WHITE PAPER

Ensuring Payment Integrity:

The COBA Trading Partner Process with CMS

By Mark McKeithen, Wellcove EVP

Background

Payment integrity is a crucial aspect of healthcare systems, ensuring that healthcare providers receive accurate reimbursement for the services they deliver. One essential component of payment integrity in the United States is the Coordination of Benefits Agreement (COBA) trading partner process with the Centers for Medicare & Medicaid Services (CMS). In order to protect this important part of our industry, we must first understand the significance of payment integrity, the role of the COBA trading partner process, and its impact on the healthcare industry.

Payment Integrity at a Glance

Payment integrity is the process of verifying that healthcare claims are accurate and compliant with regulations, preventing fraud, waste, and abuse (FWA) in healthcare programs. It encompasses various activities, such as claims validation, fraud detection, and coordination of benefits. Payment integrity is vital for maintaining the fiscal sustainability of government-funded healthcare programs like Medicare and Medicaid.

CMS Plays an Important Role

CMS is a federal agency responsible for overseeing healthcare programs that serve over 130 million Americans. These programs include Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). CMS plays a central role in ensuring payment integrity within these programs.

The COBA Trading Partner Process

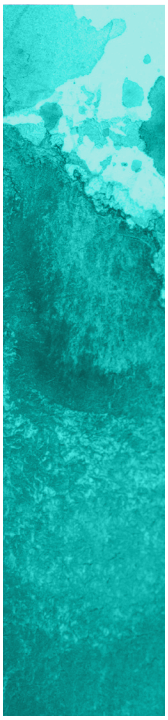
The COBA trading partner process is a collaborative effort between CMS and other health insurance providers to coordinate benefits and claims. It aims to prevent improper payments and streamline the claims process.

1. Data Exchange CMS exchanges data with other health insurance providers, including private insurers and state Medicaid programs. This data includes information about beneficiaries, their coverage, and any other insurance they may have.

2. Coordination of Benefits Through the COBA process, CMS identifies situations where Medicare is the secondary payer. For example, if a beneficiary has employer-sponsored insurance, Medicare may be the secondary payer. COBA ensures that Medicare pays its share appropriately, reducing the financial burden on beneficiaries.

3. Claim Validation The COBA trading partner process also validates claims submitted by healthcare providers. It checks for errors, inaccuracies, or potential instances of fraud. By cross-referencing data from various sources, it helps identify irregularities that may require further investigation.

4. Cost Savings One of the primary goals of COBA is to save costs by avoiding overpayments. When Medicare is the secondary payer, COBA helps ensure that other insurance providers cover their portion of the bill, reducing the overall financial burden on the federal program.



The Benefits

Reduced Improper Payments

By coordinating benefits and validating claims, COBA helps reduce improper payments, saving taxpayer dollars and preserving the financial integrity of healthcare programs.

Streamlined Claims Processing

The process streamlines the claims processing workflow for healthcare providers, reducing administrative burden and ensuring timely payments.

Enhanced Fraud Detection

COBA's data analysis capabilities contribute to the detection of fraudulent claims and billing practices, protecting healthcare programs from abuse.

Improved Beneficiary Experience

COBA ensures that beneficiaries receive the benefits they are entitled to, reducing out-of-pocket expenses and simplifying the healthcare billing process.

The Challenges

While the COBA trading partner process has been instrumental in safeguarding payment integrity, challenges remain. Complex cases, changing regulations, and data inconsistencies can pose difficulties. To address these challenges, CMS continually enhances its data-sharing capabilities, improves coordination with trading partners, and updates its fraud detection algorithms.

The collaboration between CMS and the COBA trading partner process ensures that healthcare programs like Medicare and Medicaid remain financially sustainable by facilitating the coordination of benefits, validating claims, and preventing improper payments. As the healthcare industry evolves, ongoing improvements in the COBA process will continue to uphold payment integrity, benefiting both healthcare providers and beneficiaries.

Ongoing Improvements

The COBA trading partner process uses data analysis techniques to detect fraudulent claims and billing practices by identifying inconsistencies and patterns that may indicate fraudulent activity.

Here are some of the ways in which COBA's data analysis helps in this regard:

Anomaly Detection

COBA's data analysis algorithms can identify unusual patterns or outliers in claims data. For example, it may flag providers who consistently bill for services that are statistically unlikely, given their specialty or patient population. These anomalies can be indicators of potential fraud.

Comparative Analysis

COBA compares claims data across multiple sources, such as Medicare, Medicaid, and private insurance providers. If a provider submits significantly different information to different payers, it can raise suspicions of fraudulent billing practices.

Pattern Recognition

COBA looks for recurring patterns in claims submissions. For instance, it can detect providers who bill for services that are inconsistent with typical medical practice, such as excessive or unnecessary procedures. Patterns like these may be indicative of fraudulent activity.

Geospatial Analysis

Geographic analysis is another method used by COBA to detect fraud. It can identify clusters of healthcare providers in a specific area who bill for similar services at a rate significantly higher than their peers. Such clusters may warrant further investigation.

Provider Profiling

COBA maintains profiles of healthcare providers, tracking their billing history and behavior over time. Sudden changes in billing patterns or excessive billing for certain procedures can lead to further scrutiny.

Beneficiary Analysis

COBA also analyzes beneficiary data, looking for unusual patterns of service utilization. For example, if a beneficiary suddenly receives an excessive number of services or prescriptions, it may trigger an investigation into potential fraud.

Billing Code Analysis

COBA scrutinizes the use of billing codes by providers. If a provider consistently uses codes associated with higher reimbursement rates when lower-cost codes would be more appropriate, it could be a red flag for fraudulent billing.

Network Analysis

COBA examines relationships between providers and beneficiaries. It can detect if multiple providers are billing for services for the same beneficiaries, potentially indicating collusion or kickback schemes.

Data Matching

COBA cross-references claims data with external databases and information sources to verify the accuracy of information provided in claims. Inconsistencies found during these checks can raise suspicions of fraud.

Fast Fact

CMS predicts a 176% and 139% increase in hip and knee replacements by 2040, respectively.[2]

Fast Fact

There are over 70,000 ICD-10 codes (used for diagnoses) and over 70,000 ICD-10-PCS codes (used for treatments).[3]

Machine Learning and Predictive Modeling

It is suspected that COBA may employ machine learning and predictive modeling techniques to identify potential fraud based on historical data patterns. These models can learn from past cases of fraud and apply that knowledge to flag suspicious claims.

It's important to note that the effectiveness of COBA's fraud detection relies on the continuous refinement and improvement of its algorithms and the collaboration between CMS and other insurance providers. When potential fraudulent activity is identified, it triggers further investigation and, if necessary, legal action to prevent improper payments and protect the integrity of healthcare programs.

Takeaways

When COVID-19 initially made its way through the United States, telehealth became the primary way to receive care for millions of Americans. This shift, along with many other government-funded, COVID-19-related programs, has caused fraudsters to alter and enhance their tactics in attaining stolen funds, increasing the financial burden from fraud on employers, members, and the entire healthcare system as a whole.

While the COBA trading partner process with CMS plays a significant role in ensuring payment integrity and combatting fraud for payers, employers and members alike, data shows the problem is progressively getting worse. Not only is this increasing the financial burden in our current times of economic uncertainty, but it's also creating difficulties for the millions of patients, and employers, who abide by the rules rather than trying to work around them.

How are you managing FWA in your plans? Increasing premiums to account for a target FWA% of claims? Actively using data from the COBA process to analyze claims?

Payers owe it to their members, and their stakeholders, to partner with a TPA that places combatting FWA at the top of the priority list.

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References

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