Montana
Children, Families, Health and Human Services Interim Committee

Kelli Garvanian, *Vice President – Program Integrity Solutions*

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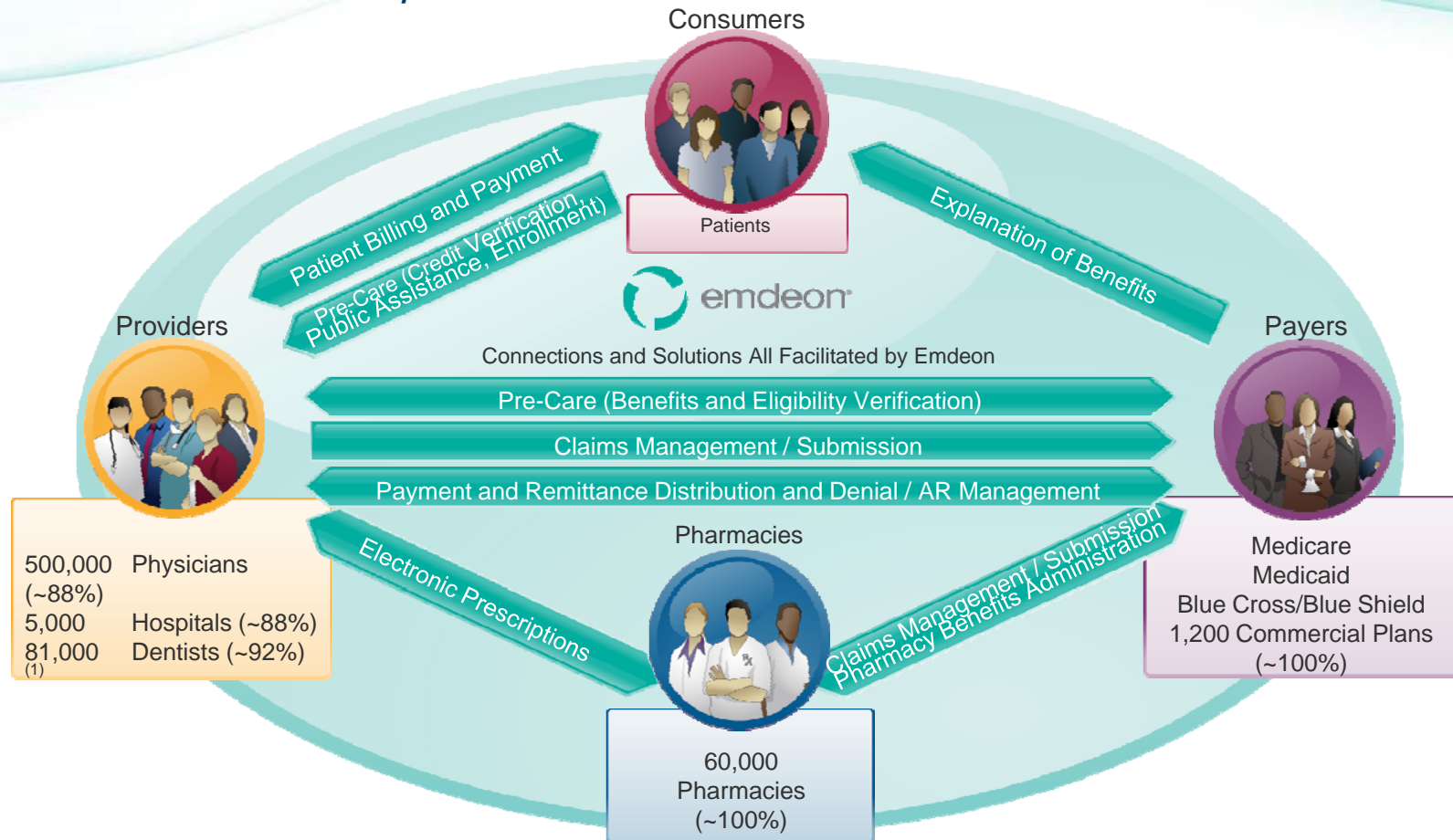
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Agenda

- Emdeon Overview
- Emdeon's Connectivity Montana
- Montana Medicaid Concerns
- Highlights of CMS Final Rule 6028
- Montana's Environment for Program Integrity Solutions
- Assisting Montana in Meeting Financial and Regulatory Goals
- The Impact for Montana
- Fraud Detection Positions
- Emdeon's Program Integrity Solutions
- Summary

Emdeon:
We Connect All Principal Healthcare Constituents

Consumers

Patients

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Providers

Patient Billing and Payment

Pre-Care (Credit Verification; Public Assistance, Enrollment)

Explanation of Benefits

Payers

Connections and Solutions All Facilitated by Emdeon

Pre-Care (Benefits and Eligibility Verification)

Claims Management / Submission

Payment and Remittance Distribution and Denial / AR Management

Pharmacies

Electronic Prescriptions

Claims Management / Submission
Pharmacy Benefits Administration

500,000	Physicians (~88%)
5,000	Hospitals (~88%)
81,000	Dentists (~92%)
(1)

Medicare
Medicaid
Blue Cross/Blue Shield
1,200 Commercial Plans
(~100%)

60,000
Pharmacies
(~100%)

Emdeon is the largest healthcare, finance administration, and clinical patient data network in the U.S. healthcare system. We are a leading provider of healthcare revenue and payment cycle management solutions, connecting payers, providers and patients in the U.S. healthcare system

Emdeon Connectivity in Montana:

- Heat Map of Claims Sent by Providers Through Emdeon to Montana: 182,000 Medicaid and 596,916 Commercial Claims
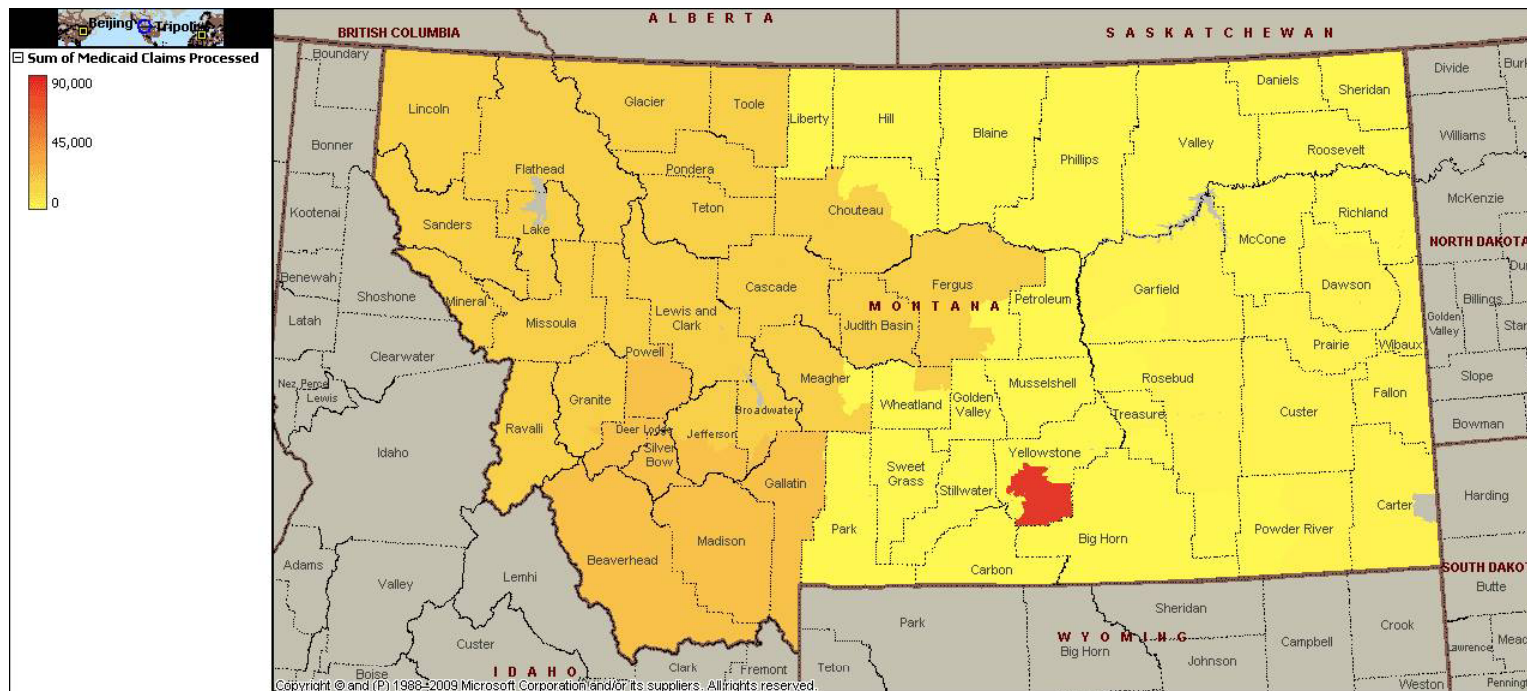
- Commercial Connectivity:
  - Support a variety of products & services with virtually all commercial payers in the State, including but not limited to Aetna, BCBS of MT, Coventry, Humana, Sterling, United, etc.

Montana Medicaid Concerns
Enrollment and Budget _Challenges Facing Montana Medicaid_

- State Budget Surplus

  - _Estimated $426 Million by Mid-2013*_

- Substantial growth in beneficiary population projected in the coming years

  - _Current enrollment: 81,597**_
  - _Projected Enrollment: 160,000_
  - _Current Medicaid Health Spending: $844 Million**_
  - _Projected Medicaid Health Spending: $1.68 Billion_

- Current Fragmentation of Medicaid Beneficiary Data

  - _100% Fee For Service_
  - _No Managed Care_

- National fraud savings estimates range from 3%- 10%***

- Improper overpayments for fee-for-service medical claims are estimated to be $12 Billion (federal share) and $21 Billion (total computable) for Medicaid in FY 2007****

- CMS estimates Medicaid payment error rates of 8.3% for fee-for-service claims****

•http://www.businessweek.com/ap/financialnews/D9RF5M3O0.htm
** http://www.dphhs.mt.gov/2011biennialreport/mtmedicaidreport.pdf
*** See, for example, Health Care Anti-Fraud Association. (2009); _The problem of health care fraud;_ Federal Bureau of Investigation. (2007); _Financial crimes report to the public: Fiscal year 2007;_ PricewaterhouseCoopers' Health Research Institute (2008); _The price of excess: Identify waste in healthcare spending_
** **These estimates are taken from the FY 2007 Comprehensive Error Rate test (CERT) program for Medicaid

Highlights of CMS Final Rule 6028

- Move from a Pay-and-Chase Model to Prevention-and-Detection
- Predictive Modeling that ranks High-Scoring Claims and providers by Degree of Suspicion
- Utilize Data Analysis to Detect and Identify Improper Payments
- Suspend payments for those providers with sanctions and pending allegations in state, out of state, Medicare or other government agencies
- Combine Detection, Action and Investigation for complete Fraud Management
- Enhanced Provider Screening and Enrollment Requirements with Provider Verification, Criminal Background Checks and Fingerprinting
- Recovery Audit Contractors must Identify and Recover Overpayments and Underpayments
- Currently implemented by Medicare now and to be implemented by Medicaid in 2014
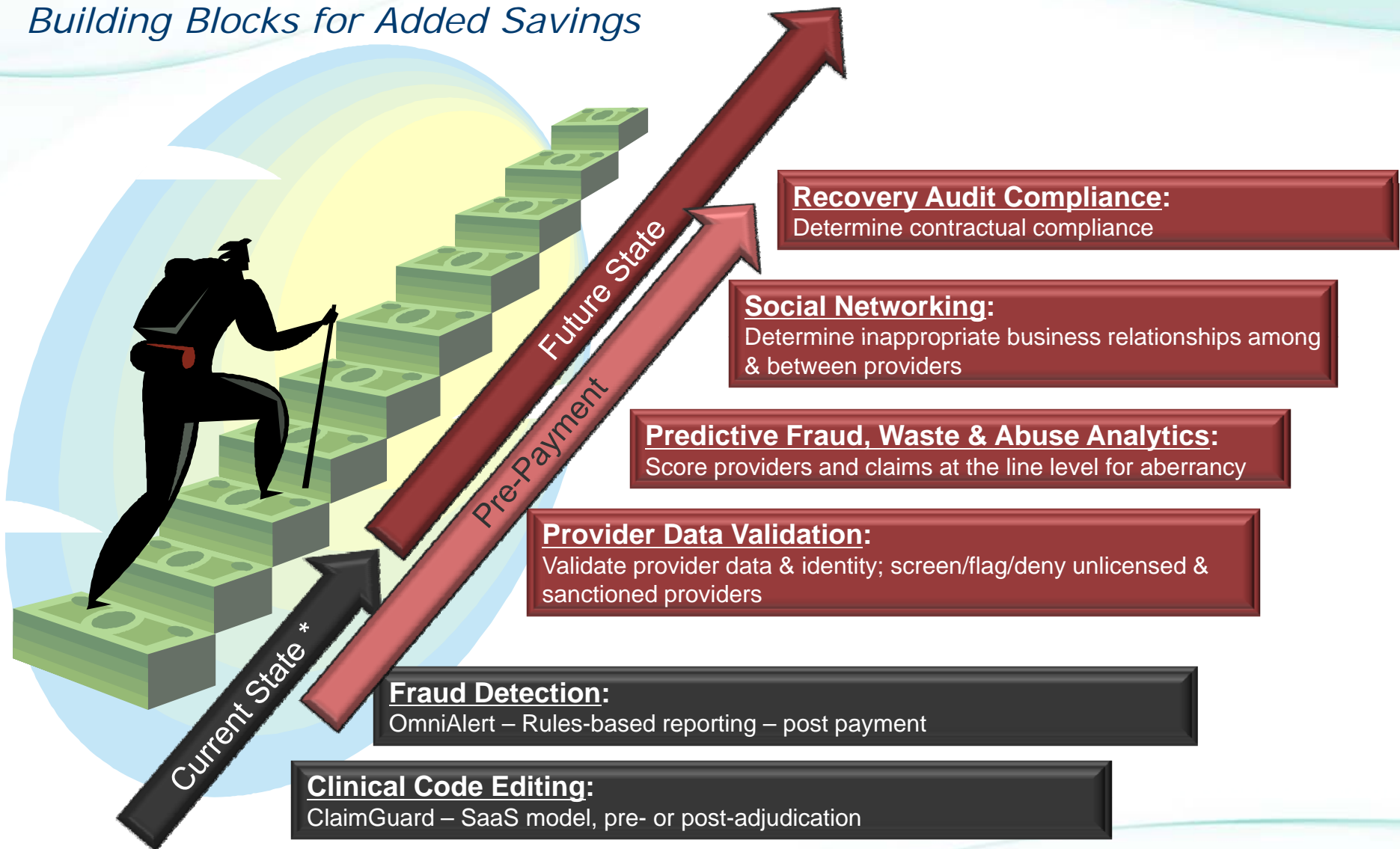
CMS Final Rule 6028
Montana Compliance

CMS Rule 6028	Current State	Future State
Move to Prospective, Pre-Payment Program Integrity		✔
Predictive Modeling Scoring of Claims and Providers		✔
Clinical Code Editing (NCCI of 2010)	✔	✔
Enhance Provider Screening and Enrollment		✔
Provider Verification, including Fingerprinting		✔
Enhance Recovery Audit Contract Compliance		✔

Montana's Environment for Program Integrity Solutions:

Building Blocks for Added Savings

Recovery Audit Compliance:
Determine contractual compliance

Social Networking:
Determine inappropriate business relationships among & between providers

Predictive Fraud, Waste & Abuse Analytics:
Score providers and claims at the line level for aberrancy

Provider Data Validation:
Validate provider data & identity; screen/flag/deny unlicensed & sanctioned providers

Fraud Detection:
OmniAlert – Rules-based reporting – post payment

Clinical Code Editing:
ClaimGuard – SaaS model, pre- or post-adjudication

Future State

Pre-Payment

Current State *

* Predictive Care Management: Impact PRO – care management tool, not designed as FWA tool
Decision Support System: QueryPath

Assisting Montana in Meeting Financial and Regulatory Goals:

Goal & Mission: **Provide care for those most in need**

Strategy: **Retain critical budget dollars**, ensuring monies spent

1.) Pay for accurately for legitimate and necessary care, and

2.) Support processes to maximize internal efficiency, allowing Montana to do more with less

Essential Tactics to Support Goal & Mission:

- **Ensure compliance** with Federal mandates, (Rule 6028, National Correct Coding Initiative & portions of Patient Protection & Affordable Care Act/PPACA)

- **Ensure cost-savings** methods are deployed and dollars retained, even in the face of modification or repeal of PPACA

- **Employ state-of-the-art technology** to maximize savings and increase operational efficiency

- **Shift to prospective detection and case building**; retain dollars before they are spent, eliminating cost of post-payment efforts which often exceed recoveries

- **Build more complete case files** faster & easier

- **Reduce costly & time consuming false-positives** from the investigative workload

- **Uncover new and previously undetected aberrancies**

- **Decrease reliance on random sample audits** and beneficiary self-reporting; eliminate bias challenges from investigations

- **Apply clinical appropriateness and contractual compliance reviews** across all beneficiaries

The Financial Impact for Montana
Using Industry-Proven Solutions

- $514.8M spent in top 4 categories of Medicaid Health Expenditures*

  - *Fraud Exposure Estimated at 3% - 10%**:*

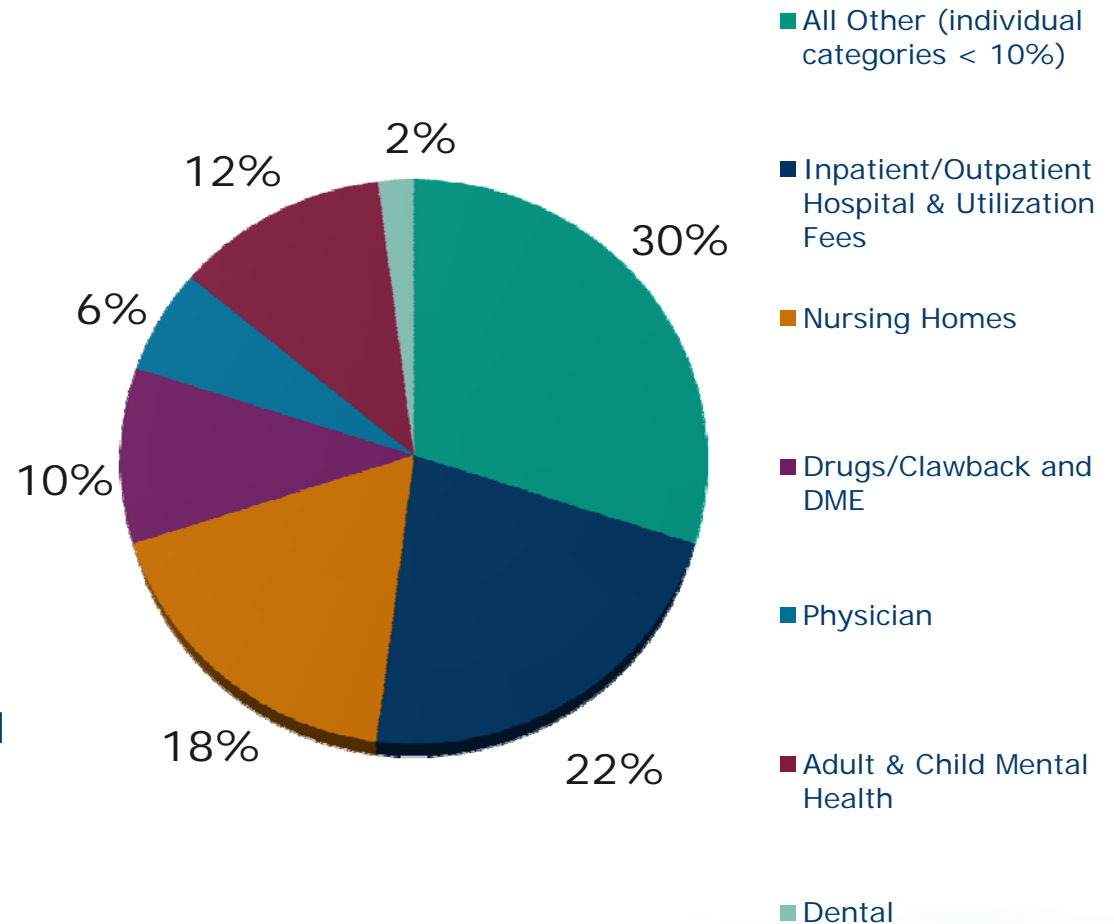 - *Potential Savings for Montana:*

    $2.6M - $15.4M

- $844M in Current Total Medicaid Health Expenditures*

  - *Potential Savings for Montana:*

    $4.2M – 25.3M

- $1.68B in Projected Total Medicaid Benefit Expenditures*

  - *Potential Savings for Montana:*

    $50.4M - $168M for Montana

Montana SFY09 Medicaid Benefit Expenditures*

Pie chart legend:
- All Other (individual categories < 10%)
- Inpatient/Outpatient Hospital & Utilization Fees
- Nursing Homes
- Drugs/Clawback and DME
- Physician
- Adult & Child Mental Health
- Dental

Pie chart values: 2%, 12%, 30%, 6%, 22%, 10%, 18%

*http://www.dphhs.mt.gov/2011biennialreport/mtmedicaidreport.pdf
** See, for example, Health Care Anti-Fraud Association. (2009); *The problem of health care fraud;* Federal Bureau of Investigation. (2007); *Financial crimes report to the public: Fiscal year 2007;* PricewaterhouseCoopers' Health Research Institute (2008); *The price of excess: Identify waste in healthcare spending*

Program Integrity Model Legislation

Move from Pay and Chase to Prevention and Detection through:

Provider Data Verification

Clinical Integrity for Claims
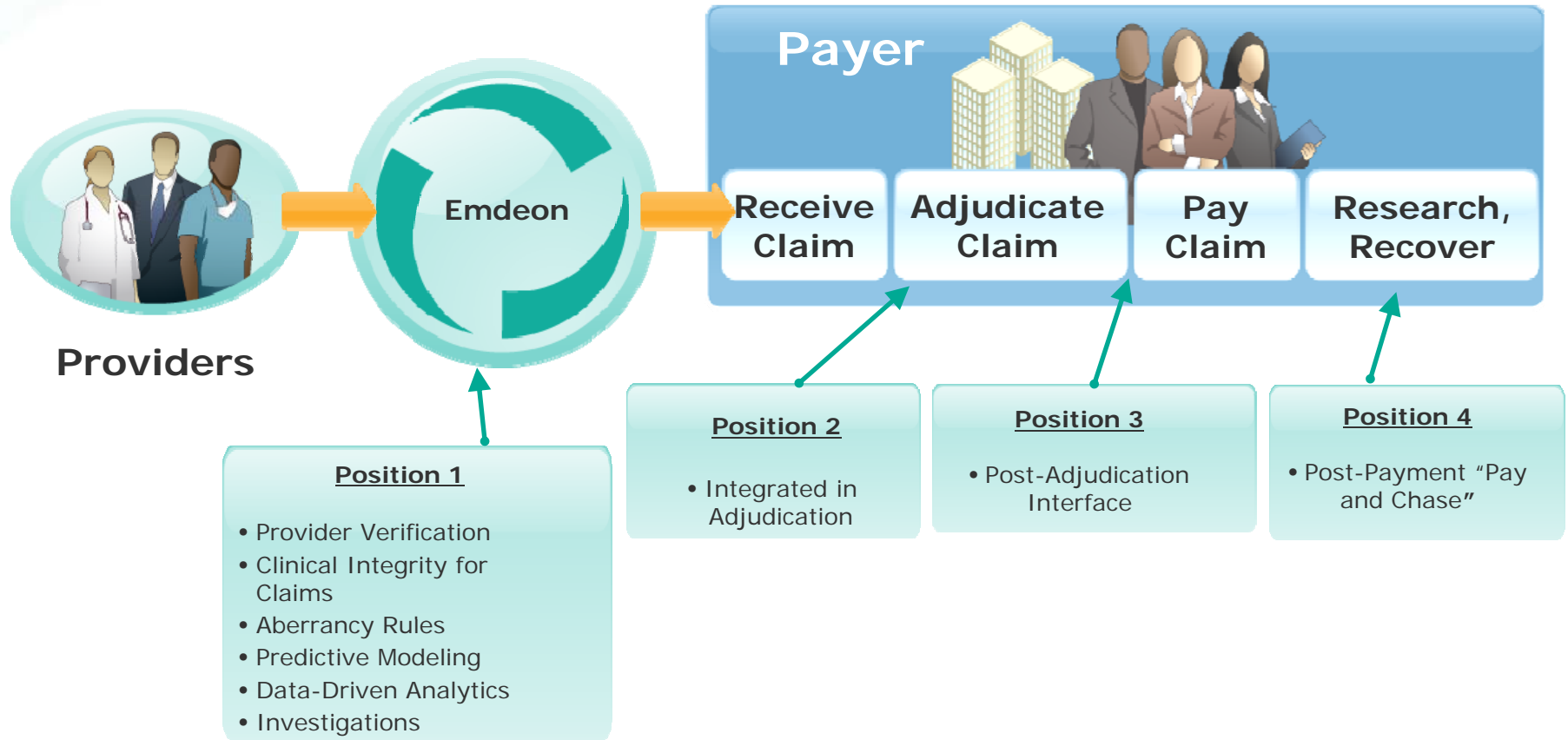
Predictive Modeling

Pre-Pay Analytics

Recovery Audit Compliance

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Fraud Detections Positions
Move "upstream" for Prevention and Detection

Providers

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Payer

| Receive Claim | Adjudicate Claim | Pay Claim | Research, Recover |

Position 1

- Provider Verification
- Clinical Integrity for Claims
- Aberrancy Rules
- Predictive Modeling
- Data-Driven Analytics
- Investigations

Position 2

- Integrated in Adjudication

Position 3

- Post-Adjudication Interface

Position 4

- Post-Payment "Pay and Chase"

Why Emdeon Program Integrity Solutions?
Prospective Prevention and Detection is the Key to Maximizing Savings

Provider Data Verification
- Dead doctors
- Licensure
- Sanctions
- Address validation
- Onsite fingerprinting

Clinical Integrity for Claims
- Duplicates
- Unbundled pairs
- CCI Editing
- Custom edits

Fraud Detection Rules
- Provider specific
- Clinically appropriate thresholds
- Specialty-specific

Predictive Analytics
- Known and unknown schemes
- Overutilization
- Data-Driven Case Management
- Social Networking

Investigations
- Triage or full outsource
- Pend/pay/deny recommendations
- Request and review medical records

Recovery Audit Compliance
- Medical billing guidelines
- Contractual obligations
- Reimbursement rates and policies

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Provider Data & Identity Verification

- In-stream real time provider verification against a Provider database that is continuously updated
- Apply provider verification at multiple positions in the claims continuum.
- Provider database is continuously updated
- We use the 'source of truth' or authority source for each element
- We update our database each time a source is changed to ensure that the healthcare provider information is as up-to-date as possible
- Provide onsite primary source provider identity validation & fingerprinting in all 50 states through industry-leading Emdeon team partner

<u>Some of our data sources include:</u>

- State License Boards
- State Sanction Boards
- OIG, DEA, NPPES
- OFAC, Social Security Deathmaster
- Proprietary Data
- Physician self-reported information

Clinical Integrity for Claims

- Edit claims in sub-second real-time, across total patient history and payer specific reimbursement policies anywhere in the claims stream and with any transaction system or interface

- Auto Denial – No Human Intervention

- Up Coding, Unbundling, Medical Necessity

- Increased savings — Typically an additional 2% above legacy editing systems

- Fully open-sourced edits from sources including CMS and the AMA

- Increased auto-adjudication and first pass rates

- Unmatched insight into operations with claims analytics and data mining from 80 terabyte data warehouse

- Low appeal rates (<3%)

Benefits and key identifiers:

- The automated edit modules shall never flag a Claim that is not supported by a clear policy

- National Correct coding Initiative Rule Set

- Outpatient Facility Logic

- Medically Unlikely Edits, Multiple Procedure Discount, Duplicate Procedure, Incidental Procedure, Global Surgery, NCD, LCD and other Rule sets

- Report Top active rules by provider, Top savings by both rule and provider

- Provider coding variance by rule

- Specific edit messages to facilitate communication with providers

Predictive Analytics, Predictive Modeling, Case Management and Social Networking

- Powerful solution the technology is similar to that used by the credit card industry to analyze healthcare claims transactions

- Risk Scores the Claim and the Provider for each transaction

- Data Driven Case Management and Social Networking System

Benefits and key identifiers:

- Ranks high-scoring claims and providers by degree of suspicion and provides reasons why – no human intervention

- Sees beyond the bigger picture of healthcare delivery, Updates historical context with every transaction

- Combines detection, action and investigation modules for complete fraud management

- The action module links scores, reasons and claims data, enabling reviewers to quickly understand problems and take the right actions

- Best of Breed Predictive Analytics: Emdeon has made significant investment in predictive modeling to leverage our breadth of data to create unique data models using data-driven analytic tools

Recovery Audit Contractor (RAC)

Emdeon's Audit and Recovery division serves as a value-added resource to healthcare payers by identifying improper payments. Emdeon's Audit and Recovery division (formerly known as EquiClaim) is one of the largest national providers of healthcare claims audit and recovery services for government and commercial payers, which includes CMS for its RAC demonstration and expansion programs

Benefits and key identifiers:

- Delivers comprehensive cost management strategies to government and commercial payers in the healthcare industry through its suite of clinical review services.

- Post-payment service capable of reviewing medical claims before or after provider payment

- Identifying new claim types to audit

- Improving processing and operating efficiencies to increase savings yield

- Increase Fraud, Waste & Abuse recovery by targeting market and sales activity to state Medicaid plans

Provider Screening Requirements According to Risk Levels
Background Check, Fingerprinting and Site Visits

Screening Requirements	Limited	Moderate	High
Verification of any provider/supplier-specific requirements established by Medicare	✅	✅	✅
Conduct license verifications (may include licensure checks across states)	✅	✅	✅
Database Checks (verify Social Security Number(SSN) and the SSA's Death Master file; the National Provider Identifier (NPI); the List of Excluded Individuals/Entities (LEIE)	✅	✅	✅
Unscheduled or Unannounced Site Visits		✅	✅
Fingerprint-Based Criminal History Record Check of law enforcement repositories			✅

Summary: Impact of Emdeon Program Integrity

Benefits can span across Montana & Beneficiaries

Budget	Operations	Legal & Compliance	Providers	Beneficiaries
• Impact bottom line • Avoid "pay and chase" • Lower IT costs • Decrease appeals • Facilitates tighter controls on MCO rate setting	• Decrease false positives • Help keep suspect claims out of claims payment cycle • Enables comparative analysis across populations, geographies, clinical indications & MCOs	• Improve data for litigation • Section 6028 compliance • Improve information sharing	• Increase transparency • Improve provider education opportunities	• Protect medical budget dollars • Direct dollars toward care • Improved care through the sanction & elimination of fraudulent providers from the network

You don't need one more partner.
You need **one** partner that does **more**.

You and Emdeon.
one.
more.

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