

The Case for the Healthcare Payments Network: Cutting Fraud, Slashing Waste, Saving Billions

By Trey Jinks, from *Stop Paying the Crooks: Solutions to End the Fraud That Threatens Your Healthcare*

The healthcare industry is choking on paper and manual processes that clog the system with more paperwork—hiding fraud, denying basic accountability, and bleeding billions of dollars per year in fraud and duplicative costs.

Even as annual spending on U.S. healthcare tops \$2.4 trillion, following the money has never been more difficult.

- In New York, a radiologist systematically billed Medicaid for thousands of medically unnecessary, duplicative, forged, or unreadable sonogram tests as his billings soared from \$8,200 to more than \$2.2 million in just two years.¹
- In Connecticut, a man used another person's health insurance information to receive approximately \$76,000 worth of treatment.²
- In Miami, six individuals who took over a clinic for a period of about a year submitted \$6.5 million in claims, including claims for beneficiaries who never went to the clinic for services.³

In all three cases—and there are thousands more that make headlines every year—the fraudulent practices took years to uncover.

The irony is hard to miss. In an industry defined by advances in medical technology that bring miracles to the emergency room, surgical suites, and outpatient care facilities, the process of medical billing is at least a generation behind other industries. Simply put, the healthcare industry is choking on paper and manual processes that clog the system with more paperwork—hiding fraud, denying basic accountability, and bleeding billions of dollars per year in fraud and duplicative costs from a system that is increasingly unaffordable to most Americans.

The National Health Care Anti-Fraud Association (NHCAA) estimates conservatively that three percent of all healthcare spending – or \$68 billion – is lost to healthcare fraud.⁴ The FBI, in its "Financial Crimes Report to the Public, Fiscal Year 2007," reports that fraudulent billings to healthcare programs, both public and private, are estimated to make up between three and ten percent of total healthcare expenditures,⁵ or more

than \$210 billion per year. This high rate of fraud is an indicator of even higher losses due to waste and abuse in healthcare, which have been estimated to be more than 30 to 40 percent of spending in some cases.⁶ If we are able to reduce fraud, we will also create transparency in healthcare payments and reduce waste and abuse as well. Protecting the integrity of healthcare payments and minimizing fraud, waste, and abuse are important components of reforming the healthcare system.

The way healthcare is administered renders the system an easy target for the unscrupulous. Fraud is typically committed by insiders with knowledge of the system and its weaknesses, and they are often brazen because they know that no one is watching. The U.S. Government Accountability Office (GAO) has highlighted the growing number of Medicaid claims paid to people who are not eligible for coverage. It also disclosed that as many as one in every ten dollars spent on durable medical equipment was paid to sham companies that had neither clients nor medical inventory.

Meanwhile, a congressional investigation found claims of up to \$92 million from 16,500 doctors—after they were deceased. Beyond the statistics, the headlines tell simple but shocking stories: the Miami clinic that repeatedly billed for the sale of a single wheelchair to the tune of \$5 million, the Brooklyn dentist who billed for 991 procedures in one day, or the Iowa anesthesiologist who routinely billed for ninety extra minutes of work after openheart procedures had wrapped up.⁷

The U.S. healthcare industry stands to learn much from the global payments business. Just consider the evolution of the payments industry during the past three decades. U.S. spending on retail purchases using payment cards amounted to \$3.9 trillion in 2007⁸—an amount nearly double the size of healthcare spending.



The structure, tools, technology, and standardization of payment cards allow participants to authorize and confirm a payment in seconds and mitigate fraud from the beginning of the transaction. In 2008, TSYS processed more than 10.7 billion payment transactions⁹ that each took a matter of seconds, a process that includes verification, authorization, fraud review, and creation of an audit trail in real time. The result was an actual fraud rate of less than 0.05 percent in 2008,¹⁰ demonstrating that the model of private partnership holds great promise for the future of healthcare.

The integrity of the system starts with the ability to verify patients, providers, and billers, a process that is often blunted today by overlapping systems, concerns about exposing confidential medical information, and a lack of standardized processes, which makes investments in verification risky. This is another instance in which the healthcare industry might consider emulating the payments industry, which has perfected the entire verification process—a cornerstone of low fraud rates.

It may be easy to take for granted the complexity which allows for millions of consumers to pull out a credit or debit card to pay for everyday items. In mere seconds, the information from the card verifies that the card is good, that funds are available, and then authorizes payment. Often overnight, a merchant is sent the money from the customers' accounts. The value to a merchant, of course, is that for the cost of mere pennies on the dollar, he is quickly paid with little risk because the payment was verified before the customer walked out of the store. This system is possible because the banks that issue the cards saw the value in sharing selected information and because technology companies like TSYS were willing to invest billions of dollars in building global networks that connected billions of cards and their banks with more than 10 million merchants.

When fraud is detected, it is quickly tracked down, and sparks the process of developing a refined detection model to be deployed in real time. The payments industry is rarely behind the fraudsters in keeping cost low and the integrity of the system high. In the healthcare market, accountability is missing because the liability for a loss ultimately falls to state and federal taxpayers or the shareholders of insurance companies.

By contrast, in the payments business, the financial liability is pushed down to the lowest level first and then comes up the payment chain until the fraud is paid for. This system reinforces accountability because it requires all participants in the system to share the risk.

The Payment Card Model

Payment cards are issued to an individual after an account has been approved by a bank. In the case of a debit card, the card accesses a deposit account, and the amount that the individual can spend is limited to the amount of funds in the deposit account. In the case of a credit card, the card accesses a line of credit that is limited to the amount of credit extended to the individual. Similarly, a merchant may accept payment cards once he has been vetted by a bank. In this vetting process, the merchant's bank reviews the merchant's financial statements, the number of years in business, average sales volume per day, and other benchmarks. In each case, the bank of either the consumer or merchant accepts the risk of non-payment if for some reason either party should fail to uphold the integrity of the system. Banks' providing individuals with payment cards and giving merchants the ability to accept cards for payment gives them the incentive to minimize losses on these accounts.

Electronic verification systems enable merchants to verify that the card is valid and the customer has sufficient funds to cover the purchase. This verification takes place in a few seconds, at time of purchase. Behind the scenes, however, a far greater number of verifications occur. In the few seconds it takes to complete an authorization from the card side of verification, fraud detectors will analyze how many transactions occur at which types of merchants and the specific dollar amounts that have been attempted in the last hour, day, or week. Other metrics on the merchant side give clarity as well. For example, fraud detectors analyze how the number and dollar amount of transactions from one day compare to those of the rest of the week, month, and year. Observing unusual transaction patterns at a specific time of day or a large number of transactions on the same account can signal red flags that indicate possible fraud.

While payment card fraud does exist, it is managed to an acceptable level, averaging less than 0.05 percent of all spending. In the past, a government employee who used his government-backed payment card for goods or services or a Hurricane Katrina victim who used a government-backed payment card for questionable necessities would go unnoticed. Now we know who is using taxpayer dollars for what purpose and can audit this usage. Simply because these wrongdoers now have a payment card does not mean they did not exhibit this behavior before; using a payment card merely brings such behavior to light.

If these verification checks were applied in healthcare, the first three examples would certainly not have been as noteworthy:

- The radiologist in New York whose billings increased nearly three hundred-fold in two years would have triggered alerts in the payment card industry much sooner and the amount of fraud would have been significantly mitigated.
- The man in Connecticut who used someone else's insurance card would have been identified as a fraudulent user much earlier, if not at the time of service.
- The clinic in Miami that submitted the fraudulent claims would have failed several checks and would have been investigated much sooner.

These examples would not have been as noteworthy if the payment cards model and its expertise were applied to healthcare. In fact, with the liability model in place and the application of sophisticated fraud tools, fraud rates in the payments industry were reduced from 0.15 percent in 1990 to 0.06 percent in 2000.¹¹ Risk and responsibility lie with the participant at the lowest level in the structure, keeping all participants accountable.

A New Model for the Future

A similar approach can modernize healthcare billing and payments while freeing up billions in savings to invest in a new operating model that emulates the best practices in billing and antifraud measures. If healthcare fraud were reduced to twenty times that of payment card fraud (or 1 percent), the savings would be anywhere between \$47 billion and \$206 billion per year.

A new system called the Healthcare Payments Network (HPN) holds great promise for wringing out inefficiency and reducing fraud. The idea starts with global transparency that connects all the players—private insurers, employers, consumers, Medicare, and Medicaid—and manages every stage in the lifecycle of healthcare payments. By its very nature, the HPN becomes a self-regulating body mandated to administer regulations, define standards, settle financial accounts, arbitrate discrepancies, and assess penalties among all the players.

The vision of the HPN is possible only through the investment that comes from a privately led partnership with the mandate to sit at the center of all of the players in the U.S. healthcare market. We see six key elements in making the HPN work for Americans:

- **Standards.** The network must support an open data format, content standards, and definitions so that information can be shared. Compatibility would be enforced through financial incentives and penalties.
- **Know your customer.** Every vendor or supplier in the system—doctors, hospitals, insurers—must go through a vetting process and submit to regular reviews for compliance with network rules.
- **Decentralized liability.** The financial risk is pushed down to the lowest-level participant in the system, with liability following the risk across the payment chain. In the payments industry, for example, if a merchant is found to be fraudulent and cannot pay the penalties assessed, the bank that set up the account is held responsible.
- **Authenticate and authorize.** At every step of a purchase, the players must be identified and authenticated before a provider is authorized to provide the service. This also allows for a preemptive screening against possible fraudulent claims by enabling the HPN to review the history of the participant and the location and type of service, among other factors, in determining if the service and payment is appropriate.
- **Carrots and sticks.** The HPN would use a combination of reimbursement rates, pricing, penalties, and payment terms to reward good behavior while constantly monitoring for problem areas to be addressed.
- **Enforcing self-policing.** The HPN would be the option of last resort to resolve disputes over payments among participants.

This model has worked well in many industries when there is broad adoption, clear standards, and a profit motive for all. The private sector is already leading efforts in other areas of healthcare by making investments in new technologies and established IT. Outsourcing and processing companies will see the opportunity if these six principles are written into policy and put into practice.

While the medical industry has piloted many new technology-driven ideas, few of these have transformed healthcare in a meaningful way. Leadership is needed to bring the players together and guide the transformation. Education, both in the industry and for consumers, is needed before the reengineering of the system will work. And, of course, technology has the power to make patients smarter consumers who understand what they are buying and what it will cost them before they make a decision, not months afterward.

Small Steps Forward

Technology is more about evolution than revolution. The first step toward realizing the billions of dollars in savings from creating the HPN is to start with simple goals like allowing patients more control over their healthcare buying decisions and giving providers a clearer path to getting paid sooner. Given that the current healthcare billing process appears to be designed to indefinitely delay the payment of claims, a cultural shift will not be quick or simple for the industry. No one expects providers or payers to scrap decades-old technology or abandon current processes overnight.

Based on experiences in the financial services market, we believe that three things need to happen to begin the transformation in 2010. First, there is a need to charter the Healthcare Payments Network with a mandate to set and implement policies and processes to standardize how medical claims will be settled. Ideally, this can be done by marshalling the other government, quasi-government, and private agencies to contribute their specialized expertise to create a transparent system. In the same way that Congress created the U.S. Department of Homeland Security to bring together disparate agencies after September 11, the same can be done in this new era to assure that the HPN has the authority to attack problems that threaten to bleed billions of dollars from the healthcare system.

Second, we believe that any good plan should start with a series of nationally coordinated regional pilots designed to build a critical mass of participation by all providers in the first two to three years. This classic approach to implementing

new, complex ideas is designed to minimize risk, to maximize creativity by leveraging the experiences and ideas from a broad range of participants, and to build a national foundation that can be leveraged as the HPN becomes funded on a fee-for-use basis.

Finally, we believe that sharing the savings through financial incentives is the clearest path toward broad national adoption. This will occur when participants in the HPN receive higher reimbursement rates, quicker receipt of funds due them, and benefit from lower fraud risk. These potential benefits will drive participation and spur providers to mandate that their partners, vendors, and patients also join the system. To be clear, this approach challenges deeply entrenched players—like billing and factoring companies—that profit from the current opaque and inefficient system.

Ultimately, the best solution is one that recognizes that healthcare is about the interaction between patients and their providers. Technology—and companies like TSYS—is vital to creating and delivering a better way to manage healthcare payments. The current process is buried in inefficiency and rests on generations-old technology that is dependent on paper rather than the real-time information management needed to stay ahead of fraud and push savings back into medicine and patient care.

- ¹ "False Claims Act," Phillips & Cohen LLP, available at http://www.phillipsandcohen.com/CM/FalseClaimsAct/cmtyph_f.asp, (last visited July 7, 2009).
- ² "Diagnosis: Identity Theft," BusinessWeek, January 8, 2007.
- ³ "Arrests Made in \$6.5 Million Health Care Fraud Scheme," Office of the Attorney General of Florida press release, November 23, 1999.
- ⁴ National Health Care Anti-Fraud Association, The Problem of Health Care Fraud, available at http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_cent&wpscode=TheProblemOfHCFraud (last visited June 8, 2009).
- ⁵ Federal Bureau of Investigation, "Financial Crimes Report to the Public, Fiscal Year 2007," available at http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health (last visited July 7, 2009).
- ⁶ Clifford Levy and Michael Luo, "New York Medicaid Fraud May Reach into Billions," New York Times, July 18, 2005.
- ⁷ "Coleman, Levin Investigate Millions in Medicare Payments for Claims Tied to Deceased Doctors," Senate Permanent Subcommittee on Investigations press release, July 8, 2008.
- ⁸ The Nilson Report, Issue 902, May 2008; 2008 Debit Issuer Study; TSYS estimates.
- ⁹ TSYS.
- ¹⁰ The Nilson Report, Issue 902, May 2008; 2008 Debit Issuer Study; TSYS estimates.
- ¹¹ Russell W. Schrader, Senior Vice President and Assistant General Counsel, VisaU.S.A., to Federal Trade Commission Secretary, September 15, 2000.

ABOUT THE AUTHOR

Trey Jinks leads TSYS' new efforts to break into the burgeoning market of healthcare payments. He plans to leverage TSYS' core assets with an innovative model that will remove payment inefficiencies from the U.S. healthcare system.

In his previous role as senior director of corporate strategy and planning, Mr. Jinks was responsible for developing international and domestic strategic and long-range plans for TSYS, as well as identifying and evaluating alliances or acquisitions to support business development efforts.

Mr. Jinks joined TSYS in 1987 and has since held a series of leadership roles in the company that include research and development, interchange and accounting, and international strategic planning. Mr. Jinks graduated from Duke University, where he earned a BS in computer science with a concentration in management science. He also graduated from the American Bankers' Association National School of Bank Card Management.

ABOUT THE BOOK

Stop Paying the Crooks: Solutions to End the Fraud That Threatens Your Healthcare by CHT Press explores alternatives to today's broken healthcare system in the U.S.

Given that healthcare costs make up around one-seventh of America's economy, it is imperative at this time to ensure that funding goes to appropriate people and organizations, not crooks seeking to rob taxpayers. The in-depth book on healthcare fraud contains a foreword by Newt Gingrich and is edited by James Frogue. It is available on-line at www.healthtransformation.net and in paperback.

TO LEARN MORE

About TSYS:
E-mail gaillee@tsys.com, or
visit www.tsys.com/healthcare.

GET TO KNOW TSYS

| | | | | | | | |
|--------------------------------|--|-------------------------------|--|--------------------------|---|---|-----------------------------------|
| ASIA-PACIFIC +603 2173 6800 | COMMONWEALTH OF INDEPENDENT STATES +7 495 287 3800 | EUROPE +44 (0) 1904 562000 | INDIA & SOUTH ASIA +91 120 4191000 | JAPAN +81 3 6418 3420 | MIDDLE EAST & AFRICA +971 (4) 391 2823 | NORTH & CENTRAL AMERICA, MEXICO & THE CARIBBEAN +1.706.649.2307 | SOUTH AMERICA +55.11.5501.2081 |
|--------------------------------|--|-------------------------------|--|--------------------------|---|---|-----------------------------------|