MATHEMATICA
Policy Research

AboutUS

Helping Health Agencies Address the Challenges of Fraud, Abuse, and Improper Payments

Fraud, abuse, and other improper payments are a persistent source of concern, frustration, and financial exposure for local, state, and federal agencies. Managing programs in a way that ensures public confidence and maximizes the impact of government investment is a key priority. Expanded access to sophisticated data and analytics makes it easier to detect, address, and most critically, prevent these issues. Mathematica combines a deep understanding of government programs with advanced data analytics to help government agencies implement state-of-the-art monitoring and detection strategies. We help our clients put practical controls in place to address waste, fraud, abuse, and payment errors in a wide array of program areas.

HELPING YOU ACHIEVE YOUR OBJECTIVES

Mathematica works closely with clients to:

- Improve improper payment detection, measurement, and prevention
- Monitor performance- and value-based payment systems
- Identify and address gaming strategies designed to violate program rules or exploit program loopholes
- Improve large-scale operational fraud prevention programs, functions, and initiatives
- Evaluate the impact of programs designed to address fraud, including the intended impacts on costs and improper payments and potential unintended impacts on quality and access
- Provide assessments and strategic guidance to improve fraud control and prevention efforts without hindering program objectives
- Use behavioral analyses to improve compliance

Our team approach combines unparalleled expertise and deep knowledge in detection and prevention of fraud and improper payments, advanced analytics, data management, data visualization, policy and operational review, and behavioral analysis. Our clients overwhelmingly express their satisfaction with our performance.

Working closely with state Medicaid agencies and the Centers for Medicare & Medicaid Services (CMS), Mathematica has developed data-driven approaches that reduce costs and better manage

payment and delivery systems, including value-based payment and delivery and managed care models. We provide dynamic, cost-effective strategies to detect and prevent improper payments and help clients identify savings, address program violations by participants, minimize gaming, and improve program elements that contribute to improper or unintended payments. Examples include:

- **Monitoring the Comprehensive Joint Replacement Program, a value-based payment system.** We work closely with CMS to scrutinize this program for gaming, noncompliant provider behavior, and improper payments. CMS pays networks of providers on a quality-adjusted basis, and we provide network analysis, exception analysis, modeling, and web-delivered reporting and visualization. We also create reports to help hospitals monitor and enhance their performance.
- **Examining fraud in alternate payment model systems.** We are helping CMS with oversight of a wide array of alternate payment model payments under the Medicare Access and CHIP Reauthorization Act and examining whether and how participants attempt to game program requirements.
- **Assessing and addressing the vulnerability of superutilizers to fraud.** For a state agency, we performed data, clinical, and regulatory analysis to identify whether Medicaid providers billed fraudulently for superutilizers—beneficiaries with complex medical and social needs and impairments. Our comprehensive set of recommendations improved the agency's oversight of care for this vulnerable population.
- **Oversight of electronic health record submissions that drive payment.** For CMS, we are examining the extent to which providers submit erroneous electronic health record data used to construct quality measurements and drive payment in performance-based payment systems.
- **Assessing and improving large-scale operational fraud control programs.** To strengthen program management, we are gauging the impact of two of CMS's prior authorization initiatives and providing recommendations to enhance them. Sophisticated modeling and stakeholder interviews are helping drive improvements.
- **Managed care oversight.** Our experience includes supporting CMS, state Medicaid program integrity directors, Medicaid Fraud Control Units, and state managed care directors in their efforts to oversee Medicaid managed care plans and address vulnerabilities and challenges to program integrity. We are leading experts in the use, understanding, and critical assessment of managed care encounter data for monitoring purposes.

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DISABILITY FRAUD

Disability programs such as Social Security will face enormous financial pressures and risk benefit cuts in the future if costs are not contained. Our policy, program, data, and operational experience sheds light on the operations and possible trajectories of disability programs. We use our expertise to help program and policy staff assess and enhance a wide array of projects. For example, our review for the U.S. Railroad Retirement Board examined the reliability of its measures to address and prevent fraud. Our comprehensive assessment of the agency's vulnerabilities included development of an integrated framework and series of recommendations to address these exposures. We also provided a road map and implementation plan to guide the agency.

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