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Combating fraud, waste, and abuse with limited internal resources

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Healthcare is becoming more consumer-driven with greater focus on improving healthcare access and driving better health outcomes from a wellness and preventive perspective. No matter the policy, payment model, or trending of care delivery systems, one element remains constant—that is, the efforts to combat fraud, waste, and abuse (FWA). Federal, state, and private healthcare insurance payers' program integrity activities are designed to not only propagate this fight against "bad actors," but to also identify areas to better educate providers, payers, and consumers, as well as to prevent erroneous payments.

Payment program integrity efforts are successful when payers, providers, and consumers have a collaborative working relationship. Government-sponsored health insurance programs, as well as private health insurance plans, set forth their requirements to operate by setting rates, enrolling providers and beneficiaries, contracting with providers, paying claims, and reporting expenditures. Covered benefits may change from year to year, so it is important to maintain knowledge of medical policies and terms of coverage for each health plan prior to conducting data analysis and audits or investigations.

Why is it important to combat fraud?

According to the U.S. Census Bureau report released on September 10, 2019, nearly 36% of the nation's population was covered by Medicare and/or Medicaid.[1] The Centers for Medicare & Medicaid Services (CMS) reports that beneficiary healthcare expenditures for Medicare and Medicaid totaled more than $1.3 trillion for 2018.[2] This lends credence to why the healthcare industry is a heavily regulated space, in addition to the fact that many of our nation's most vulnerable individuals are covered by these services.

The National Health Care Anti-Fraud Association estimates that healthcare fraud costs the US nearly $70 billion each year, although some estimates range upwards of $230 billion annually.[3] Government and private health insurance payers, in concert with providers and consumers, share accountability and work together to ensure healthcare expenditures are accurate and cost effective. The value, quality, and outcomes of healthcare are largely dependent upon the strength of these relationships.

Provider screening

Reimbursements of claims improperly paid to fraudulent providers are challenging to recover. One way to deter or prevent fraudulent behaviors from occurring is to periodically screen providers against federal and state-based databases for sanctions and exclusions, such as the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities,[4] the General Services Administration's System for Award Management,[5] and the CMS Preclusion List.[6] The OIG issued an updated special advisory bulletin on the "Effect of Exclusion from Participation in Federal Health Care Programs"[7] on May 8, 2013, and outlines the importance for provider screening as an integral part of a health insurance payer's

integrity program.

Program integrity policy, as reflected in the program integrity provisions of the 2010 Patient Protection and Affordable Care Act,[8] promulgates keeping "bad actors" out of government-sponsored health insurance plans through risk-based provider screening, routine revalidation of provider enrollment, and temporary suspension of payments while credible allegations of fraud are under investigation by regulators and law enforcement.[9] Commercial plans have followed suit by conducting periodic provider screenings more frequently as well as placing "problem" or "suspect" providers on pre-payment review or even suspension of payments while investigating credible allegations of fraud.

CMS implemented these requirements with federal regulations at 42 C.F.R. § 455.400 .[10] These regulations were published in the *Federal Register*, Vol. 76, February 2, 2011, and were effective March 25, 2011. This regulation, at 42 C.F.R. § 455.400 , requires that all participating providers be screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment.[11]

Program integrity efforts in Medicare have considerable potential to strengthen program integrity in Medicaid, and fraud identified by the states can likewise benefit the Medicare payment integrity program. CMS estimates that 12 million Americans were simultaneously enrolled in both Medicare and Medicaid in 2017. Notably, 60% of the dually enrolled beneficiaries experience multiple chronic conditions.[12] The cost of care tends to be more significant for this population. As the complexity of care and costs increase, so does the propensity for FWA to occur.