U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

July 10, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Medicare Part D: Measures Needed to Strengthen Program Integrity."

On July 14, 2015, at 10:00 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Medicare Part D: Measures Needed to Strengthen Program Integrity."

Medicare Part D is the fastest-growing component of the Medicare program. Between 2006 and 2014, spending for Part D drugs increased by 136 percent, going from $51.3 billion to $121.1 billion. As a result of the program's growth in spending, Part D has been vulnerable to fraud. On June 18, 2015, the Department of Justice announced that a nationwide sweep led by the Medicare Fraud Strike Force resulted in charges against 243 individuals for their participation in fraud schemes involving approximately $712 million in false billings.[1]

In conjunction with the nationwide takedown, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released two reports in June 2015, which highlighted potential fraud and abuse as well as identified systematic weaknesses that make Part D fraud and abuse possible. Given the substantial Federal dollars spent on Medicare Part D, and evidence of fraud and abuse in the program, the Subcommittee is conducting oversight to ensure that the program operates more effectively and tax dollars are spent efficiently. In particular, this hearing will examine the findings of two recent HHS OIG reports, "Ensuring the Integrity of Medicare Part D," available here: http://oig.hhs.gov/oei/reports/oei-03-15-00180.pdf,[2] and "Questionable Billing and Geographic Hotspots Point to Potential Fraud and Abuse in Medicare Part D," available here: http://oig.hhs.gov/oei/reports/oei-02-15-00190.pdf.[3]

[1] U.S. Dep't. of Justice, *National Medicare Fraud Takedown Results in Charges Against 243 Individuals for Approximately $712 Million in False Billing*, June 18, 2015, *available at* http://www.justice.gov/opa/pr/national-medicare-fraud-takedown-results-charges-against-243-individuals-approximately-712.
[2] U.S. Dep't of Human Services, Office of Inspector Gen., *Ensuring the Integrity of Medicare Part D*, OEI-03-15-00180 (June 2015).
[3] U.S. Dep't of Human Services, Office of Inspector Gen., *Questionable Billing and Geographic Hotspots Point to Potential Fraud and Abuse in Medicare Part D*, OEI-02-15-00190 (June 2015).

I. WITNESSES

- Ann Maxwell, Assistant Inspector General, Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services

- Shantanu Agrawal, M.D., Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

II. BACKGROUND

Medicare Part D Facts and Figures

Medicare Part D was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide an optional prescription drug benefit for Medicare beneficiaries.[4] This program started on January 1, 2006, and there are approximately 39 million beneficiaries who receive Part D supplemental coverage for outpatient prescription drugs through more than 2,000 plans sponsored by private companies.[5] Payments for Part D drugs in 2014 were approximately $121 billion per year, which was up by 136 percent from 2006 when payments were $51.3 billion per year.[6] The Centers for Medicare and Medicaid Services (CMS) is responsible for the oversight of the Part D program.[7]

June 18, 2015 National Medicare Fraud Takedown

On June 18, 2015, the Department of Justice announced a nationwide Medicare fraud takedown, which led to charges against 243 individuals for approximately $712 million in false billing.[8] More than 44 of the defendants arrested were charged with fraud related to Medicare Part D, which, according to the Administration, is the fastest-growing component of the Medicare program. The defendants were charged with various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes, money laundering, and aggravated identity theft.

Following the takedown, the OIG released two reports—a data brief and a portfolio—on Medicare Part D. The reports highlighted potential fraud and abuse as well as identified systematic weaknesses that make substantial Part D fraud and abuse possible.

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[4] U.S. Dep't of Human Services, Office of Inspector Gen., *Ensuring the Integrity of Medicare Part D*, OEI-03-15-00180 at 1 (June 2015).
[5] *Id*.; Kaiser Family Foundation, Medicare at a Glance, Fact Sheet (August 2014), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2014/09/1066-17-medicare-at-a-glance.pdf.
[6] *Id*. The $121 billion represents the negotiated payment to pharmacies, which includes not just federal government contributions, but also beneficiaries' co-payments and co-insurances.
[7] *Id*.
[8] U.S. Dep't. of Justice, *National Medicare Fraud Takedown Results in Charges Against 243 Individuals for Approximately $712 Million in False Billing*, June 18, 2015, *available at* http://www.justice.gov/opa/pr/national-medicare-fraud-takedown-results-charges-against-243-individuals-approximately-712.

OIG Data Brief, Questionable Billing and Geographic Hotspots Point to Potential Fraud and Abuse in Medicare Part D

The HHS OIG data brief was based on an analysis of prescription drug event (PDE) records from 2006 to 2014. In its data brief, the OIG described trends in spending for Part D drugs and identified questionable billing associated with pharmacies, prescribers, and beneficiaries. From 2006 to 2014, Part D spending increased by 136 percent, from $51.3 billion to $121.1 billion. The total number of beneficiaries receiving commonly abused opioids grew by 92 percent, compared to 68 percent for all drugs. The average number of prescriptions for commonly abused opioids per beneficiary grew by 20percent, compared to three percent for all drugs. More than 1,400 pharmacies had questionable billing for Part D drugs in 2014. Together, these pharmacies billed $2.3 billion to Part D in 2014 alone. Further, OIG identified pharmacy-related fraud schemes in Part D, including drug diversion, billing for drugs that are not dispensed, and kickbacks.

OIG Portfolio, Ensuring the Integrity of Medicare Part D

The HHS OIG portfolio was an overview of the OIG's investigations, audits, evaluations, and legal guidance related to Part D. In this portfolio, the OIG reported that Part D remains particularly vulnerable to fraud, resulting in an increase in Part D fraud complaints since the program's inception. As of May 2015, the OIG had 540 pending complaints and cases, a 134-percent increase in the last five years. Further, CMS does not currently require plan sponsors to report information on fraud, so less than half of sponsors choose to do so.

The OIG's portfolio highlighted several vulnerabilities and weaknesses exposing Medicare Part D to waste, fraud, and abuse. For example, excluded providers have been allowed to continue to prescribe Medicare Part D drugs. The Medicare Drug Integrity Contractor (MEDIC)—a private company which CMS contracts with to detect fraud, waste, and abuse in Part D—has conducted very little proactive data analysis to detect fraud waste, and abuse, which has allowed questionable billing and improper billing to go undetected. Part D inappropriately paid for drugs ordered by individuals who do not have the authority to prescribe, such as massage therapists and athletic trainers. Part D has also inappropriately paid for Schedule II drugs billed as refills. Because Schedule II drugs have a high potential for abuse and diversion, and are considered dangerous, Federal law prohibits refilling them. The OIG also found that Part D has continued to allow payments on behalf of deceased beneficiaries.

Further, the OIG has nine outstanding recommendations that CMS has not implemented that would greatly reduce the risk of fraud and abuse in the Part D program. All of these recommendations were issued to CMS in at least one previous OIG report, and in some instances, up to five previous reports dating back to 2006. The nine outstanding recommendations include:

- Require plan sponsors to report all potential fraud and abuse to CMS and/or the MEDIC (Recommended in October 2008, October 2009, February 2012, May 2012, and March 2014).

- Require plan sponsors to report data on the inquiries and corrective actions they take in response to incidents of fraud and abuse (Recommended in October 2008 and February 2012).

- Expand drug utilization review programs to include additional drugs susceptible to fraud, waste, and abuse (Recommended in August 2014).

- Implement an edit to reject prescriptions written by excluded providers (Recommended in December 2011).

- Exclude Schedule II refills when calculating final payments to plan sponsors at the end of each year (Recommended in September 2012).

- Restrict certain beneficiaries to a limited number of pharmacies or prescribers (Recommended in August 2014).

- Develop and implement a mechanism to recover payments from plan sponsors when law enforcement agencies do not accept cases (Recommended in January 2014).

- Determine the effectiveness of plan sponsors' fraud and abuse detection programs (Recommended in October 2008, February 2012, and March 2014).

- Ensure that plan sponsors' compliance plans address all regulatory requirements and CMS guidance (Recommended in December 2006).

III. ISSUES

The following issues may be examined at the hearing:

- Does CMS agree with the OIG's recommendations?

- Why has CMS not implemented the OIG's recommendations?

- What specific actions does CMS plan to take to address OIG's recommendations?

- Is CMS using all the tools at its disposal to mitigate vulnerabilities in the Medicare Part D program?

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Jessica Donlon, Alan Slobodin, or Brittany Havens of the Committee staff at (202) 225-2927.