Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

LESS THAN HALF OF PART D SPONSORS VOLUNTARILY REPORTED DATA ON POTENTIAL FRAUD AND ABUSE

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EXECUTIVE SUMMARY: LESS THAN HALF OF PART D SPONSORS VOLUNTARILY REPORTED DATA ON POTENTIAL FRAUD AND ABUSE OEI-03-13-00030

WHY WE DID THIS STUDY

In 2011, total expenditures for the Medicare Part D prescription drug program were $67.1 billion. The Centers for Medicare & Medicaid Services (CMS) contracts with plan sponsors to provide Part D coverage to beneficiaries. The Office of Inspector General has recommended that CMS require sponsors to report data on potential fraud and abuse related to Part D to CMS. Rather than requiring these data, CMS encouraged sponsors to voluntarily report them beginning in 2010. This study provides information on the fraud and abuse data reported by sponsors and on whether CMS used these data to monitor or oversee the Part D program.

HOW WE DID THIS STUDY

We accessed CMS's Healthcare Plan Management System to download data on potential fraud and abuse reported by Part D plan sponsors from 2010 through 2012. We also accessed CMS's public files of Part D enrollment to determine the number of beneficiaries enrolled in Part D plans from 2010 through 2012. We reviewed the sponsors' aggregate data to determine the number and percentage of sponsors that reported data on potential fraud and abuse each year. In addition, we surveyed CMS about its review and use of these reported data.

WHAT WE FOUND

More than half of Part D plan sponsors did not report data on potential fraud and abuse between 2010 and 2012. Of those sponsors that did report data, more than one-third did not identify any incidents for at least one of their reporting years. In total, sponsors reported identifying 64,135 incidents of potential fraud and abuse between 2010 and 2012. Sponsors' identification of such incidents varied significantly, from 0 to almost 14,000 incidents a year. CMS requires sponsors to conduct inquiries and implement corrective actions in response to incidents of potential fraud and abuse; however, 28 percent of Part D plan sponsors reported performing none of these actions between 2010 and 2012. Although CMS reported that it conducted basic summary analyses of the data on potential fraud and abuse, it did not perform quality assurance checks on the data or use them to monitor or oversee the Part D program.

WHAT WE RECOMMEND

We recommend that CMS (1) amend regulations to require sponsors to report to CMS their identification of and response to potential fraud and abuse; (2) provide sponsors with specific guidelines on how to define and count incidents, related inquiries, and corrective actions; (3) review data to determine why certain sponsors reported especially high or low numbers of incidents, related inquiries, and corrective actions; and (4) share sponsors' data on potential fraud and abuse with all sponsors and law enforcement. CMS did not concur with the first recommendation, partially concurred with the second and fourth recommendations, and concurred with the third recommendation.

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OBJECTIVES

To determine:

1. the extent to which Part D plan sponsors voluntarily reported data on potential fraud and abuse to the Centers for Medicare & Medicaid Services (CMS) for 2010 through 2012 and
2. the extent to which CMS used these data to monitor or oversee sponsors' activities to control fraud and abuse.

BACKGROUND

Medicare Part D is the voluntary prescription drug program that went into effect in 2006. In 2011, 35.7 million beneficiaries were enrolled in Part D and total expenditures for Part D were $67.1 billion.[1]

Plan Sponsors

CMS contracts with private insurers, called plan sponsors, to provide Part D coverage to beneficiaries. Sponsors may offer beneficiaries two types of drug plans. One type provides drug coverage only and is called a prescription drug plan (PDP), or stand-alone plan. The other type provides all Medicare benefits (e.g., hospital and physician services), including drug coverage, and is called a Medicare Advantage prescription drug plan (MA-PD).

Sponsors may have one or more Part D contracts with CMS.[2] Each contract may include one or more plans for enrollees to choose from in a specific geographic region. Plans can vary in the prescription drugs covered and the amount of out-of-pocket expenses for which the beneficiary is responsible.

Sponsors are responsible for all Medicare contract requirements and must ensure that all entities with which they subcontract meet regulatory and compliance requirements.[3] These subcontractors include, but are not limited to, pharmacy benefit managers, pharmacies, marketing firms, and claims processing firms.

[1] The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report*, p. 10.

[2] Throughout this report, the word "sponsor" also refers to individual Part D contracts because CMS requests that sponsors report data on potential fraud and abuse by contract.

[3] 42 CFR §§ 422.504(i) and 423.505(i); CMS, *Prescription Drug Benefit Manual*, Pub. 100-18, ch. 9, § 40; *Medicare Managed Care Manual*, Pub. 100-16, ch. 21, § 40.

Compliance Programs To Control Fraud, Waste, and Abuse

Sponsors are required to implement a compliance program that includes measures to control fraud, waste, and abuse.[4] Under the compliance program, CMS requires sponsors to conduct a timely, reasonable inquiry when evidence suggests potential fraud or abuse related to payment or delivery of items or services under their contracts.[5] In addition, CMS requires sponsors to carry out appropriate corrective actions in response to potential fraud and abuse.[6] Furthermore, sponsors should have procedures to report potential fraud or misconduct to CMS or its designee.[7] However, sponsors are not required to actually report this information to CMS or its designee.

Medicare Part D Drug Reporting

Each year CMS issues a *Medicare Part D Reporting Requirements* document to sponsors. This document includes topics on which sponsors must report information to CMS. Topics include, but are not limited to, enrollment, coverage determinations, appeals, pharmaceutical manufacturer rebates, and long-term care utilization.

Voluntary Reporting of Numeric Data Related to Fraud and Abuse. In January 2010, CMS added a new topic to the reporting requirements document. The new topic was "voluntarily reported aggregate data related to [sponsors'] anti-fraud, waste, and abuse activities."[8] These are aggregated numeric data. They do not provide any narrative or descriptive information about the specific incidents of potential fraud and abuse identified.

In the reporting requirements document, CMS defines incidents of potential fraud and abuse. CMS defines a "fraud incident/complaint" as an allegation that a provider, a beneficiary, or other entity "engaged in an intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person." CMS defines an "abuse incident/complaint" as an allegation that a provider, a beneficiary, or other entity "engaged in behavior that the individual should have known to be false, and the

[4] 42 CFR §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi).
[5] 42 CFR §§ 422.503(b)(4)(vi)(G)(1) and 423.504(b)(4)(vi)(G)(1).
[6] 42 CFR §§ 422.503(b)(4)(vi)(G)(2) and 423.504(b)(4)(vi)(G)(2).
[7] 42 CFR §§ 422.503(b)(4)(vi)(G)(3) and 423.504(b)(4)(vi)(G)(3).
[8] CMS, *Medicare Part D Reporting Requirements*, p. 27, effective January 1, 2010.

individual should have known that the deception could result in some unauthorized benefit to himself/herself or some other person."

Sponsors that choose to report data are asked to submit them each year by February 28 for the previous contract year and to report the numbers at the contract level. The particular types of data sponsors report include:

- the number of incidents of potential fraud and abuse identified within selected types of fraud and abuse (e.g., number of incidents related to inappropriate billing),
- the number of incidents of potential fraud and abuse identified by internal sources or external sources,
- the number of inquiries initiated as a result of incidents of potential fraud and abuse,
- the number of corrective actions initiated as a result of incidents of potential fraud and abuse,
- the number of incidents of potential fraud and abuse referred to CMS for action,
- the number of incidents of potential fraud and abuse referred to State insurance commissioners or licensing authorities, and
- the number of incidents of potential fraud and abuse referred to local or Federal law enforcement entities for action.[9]

According to CMS's reporting requirements document, these data would enable CMS to monitor sponsors' programs to control fraud, waste, and abuse. The document also states that such data would measure types of incidents of potential fraud and abuse as well as activities taken by sponsors in response to the incidents.

Technical Specifications for Reporting. In connection with the annual reporting requirements document, CMS issues a technical specifications document to sponsors. This latter document includes definitions of the types of data to report and informs Part D sponsors that the reporting of these data is voluntary.

As of the 2013 technical specifications document, CMS stated that it had not yet determined how it would evaluate the aggregated reported data on

[9] CMS, *Medicare Part D Reporting Requirements*, p. 28, effective January 1, 2010.

activities to control fraud, waste, and abuse or how it might monitor other data sources.[10]

Healthcare Plan Management System

CMS uses a system named the Health Plan Management System (HPMS) to maintain Part D records and communication with sponsors. Within HPMS, the voluntarily reported aggregate data on potential fraud and abuse are accessible in standard extract files.

Related Office of Inspector General Work

This report adds to a body of work on sponsors' identification of fraud, waste, and abuse. In February 2012, the Office of Inspector General (OIG) issued a report on Medicare Advantage (MA) organizations' identification of potential fraud and abuse in 2009. In that year, these organizations identified 147,840 incidents of potential Part D fraud and abuse, and not all of these organizations initiated inquiries or corrective actions in response to the incidents they identified.

Many MA organizations offer both Part C and Part D coverage to beneficiaries. OIG found that only 3 of 170 MA organizations identified 95 percent of the incidents of potential fraud and abuse within Part C and Part D. OIG also found that differences in the way organizations defined and detected potential fraud and abuse may account for some of the variability in the number of incidents identified. OIG recommended that CMS require MA organizations to report data on their activities to control fraud, waste, and abuse. In response, CMS stated it would explore the option of requiring MA organizations to report aggregate data on antifraud activities.[11]

Another OIG report, issued in October 2008, similarly found that most of the incidents of potential fraud and abuse identified by PDP sponsors in 2007 were reported by only a small number of sponsors. In the first 6 months of 2007, PDP sponsors identified 9,774 incidents of potential fraud and abuse, and not all PDP sponsors that identified such incidents conducted inquiries, initiated corrective actions, or made referrals for further investigation. We recommended that CMS require plan sponsors to report information related to the results of their programs to control

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[10] CMS, *Medicare Part D Plan Reporting Requirements: Technical Specifications Document, Contract Year 2013*, p. 72.

[11] OIG, *Medicare Advantage Organizations' Identification of Potential Fraud and Abuse*, OEI-03-10-00310, February 2012.

fraud and abuse. CMS did not state whether it concurred with this recommendation.[12]

METHODOLOGY

Data. We accessed HPMS to download data on potential fraud and abuse reported by Part D sponsors from 2010 through 2012.[13] We reviewed the sponsors' aggregate data to determine the number and percentage of sponsors that did or did not report data on potential fraud and abuse for each year. We analyzed the data to determine the types of fraud and abuse incidents reported and the total and average number of (1) total incidents identified; (2) incidents identified through internal efforts; (3) incidents identified through external sources; (4) inquiries conducted; (5) corrective actions initiated; and (6) referrals to CMS, State agencies, and Federal and local law enforcement entities.

To determine the type of contract that each sponsor had with CMS, we accessed CMS's publicly available Part D enrollment files for December of each year. We excluded sponsors that had only cost or demonstration contracts with CMS.[14, 15] We excluded sponsors of "employer direct" plans because they are excluded from the option of reporting this data.[16] We also excluded sponsors of Programs of All-Inclusive Care for the Elderly (PACE) because they are exempt from all Part D reporting requirements.[17]

From the enrollment files, we determined the number of beneficiaries enrolled in each contract from 2010 through 2012.[18] Because of privacy laws established under the Healthcare Insurance Portability and Accountability Act of 1996, CMS does not publish the enrollment figures for contracts covering 10 or fewer beneficiaries. To calculate enrollment statistics, we assigned such contracts a beneficiary enrollment of 10.

[12] OIG, *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse*, OEI-03-07-00380, October 2008.

[13] We accessed HPMS on March 5 and 6, 2013.

[14] Medicare payments for cost contracts are based on the reasonable costs of providing services to enrollees.

[15] Demonstration contracts test improvements in Medicare coverage, payment, and quality of care. These contracts usually operate for a limited time, are for a specific group of people, and/or are offered only in specific areas.

[16] An "employer direct" plan is one in which the employer or union contracts directly with CMS to offer Part D coverage for its Medicare-eligible retirees.

[17] PACE is a benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing.

[18] We accessed enrollment data at https://www.cms.gov on March 7, 2013.

We compared reported data among sponsors of different size on the basis of their enrollment numbers, and we identified any significant differences in reporting. To compare sponsors' rates of incidents identified relative to their enrollment size, we calculated the number of incidents that sponsors identified per 1,000 beneficiaries.

CMS Survey. We surveyed CMS about its review and use of the sponsors' reported fraud and abuse data. As part of the survey, we requested any and all policies and procedures related to CMS's collection, review, and use of the data.

We used the data to determine whether CMS had followed up with sponsors. We also determined whether CMS had used the data to share information about potential fraud and abuse with its contractors and with sponsors. In addition, we determined whether CMS had used the data to monitor or oversee the sponsors' programs to control fraud and abuse.

Limitations

We did not verify the data on potential fraud and abuse reported by sponsors to CMS.

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.

FINDINGS

More than half of Part D plan sponsors did not report data on potential fraud and abuse between 2010 and 2012

In 2010, CMS modified its Part D reporting requirements to encourage sponsors to voluntarily report aggregated data on potential fraud and abuse. Since this change, no more than 40 percent of sponsors reported any fraud and abuse data between 2010 and 2012. Forty percent of sponsors reported data in 2010, 37 percent in 2011, and 35 percent in 2012. There were 701 sponsors that had PDP or MA-PD contracts with CMS for at least one year between 2010 and 2012. Across all 3 years, 46 percent of sponsors (320 of 701) reported data. Table 1 shows the number and percentage of sponsors that reported data.

Table 1: Number and Percentage of Part D Plan Sponsors That Voluntarily Reported Data From 2010 Through 2012

	2010	2011	2012	Total Across Years[1]
Number of Part D Plan Sponsors	651	626	620	701
Number of Part D Plan Sponsors That Reported Data	263	231	217	320
Percentage of Part D Plan Sponsors That Reported Data	40%	37%	35%	46%

Source: OIG analysis of Part D plan sponsors' data reported in HPMS, 2013.

[1] The number of Part D plan sponsors in this column is a count of unique sponsors that had contracts with CMS across these 3 years.

Of the 701 sponsors that had contracts with CMS, 78 sponsors had contracts for only 1 year, 50 sponsors for 2 years, and 573 sponsors for all 3 years. Among sponsors that held contracts across all 3 years, more than half (293 of 573 sponsors) did not report any aggregate data on potential fraud and abuse for all 3 years.

The 293 sponsors that did not voluntarily report any data for all 3 years during which they had contracts with CMS covered 14.5 million beneficiaries in 2012, or 46 percent of the total number of beneficiaries enrolled in Part D plans. Therefore, CMS does not have data on incidents

of potential fraud and abuse for plans covering almost half of the beneficiaries enrolled in Part D. The largest sponsor that did not voluntarily report any data across all 3 years covered between 6 and 9 percent of the total number of beneficiaries enrolled in Part D from 2010 through 2012.

Sponsors' identification of incidents of potential fraud and abuse varied significantly, from 0 to almost 14,000 incidents a year

Sponsors identified 64,135 incidents of potential fraud and abuse between 2010 and 2012. The number of such incidents identified varied significantly among the 320 sponsors that voluntarily reported data. The number of incidents sponsors identified annually ranged from 0 to 13,919, with an annual average of 90 incidents per sponsor and a median of 4 incidents per sponsor. Nearly a quarter of sponsors identified just one incident of potential fraud and abuse during a single reporting year.

The total number of incidents of potential fraud and abuse identified did not increase over the years. Sponsors identified the highest number of incidents of potential fraud and abuse in 2010, or 26,092 incidents. In 2011 and 2012, the total numbers of incidents of potential fraud and abuse identified were 12,796 and 25,247, respectively.

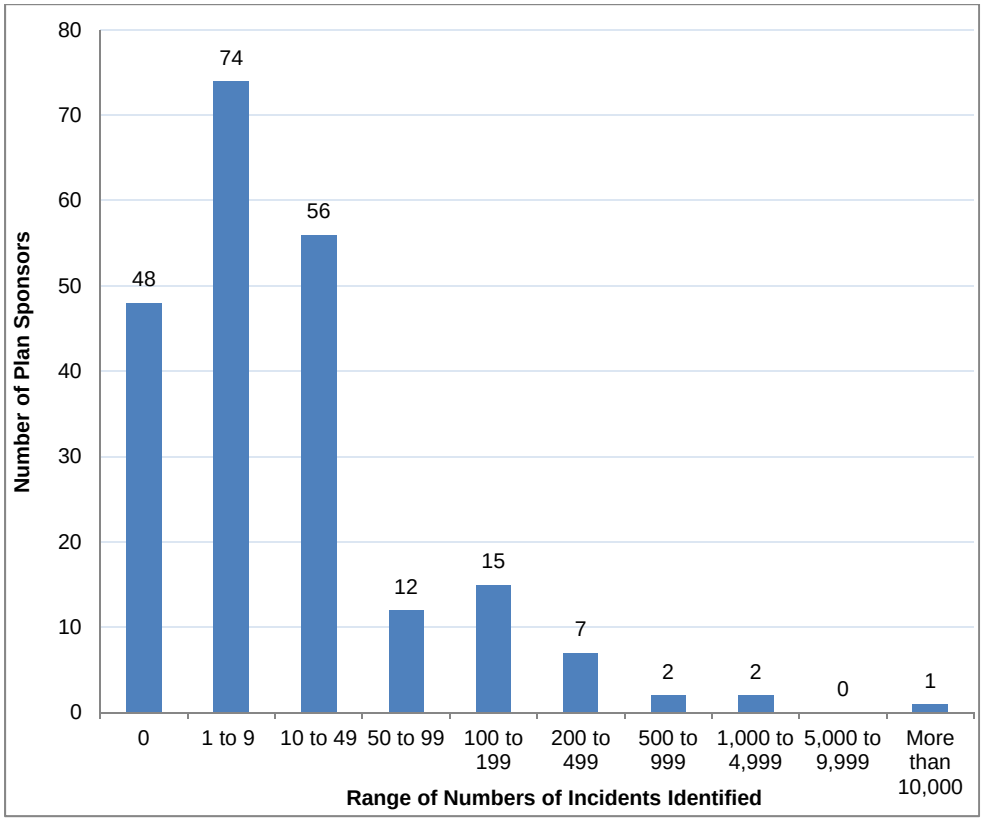
Of the 320 Part D plan sponsors that reported data, more than one-third did not identify any incidents of potential fraud and abuse in at least one year

From 2010 through 2012, 117 of 320 sponsors did not identify any incidents of potential fraud and abuse in at least one of the reporting years. The 117 sponsors covered 1.2 million beneficiaries in the years without reported incidents of potential fraud and abuse. Fifty-nine of these sponsors did not identify any incidents for any of the years for which they reported data.

In 2012, three Part D plan sponsors identified more than two-thirds of all reported fraud and abuse incidents

Of the 217 sponsors that reported data in 2012, 3 sponsors identified more incidents than all other sponsors combined. These 3 sponsors identified 13,410 incidents (53 percent of the total), 2,586 incidents (10 percent), and 1,287 incidents (5 percent), respectively. In contrast, the majority of sponsors each identified fewer than 10 incidents in 2012. Figure 1 provides the ranges of incidents identified by sponsors in 2012.

Figure 1: Range of Numbers of Incidents of Potential Fraud and Abuse Identified by Part D Plan Sponsors in 2012



Source: OIG analysis of Part D plan sponsors' data reported in HPMS, 2013.

The variability in the number of incidents identified was often not explained by the size of the sponsors' enrollment. To compare sponsors' rate of incidents identified relative to their enrollment size, we calculated the number of incidents identified by sponsor per 1,000 beneficiaries. Four sponsors identified more than 100 incidents per 1,000 beneficiaries. All four of these sponsors had low beneficiary enrollment.[19] The sponsor with the highest rate—308 incidents per 1,000 beneficiaries—identified 121 incidents, yet had only 393 beneficiaries enrolled in its plan. The majority of sponsors (159 out of 217) identified less than 1 incident per 1,000 beneficiaries. Among the sponsors that identified incidents of potential fraud and abuse, the sponsor with the lowest rate—0.03 incidents per 1,000 beneficiaries—identified just 1 incident per the 38,144 beneficiaries enrolled in its plan. Appendix A provides the number

[19] These 4 sponsors had total beneficiary enrollments of 33, 185, 393, and 1,963.

of incidents reported by each sponsor in 2012, the number of beneficiaries enrolled in each sponsor's plan, and the range of numbers of incidents identified per 1,000 beneficiaries.

CMS does not have detailed information on the incidents identified by Part D plan sponsors because of its limited reporting categories

Sponsors may use five general categories—for example, "inappropriate billing" or "providing false information"— to identify the different types of incidents. These categories provide only very broad information about the types of potential fraud and abuse that sponsors are identifying. Because of the limited categories, CMS does not have specific information about who committed the potential fraud and abuse or other details about the incidents.

In addition, for thousands of incidents of potential fraud and abuse reported from 2010 through 2012, the types are unknown because sponsors categorized these incidents as "other." In 2010 and 2011, "other" was the second most common type of incident identified by sponsors; at least 10 percent of incidents were categorized in this way. CMS does not require sponsors to specify or describe what is included in this category. Therefore, CMS does not know the incident type for a large number of incidents being reported.

Without detailed information about incidents of potential fraud and abuse reported by sponsors, CMS may be missing the opportunity to discover and alert sponsors to new fraud and abuse schemes. Appendix B shows the number and types of incidents of potential fraud and abuse identified by sponsors between 2010 and 2012.

Twenty-eight percent of Part D plan sponsors reported initiating no inquiries and corrective actions regarding incidents of potential fraud and abuse between 2010 and 2012

CMS requires sponsors to conduct a timely, reasonable inquiry and to carry out appropriate corrective actions in response to potential fraud and abuse. From 2010 to 2012, 28 percent of the 261 sponsors that identified at least 1 incident of potential fraud and abuse reported initiating no inquiries and corrective actions with regard to any of these incidents. In that timeframe, these 74 sponsors identified 4,028 incidents of potential fraud and abuse. Of these sponsors, 38 percent reported initiating no

inquiries and 51 percent reported initiating no corrective actions in response to identified incidents.

Though they are not required to do so, sponsors can also refer incidents of potential fraud and abuse to CMS, Federal and local law enforcement, and State agencies. Sixty-one percent of the 261 sponsors did not refer any identified incidents to these entities.

Across the 3 years, sponsors initiated 73,102 inquiries and 23,833 corrective actions with regard to identified incidents and they referred 3,834 incidents to CMS. Table 2 provides the number of actions taken by sponsors each year.

Table 2: Number of Actions Taken by Part D Plan Sponsors in Response to Incidents of Potential Fraud and Abuse From 2010 Through 2012

	2010		2011		2012	
Type of Action Taken in Response to Incidents of Potential Fraud and Abuse	**Number of Actions Reported**	**Percentage of 26,092 Incidents Identified[1]**	**Number of Actions Reported**	**Percentage of 12,796 Incidents Identified[1]**	**Number of Actions Reported**	**Percentage of 25,247 Incidents Identified[1]**
Initiated Inquiries	25,381	97%	5,357	42%	42,364	168%[1]
Initiated Corrective Actions	9,245	35%	2,300	18%	12,288	49%
Referred to CMS	778	3%	1,598	12%	1,458	6%
Referred to Federal Law Enforcement	55	< 1%	85	< 1%	42	< 1%
Referred to Local Law Enforcement	25	< 1%	26	< 1%	15	< 1%
Referred to State Insurance Commissioners or State Licensing Authorities	101	< 1%	172	1%	174	< 1%

Source: OIG analysis of Part D plan sponsors' data reported in HPMS, 2013.

[1] For inquiries and corrective actions, CMS does not require the data to be reported as a subset of the incidents identified for that reporting year. Therefore, it is possible that inquiries and corrective actions may correspond to incidents of potential fraud and abuse identified in a prior year. In 2012, CMS instructed sponsors to report referrals to CMS and other entities as a subset of the number of incidents identified during the reporting year.

Anomalies in inquiry data may stem from a lack of guidance to Part D plan sponsors

It is interesting to note that the number of inquiries initiated in 2012 was significantly higher than the total number of incidents of potential fraud and abuse reported that year—42,364 inquiries were made, whereas only 25,247 incidents were identified. Furthermore, this number of inquiries was higher than the combined total number of incidents identified in 2010 and 2011. The highest number of inquiries conducted by a sponsor in that year was 33,525; this was the same sponsor that identified the highest number of incidents (13,410 incidents).

CMS does not require the number of inquiries to be reported as a subset of the number of incidents identified during the year. Therefore, some of the anomalies in the inquiry data may be due in part to carryover from previous reporting years. Alternatively, it may be caused by sponsors' counting inquiries in different ways. In a 2010 report, OIG found differences in the ways in which some MA organizations defined and tracked inquiries that they initiated in response to incidents of potential fraud and abuse.[20] For example, one MA organization defined the number of inquiries it conducted as the number of its staff members who investigated a particular incident of potential fraud and abuse. Another organization defined inquiries as "the number of unique contacts that [the] organization made during the investigation of each incident." It is possible that Part D plan sponsors also may be using distinctly different methods to arrive at the number of inquiries they reported having conducted.

Although CMS reported that it conducted basic summary analyses of the data on potential fraud and abuse, it did not perform quality assurance checks on the data or use them to monitor or oversee the Part D program

CMS reported that from 2010 through 2012, it conducted basic summary analyses on data on potential fraud and abuse. For instance, CMS stated that it summarized fraud and abuse control activities across sponsors, as well as across years. CMS stated that it integrated data from other sources, such as CMS's Complaint Tracking Module, into the analysis.[21]

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[20] OIG, *Medicare Advantage Organizations' Identification of Potential Fraud and Abuse*, OEI-03-10-00310, February 2012.

[21] The Complaint Tracking Module is part of HPMS and is the central repository of Medicare Part C and Part D complaints.

However, during this time period, CMS did not perform any quality assurance checks on the data. It also did not use the data for monitoring or oversight purposes, nor did it share the data with sponsors or law enforcement.

CMS did not perform any quality assurance checks or followup on the fraud and abuse data reported by Part D plan sponsors

CMS's *Technical Specifications Document* for 2011 and 2012 states that CMS can perform quality assurance checks to establish benchmarks to identify outliers or potentially erroneous data on fraud and abuse.[22] It also states that CMS can identify outliers and notify sponsors to give them the opportunity to correct submitted data if needed. However, CMS reported that it did not perform any quality assurance checks on the voluntarily reported data between 2010 and 2012 or notify any sponsors that their data from 2010 through 2012 were deemed to be outliers.

CMS expects sponsors to validate their data. In its *Technical Specifications Document*, CMS states that sponsors should perform a data validation check prior to submitting their data. CMS specifies that the total incidents of potential fraud and abuse should equal the sum of the individual types of incidents. CMS also specifies that the incidents identified through internal efforts and external sources should be subsets of the total incidents identified in the reporting year.

We performed a number of simple checks that either CMS or sponsors could have done to ensure the accuracy of sponsors' reported data. For 2012, we found that the total number of incidents identified and reported in HPMS across sponsors did not equal the sum of the number of each type of incident. Upon further exploration, we found that this was because the total number of incidents identified and reported in HPMS did not equal the sum of the individual types of incidents identified for two sponsors. In addition, we found that for 39 sponsors, the sum of the incidents identified through internal efforts and external sources did not equal the total number of incidents reported.

Although CMS did not perform any quality assurance checks on the data from 2010 to 2012, it reported that it is designing procedures to notify sponsors that do not pass quality assurance checks. CMS stated it will review and investigate any extreme values reported by sponsors and that it

[22] CMS, *Medicare Part D Plan Reporting Requirements: Technical Specifications Document, Contract Year 2011*, p. 63; *Medicare Part D Plan Reporting Requirements: Technical Specifications Document, Contract Year 2012*, p. 67.

will attempt to determine whether extreme values are truly outliers or whether they are actually data entry errors. CMS reported it will notify sponsors when it identifies data that need clarification and ask the sponsor to correct any mistakes.

CMS did not use the fraud and abuse data to monitor or oversee Part D plan sponsors

CMS is responsible for the oversight of Part D plan sponsors. However, CMS reported that it did not use the voluntarily reported data for monitoring or oversight purposes. CMS did not follow up with sponsors about their fraud and abuse control activities related to the voluntarily reported data. CMS stated that it is formulating processes to follow up with sponsors and to use the reported data to monitor and oversee sponsors.

CMS reported that it plans to conduct further analyses on the voluntarily reported data, including statistical comparisons of fraud, waste, and abuse incidents reported by sponsors and parent organizations by each data element for 2010, 2011, and 2012. These comparisons may include percentage relationships and average values, as well as identifications of sponsors with the most and least identified incidents. CMS stated that future methodologies may incorporate results from other proactive data analysis projects and compare those results to voluntarily reported data to identify any trends, patterns, or anomalies.

CMS did not share the fraud and abuse data with Part D plan sponsors or law enforcement

CMS reported that from 2010 through 2012, it did not share the data on potential fraud and abuse with its National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), sponsors, or law enforcement (e.g., OIG, the Department of Justice).[23] CMS noted that beginning in 2013, it shared the data with its NBI MEDIC. According to CMS, the benefit integrity contractor has developed methodologies to analyze the data. CMS stated that it is discussing and formulating processes for sharing data with sponsors and law enforcement. However, CMS stated that it is difficult to draw conclusions because the reporting of these data is voluntary.

[23] The NBI MEDIC is responsible for detecting and preventing fraud, waste, and abuse in Medicare Parts C and D nationwide.

CONCLUSION AND RECOMMENDATIONS

Part D plan sponsors' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the Part D program. Although CMS does not require sponsors to report the identification of or response to incidents of potential fraud and abuse, CMS allowed sponsors to voluntarily report data on potential fraud and abuse beginning in 2010. However, more than half of sponsors did not report data on potential fraud and abuse from 2010 through 2012. Even when sponsors did report data, CMS did not use these data for monitoring or oversight purposes, nor did CMS share these data with other plan sponsors or law enforcement.

The number of incidents of potential fraud and abuse identified by sponsors varied significantly, and this variation often was not explained by the size of the sponsors' enrollment. More than one-third of reporting sponsors did not identify any incidents of potential fraud and abuse in at least one of their reporting years. Seventy-three sponsors identified just 1 incident of potential fraud and abuse in a single year, yet 1 sponsor identified over 13,000 incidents of potential fraud and abuse. Despite the variation across sponsors when reporting incidents of potential fraud and abuse and actions taken on these incidents, CMS did not review the reasons that caused sponsors' significant differences in reporting.

CMS could strengthen the usefulness of reported data on fraud and abuse by clarifying terms and requesting more specific information about incidents. CMS provided sponsors with only a few broad categories with which to report the type of data on incidents of potential fraud and abuse. In addition, sponsors reported "other" as the type of fraud for thousands of incidents. Therefore, the data reported lack details and their usefulness in identifying emerging fraud schemes or trends is limited. The lack of clear definitions for fraud terms also may have led to anomalies in the reported data. For example, sponsors, overall, reported initiating a significantly higher number of inquiries in 1 year than the total number of incidents reported that year. This may stem from a lack of guidance to sponsors on how to count inquiries, thereby leaving sponsors to develop their own, distinctly different methods to do so.

Not all sponsors that identified incidents reported initiating inquiries or corrective actions or referring incidents to outside entities for further investigation. This raises questions about whether all sponsors have fully implemented programs to effectively address potential fraud and abuse as required.

Because CMS does not have data on potential fraud and abuse for more than half of Part D plans, it cannot assess the efficacy throughout the Part D program of sponsors' efforts to control fraud and abuse. CMS itself has stated that it is difficult to draw conclusions about the fraud and abuse data because the data are reported voluntarily.

We recommend that CMS:

Amend regulations to require Part D plan sponsors to report to CMS their identification of and response to incidents of potential fraud and abuse

Since 2010, sponsors have had the option to voluntarily report aggregate data on fraud and abuse activity to CMS. In previous reports, OIG has recommended that CMS require sponsors to report incidents of potential fraud and abuse to CMS. We continue to recommend that CMS require sponsors to report to CMS their identification of and response to incidents of potential fraud and abuse. CMS should also require that sponsors provide more detailed information regarding incidents of potential fraud and abuse—specifically, information about who committed the potential fraud and other details about the incident. CMS may also want to provide more distinct categories of fraud and abuse so that sponsors could specify the types of incidents. This information could result in earlier identification of fraud and abuse schemes, which would be important to share with other sponsors and law enforcement. CMS should also use these data to target audits and to evaluate the effectiveness of sponsors' programs to control fraud, waste, and abuse.

Provide Part D plan sponsors with specific guidelines on how to define and count incidents of potential fraud and abuse, related inquiries, and corrective actions

Existing CMS documentation provides basic definitions of fraud and abuse incidents. However, there was wide variation in the numbers of incidents and inquiries that sponsors reported from 2010 through 2012. This may be due in part to the fact that CMS has not provided sponsors with more specific guidance regarding the definitions of fraud and abuse terms. Providing such guidance would help CMS to ensure that fraud and abuse information could be compared across sponsors and would promote a common understanding among sponsors.

Review data from Part D plan sponsors to determine why certain sponsors reported especially high or low numbers of incidents of potential fraud and abuse, related inquiries, and corrective actions

From this review, CMS would be able to determine the extent to which the significant variation in reporting is caused by (1) a lack of a common understanding of key fraud and abuse terms across sponsors; (2) the quality of sponsors' programs to prevent, detect, and correct fraud, waste, and abuse; (3) reporting errors made by sponsors; or (4) natural variation of fraud and abuse across sponsors and geographic areas.

Share Part D plan sponsors' data on potential fraud and abuse with all sponsors and law enforcement

CMS stated that it has begun sharing sponsors' data with the benefit integrity contractor. Sharing data on potential fraud and abuse with sponsors and law enforcement would enable them to target problematic providers or beneficiaries and quickly respond to emerging fraud and abuse issues.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS did not concur with our first recommendation. CMS stated that sponsors are held accountable for detecting and preventing fraud and abuse and sponsors already report potential fraud to CMS's NBI MEDIC. CMS also stated that requiring sponsors to report directly to CMS itself may duplicate efforts, expend unnecessary additional resources, and potentially inundate CMS and its contractors with information that would not necessarily yield a better outcome in terms of stopping Part D fraud.

CMS raised concerns that reporting data to CMS and the NBI MEDIC would be duplicative. OIG is not recommending duplicative reporting. CMS may choose to select the NBI MEDIC as its designee to receive sponsors' fraud reports.

While CMS states in its comments that sponsors already report potential fraud to the NBI MEDIC, they currently are not required to do so. The *Prescription Drug Benefit Manual*, Chapter 9, Compliance Program Guidelines, specifies that reporting of fraud, waste, and abuse is "voluntary" and that sponsors "should refer cases involving potential fraud and abuse" to the NBI MEDIC. Because these data are voluntarily reported, there is not a comprehensive set of data that enables CMS to monitor sponsors' fraud, waste, and abuse programs. Yet, according to

CMS's reporting requirements document, these data are intended to serve that purpose. Therefore, OIG continues to recommend that CMS specifically require sponsors to report their identification of and response to incidents of potential fraud and abuse to CMS or its designee. Requiring sponsors to report these data will provide CMS a more complete and accurate accounting of the identification of potential fraud and abuse incidents, as well as sponsors' efforts to reduce fraud and abuse in Medicare.

CMS partially concurred with our second recommendation. CMS stated that each year, it issues the reporting requirements document to sponsors. This document includes a discussion about voluntarily reported data related to anti-fraud activities and definitions of potential fraud and abuse incidents. CMS also reported that the July 27, 2012, revision to Chapter 9 (Compliance Program Guidelines) of the *Prescription Drug Benefit Manual* provides guidance to sponsors on how to report fraud, waste, and abuse. OIG agrees that basic definitions of potential fraud and abuse incidents are included in the reporting requirements document and the *Prescription Drug Benefit Manual*. However, these documents do not specifically outline how sponsors should define and count an incident, an inquiry, or corrective action. Therefore, OIG continues to recommend that CMS provide sponsors with specifics on how to define and count these data elements.

CMS concurred with our third recommendation. CMS stated that data sponsors report to it and the referrals sponsors send to the NBI MEDIC can be used to analyze the variation in reporting that may exist. CMS stated it can use this information to assist sponsors that may require additional assistance in understanding potential fraud, waste, and abuse issues, and the ways in which to investigate those issues and to identify schemes that may be widespread. CMS reported that it is reviewing and formulating the data reported to the NBI MEDIC and the data voluntarily reported to CMS to strengthen its outreach and education efforts.

Regarding the fourth recommendation, CMS partially concurred and stated that it shares any specific (sponsor or prescriber) information with law enforcement upon request. CMS stated that it does not believe that sending law enforcement all information would be beneficial, as law enforcement cannot pursue all leads since it has finite resources and, therefore, must narrow its focus. CMS also stated that specific data elements from individual sponsor's referrals are not typically shared with other sponsors, but information regarding Part D fraud schemes is shared

with all sponsors and law enforcement through fraud alerts and quarterly Medicare Parts C and D Fraud Work Group meetings. OIG understands that CMS may use its discretion to determine what information to share with law enforcement and sponsors.

The full text of CMS's comments is provided in Appendix C.

APPENDIX A

Table A-1 compares the number of incidents of potential fraud and abuse identified by Part D plan sponsors to the number of beneficiaries enrolled in Part D plans in 2012. The table is sorted by the number of incidents identified per 1,000 beneficiaries in descending order. Each sponsor is also ranked by number of incidents identified and number of beneficiaries enrolled.

Table A-1: Number of Incidents Identified for Each Part D Plan Sponsor That Reported Data and Number of Beneficiaries in 2012

Total Number of Incidents	Total Number of Beneficiaries Enrolled in Plan	Rank by Incidents Identified	Rank by Beneficiary Enrollment	Incidents Identified Per 1,000 Beneficiaries
121	393	22	205	307.89
6	33	110	214	181.82
305	1,963	8	185	155.37
20	185	66	211	108.11
414	4,644	7	152	89.15
2,586	38,371	2	49	67.39
148	2,513	20	175	58.89
106	1,998	26	184	53.05
193	3,887	13	159	49.65
52	1,322	38	194	39.33
13,410	383,586	1	7	34.96
230	6,785	11	134	33.90
464	16,191	6	91	28.66
217	7,837	12	129	27.69
713	30,684	4	60	23.24
13	627	89	204	20.73
281	15,537	9	94	18.09
190	14,362	14	97	13.23
35	3,300	48	167	10.61
38	4,013	44	157	9.47
73	9,029	31	117	8.09
176	25,268	16	70	6.97
42	7,960	42	128	5.28
14	2,947	86	173	4.75
16	3,490	78	164	4.58
184	40,459	15	47	4.55
60	13,246	34	102	4.53
18	4,065	72	156	4.43
154	35,027	19	55	4.40
15	3,826	81	160	3.92
51	13,896	39	99	3.67
57	15,860	35	93	3.59
1	317	169	207	3.15
30	9,739	55	111	3.08
23	8,890	60	118	2.59
5	2,083	119	181	2.40

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Table A-1: Number of Incidents Identified for Each Part D Plan Sponsor That Reported Data and Number of Beneficiaries in 2012 (Continued)

Total Number of Incidents	Total Number of Beneficiaries Enrolled in Plan	Rank by Incidents Identified	Rank by Beneficiary Enrollment	Incidents Identified Per 1,000 Beneficiaries
113	48,662	24	41	2.32
4	1,730	130	192	2.31
7	3,263	106	169	2.15
134	62,665	21	28	2.14
16	7,652	77	130	2.09
68	35,401	33	54	1.92
73	45,371	30	43	1.61
18	11,560	71	109	1.56
14	9,365	85	114	1.49
11	7,424	93	132	1.48
236	161,523	10	12	1.46
18	12,452	70	105	1.45
96	67,697	28	26	1.42
5	3,579	118	162	1.40
34	25,795	49	69	1.32
8	6,223	99	139	1.29
8	6,505	98	136	1.23
72	61,856	32	30	1.16
19	16,600	69	89	1.14
19	17,529	68	87	1.08
54	50,070	37	39	1.08
2	1,871	149	188	1.07
1	1,037	168	199	0.96
7	7,476	105	131	0.94
13	14,039	88	98	0.93
33	35,657	50	53	0.93
3	3,274	139	168	0.92
17	18,645	75	82	0.91
158	182,208	18	10	0.87
14	16,343	84	90	0.86
31	36,318	53	52	0.85
45	53,996	41	34	0.83
2	2,452	148	177	0.82
22	27,300	62	65	0.81
14	18,237	83	83	0.77
3	3,937	138	158	0.76
5	6,631	117	135	0.75
7	9,312	104	116	0.75
22	31,401	61	56	0.70
6	8,631	109	122	0.70
37	53,938	45	35	0.69
5	7,375	116	133	0.68
35	51,937	47	37	0.67
3	4,512	137	153	0.66
4	6,075	129	141	0.66
20	31,009	65	57	0.64

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Table A-1: Number of Incidents Identified for Each Part D Plan Sponsor That Reported Data and Number of Beneficiaries in 2012 (Continued)

Total Number of Incidents	Total Number of Beneficiaries Enrolled in Plan	Rank by Incidents Identified	Rank by Beneficiary Enrollment	Incidents Identified Per 1,000 Beneficiaries
4	6,347	128	138	0.63
2	3,198	147	170	0.63
2	3,367	146	165	0.59
17	28,683	74	63	0.59
5	8,789	115	120	0.57
9	15,980	97	92	0.56
1	1,795	167	190	0.56
31	57,840	52	32	0.54
1	1,867	166	189	0.54
5	9,376	114	113	0.53
23	43,783	59	44	0.53
46	88,658	40	17	0.52
13	25,160	87	72	0.52
1	2,027	165	183	0.49
15	30,892	80	58	0.49
1	2,068	164	182	0.48
4	8,850	127	119	0.45
9	20,224	96	79	0.45
31	72,472	51	24	0.43
4	9,518	126	112	0.42
2	4,820	145	148	0.41
30	72,751	54	23	0.41
11	26,798	92	68	0.41
35	88,308	46	18	0.40
2	5,054	144	147	0.40
28	73,026	56	21	0.38
105	283,508	27	9	0.37
14	38,271	82	50	0.37
21	58,808	64	31	0.36
612	1,714,406	5	2	0.36
56	157,542	36	13	0.36
15	42,358	79	45	0.35
1	2,864	163	174	0.35
3	8,710	136	121	0.34
7	20,338	103	78	0.34
1,287	3,786,436	3	1	0.34
10	29,834	95	61	0.34
3	9,341	135	115	0.32
16	51,377	76	38	0.31
12	38,560	90	48	0.31
7	22,557	102	77	0.31
7	22,855	101	76	0.31
4	13,750	125	101	0.29
85	315,913	29	8	0.27
5	18,879	113	81	0.26
171	646,772	17	5	0.26

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Table A-1: Number of Incidents Identified for Each Part D Plan Sponsor That Reported Data and Number of Beneficiaries in 2012 (Continued)

Total Number of Incidents	Total Number of Beneficiaries Enrolled in Plan	Rank by Incidents Identified	Rank by Beneficiary Enrollment	Incidents Identified Per 1,000 Beneficiaries
7	26,980	100	66	0.26
5	19,339	112	80	0.26
26	101,923	58	15	0.26
19	76,040	67	20	0.25
6	25,188	108	71	0.24
1	4,269	162	154	0.23
4	17,889	124	85	0.22
1	4,693	161	151	0.21
1	4,694	160	150	0.21
1	4,722	159	149	0.21
11	53,304	91	36	0.21
3	15,459	134	95	0.19
1	5,173	158	146	0.19
17	92,173	73	16	0.18
4	22,863	123	75	0.17
4	22,999	122	74	0.17
2	12,758	143	103	0.16
27	180,448	57	11	0.15
21	152,637	63	14	0.14
10	72,774	94	22	0.14
114	874,255	23	3	0.13
111	856,479	25	4	0.13
2	16,640	142	88	0.12
1	8,525	157	124	0.12
1	8,553	156	123	0.12
3	28,181	133	64	0.11
5	54,789	111	33	0.09
39	447,410	43	6	0.09
1	11,563	155	108	0.09
1	12,619	154	104	0.08
6	80,130	107	19	0.07
2	30,795	141	59	0.06
4	62,464	121	29	0.06
3	49,736	132	40	0.06
4	67,172	120	27	0.06
3	71,712	131	25	0.04
2	47,856	140	42	0.04
1	24,858	153	73	0.04
1	26,902	152	67	0.04
1	29,225	151	62	0.03
1	38,144	150	51	0.03
0	41,884	170	46	0
0	18,188	171	84	0
0	17,779	172	86	0
0	14,454	173	96	0
0	13,830	174	100	0

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Table A-1: Number of Incidents Identified for Each Part D Plan Sponsor That Reported Data and Number of Beneficiaries in 2012 (Continued)

Total Number of Incidents	Total Number of Beneficiaries Enrolled in Plan	Rank by Incidents Identified	Rank by Beneficiary Enrollment	Incidents Identified Per 1,000 Beneficiaries
0	12,047	175	106	0
0	11,622	176	107	0
0	9,753	177	110	0
0	8,502	178	125	0
0	8,351	179	126	0
0	8,100	180	127	0
0	6,491	181	137	0
0	6,142	182	140	0
0	5,661	183	142	0
0	5,495	184	143	0
0	5,364	185	144	0
0	5,197	186	145	0
0	4,117	187	155	0
0	3,605	188	161	0
0	3,510	189	163	0
0	3,302	190	166	0
0	3,183	191	171	0
0	3,043	192	172	0
0	2,460	193	176	0
0	2,311	194	178	0
0	2,188	195	179	0
0	2,104	196	180	0
0	1,943	197	186	0
0	1,926	198	187	0
0	1,785	199	191	0
0	1,680	200	193	0
0	1,257	201	195	0
0	1,223	202	196	0
0	1,133	203	197	0
0	1,045	204	198	0
0	763	205	200	0
0	705	206	201	0
0	670	207	202	0
0	642	208	203	0
0	379	209	206	0
0	315	210	208	0
0	297	211	209	0
0	199	212	210	0
0	174	213	212	0
0	122	214	213	0
0	28	215	215	0
0	10	216	216	0
0	10	217	217	0
25,247	**14,034,918**			

Source: OIG analysis of Part D plan sponsors' data reported in HPMS and enrollment data obtained from publically available files, 2013.

APPENDIX B

Table B-1 shows the number and types of incidents of potential fraud and abuse identified by sponsors between 2010 and 2012.

Table B-1: Number and Types of Incidents of Potential Fraud and Abuse Identified by Part D Plan Sponsors From 2010 Through 2012

Type of Incident	Number Reported in 2010	Number Reported in 2011	Number Reported in 2012
Total Incidents of Potential Fraud and Abuse [1]	26,092	12,796	25,247
Inappropriate Billing	21,365	8,940	16,848
Providing False Information	1,352	1,257	4,311
Doctor-Shopping or Drug-Seeking Beneficiary	544	592	605
Attempting To Steal Identity or Money	282	323	337
Other	2,549	1,684	3,149
Incidents of Potential Fraud and Abuse Identified Through Internal Efforts	16,547	8,872	17,946
Incidents of Potential Fraud and Abuse Identified Through External Sources	8,877	3,893	7,256

Source: OIG analysis of Part D plan sponsors' data reported in HPMS, 2013.

[1] According to CMS's *Technical Specifications Document*, the total incidents of potential fraud and abuse should equal the sum of the individual types of incidents. In addition, incidents identified through internal efforts and external sources should be subsets of the total incidents identified in the reporting year. For all years, the total number of incidents of potential fraud and abuse did not equal the sum of the incidents identified through internal efforts and external sources. In 2012, the total number of incidents of potential fraud and abuse did not equal the sum of the individual types of incidents.

APPENDIX C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN - 8 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Less Than Half of Part D Sponsors Voluntarily Reported Potential Fraud and Abuse Data" (OEI-03-13-00030)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-referenced OIG draft report. CMS is committed to combating fraud, waste, and abuse in the Part D program and is continuously taking steps to strengthen our overall efforts. Two key principles are guiding our approach: 1) reducing the number of Medicare beneficiaries receiving coverage for prescription drugs that threaten their health and safety, and 2) preventing Part D coverage for prescription drugs dispensed by pharmacies or prescribed by providers engaging in fraud or abuse.

Our strategy for Part D focuses on the validation and analysis of Part D claims data (prescription drug event, or PDE, data) that CMS receives from Part D sponsors and leveraging that data to provide Part D plan sponsors, law enforcement agencies, and licensing boards with actionable information. CMS is committed to working with Part D sponsors to implement this strategy; however, we believe that requiring Part D sponsors to report all potential fraud and abuse would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud.

Our response to each of the OIG recommendations follows.

OIG Recommendation

The OIG recommends that CMS amend regulations to require Part D sponsors to report to CMS their identification of and response to potential fraud and abuse incidents.

CMS Response

The CMS does not concur with this recommendation. Part D sponsors are held accountable for detecting and preventing fraud and abuse. CMS has issued guidance citing the revision to

Chapter 9 of the Prescription Drug Benefit Manual to help assist with these responsibilities. Also, Part D sponsors already report potential fraud to CMS's National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), CMS's contractor. Amending the regulation to require reporting directly to CMS itself could be considered a duplication of effort that would require Part D sponsors to expend unnecessary additional resources and would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud.

OIG Recommendation

The OIG recommends that CMS provide Part D plan sponsors with specific guidelines on how to define and count potential fraud and abuse incidents, inquiries, and corrective actions.

CMS Response

The CMS partially concurs with this recommendation. Each year, CMS issues a Medicare Part D Reporting Requirements document to sponsors. As of January 2010, this document includes a discussion about voluntarily reported data related to anti-fraud activities. The document also includes definitions of potential fraud and abuse incidents. In addition, the July 27, 2012, revision to Chapter 9 (Compliance Program Guidelines) of the Prescription Drug Benefit Manual provides guidance to Part D sponsors on how to report fraud, waste, and abuse.

OIG Recommendation

The OIG recommends that CMS review Part D plan sponsors' data to determine why certain sponsors reported especially high or low volumes of potential fraud and abuse incidents, inquiries, and corrective actions.

CMS Response

The CMS concurs with this recommendation. Data reported to CMS, in addition to the referrals to the NBI MEDIC, can be used to analyze the variation in reporting that may exist. This information can be used to assist those Part D sponsors that may require additional assistance in understanding potential fraud, waste, and abuse issues, how to investigate those issues, and how to identity schemes that may be widespread. We are reviewing and formulating the data reported to the NBI MEDIC and the data voluntarily reported to CMS to strengthen our outreach and education efforts.

OIG Recommendation

The OIG recommends that CMS share Part D plan sponsors' potential fraud and abuse data with all Part D plan sponsors and law enforcement.

CMS Response

The CMS partially concurs with this recommendation. CMS shares any specific (Part D sponsor or prescriber) information with law enforcement upon request. We do not believe that sending law enforcement all information would be beneficial, as law enforcement cannot pursue all leads since it has finite resources and, therefore, must narrow its focus. In addition, we have no indication to date that law enforcement would like to receive all this information. While specific data elements from individual Part D sponsor's referrals are not typically shared with other sponsors, information regarding Part D fraud schemes is shared with all Part D plan sponsors and law enforcement. A variety of methods are available for sharing information about Part D fraud schemes. One method is through fraud alerts which are issued to Part D sponsors, advising the Part D sponsors of specific fraud schemes, including the naming of specific pharmacies and prescribers when appropriate. The purpose of these alerts is to inform the sponsors of the schemes so they may, in turn, conduct data analyses within their organizations to determine whether they have had any activity with either the identified subject, if included in the alert, or with the scheme.

Additionally, information sharing takes place through the quarterly Medicare Parts C and D Fraud Work Group meetings. At these meetings, vetted representatives from sponsors meet with representatives from the NBI MEDIC, CMS, and law enforcement to discuss recent schemes that have been identified. The sponsors then take this information back to their organizations and conduct data analyses to determine if they are experiencing the same issues. These Fraud Work Group meetings, whether held in person or via a webinar, provide participants with an opportunity to communicate directly with the meeting's presenters and to share information, ideas, and ask questions.

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

ACKNOWLEDGMENTS

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Linda M. Ragone, Deputy Regional Inspector General.

Tanaz Dutia served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Philadelphia regional office who conducted the study include Joanna Bisgaier and Nancy J. Molyneaux. Central office staff who provided support include Meghan Kearns and Christine Moritz.

Office of Inspector General

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