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The Road Ahead:

New Emphasis on Prevention Key to Reducing Fraud

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Fraud, waste and abuse continue to cast a long shadow over the U.S. healthcare system, despite the best efforts of the federal government, industry groups and individual health plans. Although sophisticated detection tools have emerged over the past 15 years to help payors identify illegal or abusive practices, few would argue that the problem is under control.

To the contrary, rising clinical costs, falling reimbursements, widespread antipathy toward health plans and an increasingly complex payment system all have combined to give the small minority of unethical providers new means, motives and opportunities for engaging in illicit behavior.

A New Approach

This harsh fact is forcing a fundamental reassessment in the way plans, third-party administrators and self-funded companies tackle the issue. A growing number of payors have realized that the traditional approach to fraud abatement – one which relies almost exclusively on “pay and chase,” or retrospective investigations and recovery – has had little, if any, effect in preventing fraud from reoccurring.

As a result, a new framework is taking shape that harnesses a variety of tools to achieve true fraud prevention. This approach emphasizes cooperation and communication with providers, greater member buy-in through improved education and industrywide transparency to allow for easier identification of aberrant behavior. It's an approach that demands greater internal integration of the fraud prevention unit and one that requires effective measurement; not just of dollars recovered, but also of trendlines that collectively illuminate the real reduction of fraud and its costs.

A Brief History

By some industry estimates, 3-to-10 percent of every claims dollar today is absorbed by fraudulent or abusive provider activity. That puts the total annual loss at somewhere between \$63 billion and \$210 billion. In comparison, U.S. credit card fraud amounts to a relatively paltry \$500 million each year, according to the U.S. Department of Homeland Security.

The health insurance industry has attempted to arrest fraud's growth with increasingly sophisticated analytics and data mining capabilities designed to more quickly identify bad actors. These technologies have been effective and have yielded significant recoveries. Yet seldom does the recovered amount approach the full percentage of the loss. Nor is the malefactor necessarily dissuaded from engaging in unethical behavior in the future.

Thus, while the industry has concentrated on perfecting its detection and recovery skills, prevention has languished and the core problem has continued to fester and grow.

Changing Behavior

Shifting fraud abatement's emphasis from recovery to prevention requires major changes in long-held assumptions, philosophies and methods. Special investigative units (SIU) can no longer afford to work in isolation but must instead cooperate closely with claims, medical management, provider relations, member relations, contracting and marketing to better understand the market, to share information and to gain the knowledge required to effectively communicate with relevant constituencies.

At the heart of the new approach is a fundamental change in the way the SIU, and thus the payor, interacts with the provider. Instead of the cryptic, investigatory requests for information that have characterized SIU-provider communications in the past, plans must adopt a less confrontational stance and try to work with providers to resolve aberrant behavior once it has been identified.

This approach accomplishes several objectives: First, it puts the provider on notice that his or her behavior is atypical and/or unauthorized and thus establishes the legal foundation of prior knowledge should the behavior persist. Secondly, it compels providers to, in effect, investigate themselves through self-audits and ongoing compliance monitoring. This places greater responsibility on the provider and in so doing, gives them the opportunity to rectify the problem before it becomes worse. Finally and most importantly, it can alter behavior by fostering a new spirit of cooperation between the plan and provider. This can reduce the incidence of fraud and produce important provider-relations benefits over the long term.

Making it Personal

Just as physicians can be enlisted to police themselves (with continual oversight), so too can members be educated to play a more active role in identifying fraud, waste and abuse. This is particularly true as more consumers enroll in plans that have greater out-of-pocket expense. Showing members how much fraud is costing them personally, eliciting cooperation in identifying aberrant utilization and advocating a more informed stance when it comes to questioning treatment options can go a long way toward instilling a sense of ownership in the healthcare process. In essence, members need to be convinced that it is in their financial interest to bring the same level of scrutiny to healthcare services that they bring to every other major purchasing decision.

Measuring for Success

Effective measurement and ongoing monitoring are critical to sustaining and improving a prevention program. Quantifying the hard-dollar benefits of fraud prevention requires tracking multiple metrics over time. For example, it is not enough to simply report that high-level E&M submissions have trended down with the implementation of a prevention program. Unless per-member, per-month costs follow a similar trajectory, it is logical to assume that providers are simply making up for revenue lost in one area by increasing aberrant behavior in another. Continual assessments and measurement serve two purposes: They allow payors to conduct controlled tests of program efficacy by including one group of providers but not another and then measuring the differences, and they help sustain provider cooperation by conveying the message that prevention is not a "one-time deal" but rather a permanent, supported and integral component of the payor's operation.

Industry Cooperation

Like payors themselves, the industry as a whole gains when a greater emphasis is placed on cooperation and communication. A mechanism that fosters a more open and collaborative environment between payors would allow for quicker identification of atypical behavior across a broad spectrum of plans. This, in turn, could illuminate low-level but widespread patterns of abuse. Moreover, provider awareness that claims were being compared across carriers could serve as a significant deterrent.

Toward a Healthier System

Implementing true prevention programs is a complex, time-consuming process that requires input and cooperation from all aspects of the organization. More fundamentally, it necessitates a basic transformation in the way plans and providers interact and the suspension of years of mistrust on both sides. Yet the benefits are worth the effort, for without genuine prevention, a problem that already is enormous will only grow worse.

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