Statement of Congressman Peter Roskam
Energy and Commerce Health Subcommittee Hearing on Cutting Waste, Fraud and Abuse in Medicare and Medicaid

September 22, 2010

Chairman Pallone, Ranking Member Shimkus, and Members of the Energy and Commerce Health Subcommittee, thank you for holding this important hearing on cutting fraud, waste and abuse in the Medicare and Medicaid programs. Fraud in Medicare and Medicaid is a pervasive and problematic epidemic that necessitates an aggressive treatment remedy. A bipartisan dilemma, fraud infuriates taxpayers and Members of Congress alike. As a guardian of taxpayer dollars and the federal healthcare programs, I feel a responsibility to offer an innovative policy idea to attempt to mitigate fraud in Medicare and Medicaid. I will advocate for a deliberative move towards better prospective technologies to detect fraud before payments are made – including the use of predictive modeling analytics – to augment existing detection and enforcement efforts. I want to focus on this idea as an opportunity where we can work together.

One significant problem is that Medicare adjudicates and reimburses claims without verifying their legitimacy the way the financial services industry does with credit cards. A quick anecdote – my wife and I were traveling through Turkey when my wallet was stolen. Before I even realized my Turkish lira were lifted, my bank notified me that a scammer attempted to purchase $10,000 worth of stereos and speakers on the streets of Budapest, which is very uncharacteristic of my consumer behavior. The claim was processed but halted in the twinkle of an eye before the reimbursement made it across the Atlantic Ocean.

Secretary Sebelius described a similar analogy at the last Healthcare Fraud Summit on August 26th, "It is what credit card companies have been doing for decades: If 10 flat screen TV's are suddenly charged to my card in one day, they know something's not quite right. So they put a hold on payment and call me right away… We should be able to take the same approach when one provider submits ten times as many claims for oxygen equipment as a similar operation just down the road… It's about spotting fraud early before it escalates and the cost grows." These may sound overly simplistic but allow me to demonstrate how it could be effective.

This technology could have detected a fraudulent suburban Chicago physician who had billing privileges at three hospitals. According to the New York Times, the physician used two codes and "sent over 14,800 billings over five years to Medicare alone, billing for 24 hours or more of work every day of the year. His use of the codes represented a disproportionate use of them in the entire United States, and more than all the doctors in some states… It allowed the purchase of multiple homes, numerous bank accounts and investments, nothing especially covert or overseas." This behavior would have been detected and prevented before nearly $7 million in reimbursement that was lost.

Another major setback is the lack of accurate measurement of Medicare and Medicaid fraud. Estimates vary widely, and reliable estimates of actual dollar value lost to Medicare fraud are limited. The Washington Post, 60 Minutes, ABC World News, the Wall Street Journal, National Public Radio, and many other media outlets have reported about fake patients, deceased doctors, fly-by-night storefronts, and multi-state criminal rings bilking $60 billion or more annually from seniors and taxpayers. The FBI estimates that healthcare fraud accounts for up to 10 percent of total health spending, or up to $250 billion per year. Thomson Reuters estimates healthcare fraud and abuse accounts for $125 to $175 billion per year. In August of 2009, the Health and Human Services Office of Inspector General wrote that the Medicaid Statistical Information System had not captured data that was useful in detecting and measuring fraud, waste and abuse in the Medicaid program.

The Administration reports 7.8 percent or over $24 billion in improper payments in Medicare fee-for-service, but this metric measures over-payments and under-payments and not fraud specifically. In June, President Obama announced an initiative to slash Medicare fraud in half by 2012, but the metrics for the measurement change too often to get a firm estimate. I share his commitment to reducing the improper payment rate. In order to accomplish this goal, I believe Medicare must utilize more advanced prospective analysis of claims prior to reimbursement. Predictive modeling can provide a more accurate estimate of highly suspicious claims.

HIPAA defined healthcare fraud as any scheme to obtain payment by means of misrepresentation from any healthcare benefit program. Fraud plagues both private and public programs, but Medicare and Medicaid are especially vulnerable to fraudsters ranging from petty thieves to organized criminals. Lewis Morris of Health and Human Services Office of Inspector General has said, "Building a Medicare fraud scam is far safer than dealing in crack or dealing in stolen cars, and it's far more lucrative." Since 1990, GAO has annually declared Medicare at high risk for improper payments and fraud due to its size, scope and decentralized administrative structure. Medicaid has been included on the high risk list since 2003 and involves a patchwork of fifty separate program integrity efforts. Fraud in both federal programs robs upwards of one hundred billion of taxpayer dollars from the public healthcare systems without any benefit society's most vulnerable populations.

Analysis of the Patient Protection and Affordable Care Act anti-fraud provisions shows enhanced penalties for convicted fraudsters, increased data sharing, re-organization of program integrity efforts, greater compliance programs, and additional funding for enforcement efforts. Increased enforcement and screening efforts are positive steps towards augmenting our fraud efforts and will inevitably catch more fraud. The Office of Inspector General returns $17 for every $1 invested for investigative and enforcement activities. While these well-intentioned provisions will help, I fear these efforts could only expose more of the iceberg that is Medicare and Medicaid fraud. Also, enforcement could potentially squeeze the balloon from the HEAT strike force zones to other areas of the country and create a wild goose chase scenario. U.S. Attorney Wilfredo Ferrer

described the pursuit, "This is like a game of whack a mole. The numbers are off the charts."

During the Ways and Means Committee markup of the health bill, I offered an amendment to move the way Medicare verifies claims from current policy towards the way the financial services industry authenticates purchases – more diligence before payments are made to remedy our current "pay and chase" pursuit of fraudsters. My amendment has been developed and modified since last summer. I offered it again before the Rules Committee in November. I introduced the amendment as legislation this June – HR 5546 the Fighting Fraud with Innovative Technology Act – that I believe will both measure the amount of Medicare fraud more accurately and protect the Medicare trust fund from doling out billions of dollars in fraud. My legislation has been supported by AARP, Citizens Against Government Waste, AAHomecare, and National Health Care Anti-Fraud Association.

My legislation would reform the way Medicare pays claims by directing the Centers for Medicare and Medicaid Services (CMS) Office of Program Integrity to design a comprehensive pre-payment predictive modeling system to be applied prior to reimbursing claims, preventing improper payments from being made. Strengthening claims at the front end of the payment system will prevent suspect claims from being reimbursed. CMS currently uses a limited application of pre-payment screening, editing and selective review of claims conducted by Medicare Administrative Contractors (MACs). Most resources are utilized on post-payment review activities by Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs). Fraudsters continue to be one step ahead of our current rules- and edits-based automated claims processing. Predictive modeling can detect fraudulent claims that traditional rule-based edits cannot identify. CMS is currently developing an integrated data repository that will eventually contain all provider data that can be mined, but this will still be post-payment pursuit of fraud.

Predictive modeling "scores" a claim to identify claims that have a high probability of fraud. A predictive model creates an estimated score on claims using historical data. That estimate is then applied to new claims that are submitted. The predictive model is always evolving, improving and adapting to provider and patient behavior. Highly suspicious claims are subject to manual review to avoid false-positives and a provider self-audit appeal process is encouraged. Following successful implementation to the Medicare program, the predictive modeling system could be developed for all Federal Health Programs like Medicaid and CHIP.

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, direct mail, 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 predictive modeling. Fraudsters were

flocking to institutions that had not adapted a predictive modeling strategy. The industry, which handles $11 trillion in transactions yearly, suffers only 0.047 percent in fraud thanks to a predictive modeling system that stops fraud and abuse at the point of sale. The Lewin Group conservatively estimates that a comprehensive application of predictive modeling can save Medicare $65 billion. Another analysis by TerraMedica, a healthcare technology firm, finds between $18.6 billion and $42.2 billion in annual suspicious claims that could be subject to fraud, abuse or overutilization patterns. In 2009, Medicare was able to recover $2.5 billion in improper payments, so predictive modeling could dramatically increase the amount of fraudulent payments detected and savings to the Medicare Trust Fund. Pre-payment predictive modeling would mitigate fraud and deter future criminals from attempting to defraud taxpayer dollars and strengthen the Medicare program for seniors.

Last fall, I spoke with Nancy-Ann DeParle over the phone and she displayed interest in the proposal. President Obama then included the amendment in his health outline. I have since met in person with Ms. DeParle, CMS Legislative Affairs and the new CMS Center for Program Integrity. Again, interest was exhibited and a Request for Information (RFI) was issued in late August. It is my hope that CMS will seriously adapt innovative technologies that can significantly hamper the advantage that fraudsters have over Medicare.

There is a real opportunity here. I believe Congress can come together, put donkeys and elephants aside, and utilize and deploy the technology that is available to us for the benefit of taxpayers and seniors we are here to protect. Again, thank you for the opportunity to testify before the subcommittee today. I look forward to answering any questions for the record.