Agenda

How your SIU functions
- Basic operation of the SIU
Importance of coordination and collaboration
- SIU, general counsel and compliance department overlaps
Current trends in SIU
- Hot issues
- Analytics

Special investigation unit

Definition
- A unit whose mission is to detect, investigate and prevent fraudulent activities affecting policies issued and claims filed for payment by an insurer. The name of the investigative unit may vary, but special investigations unit is the most common

Purpose
- Operate as a centralized investigative unit with cross functional reporting activities
- Utilize personnel with varied backgrounds (investigators, coders, clinicians, etc.)
- Communicate and coordinate with senior management, the compliance department, and outside parties
- Utilize data analytics to proactively identify high risk areas of fraud, waste, and abuse
- State mandates that insurance carriers maintain in-house SIU or contract out
- The liaison with other entities handling claims fraud

The leading practices for anti-fraud units can be broken out across the following three components: Mission, Organizational structure, and Processes.

### Mission
- Centralized investigation Operating Unit
- Clearly defined policies for delegation and issue resolution
- Standardized investigation process and procedure
- Anti-fraud efforts focused on all areas in which fraudulent or abusive behavior could exist (providers, members, employees, etc.)
- Cross-functional reporting to communicate case activities and issues across the organization

### Organizational Structure and People
- Anti-fraud efforts in the organization are highly visible to Senior Management and the Board of Directors
  - Regular communications to appraise management of anti-fraud efforts and investigations within the organization
  - SIU independence, autonomy, and ability to initiate and conduct investigations across the company’s lines of business
  - Information sharing with outside parties (health care fraud task forces, anti-fraud organizations and regulators)
  - Information sharing with internal parties

### Processes and Technology
- Pre-Payment Review
- Proactive Problem Solving
- Post Payment Investigations
- Post Payment Review
- Collections

Approach to fraud and abuse
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Composition of unit
- Personnel—Multi-Discipline Team:
  - Investigators (law enforcement background), coders, clinicians, auditors, etc.
  - Skills—Analytic ability, interviewing skills, knowledge of claims processing
  - Size—FTE size aligns with claims volume and membership

Training
- SIU staff training
  - SIU staff meets all basic training requirements in subjects including current healthcare trends, anti-fraud and abuse technology, interviewing/investigation skills
  - SIU staff maintains appropriate certifications
- Plan-wide training
  - Extensive, frequent, and scheduled fraud and abuse training for all employees
  - Fraud and abuse training included in new employee training

Organizational Structure and People

Overview—Leading practices for SIU

The leading practices for anti-fraud units can be broken out across the following three components: Mission, Organizational structure, and Processes

Pre-payment review
- Aggressive use of pre-payment edits to stop fraudulent and abusive behavior before claims are paid
- Strong coordination between credentialing and the SIU to eliminate or closely monitor high-risk providers
- Translation/migration of fraud and abuse issues into analytics program
- Ability to appropriately flag out of network and abusive high volume/high cost in network providers without substantial impact to claims processing requirements

Proactive problem identification
- Formal collaboration between SIU and other internal units such as network management, provider contracting, credentialing, utilization management, etc.
- SIU has formal relationships with a variety of external resources that provide investigation leads and are used to combine efforts such as the NCAA, other health plans, or government agencies (FBI, OIG, DOJ, CMS, state insurance)
- Data Analytics is used and data triaged to identify high priority/high risk opportunities
Post-payment investigations

- Robust management information system to support:
  - Tracking of case loads
  - Staff productivity
  - Outcomes (Savings/Recovery)
  - Referral sources
  - Timelines of investigations
  - Milestones and accomplishments
- Well-defined and effective case supervision
  - Supervisor approval of case initiation and close
  - Mandatory and uniform case file system
- Uniform processes for case documentation
  - Well-defined metrics for measuring and assessing effectiveness and priorities
  - Impact on patient care
  - Monetary recovery metrics
  - Loss prevention
  - Impact on the plan/support of plan initiatives
  - Administrative activities—Credentialing and terminations/suspensions
  - Access to necessary expertise, such as medical management, finance, and information technology to support investigation activities.

Post-payment review

- Systems to conduct post-payment reviews of provider and member payments (individually and aggregate)
- Cross-functional roles and responsibilities are clearly defined
- SIU participates in cross-functional proactive risk assessments of system weaknesses
- Monitoring of pharmacy payments, specifically PBMs efforts related to retrospective claims review and collection

Collections

- Centralized area for collections with the ability to:
  - Control offsets
  - Control recoupments
  - Control repayments
  - Establish uniform policies related to the forgiveness of debt
- Clear delegation of authority regarding what levels of the organization can forgive potential debt
- Management information and metrics regarding plan collection of collection efforts

Assessing the allegation

Common Sources of Initial Information

- Current and Former Employees
- Board Members
- Internal Audit/Compliance Reviews
- Vendors
- Patients
- Physicians
- Consultants
- Competitors
- Governmental Agencies
- Hot Line
- “Whistleblower”
- Media
Concluding the investigation and reporting results

Reporting Results

- Essentials—Will reporting be verbal or written
- General parameters for reporting:
  - An impartial, fair and objective recounting of facts
  - Detail Investigative Procedures
  - Summarize Factual Findings
    - Avoid distortions and inaccuracies
    - Be mindful of drawing inferences and conclusions, and using opinions
    - Recommended Portage Remedial Actions
- Reporting to other interested parties or stakeholders
  - Independent Auditors
  - Outside agencies/Regulatory bodies/Law Enforcement
  - Business Partners
- Does reporting need to be modified for external use?

Coordination and Collaboration

Special Investigations Unit
General Counsel
Compliance Department

SIU and Compliance

- Regularly works with variety of compliance business partners
  - Regulatory compliance
  - Medicare compliance
  - Medicaid compliance
  - Commercial compliance
  - Privacy compliance
  - International compliance
  - Proactive compliance
- Works closely with Legal
  - Share data to assist with court actions
  - Work with Legal to coordinate undercover operations with law enforcement
  - Legal provides input on letters
  - Legal provides counsel in connection with investigations
  - Proactive legal training

Detect and prevent—Use of advanced data analytics
Need for fraud/waste/abuse solutions for healthcare claims fraud

- A study from the Institute of Medicine estimated health care fraud at $75 billion a year and found that about 30 percent of total US health spending in 2009—nearly $750 billion—was wasted on unnecessary services, excessive administrative costs, fraud, and other problems.1
- The median time to detection for billing fraud, if detected at all, is 24 months after the fraud is detected.2
- If the time to detection can be reduced from 19-24 months to less than 7 months, the dollar cost of fraud can be reduced by 2/3.2
- An effective anti-fraud program can save money: one governmental study showed a return of $7.20 for every $1.00 expended on fighting healthcare fraud.3

2 Source: Association of Certified Fraud Examiners: Report to the Nations on Occupational Fraud and Abuse: 2014 Global Fraud Study
3 Source: US Department of Health and Human Services and US Department of Justice, Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011, February 2012

A new approach to fraud prevention

Enterprise Fraud and Misuse Management (EFM) refers to an integrated approach to fraud management—including the technology platform, advanced analytics, and anti-fraud processes to proactively monitor for fraud. The four pillars of EFM include:

- **Time**
  - Proactively screen transactions on a real-time basis
  - Remediate issues before they cause financial or reputational damage
  - Definition of ‘real time’ can vary by industry and sector

- **Enterprise View**
  - Look inside and outside the organization for evidence of fraud
  - Move away from a siloed approach to fraud management
  - Consider both ERP and operational technology platforms

- **Data Profile**
  - Evaluate structured and unstructured data populations
  - Process ‘Big Data’—terabytes, petabytes, and beyond
  - Breadth is evolving—video imagery, voice recognition, etc.

- **Analytics**
  - Perform transaction and entity analysis on data populations
  - Map diverse tool set of techniques to business needs
  - Predictive, anomaly detection, link, text, geospatial analytics

EFM dimensions

An organization can tailor an EFM approach to its business needs.
Advanced analytics with EFM platforms

Organizations can apply sophisticated analytics to help stay ahead of fraud and corruption.

**Business Rules (Transactions)**
Use "if-then" logic to identify known patterns or clear-cut cases of fraud, waste, and abuse.

**Anomaly Detection (Transactions)**
Identify patterns that are inconsistent with normal activity with statistical profiling and outlier detection.

**Predictive Modeling (Transactions)**
Discover complex patterns in historical data and make predictions against current information.

**Network Analysis (Entities)**
Discover associations between entities to identify fraud networks and other collusive behavior.

Example: Providers who write an unusually large number of prescriptions for pain medication, relative to their historical pattern or their peers.

Example: Providers can be modeled based on their case load, patient mix, and other characteristics to determine the factors associated with writing prescriptions.

Example: Expose all of the beneficiaries associated with a fraudulent provider or uncover hidden relationships between suspicious providers.

Example: 'If' a provider is billing more patients than possible to see in a day (e.g., business rule threshold set at 30 patients per day), 'then' flag for investigation.

Advanced analytics with EFM platforms

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Advanced analytics with EFM platforms

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**Predictive Modeling (Transactions)**
Discover complex patterns in historical data and make predictions against current information.

Example: Providers can be ranked from best to worst based on the presence of outliers, trends associated with writing prescriptions.

**Advanced analytics with EFM platforms**

Discover associations between entities to identify fraud networks and other collusive behavior.

Example: Expose all of the beneficiaries associated with a fraudulent provider or uncover hidden relationships between suspicious providers.

How is this different than current claim edit approaches?

**Claim Edits**
- Uses business rules to ensure claims are properly coded, and compliant with payer requirements
- Good for addressing issues such as procedure-to-diagnosis mismatches, unbundling occurrences, use of nonspecific diagnosis codes, ...
- Rules are manually coded and updated based on subject matter experts
- Works on one claim at a time, or one set of claims at a time

**Enterprise Fraud Management**
- Uses advanced analytics to identify patterns that correspond to potential misuse or fraud
- Good for identifying anomalies and outliers over very large data sets
- Good for identifying underlying links between organizations to identify potential misuse or fraud between providers or beneficiaries
- Works on large sets of claims to identify underlying patterns

Both are valuable, and play different roles.
Current fraud and abuse trends

- Detect and Prevent
- Quality of Care
- Patient Harm
- Medical Identity Theft
- Credentialing/Provider Qualifications
- Ambulatory Surgical Centers
- Laboratories/Drug Screening
- Inpatient/Outpatient Hospital
- Rehab Facilities
- Pharmaceutical Drug Diversion/Addiction
- Home Health Care
- Hospice
- Durable Medical Equipment
- Anti-Kickback/Stark Law
- Expansion of the False Claims Act
- Self-Disclosures

Examples where SIU can help

- Par Hospital – Non-Par Physician
- Par Surgeon – Non-Par Ambulatory Surgical Center
- Par Surgeon – Non-Par Assistant Surgeon or Surgical Assistant
- Par Physician – Non-Par Facility
- Par Physician – Non-Par Lab

SIU Can Make An Impact

Get your billions back SIU
## Appendix A

### Contact Information

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<thead>
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