

# Fraud and Detection and IT

MMIS Conference

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# Agenda

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- Fraud and abuse as an issue
- Fraud and abuse technology solutions
- Some tips

- World's largest supply management and healthcare information technology company
- Fortune 20
- Products and services for providers, payors, pharmacies and manufacturers
- Broadest national customer base in healthcare
- Market leadership in the payor market
- 30,000 + employees
- Proven strength and stability over 170 years

# Fraud vs. Abuse

## *Fraud*

- ▶ Intentional misrepresentation
  - Knowing that it could result in some unauthorized benefit for provider or others.

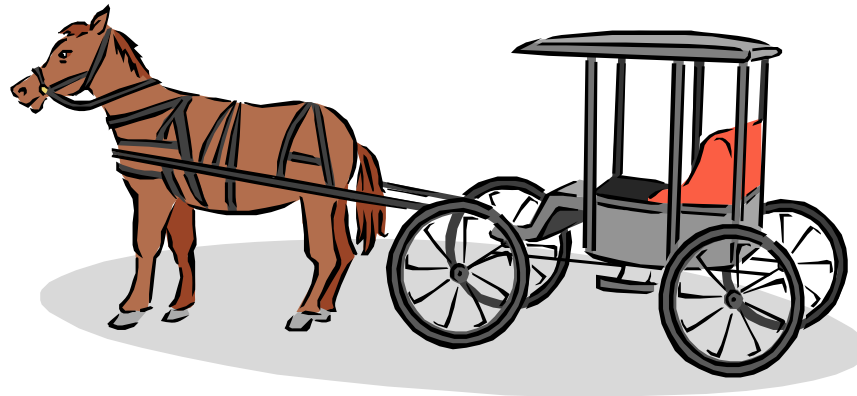
## *Abuse*

- ▶ Provider practices that fail to meet professionally recognized standards or medical practices, which result in unnecessary costs
  - Overuse of modifiers across wide range of patients

# Pay and Chase

**“We pay claims at the Speed of Light, but chase Fraud and Abuse with a Horse and Buggy”**

**-- Malcolm Sparrow, “License to Steal”**



# How Big is the Problem?

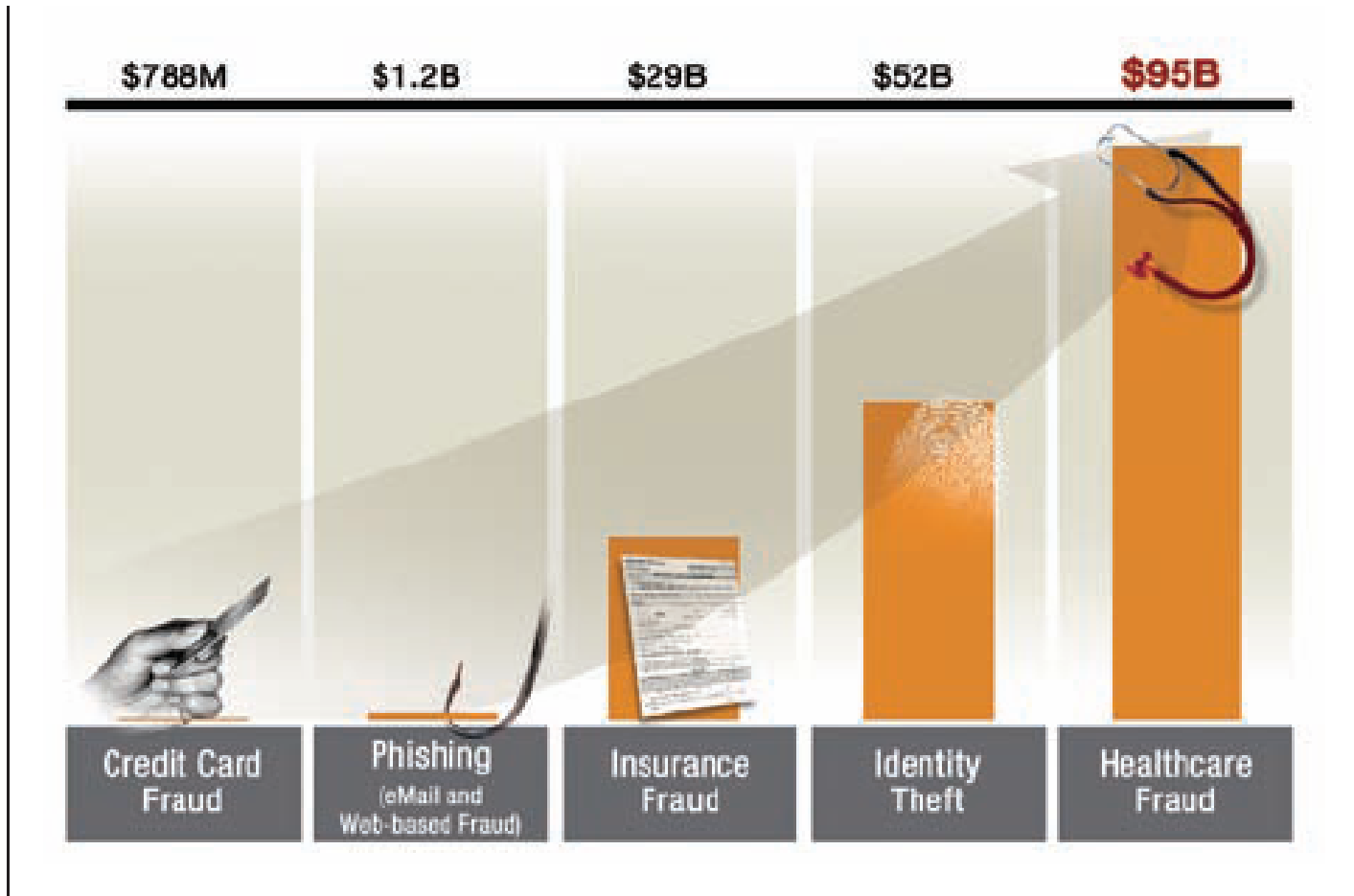


Figure 1 Fair Isaac Fraud Estimates for 2004 Based on Data From Various Sources

# Typical Provider Fraud Activities

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1. Services not furnished
2. Multiple bills for same services
3. Using a reimbursement category higher than justified by patient's condition
4. Furnished service that was not medically necessary
5. False cost reports
6. False statements or false information in
  - a) Claims
  - b) Qualifying applications

# Payors Share Detection Issues

- Avg. collection = \$0.40 - 0.60: identified \$\$\$<sup>1</sup>
- Medicaid: 6.3% of total reimbursement = fraud or abuse<sup>2</sup>
- 50% of states spend < 1/10 of 1% of program expenditures on activities to safeguard program payments<sup>3</sup>
- Lack automated detection, investigation and prevention tools.
- Only identify already known schemes
  - ▶ Heavy IT resources and investment
  - ▶ No short-term, pre-pay results



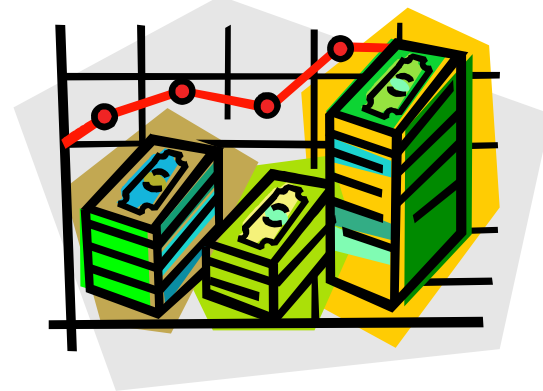
1 National Health Care Anti-Fraud Association

2. Taxpayers Against Fraud Education Fund, 2003

3. General Accounting Office, 2001

# HHS Study: 2002-2005

- 26 States accepted  $< 1$  referral/month
- 21 MFCUs received  $< 12$  referrals per state
- Only 3 MFCUs received  $> 100$  referrals
  - ▶ Florida (215)
  - ▶ Arizona (192)
  - ▶ Texas (180)



*Medicare Fraud Control Unit -- MFCU*

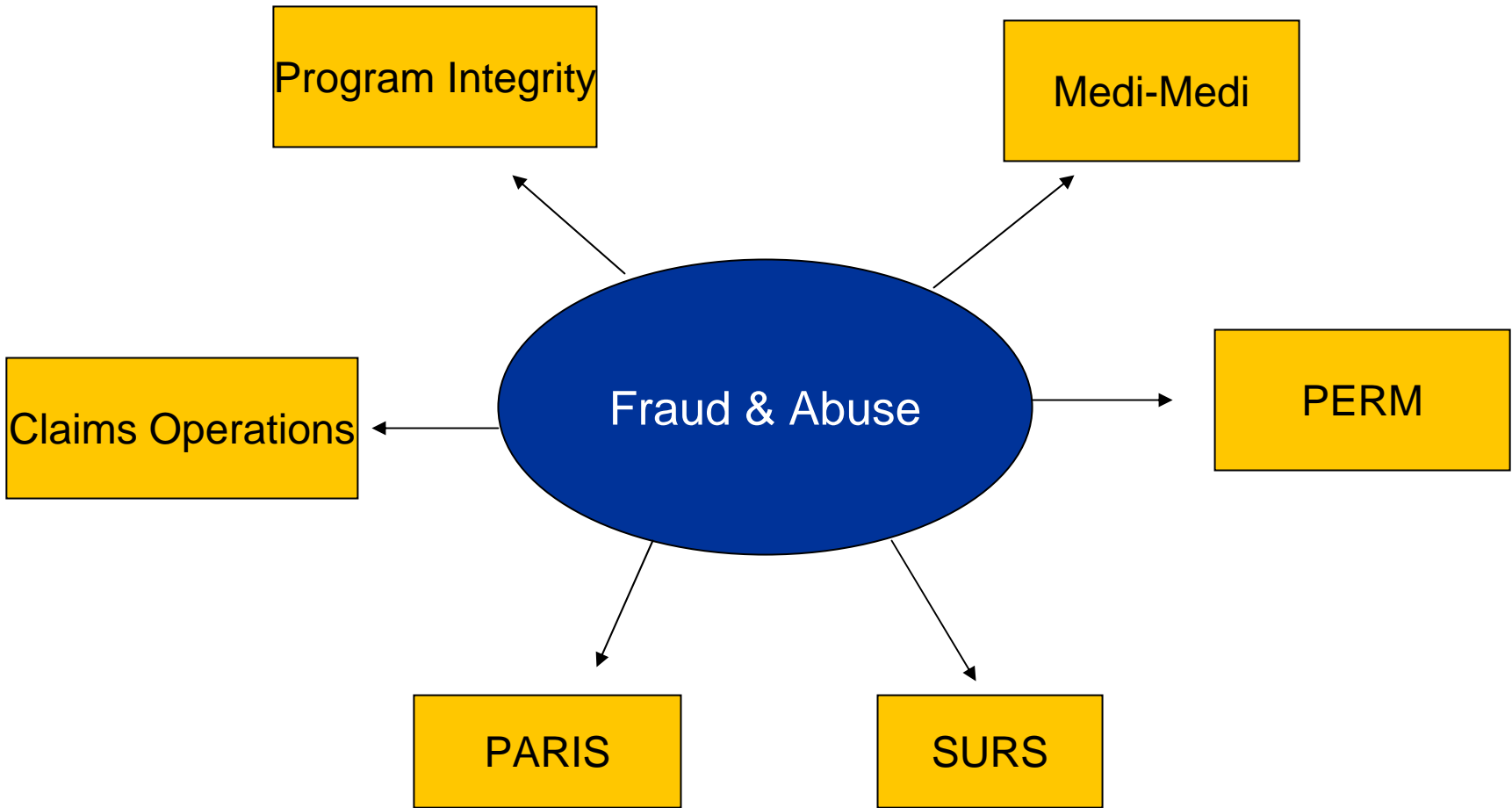
# Amount of Fraud Money Recouped/\$ MCKESSON Invested in it's MFCU, by State

## *Medicaid Fraud Control Unit (MFCU) Statistics FY2000-FY2003*

<b>State</b>	<b>Amount</b>
New Mexico	\$5.39
Indiana	\$4.58
Minnesota	\$4.55
Virginia	\$4.48
New Jersey	\$4.34

<b>State</b>	<b>Amount</b>
Iowa	\$0.40
Wyoming	\$0.35
Utah	\$0.33
Rhode Island	\$0.27
Delaware	\$0.11

# Impacts Many Areas of Medicaid



# The Impacts are Real

## ■ Direct Impact to Healthcare Payors:

- ▶ Wasted benefit \$\$\$
- ▶ Increased administrative costs
- ▶ Decreased profits
- ▶ Strain & drain on resources: PI, claims ops, clinical reviews, IT
- ▶ Detriment to delivery of quality healthcare at reasonable costs.....

## ■ Payors demand:

- ▶ Proactive solution against fraud and abuse

# What Do Payors Do Today?

- Vast amount = retrospective, post-pay
- Lack of adequate detection tools
  - ▶ Retrofit decision-support, analytics, data warehousing and reporting systems for fraud and abuse
- Unable to effectively qualify data results
- “Get the bad guys” mentality
- Functional areas siloed within organization

# F&A Evolution



Model:

**Reactive**

**Retrospective**

**Prospective**

**Integrated**

Methods:

- Hotline
- Serendipity

- Data warehouse
- Rules-based system

- Analytics
- Clinical Rules
- Integration w/ code editing

- Full automation
- Enterprise-wide access and communication

Results:

Breakeven at best

Some savings positive ROI

Significant financial and admin. savings

Significant increase ROI Process



# Why Invest in a Fraud & Abuse Solution?

- **Detect, manage & control fraud and abuse**
  - ▶ Identify areas with high \$ benefit dollar outlays
  - ▶ Identify providers repeatedly billing improperly
  - ▶ Track and report investigations; measure progress
- **Save dollars to control rising premiums**
  - ▶ Keep dollars in house (for the State, not Federal)
  - ▶ Report and prove value of anti-fraud efforts
- **Resolve issues prospectively**
  - ▶ Minimize 'pay and chase'
  - ▶ Prevent errant dollars from leaving the building
  - ▶ Manage and comply with Federal and state regulations

# Features Available

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- Pre-pay or post-pay detection
- Automated detection and analysis
- Rules, Analytics
  - ▶ Clinically based
  - ▶ Predictive and data-driven analytics
- Drill down capability
- Forwarding and assignment
- Compliments code auditing
- Reporting
- Electronic case management
- Installed and/or hosted solutions

# Benefit Impact

- Increased savings
- Quick turnaround time for detection and analysis
- Focus on highest risk claims = reduce false positives
- Clinical views help investigations: easy-to-understand, easy-to-defend
- Electronic case management = easy to share information internally and externally
- Efficiencies in IS/IT resources

# What Can You Do Now?

- **Assess your current environment: benchmark**
  - ▶ Efficiency and Effectiveness
  - ▶ Goals: current and future
  - ▶ Pre-pay vs. Post-pay
  - ▶ Technology Needs and Wants
  - ▶ Resource Needs
- **Seek help if needed**
  - ▶ MFCU
  - ▶ Fed and State Legislatures
  - ▶ Outside vendors
  - ▶ Internal IT
  - ▶ Clinical and Claims Processing

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