

# California ICD-10 Site Visit

Training segments to assist the State of California with ICD-10 Implementation

## Segment 2: Program Integrity

June 10 - 11, 2013

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graph TD; A[MITA and ICD10 Support National Quality Strategy] --> B[ICD-10 Overview]; B --> C[Analytics & Reporting]; C --> D[Program Integrity]; D --> E[Policy Remediation Best Practices]; E --> F[Managed Care]; F --> G[Claims Management]; G --> H[Provider Communication];
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**Agenda**

- **Program Integrity**
  - Background
  - Federal and State Actions
  - Identifying Cases
  - Conclusions

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### Purpose of the slide

Introduce the agenda for a session covering ICD-10 impacts, opportunities, and examples specific to SMA operations in the area of program integrity.

### Talking Points

- None

# Program Integrity

Background

**Purpose of the slide**

Introduce background slides in order to discuss ICD-10 impacts, opportunities, and examples in the area of program integrity.

**Talking Points**

- None



**CMS ICD-10**  
Official Medicare Reimbursement for ICD-10 Transition  
[www.cms.gov/ICD10](http://www.cms.gov/ICD10)

## Background

The Scope of the Problem

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Fraud & Abuse	(3-10%)
+ Waste	(15-30%)
<b>Total Loss</b>	<b>(25-33%)</b>



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#### Purpose of the slide

Discuss the general scope of the fraud, waste, and abuse and the potential opportunities and impact of ICD-10.

#### Talking Points

- Estimates of fraudulent billings to health care programs, both public and private, are between 3 and 10 percent of total health care expenditures.
- The federal government lost at least \$64 billion to fraud, waste and improper payments in 2011.
- Studies have consistently shown that up to 33% of total health expenditures do little to nothing to improve health.
- In 2012 IOM report, it estimated that \$750 billion was wasted on inefficient spending and care in 2009.

#### Source(s):

- FBI Financial Crimes Report 2010-2011. <http://www.fbi.gov/stats-services/publications/financial-crimes-report-2010-2011>. Accessed 1/12/13.
- HHS Office of Inspector General. "Semiannual Report to Congress April 1, 2012 – September 31, 2012." <https://oig.hhs.gov/reports-and-publications/archives/semiannual/2012/fall/sar-f12-fulltext.pdf>. Accessed 1/12/13.
- Thompson Reuters. "WHERE CAN \$700 BILLION IN WASTE BE CUT ANNUALLY FROM THE U.S. HEALTHCARE SYSTEM?" [http://www.ncrponline.org/PDFs/2009/Thomson\\_Reuters\\_White\\_Paper\\_on\\_Healthcare\\_Waste.pdf](http://www.ncrponline.org/PDFs/2009/Thomson_Reuters_White_Paper_on_Healthcare_Waste.pdf). Accessed 6/12/12.
- <http://www.reuters.com/article/2009/10/26/us-usa-healthcare-waste-idUSTRE59P0L320091026>

- IOM. "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America." [http://www.nap.edu/catalog.php?record\\_id=13444](http://www.nap.edu/catalog.php?record_id=13444). Accessed 1/12/13.



**CMS ICD-10**  
Official Medicare Standard for the ICD-10 System  
www.cms.gov/ICD10

# Background

## The Villains and Their Targets

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- **Fraud**: an intentional act of deception, misrepresentation, or concealment in order to gain something of value
- **Waste**: over-utilization of services (not caused by negligent actions) or the misuse of resources
- **Abuse**: excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices
- Fraud, Waste, and Abuse will be in every phase of every program and will include acts of both commission and omission



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graph LR
    A[Eligibility] --> B[Coverage]
    B --> C[Payment]
  
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#### Purpose of the slide

Define fraud, waste, and abuse and discuss recent studies that quantify their magnitude and composition.

#### Talking Points

- **FRAUD (defined in 42 CFR 455.2)**
  - Estimates of fraudulent billings to health care programs, both public and private, are between 3 and 10 percent of total health care expenditures. [FBI Financial Crimes Report. 2008]
  - The National Health Care Anti-Fraud Association estimates that fraud amounts to at least three percent of total health care spending, or more than \$60 billion per year.
- **WASTE**
  - One recent study looked into the top 5 overused clinical activities across 3 primary care specialties and found over \$5B in waste
  - Another study found that nearly \$6.8 billion is wasted each year on only 12 unnecessary tests and treatments (antibiotics for viral ear infections being an example).
  - And finally, a Senate Subcommittee found "analysis of blood glucose test strips and 17 other DME items found millions of claims that contained questionable diagnosis codes totaling more than \$1 billion...In short, the Subcommittee's investigation found that the diagnosis code requirement appears to be a mandate with little substantive purpose."
  - In April 2012, nine specialty societies collectively representing about 375,000 physicians nationwide, released a list of five procedures or tests for each of the nine specialties that they think their colleagues should think twice before ordering. The announcement is the result of a two-year effort led by the ABIM Foundation, in partnership with *Consumer Reports*, to educate physicians and patients about potentially unnecessary care through a campaign called 'Choosing Wisely'
- **ABUSE (defined in 42 CFR 455.2)**

#### Source(s)

- <http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/Michelle-Andrews-On-Unnecessary-Tests-And-Treatments.aspx>
- [http://hsgac.senate.gov/public/index.cfm?fuseAction=Files.View&FileStore\\_id=9d823f69-82c8-4181-a5d9-37fede899a-](http://hsgac.senate.gov/public/index.cfm?fuseAction=Files.View&FileStore_id=9d823f69-82c8-4181-a5d9-37fede899a-)
- [http://archinte.ama-assn.org/cgi/content/full/archinternmed.2011.501v2\]](http://archinte.ama-assn.org/cgi/content/full/archinternmed.2011.501v2)
- [http://choosingwisely.org/wp-content/uploads/2012/03/033012\\_Choosing-Wisely-National-Press-Rls-FINAL.pdf](http://choosingwisely.org/wp-content/uploads/2012/03/033012_Choosing-Wisely-National-Press-Rls-FINAL.pdf)



## Background

Program Integrity – Sounds Great But What is it?

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- **Medicaid Program Integrity - the planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse**
- **HHS OIG's 5 five principles of effective program integrity**
  1. Enrollment: Scrutinize individuals and entities that want to participate
  2. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice
  3. Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements
  4. Oversight: Vigilantly monitor programs for fraud, waste, & abuse
  5. Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy vulnerabilities

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### Purpose of the slide

Introduce some basics as to the definition of Medicaid Program Integrity and 5 principles of effective program operation.

### Talking Points

- Increases funding for the Health Care Fraud and Abuse Control fund to fight fraud in public programs. The Office of Management and Budget estimates that every \$1 invested to fight fraud results in approximately \$17 in savings.
- And for every dollar invested in investigating fraud over the past three years, the government recovered \$7.90, according to Reuters. Reuters. That is the highest three-year average since the fraud and abuse program launched in 1997.

### Source(s)

- CMS. Medicaid Program Integrity Manual. <https://www.cms.gov/manuals/downloads/mpi115c17.pdf>. Accessed 12/21/2011.
- Reuters. <http://www.reuters.com/article/2013/02/11/us-healthcare-fraud-idUSBRE91A0ZO20130211>. Accessed 2/13/13.

### Note(s)

- For an excellent discussion of fraud and abuse relative to State Medicaid Programs, see "Information Systems Can Help Prevent, but Not Eliminate, Health Care Fraud and Abuse," a paper prepared by Kentucky's Legislative Research Commission and adopted 6/8/06.  
[http://www.lrc.ky.gov/lrcpubs/RR%20333\\_forweb.pdf](http://www.lrc.ky.gov/lrcpubs/RR%20333_forweb.pdf). Accessed 12/27/2011.



**CMS ICD-10**  
Official CMS Codes, Approved for the ICD-10 Transition  
www.cms.gov/ICD10

# Background

The Types of Fraud and Abuse We Know About

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- **Providers/suppliers**
  - Billing of unperformed services (DIDN'T DO IT)
  - The deliberate delivery of unnecessary and inappropriate services for the express purpose of receiving the payment (SHOULD NOT HAVE DONE IT)
  - Intentional misrepresentation of services that result in higher payments (DIDN'T DO IT TO THE LEVEL THEY SAID THEY DID)
- **Recipients**
  - Intentional misrepresentation of information in order to gain eligibility and/or enrollment (SHOULD NOT BE ENTITLED)
  - Intentional misrepresentation of information in order to gain access to treatments not medically necessary (SHOULD NOT BE COVERED)



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### Purpose of the slide

Discuss the basic types of fraud and abuse we know about.

### Talking Points

- None



## Background

Examples of Provider Fraud and Abuse

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- **Billing for services not performed**
- **Billing for duplicate times for one service performed**
- **Falsifying a diagnosis**
- **Misrepresenting procedures (billing for a covered service when a non-covered service was performed)**
- **Upcoding – billing for a more costly service than was performed**
- **Accepting kickbacks for patient referrals**
- **Waiving copays or deductible amounts**
- **Unbundling and fragmenting**
- **Misuse of modifiers**
- **Prescribing medicines that are not medically necessary or for use by people other than the patient**

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### Purpose of the slide

Discuss some examples of provider Fraud and Abuse.

### Talking Points

- None



## Background

Examples of Recipient Fraud and Abuse

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- **Recipient Eligibility**
  - Resource misrepresentation
  - Ineligible member using eligible member's services
  - Misrepresentation of medical condition
  - Failure to report third party liability (TPL)
  - Eligibility determination issues
  
- **Recipient Coverage and Payment**
  - Filing a claim for services or products not received
  - Obtaining medications or products that are not needed
  - Providing false information for coverage of product/service
  - Doctor shopping to get one or multiple prescriptions
  - Using someone else's insurance coverage for services

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### Purpose of the slide

Discuss some examples of recipient Fraud and Abuse.

### Talking Points

- None



# Background

Managed Care Brings New Opportunities and New Challenges





Office of Medicare Programs for the ICD-10 Transition  
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## Background

“Follow the Money”

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**BUSINESS**

**WellCare finalizes settlement on Medicaid fraud charges**

The managed care organization signs what it hopes is the last legal and regulatory agreements stemming from 2008 allegations.

By EMILY BERRY, amednews staff. *Posted May 25, 2011.*

**HEALTH CARE BUSINESS**

**Hospitals Evade Audits, Penalties with Observation Status**

The controversial hospital strategy may be a loophole in Medicare cost-containment efforts on admissions. By documenting observation status rather than admissions, hospitals can avoid the Medicare penalties associated with readmissions and the close scrutiny of auditors on admission claims.

By KAREN CHEUNG, Fierce Healthcare. *Posted June 5, 2012.*

**HEALTH CARE BUSINESS**

**Medicare Overpaid PacifiCare \$424 Million for Unsupported Diagnoses**

A report from the U.S. Department of Health & Human Services' Office of Inspector General found that PacifiCare's risk assessments often made its members sicker than they were. Because Medicare pays insurers a higher rate for members with more serious conditions, PacifiCare inappropriately received too much money to insure the patients.

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### Talking Points

- We all know about the typical fraud cases, like the \$300M and \$400M fraud busts over the past year but the changing nature of payment for health care services means that the nature of fraud is changing as well.
- Medicare recommends that patients be in observation care for no more than 24 to 48 hours but says that the number who are in observation care for more than 48 hours more than doubled to 7.5 percent between 2006 and 2010. Researchers at Brown University have also documented a sharp rise in observation care for Medicare patients - up 25% from 2007 to 2009 - even though Medicare enrollment and hospital admissions have declined slightly.

### Source(s)

- <http://www.ama-assn.org/amednews/2011/05/23/bise0525.htm>
- <http://www.fiercehealthcare.com/story/hospitals-evade-audits-penalties-observation-status/2012-06-05>
- <http://www.fiercehealthpayer.com/story/medicare-overpaid-pacificare-424m-unsupported-diagnoses/2012-12-19>
- OIG. <https://oig.hhs.gov/oas/reports/region9/90900045.pdf>
- See articles from Kaiser Health News on readmissions: <http://www.kaiserhealthnews.org/Stories/2012/August/10/medicare-seniors-nursing-home-observation-care.aspx>, <http://www.kaiserhealthnews.org/Stories/2012/August/13/readmissions-sources-and-methodology.aspx>, and <http://www.kaiserhealthnews.org/Stories/2012/August/13/medicare-hospitals-readmissions-penalties.aspx>

 Official CMS Industry Resources for the ICD-10 Transition  
www.cms.gov/ICD10

## Program Integrity



Federal and State Actions

### Purpose of the slide

Introduce slides covering Federal and State actions in order to discuss ICD-10 impacts, opportunities, and examples in the area of program integrity.

### Talking Points

- None



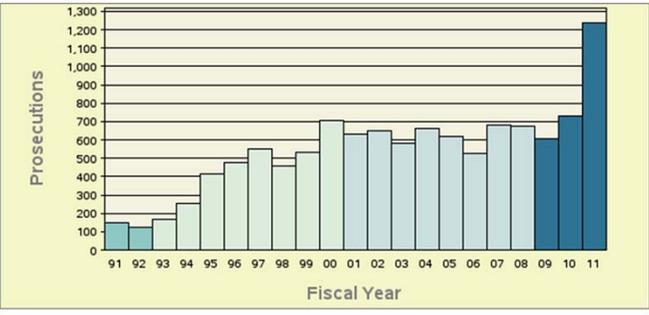
**CMS ICD-10**  
Official CMS Codes Adopted to ICD-10 Standard  
[www.cms.gov/ICD10](http://www.cms.gov/ICD10)

## Federal and State Actions

Working Harder

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- “...Good news is there’s lots of prosecutions...Bad news is there’s lots of prosecutions. The real question is what will CMS do to prevent frauds from taking place in the first place.”



Fiscal Year	Prosecutions (Approximate)
91	150
92	120
93	180
94	250
95	350
96	450
97	550
98	450
99	550
00	700
01	650
02	650
03	600
04	650
05	600
06	550
07	650
08	650
09	600
10	700
11	1250

- “At the end of the day, we can’t enforce our way out of this problem.”

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#### Purpose of the slide

Discuss the increasing focus on enforcement of fraud and abuse and the need to work smarter to prevent fraud in the first place.

#### Talking Points

- In FFY 2012, the Department of Justice recovered more than \$3 billion from health-related fraud, which is an increase over the \$3 billion in civil settlements and judgments from FFY 2011. Additionally, when restitution is factored in, over \$4 billion was returned to the Federal government.
- For FFY 2012, OIG reported expected recoveries of about \$6.9 billion consisting of \$923.8 million in audit receivables and \$6 billion in investigative receivables, which the Inspector General attributes to the improved used of analytical tools. Expected HHS receivables averaged \$4.2 billion a year between 2008 and 2012, according to annual reports from those years.
- Additionally, CMS’ Recovery Audit Contractors (RACs) collected record-high \$2.29B in overpayments during FFY 2012, which is about a 300% increase from previous year.
- Despite federal officials touting the recoveries, they acknowledged such recoveries are the result of the so-called pay-and-chase model, which the federal government is moving away from in favor of systems that seek to prevent fraudulent payments. Such initiatives include new authorities granted by the Affordable Care Act to allow federal healthcare programs to suspend payments if “credible” fraud allegations are received.

#### Source(s)

- Transactional Records Access Clearinghouse at Syracuse University. <http://trac.syr.edu/tracreports/crim/270/>. Accessed 12/31/2011.
- Department of Health and Human Services and Department of Justice. “**Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011.**” <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf>. Accessed 2/23/2012.
- CMS. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/National-Program-Corrections-FY-2012-4th-Qtr-2012.pdf>. Accessed 1/12/13.
- Goozner, M. “**Feds Winning Battle against Health Care Fraud**”. The Fiscal Times. 12/15/2011. Quote is from Louis Saccoccio, chief

executive officer of the National Health Care Anti-Fraud Association.

- U.S. Department of Justice. "**Justice Department Recovers \$3 Billion in False Claims Act Cases in Fiscal Year 2011.**" <http://www.justice.gov/opa/pr/2011/December/11-civ-1665.html>. Accessed 12/22/2011.
- U.S. Department of Justice. "**Justice Department Recovers Nearly \$5 Billion in False Claims Act Cases in Fiscal Year 2012.**" <http://www.justice.gov/opa/pr/2012/December/12-ag-1439.html>. Accessed 1/12/13.
- HHS Office of Inspector General. "**Semiannual Report to Congress April 1, 2012 – September 31, 2012.**" <https://oig.hhs.gov/reports-and-publications/archives/semiannual/2012/fall/sar-f12-fulltext.pdf>. Accessed 1/12/13.



## Federal and State Actions

The Need to Work Smarter in Medicare

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- In 2011, CMS began instituting its ‘twin pillars’ approach using predictive modeling technology to combat fraud
  - Fraud Prevention System (FPS), which uses fraud propensity scores to look for suspicious billing patterns
  - Automated Provider Screening (APS) system, which helps identify ineligible providers/suppliers prior to enrollment or revalidation
- **Intent is for anti-fraud systems to be proactive, similar to the way credit card companies detect suspicious purchases**
- In 2012, CMS began two demonstrations:
  - Recovery Audit Prepayment Demonstration in 11 states, allowing RACs to conduct prepayment claim reviews for Medicare
  - Prior Authorization for Certain Medical Equipment Demonstration in 7 states

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#### Talking Points

- The Affordable Care Act and other legislation directed the federal government to start using sophisticated anti-fraud computer systems. CMS says the systems, which are being used first in the Medicare program, are similar to those used by credit card companies to detect suspicious purchases.
- But in an Oct 2012 report, the GAO found that the FPS had not yet been integrated with the agency’s payment-processing system to allow for the prevention of payments until suspect claims can be determined to be valid. CMS stated that this functionality has been delayed due to the time required to develop system requirements; they estimated that it will be implemented by January 2013.
- In its 2012 Report to Congress, CMS stated that the new anti-fraud systems had saved the Medicare program about \$115 million since it launched in the summer of 2011
- In June 2012, CMS began a three-year project testing prepayment review of certain procedures in 11 states (California, Florida, Illinois, Louisiana, Pennsylvania, Michigan, Missouri, New York, North Carolina, Ohio and Texas). The demonstration focuses on types of claims with high improper payment rates, such as those associated with short inpatient hospital stays.
- In Sept 2012, CMS begins a three-year Medicare demonstration project requiring prior authorization for power mobility devices prescribed in California, Florida, Illinois, Michigan, New York, North Carolina and Texas.

#### Source(s)

- <http://www.kaiserhealthnews.org/Stories/2012/August/21/medicare-fraud.aspx>. Accessed 1/12/13.
- GAO. <http://www.gao.gov/assets/650/649537.pdf>. Accessed 1/12/13.
- <http://www.ihealthbeat.org/articles/2012/11/30/gao-says-cms-should-do-more-to-prevent-health-care-fraud.aspx>. Accessed 1/12/13.
- CMS. “Report to Congress: Fraud Prevention System, First Implementation Year (2012).” <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>. Accessed 1/12/13.
- <http://www.ihealthbeat.org/articles/2012/12/17/fraud-detection-system-helped-medicare-save-115m-cms-says.aspx>. Accessed 1/12/13.
- <http://www.ihealthbeat.org/articles/2012/12/18/agency-finds-flaws-in-cms-new-fraud-prevention-technology.aspx>. Accessed 1/12/13.

- CMS. <http://oversight.house.gov/wp-content/uploads/2012/06/6-7-12-GovOrg-Budetti.pdf>. Accessed 6/12/12.
- REUTERS. Government signs on insurers to fight healthcare fraud. <http://www.reuters.com/article/2012/07/27/us-healthcare-fraud-idUSBRE86Q01420120727>. Accessed 8/13/12.
- [http://www.washingtonpost.com/business/capitalbusiness/two-local-contractors-handling-two-pronged-cms-approach-to-fraud/2012/06/01/gJQA74p7BV\\_story.html](http://www.washingtonpost.com/business/capitalbusiness/two-local-contractors-handling-two-pronged-cms-approach-to-fraud/2012/06/01/gJQA74p7BV_story.html). Accessed 6/12/12.
- CMS. Recovery Auditor Prepayment Review Demonstration slide set. [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/downloads/RAC\\_Prepay\\_slides.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/downloads/RAC_Prepay_slides.pdf). Accessed 6/12/12.



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## Federal and State Actions

The Need to Work Smarter in Medicaid

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- In 2007, HHS Office of Inspector General report found challenges with the reporting of encounter data and found that 15 of 40 applicable States did not report encounters
- Since 2008, HHS has operated the National Medicaid Audit Program (NMAP), which uses Medicaid data from Federal systems and has conducted over 1550 audits but only recovered \$20 million after costing over \$102 million.
- HHS Regional Inspector General Ann Maxwell stated to a House Committee, much of the data that is mined and analyzed to identify overpayments and fraud in Medicaid is not 'current, available, complete, [or] accurate.'

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#### Purpose of the slide

Discuss some recent Federal and State actions to combat fraud and abuse.

#### Talking Points

- None

#### Source(s)

- <http://www.forbes.com/sites/insider/2012/06/14/medicaid-claims-data-is-it-really-health-care-fraud/>. Accessed 8/13/12.
- <http://articles.latimes.com/2012/jun/14/nation/la-na-medicaid-fraud-20120615>. Accessed 8/13/12.



## Federal and State Actions

Working Smarter in Medicaid (1 of 2)

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- Better linkage of Federal and State programs - CMS implemented a web-based application that allows States to share and view information regarding terminated providers
- Better use of predictive analytics in Medicaid
  - Analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and CHIP after the third year of the Medicare Fraud Prevention System (FPS)
  - Based on this analysis, the law requires CMS to expand predictive analytics to Medicaid and CHIP by April 1, 2015
- In late May 2012, CMS launched the “CMS Provider Screening Innovator Challenge” to develop a multi-State, multi-program provider screening software application

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### Purpose of the slide

Discuss some recent Federal and State actions to combat fraud and abuse.

### Talking Points

- Better linkages will allow for the termination of Medicaid providers or suppliers who have been revoked by Medicare, or terminated for cause by another State’s Medicaid program or CHIP. Similarly, under current authority, Medicare may also revoke providers or suppliers that have been terminated by State Medicaid agencies or CHIP.
- CMS is currently working to identify specific FPS algorithms that are relevant to Medicaid and will be performing an analysis of one State’s Medicaid claims data using the identified algorithms. Once the analysis is complete, the Agency plans to share the results back with the State and anticipates the analysis being complete before the end of 2012.
- CMS is also partnering with the same State to screen all of the State’s Medicaid providers using the APS. Once the analysis is complete, the Agency will provide the results back to the State for their action as appropriate.
- CMS is also supporting States’ use of predictive analytics through technical assistance and education, including specific coursework focused on predictive analytics at the Medicaid Integrity Institute.
- The challenge is an innovation competition to develop a multi-State, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs

### Source(s)

- CMS. STATEMENT OF PETER BUDETTI, M.D., J.D. DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR PROGRAM INTEGRITY ON ASSESSING MEDICARE AND MEDICAID PROGRAM INTEGRITY BEFORE THE UNITED STATES HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY, AND FINANCIAL MANAGEMENT. <http://oversight.house.gov/wp-content/uploads/2012/06/6-7-12-GovOrg-Budetti.pdf>. Accessed 6/12/12.

- <http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Provider-Screening-Innovator-Challenge.html>



## Federal and State Actions

Working Smarter in Medicaid (2 of 2)

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- A new rule from the U.S. Department of HHS Office of the Inspector General now allows states to use federal funds for data mining in their fight against Medicaid fraud
- Previously, State Medicaid Fraud Control Units (MFCU) were separate from the State Medicaid Agencies and use of Federal funds for data mining was prohibited
- The rule defines data mining as the "practice of electronically sorting Medicaid claims through statistical models and intelligent technologies to uncover patterns and relationships in Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent"

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#### Purpose of the slide

Discuss some recent Federal and State actions to combat fraud and abuse.

#### Talking Points

- CMS is also supporting States' use of predictive analytics through technical assistance and education, including specific coursework focused on predictive analytics at the Medicaid Integrity Institute.
- The new rule notes that MFCUs have been largely dependent on state Medicaid agencies and external sources to refer cases to them--and that the anti-fraud units at times were unaware of changes in reimbursement policy that made data look questionable when it was not. The changes are expected to help the anti-fraud units use their resources more effectively.
- It defines data mining as the "practice of electronically sorting Medicaid claims through statistical models and intelligent technologies to uncover patterns and relationships in Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent."
- This reversal includes additional reporting requirements by MFCUs to capture costs associated with data mining, the outcome and status of those cases, and monetary recoveries resulting from those activities, the rule states.
- It sets three conditions on the practice:
  - The MFCUs and state Medicaid agencies must coordinate their use of data mining.
  - The two must work together to ensure the results are interpreted correctly according to current policy and practice.
  - Staff must be properly trained in the use of data mining.

Source(s)

- Federal Register / Vol. 78, No. 96 / Friday, May 17, 2013 / Rules and Regulations/page 29055.  
[http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/regulations\\_statutes/fr-2013-11735.pdf](http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/regulations_statutes/fr-2013-11735.pdf).  
Accessed 5/20/13.



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## Federal and State Actions

ICD-10 as a tool

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**With increasing challenges to control cost, the intensity of audits related to fraud, waste, and abuse is increasing. In its “Justification of Estimates for Appropriations Committees,” CMS states:**

*“Reducing health care fraud, waste, and abuse is a major priority of the Administration... Although the ICD-10 code set will not eliminate all fraud, waste, and abuse, CMS believes that its increased specificity will make it much more difficult for fraud, waste and abuse to occur.”*



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### Purpose of the slide

Discuss some recent actions by CMS to combat fraud and abuse.

### Talking Points

- RAND estimated that the additional information included in ICD-10 codes would save from \$100M to \$1.5B over ten years ([http://www.rand.org/pubs/technical\\_reports/2004/RAND\\_TR132.pdf](http://www.rand.org/pubs/technical_reports/2004/RAND_TR132.pdf))

### Notes

- Source: CMS. “Justification of Estimates for Appropriations Committees: FY2012.” Accessed 09/13/2011. [http://www.hhs.gov/about/FY2012budget/cmsfy12cj\\_revised.pdf](http://www.hhs.gov/about/FY2012budget/cmsfy12cj_revised.pdf)
- Libicki, M., Brahmakulam, I., *The Costs and Benefits of Moving to the ICD-10 Code Sets*, p. xvi. The RAND Corporation Science and Technology Institute, March 2004. [http://www.rand.org/pubs/technical\\_reports/2004/RAND\\_TR132.pdf](http://www.rand.org/pubs/technical_reports/2004/RAND_TR132.pdf). Accessed 12/27/2011.
- HHS Office of the National Coordinator. “Report on the Use of Health Information Technology to Enhance and Expand Health Care Anti-Fraud Activities.” September 2005. <http://www.hhs.gov/healthit/documents/ReportOnTheUse.pdf>. Accessed 12/27/2011.

 <b>Federal and State Actions</b> Federal Investments in Technology			
<b>Information Technology</b> (Dollars)			
	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request
<b>Funds Source</b>			
Program Operations 1/	\$ 832,554,000	\$ 1,002,966,000	\$ 1,064,452,000
Federal Administration	25,523,000	46,616,000	34,533,000
Survey & Certification	4,618,000	2,795,000	2,775,000
Research 3/	5,700,000	5,850,000	
<b>Subtotal, Program Management Appropriation</b>	<b>\$ 868,395,000</b>	<b>\$ 1,058,227,000</b>	<b>\$ 1,101,760,000</b>
Coordination of Benefits (COB) User Fee	\$ 10,034,018	\$ 8,015,000	\$ 7,074,790
CLIA User Fees	4,214,607	4,500,000	4,750,000
ESRD Network	4,000,000	1,200,000	1,200,000
Program Integrity (MIP/HCFAC)	134,910,325	152,066,187	118,430,207
ARRA/Hitech	87,794,849	85,000,179	95,552,452
Quality Improvement Organizations 2/	TBD	TBD	TBD
<b>Subtotal, Additional Funding Sources</b>	<b>\$ 240,953,799</b>	<b>\$ 251,664,366</b>	<b>\$ 227,007,449</b>
<b>Total, CMS IT Portfolio</b>	<b>\$ 1,109,348,799</b>	<b>\$ 1,309,891,366</b>	<b>\$ 1,328,767,449</b>

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### Purpose of the slide

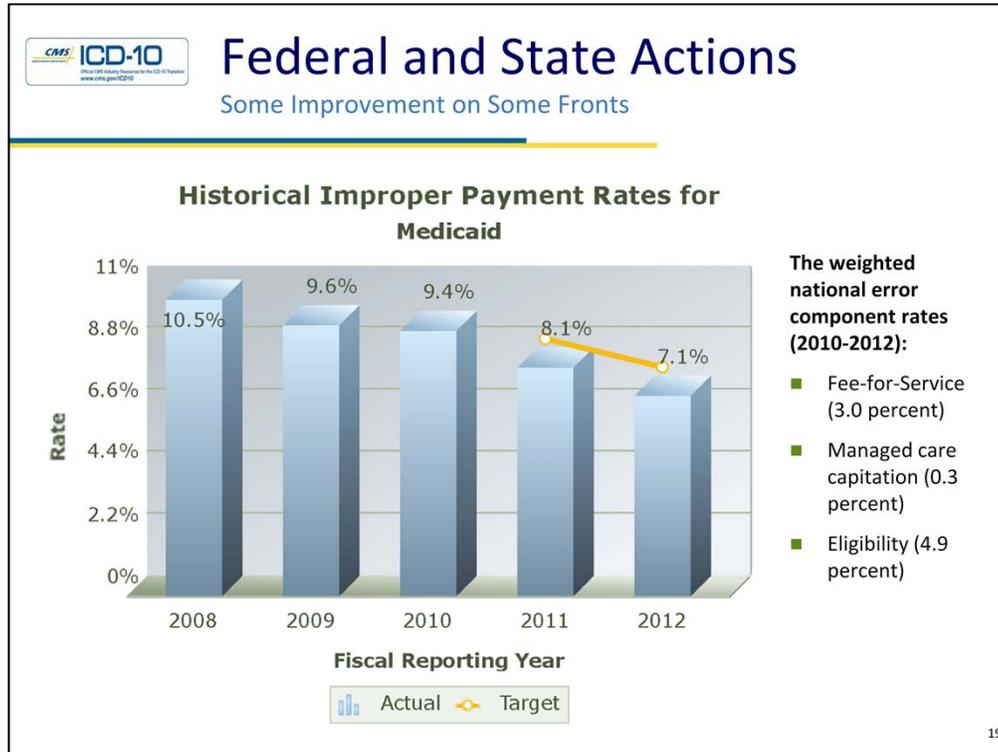
Discuss some recent actions by CMS to combat fraud and abuse.

### Talking Points

- Increases funding for the Health Care Fraud and Abuse Control fund to fight fraud in public programs. The Office of Management and Budget estimates that every \$1 invested to fight fraud results in approximately \$17 in savings.

### Notes

- Source: CMS. "Justification of Estimates for Appropriations Committees: FY2013." Accessed 1/12/13. <http://www.cms.gov/about-cms/agency-information/performancebudget/downloads/cmsfy13cj-.pdf>



#### Purpose of the slide

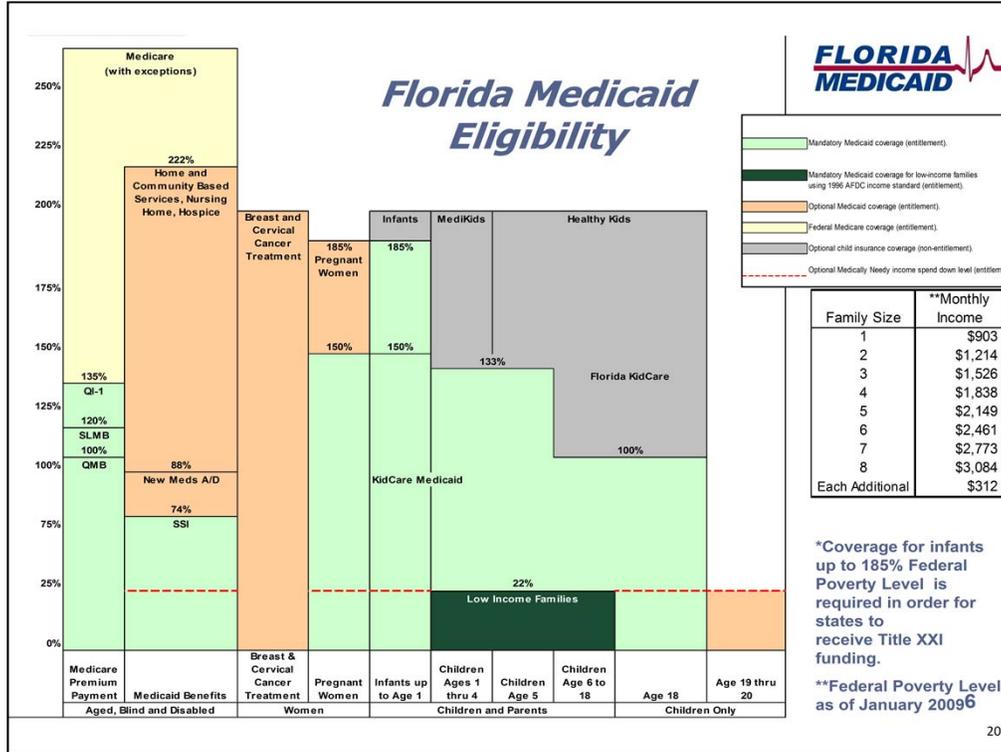
Discuss the magnitude of fraud, waste, and abuse in health care.

#### Talking Points

- CMS measures Medicaid improper payments through the Payment Error Rate Measurement (PERM) program and produces state and national-level error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care capitation payments, and eligibility components of Medicaid in the fiscal year (FY) under review. PERM uses a 17-state rotational approach to measure the 50 states and the District of Columbia over a three-year period. As a result, CMS measures each state once every three years.
- All payment error rate calculations for the Medicaid program are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. Individual state error rate components are combined to calculate national component error rates, and individual state Medicaid program error rates across all components are combined to calculate the national Medicaid program error rate.
- In the FY 2012 AFR, HHS calculated and is reporting the three-year weighted average national error rate that includes data from FYs 2010, 2011, and 2012. The three-year rolling error rate is 7.1 percent or \$19.2 billion. The weighted national error components rates are as follows: Medicaid FFS: 3.0 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 4.9 percent.
- The majority of the FY 2012 errors were a result of cases reviewed for eligibility that were either not eligible or their eligibility status could not be determined, thus they were considered errors. The most common cause of cases in error for the Medicaid FFS medical review was insufficient documentation.

#### Source(s)

- Data are from <http://www.paymentaccuracy.gov/programs/medicaid#learnmore>
- CMS PERM overview and details at <https://www.cms.gov/perm/>



**Talking Points**

- One reason why eligibility is a leading cause of payment error is complexity

**Source(s)**

- AHCA. "Florida Medicaid." *Roberta K. Bradford, Deputy Secretary for Medicaid. Presented to the Senate Health and Human Services Appropriations Committee. February 4, 2010.*



## Program Integrity

California Effective Practices

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- **Medi-Cal Payment Error Studies** – CA developed a Medicaid payment error study and also conducts weekly random audits on various provider claims. State reduced error rates from 8.4 to 5.45 percent between SFY05 and SFY08 with total savings of \$340M.
- **Multi-faceted Provider Education Program**
- **Hospice Audits** – CA completed 117 hospice audits between July 2007 and June 2011 and identified \$10M in overpayment
- **Targeted Power Wheelchairs Audits** – CA completed reviews of 81 of the 183 identified DME providers and identified \$2.5M in overpayments and projects \$11.7M once all reviews are completed
- **Individual Provider Claims Analysis Report** – CA allows individual providers to see how their billing and/or prescribing trends compare with that of their peers statewide

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### Purpose of the slide

Discuss some aspects of California's Medicaid program that are highlighted by CMS as best practices and also discuss some opportunities for improvement.

### Talking Points

- TBD

### Source(s)

- CMS. "Medicaid Integrity Program California Comprehensive Program Integrity Review Final Report (November 2012). <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/CAfy12.pdf>. Accessed 03/15/2012.

 Official CMS Industry Resources for the ICD-10 Transition  
[www.cms.gov/ICD10](http://www.cms.gov/ICD10)

## Program Integrity



Identifying Cases

### Purpose of the slide

Introduce slides covering the identification of cases in order to discuss ICD-10 impacts, opportunities, and examples in the area of program integrity.

### Talking Points

- None



Official CMS Codes, Approved for the ICD-10 Transition  
www.cms.gov/ICD10

## Identifying Cases

Good Policy and Pattern Analysis

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- **Detecting healthcare fraud often relies on mathematical formulas that look for outliers across variables such as average dollars paid per patient, average number of visits, average paid per medical procedure, and average medical procedure per visit among other parameters**
- **These algorithms also look for patterns**
  - Improbable service sequences
  - Repetitive condition service pairing
  - Recurring referral patterns
  - Provider reimbursement models that are out of line
  - Outlier referral, diagnostic procedure, or prescribing patterns
  - Recurring patterns of multiple services per patient per condition
  - Recurring and outlier intensity of service and severity of illness

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### Purpose of the slide

Discuss some pattern analysis to assist with identifying cases.

### Talking Points

- Many program Integrity efforts today focus on 'low hanging' fruits that do not need diagnostic information in order to identify cases
- But the most efficient and effective means of program integrity is using information (including ICD codes) to build predictive models to identify cases that would not be found otherwise and to prevent payment before it occurs



## Identifying Cases

Existing and Emerging Methods of Detection and Prevention

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- **States apply an increasingly sophisticated set of tools that emphasize pre-payment avoidance (e.g., predictive modeling)**
  - Dynamic Rules Engines test a transaction against a predefined set of algorithms. For example, it may target a claim if the claim exceeds a certain amount or involves multiple codes when only one should be used (KNOWN SCHEMES / KNOWN METRICS)
  - Outlier Detection monitors for changes above thresholds (e.g. determination that HIV/AIDS Infusion therapy increased by 25% in one year) (UNKNOWN SCHEMES / KNOWN METRICS)
  - Predictive Modeling uses data mining tools and fraud propensity scores (UNKNOWN SCHEMES / UNKNOWN METRICS)
  - Social Network Analysis identifies organized fraud activities by modeling relationships between entities (UNKNOWN SCHEMES / UNKNOWN METRICS)

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### Purpose of the slide

Discuss the different types of existing and emerging methods of detection and prevention that assist program integrity efforts.

### Talking Points

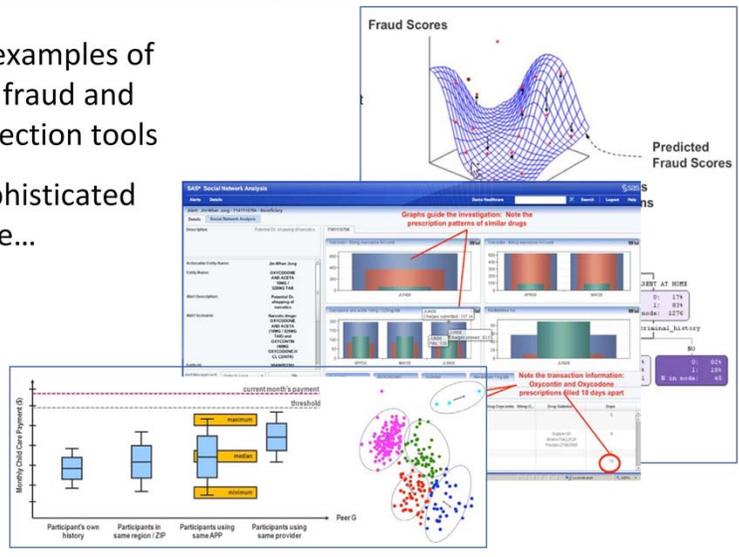
- None



# Identifying Cases

## Technological Toolbox

- Here are examples of advanced fraud and abuse detection tools
- But as sophisticated as they are...



25

### Purpose of the slide

Discuss some advanced tools that assist program integrity efforts.

### Talking Points

- None

### Notes

- Graphics source: SAS. "Combating Health Care Fraud: State-of-the-Art Methods for Detection and Prevention of Fraud, Waste, and Abuse in the Health Care Industry." White Paper. Accessed 09/13/2011. <http://www.sas.com/industry/healthcare/insurer/fraud-detection.html#section=6>



Official CMS Website: [www.cms.gov/ICD10](http://www.cms.gov/ICD10)

# Program Integrity

## Conclusions

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- **The best tool against fraud, waste, and abuse is good medical policy that answers the basic questions**
  - Is the service appropriate?
  - Under what conditions?
  
- **States face challenges in the transition**
  - Increased chance that genuine mistakes will be flagged as fraud
  - Greater likelihood that fraudulent behavior will slip through current detection algorithms
  - Operational and financial impacts related to an increase in the number of fraud investigations
  
- **But, in the long-run, ICD-10 with allow States the opportunity to improve the integrity of their programs through better medical policy and fraud & abuse deterrence**

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### Purpose of the slide

Summarize the Program Integrity session by discussing how good medical policy is the best tool against fraud, waste, and abuse and discuss the role of ICD-10 in improving medical policy.

### Talking Points

- None

# Questions

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