



ELECTRONIC SUBMISSION VIA BWebb@naic.org

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Dean L. Cameron, Chair
NAIC Medical Loss Ratio Quality Improvement Activities (B) Subgroup
Director, Idaho Department of Insurance

Brian Webb
NAIC
Manager, Health Policy & Legislation
Regulatory Framework (B) Task Force
444 North Capitol Street NW
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Washington, DC 20001

Re: NHCAA's Comments on Medical Loss Ratio Quality Improvement Activities in response to an invitation to comment by the NAIC Medical Loss Ratio Quality Improvement Activities (B) Subgroup

Dear Director Cameron:

The National Health Care Anti-Fraud Association (NHCAA) has reviewed the recent work of the NAIC Medical Loss Ratio Quality Improvement Activities (B) Subgroup, including its request for comments from regulators and interested parties. NHCAA very much appreciates the opportunity to comment.

Established in 1985, NHCAA 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 85 of the nation's most prominent health insurance plans as well as those federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud.

NHCAA's mission is 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 public program.

We understand that the charge given to the Subgroup by the Health Insurance and Managed Care (B) Committee is to review new quality improvement (QI) initiatives, as reported annually on the Supplemental Health Care Exhibit (SHCE) Allocation Report, and to make recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) on certifying for inclusion or exclusion activities in the QI expense category of the SHCE.

Health insurers typically employ myriad quality improvement (QI) activities, many of which can be accounted for within the five QI categories currently defined by statute and regulation:

- QI activities that improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- QI activities that prevent hospital readmissions;
- QI activities that improve patient safety and reduce medical errors, lower infection and mortality rates;
- QI activities that increase wellness and promote health activities; or
- QI activities that enhance the use of health care data to improve quality, transparency, and outcomes.

Upon enactment of Patient Protection & Affordable Care Act in March 2010 and throughout the subsequent rulemaking process, NHCAA has consistently argued that resources devoted to fighting fraud—including fraud detection, investigation, prevention and recovery efforts—are unequivocally activities that improve health care quality and, for that reason, anti-fraud investments should be given proper consideration on the quality side of the MLR equation.

Despite NHCAA's position, the final rule that became effective January 3, 2012, expressly excludes "fraud prevention activities" from the definition of "activities that improve health care quality." We do note that Section 158.140 of the MLR rule, which establishes the requirements around reimbursement for clinical services provided to enrollees, does offer a limited acknowledgment of the role of anti-fraud efforts. The section states that the amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses, must be included in incurred claims. So while recoveries (not to

exceed expenses) are included in the incurred claims calculation, they are not considered to be activities that improve health care quality.

NHCAA continues to believe that insurer activities devoted to anti-fraud efforts—regardless of whether they are categorized as recoveries, savings or prevention—are activities that improve health care quality. We ask that the Subgroup reconsider how anti-fraud investments are calculated for MLR by allowing them to be classified as quality improving activities, at least to some extent.

Please consider the following examples that illustrate the direct correlation between the insidious problem of health care fraud and risks to patient safety and health care quality:

- Anti-fraud efforts identify and prevent unnecessary and potentially harmful medical care and procedures. The perpetrators of some types of health care fraud schemes deliberately and callously place trusting patients at significant risk of injury or even death. While distressing to imagine, there have been numerous documented cases where patients have been subjected to unnecessary or dangerous medical procedures simply because of greed. Patients may also unknowingly receive unapproved or experimental procedures or devices. Look to the case of Farid Fata, MD, a leading hematologist-oncologist in Michigan, who deliberately misdiagnosed and maliciously mistreated hundreds of his patients for conditions they did not have to maximize billing to Medicare and private insurance companies. He was sentenced in July 2015 to 45 years in federal prison.
- Anti-fraud efforts protect, maintain and ensure the accuracy of patient medical records. Some perpetrators of fraud exploit patients by entering into their medical records false diagnoses (medical conditions they do not have) or indications of more severe conditions than they actually do have. Unless and until these discoveries are made (often when circumstances are particularly challenging for a patient), these false or inflated diagnoses become part of the patient's documented medical history. With the advent of electronic medical records, ensuring accuracy has become even more important and challenging.
- Anti-fraud efforts identify systemic patterns where necessary care is billed, but not received by the patient. This fraud scheme can happen in any situation, but it is particularly prevalent among our

nation’s vulnerable senior population. The withholding of medically necessary care can lead not only to patient harm, but death. Such was the case where a chain of nursing homes withheld basic quality of care items from patients while billing Medicaid for items and services never provided.

- Anti-fraud efforts identify dangerous prescription drug abuse by patients and overprescribing by some physicians. Prescription drug abuse is a growing problem. Addicts will go “doctor shopping” in order to get multiple prescriptions from several physicians and will then fill them at different pharmacies. Often, it is the insurer that is best able to connect the dots and identify potentially fatal overprescribing by physicians and the resulting prescription drug abuse by patients. Please read NHCAA testimony on the problem of prescription drug fraud, including drug abuse, before the Senate Committee on Homeland Security & Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services & International Security in October 2011. <http://www.hsgac.senate.gov/subcommittees/federal-financial-management/hearings/costs-of-prescription-drug-abuse-in-the-medicare-part-d-program>
- Anti-fraud efforts identify pharmacy fraud. When a patient fills a needed prescription but receives a drug that is diluted, a lesser amount than prescribed, or altogether counterfeit, it can most certainly affect the health of the patient. Consider the case of Robert R. Courtney, a pharmacist who callously diluted chemotherapy drugs destined for very ill cancer patients.
- Anti-fraud efforts help identify and prevent medical identity theft. Using a person’s name or other identifying information without that person’s knowledge or consent to obtain medical services, or to submit false insurance claims for payment, constitutes medical identity theft. It can result in erroneous information being added to a person’s medical record or the creation of a fictitious medical record in the victim’s name. Victims of medical identity theft may receive the wrong (and potentially harmful) medical treatment, find that their health insurance benefits have been exhausted, and could become uninsurable for life insurance coverage. Untangling the web of deceit spun by perpetrators of medical identity theft can be a grueling and stressful endeavor and the effects of this crime can plague a victim’s medical and financial status for years to come. Last August, *Wall Street Journal* reporter Stephanie Armour authored an insightful article that illustrates the depth of this problem: <http://www.wsj.com/articles/how-identity-theft-sticks-you-with-hospital-bills-1438966007>

- Anti-fraud efforts identify unqualified or unlicensed providers of medical care. Being treated by a provider who is unqualified or unlicensed is a dangerous proposition with potentially serious results. Consider the 2015 case of Robert Moyer, owner of Mobile Medical Resources, who knowingly allowed an unlicensed individual to administer x-rays to trusting patients.

Often, health care fraud cases will involve an amalgamation of the examples listed above. Take for instance, the case of Jose Katz, MD a New Jersey cardiologist sentenced to 6½ years after fraudulently diagnosing patients with conditions, ordering unnecessary tests and procedures, and knowingly allowing medical services to be rendered by unlicensed practitioners.

In recent years, the Department of Health and Human Services has aggressively shifted from a “pay and chase” model of fraud-fighting to one focused on prevention, prioritizing efforts such as implementing predictive analytics technologies and launching the Healthcare Fraud Prevention Partnership (HFPP). The categorization of anti-fraud activities undertaken by private insurers as simple “cost containment” is out of step with the way health care fraud is viewed in our nation’s public health care programs.

Consistent with the priority now given to fraud in the federal health care programs, private health plans should be given every incentive to invest in the technology and manpower necessary to fight fraud. However, because fraud prevention activities are specifically prohibited from being included as quality improving activities in the MLR rule, it can serve to deter private insurers from investing in the innovative tools necessary to effectively wage the battle against health care fraud through prevention. Preventing fraud can mean that bad care that would have otherwise been delivered is avoided. Fraud prevention supports health care quality and protects patients from harm.

The anti-fraud efforts of the private sector are vital to restricting the scope of health care fraud schemes, protecting patient safety and preventing more people from becoming victims. Private insurance plans staff teams of experienced, accredited investigators who can recognize anomalous health care claims and ferret out dishonest providers. In many cases, private plans have been instrumental in alerting law enforcement to suspicious activities, leading to the shutdown of several large-scale fraud operations. It requires cooperative

and concentrated efforts between the public and private sectors to most effectively root out health care fraud and protect Americans' health care quality.

We note that on June 1, 2015, CMS published a long-awaited proposed rule relating to Medicaid managed care and the Children's Health Insurance Program (CHIP). This rule would establish standards for calculating and reporting Medical Loss Ratio (MLR) under Medicaid managed care, with a federal minimum MLR of 85 percent. (States would have the discretion to establish a higher MLR.) The proposed rule appears to generally follow similar standards currently in place for calculating MLR for private plans, with some adjustments based upon the unique aspects of delivering services through Medicaid managed care.

The proposed rule states that CMS wants to encourage Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) to "build and sustain a program integrity infrastructure that has strong prevention activities as well as robust processes for the detection, referral and recovery of improper payments, including potential fraud, waste and abuse."

Consistent with this goal, the proposed rule includes expenditures by Medicaid plans for fraud prevention in the numerator of the MLR calculation, although limited to .5 percent of a Medicaid plan's premium revenues. So, while anti-fraud activities continue to be excluded from the category of "activities that improve health care quality," NHCAA supports the decision to acknowledge the importance of fraud prevention by permitting it to be included as part of the MLR numerator. We also appreciate CMS's discussion of the parameters of what constitutes prevention-related expenditures and the emphasis given to the use of advanced anti-fraud technologies such as data analytics and the application of predictive or other sophisticated algorithms.

The MLR rule currently in place for private insurers serves as a disincentive to plans from investing in cutting-edge solutions such as predictive modeling and data analytics. As the only national organization focused exclusively on the fight against health care fraud, NHCAA encourages the Subgroup to consider the important and quality-affirming anti-fraud efforts implemented every day by health insurers and re-categorize those investments as "activities that improve health care quality." Short of that, we ask the Subgroup to examine if a similar methodology proposed by CMS for Medicaid managed care plans could be applied to the MLR rule currently in place for private health insurers and Medicare Advantage plans.

In summary, NHCAA believes that health care fraud clearly has an adverse impact on patient safety and health care quality, and encourages the Subgroup and the NAIC to reconsider its classification of anti-fraud activities. Our experience has taught us that while fighting fraud is most often described in economic terms, the most significant impact is felt in human terms. Health care fraud often causes patient harm, sometimes with devastating results. Thank you for allowing NHCAA the opportunity to comment on this important work. If we can be of additional assistance, please let us know.

Sincerely,



Louis Saccoccio
Chief Executive Officer