PAYMENT INTEGRITY

Disability Payment Integrity: Advancing Solutions Through Partnership— Highlights of Roundtables

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MITRE

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Executive Summary

In 1990, fewer than 2.5 percent of working-age Americans received disability benefits, but today, that number has grown to over 5 percent—representing more than 14 million people. Various federal agencies and insurance companies, as well as some states, provide direct disability benefits to individuals, payments to providers for disability-related medical treatments, and more. While the total dollar figure for all disability-related payments each year is not known, some perspective can be gained from the Social Security Administration's (SSA) programs; for example, in the month of November 2017 the Disability Insurance program alone paid $10.83 billion to almost 10.43 million individuals. Where large sums of money are involved, fraud is almost always nearby; the SSA Office of Inspector General (OIG) reported in 2013 that disability-related fraud investigations comprised 70 percent of their caseload, but by 2015 this had grown to 86 percent.

The MITRE Corporation (MITRE), a private, not-for-profit, public interest organization that operates federally funded research and development centers (FFRDCs) on behalf of federal government sponsors, convened two Roundtables on Disability Payment Integrity[1] in conjunction with its charter to help address significant government-wide problems. The first Roundtable was comprised of experts from 11 government and law enforcement agencies, insurance companies, and professional associations, and the second of experts from the Government Accountability Office (GAO) and the OIGs from seven federal agencies.

Participants at the Roundtables raised significant issues that demonstrated the challenges of Disability Payment Integrity. They generally agreed that while the exact extent of the Payment Integrity problem is unknown, it is significant enough to deserve focused attention. Participants discussed the types of challenges their organizations face in this area, including aspects of fraud, errors, and inconsistencies in processes; these included, for example, a former employee of one agency who was dropped from that agency's disability rolls as ineligible, but who then transferred to another agency and was approved for disability benefits for the same condition, and prison inmates who have been applying for disability benefits. Participants discussed challenges with data sharing and analytics, particularly getting the right data to analyze, having staff with the necessary data analytics skillsets, and developing predictive capabilities. They addressed the lack of adequate funding for Payment Integrity initiatives, as well as cultural issues such as agencies' strong motivation to pay benefits and some beneficiaries' view that disability is a "pre-retirement" program or a means of obtaining healthcare. The special impact of compounded prescription drugs was also discussed.

Participants identified approaches that could help combat disability fraud and errors. First and foremost was a greater ability to exchange data within and among organizations, balanced with appropriate consideration for privacy and legal issues. Data analytics, including horizontal analysis and predictive modeling, would highlight possible problem areas much sooner and more quickly than is often done at present. Specific actions can be taken to strengthen organizations' Payment Integrity cultures, such as training employees to proactively look for Payment Integrity issues. Fraud deterrence approaches, such as risk

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[1] Payment Integrity refers to fraud and other improper payments and the people, processes, and technology that are meant to ensure that the payments are actually proper.

assessment and the use of peer pressure, were identified, and Public-Private Partnerships (PPP), which offer a proven approach to enhancing Payment Integrity through collaboration, were discussed.

Overall, participants at both Roundtables converged around the idea that greater collaboration to address the challenges is needed and would be highly beneficial. This is never more apparent than in the biggest challenge and solution areas discussed at the Roundtables—data sharing and analytics, which point to the value of a PPP supported by an Information Sharing and Analysis Center (ISAC). This construct would provide a cost-effective approach to facilitate collaboration, communication, and the analysis and sharing of information and data.

Acknowledgments

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- Center for Enterprise Modernization sponsored by the Department of the Treasury and co-sponsored by the Department of Veterans Affairs,

- CMS Alliance to Modernize Healthcare sponsored by the Centers for Medicare & Medicaid Services,

- The Homeland Security Systems Engineering and Development Institute sponsored by the Department of Homeland Security,

- Judiciary Engineering and Modernization Center sponsored by the Administrative Office of the U.S. Courts, and

- National Cybersecurity Federally Funded Research and Development Center sponsored by the National Institute of Standards and Technology.

MITRE also maintains a broad, independent research program, designed to explore emerging issues and potential solutions to benefit our government sponsors, industry and the public.

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1 Disability Concerns Across the Public and Private Sectors

Federal agencies estimate that they made more than $144 billion in improper payments in fiscal year (FY) 2016. This dollar figure represents nearly 4.7 percent of all payments that year, and is for only about 115 of the hundreds of federal programs. Considerable efforts are already in place at the Office of Management and Budget (OMB) and across federal agencies to identify, report and mitigate improper payments. However, the level of improper payments has nearly tripled over the last decade, exceeds $1.2 trillion since FY 2003, is unaffordable, and contributes to public concerns about the effectiveness of the government's stewardship over taxpayer dollars.

In 1990, fewer than 2.5 percent of working-age Americans received disability benefits. Even with advances in medicine, within 25 years that number has grown to over 5 percent—representing more than 14 million people. The federal government offers a variety of disability programs to veterans, federal employees, and others who meet certain qualifications. Various federal agencies provide direct disability benefits to individuals, payments to providers for disability-related medical treatments, and more. These and related federal programs had total outlays in FY 2016 of nearly $1.0 trillion (not all of which was disability-related), and improper payments of nearly $80 billion (again, not all disability-related). Further, insurance companies and some states also provide disability benefits to individuals.

The total dollar figure for all disability-related payments each year is not known. But some perspective can be gained from SSA's programs. According to the most recent publicly available information from SSA, in the month of November 2017 the Disability Insurance program paid $10.83 billion to almost 10.43 million individuals. Nearly 13.9 million individuals received Social Security, Supplemental Security Income (SSI), or both because they were disabled and under age 65; Social Security benefits can average more than $1,300 per month, and SSI benefits nearly $600 per month.

Fraud is a growing concern, as shown in Figure 1. The SSA OIG reported in 2013 that disability-related fraud investigations comprised 70 percent of their caseload; in 2015, this grew to 86 percent. The SSA OIG reported that its fraud unit saved $416 million of the $89 billion in payments made in 2015.

An Egregious Example:

Major Social Security Disability Fraud Scheme

An indictment issued in January 2017 charged 106 people with the then-largest fraud against the Social Security disability system going back to 1988. As many as 1,000 people are believed to have defrauded the disability system of some $400 million. Ringleaders included a 91-year-old consultant, a recruiter, two doctors, and a lawyer who had worked with the Drug Enforcement Agency. The lawyer worked with the consultant who completed the disability applications, and the ringleaders collected cash fees of $28,000 from each recipient's first SSA check. Of the 106 indicted, 72 were former New York City police officers and firefighters who blamed the terrorist attacks of September 11, 2001, for serious mental health disorders. Other police officers and corrections officers were also charged.

An applicant for disability benefits is required to describe his or her ability to conduct the activities of daily living. The ability to leave one's house, drive, shop, etc., helps gauge one's capacity to hold a job. Applicants said they could not sleep at night and had flashbacks and other troubling symptoms such as irritability, argumentativeness, and depression. It appeared, however, that the accused lived active lives which they documented on social media, and in many cases, were gainfully employed in various trades and enjoyed an active lifestyle, including martial arts, fishing, motorcycling, and flying a helicopter.

One of the former police officers who led the scheme coached applicants in how they should dress and act when they appeared before SSA examiners and psychiatrists; they were also coached on the symptoms of post-traumatic stress disorder and depression. Ringleaders referred the defendants to one of two psychiatrists, who would help them build a false record of mental problems over a year's period before applying for disability. Applicants were told, "All you need to do is go to a particular doctor. You're playing a game and will win the lottery." The lawyer then completed the defendants' applications using the same reasoning—even the same words or phrases—for each. The ringleaders were very attuned to what SSA requires and offered the right "evidence" to SSA doctors. As a result, these applications were 99 percent successful, when the normal success rate is 40 to 60 percent.

The fraud scheme began to unravel when a former New York City policeman filing for retirement asked to keep his police-issued weapon. To do so, he was required to complete a form stating that he was not under psychiatric care. At the same time, he was drawing Social Security Disability payments for depression. Investigators then found two retired police officers had permits to keep their department-issued weapons, yet were receiving SSA payments for a mental disability. That led to review of other applications handled by the same attorney and an extensive investigation. After 120 guilty pleas, including two criminal trials, approximately $24 million in restitution was recovered.

Figure 1. Major Social Security Disability Fraud Scheme[2]

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[2] Source: September 21 Disability Payment Integrity Roundtable keynote presentation by Christopher Santora, Assistant Chief Counsel, U.S. Immigration and Customs Enforcement, Department of Homeland Security, and formerly Assistant District Attorney for the Rackets Bureau in New York City, where he was the lead prosecutor in this case; and "Charges for 106 in Huge Fraud Over Disability," William K. Rashbaum and James C. McKinley, Jr., The New York Times, January 7, 2014.

As existing government initiatives work to identify fraudsters in healthcare entitlement programs, organized criminal enterprises have branched out into other entitlement programs, leading to the prosecution of several large disability fraud rings in recent years. Like healthcare, there are many public and private sector benefit payors, and the criminal element benefits from a lack of communication across payor organizations. Some of these organizations participate in cooperative efforts through associations like the Coalition Against Insurance Fraud, the National Insurance Crime Bureau, and the National Health Care Anti-fraud Association, or through government initiatives like the Cooperative Disability Investigations Program. However, there is no one umbrella entity that serves as a resource and conduit for information, ideas, and innovation to enhance cross-domain Payment Integrity efforts.

MITRE, a private, not-for-profit, public interest organization that operates FFRDCs on behalf of federal government sponsors, convened two Roundtables on Disability Payment Integrity in conjunction with its charter to help address significant government-wide problems. To advance the dialogue on Disability Payment Integrity, on September 21, 2017, MITRE moderated a diverse Roundtable of 20 experts from 11 government and law enforcement agencies, insurance companies, and professional associations. MITRE identified individuals with a variety of perspectives and specific knowledge of the Disability Payment Integrity issue. This was followed by a similar Roundtable of 13 experts from GAO and 7 OIGs on December 7, 2017. Participants at the Roundtables are shown in Appendix A and Appendix B.

This paper summarizes the discussion at both Roundtables, highlighting key issues and ideas that participants raised. Information provided by agency and law enforcement officials is designated as "government" or "agency;" by insurance organizations as "industry;" and by GAO and the OIGs as "accountability." Unless otherwise noted, the information presented does not necessarily represent the views of all participants, their organizations, or MITRE.

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2 Disability Payment Integrity Challenges

Participants in the Roundtables raised significant issues that demonstrated the complexity and difficulty of Disability Payment Integrity. They discussed the extent of the problem; the types of challenges their organizations face in this area, including aspects of fraud, errors, and inconsistencies in processes; data sharing and analytics; funding and cultural issues; and the special impact of compounded prescription drugs.

2.1 Types of Problems Encountered in Disability Programs

Participants' views on two topics—"What is the overall Payment Integrity situation with disability?" and "In particular, does fraud seem to be growing, in a steady state, or declining?"—varied. According to one industry representative, approximately 30 percent of their company's disability claims contain an element of fraud. On the other hand, another industry participant indicated that they believe 1 percent of their company's entire portfolio is lost through fraud, waste and abuse (FWA).

Accountability participants generally agreed that the size of the problem is unknown but is significant enough that it deserves focused attention. One accountability representative said that while there has been some improvement in recent years, their agency still makes approximately $1 billion in disability-related improper payments annually.

Government representatives commented that some citizens "triple dip" in disability funds, and that cases involving two types of funds, in particular—SSA's Disability Insurance and the Department of Labor's (DOL) workers' compensation—can be very complex. Another participant offered that many application systems are very claimant friendly without incorporating corresponding due diligence regarding Payment Integrity.

Accountability participants shared some examples of problems they have seen.

- A former employee of one agency—dropped from that agency's disability rolls as ineligible—who transferred to another agency and was approved for disability benefits for the same condition

- Prison inmates who have been identified applying for disability benefits

- Medical providers who might be defrauding multiple programs/agencies

- Agency program application instructions that are voluminous and confusing for individuals applying for benefits

- Largely trust-based healthcare claims—i.e., all that is required for a "provider" to receive Medicare reimbursements is a National Provider Identifier and a Tax Identification Number, so fraud can be relatively easy to perpetrate

- Beneficiaries who are not permitted to earn more than a certain dollar figure from working if they are to continue to be eligible for disability, but for whom it is very difficult for agencies to determine how much the beneficiaries do, in fact, earn

- New categories of diagnostic codes, such as sleep apnea and depression, that have led to lower and more subjective standards for receiving disability
- Lack of uniformity among Administrative Law Judges in rulings pertaining to the same diagnosis

One accountability participant said their agency faces a challenge in that it must use a manual process to calculate how much a beneficiary earns for work activity, as opposed to how much the individual receives for sick pay or worker's compensation (which do not count in the aggregate against the salary threshold). It can take time to collect pay stubs and/or contact every employer for details related to earnings, and it can be difficult to obtain cooperation from all employers, especially small businesses, to timely secure the needed information. The agency then matches the threshold for earnings against disability rolls to identify anyone earning more than the threshold amount who is receiving benefits.

A MITRE participant mentioned an eastern Kentucky disability lawyer who hired a doctor and a psychologist and bribed a judge in a $600 million Social Security fraud scheme, observing that the bigger cases like this one usually involve a corrupt doctor and/or attorney, just as the New York City case did (see Figure 1). A government representative noted that agencies may lack the technical sophistication to spot the problems in a broad or highly complex scheme, such as those in eastern Kentucky or New York.

2.2 Data Sharing and Analytics

Sharing data and performing robust data analytics were areas of extensive discussion. Accountability participants echoed what agencies and experts in the field have often said—challenges include getting the right data to analyze, having staff with the necessary data analytics skillsets, and developing predictive capabilities to identify the next problem that will need to be addressed.

One industry representative noted that information on disability fraud is not as readily available as information on healthcare or property and casualty fraud. A government participant commented that agencies' information is often very siloed, and restrictions on data sharing limit the ability to perform analytics. As a result, a good grasp of the "big picture" extent of the problem, as well as identification of individual problem situations, is elusive. In one case, an industry representative commented that some providers committing healthcare fraud are also involved in fraudulent disability claims. As a result, it is important to look at the universe of providers, but this can be difficult without effective data sharing and analytics.

Accountability participants echoed these thoughts, indicating that data analytics are key to spotting both larger trends and individual problems. One individual said that data matching is critical, but various accountability representatives pointed out constraints, including the following:

- Many agencies must address their own goals and issues before they can address cross-agency concerns and needs with data sharing.

- DOL shares workers' compensation (Federal Employees Compensation Act) data with their agency, but does not necessarily want to share it with the OIG.

- Because a recipient of a certain kind of disability payment must reside in the United States, their office wanted to obtain data on passports from another agency to identify recipients who might be outside the country. Attempts to obtain the data directly from the other agency were not successful, so they partnered with that agency's OIG, which obtained the data and conducted the analytics. However, the analytic results provided statistical information but did not identify specific individuals, which did not prove helpful.

One accountability representative noted that even access to agency data within the agency itself can be difficult or impossible. Agencies must consider privacy and legal issues, even internally, and data sharing agreements or Memorandums of Understanding can take as long as a year to conclude and tend to be extensively detailed.

One accountability participant observed that disability fraud often does not occur with the initial filing of a claim. The first few years may be perfectly valid, i.e., the claimant is legitimately disabled. However, after prolonged medical treatment, the OIG begins to find some claimants, especially after 7 years or so, who are clearly no longer disabled but are committing fraud by still receiving disability benefits. Consequently, the data used for analytics should include a long history.

One accountability participant noted that a lot of agencies could benefit from access to the National Database of New Hires. This database contains data that could indicate whether a disability recipient is in fact active in the labor force. Also of interest is SSA's death master file. Another individual indicated it took their agency a year to negotiate an agreement to secure information on deceased federal workers, even though death information is not protected by privacy laws. The data was being requested for a one-time match against current disability claimants because in many cases, one agency may be notified of a claimant's death, but that information is not shared with other agencies that may continue paying benefits to that claimant.

Several accountability participants noted that their agencies' disability applications do not include the same data fields. For example, one agency's application does not include a field for physician name. This complicates data matching efforts to identify doctors who may be committing fraud against multiple agencies.

Finally, an accountability participant noted that agency program offices have limited staff, and it may take a staffer an extended time to review issues of concern on a questionable claim. More robust data analytics would help by enabling staff to address questions faster and use resources more efficiently, thus providing long-term cost savings.

2.3 Funding and Culture

Accountability participants raised funding as a challenge. Some agencies lack adequate funding for Payment Integrity efforts, perhaps being able to fund only a few very targeted activities. And even when funded one year, like most programs these can be subject to budget cuts the next year.

Cultural issues can also present challenges. Some accountability participants offered that agencies are motivated to (in fact, can have a very strong bias to) pay benefits over ensuring Payment Integrity, and in some cases, consider beneficiaries to be "victims." In one case, agency management overrode the results of an analysis that showed a deceased individual was receiving disability benefits. The agency continued to pay disability to the deceased for 5 years with no evidence the beneficiary was alive and no follow-up monitoring. A high-level agency official said that because the deceased had a medical appointment one January, he still must have been alive the following March (which was, in fact, the official date of death).

A government representative said that anti-fraud policies need to be robust enough to discourage fraud while at the same time allow agencies to fulfill their duty to provide timely benefits to claimants. This "balancing" extends to prosecutions—care is taken in determining which fraud cases to prosecute; they must have a certain value (e.g., dollar size, deterrent affect) to justify investing the effort. Further, caution is involved in that the media, which is often sensitive to such cases, could portray it as the government taking away a deserving person's benefits. One industry representative asked whether government agencies have remedies besides criminal prosecution, commenting that in private sector healthcare most apparent fraud issues are not resolved as criminal actions. Through prosecutions and other means, clear messaging to encourage public awareness is needed; one government representative commented that more courage should be displayed in exposing fraud to avoid sending mixed messages to the public. In the end, participants agreed that the right balance between enforcement and services to beneficiaries is required.

A government representative said that it is important to provide robust, enterprise-wide training to help all staff recognize improper payments, and staff need to be empowered to report suspected fraud. One government participant observed that feedback to staff would be helpful so that they know what became of their referrals to the OIG, but their agency's OIG does not provide such feedback. An accountability participant made the same point and emphasized that some auditors obtain information but do not share it with agency staff at the program level. This is a concern, because it is everyone's business to reduce fraud, as well as to publicly share good news stories. The lack of feedback and information from OIG staff does not create incentives for agency program staff to continue the effort of identifying potential fraud and developing referrals. Agency program staff need to know if

their referrals are worthwhile to the OIG, what results were obtained, etc., in order to be motivated to continue investing time and resources in developing referrals.

Finally, an accountability participant observed that external pressure from Congress can impact the agency. This agency's staff is often contacted by Congress inquiring about the payment of benefits for specific constituents, but never about potential fraud issues.

Cultural issues can also be present in the beneficiary community. One accountability participant observed that some beneficiaries treat disability much like a "pre-retirement" program or as a means of obtaining healthcare (i.e., for those without healthcare coverage, disability qualifies them for Medicaid or Medicare within 2 years). Another individual referred to this as "medicalized early retirement," or free money. A participant noted that in one of the military services, it is routine for senior staff to encourage departing service members to file for disability before leaving, as if disability is presumed to be a right instead of a benefit based on need. Several agencies experience this attitude among claimants, some of whom believe they are "owed" a disability benefit.

2.4 Prescription Drugs

Prescription drugs, especially compounded opioids, for workers' compensation recipients is a risk area. One agency's annual workers' compensation prescription drug-related payments went from $5 million to more than $178 million in a 5-year period. The OIG was concerned that this was an indicator of fraud that could have been detected sooner by data analytics. A simple change—requiring a declaration of medical necessity for drugs—led to a steep decline in prescription drug payments, to approximately $7 million annually now.

An accountability representative from another agency working in the prescription drug issue area indicated that agency management's unwillingness to acknowledge the problem was the biggest hurdle, along with the absence of large-scale data analytics to identify the problem. When the OIG requested a dataset for analysis, the agency gave the OIG some spreadsheets which contained only summary statistics and de-identified information. This individual observed that agencies may fear that audits might result if they present the OIG with compiled data that enables sophisticated analytics.

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3 Solutions for Consideration

Participants at the Roundtables identified possible approaches to help combat disability fraud and errors. They identified first and foremost the need for a greater ability to exchange data within and among organizations, balanced with appropriate consideration for privacy and legal issues. Data analytics, including horizontal analysis and predictive modeling, would highlight possible problem areas much sooner and more quickly than is often done at present. Specific cultural actions and fraud deterrence approaches were discussed, as were PPPs, which offer a proven approach to enhancing Payment Integrity.

3.1 Data Sharing and Analytics Solutions

Government and industry representatives generally agreed on the importance of harnessing data across agencies. A cost is associated with such sharing, but the general belief was that it will produce a positive return on investment. Participants agreed that cross-agency data sharing efforts should be encouraged, especially SSA data sharing. In fact, one agency representative said that a cooperative data sharing program existed at one time among the Internal Revenue Service (IRS), Department of Veterans Affairs, and SSA. Some accountability representatives said that they have recommended greater data sharing and matching among agencies.

Accountability participants agreed that the Inspector General Empowerment Act of 2016, which amended the Inspector General Act of 1978 to allow OIGs to do more computer data matching, will be very helpful. Other data sharing solution ideas were the following.

- Inter-agency relationships are important.

- It is also important for attorneys involved in the process to "speak the same language."

- Chief Information Officers will want to ensure that shared data is safeguarded in line with agency security protocols.

- A partnership could be structured like the National Insurance Crime Bureau, which helps insurers share data and information.

An industry representative pointed out that care must be exercised when sharing information, even within the company, and that leading data management practices should be used.

To help strengthen data analytics, one accountability participant emphasized the importance of robust training for analysts. This includes a focus on case information that must be reviewed and understood to facilitate the analytics. Collaboration among investigators, auditors, and data scientists in a small-cell analysis approach is also important, and it is critical to have the right people on the team.

Various participants offered ideas for the use of data analytics in monitoring for fraud.

- One industry organization uses an alert system to monitor claims; outliers, such as an excessively high level of drugs prescribed, are identified. This company then sponsors educational and outreach campaigns based on the monitoring results.

- A MITRE representative, who earlier in her career led anti-fraud efforts at a large private sector insurer, noted that she reviewed all outliers for that organization. One successful analytic approach used was a velocity analytic check, which revealed whether an outlier physician certified disability beneficiaries at a much higher rate than other physicians did. Another approach was comparing U.S. Postal Service information to provider addresses to identify potentially bogus providers.

- One government agency uses predictive modeling in its fraud alert monitoring.

- A government representative suggested checking the length of time an individual is logged into an online application system, along with how many claims are submitted during that period of time.

- Another government participant recommended watching the number of times a claimant changes address or direct deposit information, as the person could be redirecting payments from numerous claims.

- An agency representative indicated that it is worth reviewing the length of time individuals receive disability payments without undergoing renewal reviews. However, they often do not have resources to conduct such periodic reviews, so the claimants may continue to receive benefits while no longer disabled.

- An industry representative recommended researching social media as a part of monitoring claims. A MITRE representative indicated that in one case, social media postings mentioned that one doctor was a "great guy to go to for narcotics." Another MITRE representative mentioned prior research into social media monitoring that showed it is possible to monitor chatter for indicators of geographic areas where fraud might be occurring, or types of providers that might be actively perpetrating fraud. Once a potential problem is identified, an outreach campaign could be conducted.

Accountability participants addressed aspects of joint work—within the OIG and between the OIG and the agency. For example, auditors and investigators need to access information from a central place for data analytics; analysts, data scientists, auditors, and investigators are often siloed but much could be accomplished if they worked more closely together. One participant discussed cooperative anti-fraud efforts between agency program officials and the OIG, citing a proactive, preventive nationwide program that investigates whether identified beneficiaries should continue receiving disability.

3.2 Cultural Actions

A government participant commented that most whistle-blowers in the public and private sectors are disgruntled spouses, partners, or neighbors, so it is important to have avenues for these individuals to provide information. Another agency representative mentioned the importance of training employees to proactively look for Payment Integrity issues and ensure accuracy in claims handling. An industry representative noted that some insurers hold employee seminars to discuss fraud indicators.

3.3 Fraud Deterrence Actions

Participants identified specific fraud deterrence actions that are being, or could be, taken to improve Payment Integrity.

- One industry representative observed that risk assessment is essential for understanding vulnerabilities and identifying needed mitigation actions. An accountability participant emphasized using GAO's fraud risk framework[3] to help agencies identify key fraud risks. The framework helps managers combat fraud and preserve integrity in government agencies and programs by presenting leading practices for managing fraud risks, organized into a conceptual framework. Further, it encompasses control activities to prevent, detect, and respond to fraud, as well as structures and environmental factors that influence or help managers mitigate fraud risks.

- An industry representative said it is now more common to thoroughly examine potential business clients during the underwriting phase of insuring them. Companies are performing greater due diligence—asking who they are dealing with and what they are getting into—and more aggressively verifying eligibility.

- At one company, a second disability claim prompts a letter to the claimant pointing out that they have more claims than most people. Related to this approach, a MITRE representative noted a study in which the United Kingdom tax authority sent letters to certain citizens asking if they realized they were not compliant with the law, although a substantial percentage (e.g., 98 percent) of their neighbors were compliant. These "peer pressure" letters produced positive compliance results.

- An accountability participant said language used in forms must be strengthened. A MITRE representative mentioned MITRE's September 2017 study report[4] addressing Payment Integrity motivators that cited research showing it is more effective to place the "tell the truth" warning box at the beginning of a form rather than at the end. One individual noted that application certifications are often submitted by attorneys, with no signature even required.

- Legal actions can also serve as deterrents. An industry representative said that by law, the private sector can build a civil case and refer it to state agencies. Another

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[3] A Framework for Managing Fraud Risks in Federal Programs (GAO-15-593SP, July 2015).
[4] Payment Integrity: What Motivates Entities Making Payments and Claimants to Optimize Ongoing Payment Integrity Efforts? (17-3400, September 2017).

industry person added that a criminal investigation is undertaken if a case is to go to court, but that it is rare to recover any money in a fraud case so most companies do not pursue any amount less than $30,000 in court.

3.4 Private Sector Approaches

Industry representatives were asked "How does private industry, specifically, address the challenges?" Government and industry participants observed that private sector insurers can change their policies instantly. A MITRE participant echoed this thought, noting that private insurers can take quick actions to facilitate Payment Integrity. For example, when one major private healthcare insurer became aware of significant fraud involving compounded prescription drugs, the firm was able to stop it quickly by immediately creating stronger medical policies, placing the providers on pre-pay claim review, and terminating providers from contracting with the insurer if they refused to change their abusive billing behavior.

The MITRE participant also said that private industry does not underwrite groups if there is any suspicion of wrongdoing, and that insurance firms are aggressive in pursuing FWA. This individual observed that persons perpetrating large dollar disability conspiracies target agencies with the large dollar programs.

3.5 Collaboration Between the Public and Private Sectors: Public-Private Partnerships

A MITRE representative discussed PPPs, which offer a proven approach to successfully facilitating collaboration among numerous, diverse parties to achieve a common mission. PPPs are a long-term (years or even decades), chartered collaboration among two or more government and commercial or nonprofit entities that produce mutual and public benefits through agreed governance, resourcing, and capabilities. Many historical government PPP successes are for public works such as toll roads, bridges, and tunnels, although in recent years there has been significant growth in PPPs with an information sharing or data-fusion focus. Figure 2 provides an overview of a highly successful information sharing PPP—the Healthcare Fraud Prevention Partnership (HFPP).

A PPP should be considered when facing a situation with limited resources and a large or complex scope. PPP value comes from sharing data and method insights, complementary capabilities, faster discovery, broader impact, and the sharing of risk and resourcing. Information-centric PPPs serve as a focal point for public and private entities to exchange insights and data to address national issues and to share information that is of greater value when it is fused across partners and/or disseminated in actionable ways to many partners. A PPP can be an appropriate vehicle for enhancing Payment Integrity through reduced FWA and more efficient shared services via broad collaboration and partnership.

> **HFPP: A Public-Private Partnership That Works**
>
> Public and private sector organizations have long recognized the importance of coordination and information-sharing to combat healthcare fraud. With that in mind, the HFPP was established as a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations, on the premise that PPPs, where data and information sharing are central pillars, yield significant value.
>
> The HFPP offers a forum that facilitates a proactive approach to improve the prevention and detection of healthcare fraud by:
>
> • Exchanging data and information among the public and private sector partners.
>
> • Leveraging analytic tools against data sets provided by the partners to deliver unique, aggregated fraud analyses.
>
> • Increasing detection of covert fraud schemes and identifying the perpetrators.
>
> • Providing a forum for public and private sector leaders and subject matter experts to share successful anti-fraud practices and effective methodologies, to identify emerging threats, and to design innovative new methods to combat them.
>
> Results from focused studies, which involve sharing data between partners, provide input for ongoing outreach, both internal and external to the HFPP. A Trusted Third Party (TTP)[5] enforces the security and de-identification of partner data; no partner—public or private—has access to the data of other partners.
>
> The current membership includes 9 federal agencies, 22 states, 48 private payors, and 12 associations. Since its inception in 2012, the HFPP has helped save more than $260 million and identify over 17,000 suspect providers.

Figure 2. Healthcare Fraud Prevention Partnership[6]

Part of the Roundtable with GAO and the OIGs involved a discussion of considerations in the formation of an information-centric PPP. Participants offered important observations in the following areas:

- Data sharing, especially tax information, information technology infrastructure, and data security;

- Data analytics; and

- Leadership to champion such an effort.

Additional details on PPPs may be found in 4Appendix C.

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[5] A TTP is the entity that engages in data collection and aggregation for studies and analytics conducted on behalf of the partnership, as well as disseminates the results of analyses related to such studies and analytics.
[6] Source: Healthcare Fraud Prevention Partnership website, and HFPP flyer dated June 10, 2016.

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4 MITRE Observations

Both innocent errors and deliberate fraud continue to drain many millions of dollars from the system. While there are variations among the disability and workers' compensation programs operated by federal agencies and private payors, there are also significant commonalities. Consequently, participants at both Roundtables converged around the idea that greater collaboration to address the challenges appears to be needed and highly beneficial.

This is never more apparent than in the biggest challenge and solution areas discussed at the Roundtables—data sharing and analytics. Both public and private sector entities can benefit greatly from data sharing, but challenges exist with the cost-effectiveness of one-on-one data sharing, data issues (e.g., the extract-transform-load [ETL] process, formatting, security), and restrictions posed by existing laws. Advanced predictive modeling and analytics are greatly needed, but having access to the right data, the availability of funding and the right staff skillsets, and other challenges exist. Comprehensive multi-organization studies and analytics would be of significant value, but these are difficult to organize and conduct without an overarching organizational framework.

All of these issues point to the value of a PPP supported by an ISAC. As discussed in Appendix C, this construct would:

- Use technology to collaborate and communicate

- Ingest, manage, prepare, analyze, and share information and data

- Incorporate a shared analytic environment to provide analysis and systems engineering and to facilitate information sharing and analysis among the PPP partners

- Address challenges with information technology infrastructure and data security

- Provide a collaborative forum to address other data issues such as format challenges

As has been demonstrated with the HFPP and numerous other PPPs, this construct offers a proven approach to enhancing Payment Integrity through collaboration.

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Appendix A   Participants—September 21, 2017 Roundtable for Agencies, Law Enforcement, and Insurance Organizations

- Department of Labor—multiple participants

- Department of Veterans Affairs—multiple participants

- Federal Bureau of Investigation, Department of Justice—one participant

- The Hartford—one participant

- MetLife Insurance—one participant

- National Heath Care Anti-Fraud Association—one participant

- National Insurance Crime Bureau—one participant

- Office of Management and Budget—multiple participants

- Railroad Retirement Board—multiple participants

- Social Security Administration—multiple participants

- SureBridge Insurance Company—one participant

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Appendix B   Participants—December 7, 2017 Roundtable for GAO and OIGs

- Department of Justice OIG—multiple participants

- Department of Labor OIG—multiple participants

- Department of Veterans Affairs OIG—one participant

- Government Accountability Office—multiple participants

- Office of Personnel Management OIG—one participant

- Railroad Retirement Board OIG—one participant

- Social Security Administration OIG—multiple participants

- U.S. Postal Service OIG—one participant

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Appendix C   Public-Private Partnerships—Additional Information

The scale and complexity of the disability programs do not allow for simple, basic protective measures to ensure Payment Integrity. Each federal agency and insurance organization represented at the Roundtable must regularly assess whether its data systems, finances, capabilities, and public trust remain intact and safe from harm. Each organization has its own mission and interests to protect, and each agency is dedicated to serving the American people who rely on it while preserving the public's confidence. PPPs can help these public and private sector organizations facilitate Disability Payment Integrity.

An information-centric PPP uses technology to collaborate and communicate, and involves ingesting, managing, preparing, analyzing, and sharing information. A TTP is usually involved—working in the public interest with no commercial interests—to provide analysis and systems engineering and to facilitate information sharing and analysis among the PPP partners.

Information-centric PPPs exist in the financial, health, homeland security, transportation, and technical innovation sectors, among others. Other examples include cybersecurity-oriented ISACs and Information Sharing and Analysis Organizations. These types of PPPs rely on collaborative governance, reciprocal information and data sharing and, often, a TTP. Important security, privacy, and legal issues must be jointly addressed by the partners in forming and operating such a PPP.

PPPs are "uniquely similar." Each addresses a specific need and has its own content. Not all PPPs need every kind of capability, nor to the same extent. Further, PPPs have a strong basis in law and practice. Federal agencies can draw on existing authorities to collaborate and establish a PPP,[7] which can be funded in a number of ways.[8]

Experience has identified the following critical success factors for PPPs.

- **Shared purpose** among partners who expect clear mutual and public benefit under a charter that aligns interests and expectations
- **Value delivery** via responsive operation, where the partners employ the most effective governance and business models, technologies, and protocols
- **Trust** among the partners, built through delivering as expected and communicating proactively
- **Accountability** via data-driven decision making and performance-linked incentives
- **Partner buy-in** based on the value and benefit to stakeholders exceeding cost and risk, as well as the empowerment of partners

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[7] The legal and policy support for PPPs is broad and well-established. Agencies can draw on existing authorities to collaborate and form partnerships under the Economy Act, Bayh-Dole Act, Federal Technology Transfer Act, and OMB guidance, as well as various agencies' policies and precedents.
[8] Agencies can fund PPPs not only by contracts and grants but also by cooperative agreements and Other Transaction Authority agreements.

Part of the Roundtable with GAO and the OIGs involved a discussion of considerations in the formation of an information-centric PPP. Regarding data sharing in a PPP, one participant observed that his agency has a lot of data, but requires an appropriate rationale in order to provide it to those outside the agency and at the same time be in compliance with the provisions of the Computer Matching and Privacy Protection Act. Another individual said that most of its audit recommendations in this issue area are to encourage data sharing among agencies.

Tax information—particularly sources and amounts of income—would be of help to agencies in addressing disability issues. However, one participant pointed out that IRS has a very high bar to clear in order to provide tax information. A potential PPP may want to examine ways to work with IRS to facilitate tax information sharing at some level.

When sharing data, information technology infrastructure and data security must be addressed. Building multiple platforms or infrastructures for sharing data would be a significant challenge due to lack of resources. One representative suggested that a central TTP is needed to support partnership data analytics and information sharing.

Regarding data analytics, a participant indicated that technical issues can hinder data matching. Ensuring data can successfully complete the ETL process between agencies would be an enormous task. The lack of common data fields is a widespread problem. For example, "DD" means Date of Death in one agency system, and Date of Discharge in another. Even within the same office, there may be different definitions for data fields.

Participants suggested that strong leadership is needed to lead and own the effort to form a PPP for Disability Payment Integrity. Priorities need to be established and a strong business case developed, including articulating both the short-term and long-term benefits of a PPP. A MITRE participant noted that one of the President's top priorities is ensuring Payment Integrity in entitlement programs, which should provide an impetus for robust measures to address Disability Payment Integrity.

Appendix D   Abbreviations and Acronyms

DOL	Department of Labor
FFRDC	Federally Funded Research and Development Center
FWA	Fraud, Waste and Abuse
FY	Fiscal Year
GAO	Government Accountability Office
HFPP	Healthcare Fraud Prevention Partnership
IRS	Internal Revenue Service
ISAC	Information Sharing and Analysis Center
MITRE	The MITRE Corporation
OIG	Office of Inspector General
OMB	Office of Management and Budget
PPP	Public-Private Partnership
SSA	Social Security Administration
SSI	Supplemental Security Income
TTP	Trusted Third Party