Statement of Louis Saccoccio

Executive Director

National Health Care Anti-Fraud Association

on

"Costs of Prescription Drug Abuse

in the Medicare Part D Program"

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Good morning, Chairman Carper, Ranking Member Brown and other distinguished Members of the Subcommittee. I am Louis Saccoccio, Executive Director of the National Health Care Anti-Fraud Association (NHCAA).

In October 2010, a Kansas physician named Stephen J. Schneider and his wife, Linda K. Schneider, a licensed practical nurse who also acted as the office manager of her husband's pain management clinic, were sentenced to 30 and 33 years in federal prison, respectively, for illegally distributing prescription pain medication to patients who overdosed. A four-year investigation of this "pill mill" uncovered evidence of extensive over-prescribing of controlled substances by Dr. Schneider. More than 100 drug overdoses requiring visits to Wichita-area emergency rooms and the deaths of at least 68 persons are linked to this case, as well as more than $4 million in Medicaid and private insurance claims. A 34-count indictment charged the Schneiders with health care fraud resulting in death, unlawfully dispensing controlled substances resulting in death, conspiracy, submitting false claims and money laundering. After an eight-week trial, the jury convicted Stephen Schneider on 19 counts and Linda Schneider on 32 counts, finding that the couple directly contributed to the deaths of several patients. Presiding U.S.

District Judge Monti L. Belot offered a bleak and succinct summary of the case calling it "an avoidable tragedy motivated by greed."[1]

As demonstrated by the Schneider case, prescription drug fraud is clearly a dangerous crime that can yield tragic results, including death, and I appreciate the opportunity to discuss the problem with you.

The National Health Care Anti-Fraud Association (NHCAA) was established in 1985 and is the leading national organization focused exclusively on combating health care fraud in all its forms. In my testimony today, I draw upon our organization's 25-plus years of experience focusing on the fraud issue. Health care fraud is a serious and costly problem that affects every patient and every taxpayer in America. The extent of financial losses due to health care fraud in the United States, while not entirely known, is estimated to range in the tens of billions of dollars or more. Extrapolating to apply those estimates to prescription drug spending suggests that billions of dollars may be lost to fraud annually in that area alone.

NHCAA is uncommon among associations in that we are a private-public partnership—our members comprise more than 85 of the nation's most prominent private health insurers, along with nearly 90 federal, state and local government law enforcement and regulatory agencies that have jurisdiction over health care fraud who participate in NHCAA as law enforcement liaisons.

[1] http://www.justice.gov/usao/ks/PressReleases/2010/oct/Oct20a.html

NHCAA's mission is straightforward: 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. The weight of this mission is the same regardless of whether a patient has private health care or prescription coverage as an individual or through an employer, or is covered by a public program such as Medicare, Medicaid, or TRICARE.

Prescription Drug Fraud and Diversion

NHCAA believes prescription drug fraud will continue to grow as a segment of the health care fraud problem based on three factors: 1) projected increases in spending for prescription drugs, 2) the expansion of health coverage envisioned by the Affordable Care Act, and 3) our experience and insight about health care fraud trends. National Health Expenditure Data reveal that in 2009, $250 billion dollars were spent on prescription drugs and by 2020, that spending is projected to more than double, reaching $513 billion.[2] It is notable that in 2014 an estimated 18 million Americans will become newly insured under Medicaid and through Exchange plans,[3] significantly influencing the 10.7 percent annual increase projected for prescription drug spending in that year alone.[4] Private and public insurers underwrite 78 percent of all spending on prescription drugs in the U.S., while consumers pay roughly just one-fifth of the cost.[5] This means insurers shoulder the bulk of exposure, risk and ultimately financial losses resulting from drug diversion and other prescription drug fraud schemes. It is notable that while year-to-year

[2] https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf
[3] http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf
[4] https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf, Table 11
[5] https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf, Table 11

increases in spending on prescription drugs is predicted, the Office of the Actuary within the Centers for Medicare and Medicaid Services (CMS) observes that these consistent increases are tempered somewhat by the anticipated loss of patent protection for many brand-name drugs.[6]

The financial losses due to health care fraud are compounded by instances of patient harm and sometimes death—unfortunate and insidious side effects of health care fraud. As shown by the Schneider case, the nature of prescription drug fraud, with its risks of overdoses and unsafe drug interactions, often leads to patient harm. The Office of National Drug Control Policy calls prescription drug abuse "the Nation's fastest-growing drug problem,"[7] and the Centers for Disease Control and Prevention classifies prescription drug abuse as an epidemic. The 2011 National Drug Threat Assessment report produced by the Department of Justice National Intelligence Center says that the abuse of controlled prescription drugs "constitutes a problem second only to the abuse of marijuana in scope and pervasiveness in the United States."[8] Of course, prescription drug abuse in itself does not necessarily indicate fraud. Abuse (resulting in overdoses and deaths) can certainly occur in situations where the prescription drugs were legitimately obtained for legitimate purposes. Nevertheless, fraud likely plays a role in many instances.

I had the opportunity to review the Government Accountability Office (GAO) report released publicly today, "Medicare Part D: Instances of Questionable Access to Prescription Drugs" and concur with many of the report's findings and recommendations. It is my understanding that the

[6] https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf, Forecast Summary
[7] http://www.whitehouse.gov/ondcp/prescription-drug-abuse
[8] http://www.justice.gov/ndic/pubs44/44849/44849p.pdf

GAO was requested to examine the drug-seeking behaviors of Medicare beneficiaries under the Part D program, focusing on those who obtain prescriptions for frequently abused drugs from multiple prescribers and then fill them at different pharmacies. This practice is frequently referred to as "doctor shopping" and represents one form of a broader prescription drug fraud scheme commonly referred to as drug diversion.

While doctor shopping by patients is the primary focus of the GAO report, NHCAA believes it is important to acknowledge that prescription drug fraud and diversion can take many forms and be extremely complex. For example, doctor shopping isn't always perpetrated by beneficiaries alone. Sometimes prescribing physicians, as well as pharmacists, are complicit or even drivers in the scheme. Patients also may be involved with the forging of prescriptions using prescription pads that have been stolen from legitimate physicians. Other schemes include unscrupulous physicians selling prescriptions to abusers or street dealers. Still another has perpetrators taking part in a criminal enterprise directed at reselling drugs in high volume (and for large profits) on the street. Regardless of the form drug diversion takes there is usually a common thread—the drugs are obtained and paid for by filing false insurance claims.

Significantly, the money lost to prescription drug fraud through payment of bogus pharmacy claims is only a part of the financial impact of this problem. In the process of obtaining a prescription, a patient typically will generate claims for related medical services. Insurers often find that they have paid not just for unnecessary medications but also for related emergency room visits, in-patient hospital stays, visits to physician offices and clinics, diagnostic testing and rehabilitation—all based on phantom injuries, illnesses and conditions feigned in order to obtain

a prescription. Then there are the additional costs associated with treating the addictions and overdoses arising from this behavior.

To offer some perspective, a 2007 study produced by the Coalition Against Insurance Fraud titled "Prescription for Peril," states that WellPoint, Inc. found that it "paid $41 in related medical claims for every $1 it paid in narcotic prescriptions for suspected doctor-shopper plan members."[9] That is an astonishing ratio and a significant waste of medical resources.

A survey conducted by the Substance Abuse and Mental Health Services Administration's Office of Applied Studies (SAMHSA/OAS) titled "The Drug Abuse Warning Network (DAWN) Report," finds: "The estimated number of emergency department (ED) visits involving nonmedical use of narcotic pain relievers rose from 144,644 in 2004 to 305,885 in 2008, an increase of 111 percent."[10] While we can't assume that all of those emergency room visits were the result of prescription drug fraud and abuse, we can reasonably assume that many of them were and therefore the cost of some of those visits constitute fraud losses.

Private Insurer Programs

NHCAA insurer members have acknowledged doctor shopping as a fraud trend for the last several years and anti-fraud efforts by our members regularly identify dangerous prescription drug abuse by patients. Most often, it's the insurer that is best able to connect the dots and

[9] http://www.insurancefraud.org/downloads/drugDiversion.pdf
[10] http://oas.samhsa.gov/2k10/dawn016/opioided.htm

identify overprescribing by physicians and prescription drug abuse by patients based on review of claims data. Many insurers use pharmacy benefit managers (PBMs) to carry out pharmacy functions, tasking them also with claims integrity. However, because a PBM's responsibility is typically limited to prescription claims it is often unable to detect the larger scheme that takes into account the related medical services.

In order to meet the growing threat of prescription drug fraud, particularly doctor shopping, several NHCAA members are devoting significantly increased resources to the problem, developing policies to quickly detect suspected doctor shopping and drug diversion, and implementing programs to stop it.

The Humana Example

National insurer Humana currently has 24 investigative anti-fraud staff members dedicated exclusively to prescription drug fraud, equating to nearly a quarter of its entire anti-fraud investigative manpower. By January 2012, Humana plans to increase its pharmacy anti-fraud team by an additional 10 to 12 investigators.

To try and identify possible doctor shopping the Humana special investigations unit (SIU) has developed what it calls the 333 report. It is a data mining report that searches across the company's nationwide claims data to identify insureds who over the last year have gone to three or more prescribing doctors, have filled prescriptions at three or more pharmacies and have received three or more prescriptions for schedule III or IV controlled substances. The SIU then

takes a closer look at the report results to try and identify members who appear as if they might be engaging in doctor shopping (it's not uncommon to find members who have seen 10+ doctors, received 10+ controlled substance prescriptions, and filled them at 10+ pharmacies). For Humana's commercial health insurance business they are able to look at the member's medical history and this will often help the investigator determine if the suspected fraud is being perpetrated by the member alone or if a prescriber or pharmacy is likely complicit. For example, Humana may see that several oxycodone prescriptions have been written by a physician and filled by the patient, but the member's record may show that no correlating medical claims were submitted. Or the member has received prescriptions for similar drugs from numerous doctors but has filled them all at the same pharmacy. In this case, the investigator might question if the pharmacist is turning a blind eye.

When an investigator is reasonably confident that doctor shopping is taking place Humana reaches out to the member to acknowledge the suspicion and offer help, including an offer to get the member into a treatment program. A letter is also sent to each prescribing physician making him/her aware that the patient has sought similar prescriptions from multiple doctors. The member receives a copy of each letter as well. Humana continues to monitor the member to see if behavior changes; for example, is there a switch to new doctors or are there suddenly visits to the emergency room based on ailments that might yield narcotic prescriptions?

When Humana determines that doctor shopping has occurred the member may be required to participate in a restricted recipient program or "lock-in" program whereby the member is limited to filling prescriptions at one pharmacy (a lock-in program could also require a patient to receive

prescriptions from just one doctor, but Humana's program only applies the restriction to pharmacy). Humana often will try to select a chain pharmacy as the single option so that the member can visit any location of that chain, thus maintaining convenience and a level of freedom. This lock-in program was put in place for Humana's commercial business two years ago and the results have been extremely positive. While Humana is not permitted to use a lock-in program for its Medicare Part D members, it does run 333 reports for Part D claims data and reports suspected doctor shopping to Health Integrity, the Medicare Drug Integrity Contractor (MEDIC).

Humana also does Medicaid business in the state of Florida, which is administered through Florida's Agency for Health Care Administration (AHCA). A year ago, Humana was granted permission by AHCA to establish a pharmacy lock-in program for Medicaid members who meet certain criteria indicating a high probability of prescription drug fraud. This program also utilizes a 333 report, albeit with slightly different criteria: the Medicaid beneficiary has filled three controlled substance prescriptions at three different pharmacies within a three month period. The agreement with AHCA allows Humana to lock-in a Medicaid enrollee for a one year period.

The WellPoint Example

Another national health insurer, WellPoint, Inc. has in place what it terms as a "pain management" program to address behavior that indicates possible doctor shopping. Like Humana, WellPoint had in place a 333 reporting program for its commercial business. Then a couple years ago, a new program was developed within WellPoint's State Sponsored Business

division called the Controlled Substance Utilization Monitoring (CSUM) program. The CSUM program was built as an automated program and was adopted for use by WellPoint's Medicare Part D, commercial and state sponsored business.

The parameters used by WellPoint's CSUM program to identify drug seekers include:

- CSUM will only look at members who are 18 years of age or older (no minors).
- There must have been 10 or more claims for controlled substances (narcotics, benzodiazepines, hypnotics) within a 90-day period.
- There must not be any claims for multiple sclerosis or oncology medication (otherwise the 10+ claims for controlled substances may be appropriate).
- Members may be re-identified every three months.

The list of members that results from running the CSUM program based on the above criteria will serve as the basis for monthly mailings to prescribing doctors, aimed at making them aware when one of their patients has been going to several providers seeking similar prescription drugs. Here is an example of the type of language used in the letter sent to physicians: "Prescription claims suggest this patient has filled 10 or more prescriptions for controlled substances within 3 months. Multiple providers may have prescribed these medications, as seen in the Patient Profile. Regular monitoring is needed to treat pain, ensure patient safety, and minimize opioid dependence. If you have not reviewed this patient's medications recently, please review them soon."

The Patient Profile, which is mailed together with the letter, lists the controlled substances filled during the three-month period and includes information like dispensing date, the drug name and strength, the quantity prescribed and the prescriber name.

In 2009, analysis was done of the CSUM program for WellPoint's Medicare Part D program. In total, 35,246 members met the intervention criteria. Of those, 17,151, or a remarkable 49%, decreased controlled substance utilization following the intervention, showing great promise for this program.

Between November 2010 and January 2011, 23,472 letters were sent to prescribing physicians under WellPoint's Medicare Part D business and 29,372 letters were sent involving members under WellPoint's commercial health insurance business (including their California state sponsored business). Utilization outcomes resulting from those mailings are not yet available.

As with Humana, WellPoint employs a restricted recipient program for its commercial business but is not authorized to lock-in any Medicare Part D members. Alanna Lavelle, WellPoint Director of Investigations and NHCAA Board member says that the restricted recipient program "has been a very effective program, has saved lives (addicts who have gone for assistance and thanked us), has saved millions in facility fees and is something we can use to better manage care."

WellPoint also applies other investigative and data mining techniques to try and detect prescription drug fraud. Some of these include utilizing geo-mapping technologies to identify

members who appear to be traveling long distances to obtain controlled substances from physicians or pharmacies, identifying prescribers who are writing prescriptions that fall outside their scope of specialty, and looking closely at large concentrations of claims coming from a single pharmacy.

Humana and WellPoint are just two examples of insurers that are using monitoring, notifications, and restricted recipient programs with success. With these promising models it is understandable that the GAO has recommended that CMS consider use of a restricted recipient program for Medicare Part D.

NHCAA is encouraged by the memorandum dated September 28th issued by CMS to Medicare Part D sponsors asking for their comments "on how the Medicare Part D program can more successfully exert control over payment for inappropriate overutilization of drugs." In addition to responding to the ideas outlined in the memo, NHCAA suspects that many Part D sponsors will suggest that a restricted recipient program be considered to curb drug-seeking behavior due to drug abuse or diversion.

State Prescription Drug Monitoring Programs (PDMP)

Thirty-seven states now have prescription drug monitoring programs (PDMP) which are electronic databases that collect data on dispensed substances in that state. Each PDMP is hosted by a state agency (regulatory, administrative or law enforcement) and each respective authorizing state law dictates who is eligible to receive program information.

NHCAA sees promise in state prescription drug monitoring programs for helping to identify fraud and saving finite health care resources. Even more important are the opportunities PDMPs offer to help ensure quality of care and patient safety, and even save lives. NHCAA recommends that state investments in these monitoring programs be incentivized whenever possible. Until every state has a PDMP in operation there will continue to be incentives for drug seekers to travel to states without a PDMP. NHCAA members have told us that their claims data often reveals that enrollees living in a state with an operational PDMP will travel to a state without a PDMP to get their prescription drugs. National insurer Humana tells us that they had often seen Kentucky-based members traveling to Florida for prescriptions, which until this year had no PDMP. Florida's new program went into effect on September 1.

Also, NHCAA recommends taking full advantage of interoperability opportunities among state prescription drug monitoring programs for states sharing boundaries with one another. For instance, in August 2011, Kentucky Governor Steve Beshear announced the formation of an interstate task force with border states Ohio, Tennessee, and West Virginia committed to targeting fraudulent or abusive prescription drug activities in those states. Governor Beshear explains: "This problem is destroying a lot of our families in Kentucky. We think together we can be a lot more effective."

The idea, espoused by PDMP advocates, of sharing information in order to be more effective in identifying prescription drug fraud and abuse resonates with NHCAA. Since our founding, NHCAA has been a facilitator of information sharing and our experience has taught us that

sharing investigative information is critical in combating health care fraud. The Schneider pill mill case discussed early in my testimony offers a perfect illustration of private-public partnership and information sharing. The investigative team in that case included private-sector investigators working with federal and state agency investigators.

Emerging Prescription Drug Fraud Trends

Health care fraud, whether it relates to prescription drugs or other aspects of our health care delivery system, is an exceptionally complex crime that manifests in countless ways. Fraud trends and schemes are constantly changing, developing, shifting, migrating and morphing and the task for anti-fraud professionals to stay ahead of the threat is daunting. Detecting health care fraud often requires the knowledge and application of clinical best practices, as well as knowledge of medical terminology and specialized coding systems, including CPT and CDT codes, DRGs, ICD-9 codes, and the forthcoming ICD-10 codes. Prescription drug fraud detection demands specialized knowledge of drug classification systems like the American Hospital Formulary Service (AHFS), National Drug Codes (NDC) and Generic Code Numbers (GCN).

Consider some of the following emerging trends in the prescription drug fraud arena:

- Drug seekers who are aware that their doctor shopping behaviors are being monitored are making several visits to emergency rooms in order to gain access to drugs.
- A new drug combination has emerged known as "Holy Trinity" which consists of opiate agonists, benzodiazepine, and muscle relaxants that produces a heroin-like high. Insurers are data-mining for that combination of drugs, whether prescribed together or as

individual prescriptions from three different physicians. This drug combination presents a high overdose risk; therefore, detecting abuse is a means to managing quality of care.

- Physician self–prescribing of schedule II controlled substances is seen as a growing problem.
- Some insurers are finding that diagnoses are being altered so that human growth hormone (HGH) will be a covered benefit, when in reality it is being used for body-building and youthfulness.
- Recurrent early refills, self-escalation of dosage without a documented change in medical condition, and a patient repeatedly claiming that medications were lost, stolen or spilled are often signs of drug diversion.
- Requesting brand name only prescription drugs may be an indicator of drug diversion. The "secondary market" or street value of brand name prescription drugs is significantly higher than generic drugs.

Hopefully, these few examples of emerging prescription drug fraud trends help provide a bit of perspective of how broad the array of fraud schemes is and the challenge investigative professionals face in trying to identify and then effectively address new fraud threats.

Conclusion

Prescription drug fraud is a serious issue with severe patient harm risks. Overdoses resulting from the abuse of prescription drugs are sadly commonplace and in many cases the drugs taken were obtained by filing false claims. In meeting their obligations to provide coverage and make

prompt claims payments, health insurers, including government programs and private health care payers, often pay for the unnecessary prescription drugs as well as the related medical services. Insurers are devoting increased attention and resources to this problem, devising new and innovative ways to detect possible drug diversion and taking appropriate steps to stop it, while also trying to help patients in need of intervention and treatment.

In the last two years CMS has demonstrated a commendable determination to ferret out fraud, waste and abuse in the Medicare, Medicaid and CHIP programs. The Center for Program Integrity of CMS has made it one of its goals to move from a pay and chase mode of fraud-fighting to one based on prepayment detection and prevention, focusing significantly on predictive modeling and data analytics. Great strides have already been made, including implementation of a predictive modeling program for Medicare fee-for-service that launched July 1. Increased emphasis on stopping prescription drug fraud and diversion in Medicare Part D program should be part of these efforts.

Today's GAO report findings certainly indicate that Part D is vulnerable to prescription drug abuse. The September 28 memo from CMS giving Medicare Part D sponsors the opportunity to comment on how to best address the problem of "inappropriate overutilization of drugs," will surely yield some good ideas worthy of consideration. In addition, some state Medicaid programs and private health insurers have implemented innovative programs, including overutilization reports, letter campaigns making prescribers aware of possible drug-seeking

behavior, and restricted recipient programs, that CMS may want to consider adopting for the Part D program.

Thank you for allowing me to speak to you today. I would be happy to answer any questions that you may have.