



HEALTH CARE FRAUD REPORT



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Common Sense and Common Ground Can End Health Care Gridlock



BY **GEORGE LAZENBY**

In 2011, our country must tackle three serious but potentially conflicting objectives to return to economic health: 1) we must decide the fate of health care reform; and, at the same time, 2) shrink the federal budget deficit; and 3) reduce the burden on taxpayers.

The stakes could not be higher as the 112th Congress debates repealing or modifying the Patient Protection and Affordable Care Act of 2010. Recently, the Congressional Budget Office announced that the federal budget

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deficit for 2011 will be at least \$1.5 trillion—a deficit record that no one wanted to see broken.

Against this challenging background, it is easy to assume we will be stuck in health care gridlock. But I believe there are common sense actions we can take today, with support from across the political spectrum, that can help lead us out of gridlock and get us back on the track to being a healthier nation with a brighter economic outlook.

A foundation for improving health care efficiency was laid early in the health care reform debate, although it never made the headlines. Versions of both the Democratic and Republican health care reform bills included sections requiring our government to put in place sensible reforms for administrative simplification and savings in federal health care programming.

These reforms include, among other things, electronic transmission of payments from Medicare, Medicaid, and private health insurers, similar to the direct deposits most Americans receive from their employers on a regular basis. Just eliminating paper checks in health care could save an estimated \$11 billion each year on postage, printing, and processing of payments using the same techniques already in use by other industries.¹

Electronic payments and other administrative simplifications represent practical policies that can help preserve scarce health care dollars and ensure that Medicare and Medicaid dollars are spent on delivering beneficiary care.

But there is much more work to be done. The new Congress and the administration can and should take more specific actions to protect the integrity of these

¹ U.S. Healthcare Efficiency Index, <http://www.ushealthcareindex.com>.

health care programs by eliminating waste, fraud, and abuse.

During 2009, the federal government estimated that taxpayers were bilked out of more than \$63 billion in improper Medicare and Medicaid payments alone.² Sustainable models to address this problem before payments are ever made have already been tested in both the government and private sectors.

These models emphasize the prevention of waste, fraud, and abuse by utilizing more comprehensive data and technology earlier in the reimbursement process. This important shift could provide the tipping point the U.S. health care industry needs to begin to reverse the loss of billions of health care dollars every year. Our nation can benefit from these proven models by taking the following practical steps:

1. Integrated Annual Health Care Waste, Fraud and Abuse Report:

The federal government operates five major health care programs through four federal agencies across all 50 states and 14 U.S. territories. These agencies—the Department of Health and Human Services (HHS), the Social Security Administration (SSA), the Department of Defense (DOD)/Veteran’s Affairs (VA), and the Office of Management and Budget (OMB) operate almost entirely independently from one another. Thus, if the president or members of Congress want to evaluate the impact of health care waste, fraud, and abuse across all federal programs, they currently have to go separately to each individual agency, program, and state—resulting in a view that is piecemeal at best. In the absence of a single national view of health care waste, fraud, and abuse, criminals and other unscrupulous individuals can move easily from one market or program to another with little chance of detection. As a result, patients are continually exposed to improper billing and other practices, and taxpayers are forced to keep paying the bill. Creation of an annual Waste, Fraud and Abuse (WFA) Report that includes all federal health care programs would foster greater collaboration, detection, and enforcement.

2. Lowered Waste, Fraud and Abuse Detection Threshold:

To detect the kinds of waste, fraud, and abuse that take place across all health care services, we need to reset the dollar threshold for screening health care claims to zero, to catch low- and mid-range offenses that typically would fall below the threshold of investigation. For instance, when the federal government audits an account, it typically looks only at individual health care claims that exceed a specific amount, like \$1,500. This kind of threshold has the potential to allow claims with lower dollar values to be paid without much scrutiny. In the private sector, technologies are already in use that can detect unusual patterns or trends across large groups of claims that are likely indicators of waste, fraud, or abuse—and prevent inappropriate payments from being made. Fraudulent claims of any amount need to be stopped. A zero threshold—in conjunction with

the use of new, prepayment screening technology—would allow us to prevent more waste, fraud, and abuse and save more taxpayer dollars.

- 3. Provider Verification Score Pilot:** Most of us can accept that our actions have consequences. The way we conduct our business and affairs affects the opportunities that are available to us. But the lack of integrated reporting on federal health care waste, fraud, and abuse makes it possible for unscrupulous individuals to continue to participate in Medicare and Medicaid. At a minimum, we need a way to link an individual’s actions to their ability to contract and earn money from government programs. Specifically, we should test the use of a Provider Verification Score that validates the health care provider’s identity and eligibility to participate in these programs through a scoring system based on a common set of objective criteria. The establishment of a pilot program sponsored by the federal government would allow time to test the appropriateness and efficacy of the criteria and ensure broad participation in their development. By using technology already available from the financial industry, and pairing it with comprehensive national data on health care claims, the Provider Verification Score could help distinguish between the vast majority of providers treating patients in good faith—and the criminals who steal billions of health care dollars every year.

Each of these steps creates important opportunities to identify and eliminate waste, fraud, and abuse and help take significant costs out of the health care system. They share a common, yet vitally important, thread: they all require the power of robust health care information technology (HIT) and data to drive the disruptive but necessary change that will be critical in reversing our current cost trends.

Similar “disruptive” opportunities are emerging through new health care delivery models that would change the way we pay for health care. In these new models, health care providers and payers would share the cost and risk of caring for patients and offer incentives for better patient health outcomes and better patient experiences.

Unlike the old health maintenance organizations (HMOs) that restricted choice to control costs, the newer models, known as Accountable Care Organizations (ACOs), maintain choice but use data analysis and connectivity to measure health outcomes and engage patients more fully in their own care.

While the long-term impact of ACOs is not yet known, they are another important example of the growing role of HIT in shaping the way health care is delivered, experienced, and financed in the United States. Meanwhile, shorter-term actions, like the ones I have described above, offer promise in harnessing HIT to address our immediate cost crisis.

There are many issues that can divide us as a country, but curbing health care waste, fraud, and abuse should not be among them.

We need to put in place these common sense reforms—like the integrated waste, fraud, and abuse report, the zero detection threshold, and the provider verification score pilot—that can help stop the waste, reduce spending, and save taxpayer dollars.

² CMS Center for Program Integrity Industry Day Presentation, October 15, 2010 (For 2009, CMS reported \$45 billion in improper Medicare payments and \$18 billion in improper Medicaid payments, totaling \$63 billion).

Our country simply cannot afford to remain in health care gridlock.