2015 Medicare Advantage and Prescription Drug Plan Spring Conference & Webcast Transcript

Be Proactive: Support the Fight Against Fraud, Waste and Abuse (FWA)

Okay, this brings us to our last group of presenters for the day, and we are delighted to have with us our next speakers, who will share how to be proactive and support the fight against fraud, waste, and abuse. Rosalind Abankwah and Beth Brady.

Hello, everyone. Good afternoon. It's good to see you all, there's still some people still here this late hour. Okay. For our agenda today, for our discussion, we're going to talk about risk assessment and routine monitoring, we're going to look at the OIG studies as it relates to the high-risk pharmacy and high-risk prescriber assessment, we're going to look at plan sponsor actions and resources that we have available.

So Beth and I are from the Center for Program Integrity, and as you would know, or maybe not know, the Center for Program Integrity, we are, our focus is to identify and deter fraud, waste, and abuse. So what is fraud, waste, and abuse? I'm glad you asked.

So fraud is knowingly and willfully executing or attempting to execute a scheme to defraud any healthcare benefit program. And examples of fraud in the prescription drug program would include drug diversion, services not rendered, and medically unnecessary services.

Waste is the overuse of services or other practices that directly or indirectly result in unnecessary costs to the Medicare program. Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare program. Improper payment, payment for services that fail to meet professionally-recognized standards of care, or services that are medically unnecessary. The key distinction between fraud and abuse is intent.

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CMS requires plan sponsors to routinely monitor and audit, with an eye towards fraud, waste, and abuse detection, based on Chapter 9 of the Medicare Prescription Drug Manual, sponsors must establish and implement an effective system for routine monitoring and identification of compliance risk; including detection of potentially fraudulent claims. Sponsors must undertake monitoring and auditing to test and confirm compliance with Medicare regulations.
Risk areas identified through CMS audits and oversight, as well as through the sponsors' own monitoring, audits and investigations are a priority in risk. The results of the risk assessment inform the development of the monitoring and audit work plan. Once the risk assessment is complete, plan sponsors are to develop a monitoring and auditing work plan. Specific components of the work plan are listed in Chapter 9, which is the Medicare Prescription Drug Benefit Manual, and the work plan may include audits to be performed, audit schedules, including start and end dates, announced or unannounced audits, audit methodology, necessary resources, types of audit, that would be the desk or even on-site audit, the person that's responsible, and the final audit report due date to the compliance officer, and follow-up activities from the findings.

Sponsors must include in the work plans a process for responding to all monitoring and auditing results, and for conducting follow-up reviews of areas found to be noncompliant, to determine if the implemented corrective actions have fully addressed the underlying problems. Corrective action and follow-up should be led or overseen by the compliance officer, and assisted, if desired, by the compliance department staff.

CMS notifications. So we have here the types of notifications that CMS provides. We have fraud alerts, we have best practices from CMS audits, and that's provided annually, that's released annually. We have the high risk pharmacy, and high risk prescriber assessment, which will be the topic of the next few slides.

High risk assessments, as I mentioned, we have a high risk pharmacy and high risk prescriber assessment. These are basically, assessments were done as a result of OIG reports. The first one I'll talk about is the pharmacy risk assessment. So we used the data, the PDE data, to identify 16 metrics that were used to identify outlier pharmacies. The pharmacies we targeted were community retail pharmacies, and some of the measures that we looked at include the total drug cost, the total paid per beneficiary, the total paid per prescriber, PDEs or prescription drug event records per beneficiary per prescriber based on a 30-day equivalent, and the percent of prescription drug events for various drug types.

Like I mentioned, or maybe I didn't, that this high risk pharmacy assessment is provided to plan sponsors, Part D plan sponsors on a quarterly basis. The pharmacies are flagged as high risk if they are considered high in at least 4 out of the 16 measures. The last pharmacy risk assessment we released to Part D plan sponsors was on March 25 of this year, and there were 381 pharmacies included in this list of high risk prescribers. Excuse me, pharmacies. I get that mixed up, so get me if I'm goofing up. I'm talking about pharmacies.

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Okay, so now, on to high risk prescribers. Basically, in that analysis, we targeted Schedule 2 drugs, prescribers of Schedule 2 drugs, based on their peers in the same state and the same specialty. So those are the two assessments that we conducted. So CMS completed these assessments based on recommendations from the OIG.

We have here the OIG's report; it's entitled Retail Pharmacies with Questionable Part D Billing. The OIG's report, they looked at retail pharmacies, and they used data from 2009, and they used eight measures to identify high risk pharmacies. The results showed that retail pharmacies each billed Part D an average of nearly $1 million for prescriptions in 2009. Over 2,600 of these pharmacies had questionable billing. These pharmacies had extremely high billings for at least one of the eight measures developed.

Miami, Los Angeles and Detroit were the areas that are most likely to have pharmacies with questionable billing, and those of you who are involved with fraud, waste, and abuse will definitely realize that those cities are often involved in fraudulent behavior activity. The OIG, the Office of the Inspector General, recommended that CMS monitor and further scrutinize outlier pharmacies. So we had our marching order.

So on this slide, you'll see the 16 distinct measures that we use for our pharmacy risk assessment, and if you notice, we have an asterisk, and that would be because we're trying to talk about the 30-day equivalent. So those are the 16 measures, and the next slide, I want to just briefly explain to you 30-day equivalent, because you'll see that as we go forward in a lot of our analysis.

So the 30-day equivalent is our way of normalizing the data. So if you look at this, prescription one, 30-day supply would be the equivalent of one 30-day equivalent. Prescription two, 90-day supply would be the same as three 30-day equivalents. So when we do the analysis, if we want to look at a 30-day equivalent, we can, instead of counting the actual PDE record that may be for not even a full month as the same as one that might be for a full month. So we're just trying to normalize the data. So prescription three, which may be for a seven-day supply is the equivalent of a 30-day equivalent of 0.23. So that's how we normalize the data so that we can be fair about our assessments.

Also, so the results of the 57,000 retail pharmacies, 1,475 pharmacies were identified as outliers in four or more of the measures, 4 out of the 16 measures. And surprisingly, or maybe not surprisingly, approximately 80% of those outliers were considered independent pharmacies. The top states involved New York, California, Florida, Texas, and New Jersey. So once again, it's one of those states that are considered hotbeds for fraud, waste, and abuse.

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CMS sent a list of these pharmacies to Part D plan sponsors through HPMS. Before we send the list to the Part D plan sponsors, we validate that information. We want to make certain that we can validate it against the fraud prevention system, which we call FPS, or the FID, the Fraud Investigation Database, or our program integrity contractor have their own internal complaints tracking, so we have some type of way of validating that material before we send out the list to Part D plan sponsors.

I also want to make certain that I emphasize that when we send the list out to Part D plan sponsors, the list of high-risk pharmacies, we want plan sponsors to be aware that it does not mean that this pharmacy is guilty of fraud, waste or abuse. We're saying our data shows that there's a high possibility, a high probability of fraud, waste, and abuse, and we want you to be aware of that. We want you to take that information to augment what you're currently doing, as a Part D plan sponsor, with your compliance program. So this information is to help you in what you're doing, because that's one of the recommendations from the OIG. Also, this high risk pharmacy assessment, like I said, is done quarterly, so it can, the number, the actual pharmacies can actually change throughout – for every release.

Now on to high risk prescribers. Once again, the OIG did a report. The report was entitled Prescribers with Questionable Patterns in Medicare Part D. The OIG conducted an analysis using 2009 PDE records. They had five measures that they used for their report on basically, like an average number of prescriptions per beneficiary, the total number of pharmacies associated with each prescriber, percentage of prescriptions that were for Schedule 2 or Schedule 3 drugs. The results of this analysis show the increased need for oversight of Part D. The OIG recommended that the Medicare Drug Integrity Contract, or we the call it the MEDIC, expand its analysis of prescribers, that we provide sponsors – CMS provides sponsors with additional guidance on monitoring prescribing patterns, and that CMS provide education and training to prescribers.

So once again, we have our marching orders from the OIG, and the next slide here, we just want to show you through – I think, did I go too fast? Let me go back. I guess. Oh well. So here we are with, actually, it says CMS analysis, but this is really the OIG analysis. So just so you see that. The next slide hopefully will have -- looks like we missed a slide here. Anyway, those things happen. CMS high risk prescriber analysis.

So for CMS, we did our analysis, and we looked at several years, 2011, 2012, and 2013. We also include – we wanted to look at Schedule 2 prescribers, so we wanted to look at those that were high utilizers. So we identified prescribers that had at least $100,000 in each year of total drug costs of Schedule 2 drugs. We also wanted to look at those that had, or had 100 PDE records in a calendar year for the years that we were evaluating, doing this analysis.

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As a result of that, we were able to identify nine specialties, of all the specialties that you can imagine that would prescribe Schedule 2 drugs, there were nine, and we wanted to make certain that the ones that we selected were the ones that were going to have – that were robustly involved in prescribing Schedule 2 drugs. So we have them listed. Anesthesiology, emergency medicine, general care practitioners or prescribers, and basically that includes internal medicine, family medicine, and general practice. We lumped those all together. So we have the types of prescribers that were included in our Schedule 2 high risk prescriber analysis.

Okay. So we only used two metrics when we looked at the Schedule 2 analysis. We looked at the total PDE record count, and 30-day equivalent. There was a peer-to-peer comparison by practice state, and specialty. So we have some prescribers who practice in a state, but their mailing address is in another state. So we looked at the practice state and their specialty. We used a two-key method to identify outliers, so basically, that put us in the 95th percentile. Then we categorized the prescribers by high, medium and low, and we targeted the high prescribers.

Our focus was on the high prescribers. So we had – we sent a communication, a letter out to high risk prescribers. So here you will see that it's broken down by 2011, 2012, and 2013. So of the 600,000 or more prescribers of Schedule 2 drugs, you'll see that we have approximately – between 50,000, almost 60,000 that would be included in our analysis. But of those, the ones that were considered high risk prescribers ended up being around 1,500 to 1,800.

So we ended up having 1,525 prescribers identified as high risk prescribers in at least two of the three years, because before we sent out any notification, we needed to make certain that they were consistently considered high risk. This is a sample of the letter that we sent to these high risk prescribers. We basically wanted them to see some type of graphic, so that they can see where they are, and where they are to their peers, so that's the same specialty in the same state. And you can see that the red bar that shows them that they are significantly higher than their peers for prescribing Schedule 2 medications or drugs. This notice was sent to the plan sponsors in September of 2014.

The response that we got from the prescribers, we thought was very interesting. The first, basically, prescribers called the NBI MEDIC, which is our program integrity MEDIC, drug integrity contractor. They said, oh, you know, by the way, I'm really – that's not my specialty, my specialty is something else. So, and our response to that was, oh, thank you very much, will you please update your specialty in NPPES? NPPES is where you go get your NPI number, you identify your specialty. So we asked those prescribers to please change, so that they won't continue to be lumped in with a similar type of specialty, if that's not truly their specialty.

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Then there were some that were returned to sender because the address that we had from NPPES was not correct. So in that sense, we said, please update – we went to look in PECOS, which is our system for Medicare enrollment. So we used PECOS as address to resend those letters. In some cases, we resent those letters, and they were still returned to us, because the PECOS address was not correct, and the NPPES address was not correct.

As the result of all of this analysis, we were able to have 38 new proactive investigations. We were able to reconfirm previously-flagged providers from 216 complaints, 155 investigations, and we had 109 referrals. So just as a note, we are in the process of sharing this high risk prescriber assessment to our Part D plan sponsors in the next couple of weeks, and we would like for those of you – we would like for everyone in the Part D plan sponsors to have access to it.

For those of you who have access to PLATO, you will be able to go and see it right away, and I'm going to use that as a plug for PLATO, so that when Beth comes up and she talks to you about PLATO, you'll be all ears to listen in, because currently that information is already in PLATO.

So at this point, I'm going to turn it over to Beth for her session, her segment of our presentation. Thank you. Beth?

Thank you, Rosalind. Good afternoon, everyone. First, I want to thank you for hanging in there with us as we get closer to the end of the day.

Now Ros talked about the high risk assessment, and what I want to talk about is the actions that are requested of you. These high risk assessments are valuable supplements to plan sponsors' internal data analysis. Plan sponsors should routinely generate and review reports on pharmacy billing, and based on data analysis, identify pharmacies and other FDRs that require further review.

Now there are several specific actions to be taken, and I'll start talking about some of those now. Our first one, monitoring processes. Use the information that's provided to augment your current monitoring processes that are established to meet Part D requirements. Confirm that existing monitoring process are aligned to effect a fraud, waste, abuse prevention and detection. Conduct routine proactive data analysis, leveraging the information you have from the high risk prescriber and the pharmacy list, and they're adjusted, based on specifics of plan membership and provider network, given that all 16 parameters that Ros talked about may not be relevant to all plans.

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Fraud detection and drug utilization review. Using the high risk prescriber analysis, you can target the efforts of fraud detection processes in a drug utilization review. Focus fraud prevention processes on those pharmacies and prescribers identified as being high risk. Pay attention to the beneficiaries who receive multiple drugs from high risk pharmacies or prescribers. Consider additional review of new providers with excessive claims volumes or dollar amounts. And last, consider implementing point of sale edits, based on parameters of the high risk assessments.

Internal claims data analysis. Some examples of this could be matching specific prescription claims to the corresponding prescription claims of high risk prescribers. Validate the addresses to confirm legitimacy of outlier pharmacies, and rule out false front pharmacies. Investigate the outliers, based on your analysis of your internal data, and monitor links between outlier prescribers, pharmacies, and the beneficiaries.

Focus data analysis. Review claims from providers billing more items or services compared with their peers in the same specialty and service area. In other words, peer-to-peer comparisons. Monitor for providers that consistently bill the same or similar items or services for the majority of beneficiaries. Identify comparison timeframes. Could be daily, weekly, monthly, or quarterly, and develop a dashboard of normal values that will show changes in developing trends over time. Establish ongoing monitoring of data analysis reports to ensure quick identification of suspects and schemes.

Contractual arrangements. Another action to consider is reviewing your contractual arrangements with the identified prescribers, if any are found to be involved in potential fraud, waste, and abuse. For example, you may consider disciplinary measures, including contract termination if that’s warranted, and if the terms of your contract with these prescribers authorize contract termination.

Now, I want to touch again on a reminder about using data analysis, and Ros touched on it earlier. Identification of a pharmacy or prescriber through assessment does not prove fraud, waste, and abuse. Plan sponsors must perform their own reviews of claims, and follow the established protocols for any action taken. Analysis itself is not sufficient grounds for a sponsor to take action, without your own supporting review of specific claims, and confirmation of fraud, waste, abuse, using your established protocols.

Now, if you do suspect fraud, waste, and abuse, you must conduct a timely and reasonable inquiry, including an investigation of that suspected fraud, waste and abuse. If warranted by the investigation, you can take one of a variety of administrative actions, and that can include prescriber education, perhaps procedural changes, or, as we talked about a little bit earlier, disciplinary actions.

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Referrals to the NBI MEDIC and/or law enforcement. If your investigation does in fact support fraud, waste, abuse activity, you want to promptly refer the results of your investigative analysis to either the NBI MEDIC and/or law enforcement. Now, Chapter 9 of the Prescription Drug Benefit Manual, and Chapter 21 of the Medicare Managed Care Manual outlines the requirements and what needs to be included in those referrals, but I just want to touch on the criteria that should be referred to the NBI MEDIC, and/or law enforcement.

One, any potential criminal, civil, or administrative law violations. Two, allegations that exceed beyond your plan, and now involves multiple plans, or perhaps multiple states, or widespread schemes. Allegations involving known patterns of fraud. A pattern of fraud or abuse that threatens the life or the wellbeing of our beneficiaries. And last, a scheme, any scheme, with a large financial risk to the Medicare program or the beneficiaries.

Now, in addition to the guidance that provide in Chapter 9 and Chapter 21, we have made available a number of education resources to assist the plans. Now, there are a couple that I just – sorry about that. There's a couple on the screen, but the outreach and education MEDIC website contains a variety of helpful tools to you that we hope that you're using. We have toolkits for investigations. We have a lot of interviewing, online courses, that type of thing. And on the screen, you'll see three. One is the fraud handbook. Now this offers best practices in conducting investigations, how to identify potential fraud, and the like.

We also offer a drug diversion webinar, and regarding the pharmacy high risk assessments, there are frequently asked questions. Now there are many, as I referenced, there are many more available to you, and I want to explain that these products are developed based on the input we receive from the plans, on things that would help them in their efforts of detecting and investigating fraud, waste and abuse.

Now, Ros talked about PLATO, so now I want to a little bit more about that tool, which is now available to you. What is it? PLATO is a web-based fraud detection tool, designed to enhance Medicare Advantage and Part D program oversight and operations, by using an established fraud detection process, in conjunction with a user interface tool. Investigative outcomes associated with pharmacies and prescribers whom are referred to as providers in PLATO, can be tracked in the PLATO application.

PLATO helps users identify potential fraud, waste, abuse leads, using data projects, and in the past, plan sponsors only had access to the data available, concerning your own members. Now with PLATO, you'll have national data summary information that will be available to the users. Benefits. There are several benefits to using PLATO. First, it allows plan sponsors, CMS, law enforcement, and the NBI MEDIC to review Medicare Advantage and Part D pharmacy and provider leads with potential risks for fraud, waste, abuse. PLATO makes national data available, and shares action taken by other Medicare Advantage and Part D plan sponsors, and it can be reviewed in real time. This enables users to see the big picture, rather than operating in a silo by only seeing your own data.

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Now, I do want to emphasize that while you will not be able to see the identity of who took the action, you will see the action that was taken. Now, types of actions that can be taken include systems edits, terminations, audits, corrective action plans, perhaps payment suspensions, referrals to law enforcement or the NBI MEDIC, and education, and there are other selections that can also be documented in this system.

And last but not least, PLATO contains data for all Part D pharmacies and providers, and offers additional details on those high risk leads identified in its data analysis results. Now CMS will be monitoring the use of PLATO and the leads that are provided, and we will observe the actions taken by the plans and the other users.

Now, I referenced the users before, again, law enforcement, CMS, the Medicare Advantage and Part D plan sponsors, and the NBI MEDIC. So collectively working together in PLATO, we'll be able to fight against Medicare Advantage and Part D fraud, waste, and abuse.

Now, I want to spend a few minutes talking about how you can gain access to PLATO as a new user. Access to PLATO is for vetted users only. As a plan sponsor, designated user of PLATO, you can access the system by going, and you'll see the URL is on this slide. When someone applies for access, an automatic email will be sent to the plan sponsor contract administrator, and that's usually the compliance officer.

The contract administrator will then verify the employment status of that potential user, and also verify the user's contract numbers. This is part of the security vetting strategy, in order to utilize PLATO. After applications are verified, automatic emails are sent to the user. One will contain the user ID, and the second one will include a link on how to set a password.

Now on the slide, you see some password lockout reminders, so I just want to draw your attention to that. At CMS, we are very excited about this tool, and we hope you share our enthusiasm in using in fighting fraud, waste and abuse.

And now to conclude this presentation, I just want to bring back to what are the values of these high risk assessments? Well, one example, and we think it's a very beneficial one. From one audit, from one plan sponsor and the PBM, and it was based on the high risk pharmacy assessment, it led to termination of 37 pharmacies. We think that is a significant value to this assessment. So on behalf of Rosalind and myself, I want to thank you for your time, and if there are any questions.

All right. Did we have any questions from our in-house audience at this time? No? Okay. Well, we do have questions that were sent in, so how about if we address a couple of those, and then we will move on to our next session.

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So the first question that was received says are there Medicare C and D regulations that address handling and reporting requests for information from law enforcement agencies, local and out-of-state, such as subpoenas or other written requests?

Thank you. Yes, in Chapters 9 and 21, Section 50.6.10, I believe, it talks about the requirements of the plan sponsor, whether it's the special investigation unit, or whomever in the plan is responsible for handling fraud, waste, and abuse, to respond to requests from law enforcement, especially in helping them gather the documentation they need for successful prosecution of cases. Thank you.

Okay, the next question that was received. FDR general compliance and FWA training. Will CMS be requiring the sponsor's FDRs to take the CMS compliance and FWA training module on the MLN beginning 1-1-2016?

I'll take that one as well. Yes, as most of you know, we did introduce the modules on the Medicare learning network a couple of years ago, but it is correct, effective in January 1 of 2016, it will be required. The reason we do this is because the whole intent is to lessen the burden on plan sponsors and the training that is required of their FDRs, and this also will ensure consistency in the training itself. The other we want to add is that the certificate of completion, that will be sufficient to the plan sponsors that the FDRs have completed their required training. Good question, thank you.

And we have one last question that came in from our audience, and that is, I read somewhere that CMS was going to require that delegates be required to complete the LMN FWA trainings as validation, instead of the company providing proof of their own internal FWA training. Is that true?

It's very similar to the question before, and yes, as I said, January 1 of 2016, that will be the requirement, to use the CMS modules, the compliance and the fraud, waste, and abuse that are available on the Medicare learning network.

Great, well that is all the questions that were received. I guess Rosalind has a question. So we'll take Rosalind's question.

So my question to the audience is, of those in the audience who are Part D plan sponsors, how many of you have access to PLATO? Okay, I see a few hands. Okay, so those who are Part D plan sponsors and do not have access to PLATO, raise your hands. One, two, three. Okay, let's check out that link. Okay, guys? I think it will be important to you. Thank you.

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