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U.S. Fee-for-Service Medicine Model Becoming Extinct, Impacting Payment Integrity

BY JULIE MALIDA AND RICKY D. SLUDER

Throughout history, payment for the number of services performed has been considered the equitable way of the world, and health care delivery has been no different. Going back to the days of the ancient Egyptians, or the more recent times of the family physician that still made ''house calls,'' physicians have expected to be paid based on how many visits they made or how many patients they treated.

More recently, beginning in the 1970's in the U.S., experiments were tried where physicians managed all the care for a patient within a fixed pre-paid dollar amount (physician risk arrangements), but these were largely rejected over time by the physician communities because they were seldom viewed as an equitable arrangement. Hence, from the late 1980's until now, there has been a groundswell of payment models back towards Fee-for-Service (FFS) medicine.

Julie Malida is the Principal for Health Care Fraud Solutions in the Security Intelligence Practice at the SAS Institute Inc. She is a 31-year veteran of the health insurance industry and is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. She is at Julie.Malida@sas.com.

Ricky D. Sluder, Certified Fraud Examiner, is a Senior Solution Architect in the Security Intelligence Practice at the SAS Institute Inc. with18 years of investigative experience in White Collar Crime, Medicare and Medicaid fraud, waste and abuse. He is at ricky.sluder@sas.com.

Many health care industry pundits are now speculating that FFS payment models in government-sponsored and private insurance plans could soon go the way of the dinosaur and dodo bird. What is different now that might make this extinction possible if it did not happen before?

What's Different Now?

Accountable Care Organizations (ACOs), patient-centered medical homes, and the move towards Managed Care Organizations for government-sponsored benefits (MCOs) are just a few of the value-based contract models that will become the norm over the next several years with legacy payment FFS systems becoming the exception.

ACOs have been in existence for several years, but the largest commercial health plans are now embracing them in earnest, putting in place shared savings models between the plan and the provider of care, based on quality and outcomes, along with the infrastructure to support it. Aetna, Cigna, several Blues, and Humana, for example, all have established several ACOs around the U.S.

According to the National Committee on Quality Assurance (NCQA), the patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into ''what patients want it to be.'' Medical homes can lead to higher quality and lower costs and can improve both the patient and the provider experience.[1] The concept is not new. It was introduced by the Ameri-

[1] http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx

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can Academy of Pediatrics in 1967, but health plans are now embracing it due to the economic pressure to improve outcomes while reducing medical costs, further fueled by incentives in the Affordable Care Act.

Per a 2012 Kaiser Family Foundation study, nationally, 26 million Medicaid beneficiaries were enrolled in plans administered by MCOs. and another 8.8 million were enrolled in Primary Care Case Management programs (another form of managed care administered by private payers), which adds to about 66 percent of the Medicaid population.[2]

There is a growing trend by the states to outsource administration of Medicaid programs to MCOs.

As we already stated, health plans who administer MCOs are moving away from historical FFS payments in favor of other shared risk and value-based arrangements. Further, one of the ways more people in this country will receive access to health care under the Affordable Care Act is to significantly expand the population covered by the Medicaid program, hence an expansion of lives administered by MCOs.

One can argue that FFS medicine will not be extinct for a very long time, as the success of value-based models remains to be seen from several standpoints: the financial viability of physicians accepting risk, how that dovetails with provider shortages, and how that complements more people covered in the U.S. health care system than ever before.

There is little question that FFS models will diminish in use. If they do, what will happen to the insidious fraud and improper payments that recently has been valued at $100 billion in health care losses each year?[3]

We do not expect the problem to reduce naturally; rather it is likely to morph instead.

New Face of Payment Integrity Challenges

Consider the shift in incentives as we enter the new paradigm. ''Creative billers'' would ply their trade in the old world by adding to the bill (being submitted to the payer) extra services or supplies that were never rendered, up-coding to show a higher level of service than was actually performed, falsifying the date of the service or ordering unnecessary procedures, not warranted by evidence-based medicine, as a few examples.

In the new world, incentives for falsifying documentation will shift to help prove: a) the provider had more patient encounters than actual fact, or b) the provider showed better quality outcomes than reality, or c) the provider's mix of patients is higher risk than normal, all of which might drive higher reimbursements in either bonus payments or future risk-adjusted capitation rates.

The point is that there remain incentives to misrepresent for those who rationalize that as acceptable behavior.

How will the government-sponsored and private insurance plans of tomorrow prepare for the data integration, data management, and data analytic challenges they will face in this new payment frontier? How can they prepare themselves for the use of new sources of data that might become invaluable for detecting misrepresentation (i.e. electronic medical records, social media, and encounter data)?

Minimizing Information Overload

To prepare for these challenges, government-sponsored and private insurance plans need a data management infrastructure that provides access to data across programs, products and channels.

Despite what many rip-and-replace vendors will say, it doesn't require a database overhaul or a massive central data warehouse, but rather a data integration layer that can source from databases around the organization, business partner organizations, social media outlets, and from external public or purchased data.

Because unscrupulous providers and suppliers often intentionally provide inaccurate, incomplete or inconsistent information to prevent records matching across disparate systems, government-sponsored and private plans need data quality capabilities that support entity resolution.

Since the devil is in the details, the data management, integration, and quality infrastructure must be supported by a robust business analytics foundation. To make proper use of internal and external data sources, the business analytics foundation must provide a variety of analytic processes to identify suspicious patterns that could point to programmatic fraud, waste, or abuse.

Unscrupulous providers and suppliers often intentionally provide inaccurate, incomplete or inconsistent information to prevent records matching across disparate systems, making it necessary for public and private plans to acquire data quality capabilities that support entity resolution.

Time is money, and in this new payment frontier, government-sponsored and private plans need an infrastructure designed to stop the improper payments, instead of chasing them down after the money is long gone.

A great example of the data management challenges in government-sponsored health plans can already be seen in Managed Care encounter claims data. Adjustment Reason (AR) codes in the Medicaid Management Information Systems (MMIS) for FFS claims are not the same as MCO HIPPA Codes that are adjusted in the encounter claims data.

To manage the contracts effectively, state Medicaid agencies must build 'crosswalks' for several different MCOs serving their Medicaid recipients across the state if they want to understand how and why claims were adjusted. Whether or not there is ever a single source of codification, these plans must account for data management challenges.

[2] http://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf

[3] http://www.thefiscaltimes.com/Articles/2014/01/15/Feds-Blow-100-Billion-Annually-Incorrect-Payments

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''Big data'' is a popular term used to describe the exponential growth of structured and unstructured data in today's information rich economy. Industry analysts often discuss the three V's: 1) large **volumes** of data that need to be efficiently processed within a narrow time window, 2) huge **variety** of data, which may include tables, documents, e-mail, web streams, videos and more, and 3) the challenge of managing the **velocity** of data, which rapidly grows on behalf of the business.

As the volume, variety, and velocity grow, the gap between relevant data and big data creates information overload. The challenge is making meaning out of the data and shrinking the information overload.

Health plans also need to possess the analytical skill sets in-house to embrace this new paradigm or partner with an organization who can provide the acumen. Ability to compete on analytics is becoming a necessity. What used to be a couple of people crunching numbers in Excel spreadsheets and calling it ''analytics'' is now a high-profile organizational investment right at the heart of health care organizations. If you don't know your complex data, you don't know your business.

Plans cannot believe that since FFS as a payment model has been become outdated, the fraud, waste and abuse has disappeared with it. The incentives for improper payments will only have changed. If all the stakeholders in the health care system had integrity, we would not lose over $100 billion annually as a nation, health plans would not have ''payment integrity'' units, and every state Medicaid agency wouldn't need a ''program integrity'' department.