

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDIC BENEFIT INTEGRITY  
ACTIVITIES IN MEDICARE  
PARTS C AND D**



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## **EXECUTIVE SUMMARY: MEDIC BENEFIT INTEGRITY ACTIVITIES IN MEDICARE PARTS C AND D (OEI-03-11-00310)**

### **WHY WE DID THIS STUDY**

This report focuses on the one Medicare Drug Integrity Contractor (MEDIC) responsible for detecting and preventing fraud, waste, and abuse in Medicare Parts C and D nationwide. The report provides an update on MEDIC identification of potential Part D fraud and abuse and is the first review of MEDIC antifraud activities for Part C.

### **HOW WE DID THIS STUDY**

From the Centers for Medicare & Medicaid Services (CMS) and the MEDIC, we collected data on the MEDIC's benefit integrity activities between April 2010 and March 2011.

### **WHAT WE FOUND**

Although the MEDIC has benefit integrity responsibility for both Medicare Parts C and D, its Part C investigations and case referrals represented a small percentage of its benefit integrity activities. In addition, a small percentage of the MEDIC's investigations and case referrals resulted from proactive methods. Moreover, barriers exist regarding data availability, access to information, and the recovery of inappropriate payments. Specifically, the lack of a centralized Part C data repository hinders the MEDIC's ability to identify and investigate Part C fraud. Additionally, the MEDIC reported that it is prohibited from sharing specific information with other program integrity contractors. Further, there is no mechanism to recover payments from Part C or Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action. Other barriers remain, such as prescription drug event data limitations; the lack of a requirement for sponsors to refer incidents of potential fraud and abuse; and the MEDIC's lack of authority to directly obtain information from pharmacies, physicians, and pharmacy benefit managers. Also, CMS does not require the MEDIC to submit data elements that could help CMS oversee the MEDIC's benefit integrity activities.

### **WHAT WE RECOMMEND**

We recommend that CMS (1) provide the MEDIC with centralized Part C data to enable it to more comprehensively and proactively identify and investigate Part C fraud and abuse; (2) clarify its policy and instruct the MEDIC as to under what circumstances the MEDIC may share specific information with other entities, including Zone Program Integrity Contractors and State agencies; (3) explore methods to develop and implement a mechanism to recover payments from Part C and Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action; (4) amend regulations to authorize the MEDIC to directly obtain information from entities such as pharmacies, physicians, and pharmacy benefit managers; (5) amend regulations to require Part C and Part D plan sponsors to refer potential fraud and abuse incidents to the MEDIC; and (6) enhance monthly workload reporting requirements to improve CMS oversight of the MEDIC's benefit integrity activities. CMS concurred with the first, second, and sixth recommendations; partially concurred with the third and fifth; and did not concur with the fourth recommendation.

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## OBJECTIVES

1. To determine the extent to which the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) performed Medicare Parts C and D benefit integrity activities.
2. To describe barriers the NBI MEDIC encountered in performing its Medicare Parts C and D benefit integrity activities and to determine whether MEDIC barriers identified previously have been resolved.
3. To identify workload data elements that could improve the Centers for Medicare & Medicaid Services' (CMS) oversight of the NBI MEDIC's benefit integrity activities.

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## BACKGROUND

The Office of Inspector General (OIG) issued a report in October 2009 that identified barriers to the three regional MEDICs' identification of potential Part D fraud and abuse during fiscal year (FY) 2008.<sup>1</sup> Since then, Part D benefit integrity responsibilities have transitioned from three regional MEDICs to one national MEDIC and CMS has added oversight of Part C as a MEDIC responsibility. This study provides an update on MEDIC identification of potential Part D fraud and abuse and is the first review of MEDIC antifraud activities for Part C.

The Balanced Budget Act of 1997 established Medicare Part C in January 1999. CMS contracts with private organizations under Part C to provide private health plan options, including managed care plans. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established Medicare Part D to provide prescription drug benefits under Medicare beginning January 1, 2006. Beginning in FY 2007, CMS awarded contracts to three regional MEDICs to address potential fraud and abuse related to the Part D benefit.<sup>2, 3</sup>

Since that time, MEDIC responsibilities and jurisdictions have been revised several times. CMS did not renew the contract for one of the MEDICs for FY 2009, transitioning its responsibilities to the remaining

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<sup>1</sup> OIG, *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse*, OEI-03-08-00420, October 2009.

<sup>2</sup> Section 202(a) of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, enacted section 1893 of the Social Security Act, 42 U.S.C. § 1395ddd, establishing the Medicare Integrity Program and providing the statutory basis for CMS to enter into contracts with entities to perform work to address potential fraud and abuse.

<sup>3</sup> In FY 2006, CMS awarded a single MEDIC a national contract to monitor fraud and abuse related to Part D enrollment and eligibility issues. In FY 2007, this MEDIC became a regional MEDIC.

two MEDICs. Additionally, in FY 2009, these two MEDICs were given oversight responsibility for Part C.

For FY 2010, CMS realigned the regional MEDICs into two national MEDICs, one designated as the NBI MEDIC and the other as the Compliance and Enforcement (C&E) MEDIC. The NBI MEDIC assumed responsibility for detecting and preventing Parts C and D fraud, waste, and abuse nationwide and transitioned its compliance workload to the C&E MEDIC.<sup>4</sup> The C&E MEDIC assumed responsibility for performing compliance and enforcement activities nationwide and transitioned its fraud, waste, and abuse workload to the NBI MEDIC.

For FY 2011, CMS retained the NBI MEDIC to detect and prevent fraud, waste, and abuse. The C&E MEDIC received a task order requiring it to perform special and ad hoc studies for CMS in addition to providing ongoing technical assistance to CMS and the NBI MEDIC for fraud, waste, and abuse activities.

As a result of these realignments, benefit integrity activities were performed primarily by the NBI MEDIC during FYs 2010 and 2011 for Parts C and D. These programs involve significant benefit expenditures and a substantial number of beneficiaries. In calendar year 2011, total benefit expenditures (excluding administrative expenses) for Medicare Parts C and D were \$190 billion.<sup>5</sup> As of March 2012, 33 million beneficiaries were enrolled in these programs.<sup>6</sup> The NBI MEDIC received a total of \$28.2 million to carry out its contractual responsibilities for FYs 2010 and 2011.

### **Types of Fraud and Abuse**

According to the *MEDIC Statement of Work*, fraud is the intentional deception or misrepresentation that an individual makes, knowing it to be false or not believing it to be true, that could result in some unauthorized benefit to himself/herself or some other person.<sup>7</sup> Abuse is, for example, billing Medicare for services that are not covered or are not correctly coded. Types of Part C fraud include misrepresenting enrollment or

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<sup>4</sup> According to the NBI MEDIC's transition and technical assistance task order, the compliance workload transferred to the C&E MEDIC is defined as: (1) non-fraud, -waste, and -abuse complaints and investigations against agents and brokers involving potential violations of Medicare regulations or guidelines; (2) referrals to State Department of Insurance; and (3) all work associated with the CMS Program Compliance and Oversight Group.

<sup>5</sup> The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report*, page 10. Accessed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2012.pdf> on April 24, 2012.

<sup>6</sup> CMS, *Monthly Contract and Enrollment Summary Report*, March 2012. Accessed at <http://www.cms.gov/MCRAAdvPartDENrolData/MCESR/list.asp#TopOfPage> on March 31, 2012.

<sup>7</sup> CMS, *MEDIC Statement of Work*, section 2.1, July 2009.

encounter data to increase payments, receiving duplicative copayments or premiums from beneficiaries, and submitting claims for services not provided. Part D fraud includes billing for drugs not provided, altering prescriptions to obtain higher payment amounts, and using another person's Medicare card to obtain prescriptions.

### **NBI MEDIC Activities**

As detailed in the *MEDIC Statement of Work* and NBI MEDIC task order, the responsibilities of the NBI MEDIC (hereafter referred to as "the MEDIC") include, but are not limited to:

- identifying and investigating potential Part C and Part D fraud and abuse,
- referring cases and making immediate advisements to the Department of Health and Human Services OIG, and
- fulfilling requests for information from law enforcement agencies.

*Identification and Investigation of Fraud and Abuse.* The MEDIC is required to identify potential fraud and abuse by means of proactive methods as well as through external sources. Examples of external sources of fraud leads include beneficiaries, law enforcement agencies, Part D plan sponsors, Medicare Advantage (MA) plan sponsors (also known as Part C plan sponsors or MA organizations), and CMS. Examples of proactive methods for identifying potential fraud include developing projects for analyzing claims data and conducting Internet searches to identify leads. Using ideas from external sources to look for unidentified billing aberrancies is also considered a proactive method. According to the *MEDIC Statement of Work*, the MEDIC is required to access data from a variety of sources and its ability to apply innovative analytical methodologies is critical to its success in benefit integrity activities.

When the MEDIC receives an allegation of fraud from an external source or proactively identifies potential fraud, it conducts an investigation to determine the facts and the magnitude of potential fraud. Investigations may include a review of claims, prescriptions, or cost reports. The MEDIC is required to prioritize its investigation workload to ensure that investigations with the greatest program impact and/or urgency are given the highest priority. The MEDIC also is required to consult with OIG to determine whether an investigation should be further developed for possible case referral to OIG.

*Case Referrals and Immediate Advisements.* According to the *MEDIC Statement of Work*, a case exists when the MEDIC has substantiated and referred a fraud allegation to law enforcement. This includes, but is not

limited to, documented allegations that a provider, beneficiary, pharmacy, pharmacy benefit manager, Part D plan sponsor, or MA plan sponsor has: (1) engaged in a pattern of improper prescription writing or billing, (2) submitted improper claims with actual knowledge of their falsity, or (3) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

According to the *MEDIC Statement of Work*, OIG has 90 calendar days to accept or reject a case referred by the MEDIC. If the MEDIC does not receive a response from OIG within 90 calendar days and its attempts to determine the status of the case are unsuccessful, the MEDIC may then refer the case to the Federal Bureau of Investigation (FBI) and/or another investigative agency with interest in the case.

The MEDIC refers certain allegations directly to OIG without first conducting an investigation. These are called immediate advisements and include, for example, allegations by current or former employees of the following entities suspected of fraud: (1) providers, (2) Part D plan sponsors and/or their subcontractors, or (3) MA plan sponsors and/or their subcontractors. Allegations involving entities that OIG is already investigating for fraud are also referred directly to OIG as immediate advisements.

*Requests for Information.* Law enforcement agencies may request beneficiary and provider information from the MEDIC to further their investigations or fraud prosecutions. These agencies include OIG; the Department of Justice (DOJ); and other entities, such as State survey and certification agencies and Medicaid Fraud Control Units. OIG's requests for information generally fall into one of two categories. Priority I requests are top-priority requests for which the information is essential to the prosecution of a provider and the data are obtained from the MEDIC's files. Priority I requests require a response within 30 days whenever possible. Priority II requests are less critical and may require, for example, soliciting information from other sources. Priority II requests require a response within 45 days whenever possible.

### **Medicare Drug Integrity Contractor Reporting Requirements**

According to the *MEDIC Statement of Work*, the MEDIC is required to submit a monthly status report to CMS. As part of its monthly reporting, the MEDIC provides data on its investigations, immediate advisements, case referrals, proactive data analyses, and requests for information.

### **Previous Office of Inspector General Work**

*MEDIC Identification of Fraud and Abuse.* In October 2009, OIG issued a report on the three regional MEDICs' identification of potential fraud

and abuse in Part D during FY 2008.<sup>8</sup> This report highlighted MEDICs' minimal use of proactive methods. The report also described problems that MEDICs encountered with accessing and using data that hindered their ability to investigate potential fraud and abuse incidents. In addition, MEDICs' lack of authority to directly obtain information from pharmacies, pharmacy benefit managers, and physicians also hindered their ability to investigate potential fraud and abuse. Furthermore, the report found that the MEDICs may not have been aware of some potential fraud and abuse incidents because plan sponsors were not required to refer them.

In the 2009 report, OIG recommended, in part, that CMS (1) ensure that MEDICs have access to accurate and comprehensive data to assist them in identifying and investigating potential fraud and abuse and conducting proactive data analysis; (2) authorize MEDICs to directly obtain information that they need to identify and investigate potential fraud and abuse from entities, such as pharmacies, pharmacy benefit managers, and physicians; and (3) require plan sponsors to report to MEDICs all potential fraud and abuse incidents that sponsors refer to law enforcement agencies.

*Plan Sponsor Identification of Fraud and Abuse.* An October 2008 OIG report examined the extent to which Medicare Part D plan sponsors identified and took steps to address potential fraud and abuse in the first 6 months of 2007.<sup>9</sup> The report found that over a quarter of plan sponsors did not identify any incidents of fraud and abuse. The report also found that a few plan sponsors identified most incidents of potential fraud and abuse. Even the sponsors that identified such incidents did not always conduct inquiries or take corrective actions. Just two plan sponsors made 89 percent of all referrals of incidents to MEDICs.

A February 2012 OIG report examined the extent to which MA organizations (i.e., MA plan sponsors, also known as Part C plan sponsors) identified and took steps to address potential fraud and abuse in 2009.<sup>10</sup> That report's findings on MA organizations were similar to those from the October 2008 report on Part D plan sponsors. The February 2012 report found that 19 percent of MA organizations did not identify any potential fraud and abuse incidents related to their Part C health benefits or Part D drug benefits. Three MA organizations identified 95 percent of the total

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<sup>8</sup> OIG, *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse*, OEI-03-08-00420, October 2009.

<sup>9</sup> OIG, *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse*, OEI-03-07-00380, October 2008.

<sup>10</sup> OIG, *Medicare Advantage Organizations' Identification of Potential Fraud and Abuse*, OEI-03-10-00310, February 2012.

1.4 million reported incidents. Although CMS requires MA organizations to initiate inquiries and corrective actions when appropriate, not all MA organizations took such steps in response to incidents they identified. Overall, in 2009, MA organizations sent 2,656 referrals of potential fraud and abuse incidents to other entities, including MEDICs and OIG, for further investigation. These 2,656 referrals included 1,728 Part C referrals and 928 Part D referrals.

*Questionable Part D Billing.* A May 2012 OIG report identified over 2,600 retail pharmacies that had questionable Part D billing in 2009.<sup>11</sup> For example, almost 800 pharmacies billed extremely high dollar amounts per beneficiary and 850 pharmacies billed extremely high dollar amounts per prescriber. OIG recommended, in part, that CMS (1) strengthen the MEDIC's monitoring of pharmacies and ability to identify pharmacies for further review and (2) require sponsors to refer potential fraud and abuse incidents that may warrant further investigation.

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## METHODOLOGY

### Scope

We reviewed Part C and Part D benefit integrity activities conducted by the MEDIC between April 1, 2010, and March 31, 2011.

### Data Collection

From CMS, we collected workload data related to the MEDIC's benefit integrity activities between April 1, 2010, and March 31, 2011. The data included information on the number of new investigations, case referrals, immediate advisements, proactive data analyses, and requests for information handled by the MEDIC. Additionally, we asked CMS about the MEDIC's responsibility regarding recommending administrative actions, such as the recovery of inappropriate payments.

We also sent a survey request to the MEDIC. Because the workload data we received from CMS were not separated into Part C-related data and Part D-related data, we requested that the MEDIC provide the separated data. We also requested that the MEDIC provide the number of new investigations and case referrals that resulted from proactive methods and external sources. We asked the MEDIC to indicate the types of Part C and Part D fraud and abuse that its investigations and case referrals involved. Additionally, we asked the MEDIC to describe the types of proactive projects that it developed and to provide data on the number of proactive projects started during the review timeframe.

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<sup>11</sup> OIG, *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012.

We requested information from the MEDIC about any issues or barriers it encountered in performing its benefit integrity activities. We also asked the MEDIC for an update about barriers identified in our MEDIC report issued in October 2009, hereafter referred to as our “previous MEDIC report.”<sup>12</sup> We followed up with the MEDIC to obtain clarification on its responses. We conducted data collection and followup between August 2011 and June 2012.

### **Data Analysis**

We compared the workload data submitted by CMS to the data submitted by the MEDIC in its survey response to determine whether the data matched. We identified some discrepancies through this review and followed up with the MEDIC to obtain the correct data.

After obtaining these data, we calculated the percentages of new investigations initiated, cases referred, and immediate advisements sent for Part C only, Part D only, and Parts C and D. We also calculated the percentages of investigations and cases that were initiated from proactive methods and external sources. Additionally, we compared the numbers of investigations initiated and cases referred during our review timeframe to those from our previous MEDIC report. We aggregated the number of requests for information received and completed for OIG, DOJ, and other law enforcement agencies for Part C only, Part D only, and Parts C and D. We also reviewed the template for the MEDIC’s workload data to determine whether any data elements were needed that could improve CMS’s oversight of the MEDIC.

We reviewed the types of Part C and Part D fraud and abuse that the MEDIC’s investigations and case referrals involved. Using the number of investigations and case referrals for each type of fraud and abuse, we ranked the types to determine which were most prevalent among the MEDIC’s Part C and Part D investigations and case referrals.

We summarized the MEDIC’s survey responses regarding issues and barriers that it encountered in performing its benefit integrity activities, such as investigating potential fraud and abuse and obtaining data. We also summarized the MEDIC’s responses regarding the status of barriers identified in our previous MEDIC report and used this information to determine whether the barriers had been resolved or still remained.

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<sup>12</sup> OIG, *Medicare Drug Integrity Contractors’ Identification of Potential Part D Fraud and Abuse*, OEI-03-08-00420, October 2009.

## **Limitations**

The workload data and survey information included in this report were self-reported by the MEDIC. Although we asked the MEDIC to reconcile inconsistencies between the workload data that CMS provided and the data that the MEDIC provided in its survey response, we did not independently validate the information.

## **Standards**

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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## FINDINGS

### **Part C investigations and case referrals represented a small percentage of the MEDIC's benefit integrity activities**

Although the MEDIC is responsible for conducting investigations and referring cases and immediate advisements involving both Part C and Part D, most of the MEDIC's workload involved Part D.<sup>13</sup> The MEDIC opened a total of 2,277 new investigations between April 2010 and March 2011. Of these new investigations, 8 percent involved Part C only, 79 percent involved Part D only, and 13 percent involved both Parts C and D. The types of fraud and abuse that the MEDIC most often investigated were suspect billing for Part C and inappropriate prescribing for Part D. Appendix A provides a complete list of the types of potential Part C and Part D fraud and abuse.

As with investigations, most case referrals involved Part D. The MEDIC referred a total of 245 cases to law enforcement between April 2010 and March 2011. Of those cases, 8 percent involved Part C only, 91 percent involved Part D only, and 1 percent involved Parts C and D. Table 1 shows the numbers and percentages of new investigations and case referrals by type of service between April 1, 2010, and March 31, 2011. Most of the MEDIC's cases—92 percent—were referred to OIG. Not all cases referred to OIG are accepted for further action. The remaining case referrals were sent to other agencies, such as DOJ and/or FBI; State and local law enforcement; and the Internal Revenue Service. The types of fraud and abuse cases most often referred by the MEDIC were those involving beneficiary or provider identity theft for Part C and inappropriate billing for Part D.

**Table 1: MEDIC Investigations and Case Referrals by Type of Service From April 1, 2010, through March 31, 2011**

| Type of Service    | Number of New Investigations | Percentage of New Investigations | Number of Case Referrals | Percentage of Case Referrals |
|--------------------|------------------------------|----------------------------------|--------------------------|------------------------------|
| Part C only        | 177                          | 8%                               | 19                       | 8%                           |
| Part D only        | 1807                         | 79%                              | 223                      | 91%                          |
| Both Parts C and D | 293                          | 13%                              | 3                        | 1%                           |
| <b>Total</b>       | <b>2,277</b>                 | <b>100%</b>                      | <b>245</b>               | <b>100%</b>                  |

Source: OIG analysis of MEDIC survey data, 2011.

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<sup>13</sup> CMS tasked the MEDIC with fraud and abuse oversight for Part D beginning in FY 2007 and added Part C in FY 2009.

The MEDIC also referred a total of 112 immediate advisements. Immediate advisements bypass a MEDIC investigation and involve, for example, complaints from former employees of a provider suspected of fraud. Twenty-four percent of the immediate advisements involved Part C only, 72 percent involved Part D only, and 4 percent involved both Parts C and D.

### **A small percentage of the MEDIC’s investigations and case referrals resulted from proactive methods**

Of the 2,277 total investigations that the MEDIC opened, 10 percent (219) were initiated through proactive methods; the remaining 90 percent were from external sources, such as complaints. Of the 219 investigations that the MEDIC initiated proactively, 10 involved Part C only, 184 involved Part D only, and 25 involved Parts C and D.

In addition to using proactive data analysis, the MEDIC reported using other proactive methods, such as holding liaison meetings with plan sponsors; pharmacy benefit managers; and Federal, State, and local law enforcement agencies, as well as conducting online searches for information on providers. Table 2 shows the numbers and percentages of new investigations that were from proactive methods and external sources.

**Table 2: Numbers and Percentages of New Investigations From Proactive Methods and External Sources From April 1, 2010, Through March 31, 2011**

| Type of Service    | Total Number of New Investigations | Number Initiated Through Proactive Methods | Percentage Initiated Through Proactive Methods | Number Initiated Through External Sources | Percentage Initiated Through External Sources |
|--------------------|------------------------------------|--|--|---|---|
| Part C only        | 177                                | 10   | 6%   | 167                                       | 94%   |
| Part D only        | 1,807                              | 184  | 10%  | 1623                                      | 90%   |
| Both Parts C and D | 293                                | 25   | 9%   | 268                                       | 91%   |
| <b>Total</b>       | <b>2,277</b>                       | <b>219</b>                                 | <b>10%</b>                                     | <b>2,058</b>                              | <b>90%</b>                                    |

Source: OIG analysis of MEDIC survey data, 2011.

Of the 245 total cases the MEDIC referred to law enforcement, 9 percent (21) were based on investigations initiated through proactive methods and 91 percent (224) were based on investigations initiated through external sources. Of the MEDIC’s 21 proactive case referrals, 2 involved Part C only and 19 involved Part D only. There were no case referrals involving both Parts C and D from proactive methods. Table 3 shows the numbers and percentages of case referrals that were from proactive methods and external sources.

**Table 3: Numbers and Percentages of Case Referrals From Proactive Methods and External Sources From April 1, 2010, Through March 31, 2011**

| Type of Service    | Total Number of Case Referrals | Number Initiated Through Proactive Methods | Percentage Initiated Through Proactive Methods | Number Initiated Through External Sources | Percentage Initiated Through External Sources |
|--------------------|--------------------------------|--|--|---|---|
| Part C only        | 19                             | 2  | 11%  | 17  | 89%   |
| Part D only        | 223                            | 19   | 9%   | 204                                       | 91%   |
| Both Parts C and D | 3                              | 0  | 0%   | 3   | 100%  |
| <b>Total</b>       | <b>245</b>                     | <b>21</b>                                  | <b>9%</b>                                      | <b>224</b>                                | <b>91%</b>                                    |

Source: OIG analysis of MEDIC survey data, 2011.

***Between 2008 and 2011, the percentage of investigations from proactive methods increased but the percentage of cases referred from proactive methods decreased***

Compared to the results from our previous MEDIC report, the overall number of new investigations increased from 1,320 in FY 2008 to 2,277 between April 1, 2010, and March 31, 2011 (hereafter referred to as “the 2010 to 2011 timeframe”). The percentage of investigations initiated by proactive methods increased as well—from 4 percent in FY 2008 to 10 percent during the 2010 to 2011 timeframe.

Additionally, the overall number of case referrals to law enforcement increased since our previous review of the MEDICs, from 65 in FY 2008 to 245 during the 2010 to 2011 timeframe. However, the percentage of case referrals initiated through proactive methods decreased—from 20 percent in FY 2008 to 9 percent during the 2010 to 2011 timeframe. Table 4 compares MEDIC investigation and case referral data from FY 2008 to the 2010 to 2011 timeframe.

**Table 4: MEDIC Investigations and Case Referrals by Method Initiated<sup>1</sup>**

|                          | New Investigations: FY 2008 |             | New Investigations: April 2010 to March 2011 |             | Case Referrals: FY 2008 |             | Case Referrals: April 2010 to March 2011 |             |
|--------------------------|-----------------------------|-------------|--|-------------|-------------------------|-------------|--|-------------|
|                          | Number                      | Percentage  | Number                                       | Percentage  | Number                  | Percentage  | Number                                   | Percentage  |
| <b>Proactive Methods</b> | 50                          | 4%          | 219  | 10%         | 13                      | 20%         | 21                                       | 9%          |
| <b>External Sources</b>  | 1,270                       | 96%         | 2,058  | 90%         | 52                      | 80%         | 224                                      | 91%         |
| <b>Total</b>             | <b>1,320</b>                | <b>100%</b> | <b>2,277</b>                                 | <b>100%</b> | <b>65</b>               | <b>100%</b> | <b>245</b>                               | <b>100%</b> |

Source: FY 2008 data from OIG report entitled *Medicare Drug Integrity Contractors’ Identification of Potential Part D Fraud and Abuse*; April 2010 to March 2011 data from OIG analysis of MEDIC survey data, 2011.

<sup>1</sup> The FY 2008 data contain the number of Part D investigations and case referrals because the MEDICs had only Part D responsibility during that time. The April 2010 to March 2011 data contain Part C and Part D numbers because the MEDIC had both Part C and Part D responsibility during that time.

### ***Most proactive projects focused on Part D***

The MEDIC started 38 proactive data analysis projects during the 2010 to 2011 timeframe. Of those projects, 31 involved Part D only, 2 involved Part C only, and 5 involved both Parts C and D.

Examples of proactive Part D projects conducted by the MEDIC included reviewing medications that were contraindicated on the basis of a beneficiary's gender, identifying top narcotic prescribers, and identifying claims involving deceased providers. The Part C proactive projects included reviewing durable medical equipment services from selected Part C plan sponsors to detect services that were not provided and analyzing data from five Part C plan sponsors to determine whether laboratory services were unbundled to increase payment amounts. Examples of proactive projects that included both Parts C and D included looking for beneficiaries whose Medicare identification numbers were being improperly used and identifying duplicate billings of particular medications to Parts C and D.

### **Barriers exist regarding data availability, access to information, and recovery of inappropriate payments**

Barriers include the MEDIC's lack of access to centralized Part C data and its inability to share specific information with other program integrity contractors. Furthermore, there is no mechanism to recover payments associated with improper Part C and D services when law enforcement agencies do not accept cases involving these services for further action. In addition, all but one of the barriers identified in our previous MEDIC report remain. We describe these barriers more fully below.

#### ***Lack of a centralized Part C data repository hinders the MEDIC's ability to identify and investigate Part C fraud and abuse***

The MEDIC reported that because of the lack of a central repository of Part C data, it was a challenge to undertake viable proactive Part C projects that would not be too labor intensive. In contrast, for Part D, the MEDIC can use the Integrated Data Repository to access prescription drug event (PDE) records from all Part D plan sponsors to conduct proactive data analyses.<sup>14</sup> These PDE records contain Part D prescription drug cost and payment data.

The MEDIC reported that because it cannot access Part C data from a central source, it must request the Part C encounter data from individual

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<sup>14</sup> CMS's Integrated Data Repository is a data warehouse that contains Medicare Part A, Part B, and Part D claims.

plan sponsors. Encounter data are records of items and services provided to Part C beneficiaries. The MEDIC explained that to determine the potential financial impact of complaint-related claims, it requests providers' payment information from the members of the Part C Fraud Work Group.<sup>15</sup> The MEDIC further explained that because not all plan sponsors participate in the Part C Fraud Work Group, the MEDIC may miss some potential fraud and abuse. According to the MEDIC, the Part C Fraud Work Group began with 16 Part C plan sponsors but grew to 32 plan sponsors by April 2011. In 2010, there were 174 Part C plan sponsors, which means that the MEDIC was requesting information from only 18 percent of Part C plan sponsors.<sup>16</sup>

In January 2012, CMS required MA plan sponsors to begin submitting Part C data to its new Encounter Data System. The MEDIC said it believes that this new requirement will allow it to undertake future Part C projects because all Part C encounter data will be contained in a centralized data repository. CMS's goal is to produce analytic reports that reflect MA beneficiaries' actual health care utilization by 2013. However, CMS plans to validate the data before allowing it to be used as the basis for plan payments in 2014. CMS has not reported when the centralized Part C data repository will be available for the MEDIC's use.

*The MEDIC does not respond to Part C requests for information because it does not have access to centralized Part C data.* The MEDIC reported that it did not receive any Part C requests for information during the 2010 to 2011 timeframe. All of the requests that the MEDIC received were for Part D-related information. The MEDIC received 273 requests for information from law enforcement and completed 288 such requests.<sup>17</sup> Most (78 percent) of the requests that the MEDIC received were from OIG; the remaining requests were from DOJ.

The MEDIC explained that it did not receive or complete any Part C-related requests for information because it does not have access to centralized Part C data for responding to such requests. The MEDIC further explained that it generally does not receive Part C requests, because it conducts outreach to law enforcement agencies to make them aware as to which data it possesses and which it does not, such as Part C data. If law enforcement personnel request Part C data, the MEDIC refers

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<sup>15</sup> The Part C Fraud Work Group was initiated in March 2009 to inform Part C plan sponsors of fraud trends to help prevent erroneous payments.

<sup>16</sup> We obtained the number of 2010 Part C plan sponsors from CMS's Health Plan Management System, Contact Information Extract, accessed March 23, 2012. We excluded sponsors that had only stand-alone Part D, 1833 cost, demonstration, or Program of All-Inclusive Care for the Elderly (PACE) contracts.

<sup>17</sup> The number of requests completed is greater than the number of requests received because the MEDIC could have completed requests that were received prior to April 2010.

them to the plan sponsors for assistance; however, the MEDIC does not track such requests.

***The MEDIC reported that it is prohibited from sharing specific information with other program integrity contractors***

In June 2012, the MEDIC reported that it did not have the authority to share specific information related to its investigations and cases directly with other program integrity contractors—e.g., Zone Program Integrity Contractors (ZPIC)—to help fight fraud and abuse in Medicare Part C and Part D.<sup>18</sup> The MEDIC explained that it is allowed to share information about fraud schemes and summary data with other program integrity contractors. However, it is prohibited from sharing specific details, such as a beneficiary’s or provider’s billing history. The MEDIC reported that sharing such information would help determine whether these beneficiaries or providers are affecting other areas of Medicare, such as Part A and Part B. The MEDIC also explained that sharing data with other program integrity contractors and State agencies would allow it to build larger investigations and to strengthen potential referrals, giving them more prosecutorial merit.

CMS acknowledged that early in the MEDIC program, MEDICs were not permitted to share Part D data with other program integrity contractors because of regulatory restrictions (42 CFR 423.322). However, CMS stated that section 6402(b) of the Patient Protection and Affordable Care Act, enacted in March 2010, authorized the MEDIC to share specific information related to its investigations and cases with other program integrity contractors. However, CMS reported that there is one ZPIC with an outstanding conflict of interest involving Part D and that the MEDIC has been instructed not to share specific claim information until the conflict of interest is mitigated.

***There is no mechanism to recover payments from Part C or Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action***

The MEDIC reported that it does not have administrative authority to recommend recoupment of payments associated with inappropriate services. When law enforcement agencies do not accept MEDIC cases for

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<sup>18</sup> The MEDIC reported that CMS instructed that 42 CFR 423.322 limits the MEDIC’s ability to share information with other program integrity contractors. Specifically, although the regulation allows use of Part D information for program integrity activities, the MEDIC reported that it is not able to share data with other program integrity contractors because these contractors’ efforts are not for the sole purpose of Part D program integrity.

further action, the MEDIC simply closes these cases. However, when law enforcement agencies do not accept a case, it does not necessarily mean that there was not fraud. Cases can be declined for a number of reasons, including lack of resources.

Under its *MEDIC Statement of Work*, the MEDIC originally was tasked with providing recommendations to CMS to support administrative actions such as recovering overpayments, suspending enrollment, and imposing civil monetary penalties. However, CMS instructed the MEDIC, first by verbal instruction and then through a contract change memorandum issued in January 2012, that the MEDIC is not required to recommend administrative actions.

CMS staff explained that the *MEDIC Statement of Work* was modeled after the *Program Safeguard Contractor Statement of Work* and reflects a fee-for-service approach to administrative actions. CMS staff further explained that the design of the Part C and D programs does not support the MEDIC's recommending administrative actions and stated that CMS components fulfill this role. CMS provided documentation of its components' key responsibilities regarding administrative functions in Parts C and D; however, there is no mention of collection of overpayments.

Under the fee-for-service payment methodology for Medicare Parts A and B, CMS pays providers directly and the ZPICs have the ability to notify claims processors of improper payments that need to be collected. However, under the capitated payment methodology for Parts C and D, CMS pays plan sponsors advance monthly payments and the plan sponsors pay providers for the services. CMS does not have a mechanism to recover payments made to plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action.

### ***All but one of the barriers previously identified by MEDICs remain***

As outlined in our previous MEDIC report, MEDICs described various barriers that impacted their ability to identify or prevent potential Part D fraud and abuse. We asked the MEDIC about these barriers to determine whether they had been resolved or still remained. We determined from the MEDIC's response that one barrier concerning prescriber identifiers has been resolved and two barriers regarding PDE data remain. Additionally, although the MEDIC reports improvement, two barriers remain concerning its ability to receive referrals from plan sponsors and information from pharmacies, physicians, and pharmacy benefit managers. We describe the barriers and the MEDIC's response below.

*Problem With Prescriber Identifiers.* As detailed in our previous MEDIC report, MEDICs reported issues with the prescriber identifier fields when accessing Part D PDE records through their data system, Cognos. The issue was that different types of prescriber numbers were not stored in the correct fields, which affected the results of the MEDICs' data analysis. For example, one MEDIC reported that when using Cognos to query records with a provider's National Provider Identifier (NPI) number, it found that NPI numbers were incorrectly being stored in the field for Drug Enforcement Agency numbers. The MEDIC explained that Cognos now has a single prescriber identifier field that contains all values submitted by the plan sponsor, so the MEDIC can query that field for any kind of prescriber identifier. Therefore, this barrier regarding prescriber identifiers has been resolved.

*Access to Important Data Variables.* As described in our previous MEDIC report, MEDICs reported that PDE data did not include, or that MEDICs could not efficiently access, certain information vital to identifying and investigating potential fraud and abuse and to building case referrals. MEDICs had reported that it would be helpful for PDE data to include beneficiary demographic information, such as name and address, because law enforcement agencies often ask for this information when requesting information from the MEDICs.

The MEDIC stated that to make data useful for law enforcement purposes, it still needs to augment the PDE data with other CMS data and data from third-party databases. The MEDIC captures information such as beneficiary and prescriber name and address from other systems and merges this information with the PDE data to obtain the full information needed. The MEDIC reported that having these additional data fields in the PDE data would enable it to respond more efficiently to requests for information. The current lack of these fields in the PDE data necessitates the MEDIC's obtaining these data elsewhere; therefore, the barrier regarding access to important data variables remains.

*Tracking Changes to PDE Data.* As described in our previous MEDIC report, MEDICs reported issues with not being able to see various iterations of a PDE record when accessing PDE data (i.e., if an adjustment was made, there was no record of the original payment amount). One MEDIC reported that this information was vital in determining trends across multiple plans and in quantifying the amount of potential fraud for a particular pharmacy. The MEDIC reported that it is still able to view only the most recent iteration of a PDE record. Therefore, this barrier regarding tracking changes to PDE data remains.

Referrals From Plan Sponsors. As described in our previous MEDIC report, MEDICs reported that they may not have been aware of all incidents of potential Part D fraud and abuse because plan sponsors are encouraged—but not required—to refer such incidents to MEDICs.

In July 2012, CMS issued an update to Chapter 9 of its *Prescription Drug Benefit Manual* and Chapter 21 of its *Medicare Managed Care Manual* regarding plan sponsors' compliance program guidelines. However, in these revisions, plan sponsors are still only encouraged—not required—to refer incidents of potential fraud and abuse to the MEDIC. The MEDIC explained that through outreach and collaborative efforts, such as the Part C and Part D Fraud Working Groups, the relationship between the MEDIC and plan sponsors has become very collaborative. The MEDIC reported that as a result, the number of referrals from plan sponsors has dramatically increased. Nonetheless, the barrier remains regarding the lack of a requirement for sponsors to report incidents of potential fraud to the MEDIC.

Authority To Directly Obtain Information. As detailed in our previous MEDIC report, MEDICs reported that they did not have the authority to directly obtain information such as prescriptions or medical records from pharmacies, physicians, and pharmacy benefit managers and that this lack of authority hindered their ability to investigate potential fraud and abuse. MEDICs explained that because CMS contracts with plan sponsors, MEDICs had the authority to request information *only* from plan sponsors, and *not* directly from entities such as pharmacies and pharmacy benefit managers.

The MEDIC reported that it is still prohibited from obtaining information such as prescriptions or medical records directly from these entities. It explained that although it is still required to request this information through plan sponsors, the increased collaboration between the MEDIC and plan sponsors has resulted in a more timely response to its requests. The MEDIC requests the information from the plan sponsors, who request the information from the entities; the plan sponsors then forward this information to the MEDIC. Although the MEDIC's increased collaboration with plan sponsors has aided its efforts, the barrier remains regarding the MEDIC's directly obtaining information from these entities.

## **CMS does not require the MEDIC to submit data elements that could help CMS oversee the MEDIC's benefit integrity activities**

*Parts C and D and Proactive Data.* The workload data that CMS collects from the MEDIC does not separate, by Parts C and D, the data on investigations, case referrals, immediate advisements, proactive data analyses, or requests for information. Although the MEDIC provided us with these data when we requested them, the information is not contained in the workload data provided to CMS. Without these data, CMS is unable to determine on an ongoing basis how much of the MEDIC's workload is associated with Part C and Part D.

Additionally, the investigation- and case-referral-related portion of the workload data that CMS collects from the MEDIC does not provide the total number of investigations and case referrals that are based on proactive methods or external sources. The investigation-related data contain a field for investigations based on "proactive data analyses"; however, the number reported in this field does not reflect the MEDIC's total number of investigations initiated by all proactive methods. Moreover, the case-referral-related data do not contain any fields to indicate whether the referrals were based on investigations initiated through proactive methods or external sources. Without these data, CMS is unable to determine how much of the MEDIC's investigation and case referral workload results from proactive methods versus external sources.

*Reporting of Investigations.* We learned from the MEDIC that when it receives multiple complaints about a single provider, the MEDIC counts each complaint as a separate investigation. The MEDIC explained that it tracks individual complaints in its case management system and that each of these is counted as a new investigation in the workload data submitted to CMS. CMS acknowledged that the MEDIC counts one investigation per complaint and explained that this item is currently under review to assess the need for changes.

A November 2011 OIG report on ZPICs determined that there were differences in the ways two ZPICs reported their new investigations in their workload statistics.<sup>19</sup> One ZPIC included all fraud complaints in its number of new investigations reported to CMS, regardless of whether multiple complaints for a particular provider were merged into a single investigation. However, the other ZPIC explained that if it received a complaint on a particular provider, started an investigation, and then

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<sup>19</sup> OIG, *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011.

received another complaint on the same provider, the second complaint would not be counted as a new investigation in the workload statistics that this ZPIC reported to CMS. Ensuring that the MEDIC counts investigations the way CMS intends for them to be counted is important to ensuring that this workload statistic is meaningful and that CMS can compare this statistic across its contractors.

*Requests for Information.* From April through July 2010, the MEDIC did not track requests for information by priority level (i.e., Priority I and Priority II). A CMS review revealed that the MEDIC was not meeting its timeliness standards, and CMS put the MEDIC on a corrective action plan to address this issue. The MEDIC began reporting by priority level in August 2010 and reported 100-percent timeliness during the remainder of our timeframe (August 2010 through March 2011).<sup>20</sup> However, a review of the workload data revealed that although the MEDIC reported on the number of Priority I and Priority II requests completed within required timeframes, the workload report does not have fields to capture Priority I and Priority II requests that do not meet required timeframes. To assess whether the MEDIC is meeting the established timeframes for Priority I and Priority II requests for information, it is important to ensure that the workload statistics are capturing the appropriate data.

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<sup>20</sup> Because of improvements the MEDIC made, CMS removed the MEDIC from the corrective action plan in December 2010.

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## CONCLUSION AND RECOMMENDATIONS

Over the past several years, MEDIC responsibilities and jurisdictions have evolved. CMS added oversight of Part C as a MEDIC responsibility for FY 2009 and consolidated Part C and D benefit integrity responsibility into one national MEDIC for FY 2010.

Although the MEDIC had been responsible for Part C for more than 2 years by April 2011, its Part C investigations and case referrals represented only a small percentage of its benefit integrity activities. In addition, the lack of a centralized Part C data repository has greatly limited the MEDIC's ability to identify and investigate fraud and abuse in Part C. Additionally, although CMS has stated that innovative analytical methodologies are critical to the success of a benefit integrity program, just a small percentage of MEDIC investigations and case referrals were from proactive methods. Moreover, there is no mechanism to recover payments associated with inappropriate Part C or D services when law enforcement agencies do not accept cases involving these services for further action. Furthermore, barriers identified in OIG's previous MEDIC report remain today. These barriers include the lack of a requirement for plan sponsors to refer fraud and abuse incidents to the MEDIC and the MEDIC's not being able to directly obtain information from pharmacies, physicians, and pharmacy benefit managers.

The Parts C and D programs involve significant benefit expenditures and a substantial number of beneficiaries—\$190 billion in 2011 and 33 million beneficiaries in 2012. CMS is relying on one contractor to perform benefit integrity functions for both these programs, and it is important to ensure that there is effective and proactive oversight of the programs by both the MEDIC and CMS.

Therefore, we recommend that CMS:

### **Provide the MEDIC With Centralized Part C Data To Enable It To More Comprehensively and Proactively Identify and Investigate Part C Fraud and Abuse**

Although the MEDIC stated that CMS's requirement for Part C plan sponsors to begin submitting encounter data in 2012 will enhance the MEDIC's ability to conduct investigations and proactive data analysis, it is unclear how soon the MEDIC will have access to the centralized Part C data repository. Until this centralized repository is available, CMS should advise the MEDIC to obtain Part C data from individual plan sponsors beyond the ones currently in the Part C Fraud Work Group. Once the centralized repository is available, CMS should ensure that the MEDIC receives timely access to the data.

### **Clarify Its Policy and Instruct the MEDIC Under What Circumstances It May Share Specific Information With Other Entities, Including ZPICs and State Agencies**

Although CMS reports that the MEDIC may share specific information with other program integrity contractors when there is not a conflict of interest, the MEDIC reported in June 2012 that it is not authorized to share such information. CMS should clarify its policy so that the MEDIC shares information to the fullest extent permitted, as this would improve the MEDIC's ability to effectively identify and investigate potential fraud and abuse.

### **Explore Methods To Develop and Implement a Mechanism To Recover Payments From Part C and Part D Plan Sponsors When Law Enforcement Agencies Do Not Accept Cases Involving Inappropriate Services for Further Action**

CMS currently does not have such a mechanism to help safeguard Medicare funds.

### **Amend Regulations To Authorize the MEDIC To Directly Obtain Information From Entities Such As Pharmacies, Physicians, and Pharmacy Benefit Managers**

Because CMS did not concur with a similar recommendation in our previous MEDIC report, OIG continues to recommend that CMS allow the MEDIC direct access to these entities. Current regulations allow sponsors' contracts to specify whether CMS or its designees (e.g., the MEDIC) may obtain information directly from these entities or whether the plan sponsor will provide the information. To improve the efficiency of the MEDIC's work, CMS should amend current regulations to require that sponsors' contracts specify that information from sponsors' subcontractors, network providers, and other associated entities be provided directly to CMS or its designees. To ensure that plan sponsors are aware of the MEDIC's requests, CMS could require the MEDIC to inform plan sponsors when it intends to collect information directly from these entities.

## **Amend Regulations To Require Part C and Part D Plan Sponsors To Refer Potential Fraud and Abuse Incidents to the MEDIC**

Although CMS has revised Chapter 9 of its *Prescription Drug Benefit Manual* and Chapter 21 of its *Medicare Managed Care Manual*, these revisions still state that plan sponsors are encouraged—not required—to refer incidents of potential fraud and abuse to the MEDIC. Additionally, in previous OIG reports we have recommended that CMS require Parts C and D plan sponsors to refer potential fraud and abuse to CMS or other appropriate entities.<sup>21</sup> However, because CMS concurred only partially with these recommendations, OIG continues to recommend that Parts C and D plan sponsors be required to refer potential fraud and abuse incidents to the MEDIC and that CMS amend current regulations to require these referrals.

## **Enhance Monthly Workload Reporting Requirements To Improve CMS Oversight of the MEDIC’s Benefit Integrity Activities**

These MEDIC workload reporting requirements should include: (1) a separation of workload data by Parts C and D, (2) a breakout of investigations and cases initiated by proactive methods and external sources, (3) fields in the workload data to capture requests for information not completed within the required timeframes, and (4) clarification on how CMS intends for the MEDIC to report its number of new investigations in relation to the number of complaints received.

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<sup>21</sup> OIG, *Medicare Advantage Organizations’ Identification of Potential Fraud and Abuse*, OEI-03-10-00310, February 2012, and OIG, *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our first and second recommendations. CMS stated that it expects to provide the MEDIC with timely access to Part C encounter data once the centralized repository is available. Additionally, CMS stated it will provide guidance to the MEDIC on when it is appropriate to share information with other entities, including ZPICs and state agencies.

CMS partially concurred with our third recommendation to develop and implement a mechanism to recover overpayments. It concurred for Part D but did not concur for Part C because of the nature of Part C payments. For Part D, CMS stated that when the MEDIC develops adequate evidence of improper payments made to Part D plan sponsors that result from inappropriate billing by pharmacies or other providers, CMS would explore recovery of any improper payments if they are final reconciled payments. Regarding Part C, CMS stated that when providers fraudulently bill Part C plan sponsors, there are no claim-specific Medicare payments implicated. Additionally, CMS stated that to the extent that fraudulent billings are identified, the Part C plan, not CMS, would be entitled to any recovered amounts. OIG understands that there are not claim-specific payments made to Part C plan sponsors by CMS because sponsors are paid a capitated rate. However, to account for improper payments paid to providers, CMS should develop a mechanism to recover some portion of these improper payments from the capitated payments made to Part C plan sponsors. To accomplish this, CMS should seek statutory authority if necessary.

CMS did not concur with our fourth recommendation to amend regulations to authorize the MEDIC to directly obtain information from entities such as pharmacies, physicians, and pharmacy benefit managers. CMS stated that it believes the choice of how requested information is to be provided should remain with the sponsor and its subcontractors. However, to increase the efficiency of the MEDIC's work, OIG maintains that CMS should amend current regulations to allow the MEDIC direct access to these entities.

CMS partially concurred with our fifth recommendation to amend regulations to require Parts C and D plan sponsors to refer potential fraud and abuse incidents to the MEDIC. CMS stated that it will explore the option of placing this additional burden on plan sponsors versus the value of the information to be gained in collecting such data. CMS added that through guidance and education, it will continue to encourage plan sponsors to voluntarily refer potential fraud and abuse incidents that may

warrant further investigation. OIG continues to recommend that CMS amend current regulations so plan sponsors are required—not just encouraged—to refer potential fraud and abuse incidents to the MEDIC. By not requiring reporting, CMS limits the MEDIC’s ability to monitor fraud trends and identify problematic providers across the Parts C and D programs.

CMS concurred with our last recommendation to enhance monthly workload reporting requirements to improve CMS oversight of the MEDIC’s benefit integrity activities. CMS stated that MEDIC reporting responsibilities have changed since the end of our review; however, it is unclear if those reporting changes incorporate the enhancements we proposed in our recommendations (e.g., separating the reporting of workload data, such as investigations and case referrals by Parts C and D). We ask that CMS, in its final management decision, provide OIG with documentation of the new reporting requirements and indicate whether they incorporate the requirements proposed in the OIG recommendation. The full text of CMS's comments is provided in Appendix B.

## APPENDIX A

### Types of Potential Part C and Part D Fraud and Abuse

This Appendix provides information on the types of potential Part C and Part D fraud and abuse associated with the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor's (MEDIC) investigations and case referrals between April 1, 2010, and March 31, 2011. The data are sorted by number of investigations.

**Table A-1: Types of Potential Part C Fraud and Abuse Associated With the NBI MEDIC's Investigations and Case Referrals**

| Types of Part C Fraud and Abuse   | Number of Investigations <sup>1</sup> | Number of Case Referrals <sup>1</sup> |
|---|---------------------------------------|---------------------------------------|
| 1. Suspect billing - Examples include (a) questionable or suspicious billing practices and (b) overutilization.   | 150                                   | 4                                     |
| 2. Billing for services never rendered - Provider submits claims or encounter data for services that were never provided to beneficiary.  | 95                                    | 10                                    |
| 3. Attempts to steal beneficiary's identity/money - Examples of this include (a) an individual or organization steals beneficiary's identity or money and (b) an individual uses or steals another person's Medicare or Medicare Advantage (MA) card.   | 49                                    | 12                                    |
| 4. Improper coding (upcoding and unbundling) - By using the wrong billing code or unbundling the codes included in a larger, more inclusive set of codes, the health care provider can be reimbursed at a higher rate than if the correct billing codes were used and the services were billed together (i.e., were bundled). | 49                                    | 1                                     |
| 5. Marketing schemes - Plan sponsor, first-tier entity, or downstream entity violated Medicare marketing guidelines or other Federal or State laws, rules, and regulations to improperly enroll a beneficiary in an MA plan.  | 38                                    | 2                                     |
| 6. Billing for ineligible consumers - Misrepresentation of beneficiary's eligibility information, medical condition, or plan enrollment information.  | 29                                    | 1                                     |
| 7. Inducements, bribes, or kickbacks - Examples include inappropriate discounts, support services, educational grants, or research funding.   | 23                                    | 1                                     |
| 8. Double billing - This occurs when the provider receives more than one payment for the same service and keeps the money.  | 20                                    | 0                                     |
| 9. Overcharging the beneficiary - Examples include (a) charging the beneficiary improper coinsurance or premium amounts, or (b) billing the beneficiary directly for the total amount of the bill, including the amount of the charge that the provider has agreed to write off after the MA organization has paid.           | 19                                    | 0                                     |
| 10. Falsification of records or other data - Examples include falsification of medical record or dates of service; member falsifying medical referral; forging a physician's signature; forged or altered prescription for durable medical equipment.   | 19                                    | 2                                     |
| 11. False-front provider - Fallacious companies created to submit fraudulent billing for services not rendered.   | 14                                    | 10                                    |
| 12. Telemarketing schemes - Contacting beneficiaries to obtain personal identifying or protected health information.  | 11                                    | 2                                     |
| 13. Failure to provide medically necessary services - Plan sponsor, health care provider, or other entity fails to provide medically necessary items or services that it is required to provide under law or under the contract, and that failure adversely affects, or is substantially likely to affect, the beneficiary.   | 9                                     | 0                                     |
| 14. Improper cost reporting or cost shifting - Provider submits inflated reports of patient traffic and treatment costs in order to induce payers to increase future per-patient capitation fees.   | 4                                     | 0                                     |
| 15. Identity theft - Use of provider's credentials to submit fraudulent claims/bill for services not rendered.  | 4                                     | 12                                    |

continued on next page

**Table A-1: Types of Potential Part C Fraud and Abuse Associated With the NBI MEDIC's Investigations and Case Referrals (Continued)**

| Types of Part C Fraud and Abuse   | Number of Investigations <sup>1</sup> | Number of Case Referrals <sup>1</sup> |
|---|---------------------------------------|---------------------------------------|
| 16. Tax evasion/fraud.  | 0                                     | 1                                     |
| 17. Health Insurance Portability and Accountability Act (HIPAA) violations - Privacy violations and misuse of protected health information. | 0                                     | 1                                     |
| <b>Total</b>  | <b>533</b>                            | <b>59</b>                             |

Source: Office of Inspector General (OIG) analysis of MEDIC survey data, 2011.

<sup>1</sup> Total numbers of investigations and case referrals do not equal totals cited in the report text because each investigation and case may have involved more than one type of fraud and abuse. Additionally, for three types of fraud and abuse, there were more case referrals than investigations. This is because some case referrals may be associated with investigations begun before April 1, 2010.

**Table A-2: Types of Potential Part D Fraud and Abuse Associated With the NBI MEDIC's Investigations and Case Referrals**

| Types of Part D Fraud and Abuse  | Number of Investigations <sup>1</sup> | Number of Case Referrals <sup>1</sup> |
|--|---------------------------------------|---------------------------------------|
| 1. Inappropriate prescribing - Examples include (a) physician writing prescriptions outside his/her scope of practice; (b) off-label prescribing of controlled substances; (c) prescriber being on the OIG exclusion list; or (d) inappropriate prescribing of controlled substances—physician being identified as prescribing high volumes of controlled substances.  | 589                                   | 64                                    |
| 2. Inappropriate billing - Examples include (a) billing for brand-name drugs when generics are dispensed; (b) billing for noncovered prescriptions as covered items; (c) billing for prescriptions that are never picked up; or (d) double billing—the provider receives more than one payment for the same service and keeps the money.                               | 547                                   | 84                                    |
| 3. Forged or altered prescriptions or other documents - Prescriptions are forged or altered by someone other than the prescriber or pharmacist without prescriber approval.  | 466                                   | 71                                    |
| 4. Attempts to steal beneficiary identity to obtain prescriptions - Examples of this include (a) individual uses another person's Medicare card to obtain prescriptions or (b) beneficiary is asked to sell Medicare card for purpose of obtaining prescriptions.  | 402                                   | 69                                    |
| 5. Diverting prescriptions - An individual obtains prescription drugs and gives or sells this medication to someone else.  | 366                                   | 46                                    |
| 6. Doctor shopping or stockpiling - Examples of this include (a) beneficiary consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs or (b) beneficiary attempts to game her/his drug coverage by obtaining and storing large quantities of drugs and then disenrolling.              | 314                                   | 38                                    |
| 7. Overcharging beneficiary for prescriptions - Examples of this include (a) charging beneficiary for drugs beneficiary did not receive; (b) pharmacy asking beneficiary to pay uncompensated amounts; or (c) "bait and switch" pricing, i.e., beneficiary is led to believe a drug will cost one price, but at point of sale, beneficiary is charged a higher amount. | 281                                   | 2                                     |
| 8. Inappropriate prescription dispensing - Examples of this include (a) dispensing expired or adulterated prescription drugs; (b) dispensing without a prescription; or (c) splitting - pharmacist or mail order pharmacy splits prescription to receive additional dispensing fee.  | 213                                   | 3                                     |
| 9. Identity theft or use of provider's identifying information, such as National Provider Identifier (NPI) or Drug Enforcement Agency (DEA) numbers.   | 146                                   | 27                                    |
| 10. Marketing schemes - Examples include (a) misrepresentation of plan benefits or (b) inappropriate soliciting.   | 92                                    | 4                                     |

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**Table A-2: Types of Potential Part D Fraud and Abuse Associated With the NBI MEDIC's Investigations and Case Referrals (continued)**

| Types of Part D Fraud and Abuse   | Number of Investigations <sup>1</sup> | Number of Case Referrals <sup>1</sup> |
|---|---------------------------------------|---------------------------------------|
| 11. Inducements, kickbacks, or bribes - Examples include (a) prescriber is offered, is paid, solicits, or receives unlawful payments as inducement or reward for writing prescriptions for drugs or products; or (b) pharmacy benefit manager receives unlawful payments in order to steer a beneficiary toward a certain plan or drug, or for formulary placement. | 84                                    | 9                                     |
| 12. Pharmacy submitting false claims under invalid NPI and/or DEA numbers.  | 18                                    | 37                                    |
| 13. Poor quality of care.   | 14                                    | 6                                     |
| 14. Pharmacy is unresponsive to audit request - Pharmacy does not respond to desk or in-store audit request.  | 11                                    | 0                                     |
| 15. Failure to provide medically necessary prescription drugs - Plan sponsor, health care provider, or other entity fails to provide medically necessary prescription drugs that the organization is required to provide under law or under the contract, and that failure adversely affects, or is likely to affect, the beneficiary.                              | 9                                     | 0                                     |
| 16. HIPAA violations - Privacy violations and misuse of protected health information.   | 5                                     | 1                                     |
| 17. Beneficiary travels an unusually long distance to obtain prescriptions.   | 4                                     | 7                                     |
| <b>Total</b>  | <b>3,561</b>                          | <b>468</b>                            |

Source: OIG analysis of MEDIC survey data, 2011.

<sup>1</sup> Total numbers of investigations and case referrals do not equal totals cited in the report text because each investigation and case may have involved more than one type of fraud and abuse. Additionally, for two types of fraud and abuse, there were more case referrals than investigations. This is because some case referrals may be associated with investigations begun before April 1, 2010.

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## APPENDIX B

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** NOV 05 2012

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** ~~Macjlyr Tavenner~~ */S/*  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "MEDIC Benefit Integrity Activities in Medicare Parts C and D" (OEI-03-11-00310)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report entitled, "MEDIC Benefit Integrity Activities in Medicare Parts C and D." The objectives of the draft report were to determine the extent to which the Medicare Drug Integrity Contractor (MEDIC) performed Medicare Parts C and D benefit integrity activities, describe barriers encountered by the MEDIC performing these activities, and determine if previous barriers were resolved. In addition, this report identified workload data elements to improve CMS's oversight of the MEDIC's activities.

The MEDIC's responsibilities include, but are not limited to, identifying and investigating potential Part C and Part D fraud and abuse. To accomplish this task, CMS provides the MEDIC with the most comprehensive and updated data available to use in proactively identifying and investigating fraud, waste, and abuse. In addition, CMS and the MEDIC prioritize regular partnering with other contractors, Parts C and D plan sponsors, and law enforcement to ensure the most effective and efficient fight against Medicare fraud, waste, and abuse.

Medicare Parts C and D plan sponsors are strongly encouraged by CMS to report fraud incidents to the MEDIC for further investigation and possible referral to law enforcement. CMS holds Part C and Part D plan sponsors solely accountable for compliance with program requirements, including the implementation of measures designed to prevent fraud, waste, and abuse.

We would also like to express our gratitude to OIG for conducting this evaluation. CMS's responses to the OIG recommendations are below.

#### OIG Recommendation 1

The CMS shall provide the MEDIC with centralized Part C data to enable it to more comprehensively and proactively identify and investigate Part C fraud and abuse.

**CMS Response**

The CMS concurs with this recommendation. CMS agrees with OIG that access to centralized Part C data would assist the MEDIC in proactively identifying and investigating Part C fraud and abuse. CMS expects to provide the MEDIC with timely access to Part C encounter data once the centralized repository is available.

**OIG Recommendation 2**

The CMS shall clarify its policy and instruct the MEDIC under what circumstances it may share specific information with other entities, including zone program integrity contractors (ZPIC) and state agencies.

**CMS Response**

The CMS concurs with this recommendation. CMS will provide guidance to the MEDIC on when it is appropriate to share information with other entities, including ZPICs and state agencies.

**OIG Recommendation 3**

The CMS shall explore methods to develop and implement a mechanism to recover payments from Part C and Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action.

**CMS Response**

The CMS partially concurs with this recommendation. Specifically, we concur for Part D, but do not concur for Part C because of the nature of the Part C payments. CMS takes seriously its responsibility to identify and prevent fraud in both the Part D and Part C programs.

Part C Medicare Advantage plans receive capitated payments to deliver Medicare benefits to enrollees. Under the Part C program, there are no claim-specific Medicare payments to Part C plan sponsors that are implicated when the MEDIC identifies cases in which providers fraudulently bill Part C plan sponsors. If law enforcement does not pursue these cases and seek recovery from the providers, there are no claim-specific overpayments to recover in cases where providers fraudulently bill Part C plan sponsors.<sup>1</sup> However, through the work of the MEDIC, CMS shares information and collaborates with Part C plan sponsors to improve sponsors' ability to detect and prevent fraud. These efforts are designed to reduce sponsors' inappropriate payments to providers. We also note that Part C Medicare Advantage plans have a financial incentive to stop fraud and are required to implement effective compliance programs to detect, prevent, and correct fraud and abuse.

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<sup>1</sup> We note that, to the extent such fraudulent billings are identified, the Part C plan, not CMS, would be entitled to any recovered amounts.

In instances where the MEDIC develops adequate evidence of improper payments to Part D plan sponsors that result from inappropriate billing by pharmacies or other providers, we would certainly explore recovery of any improper payments, if those payments are in fact final reconciled payments. If not, the Part D sponsor would be required to correct their submitted preliminary data and the inappropriate pharmacy billing would not ever impact reconciled payments. This would be true for instances where cases were not pursued by law enforcement agencies or any other instance where there might be evidence of an improper payment. In contrast to Part C, Part D plan sponsors receive both capitated payments, as well as low income subsidy (LIS), reinsurance, and, potentially, risk corridor payments that are tied to the prescription drug event (PDE) data submitted to CMS. LIS, reinsurance, and risk corridor payments can increase if PDE data is based on fraudulent claims submitted by pharmacies or other providers. CMS is open to exploring a mechanism for recouping these payments that is consistent with Part D sponsors' responsibility to administer the Part D benefit and their obligation, enforceable by CMS through compliance actions, to implement measures to prevent and detect fraud and abuse. CMS is exploring collaboration with OIG on developing such a mechanism and, in particular, developing a standard for the evidence of fraud that would trigger its implementation.

In both the Part C and Part D programs, CMS has contractual requirements that plan sponsors implement and maintain fraud prevention programs. CMS pursues an extensive compliance and oversight program, including annual compliance reviews of plan sponsors to assess the extent to which plan sponsors have operating fraud prevention programs and the results that have been achieved. CMS continues to conduct oversight of the fraud fighting efforts it expects from plan sponsors through these annual compliance reviews the agency conducts.

Finally, we note that through our public-private Health Care Fraud Prevention Partnership, CMS plans to share data and enhance cooperation with private entities, including the sponsors of Parts C and D plans, to enhance our mutual efforts to identify and prevent fraud and realize savings not only for Medicare, but for the health care system as a whole.

#### **OIG Recommendation 4**

The CMS shall amend regulations to authorize the MEDIC to directly obtain information from entities, such as pharmacies, physicians, and pharmacy benefit managers.

#### **CMS Response**

The CMS does not concur with this recommendation. As OIG notes, current regulations require sponsors to include in their contracts with first tier, downstream, and related entities language that indicates whether the entity is to provide requested information to CMS directly or through the sponsor with which it has contracted. In the preamble to the final rule where CMS adopted this regulatory provision, CMS stated that we chose not to be prescriptive with respect to the choice of method for providing requested information, noting that, "It is our opinion that this is considered to be part of the negotiation process between the Part D sponsor and its first tier, downstream, and related entities." (72 *Federal Register* 68708, December 5, 2007)

The CMS believes that the choice of alternatives for the provision of requested information should remain with the sponsor, subject to consultation and agreement with its subcontractors. As CMS stated in our response to recommendations in this area in OIG's October 2009 report, CMS does not have contractual relationships with, or have regulatory oversight of, physicians, pharmacists, or pharmacy benefit managers due to the way the program is constructed under the Medicare Advantage and Part D authorizing statutes. In fact, CMS holds the sponsors solely accountable for compliance with program requirements, including the production of books and records related to the operation of Medicare benefit plans. Since sponsors bear the risks (in the form of compliance actions, sanctions, or contract termination) associated with the provision of inaccurate or non-responsive information, it is appropriate that they retain the authority to review the quality of the data provided on their behalf to CMS, including to the MEDIC. Such a review would be difficult to conduct if the sponsor only receives a concurrent notice that the MEDIC has made a request to one of the sponsor's subcontractors.

The CMS strongly agrees that the MEDIC must have timely and complete access to the data held by sponsors and their subcontractors related to their Parts C and D operations, and we have taken multiple opportunities, through the issuance of regulations and guidance, to make that position clear. As noted in OIG's report, the MEDIC reports increased collaboration from sponsors in response to information requests, and we expect that trend to continue. Should CMS learn that sponsor collaboration with the MEDIC is waning or that sponsors are creating obstacles to the MEDIC's access to information to which it is entitled, we would consider enforcement options as well as evaluate the need for policy changes such as OIG's current recommendation.

#### **OIG Recommendation 5**

The CMS shall amend regulations to require Part C and Part D plan sponsors to refer potential fraud and abuse incidents to the MEDIC.

#### **CMS Response**

The CMS partially concurs with this recommendation. CMS will explore the option of placing additional burden on plan sponsors versus the value of the information to be gained in collecting such data. Through guidance and education, CMS will continue to encourage plan sponsors to voluntarily refer potential fraud and abuse incidents that may warrant further investigation. Further guidance was released through a Health Plan Management System memorandum that updated Chapter 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual; in it, the following were established:

- Use of Data Analysis for Fraud, Waste, and Abuse (FWA) Prevention and Detection (50.6.9)
- Conducting a Timely and Reasonable Inquiry of Detected Offenses (50.7.1)
- Procedures for Self-Reporting Potential FWA and Significant Non-Compliance (50.7.3)
- NBI MEDIC (50.7.4) and Referrals to the NBI MEDIC (50.7.5)
- Responding to CMS-Issued Fraud Alerts (50.7.6)
- Identifying Providers with a History of Complaints (50.7.7)

The plan sponsors have reported possible fraud cases to the MEDIC and will continue to do so. CMS has continuously strived to establish and enhance its relationship with plan sponsors. This relationship is founded in part on a mutual interest in combating fraud, waste, and abuse, which victimize the public and private sectors alike. To that end, CMS is committed to collaborating with plan sponsors to implement programs to prevent and detect fraud, waste, and abuse. Additionally, CMS is working collaboratively with law enforcement partners, including OIG and the Department of Justice, to actively pursue a variety of avenues to partner with the private sector, including private payers such as plan sponsors, in areas such as data sharing and other mutually beneficial anti-fraud activities.

**OIG Recommendation 6**

The CMS shall enhance monthly workload reporting requirements to improve CMS oversight of the MEDIC's benefit integrity activities.

**CMS Response**

The CMS concurs with this recommendation. The MEDIC reporting responsibilities have changed since the end of OIG's review. Currently, the MEDIC submits a wide variety of deliverables which help CMS monitor benefit integrity activities. The MEDIC deliverables include a monthly report which tracks the total complaints, investigations, requests for information, and referrals completed for the Medicare Parts C and D programs. The monthly report also provides an overview of audits, data analysis, and investigative success stories. The MEDIC submits a monthly innovation report/data analysis plan, which lists the project name, description, and status of each proactive data analysis study it conducts.

The MEDIC has started providing a revised monthly workload report which contains performance metrics which will be utilized to evaluate assignments, deliverables, and ad hoc reports. The performance metrics data file was added to the MEDIC's monthly workload report as an additional deliverable in spring 2011. It provides detailed data and tracks how many complaints, investigations, requests for information, proactive data analysis, law enforcement referrals, and outreach activities the MEDIC completes each month.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

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# Office of Inspector General

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