TESTIMONY

Curbing Prescription Drug Abuse in Medicare

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Mr. Chairman and members of the Senate Committee on Homeland Security and Government Affairs, I am Alanna Lavelle, Director of Special Investigations for WellPoint, Inc. WellPoint is one of our nation's largest companies providing health and ancillary benefits to consumers and businesses, with nearly 36 million people in our affiliated health plans, and nearly 68 million people served through our subsidiaries. I also serve as the Chair of the National Health Care Anti-Fraud Association, the leading national association composed of both private and public sectors focused exclusively on fighting health care fraud and abuse. I joined WellPoint in 2004, after serving 25 years with the FBI. My experience in the FBI included managing a national health care fraud case during the critical Columbia/HCA investigation and initiating the first Health Care Fraud Task Force in Texas. I also served as the Supervisory Special Agent FBI liaison for the Centers for Disease Control (CDC), working closely with the CDC on Bioterrorism matters in the post 9/11 era. I am a registered Mediator and a Certified Professional Coder. I hold a M.S in Conflict Management and a B.A. in International Relations.

Thank you for the opportunity to provide testimony on behalf of WellPoint on a critically important issue that often yields tragic results: prescription drug abuse in the health care delivery system.

As one of the largest health benefits companies with nearly 36 million lives in our affiliated health plans, WellPoint believes that it is critical to address health care fraud and abuse. In a time of rising health care costs, it is essential to stop funding illegitimate uses of prescription drugs. The National Health Care Anti- Fraud Association estimates that financial losses due to health care fraud and abuse range from $70 to $234 billion a year — about $190 to $640 million per day. At WellPoint, we have a number of innovative strategies in place to do our part to eliminate wasteful spending.

However, the cost goes beyond the billions of dollars consumers, payers and the government spend unnecessarily. It also puts consumers' health at risk. For example, the steadily increasing incidence of physicians overprescribing narcotics that are not medically necessary contributes to inappropriate drug use by teenagers, patient overdoses and even death.

In order to truly make inroads into the problem of fraud and abuse associated with prescription drugs, a holistic view needs to be adopted, since the enormous costs of health care fraud are borne by all Americans, whether they have private health insurance coverage or government-provided health care. Moreover, it is clear that many of the same individuals and

entities that perpetrate fraud against government health care programs also engage in fraudulent activity in the private health insurance industry. Thus, the most effective way to address prescription drug fraud and abuse is to forge a close and active partnership between private health plans, government agencies, and the provider community. Fraud and abuse affects both publicly funded health care programs and privately funded health benefits — and it is only through cooperation and collaboration between the public and private sectors that the problem can be meaningfully addressed.

In addition, it is important to understand that stopping prescription-drug fraud and abuse will require a multifaceted approach, as there is more than one problem and more than one source. For example, drug fraud or abuse can be caused by overutilization (drug abuse) or fraudulent prescribing (for financial gain), and can be driven not only by the recipients of the drugs but also by prescribing providers. In addition, new schemes to defraud the system are constantly changing and evolving. For this reason, it is important to recognize that a one-size-fits-all solution does not exist. WellPoint stands ready to share with policymakers its range of experience in fighting prescription drug fraud and abuse and to work together with Congress, the Administration, and the agencies of jurisdiction to improve our partnership in this regard.

One of the significant strengths that WellPoint and other health plans provide is the data available from our integrated health care delivery system. This allows us the ability to see the entire health care spectrum and spot trends and outliers – such as the overprescribing physician or the patient receiving multiple prescriptions from multiple providers or pharmacies. For WellPoint's members that have both pharmacy and medical coverage under WellPoint, we have been able to identify:

- Members in crisis or at risk of harmful prescription drug use, including abusive or potentially addictive usage patterns;
- Members who may benefit from chemical dependency and/or pain management intervention to improve quality of life;
- Provider practice patterns regarding the overprescribing of medications; and
- Criminal enterprise and/or individuals defrauding the health care system, through the work of our fraud and abuse Special Investigations Unit (SIU).

Our goal at WellPoint is to prevent prescription drug fraud and abuse for the benefit of our members' health, as well as for the health care system as a whole. In order to meet this goal, WellPoint has developed numerous programs to identify prescription drug abuse and to intervene when appropriate.

WellPoint's Special Investigations Unit

To enhance our efforts to combat fraud and abuse, WellPoint has a dedicated fraud and abuse prevention team known as the Special Investigations Unit (SIU). I am one of the lead investigators, overseeing a team in the Southeast region. The SIU, led by a former Los Angeles Assistant United States Attorney, is staffed with employees having prior experience in the FBI, state law enforcement, and state insurance department fraud units. Medical professionals, including doctors and nurses who have clinical and coding expertise, also work within the SIU. Finally, the data analysis team is comprised of individuals with IT or other computer-related backgrounds. The investigators are responsible for investigating assigned cases in order to detect fraudulent, abusive or wasteful activities/practices and to recover funds paid on such claims. Our programs at WellPoint also include collaborative efforts between our SIU and our contracted pharmacy benefit manager, Express Scripts, to identify retail pharmacies cooperating with overprescribing or inappropriate prescription patterns and to exclude such pharmacies from our provider networks.

Current Trends in Prescription Drug Diversion

Today, some of the top fraud and abuse schemes we currently see in prescription drug coverage include:

- The practice frequently referred to as doctor shopping, whereby individuals obtain prescriptions for frequently abused drugs from multiple prescribers and then fill them at different pharmacies. Oftentimes providers as well as pharmacies are involved in the scheme.
- Bogus providers: these are providers that, although they may have National Provider Identifier numbers (which are usually stolen or purchased), do not actually perform services for real patients but bill insurers.
- Pain management doctors overprescribing pain medications.

WellPoint currently has 160 investigations open involving Part D, which include drug seekers (doctor shoppers), identity theft, over-prescribers and bogus pharmacy cases. WellPoint SIU refers every Part D case to the MEDIC, and WellPoint has the second highest number of referrals to the MEDIC nationwide. Our advanced analytics team at SIU target fraud and abuse including:

-Identification of member drug seeking and doctor shopping

-Geographic concerns - patients traveling long distances to prescribers and or pharmacies

-Regional/national prescription fraud and abuse trends

For example, in 2011, WellPoint had a Part D member who obtained 77 controlled substances from 59 physicians filled at 51 pharmacies. Physician specialties identified on the member's profile included emergency medicine, dentistry, dermatology, cardiology and internal medicine. This member drove to five outlying states to obtain and fill prescriptions and used eight different dentists for controlled pain medications. The member also visited 29 different emergency departments, averaging $800 per visit in her drug seeking efforts. While we referred the case to the MEDIC, we were unable to restrict the individual, as we currently do not have a restricted recipient program in place in Part D.

WellPoint's Successful Fraud Prevention Programs

Our goal at WellPoint is to prevent health care fraud and abuse for the benefit of our members' health, as well as for the health care system as a whole. As such, WellPoint has developed a number of different types of programs to identify and prevent prescription drug fraud and abuse. Some of these include:

- Controlled substance utilization monitoring (CSUM) program
- Medicare and Medicaid restricted recipient program
- Pre-pay provider review program
- Bogus providers/pharmacies
- Predictive modeling program

Controlled Substance Utilization Monitoring (CSUM) Program

Our nation has a significant problem with prescription narcotic drug abuse and patients have, at times, gamed the system by a practice known as doctor shopping, whereby individuals obtain prescriptions for frequently abused drugs from multiple prescribers and then fill them at different pharmacies. Often times, they make multiple emergency room visits in order to obtain multiple prescriptions for narcotic drugs. This results in increased costs, not just for unnecessary medications, but also for related emergency room visits, in-patient hospitals stays, and visits to physician offices and clinics – all based on phantom illnesses and injuries used simply to get a prescription. WellPoint has found that its affiliated health plans have paid $41 in related medical claims for every $1 paid in narcotic prescriptions for suspected doctor shopping members.

Through a controlled substance utilization monitoring program, (CSUM), health insurers can aid in patient safety and identify those who are engaged in or contributing to prescription drug abuse. Our CSUM program in our commercial and Medicaid business identifies members who, within a three month period, visit three or more prescribing providers, visit three or more pharmacies, and have filled ten or more controlled substance prescriptions (narcotics, benzodiazepines and hypnotics) without a confirmed underlying medically necessary condition (such as cancer or multiple sclerosis) to justify numerous controlled substances. The goal is to prevent members who have exhibited a pattern of obtaining multiple prescriptions for controlled substances from different providers and multiple dispensations of these medications from continuing to obtain inappropriate amounts and dosages of drugs through their health care coverage. Members who are identified through this program are alerted to oversight of their Schedule II prescription drug activity and case managed. To date, the program has been very successful; for example it has helped saved millions of dollars in emergency department visits for drug-seeking behavior. There has not been significant abrasion, and in fact some members have found the program helpful in managing their treatment.

Medicaid Restricted Recipient Program

WellPoint has also implemented a restricted recipient program for our Medicaid plans in Indiana called “The Right Choices Program,” and in Virginia called “RX Safe Choice,” in which a member who has been identified at risk for abuse of controlled substances can be restricted to

the use of only one primary care physician, one retail pharmacy, and one hospital for any non-emergency care. Our case managers, who work specifically with both the Indiana and Virginia membership, work directly with providers and members regarding excessive controlled substance use. Once a member is placed in the program, the primary medical provider must approve all referral providers for the member. Efforts are made to connect members with behavioral health providers, case managers and community resources related to abuse and addictions.

WellPoint supports giving CMS the authority to establish a restricted recipient program in Medicare Part D for those beneficiaries displaying a pattern of misutilization. To ensure members' safety, WellPoint believes that plans should not implement policies of denying a prescription fill, even in cases of suspected overutilization. WellPoint asks that CMS be responsible for taking any enforcement action once members suspected of misuse or overutilization has been identified by the plan sponsor.

Provider Engagement in the Prescription Drug Trade

Provider involvement in the prescription drug trade of narcotics and other expensive drugs is a serious problem in our country, in particular in the state of California. As noted in a November 11, 2012 *Los Angeles Times* article, "federal researchers reported that emergency room visits resulting from the non-medical use of opioid prescription drugs - often used in pain relief - more than doubled from 2004 through 2008. There were as many visits for those prescription medications as for illegal drugs."[1] *Times* reporters analyzed 3,733 prescription drug-related deaths in four Southern California counties, revealing that just 71 doctors – one-tenth of one percent in those counties- had written prescriptions in 17 percent of such fatalities over six years. WellPoint SIU plays an instrumental part in identifying to California law enforcement agencies those providers who prescribe narcotics to individuals with no underlying medical conditions because it has access to pharmacy information and relevant medical records, enabling the identification of trends and outliers. We provide quarterly reports identifying the top prescribers in each California county and prepare individual reports where the recipients of the narcotics do not have underlying medical conditions.

[1] *Los Angeles Times*, November 11, 2012; "Legal Drugs, Legal Outcomes," by Scott Glover and Lisa Girion

Pain Management Doctors

Operation Pillbox is an example of a recent, ongoing initiative by WellPoint's SIU to identify providers who engage in unsafe practices that defraud insurers.

WellPoint's SIU launched Operation Pillbox in 2007, when our investigators noticed unusual prescribing patterns involving end-stage cancer drugs. Our investigators, working on behalf of our California health plan, determined that a number of physicians were prescribing an unusually large quantity of a very strong narcotic meant to treat cancer patients with severe pain. Their research found that just 10 physicians prescribed more than a quarter of that drug in the entire state, with some patients receiving more than $200,000 worth of the medication, despite the lack of clinical evidence that the patients had cancer.

The team then expanded their research to include other Schedule II narcotic drugs (such as oxycontin). They discovered that some physicians were prescribing these potentially addicting and life-threatening drugs with little or no medical justification. Believing that the suspect physicians may have been involved in the illegal sale and distribution of narcotics, WellPoint's investigators shared with local, state, and federal law enforcement authorities our information regarding the physician's background and prescribing patterns, the pharmacies involved, and the patients receiving the largest volume of the prescriptions. As a result, several of the physicians identified by Operation Pillbox have been arrested and criminally charged or stripped of their medical licenses. One of the physicians was linked to the overdose deaths of thirteen of his patients.

Pre-Pay Provider Review Program

Part of WellPoint's antifraud-program activities includes examining physician practice patterns, to determine whether outlier physicians whose practices are different from the norm are engaging in questionable behavior that are driving up costs and impacting patient safety. WellPoint investigators are able to identify aberrant provider practice patterns through data mining and analytics in which they look for outlier activities, such as significant dollar spikes in payments or cumulative dollar spikes in certain counties. WellPoint has implemented two such pre-pay provider review programs in which the most egregious billers who, after being educated and refusing to modify their billing behavior, are placed on "Flagged Pre-Payment Review." For

example, providers are identified as outliers if they show patterns of engaging in billing practices that are extremely aberrant compared to their specialty peers. "Upcoding" (coding a less intensive service as a more intensive procedure), billing an incorrect code to obtain coverage for a noncovered service, or billing at a particular facility to obtain extra reimbursement (e.g., billing a simple toenail clipping performed in an outpatient facility as debridement performed at an ambulatory surgery center) are examples of such outliers.

If a provider shows a pattern of engaging in such outlier behavior, WellPoint investigators and Medical Directors intervene to communicate with the provider to educate and attempt to correct his or her behavior if appropriate. About 60 percent of providers change their practices within 90 days after receiving such communications. However, the 40 percent of providers that continue to engage in incorrect coding may be placed on pre-pay review. In that case, providers must bill with paper claims accompanied by medical records so that we can determine whether the procedures billed for are reflected in the records.

Bogus Providers/Pharmacies and Identity Theft

Bogus providers are those providers that, although they may have National Provider Identifier numbers (which are usually stolen or purchased), do not actually perform services for real patients. Instead, bogus providers steal or purchase patient identification numbers, establish a fake storefront office furnished with limited inventory, obtain a post office box, and proceed to bill insurers for fraudulent services and devices. Bogus providers are a significant problem in both commercial health insurance as well as in the Medicare Advantage and Medicare Part D programs.[2]

WellPoint takes a multifaceted approach to identifying bogus providers and preventing their fraudulent billing. SIU's Provider Database team alerts investigators to the presence of new labs, pharmacies and durable medical equipment (DME) clinics, and performs a full background check as well as a drive-by of the provider's purported office space. WellPoint also matches U.S. Post Office box numbers against our current claims to determine whether multiple bogus providers are using the same P.O. Box to receive payments (or whether the new provider has simply switched names and continues to fraudulently bill). To date, in the state of California

[2] Of note is that Section 6401 of the Affordable Care Act provides for a ninety-day period of enhanced oversight for the initial claims of DME suppliers where HHS suspects there may be a high risk of fraudulent practices.

alone, WellPoint has stopped over 239 bogus DME providers before they were able to submit fraudulent claims to the company. Additionally, during the past six months, WellPoint has identified and targeted 63 bogus pharmacies through collaboration with our pharmacy benefit manager, Express Scripts. Through our combined efforts we have been able to terminate contracts and stop payments to these bogus pharmacies resulting in savings of $2.1 million.

A great example of the proactive work of the SIU in identifying bogus providers and also collaborating with our public partners at CMS and DOJ involves identifying and deterring health care fraud in the Medicare Advantage program. After a tip from one of our Medicare Advantage members who received an EOB for thousands of dollars of services he did not receive from an unknown provider, WellPoint commenced an investigation that led to the discovery of what appeared to be a large medical identity theft scheme perpetrated by an organized crime group. Further investigation of this organization resulted in discovery of bogus providers who were submitting fraudulent Medicare Advantage claims. In many cases, the perpetrators had stolen the provider identification numbers from local physicians, and utilized stolen Medicare Advantage identification members' numbers. Once this information was in hand, they began a deliberate and well-executed conspiracy to defraud our Medicare Advantage program. Our investigation revealed that claims paid from bogus providers were often for billings of a high volume of expensive infusion therapy (cancer and HIV-related) treatments for unknown conditions and from unknown providers. The claim profile of these providers exhibited the characteristics of having invalid contact information (but including identification information from legitimate doctors to make them appear genuine), as well as irregular banking methods to cash payment checks.

Our SIU worked closely with claims operations areas to develop a proactive program to assist in identifying any provider fitting the same claim and provider profile as the bogus providers. The proactive process involves identifying any previously unknown provider billing the suspicious high dollar infusion therapy. These providers and their claims are immediately pended in the system and submitted to the SIU for review. Additionally, with respect to providers already in the claims systems with the same billing and provider profile, an edit process was inserted in the claims system to pend and review claims similar to those used by the bogus providers.

As a result of the investigation, in 2011 SIU identified 36 bogus providers who engaged

in this scheme. Due to the proactive work of SIU, $33 million dollars of fraudulent claims were stopped during the claims adjudication process, or newly issued checks to the perpetrators were stopped before they were negotiated. The total amount in savings to the Medicare Advantage program was $33,748,292.94.

Predictive Modeling

WellPoint has recently contracted with a vendor to provide an automated solution to enable WellPoint to continuously monitor medical (professional claims on CMS Forms 1500) claims across the company in a post-payment or future pre-payment environment. The initial rollout focuses on deploying the solution in the post-payment environment. WellPoint initially rolled out the program in Georgia, with the intent to implement it enterprise-wide in 2013.

The program uses advanced neural network technology from FICO[3] to identify previously unknown and emerging fraud and abuse provider/member schemes. FICO-based analytics score suspect claims on a scale of 1-1000 and identify aberrant provider/member behaviors. Suspect providers and claims are reviewed by a triage unit and the SIU to identify potential fraud, waste or abuse, and depending on the type of findings are then assigned to the investigative unit to investigate, prevent and stop ongoing fraud and abuse.

Since we began using this tool, WellPoint's SIU has opened 200 investigations and has achieved $27 million in projected savings to date. For example, the program has revealed patients with consecutive days of anesthesia, which is not medically likely, as well as lab testing for cardiac risk or food sensitivities where labs were billing for hundreds of units of antigens. The program has also identified certain weaknesses in our systems and procedures, which we then work quickly to strengthen. In 2013, WellPoint will save over $13 million alone by placing a system edit for urine drug testing abuse by labs, one of the collateral abuses spawned by prescription drug abuse in the U.S.

[3] FICO is the acronym for Fair Isaac Corporation, which provides analytics and decision making services to assist financial services organizations in making complex, high volume decisions

Recommendations:

Based on our experience in combating prescription fraud and abuse, WellPoint offers the following recommendations to enhance future efforts throughout all sectors of health care:

- **Medicare Restricted Recipient Program**

WellPoint supports giving CMS the authority to establish a restricted recipient program in Medicare Part D for those beneficiaries displaying a pattern of misutilization. WellPoint systematically reports beneficiary-specific concerns— based on objective, standardized metrics—to CMS or to Medicare Drug Integrity Contractors (MEDIC) for appropriate action against the individual beneficiary. To ensure members' safety, WellPoint believes that plans should not implement policies of denying a prescription fill even in cases of suspected overutilization. From a health plan perspective, we would want to work with the prescribing physician and/or refer the case to CMS or its delegate. WellPoint asks that CMS be responsible for taking any enforcement action once members suspected of misuse or overutilization have been identified by the plan sponsor. Once sufficient due diligence has been conducted by CMS or its delegate to demonstrate abuse, or upon recommendation of the provider, the member can be placed in the restricted recipient program which the plan sponsors manage pursuant to clear regulatory protocols.

- **Dual Eligible Beneficiaries**

Through our experience in providing health care coverage through both our Medicaid state-sponsored programs and Federal programs, we have observed that a large portion of the opioid and controlled substance abuses in the Part D program occur among the dual eligible population – beneficiaries eligible for both Medicare and Medicaid and often under 65 years of age. In calendar year 2012 alone, WellPoint's SIU unit tracked 69 investigations of Medicare Part D beneficiaries under the age of 65. Under current law, dual-eligible beneficiaries are allowed to change plans on a month-to-month basis, which permits drug seekers to switch programs frequently in order to avoid detection and escape program edits or substance abuse programs.

WellPoint recommends that dual eligible beneficiaries with evidence of drug-seeking behavior should be locked into one managed care plan, rather than continue to be allowed to switch plans on a monthly basis to evade detection.

- **Improved Partnerships**

WellPoint supports better coordination and cooperation among CMS, DOJ, and all stakeholders. Right now, there is little collaboration between the agencies and the health plans that oftentimes have the information, experience and expertise necessary for preventing and fighting fraud and abuse. In order to be truly effective throughout the health care system, both public and private sectors should be working together to share successful anti-fraud practices, effective methodologies and information about ongoing fraud investigations. For example, while health plans currently share information with the MEDIC, we are rarely informed of the ultimate result, and information collected by the agency is rarely shared with the private payers. Another example is that CMS does not share information on revoked Medicare providers with private payers.

However, we are optimistic by the creation last year of the Healthcare Fraud Prevention Partnership, a voluntary partnership composed of both the public and private sector for the purposes of reducing the prevalence of health care fraud. WellPoint is an active participant, and I serve on the Data Analysis and Review Committee. It is our hope that the work of the partnership will lead to successful public/private collaboration in the prevention and detection of health care fraud.

- **Encourage Fraud Prevention by Private Health Insurers and in the Medicare Advantage Program**

Experience has proven in both private and public program fraud investigations that fraud prevention is much more effective and cost-effective than pursuing "pay and chase" type fraud investigations. "Pay and chase" investigations recoup only about 20 cents on the dollar, while fraud prevention investigations result in dollar-for-dollar savings by avoiding improper payments. Moreover, fraud prevention investigations often remove fraudulent and harmful providers from the healthcare system before they can do more damage to public and private healthcare programs and their members. In recent years the Department of Justice and HHS have

adopted successful fraud prevention tactics. The federal government should do everything it can to encourage fraud prevention for private health insurers, as well.

One way this can be done is to permit health insurers to lift the current restriction on health insurers' fraud programs in the Medical Loss Ratio (MLR) calculation, which appears in the MLR regulations for both commercial health insurers[4] as well as Medicare Advantage.[5]

For both public and private health care programs subject to the MLR, expenses for health insurer anti-fraud and abuse programs should be included as "activities that improve health care quality" in the MLR calculation, since they reduce waste in the health care system, reduce the cost of health care, and enhance patient safety by helping identify and remove providers and individuals engaging in unsafe and fraudulent practices from the health care system.

Currently the MLR final regulations for both commercial health insurance and Medicare Advantage merely give insurers a limited credit – up to the amount of fraud recoveries – for fraud prevention activities. In essence, this means that insurers will have to include as administrative expenses their largest portion of antifraud expenses -- those dedicated to fraud prevention. It is truly puzzling that at a time when the federal government is accelerating its efforts to prevent fraud in Medicare and Medicaid it has simultaneously issued regulations that will serve to discourage health insurers' fraud prevention efforts in the private and public sectors. Ironically, eliminating antifraud programs will tend to increase MLR percentages because claims will be higher, but an increased MLR will be at the expense of patient safety, quality of care, and controlling health care costs, which are the very goals of the Affordable Care Act.

If health insurers are discouraged from keeping their anti-fraud programs in place at the same time that anti-fraud efforts are increasing in the traditional Medicare program, federal law enforcement will lose a valuable source of information and tips about providers and recipients who may also be engaging in defrauding public programs. Additionally, restricting the expenses that Medicare Advantage plans can incur for fraud prevention activities may foster fraud and abuse in that program.

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[4] See 45 C.F.R. 158.140(b)(2)(iv).
[5] See 42 C.F.R. 422.2420(b)(2)(ix).

In conclusion, I would like to thank the Committee for the opportunity to testify today on behalf of WellPoint on this critical issue, and pledge our support in any efforts to make the health care system financially viable and safer for our members.