of the application. Case Coordinator creates client record in a custom application.
- **Mode**: Telephone

<table>
<thead>
<tr>
<th></th>
<th>Program Staff</th>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Client</td>
<td>N</td>
</tr>
<tr>
<td>b</td>
<td>CILs</td>
<td>N</td>
</tr>
<tr>
<td>c</td>
<td>Providers</td>
<td>N</td>
</tr>
<tr>
<td>d</td>
<td>Program Staff</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Program Staff</th>
<th>Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>e</td>
<td>Provider</td>
<td>N</td>
</tr>
<tr>
<td>f</td>
<td>Fiscal</td>
<td>Y</td>
</tr>
</tbody>
</table>

9/11/2013 © 2013 CSG Government Solutions
Healthcare Fraud Types
- Patient Fraud
- Provider Employee Fraud
- Payer Fraud
- Employer Fraud
- Vendor Fraud
State Law Listings (IL & MI)

<table>
<thead>
<tr>
<th>Administrative Code</th>
<th>Part</th>
</tr>
</thead>
<tbody>
<tr>
<td>89 Ill. Adm. Code 102 (pdf)</td>
<td>Rights and Responsibilities</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 104 (pdf)</td>
<td>Practice in Administrative Hearings</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 110 (pdf)</td>
<td>Application Process</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 119 (pdf)</td>
<td>Special Eligibility Groups</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 119 (pdf)</td>
<td>Pharmaceutical Assistance Program</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 120 (pdf)</td>
<td>Medical Assistance Programs</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 122 (pdf)</td>
<td>Covering All Kids Health Insurance Program</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 125 (pdf)</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 127 (pdf)</td>
<td>State Responsibility for Medicare Part D Low-Income补贴</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 128 (pdf)</td>
<td>Veterans Health Insurance Program</td>
</tr>
<tr>
<td>89 Ill. Adm. Code 140 (pdf)</td>
<td>Medical Payments</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 142 (pdf)</td>
<td>MedPlan Plus (Repealed)</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 143 (pdf)</td>
<td>Managed Care Community Networks</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 145 (pdf)</td>
<td>Mental Health Services in Nursing Facilities</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 146 (pdf)</td>
<td>Specialized Health Care Delivery Systems</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 147 (pdf)</td>
<td>Reimbursement for Nursing Costs for Geriatric Facilities</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 148 (pdf)</td>
<td>Hospital Services</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 149 (pdf)</td>
<td>Diagnoses Related Grouping (DRG) Prospective Payment System (PPS)</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 152 (pdf)</td>
<td>Hospital Reimbursement Changes</td>
</tr>
<tr>
<td>80 Ill. Adm. Code 153 (pdf)</td>
<td>Long Term Care Reimbursement Changes</td>
</tr>
</tbody>
</table>

**Community Health**

<table>
<thead>
<tr>
<th>Michigan Administrative Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services Administration:</td>
</tr>
<tr>
<td>Health Maintenance Organizations</td>
</tr>
<tr>
<td>EMS Organization Licensure Rules</td>
</tr>
<tr>
<td>EMS - Personnel Licensure and Regulation Rules</td>
</tr>
<tr>
<td>Enforcement System for Long-Term Care Facilities</td>
</tr>
<tr>
<td>State Vendor Participation in Medical Costs</td>
</tr>
<tr>
<td>Medical Assistance for the Aged</td>
</tr>
<tr>
<td>Adult Home Help Service Payments</td>
</tr>
<tr>
<td>Medical Assistance Program</td>
</tr>
<tr>
<td>MSA Provider Hearings</td>
</tr>
<tr>
<td>Prohibition of Discrimination in the Medical Assistance Program and General Assistance Program</td>
</tr>
<tr>
<td>Sterilization and Hysterectomy Consent Procedures</td>
</tr>
</tbody>
</table>

9/11/2013
# Typical Analyst Routine/Data Checklist

<table>
<thead>
<tr>
<th>Left Column</th>
<th>Right Column</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion Analysis and Data Pull</td>
<td>Hospital Self Disclosure verifications</td>
</tr>
<tr>
<td>Access to Care analysis</td>
<td>Hospital Utilization Report</td>
</tr>
<tr>
<td>Asthma Study</td>
<td>Lean Drug prescribers</td>
</tr>
<tr>
<td>Correct Coding Initiative (CCI) Edits</td>
<td>LTC Audits</td>
</tr>
<tr>
<td>Dental Double Billing</td>
<td>Multiple Companies Using the Same Vehicle License Number (VLN)</td>
</tr>
<tr>
<td>Department of Revenue Cross Match</td>
<td>Multiple Services Provided Within the Same Week</td>
</tr>
<tr>
<td>Electronic Health Records (EHR) – Provider Incentive Payment Eligibility</td>
<td>Optical Overuse</td>
</tr>
<tr>
<td>Excessive Allergy Services</td>
<td>Paying for scripts that have been terminated by the DEA</td>
</tr>
<tr>
<td>FFS Claim vs. All-Inclusive</td>
<td>Pharmacological Management</td>
</tr>
<tr>
<td>Food Stamps on Craigslist</td>
<td>Physicians Receiving Money from their own Practice</td>
</tr>
<tr>
<td>GIS Network Analysis</td>
<td>Physician with Ownership of Pharmacy</td>
</tr>
<tr>
<td>Group Psych</td>
<td>Postmortem Analysis</td>
</tr>
<tr>
<td>High Volume of Inpatient Detox at multiple hospitals</td>
<td>Prescription Monitoring Program</td>
</tr>
<tr>
<td>Home Health</td>
<td>Emergency Room (ER) J Code Abuse</td>
</tr>
<tr>
<td></td>
<td>Time Dependent Billing</td>
</tr>
<tr>
<td></td>
<td>Transportation</td>
</tr>
<tr>
<td></td>
<td>Weekend and Holiday Services</td>
</tr>
</tbody>
</table>
State PI Viewpoint

- **Data Sources Across Departments**
  - Medicaid Claims
  - Public Assistance Eligibility
  - EBT Transactions
  - Unemployment Insurance Tax and Benefit
  - Incarceration
  - Corporate and License
  - Workers’ Compensation
  - Civil Services
  - Drivers License and Vehicle Registration
  - Federal/State Wage and Tax
  - Social Security Administration
  - LexisNexis
  - Network IP Addresses
  - Business Telephone Directory
  - Address Patterns
  - Hunting/Fishing Licenses

**Bottom Line:** The more cross mapping accomplished the better the opportunity to catch fraud
State Fraud Detection Systems

- Typical requirements/expectations for a State Fraud Detection System:
  - Implement a commercial off-the-shelf (COTS) solution able to provide fraud detection based on State and Federal guidelines
  - Reduce the percentage of overpaid benefits from the baseline level as detailed in the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and E.O. 13520
  - Identify and report fraud characteristics by individuals or groups based on information derived from multiple data sources using data analytics
  - Recognize patterns in data that reveal organized attempts at fraud
  - Reduce the number and amount of improper payments as reported quarterly
  - Reduce the number and amount of overpayments
  - Recognize patterns in data that reveal organized attempts to defraud public assistance programs
  - Increase program integrity in public assistance programs
Periodic Reporting

**Diagnosis-Related Group (DRG) Inpatient Audits**
Audits performed as part of the Inpatient Hospital Audit Program (IHAP) began in the latter part of fiscal year 2010. All IHAP audits are conducted by vendors under contract with the state. Ten (10) IHAP audits were completed in Calendar Year 2010, and the findings were subsequently distributed to providers during Calendar Year 2011. The combined potential recoupment of these audits was over $4 million.

**Local Education Agency (LEA) - Technical Assistance Reviews**
A federal Payment Error Rate Measurement (PERM) review determines that the records submitted for PERM review by the LEA deviated from the policies of the Medicaid Assistance Program. In response, the state developed a Technical Assistance Review (TAR) for providers who had submitted records that deviated. The LEA must identify inappropriate payments and ensure coverage of covered/non-covered claims. The pilot study of this review process includes the approach of using validated estimates that by conducting the review could improve compliance with program rules.

**Noteworthy Practices**
As part of its comprehensive review process, the CMS review team has identified three practices that merit consideration as noteworthy or “best” practices. The CMS recommends that other states consider emulating these activities.

**Predictive Modeling System**
The HFS-OIG has developed an in-house predictive modeling system that will utilize cutting-edge predictive modeling techniques to detect aberrant provider behaviors at the earliest possible time. While the fraud prevention applications of the tool have yet to be fully tested and applied, the system has created a comprehensive provider profile report that is already in use. It offers a consolidated snapshot of provider patterns and activities drawing on data from diverse sources and different parts of the agency. The profile report gives HFS-OIG staff quick access to complete up-to-date information on providers of interest as they plan investigations, audits or quality of care reviews. Without it, staff would have to wait lengthy periods for different parts of the agency to supplement baseline data with other relevant information.

The provider profile tool has been utilized in the 180 day monitoring of probationary NET providers and the ongoing audits of transportation providers since March 2009. According to State data, the cost avoidance realized for disenrolling or terminating probationary providers in calendar year (CY) 2010 was $276,478. Likewise, the profiling tool helped Illinois establish a recoupment target of $227,330 as the basis for transportation provider audits. Moreover, as part of the State’s work on provider...
Medicaid Program Integrity Trends and Challenges Include:

- Complexity of software solutions
- Large volume of referrals
- Diminishing staff
- Smarter fraudsters
- Identity Theft
Future of State Program Integrity Initiatives

- Benefits of Enterprise Approach to Fraud Detection Systems and Programs Include:
  - Very high potential for determining increased overpayments
  - Uncover complex multi-program fraud
  - Consolidate fraud resources and costs where possible
Thank you!

**Dale Posont**  
*Senior Principal*  
(815) 546-5677  
DPosont@CSGdelivers.com  
[www.CSGdelivers.com](http://www.CSGdelivers.com)

**Rusty Simmons**  
*Senior Consultant*  
(217) 622-6285  
RSimmons@CSGdelivers.com  
[www.CSGdelivers.com](http://www.CSGdelivers.com)