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Subcommittee on Oversight

Good morning, Mr. Chairman and distinguished Members of the Subcommittee. Thank you for the opportunity to testify about fraud, waste and abuse in our Medicare program. My experience working in law enforcement and private practice has taught me that, notwithstanding improvements in enforcement techniques over the past ten years, Medicare remains vulnerable to criminals intent on stealing. Further, fraud will not be reduced or eradicated with a "pay-and-chase" enforcement system that relies on criminal prosecution and civil litigation. To protect Medicare and provide needed care for generations to come, we simply must find a way to stop paying fraudulent claims. As such, the use of predictive analytics and modeling to identify and stop fraudulent payments should be the focus of our efforts.

The overwhelming majority of physicians, nurses, healthcare professionals, and companies in this country work tirelessly and honestly to provide care for Medicare beneficiaries. It should always be noted that fraud is the exception, not the rule. The men and women within the Office of Inspector General in the U.S. Department of Health and Human Services (OIG), the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), Centers for Medicare & Medicaid Services (CMS) and its contractors, and the state Medicaid Fraud Control Units, should be commended for the work they do to improve and protect the programs. Based on my experience, the government has some of the best and brightest. Yet, notwithstanding these efforts, more can be done to protect taxpayer money.

Fraud control is a difficult business.[1] Those who work to identify fraud are shining a light on what some label a lapse in oversight, and those who fail to identify fraud are promoting the *status quo*. To move forward with an effective fraud identification, deterrent, and policing system, all constituent governmental agencies need to collaborate on setting key strategic priorities and grow a culture that encourages innovation and information sharing.

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[1] *See* Malcolm K. Sparrow, *Fraud Control in the Health Care Industry: Assessing the State of the Art*, Nat'l Inst. of J., p. 3 (Dec. 1998), *available at* https://www.ncjrs.gov/pdffiles1/ 172841.pdf (Professor Sparrow's research was supported under grant number 94-IJ-CX-K004 by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. His research served as one of the bases which led to the creation and implementation of the *Medicare Fraud Strike Force* model of prosecution).

Pay-and-Chase Enforcement

Recent years have produced increases in the number of individuals being prosecuted, but these cases are still the by-product of a "pay and chase" model of enforcement. Paying out funds and asking law enforcement to try to recover them is a flawed and outdated model. Only with systemic design changes that prevent the payment of fraudulent claims will the amount of fraud be significantly reduced. In this regard, Medicare[2] can learn a great deal from credit card issuers and private health insurance companies. With advances in the ability to analyze claims data, the goal of the system should be to detect fraudulent claims when they are submitted, identify the perpetrators, and to use prosecution sparingly to punish and deter.

Medicare Claims Data

The submission of a claim for payment is an essential piece of evidence in every criminal investigation. In fact, the claim serves as an element of proof that every prosecutor and juror must examine. As a lynchpin of prosecution, jurors intuitively recognize the intent behind providers who submit medically impossible claims. Unfortunately, jurors often are confronted by providers who assert that before the claim was paid, Medicare had the required information and knowingly decided to pay the claim.

CMS contractors typically pay Medicare claims based upon information contained in a Form 1500. If the Form 1500 is correctly filled out, the claim is usually processed and paid without further inquiry or preauthorization. Without understanding more than the information on the form, it is not possible to ascertain whether the service or item was reasonable or necessary. Since 2007, the government has made strides in an effort to use aggregated claims data to identify trends and patterns indicative of fraud, waste, and abuse. As technology continues to improve the ability to examine and analyze vast quantities of data, it is imperative that our federal programs and law enforcement stay ahead of those intent on taking taxpayer funds.

Effective government oversight and enforcement requires collaboration across agencies. And it also requires innovative techniques, such as sophisticated examination of claims data, including predictive analytics and modeling to identify aberrant or otherwise suspicious patterns at the time claims are submitted. There are more opportunities to come as electronic health records (EHR) containing considerable supporting documentation offer new ways for the government to analyze data.

[2] Medicare is fundamentally a trust based system. Medicare promptly pays providers and suppliers based on a trust that they order and provide what is reasonable and necessary. Without removing this trust, the question is how to implement changes to the system that balance the risks associated with governmental interference and effective program oversight. Data analytic techniques utilizing the three-prong approach discussed above sought to achieve identification of aberrant behavior without encroaching on the trust granted to providers.

Standing alone, aberrant claims patterns should not be construed as proof of fraud. Aberrations are simply a signal that may require further analysis. This is why the process used by the *Medicare Fraud Strike Force* between 2007 and 2010 required a three-prong approach to claims analysis: (i) prompt access to usable claims data with national means data [CMS and contractors]; (ii) healthcare professionals who understand standards of care and treatment regimens examining aberrations [DOJ and OIG]; and (iii) law enforcement agents with knowledge of communities and current fraud schemes [FBI and OIG]. Without the three components working together, Medicare claims data was an ocean of information that produced more false leads than usable intelligence. After medically unexplainable or impossible claims were indentified, then the traditional work of OIG and FBI agents would begin. In short, access to "big data" opens the door, but access is only attained when true community-based knowledge is coupled with the input from professional healthcare personnel.

Restructuring the Fight Against Fraud

Given estimated fraud losses, I remain concerned that the existing enforcement apparatus is not focused on stopping the payment of fraudulent claims. Criminal prosecution should be the tool of last resort reserved for the most severe perpetrators, not the principal tool used to deter systemic fraud. Time and again, whether it's bogus durable medical equipment claims, unneeded home health agency visits, fake infusion clinics, unnecessary ambulance transports, phony community mental health centers, sham physical and occupational therapy providers, and so on, the payment of obviously false claims must cease. Further, Medicare must be alert to the fact that criminals do not simply stop when claims are denied.

In conclusion, decades of expanding law enforcement, parallel criminal, civil and administrative investigations, do not address systemic weaknesses that allow the payment of obvious false claims. Civil enforcement also has been flooded with hundreds of cases where whistleblowers articulate the issues and DOJ attorneys are required to investigate the issues brought to their attention. While successful at returning a small portion of annual spending to the trust fund,[3] civil and administrative processes should have independent enforcement priorities and agendas. When claims data analysis identifies patterns of waste or abuse, civil and administrative tools, including the False Claims Act, should be used to further the goals of a collaborative system. While whistleblowers play an important role in providing information to the government, so too can a thorough analysis of claims data. There is no need to wait for whistleblowers to drive the enforcement agenda where matters of abusive practices can be evaluated when claims are filed.

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[3] Since the creation of the HCFAC account, enforcement programs have estimated a return to the trust fund of $27.8 billion. *See* Annual Report of the Departments of Health and Human Services and Justice, *Health Care Fraud and Abuse Control Program* FY 2014, p. 1 (March 19, 2015). The FY 2014 recovery under the HCFAC was reported as $3.3 billion. *Id.* Medicare was billed over $1.2 trillion dollars that year, and paid roughly $400 billion. FCA case recoveries make up the bulk of financial recoveries and yet they do not typically focus on the worst offenders, but instead focus on those capable of settling a case.