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Combatting the Opioid Epidemic: A Review of Anti-Abuse Efforts by Federal Authorities and Private Insurers

Testimony of:

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Good afternoon, Chairman Portman, Ranking Member McCaskill, and distinguished members of the Committee. I am Gary Cantrell, Deputy Inspector General for Investigations with the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). I appreciate the opportunity to appear before you to discuss prescription drug fraud in Federal health care programs and OIG's efforts to fight this threat.

OIG's mission is to protect the financial integrity of HHS programs and operations and the health and welfare of the people HHS serves. We continue to be at the forefront of the Nation's efforts to fight fraud, waste, and abuse in HHS programs. A majority of our resources goes toward oversight of Medicare and Medicaid because these programs represent a significant percentage of the Federal budget and affect the health of the country's most vulnerable citizens. Combined Medicare and Medicaid expenditures for 2014 amounted to more than one trillion dollars, and the programs served 120 million beneficiaries. It is critical to protect these vital programs from fraud, waste, and abuse. To accomplish our mission, OIG uses data analytics and real-time field intelligence to detect and investigate program fraud and to target our resources for maximum impact. We have formed strong public and private partnerships to maximize enforcement success.

My testimony today focuses on OIG's enforcement efforts to detect, investigate, and prevent health care fraud involving prescription drugs in Federal health care programs and, in particular, OIG's participation in June 2016 with law enforcement partners in executing the largest Health Care Fraud Takedown in history. The nationwide takedown involved over 1,000 law enforcement personnel, including 350 OIG special agents, who uncovered about $900 million in false billings to Medicare and Medicaid. In addition to these enforcement efforts, OIG has also identified systemic weaknesses and vulnerabilities in the Part D program and made a number of recommendations to CMS to better safeguard the program and protect beneficiaries. My testimony also highlights a June 2016 OIG report issued in conjunction with the takedown, entitled *High Part D Spending on Opioids and Substantial Growth in Compounded Drugs Raise Concerns*.

OIG LEADS THE WAY IN COMBATTING MEDICARE FRAUD

OIG advances its mission through investigations, audits, evaluations, enforcement actions, and compliance efforts. In my testimony, I focus on law enforcement activities, led by OIG's Office of Investigations, which conducts criminal, civil and administrative investigations of fraud and misconduct related to HHS programs, operations and beneficiaries. Our special agents have full law enforcement authority and take a broad range of actions, including the execution of search warrants and arrests. Using traditional and state-of-the art investigative techniques, such as data analytics, OIG and its law enforcement partners combine resources to achieve mission success and prevent and combat health care fraud, waste, and abuse.

OIG investigations have produced record-setting results. During the last 3 fiscal years (FYs 2013-2015), OIG investigations have resulted in over $10.9 billion in investigative receivables (dollars ordered or agreed to be paid to Government programs as a result of criminal, civil, or administrative judgments or settlements); 2,856 criminal actions; 1,447 civil actions; and 11,343 program exclusions.[1]

The return on investment for OIG's work is significant. OIG, and our HHS and Department of Justice (DOJ) partners have returned $6.10 for every $1.00 invested in the Health Care Fraud and Abuse Control Program (HCFAC). Since its inception in 1997, the HCFAC Program has returned more than $29.4 billion to the Medicare Trust Funds. HCFAC's continued success confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud and abuse, and to protect program beneficiaries. In addition, OIG participates in Medicare Fraud Strike Force teams that combine the resources of Federal, State and local law enforcement entities to prevent and combat health care fraud across the country. In June 2016, during the Strike Force's largest national health care fraud takedown to date, approximately one-third of the investigations focused on prescription drug fraud schemes.

OIG CONSIDERS ENFORCEMENT AND PREVENTION OF PRESCRIPTION DRUG FRAUD A TOP PRIORITY

Prescription drug abuse is a rapidly growing national health care problem, and our nation is in the midst of an unprecedented opioid epidemic.[2] The majority of drug overdose deaths involves an opioid, and more than 165,000 people have died from prescription opioid overdoses since 1999.[3] Prescription drug diversion—the redirection of prescription drugs for an illegal purpose—is a serious component of this epidemic. Although the diversion of controlled substances, such as opioids, is of paramount concern, the diversion of noncontrolled substances is becoming more common. In these cases, noncontrolled substances are combined with opioids and other controlled substances to exaggerate the user's "high" – making noncontrolled drugs susceptible to abuse. Fraud related to both controlled and noncontrolled drugs results in significant financial losses to Medicare and Medicaid and, more importantly, may also result in patient harm and even death.

June 2016 National Health Care Fraud Takedown

In a recent example of OIG's commitment to prescription drug fraud enforcement, a National Health Care Fraud Takedown[4] led by the Strike Force in 36 judicial districts resulted in criminal

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[1] OIG has the authority to exclude individuals and entities from Federally funded health care programs. The effect of an exclusion is that no payment will be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity. No program payment will be made for anything that an excluded person furnishes, orders, or prescribes.

[2] Centers for Disease Control and Prevention, *Prescription Painkiller Overdoses at Epidemic Levels* [press release], Nov. 1, 2011.

[3] Health and Human Services, *The Opioid Epidemic: By the Numbers* [Fact Sheet], June 2016.

[4] *See* Department of Justice, *National Health Care Fraud Takedown Results in Charges against 301 Individuals for Approximately $900 Million in False Billing* [press release], June 22, 2016.

and civil charges against 301 individuals, including 61 doctors, nurses, and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $900 million in false billings. The defendants were charged with a range of health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes, money laundering, and aggravated identity theft. The alleged fraud schemes involved various medical treatments and services, including prescription drugs, home health care, personal care services, psychotherapy, physical and occupational therapy, and durable medical equipment. More than 60 of the defendants were arrested and charged with fraud related to Medicare Part D -- the Medicare prescription drug benefit program.

OIG Continues to Ensure the Integrity of the Medicare Prescription Drug Program Through Evaluations and Audits

In addition to enforcement efforts, OIG has conducted audits and evaluations that identify systemic weaknesses that make Part D fraud and abuse possible. The program integrity vulnerabilities that OIG has identified relate to the three key players charged with safeguarding the program: plan sponsors, the Medicare Drug Integrity Contractor (MEDIC), and the Centers for Medicare & Medicaid Services (CMS). OIG audits have examined the adequacy of oversight mechanisms, such as plan sponsors' internal claims processing edits to prevent improper payments. OIG evaluations have reviewed plan sponsor, MEDIC, and CMS oversight of Part D, including the adequacy of the data that CMS requires plan sponsors to submit, and how effectively data are being used to target program integrity efforts.

Through its work, OIG has identified Part D vulnerabilities on all three levels of program oversight: plan sponsors, the MEDIC, and CMS. OIG has recommended improvements in two key areas. First, plan sponsors, the MEDIC and CMS, need to more effectively collect and analyze program data to proactively identify and resolve program vulnerabilities and prevent fraud, waste, and abuse before they occur. Second, plan sponsors, the MEDIC and CMS need to more fully implement robust oversight designed to ensure proper payments, prevent fraud, and protect beneficiaries.

Over the last decade, plan sponsors, the MEDIC, and CMS have taken steps to address OIG recommendations in these areas, and progress has been made. For example, the MEDIC now identifies high-risk pharmacy and outlier prescribers and it shares this information with plan sponsors for followup. However, Part D remains vulnerable to fraud, as evidenced by ongoing OIG investigations and the results of data analyses recently conducted by OIG.

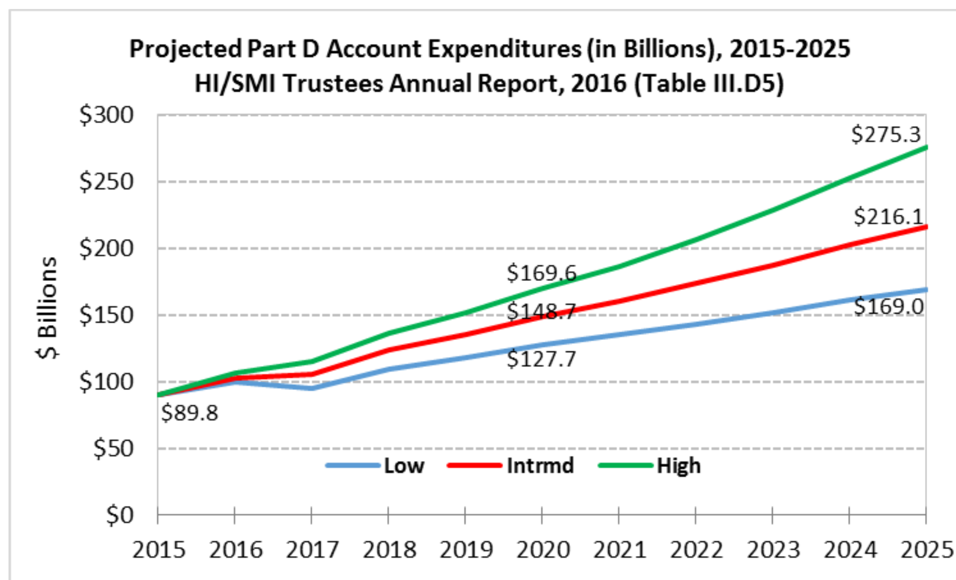
OIG USES SOPHISTICATED DATA ANALYTICS AND REAL-TIME FIELD INTELLIGENCE TO ENHANCE ENFORCEMENT EFFORTS

Data Analytics Support OIG Fraud Identification and Investigations

OIG is a leader in the use of data analytics to detect and investigate health care fraud. We use innovative methods to analyze billions of data points and claims information to identify trends that may indicate fraud, geographical hot spots, emerging schemes, and individual providers of

concern. At the macro-level, OIG analyzes data patterns to assess fraud risks across Medicare services, provider types, and geographic locations to prioritize and deploy our resources. At the micro-level, OIG uses data analytics, including near-real-time data, to identify fraud suspects and conduct investigations as efficiently and effectively as possible.

OIG's approach to fighting prescription drug fraud provides an example of how data analytics and real-time field intelligence enhance enforcement efforts. OIG has been monitoring the growth in Medicare Part D expenditures for drugs, which totaled $89.8 billion in 2015 and is projected to total $216.1 billion by 2025.[5]



These estimates alone underscore the need for strong program integrity and enforcement efforts. However, the trend of increasing costs is just one consideration. We combine our real-time field intelligence with data analytics to assess vulnerabilities across the program and to deploy our special agents to investigate the most egregious cases of suspected fraud.

For example, OIG's investigators and evaluators developed indicators of questionable billing for Part D drugs that may be associated with fraud and abuse on the basis of our experience with prescription drug investigations. OIG's evaluators have designed studies to identify questionable billing by retail pharmacies; prescribers with aberrant patterns; individuals who write prescriptions without authority to prescribe; and Schedule II drugs billed as refills. These studies, such as *Questionable Billing and Geographic Hotspots Point to Potential Fraud and Abuse in Medicare Part D,* generated law enforcement leads, resulting in multiple ongoing investigations.

[5] The Board of Trustees Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2016 Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 2016. The Trustees' report explains the increase in the projections as follows: "For 2015, per capita benefits increased faster than they had historically ***because of price increases for brand-name drugs*** and the significant amount of ***2014 reconciliation payments by Medicare for the unexpected use of the new hepatitis C drugs***." (p. 108, emphasis added)

OIG also has developed analytics to assist with proactive targeting of aberrant pharmacy and prescriber activities, and for monitoring Medicare prescription drug payments. Staff employ these tools to monitor new drugs recently approved by the Food and Drug Administration (FDA), to identify emerging schemes and trends, and to generate provider risk scores based on statistical modeling that focuses on patterns in claims data that are correlated with past fraudulent conduct.

In another example from OIG's most recent data brief, *High Part D Spending on Opioids and Substantial Growth in Compounded Drugs Raise Concerns,* OIG found high spending for opioids and monumental growth in spending for compounded drugs. Part D spending for commonly abused opioids reached $4.1 billion in 2015, up from $3.9 billion in 2014. Overall, spending for these drugs rose 165 percent from 2006 to 2015. A high portion of Part D beneficiaries continued to receive commonly abused opioids. In 2015, almost 12 million beneficiaries (30 percent) received at least one of these drugs. On average, each of these beneficiaries received five prescriptions for commonly abused opioids during the year.

Since 2006, Medicare spending for compounded drugs has risen 625 percent, and spending for one type of compounded drugs—topical medications—has risen more than 3,400 percent. Compounded drugs are customized medications tailored to the needs of individual patients. Pharmacists and physicians create these medications by combining, mixing, or altering drug ingredients. This rapid growth in the spending for compounded drugs, along with a growing number of fraud cases involving compounded drugs, may indicate an emerging fraud trend.

Medicare Fraud Strike Force Use of Data Analytics

The success of the Strike Force model demonstrates the continued effectiveness of the use of data analytics to detect and investigate health care fraud, including schemes that involve prescription drug fraud. The Strike Force effort began in March 2007; in 2009, HHS and DOJ announced the formal creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). A key component of HEAT is the Strike Force, which harnesses the efforts of OIG and DOJ, including headquarters, U.S. Attorneys' Offices, and the Federal Bureau of Investigation, along with State and local law enforcement, to fight Medicare fraud in geographic hot spots.

The Strike Force teams use near-real-time data to pinpoint fraud hot spots and aberrant billing. This coordinated and data-driven approach to identify, investigate, and prosecute fraud has produced record-breaking results, including the June 2016 National Health Care Fraud Takedown. The Strike Force, which operates in nine locations, has, since its inception in March 2007, charged more than 2,900 defendants who collectively have falsely billed the Medicare program over $8.9 billion.

PRESCRIPTION DRUG FRAUD OFTEN INVOLVES MANY CO-CONSPIRATORS AND COMPLEX SCHEMES

Prescription drug fraud often involves many co-conspirators, including physicians, pharmacies, pharmacists, and compounding facilities. These complex schemes may be characterized by complicit patients, kickbacks, medical identity theft, criminal enterprises, and money laundering. Of greatest concern are the prescription drug fraud schemes involving patient harm. The following case examples involve multiple co-conspirators:

Prescription Drug Fraud Involving Physicians

In an example of a complex prescription drug diversion scheme involving a Pennsylvania physician, 69 defendants were sentenced for their participation in a multimillion-dollar drug conspiracy involving illegal prescriptions, pseudo-patients, and multiple drug trafficking organizations.

According to court records, pseudo-patients were transported by the vanload to the medical practice of Dr. Norman Werther to obtain prescriptions for oxycodone-based products. The pseudo-patients paid about $150 in cash for the office visits; used their Medicare, Medicaid, or private insurance cards and cash to pay for filing the prescriptions at various pharmacies; and, in exchange for payments, provided the filled prescriptions to members of six separate drug trafficking organizations that would resell the drugs on the street. In return, the pseudo-patients were paid approximately $300 to $1,000 depending on the type of prescription they received.

The operation resulted in the illegal distribution of more than 700,000 pills containing oxycodone. Dr. Werther was sentenced to 25 years in prison and ordered to forfeit $10 million. In addition, Dr. Werther was convicted of one count of distribution of a controlled substance resulting in death. The case is continuing, but thus far a total of 69 defendants have been sentenced to a combined 268 years in prison and 203 years of probation.

Prescription Drug Fraud Involving Pharmacies and Pharmacists

In an egregious case involving pharmacy and pharmacist fraud, 37 defendants were convicted for their roles in a widespread scheme to defraud Medicare and Medicaid of nearly $58 million. According to the indictment, Babubhai Patel was a licensed pharmacist who either owned or controlled 26 pharmacies in Michigan. Patel concealed his ownership and control over many of his pharmacies through the use of straw owners. Patel offered and paid kickbacks, and other inducements to prescribers who wrote fraudulent prescriptions for patients with Medicare, Medicaid, and private insurance and directed the patients to fill the prescriptions at one of Patel's pharmacies.

Patel and his pharmacists billed Medicare and other insurers for dispensing the medications, despite the fact that the medications were medically unnecessary and/or were never provided. From January 2009 to August 2011, Patel's pharmacies dispensed approximately 250,000 doses of Oxycontin, 4.6 million doses of Vicodin, 1.5 million doses of Xanax, and 6,100 pint bottles of codeine cough syrup. Patel's pharmacies falsely billed Medicare and Medicaid approximately

$57.8 million for medications purportedly provided to beneficiaries over the course of the scheme.

Patel was sentenced to 17 years in prison and ordered to pay $18.9 million in restitution, joint and several. In addition to Patel, 14 pharmacists, 9 doctors, 6 business associates, 4 patient recruiters/drug dealers and 3 pharmacy technicians were sentenced to a combined 92½ years in prison and collectively ordered to pay more than $84 million in restitution.

Prescription Drug Fraud Involving Pharmacy Compounding

Prescription drug fraud involving compounding has been a growing enforcement problem. During the broad June 2016 National Health Care Fraud Takedown, Dr. Anthony Baldizzi of Florida was indicted for his alleged role in a scheme to receive kickbacks for each prescription he wrote and directed to Lifecare Compounding Pharmacy for filling. According to the indictment, the principals of Lifecare introduced Baldizzi to the principals of Centurion Compounding, a marketing firm, and these parties entered into another kickback relationship whereby Baldizzi agreed to become a Centurion "in-network" doctor and write prescriptions for compounded creams marketed by Centurion and filled at Lifecare. In exchange, the indictment states, the principals of Lifecare and Centurion jointly paid Baldizzi a kickback for each paid claim, equal to approximately 10% of the after-cost amount of the payment. Many of these prescriptions were written for beneficiaries of TRICARE, a Federal health care program. Lifecare allegedly submitted to TRICARE claims for prescriptions written by Baldizzi, pursuant to their illegal kickback agreement, totaling approximately $5.3 million. The indictment states that Lifecare also submitted to Medicare claims for prescriptions written by Baldizzi, pursuant to their illegal kickback agreement, totaling approximately $71,312.41.

Prescription Drug Fraud Involving Patient Harm

One of OIG's most disturbing cases of patient harm related to prescription drug diversion involved David Kwiatkowski, a radiologic technician who was employed at 15 health care facilities in 8 states. According to court documents, while employed at Hays Medical Center in Kansas in June 2010, Kwiatkowski became aware that he was infected with Hepatitis C. Notwithstanding that knowledge, Kwiatkowski injected himself with syringes of the anesthetic fentanyl that were intended for patients who were undergoing medical procedures. He added saline to the same syringes that were later administered unknowingly by nurses to the patients. Consequently, instead of receiving the prescribed dose of fentanyl, the patients received saline that was tainted with the Hepatitis C virus. Kwiatkowski repeated this pattern of behavior at other hospitals where he worked, which investigators determined, caused at least 45 patients to become infected with Hepatitis C. Some of these patients experienced very serious health complications, including one death in which Hepatitis C was a contributing factor. Kwiatkowski was sentenced to 39 years in prison and ordered to pay $22,680 in restitution after pleading guilty to charges of tampering with a consumer product and fraudulently obtaining controlled substances.

Prescription Drug Fraud Involving Noncontrolled Drugs

Prescription drug diversion often involves overprescribing of controlled drugs, but can also include billing for unnecessary noncontrolled prescriptions. Fraud associated with noncontrolled substances typically focuses on brand-name, high-cost medications, including respiratory, HIV, and anti-psychotic medications.

In one example of prescription drug fraud involving noncontrolled drugs, Artak Ovsepian was sentenced to 15 years in prison and ordered to pay $9.1 million in joint and several restitution after being convicted on charges of conspiracy to commit health care fraud, aggravated identity theft, conspiracy to misbrand pharmaceutical drugs, false statements to the Federal Government, and conspiracy to use other persons' identification documents in furtherance of fraud.

Ovsepian and his co-conspirators operated Manor Medical Imaging, Inc., in Glendale, California, where they employed an unlicensed medical practitioner to write bogus prescriptions using a physician's name and license number. A doctor participated in the conspiracy by allowing them to issue prescriptions in his name, helping to recruit pharmacists to fill prescriptions, and concealing the scheme in response to audits. Ovsepian and others also had close relationships with pharmacies and a fraudulent drug wholesale company, which were used to funnel prescription drugs back to the pharmacies participating in the scheme.

Beneficiaries also participated in this scheme. Patient recruiters brought beneficiaries to Manor Medical in exchange for cash or other inducements. The beneficiaries received prescriptions for antipsychotic medications, and sometimes other drugs. This occurred even though either the beneficiaries were not evaluated by a physician, or there was no medical need for the medications. The beneficiaries were then driven to a pharmacy where, under the supervision of the driver, they filled their prescriptions and then gave the drugs to the driver. In addition to recruiting beneficiaries, Ovsepian and his co-conspirators also stole the identities of beneficiaries. And they used their information to generate fraudulent prescriptions.

The drugs were eventually sold on the black market or redistributed to pharmacies, where they could be rebilled to Medicare and Medi-Cal as "new" bottles of drugs. Sixteen participants in the conspiracy have been convicted and have received a combined 56 years and 8 months in prison.

OIG MAXIMIZES IMPACT THROUGH STRONG COLLABORATION WITH PUBLIC AND PRIVATE PARTNERS

In addition to internal collaboration and Strike Force operations, OIG engages with external stakeholders to enhance the relevance and impact of our work to combat health care fraud, as demonstrated by our leadership in the Healthcare Fraud Prevention Partnership (HFPP), our association with the National Health Care Anti-Fraud Association (NHCAA), and the Global Healthcare Fraud Enforcement Network (GHCAN).

The Healthcare Fraud Prevention Partnership

The HFPP is a groundbreaking partnership between the Federal and private sectors to share data and information for the purposes of detecting and combatting fraud, waste, and abuse in health care programs. The HFPP was created as a voluntary public-private partnership between the Federal government, State officials, private health insurance organizations, and health care anti-fraud associations. OIG remains an active partner in this CMS-led initiative, and frequently shares information with HFPP partners regarding prescription drug fraud schemes.

The National Healthcare Anti-Fraud Association and the Global Health Care Anti-Fraud Network

The NHCAA is the leading national nonprofit organization focused exclusively on combatting health care fraud and abuse. The 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. In addition to presentations at numerous NHCAA conferences involving thousands of private sector investigators and program integrity personnel, OIG shared prescription drug data analysis techniques and integrity recommendations with hundreds of public and private members of the NHCAA in a conference call after 2015's national health care fraud takedown. Public and private payers can use this information to fight prescription drug fraud in their programs. OIG also is actively engaged in the GHCAN, which was founded in 2011 to promote partnership and communication between international organizations to reduce and eliminate health care fraud around the world. Regardless of the type of health care program payer, prescription drug fraud is a rapidly increasing problem nationally and internationally.

CHANGES CMS CAN MAKE TO PROTECT THE INTEGRITY OF MEDICARE PART D

Since Medicare Part D went into effect, OIG has raised concerns about oversight and made a number of recommendations to CMS to better safeguard the program and protect beneficiaries. OIG's 2015 report, *Ensuring the Integrity of Medicare Part D,* summarized the results of numerous OIG investigations, audits, evaluations, and legal guidance related to Part D program integrity and provides a compilation of OIG's priority unimplemented recommendations. OIG findings and recommendations center on two themes, as previous stated: (1) leveraging Part D data to identify vulnerabilities and (2) employing additional tools to enhance the oversight of the Part D program.

CMS has been working closely with OIG to map strategies for implementing recommendations that OIG believes are necessary to better protect Medicare Part D. Some of these recommendations could be implemented by CMS through regulation or contract language, such as:

- **Require plan sponsors to report all potential fraud and abuse and the actions taken in response to CMS**
  Plan sponsors, the private insurance companies responsible for administering the program, are the first line of defense against fraud and abuse. CMS does not require plan sponsors to report the number of instances of potential fraud, waste, and abuse they identify, nor the actions taken to address them. Without this information from plan sponsors, it is impossible for CMS to review the effectiveness of plan sponsors' fraud detection programs. The Compressive Addiction and Recovery Act (CARA) includes language to require plan sponsors to report information based on the results of their drug monitoring program. While this does not fully implement our recommendation, it is an important step in the right direction.

- **Expand drug utilization review programs to include noncontrolled drugs that are linked to beneficiary harm and are susceptible to fraud, waste, and abuse**
  Drug utilization reviews are intended to protect beneficiaries and reduce fraud, waste, and abuse. However, CMS's requirements for these reviews apply only to certain types of drugs. We recommend that CMS and plan sponsors monitor beneficiary utilization for a wider range of drugs susceptible to misuse than they do now. In particular, we recommend expanding sponsors' and CMS's drug utilization reviews to cover certain noncontrolled substances, focusing, in particular, on those noncontrolled substances that are commonly taken in conjunction with opioids and may increase the chance of harm. For example, the combination of opioids and benzodiazepines can exacerbate respiratory depression, the primary factor in fatal opioid overdose. It is important to expand these reviews to ensure beneficiary safety and to help curb opioid-related fraud.

- **Restrict certain beneficiaries to a limited number of pharmacies or prescribers**
  Plan sponsors were recently granted the authority to restrict certain beneficiaries to a limited number of pharmacies or prescribers in Parts C and D, commonly referred to as "lock-in".[6] With this new authority, plans may restrict at-risk beneficiaries to a limited number of pharmacies or prescribers when warranted by excessive or questionable billing patterns. However, as this authority is new, these programs have not yet been developed and implemented in Parts C and D. This practice has been successfully used by most State Medicaid programs. Restricting certain beneficiaries to a limited number of pharmacies or prescribers could both reduce inappropriate use of opioids among Medicare beneficiaries and reduce Part D fraud.

OIG has also made another recommendation that thus far has not been implemented. This recommendation would require that new authorities be granted to CMS:

- **Limit the ability of certain beneficiaries to switch plans**
  CMS should be granted the authority to restrict certain beneficiaries from switching their Part D plans multiple times during the year. Currently, beneficiaries who receive the low-income subsidy are allowed to switch plans every month. OIG found that a number of beneficiaries with questionable utilization patterns switched their Part D plans three or more times during the year. While CMS needs to continue to allow beneficiaries to

[6] Comprehensive Addiction and Recovery Act of 2016, Pub. L. 114-198, § 704 (July 22, 2016).

switch plans under certain circumstances, it also needs to implement some restrictions. Sponsors cannot effectively monitor the drugs that beneficiaries are receiving when beneficiaries frequently switch plans. Limiting the ability of certain high-risk beneficiaries to switch plans could improve the quality of care for these beneficiaries and save taxpayer dollars.

OIG LEVERAGES OPPORTUNITIES TO PREVENT PRESCRIPTION DRUG FRAUD

A critical aspect of the work of OIG and its external partners is to prevent fraud. OIG strives to cultivate a culture of compliance in the health care industry through various educational efforts.

Prescription Drug Awareness Conferences

OIG partners with the Drug Enforcement Agency to provide anti-fraud education at numerous Pharmacy Diversion Awareness Conferences held across the United States. The conferences are designed to assist pharmacy personnel with identifying and preventing diversion activity. Since 2013, OIG has made presentations at conferences in 36 states.

OIG Consumer Education

OIG has also made a significant media outreach effort to inform the public about prescription drug fraud. For example, NBC News and National Public Radio's "Marketplace" aired stories about our health care fraud investigations, including on prescription drug fraud, as part of the June 2016 national health care fraud takedown. And an Associated Press story about our June 2016 Medicare Part D Spending Data Brief was published widely around the country. In addition to our media efforts, we have reached out to the public directly about this issue, releasing an "Eye on Oversight" video about Medicare Part D Fraud in early 2016.

CONCLUSION

OIG is committed to overseeing HHS programs and protecting them and their beneficiaries from fraud, waste, and abuse. We will continue to leverage our analytic, investigative and oversight tools, as well as our partnerships in the law enforcement and public and private program integrity communities, to maximize our efforts. We will continue our enforcement efforts to prevent detect and investigate prescription drug fraud in Federal health care programs. We will remain vigilant in following and investigating emerging trends, such as fraud schemes related to compounded drugs and pharmacies. Of critical importance are OIG's priority efforts to combat prescription drug fraud involving patient harm.

We would like to express our appreciation to Congress and to this Committee, in particular, for its sustained commitment to our mission of protecting Medicare, Medicaid and other HHS programs and their beneficiaries from prescription drug fraud. This concludes my testimony.
I would be happy to answer your questions. Thank you.