# ACAP Fact Sheet

# Program Integrity: A Priority for Safety Net Health Plans

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## Summary

This paper profiles the types of activities that Safety Net Health Plans undertake to prevent, detect, and resolve fraudulent or wasteful activities. Anecdotes of how five Safety Net Health Plans implement these strategies on the ground illustrate the focus these plans have placed on staying ahead of schemes and fraudulent behavior, and the techniques devised by Safety Net Health Plans to do so.


## Background

The Federal government estimates that, in fiscal year 2015, 9.45% of Medicaid payments were improper: they went to the wrong recipient, were for the wrong amount, lacked documentation, or were used in an improper manner. However, most of these errors occurred in fee-for-service programs and eligibility determinations; the improper payment rate in Medicaid managed care was an estimated 0.12%.[1] To achieve this low error rate, managed care plans devote significant staff and financial resources to preventing, detecting, and investigating fraud, waste, and abuse.

This fact sheet profiles some of the initiatives and activities of five Safety Net Health Plans to ensure program integrity. The featured plans serve low-income individuals in different states with varied regulatory environments and trends and give a good overview of how Safety Net Health Plans operate in this area. The featured plans are:

- **Affinity Health Plan**, which is based in the Bronx and operates Medicaid, Medicare, and Marketplace lines of business as well as a Special Needs Plans (SNP) for individuals dually eligible for Medicaid and Medicare
- **Community Health Choice** (Community), a health plan serving people with Medicaid and Marketplace coverage in Houston
- **Neighborhood Health Plan** (NHP), a Medicaid and Marketplace plan based in Boston
- **UPMC *for You***, a health plan in western Pennsylvania that has Medicaid and Marketplace lines of business and operates a SNP
- **Virginia Premier Health Plan**, which operates a Medicaid plan in Virginia and also participates in the State's Financial Alignment Demonstration for dually eligible individuals

[1] U.S. Department of Health and Human Services. (2015). "11.41 Medicaid Statistical Sampling Process." Fiscal Year 2015 Agency Financial Report. Pp 192-194. http://www.hhs.gov/afr/fy-2015-hhs-agency-financial-report.pdf

As wise stewards of public dollars, Safety Net Health Plans prioritize their program integrity efforts. Detection and prevention of fraud, waste, and abuse ensures that Safety Net Health Plans are able to spend their limited resources providing or supporting care for the vulnerable individuals they serve.

It must be stressed that the vast majority of providers are law-abiding partners to health plans and deliver timely, high-quality care. While plans have legal and ethical requirements to thwart fraud, waste, and abuse, they must structure their program integrity efforts in a manner that is not overly burdensome to their contracted providers or members.

All health plans have staff dedicated to program integrity initiatives and most have designated program integrity departments tasked with reducing and preventing the following:

- **Fraud,** or intentional deception or misrepresentation;
- **Waste,** defined as over-utilization or inappropriate utilization of services and misuse of resources; and
- **Abuse,** or practices inconsistent with sound fiscal, business, or medical practice.

As fraud, waste and abuse do not occur in a silo, program integrity efforts cut across all operational areas of a health plan, from medical management to claims to provider relations.

## Organization and Formal Plans

Every plan organizes its program integrity department somewhat differently. But all have common elements: compliance, program or payment integrity components and a Special Investigations Unit (SIU) – or, at least, the capabilities of an SIU integrated into other departments.

Compliance is essential to program integrity. All managed care organizations must have a compliance plan that addresses seven elements: written policies, compliance officer and committee, staff training and education, internal communication, enforcement, internal monitoring and auditing, and response to and correction of detected offenses.

When plans build their program integrity team, they often seek individuals with clinical and coding expertise, audit and investigations experience, and experience in a regulatory or law enforcement role. For example, **UPMC *for You*'s** program integrity department includes specialized physical and behavioral health teams. In addition to intradepartmental expertise, the departments responsible for ensuring program integrity work closely with other areas of the health plan including quality, utilization management, claims, pharmacy, provider relations, and analytics. Many plans have established standing committees on fraud, waste, and abuse; even more are pursuing collaborative interdepartmental projects and initiatives.

While compliance, program integrity, and the SIU form the core of a plan's program integrity efforts, employees in all departments are one of the first lines of defense in detecting and preventing fraud, waste, and abuse. **UPMC *for You*** has developed extensive employee training programs. In addition to training all new hires, every employee is required to complete online training and pass an associated quiz annually. The quiz consists of multiple choice questions developed by UPMC and modeled on scenarios devised by the Centers for Medicare & Medicaid Services (CMS). Departments are given training specific to their operational area; the content varies year to year, based on laws and regulatory requirements and prior-year cases and trends.

Health plans use vendors to supplement their operational capacity and expertise. These vendors, whose services range from care coordination to claims processing to specialty pharmacy, are invaluable partners to plans. In the course of their operations, vendors have the same opportunity as health plans to identify, prevent, and report fraud, waste, and abuse. Accordingly, **Community Health Choice** (Community) requires all vendors with which they contract, regardless of operational area or service provided, to have a fraud, waste, and abuse plan they share with the health plan. Community annually reviews and analyzes these plans to ensure they meet Community's high standards – if they do not, corrective action is required.

All plans view ensuring program integrity as a cross-plan initiative, and some use it as an additional opportunity for quality improvement initiatives. Because substandard and unnecessary provision of medical services fall under waste and abuse, program integrity efforts often align closely with a health plan's quality activities. **Community Health Choice** has worked to target nosocomial infections, often referred to as hospital acquired infections, as a type of waste that has a large impact on not only the plan's finances but also its members' health. Adding nosocomial infections as a target of the plan's SIU work plan gives Community yet another way to work with providers to improve the care its members receive. The program integrity department has been able to identify providers and facilities with high rates of nosocomial infections, and if applicable deploys the plan's clinical and provider relations personnel to educate the providers and improve their performance. This is just one example of how plans can use program integrity tools to protect and improve the health of their members.

## Coordination

Working alone, it is impossible for health plans to identify many fraudulent provider behaviors because they are unable to see the full scope of the provider's claims. A provider billing a single plan for several hours of work per day may appear reasonable, but if the plan could see the provider was also billing other plans for similar amounts that in total are unfeasible, it would be clear that an investigation is necessary. Additionally, schemes are often regional. Thus, working and sharing data and information among plans is necessary to bolster program integrity efforts.

In many states, health plans come together monthly or quarterly to discuss ongoing and emerging threats with respect to fraud and abuse. **Affinity Health Plan** participates in multiple working groups with other health plans, many of which include state regulators and inspectors general. At these meetings, plans are able to share their investigations and intelligence and see whether their industry peers are having similar experiences. There are several opportunities for New York plans to share information in these settings: quarterly meetings with plans and the State Inspector General to discuss broad trends; monthly meetings of specialized working groups, including meetings for SIU directors to discuss specific behaviors, claims, and providers; and national Medicare working groups. Proactive communication among plans and State regulators has led to multiple indictments against fraudulent providers in New York, and allows plans to act quickly to shut down schemes.

Just as health plans meet to share information, services developed by external vendors can help plans collaborate in a data-driven manner. **Verisk Health's Pooled Data Alliance** (the Alliance) is a component of Verisk Health's fraud, waste, and abuse solution set and is used by health plans with members in all fifty states to achieve the benefits of a cross-payer database with analytical capabilities. As with all of Verisk Health's Fraud Detection solution clients, members of the Alliance receive turnkey advice in the form of a referral containing specific, actionable

information about providers showing aberrant behavior. The Alliance database, which meets rigorous compliance and privacy standards, holds claims and associated personal health information for tens of millions of lives from multiple insurers.

Health plans that participate in the Alliance receive the value of analytics specifically targeted to identify fraud, waste, and abuse that is not detected in individual data sets, or may be detected faster when looking at significantly more data.

A broad spectrum of behavior is either uniquely identified by the Alliance, or detected more quickly. Examples include everything from a provider that bills for more than 24 hours in a day when examined in aggregate (even though their individual payer billing is reasonable), to equipment suppliers that are identified through geographic anomalies made visible through the breadth of data in the Alliance.

When potentially fraudulent or abusive behavior is identified, Verisk Health facilitates coordination between members of the Alliance to ensure that health plan member privacy is not compromised and that no anticompetitive issues arise. The combination of access to multi-payer data and the analytical tools that Verisk Health provides makes the Alliance a way for health plans to coordinate and collaborate across the country in a data-driven manner.

## Prevention

The best way to address fraud, waste, and abuse is to prevent it, and health plans have implemented a number of methods to reduce the opportunity for fraudulent, wasteful, or abusive behavior to occur.

**Community Health Choice** conducts an annual risk assessment by surveying a randomly selected portion of the plan's employees – from administrative assistants to claims examiners to eligibility analysts – in addition to executives and management. This approach gives the plan additional insight into the areas in which employees closest to the ground feel there is risk of fraud, waste, and abuse. This survey is supplemented with information from numerous external sources, including the annual Health and Human Services Office of Inspector General (OIG) Work Plan, which identifies areas predicted to be at high risk of fraud, waste, and abuse in the coming year; industry trends; and corrective action plans to create an organizational risk profile. Community then develops its compliance, internal audit, and SIU work plans based on this comprehensive risk profile.

All health plans must credential providers before enrolling them into the health plan network to ensure they are appropriately licensed and have not been barred from participating in government programs. After enrollment, plans are required to routinely check the OIG excluded provider list to confirm that all enrolled providers continue to be eligible to participate in the Medicaid and Medicare programs. Plans also conduct provider site visits as necessary to make sure facilities exist and are clean, accessible, and contain the proper equipment to meet the needs of their members.

Provider education is the cornerstone of many prevention efforts. Often, billing activities identified as potentially abusive or wasteful are not malicious and are the result of a provider's misunderstanding or mistake. **Virginia Premier Health Plan** strives to use its SIU as an educational tool for providers. The health plan realizes the importance of delineating between cases of potential fraud, waste, and abuse and those in which the providers simply have knowledge gaps regarding appropriate documentation and coding. In those instances, the plan

focuses on provider education which ultimately strengthens relationships with providers instead of building animosity. Virginia Premier's compliance manager attends provider trainings throughout the state to discuss documentation requirements and other compliance issues in an effort to make program integrity a collaborative effort between the plan and providers.

Health plans are increasingly using prepayment holds and review for claims and providers that are considered at higher risk of being fraudulent, wasteful, or abusive. **UPMC *for You*** requires certain providers to submit medical records with their claims, and if the medical record does not support the claim the plan does not pay it. Providers can be flagged for prepayment review in several ways, including through data analytics or the use of unlisted codes which are at high risk for abusive billing. In addition to prepayment holds, health plans use sophisticated claims edits to evaluate whether a claim is valid before payment—for example, an age or gender conflict, billing for a previously provided once-in-a-lifetime procedure, or claims for procedures that require additional medical review. Such edits include those developed as part of the National Correct Coding Initiative (NCCI).

**Affinity Health Plan** in New York has developed data analytics to improve its ability to identify fraudulent schemes using the extensive amount of data that passes through the plan every day. Data analytics allow the plan to identify outliers, and departments within the plan use this information to identify and refer cases of fraud or waste to Affinity's SIU and compliance department. Affinity uses these algorithms to ensure the plan does not pay suspicious claims, since the "pay and chase" of recovering an incorrect payment for fraudulent behavior, instead of not paying the claim in the first place, is time-intensive and not always successful.

## Detection and Investigation

Like many plans, the bedrock of **Neighborhood Health Plan's** detection is data mining and analysis. When the plan, or one of its vendors, notices aberrant or unusual billing patterns they are investigated further to determine whether they may be fraudulent. Since NHP's investigation process is integrated into its analysis unit, they do not have to hand off the information to a separate unit. If after detection and investigation Neighborhood Health Plan is able to make an allegation of fraud, they refer the case to the State Attorney General. In addition to pre- and post-payment claims reviews, NHP uses sophisticated modeling tools to try to identify providers and areas likely to be a problem in the future.

There are many ways that health plans partner with their members to ensure program integrity. Most plans advise members in their member handbooks and on the plan's website of how to identify and report fraud, waste, and abuse, including avenues for doing so in a confidential manner. Explanation of Benefit (EOB) documents are seldom used by Medicaid plans because their members rarely have cost-sharing requirements and sometimes the EOB creates more confusion than clarity. However, plans can choose to use these documents on a targeted basis to verify whether billed services were actually delivered. For example, **Virginia Premier Health Plan** sends EOBs to members. The plan also sends members Validation of Services letters, asking them if they received the services for which the plan was billed. The Validation of Services letter allows members to be aware of what claims were billed with their ID. The combination of these two documents results in members contacting Virginia Premier when they did not receive the service the plan was verifying, which in turn allows the plan to investigate whether the claim was potentially fraudulent and take appropriate action.

## Referral

Once plans have amassed enough evidence, often after collaborating with their industry peers and state regulators, they refer the case to law enforcement and relevant state and federal agencies and regulators. A productive and collaborative working relationship with state investigators and law enforcement is necessary to prosecute bad actors and recover fraudulent payments. While regulators are often not able to reveal the full scope of their investigations to plans during or after a referral, a strong relationship is important.

**Affinity Health Plan** views regulators and law enforcement as an extension of the plan's SIU. Instead of merely handing off cases, Affinity's investigators work collaboratively with regulators and law enforcement throughout the course of the investigation. Integrating Affinity's resources with those of the state and law enforcement results in more productive investigations and significant findings. While many plans have strong relationships with their state regulators and OIG, building similar relationships with District Attorneys and prosecutors is more difficult. Because Affinity's SIU has expertise that is not available to many District Attorney offices, such as clinical knowledge, it has been able to act as an investigative arm for the District Attorney.

## Challenges and Opportunities

Despite the many strategies deployed by health plans to prevent fraud, waste, and abuse, significant challenges still remain. Electronic health records (EHR), for instance, offer significant clinical potential. But at the same time, they make deception easier as providers can create nearly identical patient files and updates through a simple copy and paste. However, EHRs also offer the opportunity for health plans to easily access the appropriate portions of a member's EHR, allowing them to verify claims without requiring providers to manually supply medical records to support their submitted claims.

Changes in the way health care is covered and reimbursed also pose challenges to program integrity efforts. The emergence of non-traditional and value-based payments, while key to unlocking the essential value proposition of managed care, may create a challenge for program integrity efforts.

All health plans have limited resources, and all program integrity departments have to compete with other priorities for funding and staff. The "invisible" nature of program integrity work can make it hard for executives and health plan Boards of Directors to fully recognize its value, especially as plans are better able to mitigate risk and prevent fraud, waste, and abuse so the savings come in the abstract form of cost avoidance instead of concrete, recovered monies. However, it is clear that health plan executives value the role of their program integrity and compliance departments, and their collaborative work with other departments in the health plan allows them to create a larger footprint and impact than their often limited size would predict.

Despite these challenges, there is significant opportunity for plans to improve and streamline their program integrity efforts. Working and sharing data with other health plans in all lines of business, such as through Verisk Health's Pooled Data Alliance, or leveraging all-payer claims databases give health plans additional insights beyond what their claims and analytics offer.