

**OKLAHOMA HEALTH CARE AUTHORITY  
REQUEST FOR INFORMATION  
MEDICAID CLAIMS FRAUD MANAGEMENT PROGRAM,  
INCORPORATING PREDICTIVE MODELING IN PRE-PAYMENT CLAIMS REVIEW**

**SECTION I: GENERAL INFORMATION**

**1.1 ANNOUNCEMENT**

The Oklahoma Health Care Authority (OHCA), which operates Oklahoma's Medicaid program and other health benefit programs, is issuing this Request for Information (RFI) to obtain information from prospective Respondents regarding a claims fraud management program. OHCA requests information and demonstrations of state-of-the-art analytical tools for pre-payment review to identify possible fraudulent and erroneous Medicaid claims using predictive modeling, dynamic profiling and other proven methodologies. These methodologies might include credit balance detection and recovery programs, provider profiling / credentialing programs, member profiling programs, and unique and specific provider type audit programs or others.

**1.2 POINT OF CONTACT**

This RFI is issued by OHCA and OHCA is the sole point of contact from the date of release of this RFI through the closing date as follows:

Oklahoma Health Care Authority  
2401 N.W. 23<sup>rd</sup> Street, Suite 1-A  
Oklahoma City, OK 73107-2413  
Attention: Theresa Isenhour  
Phone (405) 522-7264  
E-mail: [theresa.isenhour@okhca.org](mailto:theresa.isenhour@okhca.org)

**1.3 RFI TIMETABLE**

RFI available on OHCA website	January 25, 2012
Respondent Data Use Agreements Due	February 2, 2012
Claims and other data available	February 15, 2012
All vendor questions due	February 29, 2012
Answers posted on OHCA website	March 16, 2012
Answers and summaries due	March 30, 2012
Demonstrations	April 2-13, 2012

**1.4 RFI CLOSING DATE**

- A. Executed Data Use Agreement (See Attachment A) by 3:00pm on January 31, 2012. Upon receipt of the Data Use Agreement, OHCA will provide two sample quarters of health care paid and denied claims and related necessary data (member, provider, reference etc.) on or before February 15, 2012. The data will be in a flat file format and Respondents will be given information on how to read and interpret the data;
- B. Executed Data Use Agreement (See Attachment A) after 3:00pm CT on January 31, 2012 but prior to February 15, 2012 shall also receive claims data within one week of OHCA acceptance of these forms. However, these respondents must meet the same deadlines shown above in Section 1.3 to be eligible to be invited to provide an on-site demonstration. The data will be in a flat file format and Respondents will be given information on how to read and interpret the data

- C. Responses submitted in accordance with this RFI must be received by OHCA no later than 3:00PM Central Time (CT) on March 30,2012. Responses should be e-mailed to the Point of Contact in Section 1.2. Responses received after the closing time and date will not be accepted. Respondents may call the telephone number above to ensure that their submissions were received. Responses should include the following:
  - 1. Cover page with organization's name and contact information; and
  - 2. Answers to questions in Section 3.2 (limited to twenty (20) pages or less;
- D. After reviewing submissions, OHCA may invite some or all Respondents to demonstrate their pre-payment review systems at OHCA's offices in Oklahoma City. OHCA may, at its option, review summary findings and/or answers provided by Respondents who do not meet the above deadlines, however, these Respondents shall not be eligible to provide on-site demonstrations.

## **SECTION II: BACKGROUND**

### **2.1 Oklahoma Health Care Authority (OHCA):**

OHCA is the state agency that administers the Oklahoma Medicaid Program, known as *SoonerCare*. Medicaid is a federal and state entitlement program that provides funding for medical benefits to low-income individuals who have inadequate or no health insurance coverage. Medicaid guarantees coverage for basic health and long-term care services based upon income and/or resources. Created as Title XIX of the Social Security Act in 1965, Medicaid is administered at the federal level by the Centers of Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS). CMS establishes and monitors certain requirements concerning funding, eligibility standards and quality and scope of medical services. States have the flexibility to determine some aspects of their own programs, such as setting provider reimbursement rates and the broadening of the eligibility requirements and benefits offered within certain federal parameters.

### **2.2 Program Integrity:**

The Program Integrity & Accountability Unit is responsible for ensuring public funds are spent appropriately. To meet this responsibility, Program Integrity Unit conducts both provider and internal audits. Provider audits are designed to ensure that correct payments are made to legitimate providers for appropriate and reasonable services to qualified individuals. Internal audits are designed to identify and strengthen control environment areas and program efficiencies. In addition to overseeing the agency's duties regarding the Federal PERM (Payment Error Rate Measurement) program, the unit also performs an annual PAM (Payment Accuracy Measurement) audit to determine the accuracy in which OHCA pays its medical claims. The unit also oversees agency tasks regarding the MEDI-MEDI (Medicare-Medicaid Data Matching Program) and the Medicaid Integrity Contractor programs.

## **SECTION III: RFI INFORMATION AND QUESTIONS**

### **3.1 RFI INFORMATION**

OHCA is seeking a comprehensive healthcare fraud-management solution that includes specialized software and expert operations and support services. Our Providers have the ability to submit claims via EDI (electronic data interchange) batch transactions, through direct data entry (DDE), and on paper. DDE claims are adjudicated in real-time. EDI and paper claim are adjudicated close to real-time when they are received. Currently the OHCA

receives approximately 50,000,000 claims per year. The breakdown between the various types of claims is as shown below:

- 80% EDI
- 18% DDE
- 2% Paper

The solution should provide real time or near real-time predictive modeling capabilities that can be applied before or after claims are submitted to the McKesson Claim Check system for code auditing, and before they are submitted to the Medicaid Management Information System (MMIS) for adjudication. The solution will assign claims a risk score and refer claims which exceed a specified risk score to a manual process for further review. The solution may also include automated cross-checks of provider, member and claim information against historical trends and external databases.

New methodologies and tools must integrate seamlessly into OHCA's existing claims review process without causing a significant reduction in current claims processing time. OHCA's existing pre-payment system includes rules-based edits in the MMIS which enable automated denials, automated corrections, and flags of specific claims for manual review. Post-payment, OHCA analyzes claims data in its data warehouse using the J-SURS (Java Surveillance Utilization Review System) surveillance and utilization review system.

OHCA is also interested in an integrated workflow or case activity system that manages all aspects of the fraud-management solution that will track claims identified for manual review and ensure that the claims are reviewed in a timely manner, record dispositions of claims, track and analyze false positives, monitor quality indicators and report other necessary information to allow for continuous improvement of the system. The integrated workflow should also include user support for OHCA staff and its contractors and/or providers. The ideal workflow solution would integrate with the current MMIS system so that all claim dispositions can be viewed in or retrieved from MMIS by OHCA staff and providers at any point during the claim adjudication process. In addition, suspected fraud/abuse cases and their related claims that are generated from this solution, should interface to OHCA's Program Integrity Case Tracking system, provided by HPES (Hewlett Packard Enterprise Services).

OHCA understands that there may not be a comprehensive system that meets all of our needs. Respondents may demonstrate individual tools that might form a component of the necessary system or respondents may form partnerships to demonstrate comprehensive systems if necessary.

### **3.2 WRITTEN QUESTIONS**

Respondents may answer any of the questions below. Respondents who wish to be considered for an on-site demonstration must answer all the questions.

A. Methodology: Discuss your predictive modeling methodologies and algorithms for calculating claims risk including linear and non-linear pattern recognition and indicators such as high frequency utilization behaviors, geographic dispersion of participants and identification of aberrant practice patterns. Discuss any use of decision tree analysis, regression analysis or other statistical methods. What proprietary databases do you have available? Discuss any automated cross-checks of provider, member and claim information against historical trends and external databases. Explain how your solution is both statistically sound and empirically derived, including any discussion of correlation across multiple methods.

- B. Architecture and integration: Discuss your predictive modeling architecture, including configuration, storage requirements, scalability and data capacity. What ability do you have to handle a high volume of claims? Explain how you will integrate your tools into the existing OHCA claims process without increasing processing time or cost and suggest any improvement your architecture might have for OHCA claims processing.
- C. Customization and continuous improvement: Explain your ability to incorporate historical data, national data, external databases, and OHCA-specific edits or data into your existing tools. Once the system is operational, how do you capture feedback from system results and revise or recalibrate scoring models. What is the model that your company uses to provide clients with new algorithms? How do you analyze false positives and how are these incorporated into the scoring models? How will modifications to the software or processes be made at OHCA request or for other reasons? Explain the change management process and how you monitor quality.
- D. User interface and reporting: Explain how the results and analysis of your tools will appear to users at OHCA, including any web-based interface, graphics, geo-mapping and others. How will you train OHCA staff to configure and use your system? What user support and training will you provide on an ongoing basis? How will claim scores appear and what information will be available to the manual reviewer? Describe the manual processes that clients use when working the claims that exceed the risk score? What reports can be supplied to OHCA on a routine and ad hoc basis? How much visibility will OHCA have into the scoring and data analysis? What outputs will you provide other than claims scores? What decision support and data analysis functions are available? Discuss any ability to provide separate reporting for specific programs or member and provider groups.
- E. Case management system: How will you route and prioritize cases and alerts for manual reviewers? Will your system recommend a course of action to the reviewer? Discuss any opportunity or system for providers to self-audit and voluntarily correct identified claims. How will documentation or notes or other information be available to reviewers? Discuss whether reviewers will be able to add documentation, notes, or other information in the system. Explain any tracking of action and resolution of cases. Does the system incorporate information from the provider appeals process? What management audits and controls are available?
- F. Results/Return on investment: What is your experience with the net rate of savings incremental to existing efforts when this type of system is implemented? Discuss what reports and data you will provide to substantiate OHCA's return on investment in your tools or system. What key performance indicators do you suggest and what is your ability to track these indicators? Describe the criteria that OHCA should consider to determine the effectiveness of solutions – claims related, provider related, cost savings, etc. Discuss how OHCA can determine the efficacy of this approach compared to simple provider outreach and education.
- G. Experience with Medicaid: What is your experience with Medicaid or other public sector health insurance? What is your experience working with Medicaid fiscal agents?
- H. Other comments or products: Discuss any other tools, systems, software, etc. not covered in the questions above. These might include review of administrative claims, data mining and pooling, providing profiling or credentialing, other provider audit tools, or any other tools that you believe OHCA might incorporate into the fraud management system. Please do not include marketing material or sales pitches in this

section. Respondents should describe available products, their functions and their usefulness to OHCA briefly and succinctly.

#### **SECTION IV: OTHER INFORMATION**

##### **4.1 ACCEPTANCE OF REPOSSES**

- A. The State will accept all responses submitted according to the requirements and deadlines specified in this RFI. Responses must be complete when submitted and should clearly describe the Respondents' ability to meet the requirements of the RFI and the needs of the State.
- B. The OHCA may ask any Respondent for written clarification of their response.

##### **4.2 COST OF PREPARING RESPONSES**

- A. All costs incurred by the Respondent for Response preparation and participation in this competitive process will be the sole responsibility of the Respondent. The State will not reimburse any Respondent for any such costs.
- B. The State reserves the right to withdraw the RFI at any time during the procurement process. Issuance of this RFI in no way obligates the State to award or issue a contract or to pay any costs incurred by any Respondent as a result of such a withdrawal.

##### **4.3 RETENTION OF RESPONSES**

- A. Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information a respondent submits are public records and subject to disclosure.
- B. If OHCA proceeds with a competitive bid and contract award following this RFI, RFI responses are NOT available to the public or other vendors until the contract is awarded pursuant to OAC (Oklahoma Administrative Code)
- C. Respondents claiming any portion of their response as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional copy of the response with this information redacted. OHCA shall make the final decision as to whether the documentation or information is confidential.
- D. If the respondent provides a redacted copy of its response and OHCA appropriately supplies the redacted bid to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the respondent agrees to indemnify OHCA and step in to defend its interest in protecting the referenced redacted material.