Statement of Louis Saccoccio
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on

"Examining Options to Combat Health Care Waste, Fraud and Abuse"

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Testimony of:
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Good morning, Chairman Pitts, Ranking Member Pallone and other distinguished Members of the Subcommittee. I am Louis Saccoccio, Chief Executive Officer of the National Health Care Anti-Fraud Association (NHCAA).

NHCAA was established in 1985 and is the leading national organization focused exclusively on combating health care fraud and abuse. We are unique among associations in that we are a private-public partnership—our members comprise 90 of the nation's most prominent private health insurers representing over 300 corporate entities, along with nearly 100 federal, state and local government law enforcement and regulatory agencies that have jurisdiction over health care fraud who participate in NHCAA as law enforcement liaisons.

NHCAA's mission is straightforward: To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. Our commitment to this mission is the same regardless of whether a patient has private health coverage through an employer or as an individual, or is a beneficiary of Medicare, Medicaid, or any other federal or state program.

I am grateful for the opportunity to discuss the problem of health care fraud and abuse with you, examining options to combat it. In my testimony today, I draw upon our organization's twenty-seven years of experience examining, understanding and fighting health care fraud.

On a national level, fraud hampers our health care system and undermines our nation's economy. On an individual level, no one is left untouched by health care fraud; it is a serious and costly problem that affects every patient and every taxpayer across our nation. The extent of financial losses due to health care fraud in the United States, while not entirely known, is estimated to range in the tens of billions of dollars or more. To be sure, the financial losses are considerable, but those losses are compounded by numerous instances of patient harm — unfortunate and insidious side effects of health care fraud that impact patient safety and diminish the quality of our medical care. Health care fraud is not just a financial crime, and it is certainly not victimless.

Health care fraud takes many forms and is a serious problem regardless of the mode of health care delivery. Similarly, anti-fraud efforts must be multi-faceted, as there is no single solution to this problem. In my testimony today I will focus on the following five topics which NHCAA believes are critical for successfully combating health care fraud.

- First, the importance of anti-fraud information sharing and cooperation among all payers of health care, including the sharing of information between private insurers and public programs.

- Second, the critical and growing role of data analytics and predictive modeling in being able to detect fraud and potentially prevent precious health care dollars from being lost to fraud.
- Third, the importance of employing rigorous provider screening as a means for ensuring that only legitimate providers are able to submit claims for payment.
- Fourth, some of the innovative methods being applied with success to address a problem of growing concern for private insurers and public programs — prescription drug fraud and drug diversion.
- Finally, the importance of maintaining an anti-fraud workforce that has the skills and experience necessary to meet current and future health care fraud challenges.

I. Cooperation and information exchange between public and private payers of health care is critical to the success of anti-fraud efforts and should be encouraged and enabled.

Health care fraud does not discriminate between types of medical coverage. The same schemes used to defraud Medicare and Medicaid migrate to private insurance, and schemes perpetrated against private insurers make their way into government programs. Additionally, many private insurers are Medicare Parts C and D contractors or provide Medicaid coverage in the states, making clear the intrinsic connection between private and public interests on this issue.

The United States spends $2.8[1] trillion dollars on health care annually and generates billions of claims from millions of health care service and product providers. The vast majority of these providers of services and products bill multiple payers, both private and public. For example, a health care provider may be billing Medicare, Medicaid, and several private health plans in which it is a network provider, and may also be billing other health plans as an out-of-network provider. However, when analyzing this provider's claims for potential fraud or abuse, each payer is limited to the claims it receives and adjudicates and is not privy to claims information collected by other payers. There is no single repository of all health care claims similar to what exists for property and casualty insurance claims.[2] The complexity and size of the health care system, along with understandable concerns for patient privacy, likely make such a database impracticable. Nevertheless, the absence of such a tool limits the effectiveness with which health claims (housed in the discrete databases of individual payers), can be analyzed to uncover potential emerging fraud schemes and trends.

In this environment, fraudsters bank on the assumption that payers are not working together to collectively connect the dots and uncover the true breadth of a scheme. And it is precisely this reason why the sharing of preventive and investigative information among payers is crucial for successfully identifying and stopping health care fraud. Payers, whether private or public, who limit the scope of their anti-fraud information to data from their own organization or agency are taking an uncoordinated and piecemeal approach to the problem.

[1] National Health Expenditure Projections 2011-2021, Centers for Medicare and Medicaid Services, Office of the Actuary. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

[2] See https://claimsearch.iso.com

The value of information sharing in health care fraud investigations cannot be overstated. Our experience as a champion of this concept for the last twenty-seven years has taught us that anti-fraud information sharing is effective in combating health care fraud.

For example, NHCAA hosts several anti-fraud information-sharing meetings each year during which private health plans and representatives of the FBI, the Investigations Division of the Office of the Inspector General for the Department of Health and Human Services (HHS-OIG-OI), State Medicaid Fraud Control Units, the Centers for Medicare and Medicaid Services (CMS), TRICARE, and other federal and state agencies come together to share information about emerging fraud schemes and trends. Other information sharing methods employed by NHCAA include fraud alerts, NHCAA's SIRIS database of health care fraud investigations, and our Request for Investigation Assistance (RIA) process which allows government agents to easily query private health insurers regarding their financial exposure in active health care fraud cases as a means to bolster developing investigations. NHCAA private-public anti-fraud information sharing works, and routinely pays dividends for our members.

The Department of Justice (DOJ) also has recognized the benefit of private-public information sharing. For example, many U.S. Attorney Offices sponsor health care fraud task forces that hold routine information-sharing meetings, and when invited to do so, private insurers often participate in these meetings to gather and offer investigative insight. In fact, eighty-nine percent

of respondents to NHCAA's 2011 Anti-Fraud Management Survey[3] (a biennial survey of its private-sector members that aims to assess the structure, staffing, funding, operations and results of health insurer investigative units) report that they share case information at law enforcement-sponsored health care fraud task force meetings.

Additionally, DOJ developed guidelines for the operation of the Health Care Fraud & Abuse Control Program (HCFAC) established by HIPAA which provide a strong basis for information sharing. The "Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans" recognizes the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud.[4]

Despite DOJ's recognition of information sharing as an anti-fraud tool, many, including NHCAA, saw the need to improve and expand the cooperation and anti-fraud information sharing between the private and public sectors. The need for this expansion was highlighted at the National Health Care Fraud Prevention Summit hosted by DOJ and HHS in January, 2010, in which NHCAA and numerous private insurers participated. This summit set into motion a determined and steady effort to develop and establish a more formalized partnership between government agencies and private sector health insurers. It was envisioned that such a partnership would facilitate anti-fraud information exchange as a means to fight health care fraud. After

[3] The National Health Care Anti-Fraud Association, The NHCAA Anti-Fraud Management Survey for Calendar Year 2011 (Washington, DC, NHCAA, July 2012) p. 44.
[4] See http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm.

more than two years of discussions and meetings involving several interested parties, including NHCAA, the new Healthcare Fraud Prevention Partnership (HFPP) was formally announced on July 26, 2012 at a White House event.

The HFPP represents a joint HHS and DOJ initiative bringing together anti-fraud associations, private insurers, and government and law enforcement agencies. The HFPP charter states that: "The Partnership's purpose will be to exchange facts and information between the public and private sectors in order to reduce the prevalence of health care fraud. The Partnership will also enable members to individually share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud." The HFPP principles include:

- Sharing facts and information on data analytics and trend analysis,
- Sharing facts and information on best practices and novel, effective methodologies,
- Support equitable information exchange,
- Balance the interests of all stakeholders,
- Make results available to support their internal anti-fraud initiative, and
- Sharing individual input on expansion to include other entities that participate in detecting and preventing healthcare fraud.

The collective input of all the parties involved in the development of the HFPP has resulted in a thoughtful and sound organizational structure. An Executive Board provides the strategic direction for the initiative, and two committees will focus on different aspects of the information exchange process:

- The Data Analysis and Review Committee (DARC), which focuses on the operational aspects of data analysis and review and the management of the data analytics, and
- The Information Sharing Committee (ISC), which focuses on sharing the aggregated results and the best practices of the participants both internal to the partnership and to external stakeholders.

Both committees are working to develop short and long-term goals. One of the goals being discussed is the ability of the DARC to collect data from participants to be analyzed by a trusted-third party with the results of the analysis being shared as decided by the ISC. The ISC is looking at its interface with law enforcement, and hopes to make use of the numerous U.S. Attorney-based task forces and work groups around the country to foster greater information sharing and cooperation. NHCAA also has urged that DOJ, FBI and HHS-OIG-IG to provide detailed guidance to their agents in the field regarding the importance of information sharing and the specific criteria for sharing information with private health insurers.

NHCAA has fostered collaborative relationships between the private and public sectors for nearly three decades and it is from this perspective that we believe the HFPP holds great promise. Just getting underway, the HFPP needs time to develop and to demonstrate that it can be successful. It needs consistent, high-level support if it is to realize the sorts of tangible results we believe it is capable of.

Whether undertaken through NHCAA, regional task forces and work groups, or through the new HFPP, anti-fraud information sharing and cooperation between the private and public sectors is essential to being able to detect emerging schemes and trends at the earliest possible time. Health care payers cannot work in isolation and expect to successfully detect and prevent health care fraud.

II. There should be continued support for the critical and growing role of data analytics and predictive modeling for health care fraud detection.

The United States health care system currently spends $2.8 trillion dollars and generates billions of claims every year from millions of health care service and product providers. Medicare alone, representing nearly 50 million beneficiaries, pays over 4.4 million claims each working day to 1.5 million providers. Our nation's health care system hinges upon a staggering amount of data and countless health care claim adjudication systems.

Given the diversity of providers and payers and the complexity of the health care system — as well as the sheer volume of activity — the challenge of preventing fraud is enormous. Clearly, the only way to realistically deal with this complexity is to apply cutting-edge analytic techniques to the data to detect risks and emerging fraud trends.

It is much more cost effective to detect and prevent fraud prior to paying a fraudulent claim than to investigate and prosecute it after the fact. The "pay and chase" model of combating health

care fraud, while necessary in certain cases, is no longer tenable as the primary method of fighting this crime. The Centers for Medicare and Medicaid Services (CMS) has signaled — through testimony, resource allocation and action — that it recognizes this and is dedicating significant resources to this operational shift to prepayment anti-fraud efforts, including the application of predictive modeling to Medicare fee-for-service claims through its Fraud Prevention System.

As a precursor to efforts currently underway, Congress demonstrated its recognition of the promise that predictive modeling techniques hold for combating health care fraud by passing the Small Business Jobs and Credit Act of 2010. Establishing predictive analytics technologies requirements for the Medicare fee-for-service program, the Act directs the U.S. Department of Health and Human Services (HHS) Secretary to use predictive modeling and other analytical technologies to identify improper claims for reimbursement and prevent their payment. Clearly, one of Medicare's strengths in terms of fraud detection is the enormous amount of data the program generates and collects. We believe that applying predictive modeling to that data could yield very powerful, game-changing results.

CMS launched its Fraud Prevention System (FPS) employing predictive modeling on July 1, 2011. The technology used is similar to that used by credit card companies and financial institutions to detect and prevent fraud. The system, which is being used by CMS and its program integrity contractors, analyzes Medicare claims data applying models of fraudulent

behavior. This analysis results in automatic alerts on specific claims and providers. These alerts are, in turn, prioritized for program integrity analysts to review and investigate.

NHCAA has reviewed the recently released Government Accountability Office (GAO) report "Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness." Essentially a report card on the FPS system, the study reasonably recommends that CMS develop schedules for completing integration of the FPS with existing systems, define and report to Congress quantifiable benefits and measurable performance targets and milestones, and conduct a post-implementation review of FPS.

It is understandable that many are anxious to see immediate, positive results from the investments already made in adopting predictive modeling and analysis. On that point, NHCAA would encourage patience regarding the use of predictive modeling and data analysis for combating fraud. It will take time to effectively refine and adjust the models for such a large and complex system as Medicare in order to realize the full potential that these powerful technologies offer. Despite the challenges, this is a path that both Congress and CMS recognize has to be followed, and NHCAA strongly support this effort.

Many private health plans also have recognized the importance of predictive analytics to help detect potential fraud. Forty percent of respondents to NHCAA's 2011 Anti-Fraud Management Survey indicated the use of some form of predictive analytics in its anti-fraud work. It is

important to note that predictive analytics is an important tool in the detection of fraud, but it is not a panacea. Predictive analytics can generate leads for further inquiry and can help form the basis for the suspension of payments, but it has not been used as the sole basis for the suspension of payments by private health insurers without additional follow-up and corroboration.

III. The importance of employing rigorous provider screening.

From an anti-fraud perspective, one long-held criticism of the Medicare program has been the relative ease with which providers could gain access to the program and begin billing with little more required of them than completing and submitting the necessary paperwork. Of course, with a program that serves nearly 50 million Americans, it is important to ensure that there is acceptable access to health care to meet the needs of beneficiaries. The vast majority of health care providers are legitimate and honest, and follow the rules prescribed by the Medicare program. No one has an interest in burdening honest providers to the extent that they are dissuaded from participating in the program. These underlying considerations have for all intents and purposes culminated to establish Medicare as a program that has traditionally enabled "any willing provider" to participate.

However, to the extent that an individual or entity looks to enter the Medicare system to commit fraud, inadequate provider screening represents the Achilles' heel of program integrity. Encouragingly though, improved provider screening also may serve as our best opportunity for significant fraud-fighting "wins" under Medicare since it addresses fraud at the provider entry

point. The challenge is implementing provider screening reforms that achieve the goal of cutting down on fraud while not impacting beneficiary access to care or unnecessarily encumbering legitimate providers who wish to serve the Medicare population.

The Affordable Care Act (ACA) laid the groundwork for additional and enhanced screening of providers who participate or seek to participate in Medicare and Medicaid. Section 6401 of the ACA directs the Secretary of the Department of Health and Human Services to determine "levels" of provider screening according to "the risk of fraud, waste, and abuse…with respect to the category of provider of medical or other items or services or supplier." The Secretary is authorized also to impose additional burdens where there are more significant fraud concerns and impose a temporary moratorium on the enrollment of new providers of services and suppliers under Medicare, Medicaid and the CHIP program when necessary to prevent or combat fraud, waste or abuse.

On February 2, 2011, the final rule was published that details the new provider screening requirements envisioned in the law. The rule became effective March 25, 2011, and designates categories of providers and suppliers that are subject to varying screening procedures based on the risk presented by the category of provider. Three levels of screening and associated risk were established—limited, moderate and high—with each provider/supplier category assigned to a screening level. The following are the types of screenings delineated in the rule for Medicare:

- Verification of any provider/supplier-specific requirements established by Medicare;
- Conducting of license verifications (may include licensure checks across states);

- Database checks (SSN, NPI, NPDB licensure, OIG exclusions, tax ID, tax delinquency, death);
- Unscheduled or unannounced site visits; and
- Fingerprint-based criminal history record check of law enforcement repositories.

Building upon the new provider screening requirements enabled by the ACA and the subsequent rule, in December 2011, CMS began implementing a new Automated Provider Screening (APS) system that automates the validation of provider and supplier enrollment application information, drawing upon public and private sources. Information verification, including licensure status, is automatic and continuous. The APS replaces time- and resource-intensive manual review of provider enrollment applications, thus reducing application processing time. It is also intended to assess the individual level of risk each provider and supplier presents to the Medicare program. It is useful to note that the APS system is not yet integrated with CMS's Fraud Prevention System, but it will be. This integration, according to the GAO, should "enable the Fraud Prevention System to risk-score providers based on certain public records."[5]

NHCAA supports the reforms made to the Medicare provider screening process in the last year. In our view, they represent common sense steps that are capable of being adjusted as the discerned risks change over time. To protect our investment in the program, it is important that Medicare enrolls only qualified providers and suppliers who meet and maintain compliance with

[5] See http://www.gao.gov/assets/650/649537.pdf p. 25.

the program's participation requirements. The screening processes now in place do a good deal in the service of that goal.

IV. Special emphasis on prescription drug fraud and drug diversion.

Our resources to combat health care fraud, waste and abuse are finite. Difficult decisions must be made about how best to allocate those resources. Based on projected increases in spending for prescription drugs, the expansion of health coverage envisioned by the Affordable Care Act, and our experience and insight about health care fraud trends, NHCAA believes prescription drug fraud will continue to grow as a segment of the health care fraud problem and, therefore, deserves special consideration.

National Health Expenditure Data reveal that in 2010, $259 billion dollars were spent on prescription drugs and by 2021, that spending is projected to nearly double, reaching $483 billion.[6] It is notable that in 2014 an estimated 18 million Americans will become newly insured under Medicaid and through Exchange plans,[7] significantly influencing the 8.8 percent annual increase projected for prescription drug spending in that year alone.[8] Private and public insurers underwrite 80 percent of all spending on prescription drugs in the U.S., while consumers pay

[6] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf
[7] http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf
[8] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf, Table 11

roughly just one-fifth of the cost.[9] This means insurers and public programs shoulder the bulk of exposure, risk and ultimately financial losses resulting from drug diversion and other prescription drug fraud schemes.

No insurer or public health care program is immune. Findings from a Government Accountability Office (GAO) report issued in September of last year titled "Medicare Part D: Instances of Questionable Access to Prescription Drugs"[10] describe how the Medicare Part D prescription drug program is vulnerable to prescription drug abuse. Acknowledging this vulnerability, CMS issued a memorandum to Part D sponsors in late September 2011 seeking input on how to improve drug utilization review controls under the program[11]. This past April CMS published its Final Call Letter[12] that included a section on improving drug utilization review controls in Part D that delineates several improvements to formulary management processes that should be implemented by sponsors in order to comply with drug utilization management requirements. The letter lays out a minimum compliance standard with respect to overutilization of opioids and explains that if the drug utilization review levels described do not prove effective at establishing medical necessity, sponsors may implement beneficiary-level point of service restrictions under certain conditions.

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[9] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf, Table 11

[10] See http://www.gao.gov/products/GAO-11-699

[11] See http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Improving-DUR-Memo-Controls.pdf

[12] See http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2013.pdf, p 131

Health care fraud is most often discussed in terms of financial loss, but it can also be the catalyst for patient harm and even death. The nature of prescription drug fraud, with its risk of overdoses, unsafe drug interactions, and the taking of unnecessary and often addictive medication is particularly prone to lead to patient harm. The Office of National Drug Control Policy calls prescription drug abuse "the Nation's fastest-growing drug problem,"[13] and the Centers for Disease Control and Prevention classifies prescription drug abuse as an epidemic. The 2011 National Drug Threat Assessment report produced by the Department of Justice National Intelligence Center says that the abuse of controlled prescription drugs "constitutes a problem second only to the abuse of marijuana in scope and pervasiveness in the United States."[14] Of course, prescription drug abuse in itself does not necessarily indicate fraud. Abuse (resulting in overdoses and deaths) can certainly occur in situations where the prescription drugs were legitimately obtained for legitimate purposes. Nevertheless, fraud likely plays a role in many instances.

The practice frequently referred to as "doctor shopping" whereby individuals obtain prescriptions for frequently abused drugs from multiple prescribers and then fill them at different pharmacies, has garnered significant attention in recent years. This represents but one form of a broader prescription drug fraud scheme commonly referred to as drug diversion. With recent focus on doctor shopping by decision-makers and the media, it is important to acknowledge that prescription drug fraud and diversion can actually take many forms and be extremely complex. For example, doctor shopping isn't always perpetrated by beneficiaries alone. Sometimes

[13] See http://www.whitehouse.gov/ondcp/prescription-drug-abuse
[14] See http://www.justice.gov/ndic/pubs44/44849/44849p.pdf

prescribing physicians, as well as pharmacists, are complicit or even drivers in the scheme. Patients also may be involved with the forging of prescriptions using prescription pads that have been stolen from legitimate physicians. Other schemes include unscrupulous physicians selling prescriptions to abusers or street dealers. Still another has perpetrators taking part in a criminal enterprise directed at reselling drugs in high volume (and for large profits) on the street. Regardless of the form drug diversion takes there is usually a common thread—the drugs are obtained and paid for by filing false insurance claims.

Notably, the money lost to prescription drug fraud through payment of bogus pharmacy claims is only a part of the financial impact of this problem. In the process of obtaining a prescription, a patient typically will generate claims for related medical services. Insurers and government health care programs often find that they have paid not just for unnecessary medications but also for related emergency room visits, in-patient hospital stays, visits to physician offices and clinics, diagnostic testing and rehabilitation—all based on phantom injuries, illnesses and conditions feigned in order to obtain a prescription. Then there are the additional costs associated with treating the addictions and overdoses arising from this behavior.

To offer some perspective, a 2007 study produced by the Coalition Against Insurance Fraud titled "Prescription for Peril," states that insurer WellPoint, Inc. found that it "paid $41 in related medical claims for every $1 it paid in narcotic prescriptions for suspected doctor-shopper plan members."[15] That is an astonishing ratio and a significant waste of medical resources. And a

[15] http://www.insurancefraud.org/downloads/drugDiversion.pdf

survey conducted by the Substance Abuse and Mental Health Services Administration's Office of Applied Studies (SAMHSA/OAS) titled "The Drug Abuse Warning Network (DAWN) Report," finds: "The estimated number of emergency department (ED) visits involving nonmedical use of narcotic pain relievers rose from 144,644 in 2004 to 305,885 in 2008, an increase of 111 percent."[16] While we can't assume that all of those emergency room visits were the result of prescription drug fraud and abuse, we can reasonably assume that many of them were and therefore the cost of some of those visits constitute fraud losses.

NHCAA insurer members have recognized doctor shopping as a fraud trend over the last several years and their anti-fraud efforts regularly identify dangerous prescription drug abuse by patients. Most often, it's the insurer that is best able to connect the dots and identify overprescribing by physicians and prescription drug abuse by patients based on review of claims data. Many insurers use pharmacy benefit managers (PBMs) to carry out pharmacy functions, tasking them also with claims integrity. However, because a PBM's responsibility is typically limited to prescription claims it is often unable to detect the larger scheme that takes into account the related medical services.

In order to meet the growing threat of prescription drug fraud, several NHCAA members as well as some state Medicaid programs are devoting significantly increased resources to the problem, developing policies to quickly detect suspected doctor shopping and drug diversion, and implementing programs to stop it.

[16] http://oas.samhsa.gov/2k10/dawn016/opioided.htm

To try and identify possible doctor shopping many insurers run data mining reports that regularly search across claims data applying certain criteria in order to identify enrollees whose prescription drug claims history meet thresholds that may indicate abuse. For example, one insurer uses what it calls a 333 report which identifies enrollees who in the last year have gone to three or more prescribing doctors, have filled prescriptions at three or more pharmacies and have received three or more prescriptions for schedule III or IV controlled substances. Fraud investigators use the report to launch a more in-depth examination of the claims history to try and identify and confirm doctor shopping. Some insurers take the list of members identified via data mining reports to serve as the basis for monthly mailings to prescribing doctors, aimed at making them aware when one of their patients has been going to several providers seeking similar prescription drugs.

When an insurer determines that doctor shopping has occurred the member may be required to participate in a restricted recipient program or "lock-in" program whereby the member is limited to filling prescriptions at one pharmacy or limited to receiving prescriptions from just one doctor. Some insurers choose to employ anti-fraud staff members that are dedicated exclusively to investigating prescription drug fraud. In fact, one national health insurer that is a NHCAA member devotes a quarter of its anti-fraud investigative manpower to prescription drug fraud.

Many of the programs that private insurers have put in place to combat prescription drug fraud — things like running overutilization reports, letter campaigns making prescribers aware of

possible drug-seeking behavior and restricted recipient programs — have been quite successful. Other promising tools include utilizing geo-mapping technologies to identify members who appear to be traveling long distances to obtain controlled substances from physicians or pharmacies, identifying prescribers who are writing prescriptions that fall outside their scope of specialty, and looking closely at large concentrations of claims coming from a single pharmacy.

Prescription drug fraud is a serious issue with severe patient harm risks. In meeting their obligations to provide coverage and make prompt claims payments, health insurers, including government programs and private health care payers, often pay for the unnecessary prescription drugs as well as the related medical services. Insurers are devoting increased attention and resources to this problem, devising new and innovative ways to detect possible drug diversion and taking appropriate steps to stop it, while also trying to help patients in need of intervention and treatment. We commend these actions and encourage CMS to make rooting out fraud in the Medicare Part D program a priority.

V. Ensure a skilled and sufficient workforce of health care anti-fraud professionals with the skills and experience necessary to meet current and future health care fraud challenges.

Individuals who work to prevent, detect and investigate health care fraud, waste and abuse in our government programs have a challenging task that demands a wide set of specialized skills. Health care fraud is a complex crime that can manifest itself in countless ways. There are many

variables at play. The sheer volume of health care claims makes fraud detection a challenge. Add to that the fact that fraud can conceivably be committed by anyone, and that those committing fraud have the full range of medical conditions, diagnoses, treatments and patients on which to base false claims. Plus, detecting health care fraud often requires the application and knowledge of medical and clinical best practices, terminology and arcane coding systems including CPT, CDT and HCPCS codes, DRGs, ICD-9 codes, and the forthcoming ICD-10 codes. The unique and intricate structures of our varied and numerous government health care programs add to the difficulty of effectively combating fraud and abuse.

Fraud schemes and trends often emerge from particular medical specialty areas or involve very specific treatments, diagnoses or procedures, but those schemes constantly change, develop, shift, migrate and morph. And geography plays a prominent role too. It is typical to see a fraud scheme established in one geographic region move to a different region once the payer and law enforcement communities in the original region react to the scheme.

With its complexity, our health care system can be susceptible to creative, nimble and aggressive perpetrators who have a knack for identifying weaknesses. This fact demands that we employ fraud fighting techniques that are equally creative, nimble and aggressive. To that end, investments need to continually be made to educate and train the anti-fraud workforce on the front lines to ensure that it is knowledgeable about the latest trends and schemes, as well as the newest tools and techniques for fraud detection and prevention.

Since our founding, NHCAA has provided the professional health care anti-fraud field with superior education and training opportunities, developing and delivering unique training programs specifically designed to advance the professionalism and knowledge of the individuals, both private and public, responsible for the fight against health care fraud. Our Annual Training Conference is the largest education event we host each year, attracting more than 1,200 investigative professionals, a large percentage of whom are public sector employees. In addition, NHCAA offers the Accredited Health Care Anti-Fraud Investigator (AHFI) designation. Achieving an AHFI is widely considered the gold standard of professionalism in health care fraud investigation.

Along with education, ensuring adequate staffing levels is also critically important. There is currently much attention given to predictive modeling and prepayment analytics, and with good reason. However, the need for "boots on the ground" is as great as it has ever been. Technology professionals and data analysts will be in increasing demand as the use of prepayment technologies grows. And the leads and information developed by data analytics will continue to require, in many instances, skilled investigators and medical record reviewers with clinical backgrounds available to act on the information. It is important that the anti-fraud units responsible for ensuring the integrity of our federal health care programs are staffed sufficiently to meet the challenge that fraud and abuse presents. As we focus on the promise of technology, we mustn't overlook the vital need for smart, analytical, insightful, and committed fraud-fighting professionals.

We must maintain a multi-prong approach to fighting health care fraud that strikes a balance between technological resources and human resources. So as we continue to extol the promise of cutting-edge technologies for combating health care fraud, waste and abuse, we must also champion the continued investment in human capital. We recommend that in its allocation of funding for anti-fraud efforts in Medicare and Medicaid, Congress recognizes the necessity of building a workforce with the numbers, depth, specialization and skill necessary to be successful.

Conclusion

There is no silver bullet for defeating health care fraud. A winning strategy for Medicare must be multi-faceted and include effective information sharing among private and public payers of health care, the application of data analytics to health care claims, rigorous screening of providers attempting to enter and continue in the program, and a well-trained, adequate and multi-disciplinary work force. Also, as with prescription drug fraud and diversion, solutions specially designed to address different types of fraud must be adopted.

Additionally, a winning strategy must be supported by adequate funding. When it was established through HIPAA, the National Health Care Fraud & Abuse Control Program (HCFAC) was intended to be "a far-reaching program to combat fraud and abuse in health care, including both public and private health plans."[17] After 15 years, the HCFAC program shows a

[17] See http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf, The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011, page 3.

return on investment (ROI) of $5.10 for every $1 spent since the program began[18]. In addition, the program has returned more than $20.6 billion to the Medicare Trust Fund since its inception. Similarly, NHCAA's private-sector members consistently earn solid returns for their anti-fraud investments.

The HCFAC allocations for fiscal year 2011 totaled $608 million (including mandatory and discretionary allocations), which may seem sizeable. However, considering that nearly $1 trillion dollars is currently spent on Medicare and Medicaid ($557.8 billion spent for Medicare and $428.7 billion for Medicaid)[19], that $608 million investment is very small by comparison (representing just 0.06% of expenditures), especially in light of the demonstrated return on investment from anti-fraud spending.

Health care fraud costs taxpayers billions of dollars every year, and fighting it requires focused attention, continuous resource investment and a long-standing commitment to pursuing and adopting innovative solutions. Based on our history as a private-public partnership, NHCAA believes that a comprehensive approach to fighting fraud must include all payers, public and private, and embrace private-public solutions. Government entities, tasked with fighting fraud and safeguarding public programs, and private insurers, responsible for protecting their

[18] See https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf, p. 8.
[19] National Health Expenditure Projections 2011-2021, Centers for Medicare and Medicaid Services, Office of the Actuary. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

beneficiaries and customers, can and should work cooperatively on this critical issue of mutual interest.

Thank you for allowing me to speak to you today. I would be happy to answer any questions that you may have.