Combatting Fraud, Waste and Abuse in Medicare Parts C and D

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Stacey Plizga: And we are delighted to have with us our next speakers, who will share how to identify potential fraud, waste and abuse and take appropriate action. From the Division of Plan Oversight and Accountability, Beth Brady, Dominca Howard, and Camille Brown.

Beth Brady: Thank you. In this last session of the agenda, our segment is actually broken up into three separate topics. The topic I'm going to address is the current schemes and issues that we're seeing in Medicare Part C and D. What you see on this map -- and this information is coming from our contractor, the National Benefit Integrity MEDIC contractor -- are the top five states that account for 52% of their investigations in Medicare Part C and D. The map shows the top five states, and this is identified with current data to date for fiscal year '16. It's California, Florida, Pennsylvania, New York, and Texas. And, actually, as I mentioned earlier, this represents 52% of their investigation. If you want to round out to the top ten, the remaining five states are New Jersey, Georgia, Illinois, Michigan, and Ohio.

This graph here represents from last fiscal year, fiscal year '15, what types of investigation, what schemes that the National Benefit Integrity

Contract actually investigated. You will see number one, at 31%, is drug diversion. If you look at the next two, billing for services not rendered and misrepresentation of services or products, you will, if you add those three up, those three percentages, they represents two-thirds of all the investigation. Just moving down the rest of the investigation types you can see things like kickbacks, quality of care, revocation, and duplicate or fraudulent billing. But we just wanted to share these top statistics with you.

Now, twice a year we offer in-person fraud, waste, abuse training, and the attendees at these training sessions are the plans, normally your special investigation unit staff, sometimes your compliance staff. As I said, these are face-to-face meetings where the plan, CMS, and law enforcement and the contractors get together to talk about what they're seeing, what they're working on. And we find these training sessions to be very valuable, so we can kind of focus where we need to be.

From this last training session, which took place in March, what you'll see here are these topics, these issues that were reported to us by the plans who were in attendance at this session. You will see at the top DME supplies not received. Specifically, it was diabetic testing strips. You'll see a number of different lab scheme, genetic testing, allergy testing. All of these schemes that you see listed on this slide here were actually referred by the plans to the MBI med medics for additional investigation.

Now at these training sessions we also have plenty of opportunity to network and talk about what issues are being looked at. By issue where I make the differentiation is that these are things that the plans are looking at, they're further investigating, and maybe at this point have not yet been referred because they're still looking at it. Our purpose is sharing this information with you is that you can go back and look at your data and

focus on these type of things to see if they are affecting what's going on at your plan. And if it's appropriate, after your investigation, it may constitute referral, either to the NBI MEDIC or perhaps to law enforcement. Again, just highlighting some of the things that you see are identity theft, both provider and beneficiary, and billing for customized equipment without any face-to-face encounter with the patient.

Moving into Part D, here is, again, recent schemes that the plans reported to us at our training session. You see the first one is subsys prescriptions without clinical indication of cancer. Subsys is an opioid pain medication to treat cancer pain, collusion between pharmacies and doctors. Doctor shopping amongst beneficiaries. And, again, for these types of schemes, the plans have referred these to the NBI MEDIC and they are undergoing further investigation.

Now, on a few slides before this, I mentioned very briefly genetic testing fraud scheme. I want to bring this to your attention for a couple reasons. As you can see the type of things we were seeing or we heard about were these labs were billing for high dollar medically unnecessary tests without any specific medical condition or a physician order. Beneficiaries were being targeted at health fairs. They were being targeted at ice cream socials or senior housing or assisted living facilities. And you also see on the left side of the slide that the NBI MEDIC actually received complaints against one single laboratory.

We did issue a fraud alert last year on this topic. We do issue fraud alerts when it's brought to our attention that a scheme is rather widespread, it's with the intention of alerting you and keep up to date on what we're hearing about and what we're seeing, so, again, you can look at you data to see if you're being victimized by the same type of scheme.

On the other side, in addition to referrals to law enforcement, our outreach and education contractor frequently provides, through their website, inserts that could be customized by the plan to add to beneficiary' EOBs. The messaging is the same, specific to whatever the topic is, and then the plan can add their name and their customer service number. So an insert on this particular topic to alert beneficiaries of the schemes to be aware, not to give out their ID to people, that type of thing, was made available last year, and just within two months we know that there were 400 downloads on this insert alone. So we think this is a very effective way to get messaging out to beneficiaries that potentially are victims, and we're very pleased that the plans are actually using this resource that's available to them.

I talked earlier, you can see the focus was on providers, and I want to now focus a little bit on beneficiary fraud. Law enforcement is now more actively pursuing beneficiaries with health-care fraud. The schemes are becoming more brazen and bold. We're seeing an increase in collusion and coordination amongst some beneficiaries, providers, and pharmacies. And we're seeing targeted recruiting efforts, trying to encourage beneficiaries to get involved in fraud. So, again, we want to bring this to your attention, and the next slide I'll look at some of the schemes, so that, again, you can look at your data, focus on these type of things, and if you see something after your investigation that you think is a problem, we recommend certainly that you refer it to law enforcement and/or the NBI MEDIC.

And just now, to go over some of the schemes involve beneficiary fraud. At the top you see drug-seeking beneficiaries, identity theft -- again I referenced that earlier -- relationships and kickbacks with providers or pharmacies; recruiting, high-dollar drugs with high street value, again, for

big profit; and enrollment and eligibility fraud, attempting to enroll and qualify for low income subsidies.

I thank you for your time, and at this point I'd like to turn it over to Dominca Howard who will talk about the next segment in our presentation. Thank you.

Dominca Howard: Thank you. Awesome. So, good afternoon. I'd like to give you a brief introduction to the new cutting edge data resource that CMS launched in 2015 to help support investigations. It is already widely used in the Medicare Advantage and Part D stakeholder communities among plan sponsors, law enforcement, the NBI MEDIC, and CMS.

So the big question is, what exactly is PLATO? PLATO is a web-based fraud detection tool that is designed to enhance the Medicare advantage and Part D programs oversight and operations. Investigative outcomes associated with pharmacies and prescribers referenced as providers in PLATO can be tracked in this PLATO application. PLATO also helps you identify potential fraud, waste, and abuse leads using data projects, which work to identify fraud schemes using national data summary information. This data information is updated on a regular basis.

So the next question is, why was PLATO developed? In a congressional hearing in June 2013, congress mentioned the need to use data analytics to proactively address fraud, waste, and abuse in the Medicare Part D program. This mandate was also to address the drug diversion and associated beneficiary and public harm caused by this problem. A solution was needed to proactively address fraud, waste, and abuse at earlier stages rather than the pay-and-chase approach. Since plan sponsors directly pay Part D claims, a solution was needed to help plan sponsors detect the aberrant activity.

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Plant sponsors also have claims generated under their respective contract and don't have access to the entire bandwidth of data that would enable them to make better informed decisions. So, prior to PLATO, actions taken by one sponsor against providers or pharmacies couldn't be viewed by another plan sponsor. PLATO addressed this limitation. Some of the benefits with PLATO is it allows users to review Medicare Advantage and Part D pharmacy and provider investigative leads. It also makes national data available and shares action taken by other Medicare Advantage and Part D sponsors in real time. Also, it contains data from the Medicare Advantage and Part D pharmacies and providers and offers additional details on those high-risk leads that are identified in the data project results. So the users within PLATO, again, are CMS, law enforcement, plan sponsors, and the NBI MEDIC.

So in addition to containing the national summary data, PLATO also helps to build an overall picture of provider and pharmacy activity. It is a valuable communication tool for tracking and sharing the resulted outcomes of investigative activities. Plan sponsors can see, again, in real time the actions that have been taken by the high-risk prescriber pharmacies or by the NBI Medic or another plan sponsor. PLATO allows users to visualize risk category trends for pharmacies and prescribers that fall into a high, medium, or low fraud, waste, and abuse risk category. Users can review detailed business profiles, including such information as the business owner and the location to assess a relationship between the providers and the pharmacies. So to help support your investigation, CMS developed this cutting edge data resource that many of you, hopefully, are using today.

So PLATO can be an effective asset for your users. It offers a magnitude of information that will aid in the identification and development of investigations. The CMS approved data projects are the key components

of PLATO, used for identifying potential leads to who may be committing the fraud, waste, and abuse. By using the national data on pharmacies and providers, the NBI MEDIC developed the data project that identified the risk factors in areas that at high risk for fraud, waste, and abuse, and assigns these subjects risk scores. These risk scores help the users recognize the noteworthy subjects to further investigate and review for possible fraud, waste, and abuse.

Currently, there are three data projects that are loaded within PLATO, and in the near future we'll be loading even more projects. These three projects are the pharmacy risk assessment and a prescriber risk assessment, in addition to the Pill Mill Doctor Project.

Here are a couple screenshots of PLATO. So as the PLATO team, we work continuously to improve the tools and functions and to add some new features to make it more effective to aid in your investigative efforts. These are a few example screenshots, as I stated. The provider and pharmacy tab shows leads from existing data projects. Users can look at the relationship graph to see how various entities are related, and identify others that they may not have been aware of. This graph allows you to see other providers and pharmacies that are linked to the profile that they are reviewing. Filters are available, so they can see different relationship types, such as just a provider or just the pharmacy, as well as filtering to see who shares the same practice address, the billing address, or who shares beneficiaries. Users can even select a link and receive a snapshot of information about such NPIs, risk scores and total paid amount in the relationship graph.

Okay, there are also detailed NPI reports available within PLATO. The reports provide a great amount of detail about the high-risk NPI within PLATO. Users may also use these reports to assist in their investigation.

Another feature within PLATO is the homepage map. Rather than looking for a list of providers and pharmacies of interest, the map provides a view of the actual physical location of providers and pharmacies on the map. By being able to apply such options and filter criteria, we can see the possible leads in their location. When selecting a provider or pharmacy pin on the map, you are able to see a small pop-up screen that provides brief details about the provider and pharmacy, and select, as well as the ability to access their profile. This small pop-up window also gives users the advantage of being able to see the physical location with a 360-degree street view. This allows you to see exactly what it looks like in that area.

So some current stats. Sorry.

Stacey Plizga: We're having a bit of technical difficulty. Just hang on for a moment and we'll get right back to the presentation. In the meantime, if you have a question for any of our presenters today, remember that open Q&A session is coming up at the end of the day, and we are still taking questions that we can address at that time. So if you were unable to get your question in, please send it in.

Also, at the end of today, we will have a survey that will go out to all of the participants, and we do ask that you take the time to complete that survey and tell us about your experience here today so that we can improve upon it for future events.

Dominca Howard: So, thank you.

Stacey Plizga: You're welcome. Back to you.

Dominca Howard: Well, back to the PLATO stats. So, currently, there are over 700 users that are taking advantage of PLATO's great features. This includes over 380 plan sponsors, CMS, and law enforcement users, in addition to 320 plant sponsors, contract administrators and NBI users. These numbers are continuing to grow as more and more people learn about the collaborative value and analysis features of PLATO.

These 700 users have already documented over 3,100 activities, all of which are being shared among PLATO users. Some examples of these activities are corrective action plans, payment suspensions, post payment reviews, provider education, and referrals to the NBI Medic or law enforcement.

So, thank you very much for taking the time today to learn about PLATO. And we encourage all plan sponsors to use PLATO in their compliance and investigative efforts. So, next, I'm going to turn it over to Camille, Brown.

Camille Brown: Thank you, Dominca. So, good. I'm going to talk to you a little bit about our self-audit process that we conducted this year. So over the last couple of years, CMS has worked closely with plan sponsors to really try and improve their performance under the Medicare contract. And part of this has been done through our audits, whether it's an onsite audit or a desk review or our self-audits. One of the goals of our audits is to really ensure the appropriateness of program coverage under the Medicare Part D program, as well as ensure the accuracy of billing once coverage has actually been determined.

This year we have embarked on a limited scope of audits, and those audits have really focused on areas that have been brought to our attention as a concern. The limited scope of audits were turned into self-

audits this year instead of the actual full scope onsite audits, and they were really intended to assess the effectiveness of plan sponsor compliance, as well as for plan sponsors to utilize those audits as a tool to sort of implement additional measures into their current program. Also, we really wanted to assess the outcomes of the onsite audits versus the self-audits.

I want to talk a little bit about the subject of the self-audits, how we selected those plan sponsors and what target areas, we actually look at. What CMS did is that we conducted a data analysis, a proactive data analysis of prescription drug event records for select drugs. And the initial focus was to really look at drugs that may have been inappropriately paid under the Medicare Part D program. We also looked at proactive data analysis to determine what plan sponsors were inappropriately paying for Part D drugs. And based on those results, we developed our scope and our focus of those self-audits.

So I'm going to talk a little bit about the audit process, because we defined the scope and the focus of the audit, we began the process. We developed an audit protocol and sent that out to planned sponsors for them to use as an aid in conducting their self-audits. But we first started off with an engagement letter, and the engagement letter really provided some high-level details and expectations of what the self-audit would consist of. It focused on providing information on the contracts would be under the audit, the period that the audit would cover, as well as the drugs that would be selected for the audit. In addition to that, we provided the anticipated webinar dates, as well as the contact dates where we would hold a kickoff meeting.

So after we sent out the engagement letter, we did follow up with a kickoff meeting, and the purpose of the kickoff meeting was to really provide,

again, an overview of the self-audit process, as well as discuss any issues, concerns, the expectations, and any other logistical concerns.

So when we started the self-audit process this year, we really tried to focus on how we could streamline the process, how we could get the most and minimize resources between CMS and plan sponsors. We developed the self-audit process into two phases. We focus on, one, a webinar facilitative process, and then we focused on a self-audit process, which the sponsor was responsible for completing on its own.

So the self-audit process was really a process where the plan sponsor was responsible for walking CMS through their systems. It was an opportunity to discuss with CMS how they would provide supporting document patients towards the sample PDE records that we identified as inappropriate.

One thing we'd like to mention is that during the self-audit process, and even during the kickoff meeting, it's extremely important that you have your key folks there that are able to answer questions and to assist you along the process. And that would be folks that would really be in charge of your operational areas, folks that are familiar with your internal policies and procedures, and folks that would be responsible for going and pulling electronic records or entering into your electronic systems to really show CMS how you can support those payments of being appropriate.

So, again, at the time of the walk through, we provide plan sponsors with a sample during the webinar, and we just walk through a couple of those cases. Once the webinar is complete, we do go back and we expect for the plan sponsor to complete that sample. They complete the sample and then they return it to CMS. After it's returned to CMS, we review it and revalidate it. When we finish our validation of those results, we contact

the sponsor, is there any issues or concerns. If there are not any issues or concerns, we allow the plan sponsor to move forward and proceed with reviewing the remaining PDE records that with identified in that particular universe.

Typically, we give plan sponsors six weeks to complete the review of those PDE records that are in the universe. Once that is actually completed, we expect for them to send us the final results. After we receive the final results, CMS conducts their own validation and their review. And based on those findings, what we do is we send out a closeout letter. And what the close out letter includes is basically the findings and the results based on our review. And depending on the focus and what the results and the findings are, plan sponsors may be expected to delete the PDE records, and we give them, typically, 90 days to delete PDE records that were identified as inappropriately. And throughout that process, while you're deleting the PDE records, we will do periodic checks to make sure that those deletions were successfully processed.

So, once the entire audit review is completed, we sort of looked at what are the benefits of the self-audits versus the onsite audit. And rather than doing a full scope onsite audit, we found that the self-audits are really an effective way to review less complex issues. We also found that plan sponsors, really, they're the ones that are at the forefront. So they're learning themselves what their actual payment errors were and how to correct those errors occurring in the near future. It certainly reduces time between CMS and the plan sponsor, and we are currently conducting a lessons learned, as well as a best practice, from the self-audits that we recently conducted to improve our current process.

So, with that said, we will open it up for questions.

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Scott Levine: Hi. Scott Levine, with the Affinity Health Plan. It's still not totally clear to me what the plan is expected to do following the webinar. Is the plan supposed to basically review and audit a sample that's selected by CMS, or does it go beyond that? And, typically, how large is that sample?

Camille Brown: So CMS will send you a sample, and they'll send you a sample one week in advance of the webinar, and the expectation is to not go through the entire sample during the review but select just a couple of cases and let us know how you determined those cases were appropriate.

Scott Levine: Okay. And can you give me any kind of feel for, typically, how large these samples are, or do they really vary depending upon the plan?

Camille Brown: Yeah, the samples would really vary depending on the plan.

Scott Levine: Okay. Thank you.

Stacey Plizga: Okay. Our in-house audience, please feel free to step up to the mic should you have a question. And then I do have some questions from our virtual audience, and the first one is, "Do you consider cases of drug diversion consisting of cash payments for opioids or other controlled substances by beneficiaries as FWA; meaning, they bypass the use of their PPB to obtain the medication?"

Beth Brady: Could you just repeat that?

Stacey Plizga: Sure.

Beth Brady: It's a little long, so I just want to make sure I got it all.

Stacey Plizga: Absolutely. "Do you consider cases of drug diversion consisting of cash payments for opioids or other controlled substances by beneficiaries as FWA; meaning, they bypass the use of their PPB to obtain the medication?"

Beth Brady: In that situation, I mean, it's certainly not the way that particular drug should be handled. The reason I'm hesitating on saying fraud, waste, and abuse is because the way I understand the question, it's bypassing the Medicare program completely. The way I understand the question, it's like me going to someone on the street and buying something. I'm not submitting anything to my insurance carrier. That's the way I understood the question; that it's just strictly a cash transaction and no program is getting involved in that transaction. It's wrong, but as I said, it's not affecting the Medicare program or any of the plans.

Stacey Plizga: All right. The next question that I have here from our virtual audience, "Do you have any suggestions or tips for how PDP plans with no access to medical claims data can become more effective in their FWA efforts?"

Beth Brady: That's a good question. We certainly understand the limitations that PDP plans face. There are, however, a number of things that can be accomplished. Dominca talked a lot about PLATO and the benefits of PLATO. For those of you who use it -- and we hope everyone's using it -- we encourage you to enter the actions that you're taking, effective actions. Again, it's not identifying you or your plan as to what -- you know, who did it, but you're showing that perhaps you removed a pharmacy from your network or you provided some education. So that's a tool that if you're using PLATO, you can see what other plans are doing to correct inappropriate actions.

There's a lot of tools that are available on our Outreach and Education website, that, again, help you in an investigation. So I think the important thing that would recommend, and I think Camille and Dominca would echo that, is to work closely with your FDR. So if you stay on top of things, if you have any questions, if you're not sure, you can reach out to CMS. You could certainly reach out to MBI Medic. If it's appropriate to make a referral, the MBI Medic will continue the investigation, bring in law enforcement when needed. So, again, we understand the limitations, but we do believe there are some positive steps that can be taken.

Stacey Plizga: Okay. Thank you. The next question that I have "Can a plan sponsor have more than two users per contract number?"

Dominca Howard: So, currently, no. But we are looking at possibly, later on, expanding that number.

Stacey Plizga: Okay. All right. Lots of questions here, popular group. "If we are providing benefits in any of the states that are high in the potential for FWA, is there anything specific we should be doing?"

Beth Brady: Thank you. The reason we do provide this information -- and, again, this is what we provided in our face-toe to-face training programs -- is to give you a head's up basically. If you have business in those states, we're not saying that your plan is effective, but it is to give you the head's up that this situation is going on, these schemes are taking place, and to focus -- you know, in your plan for the year, focus on those types of things. That's why the information is being shared with you, so you know whether this is something I need to be concerned about or, for whatever reason, I'm not affected by it. But, again, we want to share this information so that you can stay on top of it, as much as we want to stay on top of it as well.

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Stacey Plizga: Thank you. "What are the expectations of the audits?"

Camille Brown: So the expectations of the audits is really for the plan sponsors to collaborate with CMS, to communicate with us, to provide as much documentation as possible when you're conducting your audits in order to support those payments that have been identified as inappropriate. It's also an opportunity to really use it as an educational tool, as a learning tool to sort of identify areas within your organization that you can improve.

Stacey Plizga: Okay. Thank you. "Can a contract administrator also be a PLATO user?"

Dominca Howard: Well, we would prefer not. We prefer for the contract administrator to provide the licenses to other individuals within an organization. The contract administrator, we would hope, is the compliance officer within the organization. So that's something that we would not suggest.

Stacey Plizga: Okay. Our next question, "If we identify a new scheme, how can we share that information?"

Beth Brady: Again, I referenced the training sessions. In addition to the face-to-face training we provide, we actually offer two webinars each year. I mean, webinars are good, don't get me wrong. I mean, it allows an opportunity for those plans that cannot travel to the face-to-face meetings to participate. Our attendance in the webinars is increasing every single time we do them, and we're very grateful to the new attendees, as well as those that have joined in the past. So that's one opportunity.

As I mentioned, bringing CMS into it, you have your account manager. Contact any of us in Center for Program Integrity and DPOA. Talk to the MBI Medic. So there's plenty of avenues that we encourage you to use to

share this information so that, again, the more information we all have collectively all helps us in combating fraud, waste, and abuse.

Stacey Plizga: Okay, our next question, "How frequently are the data projects updated?"

Dominca Howard: So they're pretty much updated regularly. The Pill Mill Data Project is updated on a monthly basis. The pharmacy risk assessment is updated on a quarterly basis, and then the prescriber risk assessment, that's a static report.

Stacey Plizga: Next question that I have is, "If we find a similar pattern to what has been identified in a fraud alert, what should we do?"

Beth Brady: As I mentioned earlier, the purpose of the fraud alert is for us to share with you what we know is taking place. The fraud alert, again, strongly recommends that you look at your own data and not take any action unless it's based on the data you are seeing, not just the fact that we said, X, Y, Z is taking place somewhere else. The fraud alerts always have the same messaging at the end, talk to your account manager, talk to the MBI Medic. Again, communication is the key to all of this, so we can all sort it out. But that's what we recommend, is to make those contacts if you're unsure of anything.

Stacey Plizga: Okay. Thank you. And I do have one more question here, and it is, "How can I find out about just these quarterly fraud, waste, and abuse training meetings?"

Beth Brady: I guess this is my time to talk. Our outreach -- we do have an outreach in education on Medic contractor, and their purpose, as I said, is outreach and education. They are the ones that offer these trainings on our behalf. They have a website, and if you're not already part of that website, we do

strongly recommend that you become part of it. Once they go through the vetting process, they will then assign you a user ID and a password.

Accessing that website gives you all the information about the upcoming trainings. It gives you links to a number of tools I referenced earlier, you know, some of the tools, I referenced, the inserts. We have a fraud handbook to help you how to investigate fraud, waste, and abuse. We have interview guides. We have plenty of information on that website as education tools. The actual website -- and I will read it so I don't mess it up -- is http://medic-outreach.rainmakersolutions.com. And, again, if you're not already a member of that website we strongly recommend it. There's great tools out there, great information, and you certainly will know when we are hosting either the webinars, the quarterly webinars, or the in-person trainings. There's a total of four. Two in person, two webinars each year. Thank you.

Stacey Plizga: Okay. And that wraps up all the questions that I had for this particular group, so I would like to thank Beth, Dominca, and Camille for your presentation today. And also ask any speakers who are out there to meet in the speaker ready room so that we can get ready for the Open Q&A Session. So thank you, ladies.

I love that you guys are already responding. All right, so it's that time again to do an evaluation of the session, so please take out your cell phones or go to the pollev site and type in A and then follow the instructions.