

EXHIBIT NO. 1DATE: 3.20.13BILL NO. HB 171

Pre-Payment Fraud Detection and its Impact on the Bottom Line

An ounce of prevention is worth a
pound of cure.

Summary

The phrase, "An ounce of prevention is worth a pound of cure" aptly applies to a movement within the healthcare payment industry: Fraud, waste and abuse (FWA) prevention. Today, because of lean budgets and compelling cost analyses, payers are motivated to find solutions that can offer payment integrity by identifying FWA before they pay erroneous claims. However, to achieve payment integrity, payers must consider adopting a proactive, preventive approach for optimal aberrance detection.

This paper intends to help payers determine the best ways to protect themselves against FWA. It demonstrates the benefits of proactive, in-stream claim review and illuminates powerful preventive resources, helping payers understand how to limit unnecessary claim payment, which could save them significant time and money.

In this Paper, You Will Learn:

- How shifting to a pre-adjudication or pre-payment fraud detection solution can yield significant financial impact
- Characteristics of an effective pre-payment FWA management solution
- Organization, system and process implications of adopting a pre-payment FWA management solution

An Emdeon and FICO
White Paper



emdeon®

Simplifying the Business of Healthcare

Introduction

Recent estimates indicate three to ten percent of national healthcare spending is lost annually to abuse. The Patient Protection and Affordable Care Act, enacted in March 2010, brought about requirements and changes in federal law that directly and substantively addressed costly abuses.⁽¹⁾

As a result, the payer community has collectively deemed FWA management solutions a top priority. In the past, payers often saw FWA solutions as legal and regulatory expenditures, but many now see them as an essential business initiative. To operate effectively, payers must respond to new laws directly, understanding that FWA programs can help them avoid significant costs and improve overall profitability.

Payers' Pain Points

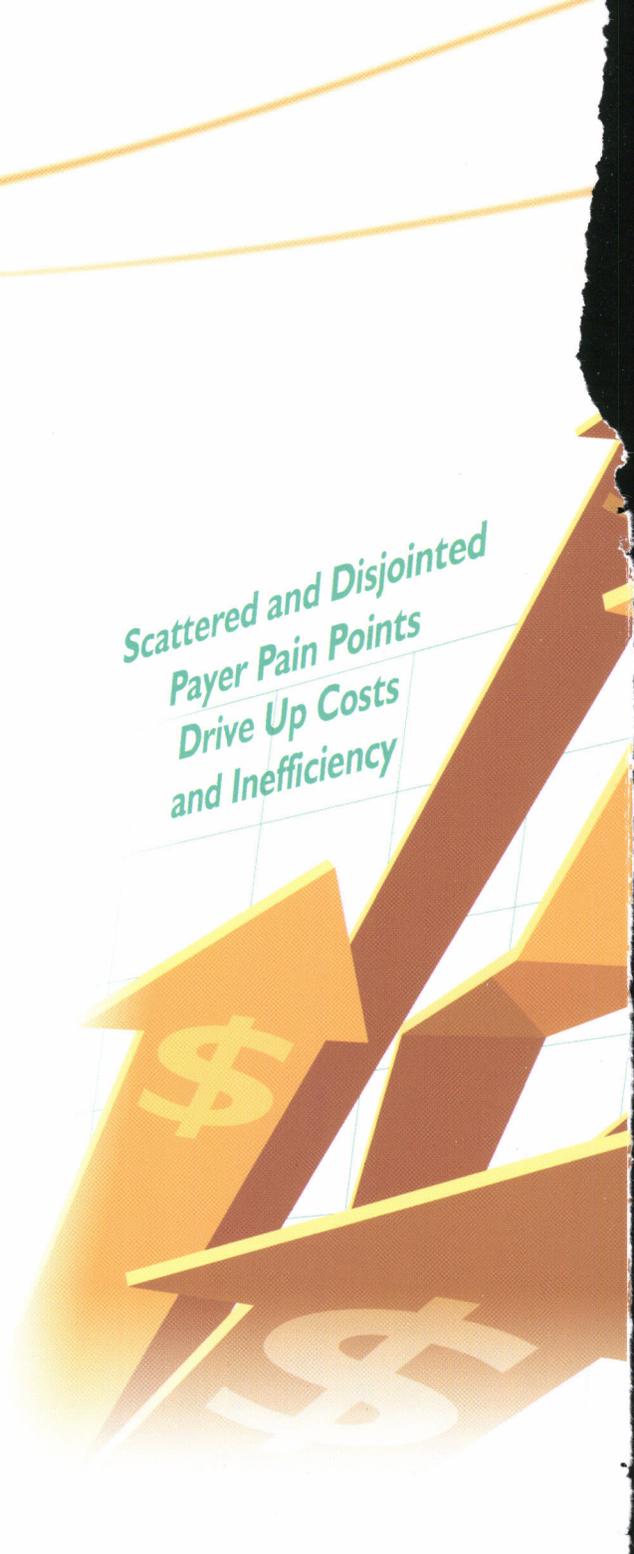
Several factors influence a payer's business objectives and, when combined, can dramatically affect the bottom line:

- **The high cost of FWA.** The \$68-\$226 billion of healthcare dollars lost annually is an enormous blow to health insurance organizations—particularly when some of those dollars are lost trying to fight FWA with limited success.⁽²⁾ Investing in a comprehensive payment integrity solution can help payers make significant progress in the fight against erroneous claim payments.
- **A constrained economy.** Economic factors are driving the need for more cost containment, forcing payers to prioritize resources based on their financial impact. Healthcare payers must address these issues head on to survive a highly competitive landscape. Because managing costs is imperative, many payers must determine where to reduce operational and medical expenses; a comprehensive FWA program may help reduce both.
- **High claims volume.** The sheer number of claims processed is daunting, creating a needle-in-a-haystack scenario for identifying FWA. Even with automation and safeguards, erroneous claims can go undetected, easily bypassing administrative edits in most claims adjudication systems.
- **Difficulty identifying FWA.** Many claims appear compliant initially, but when investigated, prove aberrant. These claims are innately difficult to identify, prove erroneous and resolve, and may include procedures that are:
 - Medically inappropriate
 - Beyond the scope of the provider's medical license
 - Billed but never performed

⁽¹⁾ FBI Financial Crimes 2008, http://www.fbi.gov/stats-services/publications/fcs_report2008

⁽²⁾ From The National Health Care Anti-Fraud Association (NHCAA),

http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_central&wpscode=TheProblemOfHCFraud



Scattered and Disjointed
Payer Pain Points
Drive Up Costs
and Inefficiency

- 
- **The enormous scope of FWA.** The scope of FWA is so large it overwhelms many commercial insurers' resources, which are not equipped to address the issue. While some payers staff special investigation units (SIUs), many lack the tools and resources necessary to combat FWA extensively or to their maximum benefit.
 - **The prevalence of fraudsters.** Along with unscrupulous providers, organized crime rings steal patient identification and create fictitious services and procedures that not only defraud payers but also alter patients' medical histories permanently, endangering their health and safety. Perpetrators often elude detection and relocate before the fraud is uncovered. Some patients may commit fraud by allowing friends and family members who have little or no health coverage to use their identities.
 - **Ineffective claims processing methods.** Retrospective claim review frequently fails to recover the majority of money paid. Some payers' in-house FWA detection programs are understaffed and ill equipped to assess suspicious claims. In addition, post-payment (or "pay and chase"), technology can take months to detect and analyze the problem. By this time, payers are less willing to negotiate settlements, and truly criminal organizations may have already changed locations and schemes. Proactive fraud abatement and automated review processes can help payers fight fraud more effectively.
 - **A changing landscape of players.** An increase in mergers, acquisitions and consolidation of payer organizations has changed how payers approach FWA, given evolving organizational infrastructure and associated adjustments.
 - **Changing ICD-10 Standards.** U.S. providers will soon adopt new global coding standards that may inadvertently open the door for wasteful, innocent errors as well as fraud and abuse. Providers will be required to change their coding systems to reflect new codes for thousands of diseases, symptoms, injuries and abnormal findings, in accordance with the World Health Organization's International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) for diagnosis coding.⁽³⁾

⁽³⁾ From: The World Health Organization, <http://www.who.int/classifications/icd/en/>

Pre-Payment Benefits for Private Payers

The shift in the federal government’s approach - from pay and chase to a pre-payment fraud detection model - is also leading to a procedural shift for private payers. According to the National Health Care Anti-Fraud Association (NHCAA), most of the 70 percent of private payers who use anti-fraud solutions do so retrospectively.⁽⁴⁾ Though post-payment has been status quo for many years, recovering funds can be a costly endeavor.

Payers that implement a pre-payment FWA model can use analytic tools to identify potential problems early in the claim life cycle—pre-adjudication or pre-payment—and, thus, catch FWA before paying the claim. Pre-adjudication solutions combine predictive, data-driven analytics, rules-based analytics, integrated code edits, clinical aberrancy rules and provider verification to catch potentially fraudulent or erroneous claims even before claims reach payers.

This prospective approach can help payers:

- Drive down costs from invalid or inappropriate claims
- Reduce payment errors
- Avoid payment delays for claims deemed legitimate
- Improve processes, for more accurate data
- Systematically remove unnecessary costs in the claims process
- Improve capital position by retaining funds earlier in the process

“Gartner believes government mandates emerging from healthcare reform will require a paradigm shift for fraud, waste and abuse detection that will force commercial health insurers to evolve to a pre-payment, pre-adjudication review. This will demand new IT capabilities, an enhanced role for risk management and a profound cultural change among health insurers.”

Maureen O’Neil,

Principal Research Analyst, Gartner Research
 “FICO, Emdeon Offer New Model to Combat Health Insurance Fraud,” April 19, 2010

The following table summarizes the benefits of moving from post-payment analytics to pre-payment analytics.

Post-Payment Analytics	Pre-Payment Analytics
Delayed response to risk results in costly pay and chase	Same-day or real-time analysis helps prevent payers from issuing checks for suspicious or erroneous claims
Requires stable, complete data	Can analyze risk accurately even when data is incomplete
Action is cost-justified only when there is a large financial impact	Action is cost-justified even for small instances of FWA, which become significant as they accumulate
Results in costly legal proceedings against perpetrators	Shapes billing behaviors proactively, reducing the need for legal proceedings

⁽⁴⁾ From National Health Care Anti-Fraud Association figures, <http://www.nhcaa.org/>



Eight Characteristics of a Best-in-Class FWA Solution

FWA 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

Data-Driven, Predictive Analytics

These analytic-based systems examine patterns and trends to detect outliers. For the best results, payers can deploy predictive analytics *before* payment, either prior to or during adjudication. Unlike rules-based systems, data-driven analytics delve deep into data and find not only known aberrancy, but also unknown and emerging schemes that rules-based analytics may not recognize.

Analytic solutions review hundreds of thousands of data, examining hundreds of variables in various combinations simultaneously to detect unusual fraud patterns that emerge—patterns that were previously unknown. Along with that information, the analytic models provide reasons and contextual information so investigators and analysts can make rapid, informed decisions.

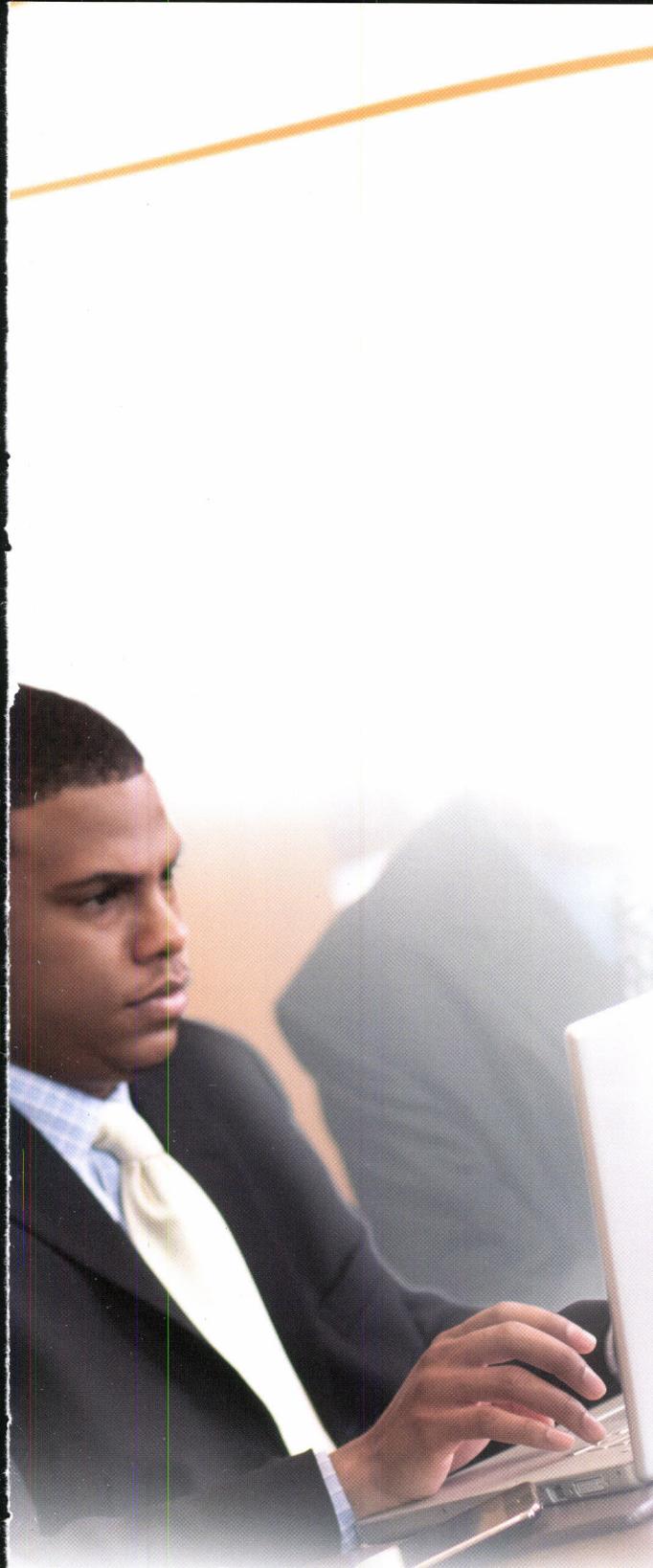
Cross-Payer Data

Payers that manage their own FWA detection see only a very small slice of the (healthcare) world, and are unable to readily identify and prevent claims payment related to new fraud and abuse schemes. Solutions that combine data from multiple sources provide a more complete view of potential FWA.

Aberrancy Rules

As a conduit between clinical edits and FWA-focused predictive analytics, clinical aberrancy rules provide a safety net. Unlike traditional clinical edits or fraud-based rules, aberrancy rules look across multiple data variables and time to determine unusual behavior in the claim. These rules are also able to “count,” so an alert is fired only when the claim exceeds a clinically determined threshold. Not only does this provide one more layer to a multi-faceted payment integrity program, it also gives clinical context to the analytics, allowing even more certainty that a claim or provider is aberrant.





Clinical Code Edits

Most pre-payment systems are rules-based solutions, featuring clinical code screens and edits. These software solutions apply clinical code edits to incoming claims to determine if the claims comply with the payer's payment policy. Using millions of open-source edits to catch aberrations, clinical code edit technology can find coding errors, unbundled treatments, unusual and inconsistent treatment patterns and inappropriate diagnoses. After review, the vendor returns the claims to payers or providers with corrected claim information. Payers can use these solutions pre- or post-adjudication, but always before they pay a claim.

Fewer False Positives

For years, frequent false positives and the time and money spent investigating them made pre-payment analysis undesirable. However, new technologies have significantly decreased both the occurrence of false positives and the subsequent number of manual reviews needed to respond to them. Though a comprehensive solution might identify claims that are not fraudulent, the solution can also point to flaws in provider policies a payer needs to address.

Highly Trained, Experienced Investigators

Knowledgeable, seasoned investigators—with backgrounds in law enforcement, criminal justice, private investigation, claims investigation, statistics and analytics—are often a critical part of finding and stopping true fraud. Expert investigators review and analyze historical claims data, medical records, suspect provider databases and high-risk identification lists while also conducting patient and provider interviews. An outsourced SIU can help recover payments and supplement investigation methods of an existing SIU staff, while an onsite medical director, staff clinicians and certified coders further strengthen the investigatory process.

Prioritized Outcomes

To help payers understand how claim aberrance affects their bottom line, analytic software should score and rank each claim to demonstrate the measure of risk, or aberrancy, it represents. Having a quantified risk analysis for every claim helps payers quickly and efficiently decide how to handle it. Armed with ranked scores backed by explanation, payers can quickly investigate suspicious claims and avoid questionable and perhaps unnecessary payments. Combined with claims amounts, this becomes a powerful tool to prioritize high value items for maximum business benefit.

Claim-Level and Provider-Level Consideration

Every healthcare payer must find the balance between claims adjudication and provider management when assigning valuable company resources. However, using a FWA solution that addresses both areas can significantly improve the effectiveness of each. Sometimes, only during a thorough FWA claims review does it become evident that a provider policy has had unintended consequences. This discovery can give healthcare payers access to powerful tools for provider negotiations.

Successful Integration of a Payment Integrity Solution

The government's increased focus on FWA, along with costly and unnecessary losses, is forcing payers to address FWA management. However, for a new fraud prevention solution to become a company priority and practice, it is critical to:

- Prepare and present a compelling business case that demonstrates urgency and offers a solid ROI
- Position the new solution as a valuable new tool for an existing SIU, rather than a source of more work
- Select a vendor that can help an organization meet its business goals and has experience implementing a FWA management solution
- Choose a solution that can compare your data with national norms. Provider practice habits differ across the country.

Executives will likely question initial investments in payment integrity programs, especially if they are operating with lean budgets. Decision-makers must see that the proposed solution can quickly pay for itself.

When building a case for a new payment integrity solution, include the following components:

- The volume of claims processed compared to personnel needed for claims investigations
- The ability to prioritize high-dollar claims that could significantly improve the bottom line
- Examples of FWA from an impact analysis or proof of concept that identify associated costs
- The growing, pervasive nature of FWA
- Annual FWA detection costs, including the cost of internal analytic resources that produce and maintain predictive models, if they're implemented internally
- Potential results of using multi-payer data for better aberrance identification
- How policy changes discovered in anomaly detection can contribute to ROI





To realize the full value of a payment integrity solution, payers must have an adequate and trained staff to manage the solution. As it begins and then continues to detect fraud, a payer can employ additional resources to work toward achieving greater ROI. The technology a payer chooses helps determine what it needs to make the program successful.

Payer operations groups should consider ease of use and training requirements. IT and analytics organizations will need systems and model maintenance. Some vendors offer programs that require a payer to build the analyses using their own tools, which requires IT and analytic staff to build and refine core software. Other solutions offer client-based models delivered with the system that address the costliest FWA.

Since the introduction of a payment integrity solution affects several groups within an organization, it is essential that executive management gain the support and involvement of the SIU, claims, provider relations, finance, legal and administrative departments to successfully move to a pre-payment FWA detection model. Workflows and processes will likely change, but subsequent benefits should become apparent. Internal departments and divisions must embrace the shared goal of achieving effective FWA prevention.

Though payment integrity solutions must include the best and latest technology, vendors must offer the right blend of services and personnel. For fully outsourced payment integrity solutions, payers may need fraud analysts and investigators, certified claim coders and a medical director or other medical personnel. Even when fraud is detected pre-payment, there is always a need for discerning and experienced fraud investigators and analysts, many of whom have uncovered millions of dollars of fraudulent and abusive claims throughout the years.

Emdeon and FICO—a Powerhouse Combination

Emdeon is a leading provider of revenue and payment cycle management, and clinical information exchange solutions, working with more than 1,200 government and commercial healthcare payers and 340,000 healthcare providers nationwide. FICO, serving the top global financial institutions and leading healthcare payers with their anti-fraud services, has developed sophisticated fraud detection and prevention capabilities. FICO and Emdeon have created a unique solution for the payer market, leveraging Emdeon's repository of healthcare claims data and central position in the healthcare workflow with FICO's sophisticated FWA analytics, as well as other data and technical assets. Emdeon's Payment Integrity Solutions with predictive analytics powered by FICO brings a powerful solution set to the healthcare market.

FICO's predictive analytics technology has its roots in the credit card industry, reducing fraud by more than 50 percent for global credit card issuers. FICO's capabilities reduced fraud losses in the U.S. credit card market by two-thirds in a 15-year period, saving card issuers billions of dollars.⁽⁵⁾

Emdeon Payment Integrity Solutions combines Emdeon's vast amount of payer and provider data with FICO's predictive analytic capabilities to produce an advanced FWA management solution that can offer healthcare payers:

- Highly tuned predictive models that can detect new FWA sources
- Prioritization of FWA results, focusing efforts on high value claims
- A fully developed case management system to help investigators fight FWA
- A view into both claims-level and provider-level claims, to maximize results
- Fewer false positives, for greater processor productivity
- Multi-payer data, which may detect new and emerging fraud schemes
- An industry tested solution with market-proven ROI⁽⁶⁾

A comprehensive, versatile payment integrity solution can produce significant results, as it addresses all points in the claim process. The best programs meld rules-based software with predictive analytics, accommodating both pre- and post-payment reviews and audits. As reliable and broad sweeping as technology can be, any well developed FWA solution must also include experienced claims investigators and analysts, who play a key role in identifying aberrant claims and irregularities. Emdeon's Payment Integrity solution meets these criteria.



Emdeon and FICO together provide payers a comprehensive solution to help reduce FWA and improve financial health

⁽⁵⁾ From 'The Nilson Report,' Issue #858, June 2006: "Credit Card Fraud - U.S."

⁽⁶⁾ From FICO News Releases <http://www.fico.com/en/Company/News/Pages/03-16-2011a.aspx>

Conclusion

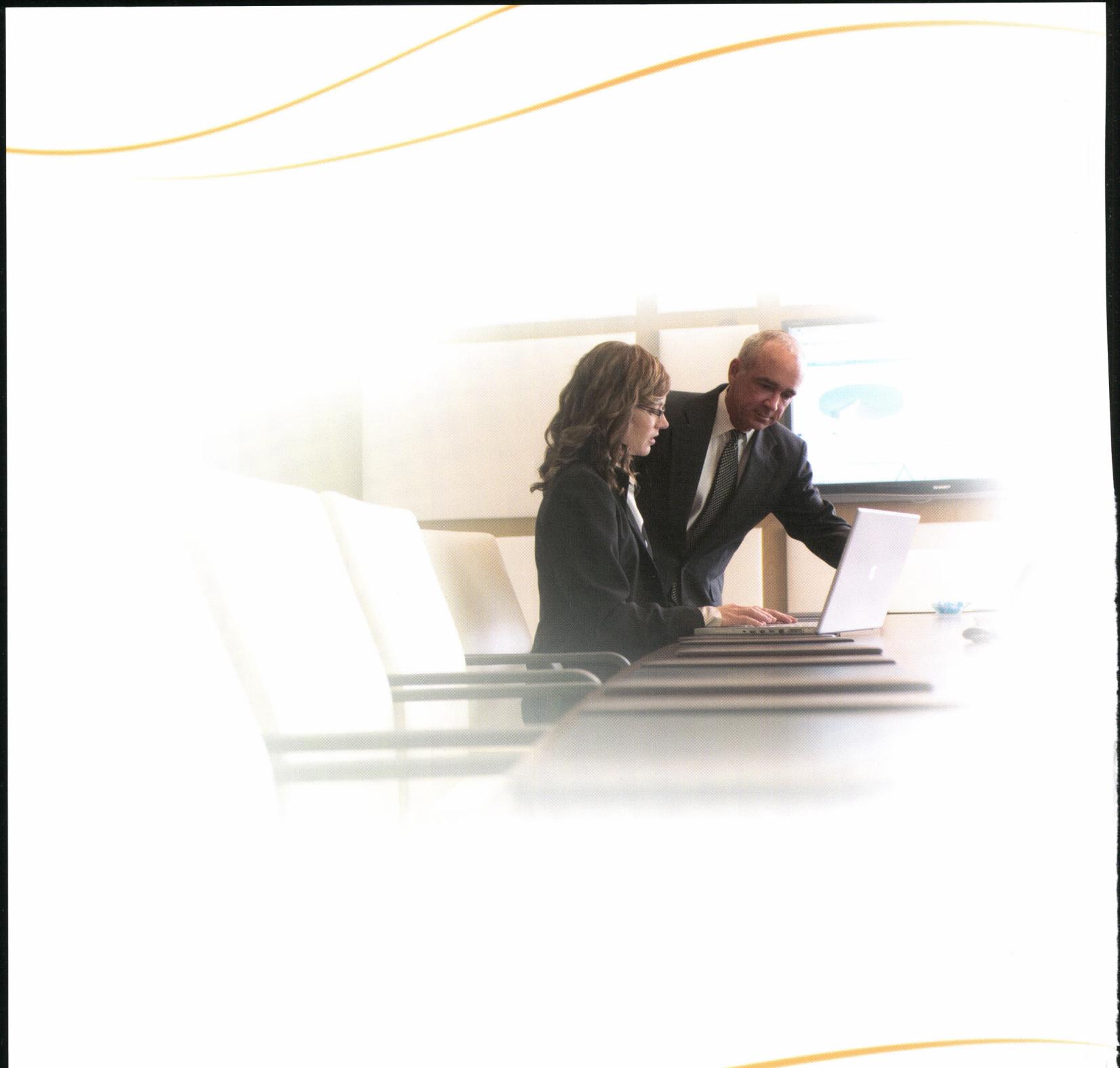
In light of unpredictable economic factors and tight budgets, health insurance companies must continue to search for efficiencies wherever possible. The pay and chase approach to FWA management is largely ineffective, compelling healthcare companies to consider switching to pre-payment solutions to achieve meaningful payment integrity.

Effective pre-payment FWA solutions draw upon multi-payer data and sophisticated analytics. Individual payers—regardless of size—do not have the depth of information gleaned from analyzing multiple payers' claims data. Further, by leveraging the power of predictive analytics to continuously identify new forms of FWA, and by prioritizing suspicious claims for maximum financial benefit and fewer false positives, payers can take tremendous steps toward effectively combating FWA and minimizing lost healthcare dollars.

Ongoing revenue loss often forces payers to impose increased premiums and coverage limitations for patients. Payers that once presumed they could not afford to invest in fraud prevention now realize that market forces and internal financial pressures make critical the need to identify and prevent unnecessary claims payments. Detecting and preventing erroneous claims pre-payment is a strategic way for payers to reduce liabilities and improve their overall financial health.

Combining Emdeon's exceptional connectivity, depth of data and unique position in the healthcare claims workflow with FICO's sophisticated analytics and fraud experience creates a powerful solution. This arrangement is designed to uncover aberrations and anomalies like no other solution available, helping healthcare payers reduce FWA and improve their overall financial health.





Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers and patients in the U.S. healthcare system. To learn more, visit our website at www.emdeon.com.

FICO is a trademark of Fair Isaac Corporation. Other product and company names herein may be trademarks of their respective owners.

© 2011 Emdeon Business Services LLC. All rights reserved.
EMDA1010357 rev 7.11



3055 Lebanon Pike, Suite 1000
Nashville, TN 37214 USA
877.EMDEON.6 (877.363.3666)
moreinfo@emdeon.com

Provider Data Validation



- 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
- Speciality-specific

Predictive Analytics



- Known and unknown schemes
- Overutilization
- Data-Driven Case Management
- Social Networking
- Data seeded with over 1 billion Emdeon cross payer claims

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

Queries/Rules for Known Fraud

Simple schemes and billing errors
Known fraud and abuse patterns

Predictive/Data-Driven

Analytics for Unknown Fraud

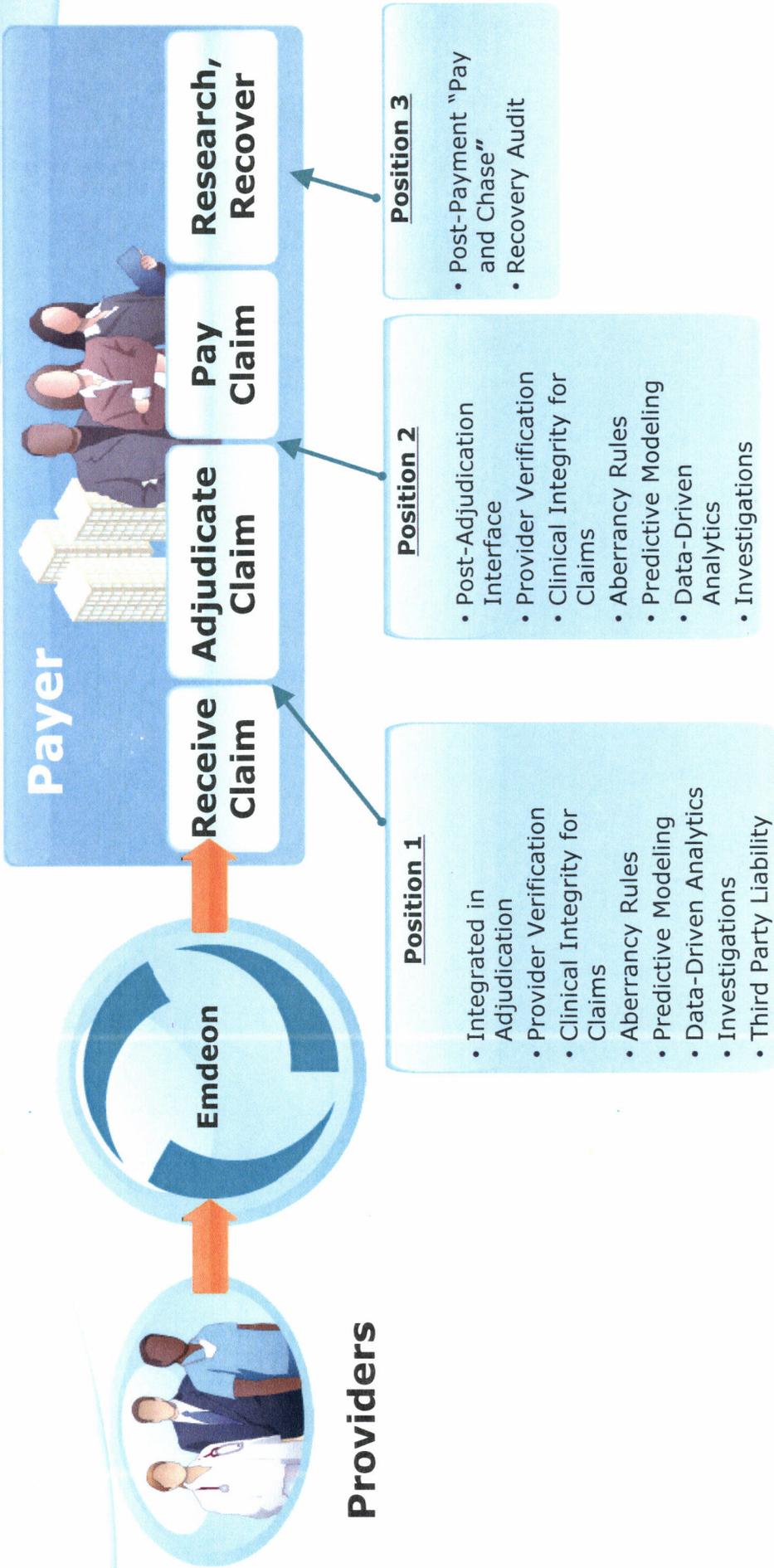
Queries/Rules benefits above

AND

Complex fraud and abuse patterns
Undiscovered schemes
New and emerging issues
Organized Fraud

Fraud Detections Positions

Move "upstream" for Prevention and Detection



- National fraud savings estimates range from 3%-10% or **\$68 - \$226 Billion each year***
- 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**
- What Can Your State Save by Moving to Prevention and Detection Using in Stream Multiple Safety Nets? **Between .5% and 3% of your paid claims - Turn over to learn more!**



Emdeon Proprietary & Confidential

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*. Princeton: Princeton University. Health Research Institute. (2008). *The price of success: Identifying waste in healthcare spending*.
**These estimates are taken from the FY 2007 Comprehensive Error Rate Test (CERT) program for Medicaid

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 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 annually. 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***
 - **Current enrollment: 151,422****
- **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 with Case Management and Link Analysis: 0.5% - 2.0%

Annual Savings Range : \$4 Million – \$14 Million

Annual Savings Range			
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

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 Northrup 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. This claims flow should be done in such a way to mirror the claims flow of the Pre Pay Clinical Code Editing format of Bloodhound / Versk currently runs.

8. This is new technology and it's not being adopted by states

Yes and no. CMS has contracted with Northrup 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...after 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 identify 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/D9RF5M300.htm>

** <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/montana.html><http://www.dphhs.mt.gov/2011biennialreport/mtmedicaidreport.pdf>

***<http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=56&rgn=5><http://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