Health Care Enforcement Defense Alert

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The Government Announces Predictive Modeling Technology for Medicare To Go Live on July 1, 2011

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Health care providers have known for some time that the government intended to adopt a predictive modeling data analysis system to supplement its Medicare fraud-fighting efforts.[1] And on Friday, June 17th, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) announced that through a competitive bidding process, Northrop Grumman had been selected to develop and implement CMS's national predictive modeling technology format for Medicare data, utilizing the best practices of both public and private stakeholders.

CMS plans to begin using the technology on July 1, 2011. Northrup Grumman will partner with two other government information systems analysis contractors—National Government Services and Federal Network Systems, LLC—to analyze CMS claims by beneficiary, provider, service origin, and/or other identifying information. The technology is based upon that used by credit card companies to identify fraudulent practices early. By identifying what appear to be aberrant billing and claims patterns, these contractors will assign "risk scores" to questionable claims and potentially stop reimbursements from being issued to the providers that submitted them. Through an as-of-yet unspecified process, CMS plans to use this information to determine which claims merit further investigation or enforcement action. "CMS has worked with public and private stakeholders throughout the process of developing this program, and the key insight they shared on their successes and innovations have helped ensure it will significantly help us address fraud in the Medicare program," said Peter Budetti, M.D, J.D., director of CMS's Center for Program Integrity (CPI).[2]

The announcement of the implementation of predictive modeling coincided with the Sixth Regional Health Care Fraud Prevention Summit held in Philadelphia, Pennsylvania, on June 17th (Summit). At that meeting, U.S. Attorney General Eric Holder and HHS Secretary Kathleen Sebelius highlighted the success of private-public partnerships in investigating and prosecuting health care fraud, including the conviction of a chiropractor who attempted to bill nearly two million dollars to a private insurer for treatments he never performed.[3] In his remarks at the Summit, Attorney General Holder stressed the importance of the government obtaining input and guidance from the private sector to enhance the government's continued anti-fraud efforts in health care.[4]

However, the Attorney General's comments fell short of what some in the private sector seek: a true government/private sector health care fraud-fighting partnership. In testimony earlier this year before the Oversight Subcommittee of the House Committee on Ways and Means, Louis Saccoccio, the Executive Director of the National Healthcare Anti-Fraud Association, called on government investigators to fully share investigative information with the private sector to enhance health care fraud investigations.[5] Noting that some government agents and agencies have a "misapprehension"

about sharing investigative information, Saccoccio encouraged the creation of government guidelines for sharing health care fraud investigative information with the private sector.

But in his prepared remarks, Attorney General Holder steered clear of any mention of the government sharing investigative information with the private sector. And the day before the Philadelphia Summit, in a speech before a lunchtime audience at the American Bar Association's Physician-Legal Issues Conference, Lewis Morris, Chief Counsel to the Inspector General of HHS, acknowledged that government agencies have not effectively facilitated partnerships between the private and public sector to combat health care fraud, but noted existing legal prohibitions complicate the issue.[6]

So as of now, the government/private sector "partnership" is largely a one-way street. Relying on technology developed in the private sector, and using private sector contractors, HHS and the Department of Justice hope to accelerate government health care fraud investigations and prosecution through early detection of fraudulent trends to identify government investigation and prosecution targets. But *qui tam* seals, HIPAA prohibitions on dissemination of protected health information, state and federal legal limits on sharing pre-indictment criminal investigative information, and state/federal grand jury secrecy laws will continue to limit the government's ability to share with private payors the information developed in the course of those government investigations.

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Endnotes

1 Mintz Levin Health Care Enforcement Defense Alert, DOJ and HHS Announce Efforts to Obtain Proactive Data Mining Tools to Supplement Anti-Fraud Efforts, 12/17/2010.

2 Press Release, HHS Centers for Medicare & Medicaid Services, New Technology to Help Fight Medicare Fraud, (June 17, 2011), available at: http://www.cms.gov/apps/media/press/release.asp?Counter=3983.

3 Press Release, Departments of Justice, Health and Human Services Highlight Joint Efforts to Combat Health Care Fraud in Philadelphia, (June 17, 2011), available at: http://www.hhs.gov/news/press/2011pres/06/20110617a.html.

4 Eric Holder, Attorney General Eric Holder Speaks at the Health Care Fraud Summit in Philadelphia, (June 17, 2011), available at: http://www.justice.gov/iso/opa/ag/speeches/2011/ag-speech-110617.html.

5 Oversight Subcommittee Hearing on Improving Efforts to Combat Health Care Fraud, Waste, and Abuse: Hearing Before the H. Committee on Ways and Means, 112th Cong. (March 2, 2011) (statement of Louis Saccoccio, available at: http://waysandmeans.house.gov/UploadedFiles/Socc.pdf.

6 Press Release, Fraud and Abuse: HHS, Justice Department to Kick Off Anti-Fraud Initiative with Private Insurers, BNA Health Care Daily Report (June 16, 2011).

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