

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

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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. And while ROI is most often described in financial terms, other non-financial measures and variables can certainly be used to determine a return on investment.

The unit or department within a health insurance company whose responsibility is to address health care fraud and abuse is 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 by the insurer and the claims filed for payment to 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 in accordance with applicable policies, contracts, laws, and regulations; 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 continues to do so. SIUs of individual health insurers vary widely, company to company, in terms of staffing, budget, jurisdictional boundary, placement and structure within the larger organization, and even the philosophy that underlies the SIU’s designated role within the organization.

For more than two decades, the National Health Care Anti-Fraud Association¹ (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 regularly turns to the survey report to seek guidance when decisions need to be made, such as resource allocation or hiring of investigators, analysts, and other SIU staff. One consistent 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 affirmed that private insurer SIUs are a sound investment, consistently yielding positive ROI.

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 the U.S. 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.

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 several decades. When NHCAA was established in 1985, 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 health and medical claims and the SIU would then attempt to recover claims payments determined to have been paid erroneously.

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. Both categories primarily relied on an assumption that a claim had been submitted. 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 submitted claims were quickly determined to represent potential fraud or abuse.

The role of the SIU has evolved significantly since that time. Recoveries and savings persist as important categorical targets that customarily figure into an SIU’s mission, but extraordinary advances in technology—particularly over the last two decades—have changed how many SIUs fundamentally operate, often altering or 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 literally billions of health insurance claims processed each year. This immense volume of activity has inspired the creation of cutting-edge technologies 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 arsenals with powerful data mining and predictive modeling tools that detect risks and emerging fraud schemes. Some of them even anticipate fraud before it occurs. Many of the fraud schemes that would have resulted in costly, time-consuming litigation years ago are now avoided entirely through the application of things like prepayment edits and the use of smart algorithms.

However, this shift, or more aptly expansion, of the SIU’s responsibilities and activities creates real challenges when trying to calculate the impact of these 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 appropriately project, quantify, and capture the financial impact of those SIU-directed recommendations and decisions can be 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 work, outcomes, and successes so that it can clearly articulate its value within the organization.

In 2007, NHCAA spent several months identifying and discussing the various activities and financial outcomes 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 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 and a half after their release, these return on investment terms remain valid and relevant, and continue to be used by the association. In recent years, other organizations such as the Healthcare Fraud Prevention Partnership (HFPP)² have looked to NHCAA's ROI definitions for guidance.

As the nature of health care fraud fighting changes and evolves, NHCAA regularly revisits the ROI terms to ensure that they continue to sufficiently capture the varied aspects of the SIU's work. A comprehensive review of the ROI definitions was most recently completed in 2022. This included not only an examination of the already defined terms, but also several in-depth discussions—involving NHCAA staff and members—about all manner of SIU activities to determine which ones are adequately captured in existing definitions, and whether there are SIU activities that demand the creation of new ones.

² Founded in 2012, the Healthcare Fraud Prevention Partnership (HFPP) 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://www.cms.gov/hfpp>

A leading topic during this series of 2022 discussions was the idea of “early detection/prevention activities” run by the SIU. In fact, NHCAA administered a Member Survey to gather insight about this. Several NHCAA members describe new and innovative efforts and programs they have undertaken that hold promise for anticipating and avoiding fraud altogether. These activities are described as “early” because they target entry points for potential health care fraud, often before care is rendered and claims are submitted. Generally, these early detection/prevention programs emphasize greater scrutiny of providers or feature a novel application of data analytics. Examples offered by NHCAA members include:

- Enhanced provider verification and authentication (may include things such as automatic licensure checks, identifying existing relationships with perpetrators of fraud, identifying fraudulent providers who seek to submit claims under new credentials, etc.).
- Enhanced provider credentialing.
- Programs specific to out-of-network providers that may involve risk scoring, validation, and authentication.
- Automatic review of first-claim submissions by non-participating providers.
- Medical record review prior to authorization for providers in high-risk categories.
- Provider revocations, deactivations, and exclusions.

While there is little doubt these SIU-led activities help prevent and avoid health care fraud, quantifying their impact financially through a documented system of measurement (the standard used for NHCAA ROI definitions) can be extremely difficult, if not impossible. One NHCAA member described an enhanced provider verification program the SIU implemented with great success to their pharmacy program that kept several suspect pharmacists out of the provider network. Some of these pharmacists were later named in a nationwide

takedown. So, while it is clear the member avoided fraud losses (while also protecting patients), it is a challenge for the SIU to calculate and report the financial impact for this particular program.

Another notable outcome of the 2022 review of NHCAA ROI terms is the recognition that for most SIUs, comprehensively demonstrating and proving their overall effectiveness to their organization does not need to be limited to just financial results. The review revealed several types of non-financial metrics that an SIU might track that can help paint a more complete picture of the SIU's value. Examples include:

- the number of suspect providers an SIU identifies and keeps out of the provider network.
- the number and frequency of referrals made to law enforcement and state licensing authorities.
- The number of cases the SIU referred to internal network management or credentialing teams.
- The number of provider outreach efforts to include warnings and education.
- The number of provider revocations, payment suspensions, deactivations, exclusions, and terminations.
- The ratio between provider review and provider denials.
- The number of prepayment claim reviews, prior authorizations, claim system edits.
- Metrics that represent the SIU's coordination with other key departments or teams within the organization.
- Case statistics, including the number of cases opened, closed, average caseload per investigator, etc.

Something else the 2022 definition review revealed is that SIUs sometimes coordinate and partner with internal departments and teams. Some of these partnerships are project-specific while others may be more routine. NHCAA members named the following departments as examples of ones the SIU sometimes works with in some capacity on anti-fraud efforts: Authentication, Claims, Client Engagement/Relations, Clinical and

Medical Policy, Credentialing, Data Analytics, Finance, Network Development/Management, Payment Integrity, Provider Audit, Provider Contracting, Provider Engagement/Relations, Provider Validation, Underwriting, and Utilization Management.

The NHCAA ROI definitions are intended to measure strictly the ROI of the SIU, not the broader anti-fraud efforts of the insurer or organization. The standard established for the SIU to claim an outcome is that it must be “a direct result of actions of the SIU.” Therefore, to the extent the SIU was the lead or primary driver in an anti-fraud effort that involved another department or team, that outcome should be included in the SIU’s return on investment. However, if the SIU’s role was ancillary (and the other department claims the result), it should not. But regardless, it is worthwhile to include these partnerships when documenting the full breadth of the SIU’s work and subsequent value.

The 2022 review of NHCAA Return on Investment terms ultimately resulted in minor tweaks to the existing definitions, and the addition of no new terms. NHCAA also reaffirms that the ROI terms are limited to measuring financial anti-fraud outcomes of just the SIU, not the broader organization. Nevertheless, NHCAA acknowledges that the valuable work that SIUs do that cannot be quantified for the purposes of a financial ROI and encourages SIU to promote these efforts.

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

Term: RECOVERIES

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

Definition: Recoveries shall mean actual monies received by the company or organization, 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, based upon the amount the company or organization would have paid, not necessarily the billed amount. 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.

Term: PREVENTED LOSS

Objective: To define those reportable amounts associated with losses prevented on a pre-payment basis where no actual claim was submitted as a direct result of SIU activity.

Definition: A quantifiable financial impact resulting from the direct action(s) of the special investigations unit (SIU). The quantifiable impact may be the result of:

- a. Change in Behavior—External, Claims Related

A clear change in provider billing patterns 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 or adoption of internal policy, edit or process, or SIU-led program. 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, program, or insurer pursuant to a criminal or civil legal proceeding.

This category comprises two separate reporting sub-categories:

- a. Court-Ordered Restitution which will mean the actual amount ordered by the court as documented in a court order pursuant to a legal proceeding. This amount can be claimed regardless of whether 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, program, or insurer. This total of actual monies collected will also be included as a recovery.

When these definitions were first 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, name, and categorize their ROI activities in a variety of ways.

The Anti-Fraud Management Survey for Calendar Year 2020 was administered in the spring of 2021. 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. Survey respondents were also asked to self-report their SIU's ROI ratio (based on their own internal parameters), as opposed to having it be calculated by NHCAA 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 to impose a uniform standard.

The responses to the survey question seeking ROI detail confirms that the use of the terms "recoveries" and "savings" is quite standard, although it is not clear that each company defines those two categories the same. For instance, it appears some insurers call all the SIU's quantifiable financial impact "savings." Beyond recoveries and savings, SIUs employ a range of additional terms to internally classify the activities that are included in their ROI calculations. Some examples: "total dollars referred for recovery," "prepayment review denials," "recoupments," "avoidance," "cost avoidance," "claims denials," "hard dollars," "soft dollars," "sentinel savings," "direct impact," "positive economic impact (PEI)," "claim savings," "manual savings," "implied savings." (To see the full list of ROI components reported by survey respondents, see the Appendix.)

It is clear that insurer SIUs don't always track and calculate their financial results in the same way. And each insurance company surely 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. Add to that, the non-financial metrics, early detection/prevention activities, and SIU partnerships with other organization departments, which present limited opportunity to reliably quantify anti-fraud benefits.

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 are not 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. As stated earlier, 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 also make it difficult to dependably compare them in any sort of uniform fashion. Some examples of how the jurisdiction of SIUs can differ include:

- The SIU can report to or sit within different departments, which in turn may dictate or influence its jurisdiction and responsibilities. Prominent examples include Legal, Compliance, and Audit.
- Departments other than the SIU may be given some aspects of responsibilities that traditionally sat with the SIU. For instance payment integrity functions vary significantly among insurers, as does the relationship between the payment integrity department and the SIU.
- Some SIUs are responsible for oversight of hospital or facility billing which can often yield six figure annual recoveries, while other SIUs do not 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 does not 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 is quite a broad definition that can encompass many distinct concepts including fraud, abuse, and waste. Something as basic as insufficient

documentation can render a payment improper. Regardless, it is 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 identifying and prosecuting the most egregious instances of health care fraud, preventing future fraud and abuse, and protecting 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 2021 reports that the program averaged a return on investment of 4 to 1 for fiscal years 2019-2021.

³ “Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2021,” page 123. 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/FY2021-hcfac.pdf>

Conclusion

For more than 20 years, NHCAA’s industry benchmarking survey, *The 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. Anticipating health care fraud and thwarting it before it begins 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. Beyond the financial metrics, SIUs should also promote the anti-fraud successes they realize in other ways, whether it is through the tracking of non-financial outcomes data, early detection/prevention activities, or partnerships with other teams that result in anti-fraud success.

To the extent that SIUs can adopt uniform standards for capturing and reporting the financial impacts of SIU work, 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

National Health Care Anti-Fraud Association

Definitions for Return on Investment (ROI) Terms

November 2007

Revised: September 2022

National Health Care Anti-Fraud Association (NHCAA) Definitions for Return on Investment (ROI) Terms

Main Entry: RECOVERIES

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

Definition: Recoveries shall mean actual monies received⁽¹⁾ by the company or organization, 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 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 its 50% and not the entire recovery. Monies recovered via other means within the company or organization that were not directly a result of 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 or organization, electronic funds transfer (EFT) to the company or organization, 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 as Recoveries but rather as non-recoverable losses (if it is the company or organization's practice to track non-recoverable losses).

National Health Care Anti-Fraud Association (NHCAA) 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, based upon the amount the company or organization would have paid, not necessarily the billed amount. 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 and organizations 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 the 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 or organization 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 or entity (meaning direct and constant involvement of the SIU) the savings identified by the vendor or entity may be reported as a savings amount under this category.

National Health Care Anti-Fraud Association (NHCAA) 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 no actual claim was submitted as a direct result of SIU activity.

Definition: A quantifiable financial impact resulting from the direct action(s) of the special investigation unit (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 provider billing patterns 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 or adoption of internal policy, edit, or process, or SIU-led program. 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, defensible system of measurement, the SIU 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.

National Health Care Anti-Fraud Association (NHCAA) 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 investigations 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 investigation, 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 and limited to the lesser of 1) the most recent three-year period in which the fraud was determined to have occurred, or 2) the allowance or requirement established by applicable law, regulation, or program. 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 investigations 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. No variance was noted in Provider A’s billing for the previous three years and thus estimate the loss to be \$30,000 (\$10,000 X 3 years) for the three years prior to the investigation.

National Health Care Anti-Fraud Association (NHCAA) Definitions for Return on Investment (ROI) Terms

Main Entry: 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, program, or insurer pursuant to a criminal or civil legal proceeding.

This category comprises two separate reporting sub-categories:

- a. Court-Ordered Restitution which will mean the actual amount ordered by the court as documented in a court order pursuant to a legal proceeding. This amount can be claimed regardless of whether 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, program, or insurer. This total of actual monies collected will also be included as a recovery.

Clarification:

Restitution collected in one year may have actually 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, program, or insurer, as well as the NHCAA to evaluate the impact of a legal proceeding as it relates to the ability to recover overpayments as a result of that legal proceeding.

Appendix B

Survey Responses to Question 5.9 of the NHCAA Anti-Fraud
Management Survey for Calendar Year 2020

NHCAA Anti-Fraud Management Survey for Calendar Year 2020

Question 5.9 – 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:

- Savings, recoveries & projected savings.
- We are not currently tracking ROI as we are in the early stages of building out our SIU, creating P&P, hiring/training staff, obtaining case tracking software, etc.
- Low ROI was due to the unprecedented year of 2020 with the pandemic, the state issued as a part of the PHE, a mandate stopping all refund/offsets recoveries from providers on paid claims. No recoveries were allowed from April 2020 to late November 2020.
- Dollars recovered + actual savings (claims denied + investigative expenses recovered)/actual fraud expenses incurred.
- Reporting in conjunction with Payment Integrity team, includes recoveries and revenue generated through return on recoveries programs from both teams. No savings or prevented losses are included.
- Added our total dollars referred for rec + our cost avoidance + actual savings + prepayment review denials we stopped from going out the door to total our department's total value. Divided our total value by our department budget to equal our ROI.
- Direct recoveries, civil settlements received, criminal restitution received, actual savings and prevented loss.
- Recoveries, Savings and Prevented Loss.
- Majority of ROI is based on Medicaid due to low enrollment in Medicare Advantage and Marketplace.
- Savings and recoveries
- $(\text{Recoveries including restitution} + \text{Savings} + \text{Prevented Losses}) - \text{Expenses} / \text{Expenses}$
- Includes SIU savings, recoveries, prevented loss, cost avoidance only. No other departments within [our organization] are included.
- Combination of direct claim denials, reduced billing, and recoveries.
- $(\text{Reversals} + \text{PrePay Savings} + \text{Recoveries}) - \text{Budget} / \text{Total SIU Budget}$
- $\text{Prevented Loss} + \text{Savings} + \text{Direct Recoveries} : \text{Total Annual Operating Budget}$
- $\text{ROI} = (\text{Net Return on Investment} / \text{Cost of Investment}) \times 100\%$; Savings = Prepay, Postpay Recoveries (including Settlement & Restitution), and Prevented Loss. Net Return on Investment = Savings - Cost of Investment. Cost of Investment = Unit Operating Budget noted in question 2.22
- $\text{SIU Savings \& Recoveries} / \text{SIU Budget} + \text{Clinical review staff budget}$

- ROI is the total savings, which includes pre-pay, recoveries, and prevented losses divided by the cost of the unit. No outside departments are included, SIU only.
- The ROI number provided here represents only the financial actions recorded by the SIU (Recovery, Savings, Prevention) compared to the SIU department budget.
- We only use hard dollars (not behavior change/ sentinel savings) versus budget expenditure to calculate ROI
- ROI includes recoveries, direct impact and prevented loss amounts.
- Savings were used this year. Due to timing unable to capture prevented losses and changed process improvement.
- Total program savings is a combination of hard and soft dollars. Hard dollars are recovered monies stemming from overpayments. Soft dollars are a value assigned to prepayment review and denials, change in behavior and other factors determined by finance/accounting methods specific to our company. Hence, TPS is reference against our budget.
- Does not include financial gains generated outside the SIU. Case related only - Recoveries, Savings, Prevented Loss
- Includes our claim savings, manual savings (recoveries), and implied savings.
- This ROI is specific to the SIU and does not include any recoveries by other departments.
- Prevented losses + recoupments were included in the ROI calculation.
- ROI Calculation: $\text{Dollars Recovered} + \text{Actual Savings} / \text{FWA Expenses Incurred}$
- We calculate prepay, projected and restitution received. This does not include work from the PVU. This is a conservative estimate.
- $\text{Overpayments} + \text{Avoidance} / \text{Total budget amount}$
- $\text{Internal Savings} + \text{Avoidance} + \text{Prepayment} + \text{CAPL} + \text{DMR}$
- The ROI is determined by the SIU's Savings (Recoveries, Restitution, Prevented Loss and Prepayment Savings and the Administrative Expenses (Salaries, Benefits, Travel, Office Supplies, Membership dues, Anti-Fraud software, etc... The [ROI reported above] reflects the combining of [our organization's] teams.
- Includes all documented SIU Positive Economic Impact (PEI), including disability reviews
- ROI is calculated by combining recoveries, settlement dollars, prevented losses and change in behavior and dividing this by the department's budget.
- ROI by LOB [line of business]