Strategy for Identifying and Addressing Prepayment Fraud

Session Law 2016-94, Section 12H.3A.(b)

Legislative Report to the
Joint Legislative Oversight Committee on Medicaid
and NC Health Choice

by

North Carolina Department of Health and Human Services

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Introduction

Section 12H.3A.(b) of Session Law 2016-94 required the Department of Health and Human Services, Division of Medical Assistance, to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on a strategy for identifying and addressing prepayment fraud no later than October 1, 2016.

The Division of Medical Assistance, Office of Compliance and Program Integrity (DMA, OCPI) works to promote compliance, efficiency, and accountability within the North Carolina Medicaid program by detecting and preventing fraud, waste, and abuse and by assuring compliance with state and federal requirements governing the expenditure of Medicaid funding. OCPI ensures that Medicaid dollars are appropriately expended by reviewing Medicaid claims, investigating fraud and noncompliance, implementing recoveries, pursuing recoupments, and identifying opportunities for fraud-related cost avoidance.

Post Payment vs. Prepayment

Aggressively seeking opportunities to prevent fraud, waste, and abuse within the Medicaid and Health Choice programs is critical to protecting state resources and provides a significant return on investment. This work is currently conducted using both post payment recovery work as well as through preventive measures, often referred to as prepayment review.

Post payment review activities focus on overpayments that have been identified after a claim has been paid. These overpayments may be identified through investigation, audit, or analytics. If there is reason to believe that a beneficiary has abused the Medicaid program, DMA is required by law (see Appendix C) to investigate the alleged abuse and pursue recoveries.

Although post payment investigations and recoveries will always be a core function of OCPI, current and future investments have been dedicated to activities that support prepayment fraud prevention activities within the Medicaid program. Prepayment fraud prevention has important advantages compared to post payment review activities, including being lower cost and avoiding the issues inherent with fund recoveries.

Preventive strategies that DMA uses to *identify* fraud include:

- Utilizing predictive data analytics to identify unusual billing practices;
- Investigating consumer complaints;
- Examining claim activity systemically to identify opportunities to strengthen Medicaid policies and system edits; and
- Overseeing local management entities to ensure provider networks deliver stated services and comply with federal and state regulations.

Preventive strategies OCPI uses to *address* fraud include:

- Leveraging information identified through reviews, investigations, and external audits and systemic claims reviews to identify and implement strengthened controls for the Medicaid program;
- Conducting prepayment claims review for providers suspected of fraud, waste, or abuse;

- Investigating fraud and pursuing recoveries of inappropriately expended funds; and
- Working with the North Carolina Attorney General's Office, Medicaid Investigations Division to prosecute providers and beneficiaries in criminal and civil actions for Medicaid fraud.

For SFY 2017 DMA has taken a number of important steps to implement effective strategies for preventing fraud within the Medicaid and Health Choice programs. This report focuses on DMA's primary strategies including: 1) use of predictive data analytics to identify high risk claiming; 2) initiation of systemic reviews to identify opportunities to strengthen Medicaid program policies and remediate systemic vulnerabilities; 3) use of the prepayment claims review program to prevent improper claiming; and 4) enhanced post payment review processes to mitigate ongoing claiming associated with fraud, waste, or abuse.

Predictive Data Analytics

During SFY 2016, OCPI underwent an office-wide reorganization to better support current and future program integrity efforts, including support for proactive opportunities to reduce fraud, waste, and abuse. As part of this effort, OCPI has established a Data Analytics Unit. This unit will be dedicated to planning, coordinating, executing, and tracking results of OCPI's analytic projects.

This unit has developed a risk-based algorithm to assist in the prioritization of work that OCPI will perform on an annual basis. The algorithm utilizes historical claiming, expenditure, and other relevant data from the Medicaid Management Information System (MMIS) to measure relative risk within each of DMA's twenty-two service areas. OCPI has already begun work on targeted projects to address service areas that have been identified as high risk. These projects were selected based on an assessment of potential risk for exposure to overpayments.

While all service areas will be reviewed under one or more projects during SFY 2017, service reviews that have been specifically prioritized due to high risk factors include personal care services (PCS), pharmacy, and durable medical equipment (DME). Some of the examples of these initiatives include:

- Auditing newly enrolled PCS providers deemed as high risk within one year of enrollment. The purpose of this audit is to ensure compliance with Medicaid regulations. Investigations will identify PCS providers that have improperly billed Medicaid, recoup payments, and intervene to correct improper ongoing billing.

- Analyzing pharmacy claims to identify beneficiaries who may be overusing or abusing certain prescribed controlled substances, including opioids and benzodiazepines. Identified beneficiaries may be enrolled in DMA's Beneficiary Management Lock-In Program, which is intended to monitor and prevent overutilization and abuse by restricting beneficiaries who qualify for the program to one prescriber and one pharmacy for those prescriptions. In accordance with Session Law 2015-268, Section 4.4., the Department reported to the Joint Legislative Program Evaluation Oversight Committee on September 30, 2016 on DMA's progress toward expanding this program.

- Identifying improperly paid pharmacy claims using predictive algorithms to identify possible package unbundling. Examples include billing by the unit instead of the box or the mL instead of the bottle. Using a prediction model involving the units and paid deviations from the peer group, claims can be identified as potential overpayments for review by OCPI.

- Examining and identifying pharmacy claims that are deemed suspicious as a result of data-driven standard deviation analysis. The goal of this work is to recover overpayments from pharmacy providers and identify system edits to reduce risk of future improper pharmacy claiming.

- Identifying DME supply and nutrition improper billings using predictive algorithms that compare units per claim for each procedure and finding outlier unit amounts based on deviations from the norm quantity, resulting in an overpayment. Results will be investigated for post payment recoveries and, if validated, potentially result in the implementation of system edits and audits.

DMA will also continue to review current Medicaid claims data to detect unusual ongoing billing practices. DHHS currently owns two data analytics tools for this purpose: (1) the Fraud and Abuse Management System (FAMS), which performs peer group behavioral predictive modeling to identify providers with suspicious activities; and (2) the Identity Insight System, which performs network analysis to determine connections among provider identifications and relationships within the Medicaid system. These two tools are used to review paid claims, refer providers for review, and screen incoming provider applications.

DMA also encourages Local Management Entity-Managed Care Organizations (LME-MCOs) to use the DHHS FAMS to perform their own analytics for behavioral health services claims (Medicaid providers enrolled with LME-MCOs bill the LME-MCOs directly; DMA pays the LME-MCOs a capitated, per member per month rate). This provides DHHS and LME-MCOs with a comparison of behavioral health providers' billing patterns. DMA also utilizes information gained through these individual reviews to identify opportunities for program policy and system edits enhancements.

As a result of predictive analytics, in SFY 2016:

- 46 Medicaid providers were referred for suspension of payments and for placement on prepayment billing review;
- 11 Medicaid provider applications were referred for additional review or denial of application based on suspicious activity; and
- 13 providers were referred for investigation to the Medicaid Investigations Division of the NC Department of Justice for possible legal action.

Strengthening Integrity Infrastructure

In addition to the targeted reviews as detailed above, DMA has initiated two new projects that are intended to take a holistic approach toward the examination of inherent risks within the Medicaid

program and systems. These initiatives are designed to examine claims systemically across all service areas in order to identify post payment recoveries and, more critically, opportunities to strengthen the overall Medicaid program integrity infrastructure.

In SFY 2017 DMA has initiated a project to examine and identify claims across all service areas that are deemed medically unlikely based on existing Medicaid policies and other service specific criteria. While the results of this work will help to identify post payment recovery opportunities, DMA will also use the results from this system-wide examination to further mitigate risks within Medicaid. Results from this comprehensive review will be used to strengthen program policies in support of program integrity efforts and identify system edits to reduce risks of inappropriate claiming. Results will also be used to further refine the prioritization of risks within Medicaid claiming specific to service area and claim type.

DMA is also in the initial stages of a project that will leverage third party public, corporate, and criminal databases to identify potential high risk claiming within Medicaid. Results of these efforts will be examined to identify opportunities to strengthen the automated program integrity capabilities of MMIS.

Preliminary results from each of these efforts are expected to be available within the first half of calendar year 2017.

Prepayment Claims Review

Legal Authority

The Prepayment Claims Review program is authorized by N.C.G.S. §108C-7 (see Appendix A) and implemented by 10A N.C.A.C. 22F .0104 (see Appendix B). It is intended to ensure that claims presented by a provider to DMA for payment meet the requirements of federal and state laws and regulations and medical necessity criteria. This program is administered primarily by DMA's contractor, Carolina Center for Medical Excellence (CCME). Under the program, providers with high-risk claims are scheduled for review to assure compliance prior to payment.

Prepayment Review Process

The prepayment review program is highly targeted. Since the program's inception in 2010, a total of 157 providers have completed the prepayment claims process or are currently on prepayment review. This represents less than 0.2% of the 80,000 providers currently in the Medicaid network. DMA may place a provider on prepayment claims review for a variety of reasons, including receipt of credible allegations of fraud and identification of aberrant billing practices through investigation or data analysis. Examples of the types of providers who have historically been found to have high-risk claims include:

- Providers who are suspected of not actually providing billed services;
- Providers who bill large volumes of claims before completing services;
- Providers who bill over 24 hours in a day; and
- Providers who are part of a network with other providers previously terminated from Medicaid and/or charged with fraud.

Claims for providers placed in the program go through comprehensive, hands-on, and clinically focused reviews in advance of payment. The review process:

- Eliminates payment of incorrect, unnecessary, or potentially fraudulent claims;
- Safeguards against unnecessary, excess payments or improper use of services;
- Determines whether the individual provider or agency providing services is appropriately qualified and trained, and whether provider documentation complies with DMA policy; and
- Identifies potentially fraudulent providers to submit referrals to DMA for further investigation.

In addition to fraud prevention, the review process promotes quality and beneficiary safety by assuring that appropriately qualified staff are providing services in adherence with Medicaid policy.

A provider placed on prepayment review remains subject to the claims review process until the provider is able to achieve three consecutive months with a minimum 70% clean claims rate. If the provider does not meet this standard within six months of being placed on prepayment claims review, the Department may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement or continuation of prepayment review for an additional six-month period. In no instance does prepayment claims review continue for longer than 12 continuous months.

Whenever a provider on prepayment review submits questionable or potentially fraudulent documentation to support claims billed, CCME submits a referral to OCPI for further investigation. Such falsified documents might include: (1) questionable employee records, timesheets, or logs; (2) potentially falsified degrees or certificates; (3) questionable applications or resumes; or (4) practices or procedures outside of acceptable scope.

Impact on State Agency Expenses

Prepayment claims review has proven to be an effective tool at reducing fraud, waste, and abuse. For SFY 2016, prepayment reviews resulted in over $20.5 million in denied claims and/or reduced claiming to the state associated with providers who were ultimately terminated from the Medicaid program.

DMA will continue to target prepayment reviews for providers with claims identified as high risk. In order to assure that the program is operating as efficiently as possible for providers and the state, DMA is currently working with stakeholders to review the existing program processes and requirements and determine if there are opportunities to streamline and expand the prepayment review process, while maintaining the integrity of the program.

Post Payment Claims Review

Under federal law (see Appendix C), DMA is required to investigate all complaints of Medicaid fraud or abuse. In these cases, OCPI begins with a preliminary investigation which, if warranted,

proceeds to a full investigation, and then to recovery. This method of addressing fraud is known as "pay and chase."

While this method is valuable and identifies substantial recoveries, it can be high cost and often only recovers a percentage of what is owed. In addition to the costs associated with the actual investigation there are legal costs associated with defending the cases, cases are often settled for amounts that are less than the initial notice of overpayment, and actual collections on average represent only a subset of the final overpayment amount. For example, in SFY 2016, OCPI completed 1,348 preliminary and 932 full investigations. Nearly 60% of the investigations conducted in SFY 2016 stopped at the preliminary level. For these cases, there were no recoveries associated with the costs of these efforts.

Recognizing the inherent inefficiencies of this "pay and chase" model, OCPI has taken steps to revise the core post payment claims review process to leverage this work in order to mitigate future improper and fraudulent claiming. Specifically, as part of the post payment investigation process providers may be:

- Issued notices detailing the specific findings associated with the investigation;
- Required to complete training that is tailored to address the specific issue identified;
- Required to develop a plan of corrective action; and
- Subjected to additional monitoring and review of claim activity and follow up visits.

The outcome of this change in process has been a noticeable and significant shift in provider billing behavior. For example, since SFY 2015, 319 providers have received a notice of finding resulting from one or more OCPI investigations. For these same providers, monthly claiming declined by an average of 7.5% in the 12 months after receiving a notice (through April 2016). Collectively, the annual reduced spending for providers who received findings notices in SFY 2015 totaled $9.9M. This difference is not estimated or projected, but rather is the actual observed difference in the average monthly billing for the identified providers for the 12 months immediately succeeding the receipt of a findings notice and requirement for corrective action.

While there are a number factors which contribute to the level of Medicaid billing on a month to month basis, there is a clear and consistent correlation over time between the receipt of OCPI findings and a sustained decrease in billing. This has allowed OCPI to leverage its post payment review process not only for recoveries, but also for mitigation and deterrence of future fraud, waste, and abuse. DMA will continue to refine, examine, and measure the outcomes of these efforts to validate these results over a larger set of data and time.

Conclusion

DMA is committed to having an active and robust integrity program that ensures state and federal dollars are appropriately expended for Medicaid services. Prepayment fraud prevention measures provide the most significant and efficient opportunities to address fraud, waste, and abuse. DMA has already implemented several highly successful strategies to identify and address prepayment fraud. Moving forward DMA will continue to build on this work through further refinement of these initiatives and through advancement of opportunities to strengthen program integrity infrastructure informed by these efforts.

Appendix A: N.C.G.S. § 108C-7. Prepayment claims review.

(a) In order to ensure that claims presented by a provider for payment by the Department meet the requirements of federal and State laws and regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review by the Department. Grounds for being placed on prepayment claims review shall include, but shall not be limited to, receipt by the Department of credible allegations of fraud, identification of aberrant billing practices as a result of investigations or data analysis performed by the Department or other grounds as defined by the Department in rule.

(b) Providers shall not be entitled to payment prior to claims review by the Department. The Department shall notify the provider in writing of the decision and the process for submitting claims for prepayment claims review no less than 20 calendar days prior to instituting prepayment claims review. The notice shall contain the following:
    (1) An explanation of the Department's decision to place the provider on prepayment claims review.
    (2) A description of the review process and claims processing times.
    (3) A description of the claims subject to prepayment claims review.
    (4) A specific list of all supporting documentation that the provider will need to submit contemporaneously with the claims that will be subject to the prepayment claims review.
    (5) The process for submitting claims and supporting documentation.
    (6) The standard of evaluation used by the Department to determine when a provider's claims will no longer be subject to prepayment claims review.

(c) For any claims in which the Department has given prior authorization, prepayment review shall not include review of the medical necessity for the approved services.

(d) The Department shall process all clean claims submitted for prepayment review within 20 calendar days of submission by the provider. If the provider failed to provide any of the specifically requested supporting documentation necessary to process a claim pursuant to this section, the Department shall send to the provider written notification of the lacking or deficient documentation within 15 calendar days of receipt of such claim. The Department shall have an additional 20 days to process a claim upon receipt of the documentation.

(e) The provider shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum seventy percent (70%) clean claims rate. If the provider does not meet this standard within six months of being placed on prepayment claims review, the Department may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement, or continuation of prepayment review for an additional six-month period. The Department shall give adequate advance notice of any modification, suspension, or termination of the Medicaid Administrative Participation Agreement. In no instance shall prepayment claims review continue longer than 12 months.

(f) The decision to place or maintain a provider on prepayment claims review does not constitute a contested case under Chapter 150B of the General Statutes. A provider may not appeal or otherwise contest a decision of the Department to place a provider on prepayment review. (2011-399, s. 1.)

Appendix B: 10A NCAC 22F .0104 PREVENTION

(a) Provider Education. The Division may at its discretion, or shall upon the request of a provider, conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program.

(b) Provider Manuals. The Division will prepare and furnish each provider with a provider manual containing at least the following information:
   (1) amount, duration, and scope of assistance;
   (2) participation standards;
   (3) penalties;
   (4) reimbursement rules;
   (5) claims filing instructions.

(c) Prepayment Claims Review. The Division will check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and other appropriate methods of review.

(d) Prior Approval. The Division shall require prior approval for certain specified covered services as set forth in the State Plan.

(e) Claim Forms. The Division's provider claim forms shall include the following requirements for provider participation and payment. These requirements shall be binding upon the Division and the providers:
   (1) Medicaid payment constitutes payment in full.
   (2) Charges to Medicaid recipients for the same items and services shall not be higher than for private paying patients.
   (3) The provider shall keep all records as necessary to support the services claimed for reimbursement.
   (4) The provider shall fully disclose the contents of his Medicaid financial and medical records to the Division and its agents.
   (5) Medicaid reimbursement shall only be made for medically necessary care and services.
   (6) The Division may suspend or terminate a provider for violations of Medicaid laws, regulations, policies, or guidelines.

(f) Pharmacy and Institutional Provider Agreements. All institutional and pharmacy providers shall be required to execute a written participation agreement as a condition for participating in the N.C. State Medical Assistance Program.

(g) The Recipient Management LOCK-IN System. The Department of Health and Human Services, Division of Medical Assistance, will establish a lock-in system to control recipient overutilization of provider services. A lock-in system restricts an overutilizing recipient to the use of one physician and one pharmacy, of the recipient's choice, provided the recipient's physician can refer the recipient to other physicians as medically necessary.

Appendix C: Federal Regulations

42 C.F.R. § 455.14 - Preliminary investigation

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

42 C.F.R. § 455.15 - Full investigation

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

(a) If a provider is suspected of fraud or abuse, the agency must—

(1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under §1002.309 of this title; or

(2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.

(b) If there is reason to believe that a beneficiary has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.