Fostering Innovation to Fight Waste, Fraud and Abuse in Health Care

by

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I. Introduction

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am Darrell Langlois, Vice President of Compliance, Privacy, and Fraud for Blue Cross and Blue Shield of Louisiana. I have over 20 years of experience in fighting health care fraud, both locally and nationally. I sit on the board of directors of the National Health Care Anti-fraud Association and the Blue Cross and Blue Shield Association National Anti-fraud Advisory Board. Additionally, I am a member of the Health Care Fraud Prevention Partnership that was created by Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder. Blue Cross and Blue Shield of Louisiana has long been a leader in the fight against health care fraud as evidenced by their support of the investigations office and investment in technology to identify such fraud. Further, we have worked closely with the State legislature to craft legislation that places Louisiana in the forefront of this fight.

I appreciate this opportunity to testify on the strategies Blue Cross and Blue Shield of Louisiana has developed and implemented to prevent and detect health care fraud. Recognizing that fraud has far-reaching implications both for health care costs and quality, we are continually developing new and innovative strategies to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients. These fraud prevention and detection programs are part of our broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars on behalf of the enrollees we serve.

Our testimony focuses on two broad topics:

- The specific initiatives we have developed and implemented to fight health care fraud to improve quality and to prevent health care dollars from being wasted.

- The importance of recognizing, under the regulations for the new medical loss ratio (MLR) requirements, that fraud prevention programs play a key role in advancing quality improvement.

II. Our Programs to Prevent and Detect Health Care Fraud

Blue Cross and Blue Shield of Louisiana recognized the need to fight health care fraud in 1990 and dedicated an office for this purpose at that time. Since, we have continuously worked to improve our strategies based on national and local trends and data. Our number one strategy is the use of data to filter out those who defraud and abuse the system. We have utilized a peer comparison fraud management system by IBM since 1995 and have built numerous cases with evidence from this system. Claims are run through this system and can be measured against any number of over 3000 algorithms that are built specifically to identify possible fraud and abuse. Our second strategy is to partner with federal and local law enforcement as we believe strongly that a collaborative effort is far more productive than an isolated approach. We have been one of only two health care plans in the country to be included in the government's HEAT (Health Care Fraud Prevention Enforcement and Action Team) cases. We believe that those who defraud the system should be held accountable and not simply slapped on the wrist. This is why we work so closely with law enforcement. Finally, we hold to a strategy that we identify as many fraudulent claims as possible before they are paid. Recovering funds lost to fraud on a post-payment basis is largely unsuccessful. This approach requires sophisticated technological approaches that have not been widely used to date.

With these successful strategies, we have consistently outperformed national averages and gained national respect among our peers and government counterparts. However, the greatest achievement is when these strategies serve to identify and stop patient harm cases. We have identified, built and assisted in the successful prosecution of numerous cases that have stopped those who were physically harming patients in the name of money.

Many of the most egregious professionals who are willing to harm patients in the pursuit of more money are not halted in the traditional quality improvement programs. There are many reasons for this and often those who run such quality improvement programs reach out to the investigations office for assistance when they identify issues not already identified by fraud data research. Quality programs view claim data as largely accurate and truthful, thus patient harm is not easily identified with these assumptions. Anti-fraud techniques first work with the assumption that not all data is accurate and truthful and should be challenged for veracity and appropriateness. This is often where patient harm cases come to light as the investigations office has the ability to look deeper into the reality of what the data tells us. Quality improvement programs are not designed to challenge and further investigate what otherwise appears to be accurate and appropriate.

Our office has recently helped identify and stop patient harm cases involving cardiologists, internal medicine practices, and neurosurgeons. In these cases, patient harm ranged from death to irreparable harm to critical physiologic functions. Two of these cases resulted in professionals serving significant criminal sentences and a third resulted in the suspension of his license to perform surgery pending a review of his peers.

III. Recognizing the Role of Fraud Prevention in Quality Improvement

Under the Affordable Care Act (ACA), health plans are required to meet annual medical loss ratio (MLR) requirements of 80 percent in the individual and small group markets and 85 percent in the large group market. This means that health plans must spend a specified percentage of premium revenue on either reimbursement for clinical services provided to enrollees or "activities that improve health care quality." Health plans are required to pay rebates to enrollees if they fail to meet the MLR requirements. In addition to having broad concerns about the unintended consequences of these MLR requirements, we have specific concerns about the fact that the regulations for implementing this ACA provision do not properly recognize the important role that fraud prevention programs play in advancing quality improvement.

At Blue Cross and Blue Shield of Louisiana, our anti-fraud initiatives are strongly focused on preventing fraud before it takes place, rather than "paying and chasing" after the fact. This approach serves as a powerful deterrent in preventing not only inappropriate billings, but more importantly, preventing inappropriate delivery of unnecessary or inappropriate services from occurring in the first place. The success of these fraud prevention initiatives is evidenced by the fact that government programs now are incorporating these innovative private sector practices.

Given the role that health plan fraud prevention and detection programs have played in establishing effective models for public programs, improved data for law enforcement, and successful prevention efforts, we believe policymakers should reevaluate the treatment of such programs by the regulation for implementing the MLR requirements. Our specific concern is that the MLR regulation only provides a credit for fraud "recoveries" (i.e., funds that were paid out to providers and then recovered under "pay and chase" initiatives). It does not include the cost of developing and administering anti-fraud programs that detect fraud before claims are paid and in the process protect consumers, purchasers, and patients. As a result, the regulation

penalizes health plans for committing resources to innovative programs that prevent and detect fraudulent conduct or prevent the delivery of unnecessary services or care.

By taking this approach, the MLR regulation's treatment of fraud prevention expenses works at cross purposes with efforts by the federal government to emulate successful private sector programs. Instead of encouraging fraud prevention, the regulation threatens to stifle the next generation of private sector innovations that will be helpful to the federal government in the future. This approach also is at odds with the broad recognition by leaders in the private and public sectors that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

We urge Congress and the Administration to reconsider the treatment of fraud prevention programs under the current MLR regulations. Excluding these expenses, which help to improve quality, is contrary to the health reform goals of developing a system that delivers consistently high quality care, optimizes the use of health care resources, and enhances anti-fraud cooperation between private and public entities.

IV. Conclusion

Thank you again for the opportunity to testify on these important issues. We appreciate the committee's interest in strengthening efforts to prevent and detect health care fraud, and we stand ready to provide further information to assist in this effort.