EXHIBIT 2
DATE 1/30/13
HB 171

Montana Program Integrity (HB Bill 171) FAQs and Talking Points:

The Issues: The problem of healthcare fraud, waste and abuse is a serious and ongoing one. As a Medicaid plan with annual expenditures of over $936 million and a projected growth to $1.4 billion by 2014, the State of Montana Department of Public Health and Human Services provides an attractive opportunity for a small number of unscrupulous individuals to enrich themselves at the public expense.

The Patient Protection and Affordable Care Act of 2010 Final Rule 6028 calls for state Medicaid's to implement Pre-Pay, Prevention and Detection Fraud, Waste and Abuse methodologies by 2014. In stream, real time integration of Predictive Modeling and Provider Verification enables the states department of health to meet this challenge quickly and flexibly and secure the CMS match.

These services could help the state recover between $4 - $14 million in 2013 and $7 - $21 million in 2014 when the Medicaid enrollment is projected to almost double in Montana. Second it will help the state move from its current ranking of 49th in the number of fraud investigations and move from its position of 48th in the recovery rate for every federal dollar spent, all while driving tremendous efficiencies in the related departments by incorporating these data driven technologies, which allow the staff to do more with less.

The assumption behind this program is that the majority of providers are honest. The goal is to work behind the states MMIS system after it has completed its edits, but before any payments are released. Predictive Modeling would identify and filter out the rare exceptions, providers committing fraud or creating waste. Intelligent logic would be used to set a minimal amount of flags, stopping only the most egregious claims. 99% of claims are paid without impact. For the remainder, the majority is cleared immediately; the data builds the case allowing staff to investigate efficiently.

Remember it's not what you know it's what you don't know. Rules and queries are for Known Fraud Schemes, Predictive Data Driven Analytics with link analysis are for unknown fraud such as;

- Complex fraud and abuse patterns
- New and emerging Fraud Issues
- Undiscovered schemes
- Organized fraud

Section 1: State Metrics

- **State Budget Surplus**
  - **$426 Million surplus by Mid-2013***
- **Substantial growth in beneficiary population projected in the coming years**

- Current enrollment: 151,422**
- Projected Enrollment: 233,947 (based on growth of 54.5% between 2014 – 2019)
- Current Medicaid Expenditures: $936,180,189***
- Projected Medicaid Health Spending: $1,446,398,392

- Current Fragmentation of Medicaid Beneficiary Data
  - 100% Fee For Service**
  - 0% Managed Care**

Section 2. Current State of Montana Medicaid

Montana Ranks 49th of 50 states in number of fraud cases investigated, with only 19 cases in FY11****

Montana Ranks 48th in recovery rate at $.92 for federal dollar spent*****

Montana – MFCU Statistical Data for Fiscal Year 2011****					
Investigations			Indicted/Charged		
Total	Fraud	Abuse/Neglect	Total	Fraud	Abuse/Neglect
21	19	2	2	2	0
Convictions			Recoveries		
Total	Fraud	Abuse/Neglect	Total	Criminal	Civil
1	1	0	$2,751,485.89	$5,916.32	$2,745,569.57
Expenditures					
MFCU Grant Expenditures			Total Medicaid Expenditures		Staff on Board
$724,218.59			$1,006,762,581.00		8

Current State – Future State

CMS Rules 6028	Current State	Future State
Move from a Retrospective, Pay and Chase model to a Prospective, Pre-Pay Model	OmniAlert – Rules-based reporting (post-pay)	Move to a pre-pay predictive modeling and provider validation system
Predictive Modeling Scoring of Claims and Providers	OmniAlert- Rules-based post payment reporting system	Predictive Modeling that scores individual claims at the claim line level for aberrancy with a data driven case management system. This system also includes social networking/link analysis that determines

		inappropriate business relationships among and between providers.
Clinical Code Editing (NCCI of 2010)	ClaimGuard – Bloodhound code editing software	Meets the requirements of CMS Rule 6028
Provider Verification	Various degrees of sanctions related to medical professional licensing boards	Automated provider screening and validation performed on a claim by claim basis
Enhance Recovery Audit Contract Compliance	State awarded a RAC contact in December 2012	Meets the requirements of CMS Rule 6028

Section 3: Eight Characteristics of a Best-in-Class FWA Solution

Fraud, Waste and Abuse management solutions vary in both sophistication and efficacy. However, the most effective programs have many or all of the following characteristics and can:

1. Use data-driven analytics to drive meaningful understanding of patterns, trends and FWA identification in a continuous learning mode
2. Leverage large cross-payer database for more comprehensive FWA analysis, which is especially valuable to regional payers
3. Employ both rules-based and predictive, data-driven analytics for provider profiling
4. Apply clinical code edits with business rules, to reflect and enforce a payer's contracts and payment policies
5. Reduce false positives
6. Employ experienced, highly trained investigators and analysts
7. Facilitate the investigatory workflow by prioritizing outcomes
8. Examine both provider-level and claims-level data

Section 4: The Solution

1. **Pre Pay Provider Data Validation:** The pre-adjudication in stream claim validation of deceased, retired, expired license, possible allegations of fraud and sanctioned providers, including provider sanction details and related professional background information, serves as an additional net to identify suspect claims and providers.

2. **Pre- Pay Predictive modeling with an integrated case management system with link analysis:** Using a neural network as the basis for its predictive analytics, Predictive Modeling solution "learns" as more data is fed into the system. Therefore, the aberrance, subtle nuances, and changes in the data are discovered, and the model changes as the data, as well as the fraud and abuse, changes. This allows for future claim lines and providers to be scored differently, based on the historical data and algorithms existing within the system.

a. **Seeded Analytics:** The predictive analytics organization which serves as the backbone of the credit card fraud detection industry, to develop and deploy a solution unparalleled in the healthcare industry. This powerful solution uses a combination of patented profiling technology, predictive models, statistical analysis and rules to achieve a level of detection accuracy that is unmatched. The analytics models are seeded with close to one billion claims. By pairing analytics models with proprietary analytics and cross payer data base claims experience, this has created an unparalleled predictive analytics engine that is able to dig deeper into the data to find more potential savings.

b. **Link Analysis:** A link analysis engine finds connections between transactions, people, third parties and discrete fraud events that can reveal previously-hidden fraud schemes. The combined capabilities expand the view of the fraud investigator and enable the identification of more-complicated fraud patterns, criminal fraud rings, and networks of collusive participants that might otherwise appear disconnected from a fraud problem.

Section 5: Expected Savings

Pre Pay Provider Validation: **0.5% - 1.0%**

Pre Pay Predictive Modeling and Case Management: **0.5% - 2.0%**

Current Savings Range (2013): **$4 Million – $14 Million**

Projected Savings Range (2014): **$7 Million - $21 Million**

2013 Expected Savings			
Acute Care		**Potential Savings Percentage**	
		1%	**3%**
Inpatient Hospital	**$180,446,399**	**$1,804,464**	**$5,413,392**
Physician, Lab & X-ray	**$54,028,302**	**$540,283**	**$1,620,849**
Outpatient Services	**$71,105,402**	**$711,054**	**$2,133,162**
Prescribed Drugs	$32,644,257		
Other Services	$181,289,148		
Payments to Medicare	$32,630,058		
Managed Care & Health Plans	**$5,922,228**	**$59,222**	**$177,667**
Totals	**$558,065,794**	**$3,115,023**	**$9,345,070**

Long Term Care		Potential Savings	
		1%	3%
ICF-ID	$12,659,441		
Mental Health Facilities	$15,429,808		
Nursing Facilities	**$155,934,899**	**$1,559,349**	**$4,678,047**
Home Health & Personal Care	$176,696,886		
Disproportionate Share Hospital Payments	$17,393,361		
Totals	**$378,114,395**	**$1,559,349**	**$4,678,047**
Grand Totals	**$936,180,189**	**$4,674,372**	**$14,023,117**

Expected Savings in 2014 *Medicaid Expansion to 133% of Federal Poverty Level (FPL): Estimated Increase in Enrollment and Spending Relative to Baseline by 2019. Expected increase is 54.5%.			
Acute Care		**Potential Savings Percentage**	
		1%	3%
Inpatient Hospital	**$278,789,686**	**$2,787,897**	**$8,363,691**
Physician, Lab & X-ray	**$83,473,727**	**$834,737**	**$2,504,212**
Outpatient Services	**$109,857,846**	**$1,098,578**	**$3,295,735**
Prescribed Drugs	$50,435,377		
Other Services	$280,091,734		
Payments to Medicare	$50,413,440		
Managed Care & Health Plans	**$9,149,842**	**$91,498**	**$274,495**
Totals	**$862,211,652**	**$4,812,711**	**$14,438,133**
Long Term Care		**Potential Savings**	
		1%	3%
ICF-ID	$19,558,836		
Mental Health Facilities	$23,839,053		
Nursing Facilities	**$240,919,419**	**$2,409,194**	**$7,227,583**
Home Health & Personal Care	$272,996,689		
Disproportionate Share Hospital	$26,872,743		

Payments			
Totals	**$584,186,740**	**$2,409,194**	**$7,227,583**
Grand Totals	**$1,446,398,392**	**$7,221,905**	**$21,665,716**

Section 6. Frequently Asked Questions

1. ***What's the cost of the system?***
   As the technologies all exist today, it is recommended that the state pursue a Software as a Service, (SaaS), approach. This way there is no cost to the state for hardware, hefty license fees or "build-it" costs; the costs themselves would be based upon the running and maintenance of the Program Integrity tools themselves, as well as potentially the savings generated.

2. ***Are these products available in a Commercial off the Shelf format?***
   Yes

3. ***What are the various ways the state can contract for these types of services?***
   In the original draft of the model legislation, the intent was for the savings generated from the solutions to fund the cost of the tools themselves, so separate budgetary line items or allocations would not be needed. The payment methodology to the vendor(s) could be made in any number of ways: contingency basis, per-beneficiary-per-month, per-transaction or mixed model.

4. ***Where is this system being used or being purposed? Federal, States, managed care , etc***
   There are a number of services contained in the legislation and to ensure compliance with the Affordable Care Act, Section 6028; these services are live and actively deployed in varying degrees across both the public and private sector. In addition CMS has contracted with Northup Grumman/ Verizon in 2011 to deliver this service for Medicare.

   For example Texas, Kansas & California Medicaid utilizes predictive modeling tools, though it is done on a retrospective basis. Many states are now performing pre-payment Clinical Code Editing on Medicaid claims in compliance with the 2010 deadline established under the National Correct Coding Initiative. However, no state is performing all checks and balances as outlined in Section 6028, with pre-payment fraud detection being the major outlier, though this is being done in the commercial payer sector today.

5. ***How do you detect over utilization?***
   Over-utilization is detected is a number of ways – analysis is done based on provider, beneficiary and service types. Providers are profiled to determine practice patterns and comparisons to their peers – that is like provider specialties serving like populations. Providers with specific service types which fall outside "normal parameters" are recommended for further investigation. Regression analysis is also done to look at patterns of services to determine whether specific billing patterns or beneficiary usage also fall outside the norm and warrant further review.

6. ***Is this technology proven?***
   See #4

7. ***How can Montana's system, current and future, work with a Pre Pay predictive modeling and provider verification program or do we have to scrap our investment?***
   No, the state does not need to scrap existing systems and investments.

   The solutions discussed can be plugged in virtually anywhere along the claim processing lifecycle, prior to actual payment of the claim. Each solution can also be plugged in individually in different places – it all depends on what the state decides will integrate best into the workflow.

   Since it is recommended that the solutions are interfaced in a "Software as a Service" (SaaS) model, the claims would loop out from the state after adjudication but before the claims is paid , run through the appropriate analytic engines and then return to the state to continue along the processing and analysis workflow.

8. ***This is new technology and it's not being adopted by states***
   Yes and no. CMS has contracted with Northup Grumman/ Verizon to deliver this service for Medicare however Predictive modeling and Provider Verification isn't adopted by the states on a pre-payment basis yet (though TX ,WA, PA, RI, IL, FL, MN, AZ have RFI's and RFP's respectively). However, many are doing some form of RAC work, utilizing pre-pay clinical code editing and performing some form of provider validation

9. ***This will slow down the payment to the providers and/or care to beneficiaries:***
   It is important to note the measures would not:

   - impact or delay the delivery of care to patients in any way, as all tools are utilized to assess claim data, which is submitted for payment as it is today...<u>after</u> services are rendered

   - Or delay payment of legitimate reimbursements to providers, as all electronic validations and scoring of claims happens within hours...24 hours at most...of receipt of the claims

10. ***Will the state be flagging a very large number of claims and creating tremendous provider disruption?***
    The State is able to set the sensitivity on what scores they want to flag for review and which they want to let pass through. Typically in a rules-based only fraud, waste & abuse detection system, one should see between 0.5% - 2% flagged claims. Of that, typically ~90% are given the all-clear in 24 hours. So, the numbers are very small. When utilizing a predictive modeling solution, there will be some lift in the number of cases flagged, but it's not like it will jump to 10% of all claims.

Section 7. Success Stories and Client Experiences

1. **Commercial Medicaid Client** - $16M in savings - Circumventing the capitation payments by billing physicals (not covered under capitation) rather than problem-focused visits (which were covered under capitation)

2. **Medicaid Client** - $249K in savings - Incorrect calculation of quantities for a pulmonary hypertension drug that is administered via infusion.

3. **Medicaid Client** - $Savings Not Disclosed - Providers billing for periodontal scaling & root planing on children (periodontal disease is an adult disease). Policy Change Implemented: Disallowed for bene's under age 14

4. **Medicaid Client** - $Savings Not Disclosed - Dentists billing $8/tooth pulp vitality tests for every tooth, for every beneficiary seen. Policy Change Implemented: $1/mouth for this procedure.

5. **Commercial Client** - $15.3M in savings - From identifying systematic problems and policy concerns based on 15 months of data scored in a fraud project.

6. **Commercial Client** - $15M in savings - Policy gap ID'd that had allowed billing of small amounts as professional interpretation of automated lab tests

7. **Commercial Client** - $6.4M in savings – Policy gap ID'd that had allowed a contracted Specialty Pharmacy to circumvent the contracted negotiated rates and system limits for provision of IVIG (Immunoglobulin) by filling prescriptions from an out of state pharmacy.

Section 8. Summary of Key Talking Points

- This bill reinforces requirements on the Medicaid program under the Affordable Care Act, but takes them a step further for enhanced fiscal conservancy and assurance that scarce budget dollars will be utilized for those most in need...not for those attempting to defraud the State.

- The review of each medical claim on a claim-by-claim basis is an enhancement above current protections in place to ensure *at the time of payment* that the provider billing for services has not been sanctioned, otherwise suspended, (in any state, not just Montana), or is deceased. Current methods employed by most states rely on the provider's status at time of enrollment or re-enrollment with the Medicaid program, followed by retrospective reviews after claims are paid.

- The pre-payment scoring of claims for the likelihood of fraud/waste/abuse much like the credit card industry flags suspicious transactions prior to allowing the charge to appear on your card. The approach mirrors programs implemented by CMS for the Medicare program and stops

improper payments from being made, while having minimal impact and creating no discernible delays in the processing of proper payments to legitimate providers for care rendered

- Pre Pay Predictive Modeling and Provider Verification are currently being used on all Medicare claims and selective private insurance companies
- This legislation has no up-front costs – it is based upon the industry's standard shared-savings model
- This legislation will help bring the state into compliance with the ACA by 2014
- This legislation changes the state's model from what is called a "pay and chase" model to a "prevention and detection" model.
- This legislation allows the state to seek out patterns of fraud and indentify emerging schemes as they happen with a integral case management system that in real time data builds the case for the investigator
- This legislation allows for peer to peer Medicaid billing comparison of real time claims with the advantage of a multi payer data base
- The intent is to make the state more efficient and to successfully prosecute more fraud cases with less effort
- These solutions are already being used in the private sector, Medicare, and states will be the last adopters for Medicaid and CHIP
- Is not specific to any one vendor (about 5 vendors that provide this technology)
- This is simply a tool for the state's existing fraud team to catch more fraud, waste and abuse, up-front (pre-payment), rather than post-payment.
- Across the board, we have found that this is a bipartisan bill that members of both parties have jointly supported.
- This legislation can save the state between 1% and 3% of its paid claims
- This legislation can be up and running in 120 days or less

* http://www.businessweek.com/ap/financialnews/D9RF5M3O0.htm
** http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/montana.htmlhttp://www.dphhs.mt.gov/2011biennialreport/mtmedicaidreport.pdf
***http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=56&rgn=5http://www.statehealthfacts.org/profileind.jsp?ind=198&cat=4&rgn=12&cmprgn=1 - - projections based on Kasier Family estimates of enrollment to change by 54.5% by 2019
****Numbers based of the MFCU statistical data report - https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp
***** U.S. Department of Health and Human Services ranks Missouri Medicaid Fraud Unit number one in nation for 2008, Missouri Attorney General, Jan 12, 2010