THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

November 20, 2012

To: Health Subcommittee

From: Health Team

Re: Hearing entitled "Examining Options to Combat Health Care Waste, Fraud and Abuse."

On Wednesday, November 28, 2012 at 10:00 a.m., in Rayburn 2123, the Health Subcommittee will hold a hearing entitled "Examining Options to Combat Health Care Waste, Fraud and Abuse."

I. **Witnesses**[1]

Ms. Kathleen M. King
Director, Health Care
Government Accountability Office

Mr. Neville Patterson
Senior Vice President Government Affairs, Standards and Business Development,
Gemalto, Inc.
on behalf of
The Secure ID Coalition

Mr. Dan Olson
Director of Fraud Prevention
Health Information Designs

Ms. Alanna Lavelle
Director Investigations, East Region/Special Investigations Unit
Wellpoint

Mr. Michael Tezrich
Senior Vice President, Global Sales and Marketing
Zebra Technologies

Mr. Louis Saccoccio
Chief Executive Officer
National Health Care Anti-Fraud Association

Dr. Kevin Fu
Associate Professor of Computer Science and Engineering
University of Massachusetts Amherst

[1] Additional witnesses may be added.

II. Background

The true annual cost of health care fraud and abuse to the Federal government is not known. The Centers for Medicare and Medicaid Services (CMS) estimated that in fiscal year 2010 it made more than $65 billion in "improper federal payments," defined as payments that should not have been made or were made in an incorrect amount. Adding to that figure the improper payments made by States under the Medicaid program increases the estimated total annual cost by another $10 billion annually.

Unfortunately, the problem may be much worse. CMS's estimate of improper payments, which relies on random samples of claims data, is widely thought to understate the true size of the problem. In an April 2012 study, former CMS Administrator Donald M. Berwick and RAND Corporation analyst Andrew D. Hackbarth estimated that fraud and abuse added as much as $98 billion to Medicare and Medicaid spending in 2011.[2] A study from the Institute of Medicine estimates health care fraud at $75 billion a year and found that about 30 percent of total U.S. health spending in 2009 -- roughly $750 billion -- was wasted on unnecessary services, excessive administrative costs, fraud, and other problems.[3]

Medicare and Medicaid were designed to allow "any willing provider" to treat program beneficiaries and to reimburse claims quickly for services provided. Today, Medicare administrative contractors (MACs) process about 4.5 million claims from 1.5 million providers on a daily basis. In addition, they process roughly 30,000 enrollment applications each month from health care providers and suppliers of medical equipment seeking to bill under the Medicare and Medicaid programs. This large volume of claims creates an environment for questionable or even openly fraudulent claims to escape detection.

The Government Accountability Office (GAO) has repeatedly designated Medicare and Medicaid as being at "high risk" for fraud, abuse, and improper payments. An April 2012 GAO report noted that, although CMS had made progress in implementing fraud prevention strategies, it had not completed certain other anti-fraud actions.[4] For example, CMS was supposed to extend the requirement for surety bonds to other high-risk providers in addition to those currently obligated to do so, namely providers of durable medical equipment, orthotics, and supplies yet failed to do so. (A surety bond allows CMS to recover money even if it turns out that fraud was involved in the submission of claims.)

Health care fraud is an opportunistic crime and continuously changing. Therefore, approaches to preventing and fighting health care fraud need to be sophisticated and require that investigators keep pace. There are a number of novel anti-fraud tools that have been proposed recently, some of which have already been implemented.

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[2] Donald M. Berwick, MD, MPP; Andrew D. Hackbarth, MPhil, "Eliminating Waste in US Health Care," JAMA. 2012; 307(14):1513-1516. doi:10.1001/jama.2012.362, available at: http://jama.jamanetwork.com/article.aspx?articleid=1148376.

[3] Best Care at Lower Cost: The Path to Continuously Learning Health Care in America Mark Smith, Robert Saunders, Leigh Stuckhardt, J. Michael McGinnis, Editors; Committee on the Learning Health Care System in America; Institute of Medicine.

[4] Important Steps Have Been Taken, but More Could Be Done to Deter Fraud GAO-12-671T, Apr 24, 2012: available at: http://www.gao.gov/products/GAO-12-671T.

Currently, CMS has made some attempt to catch fraud before payments are made through the use of a so-called twin-pillar approach. One pillar is a fraud prevention system that uses advanced analytic techniques, including algorithms and historical data, to flag suspicious claims, similar to fraud detection efforts used by major credit card companies to identify suspicious charges and flag them for closer examination. The second pillar is an automated provider screening program, which identifies ineligible providers or suppliers before they are enrolled or revalidated by the use of enhanced screening procedures. However, fraud continues on a large scale and additional measures will be needed to protect the integrity of the Medicare program from theft.

The field of Data Analytics is one area that holds promise. This field encompasses concepts such as predictive modeling, retrospective modeling, rules (based on algorithms), predictive scoring models, data mining queries and billing patterns. By running large amounts of data against specific algorithms, analysts can pinpoint cases of potential fraud and abuse for follow-up and further investigation.

Other anti-fraud measures that hold promise include: use of a unique identifier for both patients and providers; the use of smart cards to replace the use of social security numbers; and greater data sharing and transparency.

III. **Issues**

The purpose of this hearing will be to assess the existing state of health care waste, fraud and abuse and the anti-fraud measures currently being used, as well as to discuss new approaches to this substantial and ongoing threat.

IV. **Staff Contacts**

Should you have any questions regarding this hearing, please contact Robert Horne, John O'Shea or Ryan Long at (202) 225-2927.