STOP PAYING THE CROOKS

Solutions to End the Fraud that Threatens Your Healthcare

Foreword by Newt Gingrich

Edited by James Frogue

Stop Paying the Crooks

solutions to end the fraud that threatens your healthcare

Edited by James Frogue

The following chapter is an excerpt
from *Stop Paying the Crooks*, a
Center for Health Transformation publication.
For more information or to purchase
a copy of the book, visit
www.healthtransformation.net.

CHT Press
1425 K Street, NW
Suite 450
Washington, DC 20005

President and CEO: Nancy Desmond
Media Coordinator: Alissa Momberg

© 2009 by the Center for Health Transformation

Printed in the United States of America.

All rights reserved.

Internet address: www.healthtransformation.net.

No part of this publication may be reproduced, stored in retrieval systems, or transmitted in any form or by any means electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of the publisher.

Additional copies of this book may be ordered by calling 202.375.2001 or visiting the CHT website at www.healthtransformation.net.

ISBN 978-1-933966-04-5

The authors, editors, and publisher of this work have checked with sources believed to be reliable in their efforts to confirm the accuracy and completeness of the information presented. However, neither the authors nor the publisher nor any party involved in the creation and publication of this work warrant that the information is in every respect accurate and complete, and they are not responsible for any errors or omissions or for any consequences from application of the information in this book.

Information provided in this book is for educational and demonstration purposes and is not intended to constitute legal advice. If legal advice is required, the services of a competent professional should be sought. All comments, opinions, and observations are those of the authors, and do not represent official positions or opinions unless specifically noted.

Contents

FOREWORD 1

Newt Gingrich,
Former Speaker of the House of Representatives and Founder of the Center for Health Transformation

CHAPTER 1
Healthcare Fraud, Waste, and Abuse: A Smarter Way to Deter and Prevent 7
George Lazenby,
Chief Executive Officer, Emdeon

CHAPTER 2
Blue Plans Leading the Way: Innovative Solutions for Fighting Healthcare Fraud 21
Scott P. Serota,
President and CEO, Blue Cross and Blue Shield Association

CHAPTER 3
The Case for the Healthcare Payments Network: Cutting Fraud, Slashing Waste, Saving Billions 31
Trey Jinks,
Group Executive, TSYS, Inc.

CHAPTER 4
South Florida: Ground Zero for Healthcare Fraud 41
Craig H. Smith,
Partner, Hogan & Hartson

CHAPTER 5
A Closer Look at Public and Nonprofit Hospitals 59
James R. Frogue,
Vice President and Director of State Policy, Center for Health Transformation

CHAPTER 6
Medicare Fraud: What the Government Can Learn from the Private Sector 81
Merrill Matthews, PhD,
Director, Council for Affordable Health Insurance;

Meredith Matthews, PhD Candidate in Criminal Justice at University of Texas at Dallas

CHAPTER 7
Fraud and Beyond: Taking Program Integrity to the Next Level 101
Tom McGraw,
Senior Vice President of Government Solutions, Ingenix

CHAPTER 8
The "F" Word: $250 Billion of Easy Money 117
J. Christian Kryder, MD,
Chief Executive Officer, Verisk Health;

Barry L. Johnson, DDS, CDC, FAGD,
President, HealthCare Insight

CHAPTER 9
The Spectrum of Fraud: From an Ocean of Pennies to a Galley of Crooks 129
Merrit Quarum, MD,
Chairman of the Board, President, and Chief Executive Officer, Qmedtrix

CHAPTER 10
The Medicare to Medicaid Crossover: An Open Door to Waste and Fraud 149
Mark D. Birdwhistell,
Chief External Affairs Officer, University of Kentucky Medical Center, and former Secretary of Health and Family Services for Kentucky

CHAPTER 11
Creative Approaches to Combating Fraud in State Medicaid Programs 163
Janet Rehnquist, Esquire,
Founder, The Rehnquist Group;

Jonathan Javitt, MD, MPH,
Senior Fellow, Potomac Institute for Policy Studies

CHAPTER 12
Connected Care: The Solution to Medication Errors, Duplicate Testing, and Preventable Hospitalization 175
James R. Mault, MD, FACS,
Director of New Products and Business Development for the Health Solutions Group, Microsoft

CHAPTER 13
Medicaid: Reforming a Fourth-Party Payer System 187
James R. Frogue,
Vice President and Director of State Policy, Center for Health Transformation;

Elizabeth A. Noelcke, State Project Coordinator, Center for Health Transformation

APPENDIX A 197

APPENDIX B 203

APPENDIX C 205

APPENDIX D 207

ABOUT THE EDITOR 211

Foreword

Newt Gingrich

We Americans are getting fleeced.

Recently, 97 percent of Long Island Rail Road career employees retired on disability in one year, according to an October 20, 2008, story in the *New York Times*. Their retirement packages even included free golf. New York taxpayers have forked over $250 million to this racket since 2000.[1]

Eighty percent of California Highway Patrol assistant chiefs retired on disability, according to an ABC News story in 2006. Nearly as many deputy chiefs did so as well. California state law actually forbade requiring a second medical evaluation in these cases, even where fraud is suspected.[2]

The federal government is much worse. Neil Barofsky is the Special Investigator General for the $750 billion Troubled Assets Relief Program (TARP) signed by President George W. Bush in October 2008. In April 2009, Barofsky sent a 250-page report to Congress stating that the TARP funds are inherently vulnerable to fraud, waste, and abuse, including significant issues relating to conflicts of interest facing fund managers, collusion between participants, and vulnerabilities to money laundering. Barofsky estimated that "we are looking at the potential exposure of tens if not hundreds of billions of dollars in taxpayer money lost to fraud" within TARP.[3]

The $787 billion stimulus package passed by Congress and signed into law in February 2009 is already rife with fraud. FBI director Robert Mueller said in June 2009, "The funds are inherently vulnerable to bribery, fraud, conflicts of interest, and collu-

sion. There is an old adage that where there is money to be made, fraud is not far behind, like bees to honey." Estimates are that $50 billion of stimulus money will be lost to fraud.[4]

General Motors sucked down $50 billion in bailout funds before declaring bankruptcy on June 8, 2009. The bailout of AIG has cost taxpayers more than $150 billion. A package of housing guarantees totaling $300 billion has failed to stem the tide of foreclosures and falling home prices.

The Congressional Budget Office estimates that the 2009 federal budget deficit will be nearly $2 trillion.[5] That is roughly quadruple the largest deficit ever run during the presidency of George W. Bush.[6] It is also well over double the entire cost of the war in Iraq to date.

Part of the backdrop to all this was the Bernard Madoff scandal, which cost private investors $50 billion.

Everywhere Americans look, we see fraud and waste on scales heretofore unimaginable. We are outraged, and with great justification. We may not know every detail of every last scam, but we are instinctively aware that corruption is virtually everywhere and that it is worst in the biggest institutions, be they government or private.

Fortunately, the fight back has begun.

On May 19, 2009, California voters delivered a decisive and powerful message to the ruling class in Sacramento. By an average margin of nearly two to one, voters crushed five ballot initiatives that would have allowed politicians to continue their irresponsible, spendthrift ways. Every one of California's fifty-eight counties had majorities against all five initiatives, with only three exceptions.[7]

Healthcare Fraud

Healthcare is one-seventh of our nation's economy. It is rife with endless examples of fraud, and wasted money is flying from the

pockets of government programs into the hands of crooks. And yet too little attention is given to this fraud. Our healthcare sector made up 17 percent of America's GDP, or $2.4 trillion, in 2008, en route to an estimated $4.3 trillion in 2017—20 percent of GDP.[8] In contrast, healthcare made up only 11.9 percent of GDP in 1990.[9] The costs of taxpayer-financed Medicare and Medicaid will exceed $900 billion in 2009 with the infusion of $87 billion in stimulus money by Congress for state Medicaid programs. This level of growth is simply unsustainable, and if left unchecked will continue to drive the U.S. economy downward.

Amounts this large and institutions this expensive, particularly when teeming with perverse incentives, virtually guarantee significant fraud, waste, and abuse. Unfortunately, healthcare has more than its fair share, Medicare and Medicaid in particular.

Harvard professor Malcolm Sparrow, author of *License to Steal*, has been a leading thinker in healthcare fraud since the early 1990s. On May 20, 2009, he testified to the Senate Judiciary Committee. Among his statements was this: "The units of measure for losses due to healthcare fraud and abuse in this country are hundreds of billions of dollars per year. We just don't know the first digit. It might be as low as one hundred billion. More likely two or three. Possibly four or five." Sparrow also lamented, "One of my deep regrets is to discover that academia has paid almost no serious attention to this critical problem."[10]

Oklahoma senator and physician Tom Coburn estimates that a full one-third of all healthcare spending—an amount in the neighborhood of $800 billion annually—is wasted on defensive medicine, paperwork, and outright fraud.

Specific examples of fraud are endless. In January 2009, the Government Accountability Office issued a report that found "10 percent, or $32.7 billion, of Medicaid payments made in 2007 were improper."[11]

In July 2005, the *New York Times* ran an excellent series on fraud in New York's Medicaid program. The authors interviewed James Mehmet, the former chief state investigator of Medicaid

fraud and abuse for New York City. Mehmet said his team believed that 10 percent of Medicaid spending was flat-out fraud and another 20 to 30 percent was unnecessary spending. "So we're talking about 40 percent of all claims are questionable," according to Mehmet. That would have been $18 billion in 2005. That is in one state's Medicaid program in one year.[12]

The *Miami Herald* has also done impressive investigative work on healthcare fraud. In August 2008, the paper reported that in 2005, South Florida clinics (mostly in Miami-Dade County) billed Medicare $2.2 billion for HIV infusion therapy. This amount "was 22 times more than the total HIV infusion claims submitted to Medicare by healthcare clinics in the rest of the country combined. The trend continues to this day."[13]

Compare the above examples with credit card fraud. The U.S. credit card industry processes more than $2 trillion in transactions annually, making it approximately the same size as the healthcare industry. There are 700 million credit cards circulating, millions of vendors, and countless products for purchase. Yet total credit card fraud is a fraction of 1 percent. This industry is able to combat fraud very effectively, while healthcare is orders of magnitude worse.

We are at a tipping point in American history, when average voters are waking up to how badly we are being fleeced by institutions ranging from federal and state governments to healthcare to big businesses with politicians in their pockets.

We have several objectives with this book. The first is to begin a serious national discussion about healthcare fraud, the incentives that allow it to flourish, and potential fixes. We want to give the reader a real sense of the vastness and to suggest key strategies for ending the waste. This discourse is long overdue.

It is also our goal to leave you with an understanding of how dramatically waste, fraud, and abuse impact *your* access to healthcare services. These massive, unnecessary additional costs inevitably lead to costlier healthcare services and/or reduced

access to care. Honest doctors and hospitals should also pay close attention, because fraud by the bad actors is a major contributor to lower reimbursement rates for legitimate care.

This book is a collaboration of experts from a variety of fields: healthcare, information technology, the credit card industry, and-more. Each author brings a unique point of view to the world of healthcare fraud, and each offers creative and doable solutions. No one solution is a fix-all, nor do we pretend that this book is a comprehensive look at all healthcare fraud. Instead, we hope to facilitate collaboration and proper discussion on the topic of healthcare fraud—the effective opposition of which we believe is vital to the long-term success of America's healthcare and economy. Our intention is to spark a chain reaction of people coming forward with ideas and solutions. So every physician, nurse, front office staff member, hospital custodian, union representative, insurance claims processor, patient, and anyone else with a story to tell, please contact us at fraud@healthtransformation.net. We look forward to the discussion.

Newt Gingrich, July 2009
Former Speaker of the U.S. House of Representatives
Founder of the Center for Health Transformation

---

[1] Walt Bogdanich, "A Disability Epidemic Among a Railroad's Retirees," *New York Times*, September 20, 2008.

[2] Vic Lee, "More Questions in CHP Disability Fraud Probe," ABC7, November 24, 2006, available at http://abclocal.go.com/kgo/story?section=news/local&id=4792870 (last visited June 22, 2009).

[3] "Quarterly Report to Congress," Office of the Special Inspector General for the Troubled Asset Relief Program, April 21, 2009.

[4] Greg Morcroft, "Fraudsters eye huge stimulus pie, consultant says," *MarketWatch*, June 12, 2009.

[5] "A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook," Congress of the United States Congressional Budget Office, March 2009.

[6] "Revenues, Outlays, Surpluses, Deficits, and Debt Held by the Public, 1969 to 2008," Congressional Budget Office.

[7] The only exceptions were Santa Clara, San Francisco, and Santa Cruz counties, which voted to pass the education funding payment plan. These were the only three counties to pass any of the five ballot initiatives.

[8] "Health Insurance Costs," National Coalition on Health Care, available at http://www.nchc.org/facts/cost.shtml (last visited June 22, 2009).

[9] "Health Care Spending in the United States and OECD Countries," Kaiser Family Foundation, January 2007.

[10] Malcolm K. Sparrow, "Criminal Prosecution as a Deterrent to Health Care Fraud," Testimony to Senate Committee on the Judiciary: Subcommittee on Crime and Drugs, May 20, 2009.

[11] "High-Risk Series: An Update," GAO Report to Congress, January 2009.

[12] Clifford Levy and Michael Luo, "New York Medicaid Fraud May Reach Into Billions," *New York Times*, July 18, 2005.

[13] Jay Weaver, "Medicare fraud rampant in South Florida," *Miami Herald*, August 3, 2008.

CHAPTER 1

Healthcare Fraud, Waste, and Abuse: A Smarter Way to Deter and Prevent

George Lazenby

"By taking the fraud and abuse problem seriously, this administration might be able to save 10 percent or even 20 percent from Medicare and Medicaid budgets. But to do that, one would have to spend 1 percent or maybe 2 percent (as opposed to the prevailing 0.1 percent) in order to check that the other 98 percent or 99 percent of the funds were well spent. But please realize what a massive departure that would be from the status quo. This would mean increasing the budgets for control operations by a factor of ten or twenty. Not by 10 percent or 20 percent, but by a factor of ten or twenty."

– Harvard professor Malcolm Sparrow,
May 20, 2009,
testimony to United States Senate Judiciary Committee

Healthcare fraud, waste, and abuse are significant and growing problems for the entire industry. The healthcare system—as well as, frankly, our economy—is collapsing under this weight. Besides the financial pain inflicted, one could argue that the most significant damage is the erosion of trust between the public and the provider community.

The issue of fraud and abuse affects all of us, including payers, providers, and consumers. The increased participation in healthcare costs by the patient/consumer is also driving more complexity

and urgency in resolving these problems. The current paradigm of fraud and abuse detection, analysis, investigation, and ultimately prevention just does not work, and we need to fix it quickly and effectively. A new approach is needed and should have several critical characteristics. This new and enhanced model must leverage sophisticated and available technology and must be data-driven, collaborative among all stakeholders, more proactive, and easy to enable while fitting within our current infrastructure and process flows.

The problem is so large that at its current growth rate, many experts in the industry, including the Centers for Medicare & Medicaid Services and the National Health Care Anti-Fraud Association, have projected healthcare fraud, waste, and abuse to rise as high as $330 billion by 2013. And while a significant portion of these cases occur in the public sector (Medicare and Medicaid), we believe the problem's characteristics and the solution's details are equally relevant for both the public and private sectors. As such, we see several fundamental challenges in the way the current model works in detecting, investigating, and recovering lost monies that must be addressed. Ultimately, the model should be moved to detecting, investigating, and preventing fraud, waste, and abuse. The fundamental issues that exist in the current model are:

- The current healthcare model encourages maximum usage, not efficient outcomes.
- The detection, investigation, and collection model is highly reactive and retrospective (i.e., pay and chase).
- Detection is highly manual and resource intensive with limited use of sophisticated technologies.
- In both the public and private sectors, the current deployments tend to be single-payer oriented, meaning that each payer uses its own myopic and suboptimal view of the provider-centric problem.

Whether fictitious companies providing phantom services or fraudulent providers submitting claims for deceased patients or for medically unnecessary procedures or upcoding claims, most of the simplest schemes are not identified before restitution is even a

possibility. It has been proven within payer organizations that the greater the lag time between payment and the pursuit of falsely paid claims, the less money is recovered. And in fact, many times perpetrators are caught only because the financial institutions they use to hold their loot notice "aberrant patterns" in their customer activities and alert authorities. Even dead patients show up in Medicaid claims around the country. A report by the Office of the Inspector General in 2006 summarized findings from ten different states, revealing $27.3 million in Medicaid payments for services after death.[1]

Today's retrospective model relies heavily on manual processes and human resources. As a result, it cannot possibly keep up with the volume, sophistication, and complexity of fraudulent schemes, much less deter them. Further exacerbating the problem is that healthcare payers have not invested much in labor or technology to combat the issue. In fact, a Health Industry Insights study completed in mid-2006 indicated that nearly 50 percent of the respondents had limited or no fraud and abuse technologies in use.[2] Many of the systems in place today to protect against fraud and abuse either employ outdated technology or are ill suited to handle today's complex data and fraud schemes.

When left with only manual processes or poorly suited technology, payers are forced to set parameters that severely limit the number of claims reviewed. As a result, someone with corrupt intentions can easily determine the attributes of claims that will fly under a payer's editing and detection radar. Millions of dollars in claims are missed, resulting in "death by a thousand paper cuts." To say that those committing fraud and abuse know and understand this limitation in the payers' systems is an understatement.

When fraud detection is done today, retrospective, rules-only reporting systems are used. These methods are costly and fraught with challenges. We believe there is a smarter way to approach the issue of fraud, waste, and abuse. This solution has five core tenets:

- Utilize a data-driven approach with a broad set of multiple-payer data (from both public and private sectors). A broad

data set will not only improve detection efforts for each organization by improving the analytics' effectiveness but will also establish key benchmarks to identify trends.
- Leverage new and advanced technology to identify fraud, waste, and abuse more efficiently and to better align resources for recovery.
- Deploy a complementary prospective and retrospective approach (multiple "nets") that is more integrated across the payment integrity continuum.
- Present a broad and flexible solution that can be easily implemented and can grow and change as the fraud, waste, and abuse program changes.
- Leverage the network effect of all constituents to enable a collaborative and integrated communication flow among providers, payers, and consumers.

In the next few sections we will review each of these five tenets in detail and provide a road map to integrate each component.

We believe healthcare fraud, waste, and abuse detection will eventually mirror that of the credit card and banking industries. Like healthcare, those industries faced a transformational period in which they switched from a heavily manual, paper-based processing environment to one of speed and electronic sophistication. Banking and credit card companies spent nearly twenty years investing heavily in their IT infrastructure and developing ways to share data so they could achieve significant processing efficiencies while reducing their fraud exposure. Even though fraud remains a significant issue for them ($.07 for every $100), it pales in comparison to healthcare fraud, which is estimated at a hundred times that number.[3]

Pattern recognition, practice pattern monitoring, and comprehensive auditing are the norm in the credit card and banking industries today. We believe the healthcare transaction processing will emulate the credit card industry, where detection is built into the processing systems and performed in real time.

Given the powerful analogy to the financial services industry, we would submit that the clearinghouse is an ideal processing location to begin leveraging better data and technology to automate fraud detection in healthcare. Like the banking and credit card industries, detection at the clearinghouse must also be complemented with a robust recovery and audit capability.

Leverage a Data-Driven Approach with a Broad Set of Multiple-Payer Data

Fraud, waste, and abuse are primarily found among providers. If a provider is abusing Medicare or Medicaid, there is a high probability that the same provider is also abusing reimbursement from the Blues, Cigna, United, and other private payers. However, today all the fraud solutions center on the payer. As a result, payers have a limited ability to see patterns because they are looking at a limited data set—their own. We believe this myopia is a severe limitation in accurately detecting fraud and abuse.

With a large multi-payer data set, it becomes much simpler and quicker to identify and act on aberrations. Different technologies can be used for "clustering" analysis that help to identify aberrations, but it is the robustness of the data set that enables us to find statistically significant anomalies.

Thus we believe it is important to holistically look at the issue across payers to identify patterns, aberrations, and schemes. Many Special Investigations Unit heads also believe that this detection approach can more accurately demonstrate intent (i.e., fraud) as opposed to one-off billing mistakes (abuse). As a result, false positives and administrative waste will be reduced. Of course, this will require a very large data set that is provider-centric and cross-payer, as even the best technologies and models are reliant on the robustness of the underlying data set.

Utilize the Full Array of Technologies and Resources Available

In his report to the Senate Committee on the Judiciary Subcommittee on Crime and Drugs in May 2009, Harvard

University Professor of the Practice of Public Management Malcolm Sparrow stated that, "The resources available for fraud detection and control in healthcare are not only inadequate; they are of the wrong scale. The credit card industry has established benchmarks for 'acceptable business risk' with respect to fraud losses. Their threshold is ten basis points on transaction volume, or one-tenth of 1 percent. By contrast, estimates of fraud losses in the health industry range from 3 percent to 10 percent to 14 percent, depending on who you ask. Suppose for a moment the loss rate were 10 percent. That would be one hundred times the acceptable business risk threshold set by the credit card industry."

Providers that exhibit fraudulent behavior are getting more sophisticated, cunning, and elusive in their schemes. Today many payers are investigating claims only over a certain amount, and criminals and abusers know this fact and take advantage of it. In order to succeed in the fight against fraud and abuse, payers must begin to adopt newer, more cutting-edge technologies, coupled with a re-evaluation of their processes and staffing of the fraud unit.

Data-driven, predictive analytics can greatly enhance our capabilities in detecting fraud, waste, and abuse. With this technology, payers can analyze massive amounts of data with techniques used to uncover very subtle patterns and associations. Many of these patterns would take hours, days, or even months to be discovered if the data were analyzed manually. In addition, with the right data set, these technologies can identify useful anomalies that "look interesting." As noted in a Gartner Industry study:

> Predictive analytics "learns" from data, building models or tables by constantly analyzing certain pieces of information (such as specific procedures and diagnosis). Predictive analytics continues to learn about the characteristics and patterns of legitimate and illegitimate claims behavior, becoming more intelligent and increasingly accurate in its detections over time. Predictive analytic tools expose multiple access points and databases to rigorous algorithms to predict and link data into meaningful segmentation and clustering for evaluation

and scoring. Fraud scoring helps users distinguish suspicious or fraudulent claims from normal claims activity.[4]

Several schemes that are well under the thresholds of investigation are nickel and diming the system, yet on aggregate yield significant dollar amounts for the perpetrators. An example highlights our point:

- A federal jury in Miami convicted the owner of a Miami pharmacy for his role in a $3 million Medicare fraud scheme and for money laundering. The defendant, an "owner" of a durable medical equipment (DME) company, was charged with seventeen counts in September 2007, including conspiracy to defraud the U.S. government, to commit healthcare fraud, and to submit false claims to the Medicare program; seven counts of healthcare fraud; seven counts of submitting false claims to the Medicare program; conspiracy to commit money laundering; and one count of money laundering. As part of the scheme, over the course of approximately one year, the defendant billed the Medicare program approximately $3 million for negative pressure wound pumps, wound care supplies, and pharmaceuticals.

- The defendant also owned and operated another company, Orthotics Fitters, through which he was billing the Medicare program for the same equipment he billed through the DME company. During 2006, he billed approximately $2.9 million in fraudulent claims for negative pressure wound pumps and wound care supplies that were never actually provided to Medicare beneficiaries.[5]

Such schemes are not uncommon, yet are hard to detect and often difficult to investigate. The criminal abusers are also highly dynamic in their approach, often setting up and shutting down schemes within days or weeks to make a quick profit and avoid detection. They prey on the system's inability to react promptly. In his Senate testimony, Dr. Sparrow mentioned that, "Any time we [payers] discover that totally implausible claims have been paid, there are two questions that should spring immediately to mind: First, how did these obviously fictional claims get generated? Second, why did we pay them?"

All of this requires leveraging equally sophisticated technology. So even with a cross-payer data set, it is important to deploy predictive modeling and detection software that keeps up with the dynamic nature of the issue. The credit card industry has responded similarly, and there are several lessons to be learned.

First, predictive technologies can be very effective at detecting schemes and patterns as they are developing—nipping the problem in the bud. As schemes change, the technology understands how they are changing. The current complaint that the technology is ineffective and that the volume of false positives is high lies in the amount of data used for the modeling. We believe it will take an organization with a tremendous amount of cross-payer data to overcome this obstacle, and frankly there are only a few in the industry that could bring that kind of scale to bear.

Second, we have to augment predictive modeling technology with identity theft prevention. The most sophisticated predictive models will not be able to tell that it was not John Smith who actually had the procedure done. This is an issue specifically formidable to Medicare and Medicaid. While it is not clear how many schemes rely on use of non-present patients, clearly biometric technologies can be used to ensure proper billing.

Biometric technologies like those used by universities and corporations are easy to deploy and manage. Identity authentication will become an increasingly important component in solving fraud, waste, and abuse. Besides helping to stop phantom services, the accurate noting of in and out times within the facilities also helps to ensure accurate and proper billing.

As the consumer becomes more responsible for payments, there will be significant motivation for consumer-oriented fraud schemes, including identity theft. We believe shoring up this weak point in the current system is imperative, and well-established biometric solutions currently deployed in other industries can easily be applied to achieve this.

Deploy a Complementary, Integrated, Prospective, and Retrospective Approach across the Payment Integrity Continuum

As we have stated, the industry has been applying a retrospective "pay and chase" model for many years, and most fraud detection and recovery efforts across the industry are still applying a simple solution to a highly sophisticated problem. The focus of the industry has been to stop payment on those clear cases or to pay and chase quickly to recover greater amounts.

We believe the credit card industry provides a clear and highly relevant analogy. Why can we not stop and identify fraudulent claims in the processing stream? With the right technology and the right hooks into the clearinghouses, we can.

But with some schemes and aberrations, more context is needed than is available at the time of claims processing. As a result, we believe the solution to fraud and abuse detection will require multiple filters or nets across the claims processing workflow. But there is still a compelling value to deploying a model that entails placing nets in the post-adjudication/pre-payment and even post-adjudication/post-payment positions. We now have the ability to align our resources better and more effectively against the problem, using the technology in the clearinghouse to catch most of the problem and using human resources more effectively to review the schemes where human context is critical (medical judgment, for example). By applying simple Six Sigma principles, we could solve 80 percent of the problem with technology and let our better aligned resources attack the other 20 percent. This not only helps with the detection accuracy, but also allows fraud investigators to be more efficient and effective.

Ease of Implementation and Adoption

One of the biggest issues in deploying and utilizing technology in the healthcare industry is the ability for constituents to develop and deploy solutions. Again, while payers are very intrigued with utilizing more sophisticated technology and employing it "upstream" at either pre-adjudication/pre-payment or post-adjudi-

cation/pre-payment positions, there are powerful impediments to doing so, mainly auto-adjudication rates, payment efficiency, interpretation of state-by-state prompt pay laws, and provider relationships.

In the credit card industry, the widespread adoption of the new fraud and abuse detection technology occurred largely because banks were willing to allow the processors to put the fraud detection capabilities in their systems. It would have taken much longer to achieve the current results if every bank had deployed individual solutions. Clearinghouses are analogous to the credit card transaction processors for healthcare. We believe that if the technology can be deployed in the clearinghouse, it would benefit the entire industry for several reasons.

First, all payers, not just the large ones, would be able to afford to deploy world-class, highly sophisticated predictive modeling software.

Second, fraudulent activities would be centrally identified and deterred. Centralization provides a powerful feedback mechanism that enables the system to learn and improve. Similar to other "network effects" that take advantage of their scale, this new paradigm would subscribe to the law of increasing returns.

Third, there is no rerouting of claims or a heavy IT investment on the payers' end because the claims are already traversing the clearinghouse systems. While the routing is extremely sophisticated, we should be taking advantage of applying intelligence to those transactions as they are processed.

Finally, payers must often share data with outside investigative and prosecutorial organizations, such as the Federal Bureau of Investigation, attorney general's office, or the Office of the Inspector General, as part of their regular investigations. However, rarely do payers in the same market share data on potential fraud schemes stretching across organizations. This "consortium" will allow that sharing so emerging schemes can be discovered earlier, with all payers put on alert for a specific scheme or provider.

We believe that the ease of implementation is critical to gaining payer adoption to this new model of fraud, waste, and abuse prevention. There are lessons even within the industry that would support that assertion. One need look no further than the adoption of electronic medical records. Adoption has been slow because the providers have borne all the investment costs and significant effort is required to install the software and adapt business processes to utilize the new technology.

Collaborative and Integrated Among All Stakeholders: Payers and Providers

Waste, fraud, and abuse are everyone's problems, and it will take everyone to help solve them. Payers cannot do it alone. Provider education is a very important piece in solving the problem. While outright fraud is clearly a large issue, so are abuse and waste, and providers in that second and third category may not realize the effects of their actions or coding practices on the collective system. It is the duty of the payers to ensure they are proactively and positively communicating where abuse and waste are happening.

As with our complicated tax code and system, there are many providers and coders who have trouble dealing with the complexity of the reimbursement system. We should not punish those who make honest mistakes but rather take the more appropriate approach of educating them.

The Road Map to Success

Whether you agree with our principles or not, it cannot be denied that they are irrelevant without proper and adequate implementation. So how do we get there, and what are the catalysts for improving the system? First, it will take an organization with scale and sophistication to leverage a multiple-payer data set to create world-class fraud detection capabilities. These capabilities will be based on using currently available advanced predictive modeling technologies coupled with other technology safety nets.

Second, health payers must be willing to experiment with this new, disruptive approach. It is so fundamentally counter to the

current system that it will take several early adopters to prove its effectiveness. Third, resourcing and realignment of resources must become a priority. Remember that it took the financial services and credit card industries many years to develop and deploy their technologies and systems. Finally, the need to build collaboration mechanisms will be critical. Consumers need to learn when and how to spot fraud and abuse. Providers need to be educated on how their practices and processes affect the billing and payment processes, particularly when it comes to waste. Education is a critical lever to fighting fraud and abuse today; it will become even more critical in the future.

We believe that the steps listed in this chapter, along with others, can help reduce the fraud, waste, and abuse in the American healthcare system by as much as 33 to 50 percent over time. However, this will take an investment by key stakeholders as well as public recognition that this is a serious problem. This investment can have significant savings, overall cost of care reductions, and, ultimately, improved quality of care.

Summary

The healthcare industry is moving from a "pay and chase" model of fraud, waste, and abuse detection and recovery to a more sophisticated model that emphasizes prevention. The path from retrospective analysis to prospective to preventative is clear. We believe that utilizing better, more robust data and technology in the clearinghouse can provide the tipping point the industry needs to reduce fraud, waste, and abuse.

As Emdeon's CEO, George Lazenby leads the largest healthcare financial and clinical network in the nation. Emdeon connects 1,200 payers, 500,000 providers, 5,000 hospitals, 77,000 dentists, and 55,000 pharmacies and processes nearly 4 billion healthcare information exchanges per year. Prior to his appointment to CEO, Mr. Lazenby was the Executive Vice President for Emdeon Provider Services and was responsible for several industry innovations in

the revenue cycle management arena, delivering record sales and revenue growth.

Formerly, Mr. Lazenby served as Chief Operating Officer of Medifax-EDI, which Emdeon acquired in 2003. As COO, he was responsible for managing all provider and payer activities as well as Medifax's Medical Practice Management software business. Mr. Lazenby graduated from the University of Alabama and is a certified public accountant. He has served on many industry boards, including the Cooperative Exchange, AFEHCT, and the Nashville Healthcare Council.

---

[1] "Audit of Selected States' Medicaid Payments for Services Claimed to Have Been Provided to Deceased Beneficiaries," Office of the Inspector General, U.S. Department of Health and Human Services, September 26, 2006.

[2] Health Industry Insights Newsletter, July 2007, #H1207853.

[3] Gartner Research, "Investments by Health Insurers in Fraud Management Will Take Off in 2007 and 2008," April 2007.

[4] Ibid.

[5] "Miami Jury Convicts Pharmacy Owner of Medicare Fraud," U.S. Attorney's Office, Southern District of Florida, April 24, 2008.