STATEMENT OF
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ON

CURBING PRESCRIPTION DRUG ABUSE IN MEDICARE

BEFORE THE

U.S. SENATE COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

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Statement of Jonathan Blum on
Curbing Prescription Drug Abuse in Medicare
U.S. Senate Committee on Homeland Security and Government Affairs
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Chairman Carper, Ranking Member Coburn, and members of the Committee, thank you for inviting me to discuss the Centers for Medicare & Medicaid Services' (CMS) work to improve the Medicare Prescription Drug Program, also known as Medicare Part D, to ensure that all Medicare beneficiaries are receiving the medicines they need while also reducing and preventing prescription drug abuse.

The Medicare Part D prescription drug benefit program has been very successful by several measures. In its eight years of operation, Part D has made medicines more available and affordable for Medicare beneficiaries, leading to improvements in access to prescription drugs, better health outcomes, and more beneficiary satisfaction with their Medicare coverage. In addition, the drug benefit is helping beneficiaries avoid the need for other services that would otherwise be covered under Medicare Parts A and B; the Congressional Budget Office (CBO) recently estimated that a one percent increase in the number of prescriptions filled by beneficiaries causes Medicare's overall spending on medical services to fall by roughly one-fifth of one percent.[1]

The Medicare Part D program provides outpatient prescription drug benefits to about 37 million Medicare beneficiaries[2] through a wide range of plan choices, with an average of 31 plans per region[3] competing to provide drug benefits to Medicare beneficiaries at the average monthly premium of about $30.[4] According to surveys, 95 percent of Part D enrollees are satisfied with their drug coverage and confident that the level of coverage meets their needs.[5]

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[1] http://www.cbo.gov/sites/default/files/cbofiles/attachments/43741-MedicalOffsets-11-29-12.pdf.
[2] MedPAC. "Status Report on Part D." March 1, 2013. http://www.medpac.gov/chapters/Mar13_Ch15.pdf.
[3] 2013 Prescription Drug Plan Landscape available at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html.
[4] http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/PartDandMABenchmarks2013.pdf.
[5] MedPAC. "Status Report on Part D." March 1, 2013. http://www.medpac.gov/chapters/Mar13_Ch15.pdf.

Meanwhile, the overall costs for the Part D program have risen more slowly than originally projected. According to CBO's data, Part D is on track to cost 45 percent less than projected for the initial 2004-to-2013 forecast period,[6] and as we announced earlier this year, Part D's per capita costs will only rise 1.83 percent for 2013 — the lowest growth rate in the history of the program.[7] Additionally, the deductible and out-of-pocket limit for Part D will be lower in 2014 than in 2013, and beneficiary costs will be further reduced as coverage in the prescription drug coverage gap, or "donut hole," continues to expand in 2014. To date, 6.3 million beneficiaries have saved over $6.1 billion on prescription drugs through the Affordable Care Act's discounts, rebates, and additional coverage.[8]

While beneficiaries are saving money on prescription drugs, the quality of Part D plans is improving. The average star rating among standalone Part D sponsors, weighted by enrollment, in 2013 is 3.3 stars out of five, compared with 2.96 for 2012.[9] These ratings are based on quality measures including patient safety and appropriate medication use metrics. Sponsors have incorporated the Medication Therapy Management Programs into their plans' benefit structures to ensure optimum therapeutic outcomes through improved medication use and a reduced risk of adverse outcomes.

While the Part D program is strong, CMS knows it must continually improve the program and address vulnerabilities. CMS appreciates the thoughtful work of this Committee[10] and the Department of Health & Human Services (HHS) Office of the Inspector General (OIG)[11] that highlights the potential for fraud, waste, and abuse in Part D. We agree that CMS can do more to reduce fraud and abuse in order to ensure that beneficiaries receive high-quality, appropriate care, while also making sure that we spend every federal dollar as wisely as possible.

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[6] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf
[7] Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter . http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/RateNotice.pdf
[8] http://www.hhs.gov/news/press/2013pres/03/20130321a.html
[9] MedPAC. "Status Report on Part D." March 1, 2013. http://www.medpac.gov/chapters/Mar13_Ch15.pdf
[10] http://www.hsgac.senate.gov/subcommittees/federal-financial-management/hearings/costs-of-prescription-drug-abuse-in-the-medicare-part-d-program
[11] HHS OIG has a large body of work examining Part D billing including: OEI-02-09-00603, OEI-02-09-00608, OEI-02-09-00140, OEI-03-11-00310, OEI-07-09-00150, OEI-07-10-06004

As the program matures, CMS is broadening its initial focus of ensuring beneficiaries have access to prescribed drugs to also ensure that Part D sponsors implement effective safeguards to prevent fraud and drug abuse, and provide coverage for drug therapies that meet standards for safety and efficacy. Based on the lessons learned from activities in fee-for-service Medicare and input from this Committee, the HHS OIG, and the Government Accountability Office (GAO), we have enhanced our data analyses and improved coordination with our law enforcement partners to get a more comprehensive view of activities in the Part D program.

Prescription drug abuse is the Nation's fastest-growing drug problem, and the Centers for Disease Control and Prevention (CDC) has classified prescription drug overdose as an epidemic.[12] In 2010, more than 100 people died from drug overdoses every day in the United States,[13] and drug overdose death rates have more than tripled since 1990.[14] Between 1997 and 2008, the rate of hospital admissions for conditions related to prescription medication interactions and illicit drug use rose by 96 percent among people ages 65 and 84, and for people 85 and older, admissions grew 87 percent.[15]

In response to this growth in prescription drug misuse and abuse, the Administration released its "Prescription Drug Abuse Prevention Plan" in 2011.[16] This plan includes four pillars: education, monitoring, proper disposal, and enforcement. National survey data indicate that the number of people in the United States currently abusing prescription drugs decreased from 7 million in 2010 to 6.1 million in 2011,[17] a promising trend.

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[12] Paulozzi, L. et al. (2012). CDC Grand Rounds: Prescription Drug Overdoses—a U.S. Epidemic. *Morbidity and Mortality Weekly Report*, 61(01):10-13, January 13.
[13] CDC/Wonder, extracted February 11, 2013, showed 38,329 deaths in 2010.
[14] http://www.cdc.gov/homeandrecreationalsafety/rxbrief/.
[15] Based on analysis by the Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistic and Quality. http://www.samhsa.gov/grants/2011/sm_11_009.aspx#f4
[16] *Epidemic: Responding to America's Prescription Drug Abuse Crisis.* Executive Office of the President of the United States. 2011. http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan_0.pdf.
[17] *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings*. Substance Abuse and Mental Health Services Administration, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.htm.

The growth of prescription drug abuse has touched providers, pharmacies, and beneficiaries in the Part D program. CMS recognizes that Part D plan sponsors face unique challenges in administering the Medicare prescription drug benefit. Part D plan sponsors can manage the benefit only at the beneficiary level, because they do not have access to Part D prescriber and pharmacy data beyond the transactions they manage for their own enrollees, which makes it more difficult to identify prescribers or pharmacies that are outliers in their prescribing patterns or are filling patterns relative to the entire Part D program. Unlike Medicare Advantage plans offering Part D, stand-alone plan sponsors face additional challenges because they manage only the drug benefit, which leaves plan sponsors without a direct relationship with the prescriber, while CMS manages the medical benefit. These plan sponsors operate under a different legal and regulatory framework than the traditional Medicare fee-for-service benefit. The ability of Medicare providers, pharmacies, and beneficiaries to abuse the Medicare prescription drug benefit is one symptom of the complex health care delivery system that must be addressed through broader reforms that result in better-coordinated care.

By focusing on stringent plan compliance and increased use of data analytics to identify outliers and suspicious prescribing patterns, we can provide Part D plans with the tools needed to prevent abuse, improve care, and ensure federal dollars are spent appropriately. As this public health challenge grows in size and scope, CMS is protecting our beneficiaries through new programs and technologies, such as enhanced Drug Utilization Review (DUR) procedures, increased use of analytics on prescriber and pharmacy data, and improved collaboration between Medicare Part D stakeholders. In addition, we are looking at ways we can leverage the administrative authorities we have to oversee fee-for-service providers and apply those same principles and techniques in the Part D program, where possible. Any policy response to Part D drug abuse must balance our desire to minimize prescription drugs abuse with the need to ensure access to prescription drugs for legitimate clinical use.

Background on Medicare Part D

The Medicare Part D prescription drug benefit program was established under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108-173).

Launched in 2006, Part D is designed to provide beneficiaries with access to drug coverage through private prescription drug plans.

In Part D, CMS contracts with private entities—stand-alone prescription drug plan (PDP) sponsors, MA organizations, and other types of Medicare health organizations—who then act as the payers and insurers for prescription drug benefits. CMS pays sponsors on a per enrollee basis and the sponsors compete for enrollees based on premiums and coverage. In general, Medicare subsidizes about 75 percent of the average cost for basic coverage for beneficiaries who choose to enroll in the voluntary Part D benefit, and those beneficiaries pay the balance through monthly plan premiums. Additionally, some beneficiaries qualify for "extra help" through the Part D low-income subsidy program.

All Part D sponsors are required to have a comprehensive plan to detect, correct, and prevent waste, fraud, and abuse. This plan consists of written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards related to fraud and abuse. Sponsors must have a properly trained, effective compliance officer, and provisions for internal monitoring and auditing, as well as other requirements. These requirements help ensure that sponsors track and identify potential beneficiary or provider abuse. Chapter 9 of CMS's Prescription Drug Benefit Manual[18] recommends that Part D sponsors generate and review reports, such as the following:

- **Prescription Drug Event (PDE) Payment Reports** which detail for every prescription filled: (1) the amount paid by the Part D sponsor; (2) the pharmacy and provider identification numbers; (3) the beneficiary; and (4) a description of the drug, including dosage and amount. Part D sponsors use these reports to identify over- and under-payments, duplicate payments, timely payments, and pricing aberrances, and, also, to help verify correct pricing.
- **DURs** which identify the number of prescriptions filled by an individual enrollee, and, in particular, the number of prescriptions for certain classes of drugs, such as narcotics, to identify potential therapeutic abuse or illegal activity by an enrollee.

[18] Chapter 9 of CMS' Prescription Drug Benefit Manual: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/PDBManual_Chapter9_FWA.pdf

- **Prescribing Patterns by Physician Reports** which identify the number of prescriptions written by a particular provider and typically focus on a class or particular type of drug such as narcotics. Part D sponsors generate these reports to identify possible prescriber, provider, or pharmacy fraud.

CMS also contracts with a private organization, called the Medicare Drug Integrity Contractor (MEDIC), to assist CMS in managing its Part D audit, oversight, and anti-fraud efforts. The MEDIC's main functions include identifying and investigating potential Part D fraud and abuse, developing potential Part D fraud or abuse cases for referral to law enforcement agencies, acting as a liaison to law enforcement, and collaborating with Part D sponsors on identification of potentially fraudulent schemes. The MEDIC is also responsible for auditing the anti-waste, fraud, and abuse compliance programs detailed above that are requirements for participation as a Part D sponsor.

Medicare Prescription Drug Benefit Program Integrity Activities

To combat prescription drug waste, fraud, and abuse more effectively, CMS evaluates Part D sponsors' operations to ensure that they are compliant with the regulations detailed above, as well as the guidance in the Prescription Drug Benefit Manual. As part of program oversight, CMS uses the Fraud Prevention System (FPS) in Medicare fee-for-service to target investigative resources to suspicious claims and providers and swiftly impose administrative action when warranted. Lessons learned from the FPS are providing insights into new methods and technologies to get ahead of people who would abuse the Part D program and identify their patterns of behavior early. CMS is now considering implementing similar strategies and administrative actions into its management of the Part D program and its sponsors to ensure a more systematic analysis of the claims data to prevent and detect abuse.

Improving Data Analysis to Address Opioid Overutilization and Questionable Prescribing Patterns

An individual beneficiary's behavior, such as "doctor shopping" to obtain frequently abused prescription drugs from multiple prescribers, may indicate fraud, waste, or abuse, and might also signal troubling patterns that endanger the beneficiary's health or indicate illegal selling of

prescription drugs. DUR programs can help preserve program integrity, while also promoting safety, improving the quality of care, and preventing prescription errors. Part D plan sponsors must in place concurrent DUR programs for reviewing prescribed drug therapies at point-of-sale, as well as retrospective DUR programs for conducting ongoing, periodic examinations of claims data to identify patterns of inappropriate or medically-unnecessary prescription, dispensing, or use of prescription drugs. A concurrent DUR program must include screening for the following problems each time a prescription is dispensed:

- Screening for potential drug therapy problems due to therapeutic duplication
- Age/gender-related contraindications
- Drug over-utilization and under-utilization
- Drug-drug interactions
- Incorrect drug dosage or duration of drug therapy
- Drug-allergy contraindications
- Clinical abuse/misuse of drugs

Examining DUR-related analyses, claims data, and other records allows Part D sponsors to identify questionable utilization patterns that may indicate fraud, abuse, gross overuse, or inappropriate or medically-unnecessary prescription, dispensing, or use of prescription drugs. The Part D sponsors can also look for suspicious patterns associated with specific drugs or groups of drugs. Part D sponsors can then refer suspected fraud to CMS, the MEDIC, or a law enforcement agency, as appropriate.

A 2011 GAO report[19] found examples of potential egregious overutilization of medications by Part D beneficiaries who were obtaining opioid medications from multiple prescribers, with the vast majority of these beneficiaries receiving medications from between five and ten providers. Through discussions with the industry, CMS determined that sponsors need to employ more effective concurrent and retrospective DUR programs to address overutilization of medications to protect beneficiaries, and to reduce fraud, waste, and abuse in Part D.

[19] GAO-11-699 "Medicare Part D: Instances of Questionable Access to Presciption Drugs" http://www.gao.gov/assets/590/585424.pdf

CMS, through its Final Calendar Year 2013 Call Letter and subsequent guidance,[20] outlined an approach to reduce potential opioid overutilization in the Part D program. Under this approach, Part D plans ensure safe dosages are dispensed through the improved use of concurrent claim edits and formulary utilization management design. CMS's guidance clarified that sponsors should clinically analyze cases for unsafe cumulative dosing that DUR programming has identified through patterns that suggest potential overutilization of drugs.

The effective DUR program should include case management, outreach to providers, and, if necessary, beneficiary-level controls to prevent overutilization of opioid therapy and ensure beneficiary safety. During case management, clinical staff should communicate with prescribers and beneficiaries to understand the beneficiaries' medical needs. This clinician-to-clinician communication should result in beneficiaries receiving appropriate levels of medication through improved care coordination.

If prescribers are non-responsive after multiple attempts, or prescribers concur that the current level of medication is unnecessary, a sponsor may implement beneficiary-level claim edits, but they must inform the beneficiary and their prescribers of those restrictions, and allow beneficiaries to appeal these restrictions. If a Part D sponsor implemented a point-of-sale edit for a beneficiary based on retrospective review, and that beneficiary then voluntarily changed to another plan, the initial sponsor should share this information with the subsequent sponsor so it can immediately implement similar beneficiary-level edits. CMS is monitoring Part D sponsors' implementation of the opioid overutilization policy, and if warranted, CMS will issue additional guidance to Part D sponsors identified from our oversight of the implementation of these measures.

Additionally, CMS undertook a communication and educational campaign about medication overutilization, particularly opioids, for physicians and pharmacies in the fall of 2012 to support sponsors' strengthened efforts to address this issue in the Part D program. In November 2012, as

[20] Final Calendar Year 2013 Call letter: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2013.pdf and August 31, 2012 HPMS memo "Supplemental Guidance Related to Improving Drug Utilization Review Controls in Part D".

part of the annual Medicare "Dear Doctor" letter (*e.g.*, the "Announcement About Medicare Participation for Calendar Year 2013"), CMS encouraged prescribers to work with Part D sponsors on overutilization case management. To encourage further dialogue between CMS and Part D sponsors about overutilization, we also offered a session on overutilization at the Medicare Advantage and Part D Spring Conference in April 2012.

Monitoring Prescribers and Pharmacies

Part D is potentially vulnerable to fraud at the prescriber and pharmacy levels, as well. Providers and pharmacies may participate in drug diversion by participating in a "pill mill" scheme. This typically involves a pharmacy or other entity that pays kickbacks to a physician to write prescriptions for an illegal or inappropriate purpose so the pharmacy can bill for a Part D drug that is ultimately never dispensed. The HHS OIG, through a series of investigations, identified questionable Part D billing in 2009, including instances where PDE data contained invalid prescriber identifiers[21] and where pharmacies billed extremely high dollar amounts or a high number of prescriptions per beneficiary, prescriber, or per type of drug.[22]

Over the last few years, CMS has taken a series of steps to ensure that valid prescriber identifiers accompany Part D claims and that the MEDIC and plan sponsors are monitoring pharmacy billing patterns. In 2011, to enhance then existing practice and in collaboration with the Drug Enforcement Administration (DEA), we directed Part D sponsors to ensure that the prescriber identifier submitted on a PDE was active and valid starting in the 2012 coverage year, whether it be a national provider identifier (NPI), DEA number, unique physician identifier number, or state license number. Additionally, we began validating the format of all prescriber identifiers on PDEs that were coded as an NPI and excluded from payment reconciliation PDEs with invalid NPIs. We began assessing each sponsor's performance regarding NPI use and validity and notified them of their performance. We also directed Part D sponsors to check that all prescriptions for controlled substances under Part D were associated with DEA numbers that indicated there was appropriate authority to prescribe the controlled substance.

[21] This refers to two upcoming reports. OEI-02-09-00603 "Prescribers with Questionable Patterns in Medicare Part D" and OEI-02-09-00608 "Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority"

[22] OEI-02-09-00600 "Retail Pharmacies with Questionable Part D Billing" https://oig.hhs.gov/oei/reports/oei-02-09-00600.pdf

Through rulemaking finalized in 2012,[23] CMS required Part D sponsors to submit PDEs with active and valid individual prescriber NPIs, beginning January 1, 2013. CMS, through the annual Medicare "Dear Doctor" letter, explained the NPI requirement to prescribers. CMS began to deny any PDE without an active and valid individual NPI beginning on May 6, 2013. We have continued to assess each sponsor's performance regarding NPI use and validity of submitted NPIs and notified sponsors of their performance in preparation for this deadline. Based on this assessment, we found that 99.6 percent of the 2013 PDEs received during the first quarter of the coverage year reported the prescriber's NPI; all but 0.002 percent of the reported NPIs were valid and currently active or active within a year of the date of service. We also examined the taxonomy codes, which are self-reported by the providers to identify their specialty. We found 0.7 percent of these codes would be unreasonable for a prescriber. As a result, we have initiated a review of the PDEs reporting these NPIs to determine what drugs were prescribed, if any are controlled substances, and if the prescriber has a valid individual DEA number.

These actions ensure improved sponsor compliance with the PDE reporting requirements, enhance CMS's ability to review claims data to identify possible fraud and abuse, and help determine whether prescribers of controlled substances are writing prescriptions in accordance with their DEA registration.

CMS has increased its monitoring of prescribers through the Part D Recovery Audit Contractor (RAC), with which CMS has contracted to identify and recover Part D improper payments. In 2011, CMS implemented the RAC program for Medicare Part D, and overpayment recoupment began in November 2012. The Part D RAC recently completed an analysis of PDE data to determine if any claims were prescribed by individuals or entities on OIG's List of Excluded Individuals and Entities (LEIE) for contract year 2007, and is currently reviewing LEIE data for contract years 2008 through 2011.[24]

[23] 77 FR 54664: http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf
[24] More information about Part D RACs is available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Part-D-Recovery-Audit-Contractor.html

Additionally, in response to the concerns identified by recent HHS OIG reports and this Committee, we are currently exploring whether to use the Secretary's authority under section 6405 of the Affordable Care Act to require Medicare enrollment of the prescribing provider in order for the Part D program to cover the provider's prescriptions. This is similar to the Medicare fee-for-service rule that was finalized in April 2012. Based on CMS's experience with the FPS in Medicare fee-for-service and the critical reviews conducted by the HHS OIG, GAO, and this Committee, we have stepped up our efforts to take a cross-sectional look at our data to identify outliers or questionable patterns, particularly with respect to pharmacies. MEDICs are currently analyzing pharmacy data to detect anomalies, trends, patterns, and spikes to identify and refer to law enforcement pharmacies that present a fraud risk. We also plan to share this pharmacy data with Part D plan sponsors and will work with them to ensure they understand what actions they can take when conducting their own reviews of the outlier pharmacies.

CMS also sends letters to Part D sponsors about fraud schemes that are being perpetrated across the country at the beneficiary, prescriber, and pharmacy levels. The letters summarize the schemes and explain how they are perpetrated, and encourage Part D sponsors to contact the appropriate MEDIC if they have encountered a similar scheme.[25] Part D sponsors may deny or reverse claims when they confirm such fraud schemes.[26] Sponsors may also terminate their contracts with indicted pharmacies, as contractually appropriate. This collaboration and information sharing allows CMS, Part D sponsors, and MEDICs to identify potential fraud and stop it before payment is made.

Sharing Data to Fight Abuse

The Affordable Care Act requires the centralization of certain claims data from CMS (Medicare, Medicaid, and the State Children's Health Insurance Program); the Department of Veterans Affairs; the Department of Defense; the Social Security Administration; and the Indian Health Service. Data-sharing makes it easier for agency and law enforcement officials to coordinate and

[25] To see an example of a fraud alert, please visit: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/FraudAlert.pdf

[26] Guidance to sponsors about fraud alerts is available at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/FraudAlertGuidance122211.pdf

identify criminals and prevent fraud on a system-wide basis. CMS has an Integrated Data Repository (IDR), a data warehouse to integrate Medicare and Medicaid data so CMS and our partners can access data from a single source. The IDR provides a comprehensive view of Medicare data including claims, beneficiary, and drug information. The IDR provides greater information sharing, broader and easier access to data, enhanced data integration, and increased security and privacy of data, while strengthening our analytical capabilities. The IDR makes fraud prevention and detection efforts more effective by eliminating duplicative agency and law-enforcement efforts to identify and prevent waste, fraud, and abuse.

The IDR is currently populated with seven years of historical Medicare Parts A, B, and D paid claims, and pre-payment claims data. These additional data may allow us to analyze previously undetected indicators of aberrant activity throughout the claims process. The One Program Integrity ("One PI") web-based portal shares data with our contractors and with law enforcement by providing a single access point to IDR data as well as analytic tools for reviewing the data. CMS is working closely with law enforcement to provide One PI training and support.

Information technology also can help prescribers share data while improving the quality of care and clinical outcomes, while also reducing fraud, waste, and abuse in Part D. E-prescribing can reduce instances of unauthorized, improperly altered, and counterfeit prescriptions. For example, in Part D, an e-prescribing system could show the clinician the patient's real-time medication history across all providers. The e-prescribing tool may indicate if a prescription was filled, what the dosage was, and who prescribed it and when. These data may indicate if the patient is "doctor shopping" for pain medications or other misused drugs. Hospital emergency department doctors appreciate e-prescribing for this reason, as they often struggle to distinguish between an attempt to get medications fraudulently, versus a true medical complaint. An electronic health record with an e-prescribing function provides a more complete picture because it offers the service utilization history, diagnoses, lab results, and other data that can help clinicians determine the best course of treatment and if there is potential fraud or abuse involved, and is part of the meaningful use requirements.

Collaborating with Part D Stakeholders

CMS's approach to program integrity once involved stand-alone programs with siloed communications that did not engage other Federal partners or allow for shared best practices. Now, however, thanks to a variety of efforts, Federal, state, and local law enforcement health care fraud activities are being coordinated to a greater extent than ever before. CMS is also engaging with the private sector in new ways to better share information to combat fraud.

CMS has established collaboration between program officials and law enforcement as a critical cornerstone in improving health care fraud detection and investigation. As a natural progression from early collaborative meetings, on July 31, 2012, CMS opened the Command Center, which provides the advanced technologies and collaborative environment for a multi-disciplinary team of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. Since its opening, the Command Center has supported 61 missions that included over 450 unique participants from CMS and our partners, including the HHS OIG and the Federal Bureau of Investigations (FBI). Earlier this month, the Command Center held an all-day collaborative workgroup about prescription drug fraud; participants included CMS, the MEDIC, a representative from Florida's Medicaid Program Integrity Unit, a Medicaid Fraud Control Unit, and the HHS OIG. They outlined current efforts to prevent and fight prescription drug fraud, discussed barriers and gaps, shared analysis results, and presented new trends.

In addition to CMS's commitment to collaboration, the sustained success of the Health Enforcement Action Team (HEAT) demonstrates the effectiveness of the Cabinet-level commitment between HHS and the Department of Justice (DOJ) to prevent and prosecute health care fraud. Since its creation in May 2009, HEAT has played a critical role in identifying new enforcement initiatives and expanding data sharing to a cross-government health care fraud data intelligence-sharing workgroup. A key component of HEAT is the presence of Medicare Strike Force Teams, interagency teams of analysts, investigators, and prosecutors, who target emerging or migrating fraud schemes such as criminals masquerading as healthcare providers or suppliers.

Medicare Strike Force Teams coordinated three major takedowns in 2012, and CMS took administrative action against 160 providers and suppliers associated with those law enforcement activities. One major takedown included a Miami pharmacy owner who was sentenced to 14 years in prison for a $23 million health care fraud scheme involving illegal kickbacks to physicians in exchange for prescription referrals, which the pharmacies ultimately billed to Medicare.[27]

In addition to collaborating with other agencies, CMS is partnering with the private sector in anti-fraud efforts. Last year, HHS and DOJ announced the creation of a voluntary, collaborative Healthcare Fraud Prevention Partnership, involving the Federal Government, state officials, private health insurance organizations, and other health care anti-fraud groups.[28] The goal of this collaboration is to improve fraud detection and prevent payment of fraudulent health care billings by finding and stopping schemes that cut across public and private payers. CMS and the MEDICs also host quarterly Part C and Part D Working Groups, during which plan sponsors share their experiences with fraud schemes.

Finally, CMS works with the states to address prescription drug abuse. States began to monitor and prevent prescription misuse and abuse more than 60 years ago by creating programs to track the dispensing of prescription drugs. Currently, 49 states have enacted legislation authorizing Prescription Drug Monitoring Programs (PDMPs), and 46 states have operational PDMPs.[29] PDMPs aim to detect and prevent the diversion and abuse of prescription drugs at the retail level by tracking controlled substances prescribed by authorized practitioners and dispensed by pharmacies, including those dispensed to Part D beneficiaries. CMS, through the annual Medicare "Dear Doctor" letter, encouraged prescribers to use PDMPs. CMS also distributed an

[27] More information is available at http://www.justice.gov/opa/pr/2013/February/13-crm-233.html.

[28] Among the first to join this partnership are: America's Health Insurance Plans, HHS (including CMS and HHS OIG), DOJ (including FBI), Amerigroup Corporation, Blue Cross and Blue Shield Association, Blue Cross and Blue Shield of Louisiana, Coalition Against Insurance Fraud, Humana Inc., Independence Blue Cross, National Association of Insurance Commissioners, National Association of Medicaid Fraud Control Units, National Health Care Anti-Fraud Association, National Insurance Crime Bureau, New York Office of Medicaid Inspector General, Travelers, Tufts Health Plan, UnitedHealth Group, and WellPoint, Inc.

[29] *Status of Prescription Drug Monitoring Programs (PDMPs)*, PDMP Training & Technical Assistance Center, available at http://pdmpassist.org/pdf/pmpprogramstatus2013.pdf (last revised June 5, 2013).

article to encourage physicians to use their state PDMPs in the December 2012 issue of the Medicare Learning Network.

The President's Fiscal Year (FY) 2014 Budget includes proposals to build on these efforts. The first proposal would require states to monitor high-risk billing activity in the Medicaid program to identify prescribing and utilization patterns that may indicate abuse or excessive utilization of certain prescription drugs. This proposal, if enacted, would ensure that all states have efforts in place to track high utilizers, and is estimated to save $1.8 billion over ten years. The Administration is evaluating the utility of state PDMPs for reducing Medicare and Medicaid fraud as called for in President Obama's prescription drug abuse prevention action plan.[30] The second proposal would invest $640 million ($311 million base discretionary funding and $329 million proposed mandatory funding) in the Health Care Fraud and Abuse Control Program in FY 2014, to support efforts to reduce fraud through initiatives such as the HEAT task force and the Health Care Fraud Prevention Partnership.

Conclusion

CMS's role in the Part D program is not to just pay for drug coverage, but to ensure the best possible care for its beneficiaries. As evidenced by my testimony today, we are addressing the serious issues raised by the Committee, HHS OIG, and the GAO through a number of reforms, including enhanced Medicare provider screening, advanced data analysis, and improved stakeholder collaboration to change how we approach waste, fraud and abuse and improve the accuracy of our payments. CMS is broadening its focus from ensuring beneficiaries have access to prescribed drugs to ensuring that Part D sponsors implement effective safeguards and provide coverage for drug therapies that meet standards for safety and efficacy. CMS will continue to work with the Congress and this Committee in protecting taxpayer dollars, beneficiary health, and the integrity of the Medicare program.

[30] *Epidemic: Responding to America's Prescription Drug Abuse Crisis.* Executive Office of the President of the United States. 2011. http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan_0.pdf