

Statement for the Record

Ways and Means Oversight Subcommittee Hearing on Improving Efforts to Combat Healthcare Fraud

Congressman Peter Roskam

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Chairman Boustany, Ranking Member Lewis, and Members of the Ways and Means Oversight Subcommittee, thank you for holding this important hearing on improving efforts to combat healthcare fraud. Last Congress, I was given the opportunity to testify before Ways and Means and Energy and Commerce Subcommittees on similar topics and I am thankful for the opportunity to submit a statement today. What differentiates this opportunity from similar hearings on this topic in the past is that the subcommittee is bringing together the private and public sectors to share strategies and ideas on fraud mitigation.

Fraud permeates both private and public healthcare programs, but Medicare and Medicaid are especially susceptible to fraud due to their size and centralized administrative pricing structure. Fraudsters often jump between public and private programs and move from region to region to evade detection. A collaborative effort is necessary to gain a holistic view of the problem in its entirety. Private insurers have incentives and innovative strategies to prevent fraud and the Centers for Medicare and Medicaid Services (CMS) has the largest, most comprehensive claims database in the country. These services and resources are integral towards improving efforts to combat healthcare fraud and communication between parties is essential to any prevention and detection strategy. There is near unanimity from the witnesses that mitigation efforts need to move towards a more effective pre-payment strategy and I have been an advocate for by pushing predictive modeling and other innovative technology.

President Obama said at the State of the Union Address, "Let me be the first to say that anything can be improved. If you have ideas about how to improve this law by making care better or more affordable, I am eager to work with you." The House will take a major step towards improving the regulatory environment for businesses by repealing the onerous 1099 tax form reporting requirements of the healthcare law tomorrow. I propose improving efforts to combat healthcare fraud in a bipartisan manner and hearings such as this are an important first investigatory step towards that goal.

I welcome efforts by CMS to better measure Medicare fraud. The Health and Human Services/Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010 said, "The purpose of the first research project is to begin the implementation of the determination of a baseline estimate of Medicare fraud. This involves developing and prototyping a methodology to estimate the total amount of fraudulent payments." Currently, the Administration has the Comprehensive Error Rate Testing (CERT) percentage but it is not a measurement of over- and under-payments, not fraud specifically. It is difficult to prescribe a solution to a systemic problem if one cannot fully comprehend the scope of that problem. This is a logical starting point.

Witnesses today will discuss the virtues of predictive modeling technology to better detect fraud before payments are made. On the first panel, CMS and HHS-OIG are realizing the potential benefits. In his testimony before the Ways and Means Full Committee earlier this month, CMS Administrator Berwick said, “CMS is currently integrating predictive modeling as part of an end-to-end solution that is transparent, measurable, and triggers effective, timely administrative actions. Innovative risk scoring technology applies a combination of behavioral analyses, network analyses, and predictive analyses that are proven to effectively identify complex patterns of fraud and improper payment schemes... CMS is very excited about the potential of new data analysis and prediction tools to improve the Agency’s ability to prevent payment of fraudulent claims.” Last fall, the HHS-OIG office testified, “We are committed to enhancing existing data analysis and mining capabilities and employing advanced techniques such as predictive analytics and social network analysis, to counter new and existing fraud schemes.” However, this technology will first be applied post-payment. I do not want the technology to be implemented poorly or have high incidences of false positives, but I would like to see the technology applied pre-payment sooner rather than later in order to prevent reimbursement from leaving the Medicare Trust Fund. Post-payment review may help focus scarce enforcement resources, but pre-payment review will prevent the payments from going out the door in the first place. This is a much wiser solution. I will use my Congressional oversight responsibilities to ensure effective implementation, but want to serve as a resource to CMS as a partner in fraud prevention.

It works and needs to be effectively implemented. Predictive modeling is a process used in analytics to create a statistical model of future behavior that is used in industries such as financial services, utility companies, and retail for multiple applications including probability scoring assessments. Predictive modeling was utilized by the financial services industry in the early 1990s to model consumer behavior. Initially, there was a cultural resistance to implement predictive modeling throughout the industry. However, within five years, 80 percent of financial services institutions had implemented the solution. Fraudsters were flocking to institutions that had not adapted a predictive modeling strategy. The industry, which handles \$11 trillion in transactions yearly, suffers only .047 percent in fraud thanks to a predictive modeling system that stops fraud and abuse at the point of sale. Fraud in Medicare accounts to closer 10 percent of payments. The technology works but needs to be moved quickly and seamlessly to the front-end of the claims process, before payment is made.

Before CMS embraced the technology, representatives from the second panel were utilizing analytics and advocating for wide adoption. The National Health Care Anti-Fraud Association (NHCAA) wrote me last year supporting my legislative efforts, “For the last several years NHCAA has been examining the value of prepayment medical claims review and we are convinced that this approach holds great promise... Many NHCAA members are beginning to devote additional resources to predictive modeling technology and real-time analytics and applying them to fraud prevention efforts on the frontend, prior to medical claims being paid. Put simply, stopping a fraudulent dollar before it goes out the door is inherently more efficient than trying to recoup that dollar after it has been paid.” America’s Health Insurance Plans (AHIP) recently surveyed

members and found they foresee more “modeling with analytics to identify aberrant claims earlier... eliminate pay and chase scenarios.” The industry must work with CMS to integrate this technology into the Medicare claims database. Communication and collaboration are vital and it is necessary for the private sector to work with the federal government.

One problem inhibiting private sector adoption and development of predictive modeling and other fraud prevention efforts is the arbitrary medical loss ratio (MLR) requirements of the new healthcare law. These requirements limit investment and options for saving beneficiaries’ premium dollars from fraud. In fact, the Congressional Budget Office (CBO) said that if the MLR levels were only five percentage points higher, “this further expansion of the federal government's role in the health insurance market would make such insurance an essentially governmental program.” Even federal officials have repeatedly pushed for more funding to prevent fraud, insisting they would detect and prevent more of it from occurring, returning taxpayer dollars to the Medicare Trust Fund. Private insurers should not be limited in fraud prevention efforts.

Again, thank you for this opportunity to submit my comments. This is an important first step in what I hope to be a bipartisan healthcare fraud prevention effort. The American people are looking for Members of Congress to cut unnecessary spending with a projected budget deficit of \$1.5 trillion. Preventing fraudulent payments before they go out the door is vital to the sustainability of public healthcare programs. Let’s turn “pay and chase” to “pay quickly, but only if legitimate.”