NHCAA
National Health Care Anti-Fraud Association®

The ROI of Fighting Health Care Fraud: The Impact of Methodological Variability

July 2018

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Introduction

The concept of "return on investment" or ROI is a fairly simple one. It is typically expressed as a ratio and measures gain or loss relative to an investment. In a financial sense, think of it as net profit (or loss) resulting from an investment compared to the amount initially invested. ROI is often used as a performance measure to evaluate the efficiency of an investment. A high ROI means an investment's gains compare favorably to its cost. Put simply, ROI can tell you if something is financially worth the investment.

The unit or department within a health insurance company whose responsibility it is to address health care fraud and abuse it often called a Special Investigations Unit or SIU. Broadly speaking, the mission of most SIUs today is to detect, investigate and prevent fraudulent or abusive activities affecting policies issued and claims filed for payment by the insurer. Insurer SIUs typically strive to accomplish two fundamental things:

1) Protect the finite financial resources the insurer has available to pay for the provision of health care by ensuring that it is spent on legitimate care; and
2) Protect enrollees from harm—physical and financial—caused by health care fraud and abuse.

The scope of responsibility of insurer SIUs has evolved over the last several decades and the SIUs of individual insurers vary widely, company to company, in terms of staffing, budget, jurisdictional boundaries and even the philosophy that underlies their designated role within the organization.

For nearly two decades, the National Health Care Anti-Fraud Association[1] (NHCAA) has administered a biennial *Anti-Fraud Management Survey* to serve as a benchmarking tool for assessing the structure, staffing, funding, operations and results of the special investigations units that support NHCAA Member Organizations. SIU leadership often turns to the survey report seeking guidance when decisions need to be made, such as resource allocation or hiring of investigators or analysts. One feature of the survey has been the reporting of average return on investment, where the SIU budget represents the "investment." Starting in 2001, each consecutive Survey Report has revealed and confirmed that private insurer SIUs are a sound investment, consistently yielding positive ROI.

ROI in Health Plan SIUs

Measuring and comparing the ROI of special investigations units with any degree of accuracy demands that we define the inputs or variables in the same manner. That has proven particularly difficult not only because of how differently SIUs operate across the health insurance industry; but also because the nature of health care fraud-fighting has changed significantly over the last 30 years. When NHCAA was established, health care fraud investigations were predominantly paper-based and any analytics used were decidedly rudimentary. The primary strategy was one of "pay and chase," where the insurer would pay the medical claims and the SIU would then attempt to recover claims payments determined to have been paid erroneously.

[1] The National Health Care Anti-Fraud Association was founded in 1985 by several private health insurers together with federal and state government officials who recognized health care fraud as a serious and costly problem that infects and undermines our health care system and affects every patient and every taxpayer in America. The NHCAA Mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. NHCAA is dedicated to serving and supporting health insurer SIUs and the anti-fraud professionals who work for them.

The first three iterations of the *NHCAA Anti-Fraud Management Survey Report* (reflecting data from 2001, 2003 and 2005) calculated SIU return on investment by combining two categories: "recoveries" and "savings" and comparing that number to the SIU budget. It was generally accepted that recoveries were monies recouped by the SIU on behalf of the insurer because those payments were made based on false or erroneous claims, while savings were monies the SIU prevented the insurer from ever paying because the claims were determined to represent potential fraud.

The role of the SIU has evolved significantly since that time. Recoveries and savings persist as important categorical targets that usually figure into an SIU's mission, but extraordinary advances in technology—particularly over the last decade—have changed how SIUs operate, often expanding their traditional functions. The concepts of recoveries and savings are no longer sufficient to capture the totality of the SIU's work.

Today, our nation's health care system hinges upon a staggering amount of data, with billions of claims processed each year. The volume of activity has inspired the creation of cutting-edge technology solutions and many SIUs now devote increasing attention and resources to fraud prevention, aided by these new advances. SIUs no longer adhere exclusively to "pay and chase" methodologies. Instead, they are diversifying and augmenting their anti-fraud toolboxes with powerful data mining and predictive modeling tools that detect risks and emerging fraud schemes. Many of the fraud schemes that would have resulted in costly and time-consuming litigation years ago are now avoided through the application of things like prepayment edits and the use of smart algorithms.

However, this shift—or expansion—of the SIU's activities creates real challenges when trying to calculate the impact of these newly adopted prepayment and predictive tools. Savings from avoiding paying submitted false or abusive claims and hard dollar recoveries are relatively easy to track and calculate. Filed claims and

payments create indisputable paper trails. What is more difficult, for example, is quantifying how an SIU's efforts and interventions impact and alter the behavior or billing patterns of health care providers who exhibit signs that infer possible fraud and abuse. Another example is when the SIU recommends that a policy be modified or a claim edit be implemented to address a fraud concern. Determining how to project and quantify the financial impact of those SIU-directed decisions is a challenge.

The precision with which anti-fraud professionals apply language and words used in the service of fighting health care fraud is critically important. Medical terminology, complex legal terms and concepts, dense statutory and regulatory provisions, prescriptive contract jargon and numerous billing and coding languages all come into play on a daily basis for fraud investigators and other professionals working in SIUs. In that same vein, it is crucial that an SIU takes care to clearly define the activities that comprise its outcomes and successes so that it can clearly articulate its value within the organization.

In 2007, NHCAA spent several months identifying the various activities and financial outcomes that should be included in an SIU's ROI and, as a result, developed detailed definitions to express these activities and outcomes. The initial goal of this effort was to produce standardized definitions that would hopefully enable NHCAA to collect relatively consistent data from its members through the *Anti-Fraud Management Survey*.

NHCAA considers this set of definitions to be a uniform and voluntary standard for industry SIUs when measuring and reporting financial results. A decade later, these return on investment terms remain valid and relevant, and continue to be used by the association. As the nature of health care fraud fighting changes, NHCAA revisits these ROI terms to ensure that they continue to sufficiently capture the varied aspects of the

SIU's work. In recent years, other organizations such as the Healthcare Fraud Prevention Partnership (HFPP)[2] have looked to NHCAA's ROI definitions for guidance.

The following is a summary of the most essential ROI definitions developed by NHCAA (the full document that includes all of the terms, along with detailed guidance can be found in the Appendix).

Term: RECOVERIES

Objective: To define those reportable amounts associated with losses recovered on a post-payment basis.

Definition: Recoveries shall mean actual monies received by the company, or its agent, for funds previously paid and as a direct result of actions taken by the special investigations unit (SIU) and shall be reported in the same period as they are received.

Term: SAVINGS

Objective: To define those reportable amounts associated with losses prevented on a pre-payment basis once a claim has been presented for payment.

Definition: Savings shall mean actual or appropriately estimated payments associated with an SIU-directed pre-payment denial of a claim. These claims must have received their final determination and denial must be as a direct result of actions taken by the SIU and shall be reported in the same period as the claim received final adjudication. Claim system edits that are not under the control of the SIU shall not be reported waste category.

[2] Founded in 2012, the Healthcare Fraud Prevention Partnership (HFPP) is a is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent healthcare fraud through data and information sharing. Website: https//hfpp.cms.gov

Term: PREVENTED LOSS

Objective: To define those reportable amounts associated with losses prevented on a pre-payment basis where an actual claim was not submitted as a result of SIU activity.

Definition: A quantifiable financial impact resulting from the direct action(s) initiated and completed by the SIU. The quantifiable impact may be the result of:

a. Change in Behavior—External, Claims Related

   A clear change in the billing pattern with a direct relationship to SIU actions, the result of which is a quantifiable financial impact. This impact must be measured "real time", and not projected, or forecasted into the future. The change in behavior measurement is recorded for the lesser of the length of the scheme, or 12 months from the resolution of the issue with the provider.

b. Process Improvement—Internal Impact

   A specific and quantifiable financial impact resulting from the modification of internal policy, edit or process. These changes must be the direct result of actions taken or recommendations made by the SIU. The measured results are limited to 12 months.

Term: COURT-ORDERED RESTITUTION

Definition: Court-ordered restitution will mean any order from a local, state or federal court, either criminal or civil, which directs a provider, corporation, facility or individual to repay money to a health insurance plan pursuant to a criminal or civil prosecution.

This category will have two separate reporting categories:

a. Court-Ordered Restitution which will mean the actual amount ordered by the court as documented in a court order pursuant to a sentencing. This amount can be claimed regardless of whether or not it has been collected or is likely to be collected. It will be reported in the year in which the restitution order was issued.

b. Restitution Received will be any actual monies collected pursuant to a court order and will be reported in the actual year in which it is received by the plan. This total of actual monies collected will also be included as a recovery.

Once these definitions were deemed final by the Membership, NHCAA began applying them to the *Anti-Fraud Management Survey* beginning in 2007. When asking respondents to report data relating to SIU results, the survey requested that they adhere to these categories precisely according to how they were defined. The concept was that the data reported through the survey would be more reliably comparable if respondents were asked to report them according to specific parameters. Despite establishing these uniform terms, in practice, insurer SIUs continue to track and categorize their ROI activities in a variety of ways.

The Anti-Fraud Management Survey for Calendar Year 2017 was administered in the spring of 2018. As with past surveys, it asked respondents to report their recoveries, savings, prevented losses and court-ordered restitution, which could cumulatively be used to calculate ROI. As a new addition to the survey, respondents were also asked to self-report their SIU's ROI (based on their own internal parameters), as opposed to having it be calculated based on various survey data responses. The survey also requested that respondents describe, in their own words, how their SIU calculates its ROI. This exercise yielded a wide assortment of explanations that illustrate how difficult it is impose a uniform standard.

The responses to this survey question seeking ROI detail confirms that the use of the terms "recoveries" and "savings" is rather standard (although it's not clear that each company defines those categories the same). Beyond recoveries and savings, SIUs employ a range of additional terms to classify their activities and include in their ROI calculations. Some examples: "prevented costs," "total dollars referred for recovery," "implied

savings," "prepayment review denials," "recoupments," "cost avoidance," "claims denials." (To see the full list of ROI components reported by survey respondents, see the Appendix.)

It's clear that insurer SIUs don't always track and calculate their financial results in the same way. And each insurance company likely has valid reasons for choosing the manner in which it tracks SIU outcomes. Nevertheless, this lack of consistency works to undermine efforts—by the *Anti-Fraud Management Survey* for one—to capture industry-wide information from private health insurers about the successes of anti-fraud activities. And this impacts the private sector's ability to articulate a unified, clear and powerful message about the value of what insurer SIUs do.

The challenge of speaking a consistent language has long been an underlying theme for SIUs. For many years the collective phrase "fraud, waste and abuse" has been in frequent use by the media and among decision makers to the extent that average citizens often link or conflate the concepts. While fraud, waste and abuse have long been established as related, intersecting or even evolving concepts, in the realm of health care and in legal terms, these words can have distinct, but also varied and overlapping meanings.

Historically, SIUs have been tasked with focusing almost exclusively on fraud. Today, the scope of responsibility for some SIUs has grown to include aspects of waste and abuse as well. The concepts of waste and abuse aren't always as clear cut as fraud. The fact patterns that underlie these terms are often subject to interpretation. Therefore, there could be SIU-led activity that results in cost savings within the categories of waste and abuse which may or may not be accounted for in the SIU's ROI, depending on the scope of the SIU's responsibilities and the interpretation of the definitions used.

An insurer establishes the boundaries of its SIU's jurisdiction as well as where it sits within the organizational structure of the company. These decisions can sometimes be influenced or dictated, to some extent, by state or federal regulation. The role and responsibility of insurer SIUs vary widely. For instance, while recovery of fraudulent or erroneous claims payments has traditionally been the bailiwick of SIUs, this is not universal. An insurer respondent to the *2017 NHCAA Anti-Fraud Management Survey* reported that their SIU is no longer responsible for recoveries. Instead, this task now falls to the Provider Audit department, which means the SIU cannot claim those recoveries for its ROI.

With regard to insurer SIU scope of responsibility, it's relevant to note that some insurers utilize outside vendors for tasks relating to fraud, waste and abuse. For instance, a vendor might be enlisted to investigate certain specialty areas, like home health care or pharmacy. These vendors may or may not report to the SIU and it is not consistently agreed upon within the industry where the savings realized through vendor efforts are accounted for. If the SIU is providing oversight and management of the vendor, does the SIU include those vendor savings in its ROI?

The wide-ranging differences in jurisdiction and responsibility of SIUs make it difficult to dependably compare them in any sort of uniform fashion. Payment integrity functions vary significantly among SIUs. Examples of how the jurisdiction of SIUs can differ include:

- Some SIUs are responsible for oversight of hospital or facility billing which can often yield six figure annual recoveries, while other SIUs don't have this responsibility. Instead, jurisdiction for this work is allocated to another program integrity department within the company.
- Some SIUs, particularly those that operate as federal and state program units, include savings from pharmaceutical investigations in their ROI, although the allegations often involved (mislabeling, patent

infringement, failure to disclose safety concerns, etc.) are not typically considered to be fraud, waste and abuse by most private insurers.

- Some SIUs are responsible for internal employee investigations that may be time consuming but produce little, in terms of ROI.

ROI in the Public Programs

Founded as a private-public partnership, NHCAA serves as a champion of anti-fraud information exchange—an effective and proven strategy in combating health care fraud. Health care fraud doesn't limit its impact to private insurance. It affects our nation's entire health care system. Fraud in federal health care programs like Medicare and Medicaid is an enormous and persistent concern. NHCAA regularly helps facilitate cooperation and collaboration between government entities, tasked with fighting fraud and safeguarding public programs, and private insurers, responsible for protecting their beneficiaries and customers. Having the private and public sectors together at the table creates opportunities for understanding.

The lack of clarity in categorizing and measuring the ROI of health care anti-fraud efforts by private insurers is made further elusive when we add in the terminology and categories employed by government health care programs and law enforcement when they discuss health care fraud and measure outcomes. For instance, the term "improper payments" is regularly used within the scope of Medicare and Medicaid. It is defined as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." It's quite a broad definition that can encompass many distinct concepts including fraud, abuse and waste. Insufficient documentation can render a payment improper. Regardless, it's common for people to hear "improper payment" and infer that it simply means fraud.

Many entities have an interest in or responsibility for addressing health care fraud, such as law enforcement agencies like the Federal Bureau of Investigation (FBI) and the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), and legal entities like the Department of Justice (DOJ).

Each fiscal year, HHS-OIG and DOJ issue a joint Health Care Fraud and Abuse Control (HCFAC) Program report. The HCFAC Program was established in 1996, and employs a "collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud and abuse, and to protect program beneficiaries." A feature of each year's report is the program's return on investment, along with an explanation of the ROI calculation.[3]

For the HCFAC Program, ROI is defined as follows: "The return on investment (ROI) for the HCFAC program is calculated by dividing the total monetary results to the Federal government (not including relator payments) by the annual appropriation for the HCFAC Account in a given year (not including portions of CMS funding dedicated to the Medicare Integrity Program)."

While this may be similar to how ROI is tracked and calculated by private insurers, the calculation of return on investment by the HCFAC program is still different and unique. The HCFAC Report for Fiscal Year 2017 reports that the program averaged a return on investment of 4.2 to 1 for fiscal years 2015-2017.

[3] "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2017," page 92. U.S. Dept. of Health and Human Services, Office of Inspector General, United States Department of Justice. URL: https://oig.hhs.gov/publications/docs/hcfac/FY2017-hcfac.pdf

Conclusion

For nearly 20 years, NHCAA's *Anti-Fraud Management Survey* has shown that the special investigations units of private health insurers can be depended upon to yield a positive ROI. SIUs consistently and reliably yield financial results that exceed the investment made in them by their respective companies. Through their work, SIUs also offer an important line of defense in helping protect patients and ensuring health care quality.

The challenge now facing SIUs is how to effectively continue to demonstrate and articulate their value as their roles continue to evolve. Health care fraud is a constantly moving target. The same can essentially be said for SIU return on investment. As SIUs expand their fraud fighting activities and continue to evolve from a recoveries-focused mission focused on "pay and chase" to one more concentrated on fraud prevention, it is crucial that they be able to clearly discuss how the innovations they adopt improve their work and yield measurable outcomes.

The executives and customers of insurance companies have grown to expect ever-increasing reports of recoveries and savings from their SIUs. But as SIUs devote more attention to fraud prevention activities, it may mean a decrease in the traditional categories of recoveries or savings. But this needn't be viewed as failure, because ideally, the goal should be to prevent fraud—and the damage it renders—before it has a chance to occur. This should be viewed as success.

It is incumbent upon the SIU and its leadership to not only meticulously quantify the SIU's value, but to be able to speak with clarity about its work and the various categories and activities that go into its ROI calculation. To the extent that SIUs can adopt uniform standards for capturing and reporting the financial

impacts of SIU activities, that would go a long way in quantifying the overall success SIUs have in fighting health care fraud and abuse. When SIUs can speak with one voice about the value of investing in strong fraud fighting efforts the message becomes undeniably more powerful.

Appendix

Appendix A

NHCAA SIU Standards Development Work Group

Definitions

Return on Investment (ROI) Terms

Final as of

November 15, 2007

NHCAA SIU Standards Development Work Group
Definitions for Return on Investment (ROI) Terms

Main Entry: RECOVERIES

Objective: To define those reportable amounts associated with losses recovered on a post-payment basis

Definition: Recoveries shall mean actual monies received[(1)] by the company, or its agent, for funds previously paid and as a direct result of actions taken by the special investigations unit (SIU) and shall be reported in the same period as they are received.

GUIDANCE

Key points to consider about this definition include:

Received:

Reports under this category should not be estimated or reported prior to actual receipt, e.g. simply referring the request to a collection department is not sufficient for reporting under this category. (1) - Also, received shall mean dollars received from an external source and/or captured from future payments such as through your claims retraction or offsetting procedures.

Direct result:

SIU personnel should take care to report only monies recovered that resulted from their actions or only the portion that is allocated to their actions in the case of a shared case/recovery. Monies attributed to and reported by other departments for work on a given case shall not be included by the SIU in this category. For example, if the SIU and Bill Audit department jointly work a case and agree to split the recovery 50/50, then the SIU should only report their 50% and not the entire recovery. Monies recovered via other means within the company that were not directly a result of the SIU actions may be captured in other categories by other departments.

Period received:

Recoveries should be treated as cash received and only reported as received in the period in which the recovery is actually received, even if the recovery spans multiple years. For example, if a provider agrees to repay and complies with the agreement to repay $10,000 over 2 years, then the SIU should report $5,000 in year one and $5,000 in year two, as opposed to $10,000 in year one because of the agreement.

Typical forms of recovery include actual checks sent to the company, EFT to the company, and/or the offset or retraction of funds from future claims to repay a debt from the past.

CLARIFICATION:

Recoveries that are pursued by the SIU but are ultimately not recovered as the result of circumstances outside the control of the SIU should not be reported under Recoveries but rather under Non-recoverable loss (if it is your company's practice to track non-recoverable losses).

NHCAA SIU Standards Development Work Group
Definitions for Return on Investment (ROI) Terms

Main Entry: SAVINGS

Objective: To define those reportable amounts associated with losses prevented on a pre-payment basis once a claim has been presented for payment.

Definition: Savings shall mean actual or appropriately estimated payments associated with an SIU-directed pre-payment denial of a claim. These claims must have received their final determination and denial must be as a direct result of actions taken by the SIU and shall be reported in the same period as the claim received final adjudication. Claim system edits that are not under the control of the SIU shall not be reported under this category.

GUIDANCE

Key points to consider about this definition include:

Actual or Appropriately Estimated:

Monies reported shall be the amounts that would have paid or that can be reasonably estimated in accordance with good practices as opposed to the billed amounts. It is understood that some companies cannot adjudicate these claims completely in all instances and that estimation must occur to report these amounts. Some acceptable forms of estimation include, reviewing the billed amount versus the amount paid percentage for this provider in the past, or periodic global analysis across many lines of business that can be applied to all cases.

Pre-payment denial of a claim:

Claims that are to be reported in this category are restricted to actual claims received by a company and presented for payment. Multiple submissions of the same or similar claims by a provider can only be reported multiple times so long as the SIU was the department responsible for the denial of the claim as opposed to a claim system edit that would have otherwise stopped the claim.

Final Adjudication:

Amounts should only be reported in this category once the claim receives final payment determination. If a claim is simply held up pending further review, this is not sufficient grounds for reporting a savings amount under this category.

Direct actions of the special investigations unit:

If the SIU has oversight of the function performed by a vendor (direct and constant involvement of the SIU) the savings identified by the vendor may be reported as a savings amount under this category.

NHCAA SIU Standards Development Work Group
Definitions for Return on Investment (ROI) Terms

Main Entry: PREVENTED LOSS

Objective: To define those reportable amounts associated with losses prevented on a pre-payment basis where an actual claim was not submitted as a result of SIU activity.

Definition: A quantifiable financial impact resulting from the direct action(s) initiated and completed by the SIU. The quantifiable impact may be the result of:

a. Change in Behavior—External, Claims Related
b. Process Improvement—Internal Impact

a. Change in Behavior

A clear change in the billing pattern with a *direct relationship to SIU* actions, the result of which is a *quantifiable financial impact*. This impact must be measured "real time", and not projected, or forecasted into the future. The change in behavior measurement is recorded for the lesser of the length of the scheme, or 12 months from the resolution of the issue with the provider.

b. Process Improvement

A specific and *quantifiable financial impact* resulting from the modification of internal policy, edit or process. These changes must be the *direct result* of actions taken or recommendations made by the SIU. The measured results are limited to 12 months.

GUIDANCE

Key points to consider about this definition include:

Quantifiable Financial Impact:

Quantifiable financial impact shall mean that through a documented system of measurement, you will clearly be able to demonstrate that a beneficial impact was achieved by reducing the suspect behavior, and as such, the overall payments.

Real Time:

Real time shall mean that the impact is measured at regular intervals, most often monthly. No forecasts, or assumptions shall be made. For example, impact through January will be measured once January has closed, and January claim receipts are able to be reported against.

One special note related to timing. As impact will be measured "real time" should the measurement cross years, it is conceivable that the 12 month period will include some measures from both a current, and previous year.

Direct Relationship to SIU:

Direct relationship to the SIU shall mean that the SIU must be the driver behind the discovery, review and recommendations made. Recommendations resulting from consultants, vendors, or other departments shall not be included in this category, except in those cases when such a subject matter expert is engaged by the SIU for the specific purpose of reviewing, and making recommendations relative to an issue identified by the SIU.

The SIU is not obligated to write or program any related policy or edit, but must be the driver behind the identification, quantification and recommendations that compel such change.

NHCAA SIU Standards Development Work Group
Definitions for Return on Investment (ROI) Terms

Main Entry: IDENTIFIED LOSS

(This item for reporting to the NHCAA only – not for public reporting)

Objective: To define those amounts associated with total losses associated with a case investigation whether or not the amounts are recoverable, in order to demonstrate the extent of health care fraud in the health care system.

Definition: A quantifiable, financial impact that describes the loss determined by the special investigative unit at the completion of a case investigation. When calculating the financial impact, the following should be included:

a. All actual financial losses identified as a part of the SIU case/project, whether or not those losses were pursued by the SIU as recoveries. Actual evidence should be available to support losses included in this category and should not be estimated.

b. All estimated financial losses not included with those identified in "a" above, limited to no more than the most recent three-year period in which the fraud was determined to have occurred. Future losses are not to be included as identified losses.

GUIDANCE

Key points to consider about this definition include:

Quantifiable Financial Impact:

Quantifiable financial impact shall mean that through a documented system of measurement, you are able to clearly identify the total losses associated with an investigation.

Timing:

One special note related to timing. As impact will be measured, should the measurement cross years, it is the intention that all losses would be aggregated across multiple years and reported as one number in the year identified.

Estimated Loss:

The special investigative unit should establish a conservative method for arriving at such estimates and follow that method consistently. Further, each case requiring an estimated loss should include documentation supporting the calculation of the reported loss.

For example, Provider A billed 50% of all EM Codes incorrectly resulting in an annual loss of $10,000 this year. We noted no variance in Provider A's billing for the previous three years and thus estimate our loss as $30,000 ($10,000 X 3 years) for the three years prior to this investigation.

NHCAA SIU Standards Development Work Group
Definitions for Return on Investment (ROI) Terms

Main Entry: COURT-ORDERED RESTITUTION

Objective:

Definition: Court-ordered restitution will mean any order from a local, state or federal court, either criminal or civil, which directs a provider, corporation, facility or individual to repay money to a health insurance plan pursuant to a criminal or civil prosecution.

This category will have two separate reporting categories:

a. Court-Ordered Restitution which will mean the actual amount ordered by the court as documented in a court order pursuant to a sentencing. This amount can be claimed regardless of whether or not it has been collected or is likely to be collected. It will be reported in the year in which the restitution order was issued.

b. Restitution Received will be any actual monies collected pursuant to a court order and will be reported in the actual year in which it is received by the plan. This total of actual monies collected will also be included as a recovery.

Clarification:

Restitution collected in one year may have actually have been reported in a prior year as ordered by the court however this is not considered double-counting since the categories are clearly defined.

It is anticipated that this standard will enable a plan as well as the NHCAA to evaluate the impact of prosecution as it relates to a plan's ability to recover overpayments as a result of that prosecution.

Appendix B

Survey Responses to Question 5.9a of the NHCAA Anti-Fraud Management Survey for Calendar Year 2017

NHCAA Anti-Fraud Management Survey for Calendar Year 2017

Question 5.9a – ROI Explained: *Please describe the categories, elements and variables that are included in your SIU's ROI (i.e. savings, various types of recoveries, prevented losses, etc. If the ROI number you report includes financial gains generated from departments outside the SIU, please describe). Please offer as much detail as possible.*

Responses:

- Annual budget for 2017 divided by Recoveries, Denied Claims/Savings, and Prevented Losses for 2017
- Avoidance plus actual recoveries divided by budget
- Basically recoveries to budget. Budget is comprised or almost all salary.
- Calculated using Savings Amount divided by Operating Budget.
- (Civil Settlement Payments Recovered + Direct Recoveries + Pre Payment Savings + Provider Billing Changes Savings + Plan Policy Savings + Criminal Restitution Actually Received + Civil Judgments Actually Received) / Budgeted Expenses for the Professional Team
- Criminal restitution received, direct recoveries, civil settlements received, actual savings and prevented loss
- Hard dollar recovery + Prepayment Savings + Yearly Prevented Loss + Identified Lost + Court Order
- Includes only recoveries, prevented losses and savings actually generated by the SIU in its calculations
- I divided our annual operating expenses by claims denials.
- Includes all administrative costs from SIU and supporting teams (ie, clinical review, data analytics, claims processing, prepay/postpay claims processors, etc.) and only those savings/recoveries generated directly by SIU work.
- Internal Savings & Avoidance + PrePay + Projected/CAPL + DMR/Recovery
- Nothing to report.
- only savings and recoveries are included
- Prevented Loss + Process Improvement + Savings + Direct Recoveries + Criminal Restitution : Annual Operating Budget
- Prevented loss calculated + Dollar Recovered divided by SIU Budget Expenses
- Prevention + Savings + Recoveries/Operating Budget
- recovered dollars + actual savings/fraud expenses incurred

- ROI includes all dollars recovered by direct recoveries, all criminal and civil restitution, prevention savings associated with claim denials, edit savings implemented at the direction of the SIU, and change of provider behavior one year after the case closing.
- ROI is based on a combination of recoveries, pharmacy and device manufacturing litigation cases, savings and prevented loss.
- ROI is calculated on hard $$ recovered and does not include prevented loss $$.
- ROI was calculated as total savings and recoveries divided by SIU budget.
- (Savings + Recoveries)/ Budget
- Saving, recovery, prevented cost.
- Savings from pre-payment review + Recoveries/cost of unit
- Savings, Recoveries, Denials
- SIU Financial Impact Compared to SIU Budget.
- The budget portion of the ROI includes the budget as reported in this survey plus the fraud detection software licensing fee which is not within the SIU budget. The recoveries include only recoveries "worked" by the SIU staff or were a direct result of a SIU intervention.
- The input of the team members, budget in comparison to prepayment savings and recoupments.
- The ratio above includes all financial actions taken by the SIU, including recoveries, cost avoidance, and savings. These actions are divided against the total 2017 cost for the SIU.
- The ROI includes disability income reserve savings, for which dollar amounts are not included with parts B or C of this section of the survey. Includes all SIU expenses compared to positive documented financial impact.
- The SIU's review of split billing (as referenced in 4.2b) resulted in education to participating facilities and netted the plan with significant recoveries and savings.
- This number comes from the savings and recoveries received in 2017....actual claims denied. We do not calculate soft savings.
- Total financial impact generated by SUI versus actual expenses related to SIU.
- vendor savings from Audits + SIU audits + credit balance audits
- We added our total dollars referred for recovery plus our implied savings plus actual savings & prepayment review denials we stopped from going out the door to total our departments total value. Divided our total value by our department budget to equal our ROI.
- We don't report ROI