Fraud and Abuse in Healthcare

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AGENDA

- Overview of the Healthcare Fraud Issue
- Why it is so Hard to ***Measure*** Dollars Lost to Healthcare Fraud
- Why it is So Hard to ***Identify*** Fraud
- Where Fraud Can be Identified
- Where the Identification is Being Done Now
- The Technologies Being Used to Identify Fraud
- Thomson Reuters Applications and Technical Solutions in Fighting Fraud
- Results of Pay-and-Chase Efforts

FRAUD, WASTE, AND ABUSE VIRTUALLY EVERYWHERE

"In FY 2009, the National Health Care Anti-Fraud Association estimates conservatively that *at least 3 percent of health care spending is lost to fraud.*"

— Daniel R. Levinson, Inspector General, Office of the Inspector General, U.S. Department of Health and Human Services on Health Care Reform: Opportunities to Address Waste, Fraud and Abuse before The House Energy and Commerce Committee, Subcommittee on Health, United States House of Representatives, Thursday, June 25, 2009

OVERVIEW OF THE ISSUE

- Medicare (45m people) spending in 2008 - $470 billion
- Medicaid (52m people) spending in 2008 - $344 billion
- $1.2 trillion in drugs in next 10 years
- $70 - $200 billion in Fraud in Medicare and Medicaid – per year
- With billing errors – it is higher
- Unmeasured fraud in commercial health care
- In the early 1990s – Janet Reno made Healthcare Fraud the number 2 priority of the Department of Justice
- Operation Restore Trust started the focus on Healthcare Fraud
- The Federal Government spends over $1 billion per year fighting Medicare fraud (before recent legislation)
- CMS spends $1 billion in combating fraud (growing to $1.7 billion in 2011)

THE NEW REALITY IN HEALTHCARE FRAUD

- Collusive Fraud Networks
  - Ethnically focused
  - Organized Crime/Mafia
  - Move from Home Country to USA – lucrative
  - One or two get medical degrees
  - Non-physician practitioners
- The Fraudsters are Getting Smarter

SCAMS AND TESTIMONIES

Providing milk to non-English speaking recipients and billing Medicaid for "nutritional therapy"	Putting steel caps on children's teeth instead of fillings, because it pays 4 times more	**Billing Medicare for $16 million in prostheses – for patients who never had an amputation**	Adding an expensive "iron test" to every routine blood chemistry that came to the lab: >$100 million recovered by Medicare
Watered chemo drugs; patient harm	Weight Loss Vacations	**Hurricane Katrina**	Ambulance trips to nowhere
Providing power wheel chairs to anyone who wants them – Scooter Store and Hoveround	Post surgical DME and/or oxygen – forever	Free services at mall	**Diabetic Test Strips at Flea Markets**
An ex-physician told how he sold prescriptions to junkies in a Los Angeles Medicaid mil	One Buffalo school official sent 4,434 students into speech therapy in a single day without talking to them or reviewing their records	A former nightclub owner revealed that he made millions by opening a crooked home health agency	Provider identity theft; dead MDs ordering drugs

WHY IT IS SO HARD TO ***MEASURE*** DOLLARS LOST TO HEALTHCARE FRAUD ?

Incredible Amounts of Data To Evaluate

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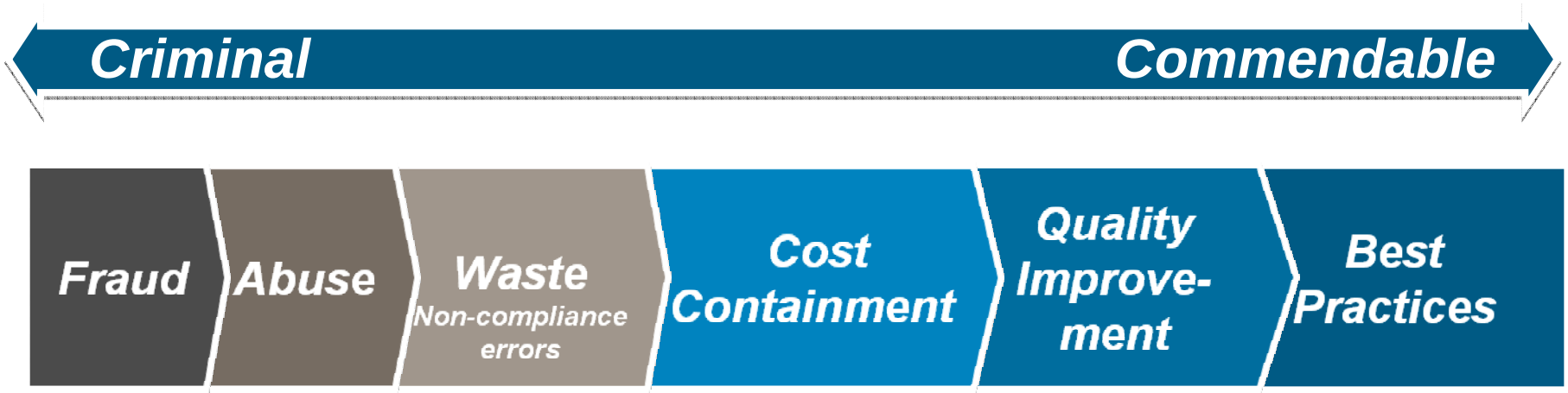
WHY IT IS SO HARD TO ***MEASURE*** DOLLARS LOST TO HEALTHCARE FRAUD ?

Sorting Fraud, Waste, Abuse & Overpayment



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WHY IS IT SO HARD TO ***MEASURE*** DOLLARS LOST TO HEALTHCARE FRAUD?

- Medical record review; episodes
- 2007 Medicaid Perm ***Error*** Rate = 10% = $34.4 billion
- 2008 Medicaid CERT ***Error*** Rate = 7.8% $36.6 billion

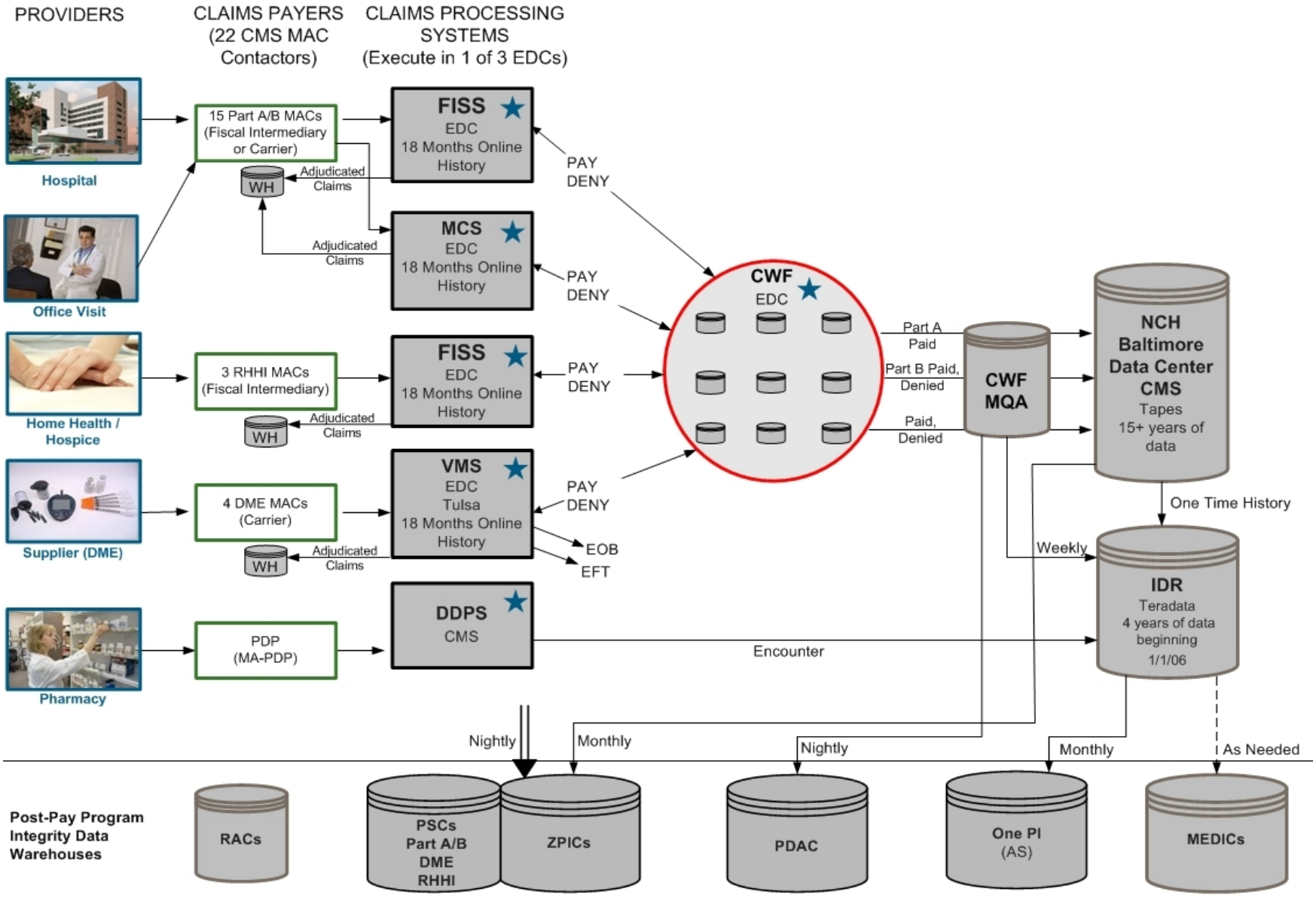
WHY IT IS SO HARD TO ***IDENTIFY*** FRAUD

- ***Data and Technology issue***
- Massive Data Sets
- Many Payers
- Different Systems Pay Different Claim Types
  - Most fraud found by comparing claim types (e.g. drugs)
- Pre-Payment solutions will not catch all fraud
- Old Complex Systems can't be modified fast enough
- Prompt pay pressure
- Claim lag and adjustments
- Complexity of the data elements (unlike credit card transactions)
- Fraudsters constantly innovating

DATA & SYSTEM COMPLEXITY

- **Medicare** (15.2% of US population) – 46.6 million
  - 350 million claim lines per month
  - 4.2 billion claim lines per year ($1.2 billion claims)
  - *Each claim has 300+ important variables (2000+ bytes)*
  - *Each claim has to be compared to all other claims for the past 4 years to identify just a portion of the fraud*
  - Over 25 companies using 15+ data centers and 10 systems pay these claims (to get the throughput)
  - The rules are close to the same for the country (but not quite)
  - Ambulance and injectible drugs
- **Medicaid** (15.3% of US population) – 46.9 million
  - 10 companies using 20+ systems and 40+ data centers
  - *Rules vary for each state*
- **Etc**.

Medicare Claims Flow



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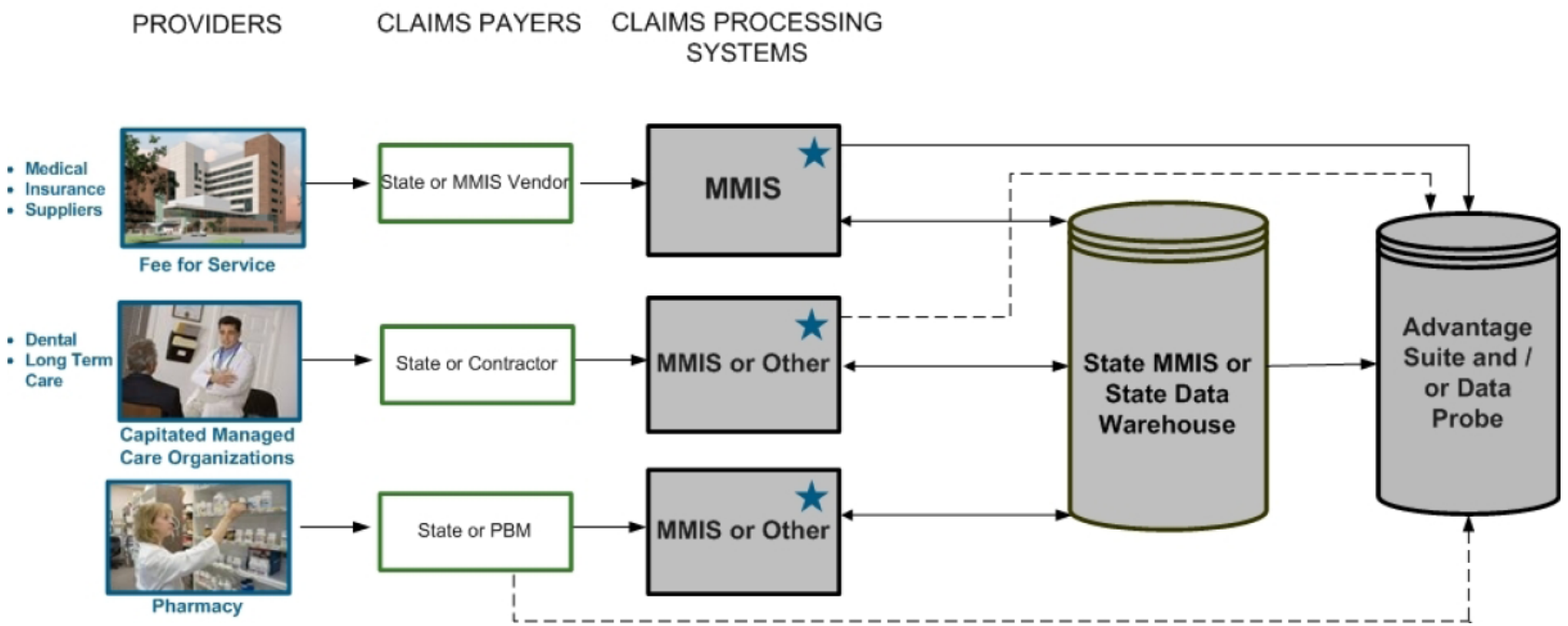
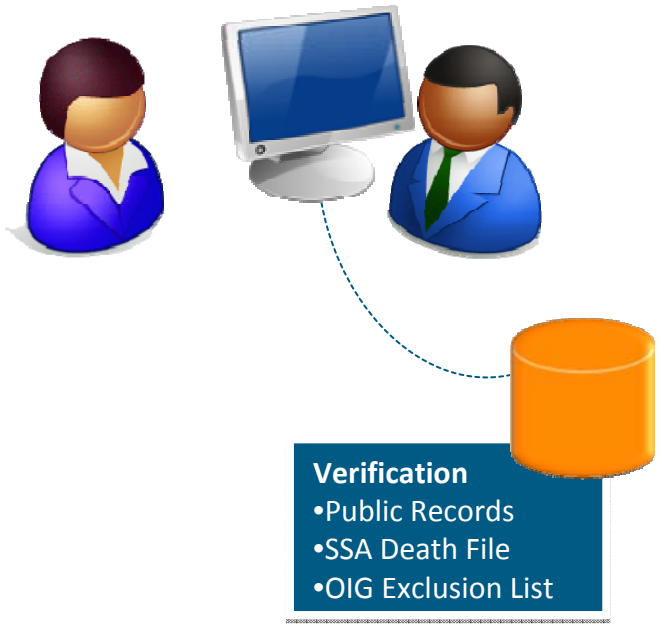
Medicaid Claims Flow



WHERE CAN FRAUD BE IDENTIFIED ?

- **Provider Enrollment**
- **Beneficiary Enrollment and Eligibility Check**
- **Claims Processing**
- **After Payment**



COLLABORATION AND INNOVATION ARE ESSENTIAL

- Avoid paying claims inappropriately and chasing recoveries
- Ensure edits are tuned to current program policies and national efforts
- Identify criminals before credentialing
- Use predictive modeling to establish fraudulent profiles
- Conduct gap analysis

- Enlist experts with knowledge of latest fraud schemes
- Integrate data from multiple sources and ensure accuracy and completeness
- Enhance data and provide easy access to custom algorithms, measures, and reports
- Develop innovative, consensus-based analytic agenda
- Mine selected data and perform advanced analysis

- Provide reports to identify trends, aberrancies, significant changes, etc.
- Ensure effective, user-friendly information
- Use report output to influence policy changes

- Collaborate with stakeholders to pursue recoveries
- Determine if recoveries and cost avoidances contribute to substantial savings
- Estimate the impact of fraud recovery efforts
- Outline policy implications of recovery efforts

WHERE THE IDENTIFICATION IS BEING DONE NOW

- Pre-payment
  - Clinical editing: Medicare, Medicaid, Commercial Payers
- After Payment
  - Medicare: PSCs, ZPICs, MEDICs and RACs
  - Federal Medicaid: Review of Provider and Audit MICs
  - State Medicaid: SURS units and MFCUs
  - HHS OIG and FBI
  - Commercial Healthcare: SIUs
  - Law enforcement & others: Tips, Complaints, Referrals
- Provider & Member/Beneficiary Enrollment
  - National Supplier Clearing House (NSC)
  - Medicare DME Surety Bonds
  - Medi-Cal re-enrollment of providers and recipients (very costly)
  - NPI and NPPES

THE TECHNOLOGIES BEING USED TO IDENTIFY FRAUD

Pre-Payment

- Clinical Editing
- New Innovations

Post-Payment

- Data management & warehousing
- Specialized surveillance and utilization review tools
- Data mining
- Reporting
- Predictive analytics
- Case management systems
- Audit and recovery tools
- New innovations

THE TECHNOLOGIES BEING USED TO IDENTIFY FRAUD

- Medicare
  - PSCs and Medi-Medis
    - SAS, Clementine, DataProbe, Business Objects, Oracle, DB2, predictive modeling
  - ZPICs and Medi-Medis
    - SAS, DataProbe, Business Objects, Oracle, DB2
  - MEDICs
    - IDR/Teradata and SAS
  - RACs
- One Program Integrity (One PI)
  - Teradata (80+ terabytes and growing to 300+)
    - Business Objects, Advantage Suite, SAS
- Medicaid Integrity Program
    - SAS on Oracle
- SURS, MFCUs, FADS
- SIUs

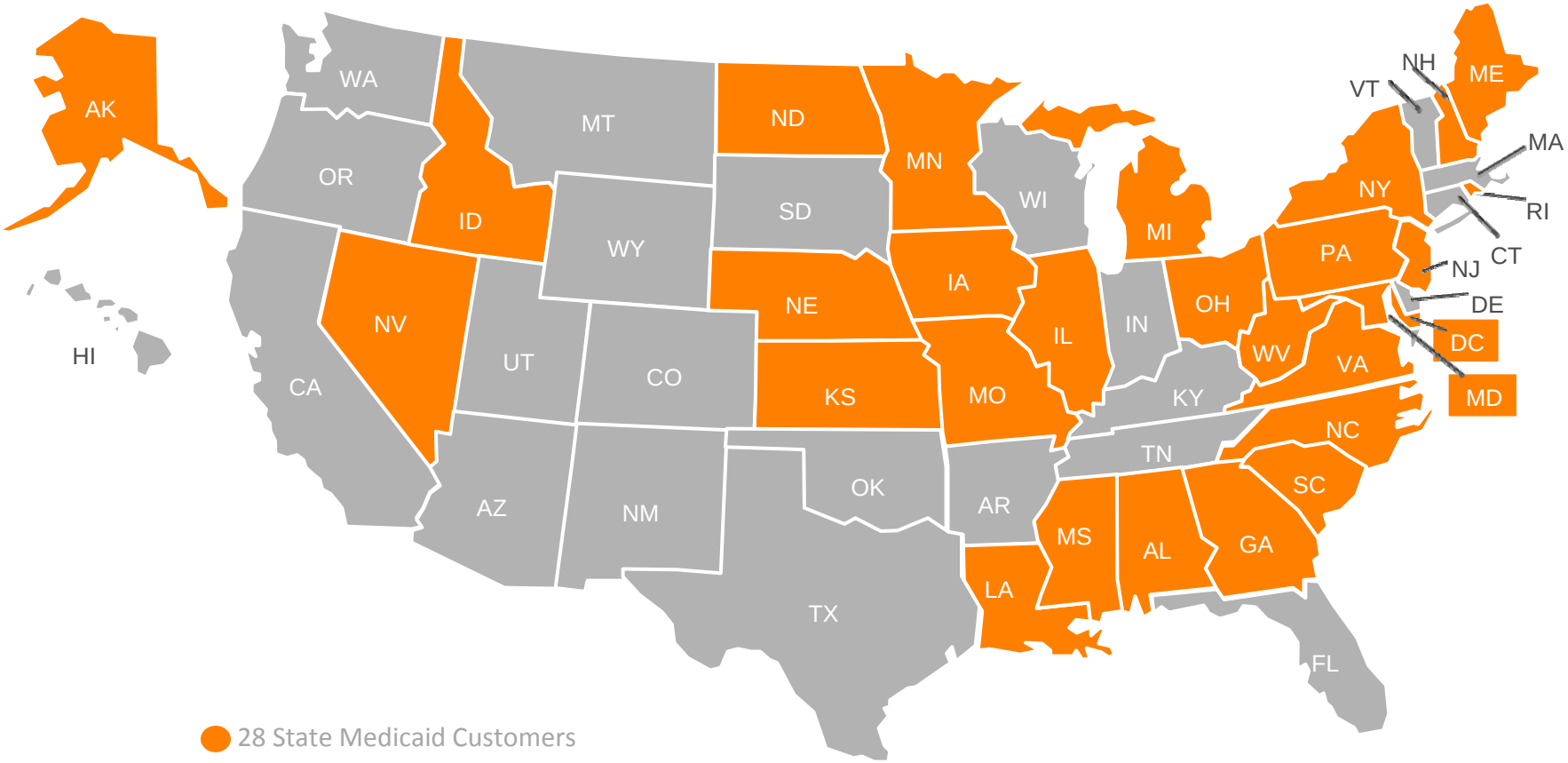
THOMSON REUTERS KEY CAPABILITIES

- Applications
- Data Management
- Data Mining
- Analytic Methods
- Patient and Provider Profiling
- Subject Matter Experts
- Extensive Algorithm Library
- Thought Leadership

PRODUCTS

- Advantage Suite (DB2, Oracle, Teradata)
- DataProbe (20+ Terabytes)
- J-SURS
- Medical Episode Grouper (MEG)
- West Government Services CLEAR
  public records
- Westlaw *legal reference*
- Auto-Audit *edit engine*
- Redbook
- DrugDex
- DiseaseDex
- Market Expert

STATE MEDICAID CUSTOMERS



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FEDERAL EXPERIENCE

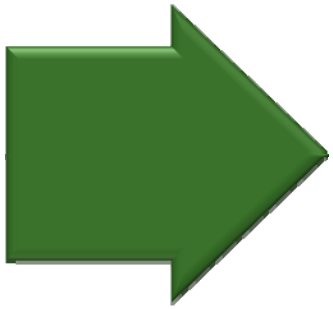
Projects:

- One Program Integrity (OnePI)
- Medicaid Integrity Contractor (MIC) Provider Review
- Program Safeguard Contractor (PSC)
- Zone Program Integrity Contactor (ZPIC)
- Pricing, Data Analysis, and Coding (PDAC) for Durable Medical Equipment
- West Medicare Prescription Drug Integrity Contractor (MEDIC)

RESULTS OF POST-PAYMENT EFFORTS

$ 1.00

Investment



$ 3.00 - $12.00

Return

Actual recovery versus cost avoidance

- In 2009, Medicare recovered $2.5 billion (up 29%)
- Unmeasurable cost avoidance savings
- A drop in the bucket

EXAMPLES OF OUR CUSTOMER'S SUCCESSES

Fraud Type	Results (ROI)
SC Medicaid press release of $1m in early findings in ambulance, time bandits and narcotics	$1 million
Lab services with no episode of care	$18.8 million
Non-required Power Wheelchairs	$50 million
Collusive Fraud Networks	$32.5 million
Pharmacy Fraud and Collusion	$5 million
Vulnerable Procedure Codes	$62 million
Hospice Fraud	$.5 million

EXAMPLE CLIENT CASE STUDIES

Fraud Type	Results (ROI)
Provider Re-Enrollment	Saved almost $8 million during the re-enrollment process
Pharmacy	Recovered $1.8 million in pharmacy claims
Medically Unnecessary Transportation	Recovered $1 million in waste
NCCI Correct Coding Edits	Identified $11 million in improper payments
Inappropriately Billed Admissions	Recovered $1.6 million in overpayments
Dental Services and Billing	Identified more than $9 million in suspicious claims
PARIS Interstate Eligibility Matching	Avoided $2 million in costs in first year
Multiple “New Patient” Visits	Identified $3.9 million in clear overpayments
Managed Care Overpayment	Revealed $6 million in overpayments

QUESTIONS