June 15, 2007

Washington State Department of Social and Health Services

Health and Recovery Services Administration

Medicaid Transformation Grant Proposal

2nd Generation Fraud and Abuse Detection System

Contact: Paige Wall, Payment Review Program Manager
wallpg@dshs.wa.gov
360-725-2117
360- 586-0615 FAX

Abstract
2nd Generation Fraud Abuse and Detection System

Washington's Department of Social and Health Services (DSHS) provides medical services to nearly 1 million low-income residents, paying $4 billion annually to more than 40,000 medical providers. In delivering these services, we take our fiduciary responsibility very seriously to protect against fraud, waste, and abuse. Washington State's Payment Review Program (PRP) has been nationally recognized for its progressive and innovative approach in the detection and prevention of Medicaid fraud, waste and abuse through its use of sophisticated data mining processes and analyses. Since its inception in 1999, PRP has continually identified and implemented new methods of post-payment review to realize $31.9 million in department-wide savings.

Approval of this Medicaid Transformation Grant proposal will allow Washington to take Medicaid Program Integrity program to the next level. The timing for the development and implementation of a comprehensive FADS lines up well with Washington's current development of a new MMIS. The new MMIS combines payment, health information, plus provider and recipient demographic data from two payment systems – the MMIS and the Social Service Payment System (SSPS). The grant funds will enable a new FADS to leverage the combined Medicaid data (e.g. traditional MMIS medical provider payments, and Medicaid social service payments such as in-home and residential personal care services) to enhance and intensify Washington's fraud and abuse detection efforts.

Federal funds in the amount of $5,948,000 are requested for the 18 month design, develop, and implement of a comprehensive FADS which will support a new approach to Medicaid payment integrity. The system will bring new tools and resources to support a comprehensive payment integrity model expected to achieve the following outcomes:

- Enhanced opportunities for fraud, waste, and abuse prevention and detection for Medicaid fee-for-service and Medicaid social services
- New opportunities for fraud, waste, and abuse prevention and detection for Medicaid managed care, Medicaid client fraud, and employee fraud impacting Medicaid services.
- New opportunities to protect at-risk populations i.e. children and aged
- Improved audit management and stakeholder collaboration –complete management and tracking of fraud, waste, and abuse activities (leads, audits, investigations, prosecution, etc.). System will support collaboration and interface with payment integrity partners (Medi-Medi, MFCU, law enforcement, and other state health care entities).

The tools, resources, and comprehensive approach for detection and prevention of fraud, waste and abuse demonstrated by this project will be a national model for Medicaid payment integrity.

1. Statement of Project/Need:

Washington State is committed to continually improving our performance in payment integrity and ensuring state and federal resources are used for their intended purpose, serving the health care needs of our clients. Transformation Grant funds are requested to procure a system which will have a broader range of new detection and analytical tools and will establish a comprehensive method of managing payment integrity. While DSHS has established a history of using advanced tools and technology, there are many new opportunities for payment integrity improvement within the scope of this proposal. Expected outcomes include:

- Enhanced opportunities for fraud, waste, and abuse prevention and detection for Medicaid fee-for-service and Medicaid social services. The combination of data supports the application of models, algorithms, and other detection techniques resulting in increased detection and prevention activities.
- New opportunities for fraud, waste, and abuse prevention and detection for Medicaid managed care. Use of standardized encounter data supports application of models, algorithms, and other detection techniques to support new innovations in managed care fraud, waste, and abuse.
- New opportunities for fraud, waste, and abuse detection for Medicaid client fraud.
- New opportunities for deterring and detection employee fraud impacting delivery of Medicaid services.
- New opportunities to protect at-risk populations i.e. children and aged
- Improved audit management and stakeholder collaboration –complete management and tracking of fraud, waste, and abuse activities (leads, audits, investigations, prosecution,

etc.). System will support collaboration and interface with payment integrity partners (Medi-Medi, MFCU, law enforcement, and other state health care entities).

Washington is currently developing a new MMIS with an implementation scheduled for 2008. In the development of this new MMIS, we have recently learned that the data model is so extremely different that the legacy system, that our existing FADS system will not be functional and will require replacement. Given the magnitude of the changes required, limited period remaining on the current FADS contract, and the opportunities to develop the next generation FADS, we believe that this is a perfect candidate for Medicaid Transformation Grant funding.

2. Project Justification

The mission of the Department of Social and Health Services is to improve the quality of life for individuals and families in need. This second generation FADS supported by this Medicaid Transformation Grant proposal will improve the department's ability to protect Medicaid dollars and the ensure availability of services to individuals and families in need.

This system will support a comprehensive approach to managing payment integrity. The efficiency and effectiveness of Washington State's Medicaid program will be improved by implementing a more innovative, robust fraud and abuse detection system. The costs either being avoided or recovered due to the FADS and Medicaid Program Integrity functions will be returned to Medicaid to continue to fund needed services for the vulnerable individuals and families of Washington State.

This proposal will also improve Washington's ability to support the success of the CMS Medicaid Integrity Program (MIP) and Medi-Medi Program. Effective use of interfaces and case management tools will support the effectiveness of both programs.

For Washington to continue and enhance our proven commitment to Medicaid program integrity, we must implement a new comprehensive FADS. The new FADS will also play an

important part in validating the new MMIS data and identifying inappropriate payments related to system edits.

From Washington's participation in Medicaid Program Integrity activities at a national level, we have gleaned that states do not have the expertise or capability to identify fraud, waste and abuse utilizing Managed Care encounter data or social services data. Washington is ready to blaze new trails in the Medicaid program integrity arena for these claim types. We believe that vendors with expertise are available with advanced functionalities in areas relating to: Managed Care fraud and detection; predictive modeling; unsupervised/neural net modeling; and client and employee fraud. These functionalities will strengthen Medicaid program integrity agency-wide.

The case management system will have advanced functionality that will allow users to share cases with various internal DSHS partners and external organizations such as the Medicaid Fraud Control Unit, law enforcement, Medi-Medi, and other state and federal health care entities. This will enable organizations to cooperate and collaborate when reviewing, sanctioning or terminating providers so other agencies do not inadvertently enroll a provider who has been terminated from another agency.

The strengthening of Medicaid Program Integrity utilizing a new comprehensive FADS will ensure that: fraudulent or abusive providers will be identified and terminated swiftly; vulnerabilities related to policies and needed system edits will be identified and implemented; and risks will be aggressively identified and analyzed.

3. Project Goals and Outcomes

The goal of this project is to design and procure a cutting-edge, innovative fraud and abuse detection system that will enable Washington to:

- Compare all services a recipient receives for Managed Care and fee-for-service. We expect this functionality to enable the identification of MCOs/providers who misuse Medicaid funding in a variety of ways, including: manipulation of encounter data to justify a higher capitation amount; engaging in inappropriate enrollment practices (attract healthy people, refuse or force sicker people to disenroll); exclusion and/or under-treatment of certain identifiable vulnerable groups (i.e., those with mental problems, children, infants, the elderly); enrolling people in managed care but never delivering services; participating in kickback schemes for primary care physicians referring to fee-for-service specialists; and assigning unreasonably high numbers of beneficiaries to providers which makes adequate service impossible.
- Link analyses that enable users to track ownership associations and business relationships to detect fraudulent provider activities, such as Medicaid client sharing "rings"; billing relationships between providers and referring/prescribing providers; and provider billing number rotations.
- Identify multiple providers whose payments are being routed to a common bank account.
- Display a provider's geo-location in proximity to the residence of their respective services recipients to identify aberrancies.
- Utilize other DSHS information systems to compare services rendered against predetermined levels of care.

- "Follow" new DME provider payments for period of time looking for patterns of fraud and abuse.
- Provide "alerts" when an elderly client's income drops significantly, which research shows may be an indication of elder abuse, as well as tracking family members medical and prescription information to assist in spotting potentially abusive caretakers, etc.
- Utilize data analysis that determines when residential treatment centers or child care providers are billing over their maximum capacity.
- Alert FAD users to spiked billings by providers including the detection of provider billing pattern deviations.
- Create a case management system that can be utilized by internal and external users.

Procuring the comprehensive, advanced FADS, with extensive drill-down capability, will enable Washington State to obtain its fraud and abuse detection goals with the following components and functionality:

- Managed Care Fraud. Washington State's Medicaid Managed Care comprises approximately 56% of the population eligible for Medicaid coverage, which makes it essential that Washington's new FADS identifies Manage Care fraud, waste and abuse.
- Integration with other DSHS systems such as Aging and Disability Services Administration case management applications, central contract database, day care licensing information, and the DSHS agency eligibility system.
- Predictive modeling. Washington State is committed to identify and reduce incidences of both child abuse and elder abuse. Predictive modeling will give us the capability to identify at risk populations and identify trends leading to child or elder

abuse, serving as a front line of detection in the form of identifying patterns of treatment and/or physician hopping in order to prevent suspicion, as well as, sends alerts when an elderly recipient's income changes drastically. These are all signs of suspicious behavior and possible abuse.

- Unsupervised/neural net models. These models will identify aberrant provider billing patterns for possible fraud, waste and abuse investigations by using the data exclusively.
- Supervised models. Washington will build on what we've learned by developing supervised models and work with a new FADS that can release models on more flexible, user defined cycles.
- Ad hoc querying capability. Ability for state staff to drill down into the FADS data.
- Rules-based algorithms that incorporate state specific or national rules. FADS vendor must have subject matter experts in all Medicaid programs to assist state staff in design.
- Robust case management system. This system will be used by various internal sections of DSHS that review, investigate, and audit providers for both billing aberrancies and quality of care issues. This system will also have the capability of sharing information on provider investigations with other state agencies.
- Geo-mapping capabilities. Ability for FADS user to utilize geo-mapping as part of their fraud and abuse detection activities.

4. Estimate of Impact to Beneficiaries

By enhancing our fraud and abuse detection program, we will benefit DSHS service beneficiaries by:

- Stopping inappropriate payments from being made and returning any recovered overpayments back into the Medicaid program and services;
- Protecting recipients from fraudulent providers that may be attempting to charge recipients for services; and
- Identifying abusive providers who may be delivering poor or no quality of care.
- Developing new techniques to predict or detect child or elder abuse will impact that vulnerable population identifying abuse early on so that it can be stopped.

5. Description of Magnitude of Transformation / System Change

The magnitude of change the new FADS will bring to Washington's Medicaid program integrity is enormous. Washington has been extremely successful in areas of Medicaid fraud, waste and abuse but must transform because (a) DSHS cannot continue using a FADS that requires data incompatible with our new payment system and (b) our program will be more successful with the enhanced functionality in the new FADS. Washington looks forward to expanding our technological capacity to combat various types of fraud and abuse that our current FADS and data sources are unable to identify, such as Managed Care, child and elder abuse, and client and employee fraud. The case management functionality will change and enhance our communication with federal, state, and law enforcement partners by allowing us to collaboratively work cases and share findings on provider investigations, audits and terminations.

These proposed new functionalities will change the way various DSHS programs are able to view their program data and allow them to quantify and correct vulnerabilities in their programs and systems.

The FADS functionality may be replicated in other states since other states are at risk for similar schemes in fraud, waste and abuse.

6. Description of Sustainability of the Project

DSHS has a proven track record of payment integrity sustainability which this grant will support and enhance. DSHS began as a project in 1999 and has developed into an institutionalized agency-wide program due to its success in identifying and recovering inappropriate payments and system improvements. DSHS presents data mining fraud and abuse techniques and methodologies at national conferences. DSHS is dedicated to continued program integrity and battling fraud, waste and abuse in the Medicaid program. Our baseline budget includes funds for operations and maintenance of the proposed 2nd Generation FADS. Given the positive return on investment demonstrated by DSHS payment integrity initiatives, we expect continued funding in future budget cycles.

7. Evaluation Plan

Evaluation of the success of the FADS is important to demonstrate to stakeholders and federal and state oversight bodies that the funding was a sound investment. In addition to meeting quarterly reporting requirements regarding expenditure of grant funds, we will provide CMS with an annual report for each year of the funding which complies with the reporting requirements outlined in Section 1903(z)(3)(C) of the Social Security Act and includes the following components:

- Identifies the specific uses of the grant funds in detail for the previous fiscal year, as well as for the coming fiscal year

- Reports on quality improvements, and estimates of cost savings directly related to the FAD system performance

8. Description of Project Implementation Readiness

In anticipation of receiving the grant award, Washington is aggressively proceeding to address all action items and tasks that can be addressed at this time. This project will include the following tasks:

Task 1, Request for Information and System Requirements (Months 1-4)

Resources: DSHS, subject matter experts

- Procure FADS Project Management Contract
- Define Scope of work and data sources
- Gather initial requirements
- Write and publish Request For Information
- Schedule and attend demos of products
- Incorporate all requirements from RFI, etc. into RFP

Task 2, RFP issuance, evaluation and scoring (Month 5-7)

Resources: FADS Project Manager, DSHS, stakeholders and contractors

- Issue RFP
- Answer RFP questions and hold Bidder's Conference
- Issue RFP amendments, if necessary
- Receive RFP Responses
- RFP evaluation and scoring process (may include interviews and demonstrations)
- Complete RFP evaluations
- Announcement apparently successful bidder, debriefing of non-successful bidders, protest resolution, contract negotiations

Task 3, System Design (Months 8-10)

Resources: DSHS, ISSD, FADS Project Manager, stakeholders and contractors

- Execute Contract
- Build a detailed project plan that details overall project timeline; update schedules; staffing needs and deliverables; training; help desk support; plus inclusion of additional data sources.
- Requirements Validation
- Data mapping
- System Design
- Establish Security, and Disaster Recovery plans and ongoing Quality Assurance processes

Task 4, Development, Verification and Implementation (Months 11-18)

Resources: DSHS, FADS Project Manager, subject matter experts and contractors

- Interface state data and third party data files to vendor system
- Load and test data
- Validate data and functionality
- Develop the data analyses to be performed
    - Algorithms for both Managed Care and Fee-For-Service
    - Ad Hoc queries
    - Supervised and Unsupervised/neural net models
    - Trend analyses
    - Spike Billing and Billing Aberrancy alerts
    - Predictive models for at risk populations
    - Linking/Ownership tracking

- Robust case management

Task 6, Evaluation (Month 18)

Resources: DSHS, FADS Project Manager

- Evaluate results and assess each of the previous tasks to identify successes, areas for improvement and future directions
- Develop final report that will be presented to CMS at the end of the project

Budget

Washington is absorbing the state staff costs to participate in this Project. Contracted amounts for the design, development and implementation of the FADS are estimated based on review of other Medicaid Program Integrity technology projects. Quarterly fund distribution may change based on results of contractor procurement. If this occurs Washington will coordinate with CMS.

Washington Payment Review Program Comprehensive Fraud Abuse and Detection System Budget	
Item	***FFY08*** ***Estimated Costs***
System Contract Costs: Design, Development and Implementation	$5,300,000
FADS Project Management Contract	$396,000
Quality Assurance Oversight Contract	$252,000
Total Budget	**$5,948,000**