

The Amendment in the Nature of a Substitute

AMENDMENT TO H.R. 4872, AS
REPORTED

OFFERED BY MR. ROSKAM OF ILLINOIS

Strike

Sec. 1302 & Insert at the appropriate place the following new section:

1 SECTION [___]. MEDICARE WASTE, FRAUD, AND ABUSE
2 PREVENTION PILOT PROGRAM.

3 (a) ESTABLISHMENT.—The Secretary of Health and
4 Human Services, acting through the Centers for Medicare
5 and Medicaid Services Office of Program Integrity, shall
6 establish a pilot program to develop and implement a
7 waste, fraud, and abuse prevention system for reviewing
8 reimbursement claims under title XVIII of the Social Se-
9 curity Act.

10 (b) SELECTION OF CLAIMS.—

11 (1) ALL PROVIDER TYPES.—The prevention
12 system under subsection (a) shall cover all types of
13 providers under the Medicare program, but may be
14 limited to a subset of claim segments.

15 (2) PERCENTAGE OF CLAIMS REVIEWED.—The
16 Secretary of Health and Human Services shall en-
17 sure that between 5 and 10 percent of all Medicare
18 claims in a year are received, reviewed, scored, and

1 evaluated by the prevention system under subsection
2 (a).

3 (3) VALID SAMPLE.—The claims reviewed by
4 the prevention system under subsection (a) shall be
5 selected from all Medicare claims, based on criteria
6 to establish a statistically valid sample.

7 (c) SYSTEM DESIGN ELEMENTS.—

8 (1) SYSTEM DESIGN IDEALS.—The ideal pre-
9 vention system shall—

10 (A) be holistic;

11 (B) be able to view and analyze all pro-
12 vider and patient activities from multiple Medi-
13 care providers;

14 (C) be able to integrate into the existing
15 healthcare claims flow with minimal effort,
16 time, and cost;

17 (D) be modeled on predictive scoring fraud
18 prevention systems used in the Financial Serv-
19 ices industry, such as the credit scoring systems
20 described in Regulation B under Fair Credit
21 Reporting Act of 1970; and

22 (E) utilize integrated real-time transaction
23 risk scoring and referral strategy capabilities to
24 identify transactions that are statistically un-
25 usual.

1 (2) MODULARIZED ARCHITECTURE AND OTHER
2 DESIGN ELEMENTS.—The prevention system under
3 subsection (a) shall be designed—

4 (A) from an end-to-end modularized per-
5 spective to allow for ease of integration into
6 multiple points along the Medicare claims flow
7 process (including to allow review of claims pre-
8 or post-adjudication of such claims);

9 (B) to identify unusual claims based on
10 data that is empirically derived from previous
11 or existing Medicare claims data;

12 (C) to use commonly accepted, statistically
13 sound techniques;

14 (D) to demonstrate that it ranks claims
15 based on the likelihood of waste, fraud, or
16 abuse;

17 (E) to perform better than mitigation
18 strategies and decision rule solutions currently
19 used by healthcare payers, including Medicare;

20 (F) to ensure access through a secure pri-
21 vate data connection rather than the installa-
22 tion of software in multiple information tech-
23 nology infrastructures (and data facilities);

1 (G) to provide access to the best and latest
2 software without the need for upgrades, data
3 security, and costly installations;

4 (H) to permit modifications to the software
5 and system edits in a rapid and timely manner;

6 (I) to ensure that all technology and deci-
7 sion components reside within the module; and

8 (J) to utilize experimental design method-
9 ology to monitor and measure and compare the
10 performance of the methods and assessment
11 tools used to identify waste, fraud, and abuse
12 before the implementation of the prevention
13 system and methods and assessment tools used
14 by the prevention system identification for the
15 purpose of determining the incremental lift and
16 the overall return on investment of using the
17 prevention system.

18 (d) SYSTEM OPERATION.—

19 (1) SCORING AND REAL-TIME ANALYSIS.—

20 (A) IN GENERAL.—The prevention system
21 under subsection (a) shall identify high-risk
22 claims by scoring all such claims in real-time,
23 prior to the Centers for Medicare & Medicaid
24 Services making payment on such claims.

1 (B) USE OF SCORES.—The scores under
2 paragraph (1) shall be communicated to the
3 fraud management system under subsection (f).

4 (C) REAL-TIME ANALYSIS.—Under the
5 prevention system, the real-time analysis of
6 claims data shall be conducted in a manner that
7 ensures—

8 (i) prompt identification of waste,
9 fraud, and abuse; and

10 (ii) prompt payment of legitimate
11 claims.

12 (2) CROSS-MARKET, GEOGRAPHIC AREA, AND
13 BEHAVIORAL REVIEW.—

14 (A) IN GENERAL.—The prevention system
15 under subsection (a) shall analyze claims data
16 across all Medicare markets, geographic areas,
17 and provider types for the purpose of identi-
18 fying—

19 (i) high-risk behavior patterns across
20 markets, geographies, and types of pro-
21 viders (including specialty group pro-
22 viders); and

23 (ii) providers and patients that exhibit
24 unusual transaction and behavioral pat-
25 terns.

1 (B) BEHAVIORAL PATTERN TECH-
2 NOLOGY.—For purposes of subparagraph
3 (A)(ii), the prevention system shall utilize be-
4 havior pattern technology that is capable of
5 comparing—

6 (i) a provider's current behavior to
7 such provider's past behavior; and

8 (ii) a provider's current behavior to
9 the behavior of other providers in the type
10 of practice and geographic location.

11 (3) PREDICTIVE MODELING.—The prevention
12 system under subsection (a) shall involve the imple-
13 mentation of a statistically sound, empirically de-
14 rived predictive modeling technology that is designed
15 to prevent waste, fraud, and abuse (by identifying
16 such waste, fraud, and abuse before payment is
17 made on related claims). The prevention system
18 shall use a predictive model to identify fraud, waste,
19 and abuse that is—

20 (A) based historical transaction data, from
21 across all markets and regions available, to
22 build and continuously re-develop scoring mod-
23 els, capable of incorporating external data and
24 external models from other sources into the pre-
25 dictive model; and

1 (B) regularly updated, through the feed-
2 back loop under subsection (g), to provide infor-
3 mation and incorporate data on reimbursement
4 claims that is collected during the operation of
5 the pilot program under subsection (a), includ-
6 ing information gathered through the investiga-
7 tion of reimbursement claims that the system
8 identifies as being potentially fraudulent, waste-
9 ful, or abusive.

10 (4) DECISION TECHNOLOGY.—The prevention
11 system under subsection (a) shall have the capability
12 to monitor provider and consumer behavior in real-
13 time, at different stages within the transaction flow,
14 based upon provider, transaction, and consumer
15 trends. The prevention system shall provide for the
16 identification of provider and claims excessive usage
17 patterns and trends that differ from similar peer
18 groups, have the capability to trigger on multiple
19 criteria, such as predictive model scores or custom
20 attributes, and be able to segment transaction waste,
21 fraud, and abuse into multiple types for healthcare
22 categories and business types.

23 (5) PROTECTIONS FOR PATIENTS AND PRO-
24 VIDERS.—The identification of an unusual or sus-

1 pect claim by the prevention system under sub-
2 section (a) shall—

3 (A) not result in the denial of a healthcare
4 services to an individual until such claim is fur-
5 ther reviewed; and

6 (B) not result in a failure to comply with
7 prompt payment laws.

8 (6) COMPLIANCE WITH HIPAA.—All data col-
9 lected, stored, and reviewed under the pilot program
10 under subsection (a) shall be treated in a manner
11 that is in compliance with the Health Insurance
12 Portability and Accountability Act of 1996 and any
13 other applicable laws and regulations.

14 (7) TRACKING AND REPORTING.—

15 (A) IN GENERAL.—The pilot program
16 under subsection (a) shall ensure that the infra-
17 structure exists to ascertain whether the pre-
18 vention system (including the related implemen-
19 tation strategy and predictive model) generates
20 sufficient savings to provide a positive return
21 on investment.

22 (B) VALIDATION.—Dynamic model valida-
23 tion and strategy validation analysis and report-
24 ing shall be used to ensure that a strategy or
25 predictive model—

- 1 (i) has not degraded over time; and
2 (ii) is still effective.

3 (C) REPORTING.—Reporting must be cre-
4 ated and made available for population esti-
5 mates of what claims were flagged, what claims
6 received treatment and whether claims were ul-
7 timately determined (by segment or decile) as—

- 8 (i) waste, fraud, or abuse identifica-
9 tion; or
10 (ii) a normal claim.

11 (D) DETERMINING SAVINGS.—

12 (i) METRIC.—The pilot program
13 under subsection (a) must develop—

14 (I) a reliable metric to measure
15 the dollars that are never expended
16 due to identification of waste, fraud,
17 and abuse; and

18 (II) the capability to effectively
19 test and estimate the impact from dif-
20 ferent actions and treatments utilized
21 to detect and prevent waste, fraud,
22 and abuse.

23 (ii) COMPLETE DETERMINATION.—
24 Measuring results shall not be limited to
25 actual identified fraud. Results must also

1 capture waste and abuse mitigated by the
2 prevention system.

3 (e) TREATMENT OF DATA.—

4 (1) IN GENERAL.—The prevention system shall
5 be a high volume, rapid, real-time information tech-
6 nology solution, which includes data pooling and
7 scoring capabilities to quickly and accurately capture
8 and evaluate data.

9 (2) DATA SOURCES.—The prevention system
10 under subsection (a) shall—

11 (A) use data from reimbursement claims
12 contained in existing files of Medicare claims
13 data, including within Medicare’s “Common
14 Working File”; and

15 (B) pool data from all available govern-
16 ment sources (including the Social Security Ad-
17 ministration’s Death Master File),
18 for the purpose of waste, fraud, and abuse preven-
19 tion.

20 (3) DATA STORAGE.—The prevention system
21 shall be stored in an industry standard secure data
22 environment that complies with applicable Federal
23 privacy laws for use in building Medicare waste,
24 fraud, and abuse prevention predictive models that

1 have a comprehensive view of provider activity across
2 all markets, geographic areas, and provider types.

3 (4) CENTRAL LOCATION.—The claims data
4 shall be collected in a central location in order to
5 allow the analysis required under subsection (d)(2).

6 (f) FRAUD MANAGEMENT SYSTEM.—

7 (1) IN GENERAL.—The prevention system
8 under subsection (a) shall utilize a fraud manage-
9 ment system, containing workflow management and
10 workstation tools to provide the ability to systemati-
11 cally present score, reason codes, and treatment ac-
12 tions for high-risk scored transactions.

13 (2) REVIEW OF CLAIMS.—The fraud manage-
14 ment system shall ensure that analysts who review
15 claims have the capability to access, review, and re-
16 search claims efficiently, as well as decline or ap-
17 prove payments on claims in an automated manner.

18 (3) STRATEGY TESTING.—Workflow manage-
19 ment under this subsection shall be combined with
20 the ability to utilize principles of experimental design
21 to compare and measure prevention and detection
22 rates between test and control strategies. Such strat-
23 egy testing shall allow for continuous improvement
24 and maximum effectiveness in keeping up with ever
25 changing fraud and abuse patterns. Such strategy

1 testing shall provide the capability to test different
2 treatments or actions randomly (typically through
3 use of random digit assignments).

4 (g) FEEDBACK LOOP.—

5 (1) IN GENERAL.—The prevention system
6 under subsection (a) shall utilize a feedback loop to
7 gain access to outcome information on adjudicated
8 claims so future system enhancements can learn
9 from previous experience.

10 (2) PURPOSE.—The purpose of the feedback
11 loop under paragraph (1) is to—

12 (A) enable the Secretary to measure the
13 actual amount of fraud, waste, and abuse, as
14 well as the savings resulting from the imple-
15 mentation of the prevention system under sub-
16 section (a); and

17 (B) provide necessary data to re-train fu-
18 ture, enhanced models for use in the prevention
19 system

20 (3) ANALYSIS OF FINAL CLAIMS STATUS.—The
21 feedback loop under paragraph (1) shall analyze
22 data from all carriers to provide post-payment infor-
23 mation about the eventual status of a claim as
24 “Normal”, “Fraud”, “Waste”, “Abuse”, or “Edu-
25 cation required”.

1 (h) FRAUD ALERT FILE.—The Secretary shall de-
2 velop a file that contains information on previous claims,
3 consumers, providers, and fraud rings determined to be
4 fraudulent or abusive. Such file shall be used—

5 (1) to alert carriers of such fraud and abuse;

6 and

7 (2) for fraud and abuse solution development.

8 (i) CLAIMS RESEARCH.—If a reimbursement claim is
9 selected to be reviewed by the prevention system under
10 subsection (a), the following shall occur:

11 (1) ASSOCIATION.—The entity operating the
12 prevention system shall be associated or integrated
13 with a Medicare Administrative Contractor that has
14 extensive experience in evaluating and researching
15 Medicare claims for waste, fraud, or abuse.

16 (2) SCORE OUTPUT.—The predictive scoring
17 system under the prevention system shall be able to
18 output a risk score, score descriptions, and reasons
19 why each claim had a high-risk score.

20 (3) CLAIMS REPORT.—A detailed claim report
21 shall be systematically available for each claim with
22 a high-risk score. A historical claim report must be
23 systematically available for each beneficiary associ-
24 ated with each claim with a high-risk score.

25 (j) CLAIMS REVIEW PRIOR TO PAYMENT.—

1 (1) REVIEW BEFORE PAYMENT.—If a reim-
2 bursement claim is selected to be reviewed by the
3 prevention system, the Secretary of Health and
4 Human Services shall not make a payment on such
5 claim until such claim has been reviewed by the sys-
6 tem. In order to accomplish this task, appropriate
7 controls and technology must be in place to both as-
8 sess and measure the effectiveness of the prevention
9 system, predictive models used by such system, and
10 overall strategy.

11 (2) TIMELY REVIEW.—The review under para-
12 graph (1) shall occur in a timely manner and shall
13 not interfere with the prompt payment of such
14 claims.

15 (3) RESEARCH OF CLAIMS.—If automated tech-
16 nology shall provide the ability to systematically
17 present scores, reason codes, and treatment actions
18 for claims that are scored as “high-risk”, the ana-
19 lysts who work claims must have the capability to
20 access, review, and research claims efficiently, as
21 well as to decline or approve payments on claims in
22 an automated manner.

23 (k) REQUIREMENT OF DEVELOPING ENTITIES.—Any
24 entity providing the prevention system under subsection
25 (a) shall adhere to test and control policies for testing new

1 programs, predictive models, decision logic, or strategies.
2 Components of such system shall be summarized in a doc-
3 ument for reference purposes. This document will include
4 details of the operation of the system, such as the objective
5 of the program, model, and strategy used in such system,
6 performance metrics, duration, and reporting. An appro-
7 priate sign-off process shall be defined and is required be-
8 fore implementation of each new program, model, strat-
9 egy. The developing entity shall create a Test and Control
10 Policy document that describes the following:

11 (1) AREAS OF RISK.—Potential adverse effects
12 to Medicare program integrity or providers.

13 (2) TEST DURATION.—Policies outlining min-
14 imum standards for observing performance of chal-
15 lenger strategies and programs before authorization
16 of an expansion of a test strategy.

17 (3) MEASUREMENT METRICS.—Metrics to be
18 observed for each strategy or program to determine
19 effectiveness.

20 (4) SAMPLE SIZE QUANTITY.—Requirements re-
21 garding sample size quantities for each strategy or
22 program (and methods utilized to estimate sample
23 size).

1 (5) EXPERIMENTAL DESIGN.—Overall require-
2 ments for the percentage of the population that will
3 be devoted to challenger strategies.

4 (6) CHANGE CONTROL.—Policy addressing the
5 change control process.

6 (7) TRACKING.—Requirements detailing the
7 type and frequency of strategy and program track-
8 ing.

9 (8) SUCCESS MEASUREMENT.—A statement of
10 the criteria used to determine success or failure of
11 a particular demonstration or test.

12 (1) IMPLEMENTATION.—The prevention system under
13 subsection (a) for reviewing reimbursement claims shall
14 be designed in such a manner that upon successful com-
15 pletion of the 12-month pilot program under subsection
16 (a), the prevention system can be rolled-out over a 3 to
17 4 year period. This rollout shall only occur upon successful
18 pilot program results, documented annual prevention sav-
19 ings, and projected annual operating expenses (with de-
20 creasing unit costs of 10 percent annually). During the
21 rollout period, constant and consistent test and control
22 strategies shall be implemented by stakeholders, with re-
23 sults shared with leadership on a quarterly basis to vali-
24 date progress in improving efficiency and effectiveness in
25 identifying and preventing waste, fraud and abuse. Upon

1 or during the rollout period, redundant integrity or over-
2 sight entities will be evaluated to determine whether they
3 can be eliminated in order to further reduce healthcare
4 costs related to Medicare.

5 (m) PILOT ASSESSMENT REPORT.—

6 (1) IN GENERAL.—Not later than 3 months
7 after the completion of the 12-month pilot program
8 under subsection (a), the Secretary of Health and
9 Human Services shall submit to the Congress a re-
10 port on the implementation of such program.

11 (2) CONTENTS.—The report shall contain—

12 (A) a detailed business analysis including
13 waste, fraud, and abuse prevented under the
14 previous fraud management strategy, compared
15 to the prevention system under subsection (a);

16 (B) the costs of operating the prevention
17 system, compared to the cost of the previous
18 fraud management strategy;

19 (C) a overall return on investment analysis
20 for the prevention system; and

21 (D) if the pilot program is successful—

22 (i) a cost-benefit analysis of rolling-
23 out the prevention system over a 3 to 4
24 year period; and

1 (ii) a detailed rollout plan with key
2 milestones, dates, and budgeted costs.

3 (n) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2011 and 2012.

