

March 15, 2011

Academy of Managed Care Pharmacy
100 N. Pitt Street, Suite 400
Alexandria, VA 22314

The Honorable Charles Boustany
Chairman
Subcommittee on Oversight
Committee on Ways & Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Boustany:

Thank you for the opportunity to provide written comments related to the March 2, 2011, hearing entitled “Improving Efforts to Combat Health Care Fraud.” The Academy of Managed Care Pharmacy (AMCP) is pleased to have the opportunity to suggest additional approaches to stemming the growth of Medicare fraud.

The Academy is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's 6,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit. Various of the Academy's members work within managed care organizations to prevent Medicare fraud in the Medicare Part D drug benefit.

Federal and private-sector estimates of Medicare fraud range from three percent to 10 percent of total expenditures, amounting to between \$68 billion and \$226 billion annually. HHS Secretary Sebelius said “When criminals steal from Medicare, they are stealing from all of us.”¹ The substantial size of the dollars lost annually in fraud, waste and abuse in Medicare Parts A, B, C and D have prompted Medicare fraud to be one of the federal government's top priorities. Fraudulent activity within pharmacy benefits can take many forms, including patients acquiring prescriptions under false pretenses, providers writing illegitimate prescriptions and the trafficking of counterfeit drugs.

First, the Academy strongly supports the premise of stopping the cycle of “paying and chasing” fraudulent activity. The Academy appreciates the inclusion of Section 6402 in the Patient Protection and Affordable Care Act, P.L. 111-148, (the Affordable Care Act) that permits the Secretary to suspend payments to a provider of services or supplier under Medicare Parts A and B, pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless there is good cause not to suspend the payment. Pursuant to this provision, the Secretary is required to consult with the

¹ Gebhart, F., “CMS Launches Anti-fraud Program,” *Drug Topics*. December 2009.

Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud.

The Academy strongly recommends that the Committee consider legislation that would extend the authority in the Affordable Care Act to suspend payment of claims wherein there is a credible allegation of fraud in Medicare Part D. Such legislation should provide for an expansion of time in which managed care organizations pay claims believed to be fraudulent. Further, AMCP recommends that Medicare Part D be included in the law by extending to the Secretary and/or Office of Inspector General the authority to suspend payments through the existing managed care organizations in instances of fraud.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) adopted a reduced period in which prescription drug plans (PDP) are required to pay pharmacies. As a result, Part D plans are limited to a retrospective analysis of pharmacy claims and provider payment trends which are primarily directed at administration errors, e.g., coding errors, etc.

Generally, a seven to 10-day payment cycle is required to meet MIPPA's 14 day "prompt payment" standard. For instance, a two-day time period between the end of a payment cycle (run on day 11) and the production of payment (run on day 13) obviates any significant prospective opportunity to conduct analysis of claims and reimbursement data prior to payment being sent to the pharmacy provider. As a result, Part D plans must rely on a "pay and chase" approach to recovering suspected fraud once proven. One plan's experience is that since 2006, approximately 9% to 12% of retrospectively reviewed claims have been deemed outliers and warranted additional scrutiny and investigation. Some of the metrics used by managed care organizations in a retrospective analysis include the following:

- Pharmacy provider reimbursement spikes relative to peers per payment cycle
- Increased brand drug dispensing, relative to generic drug dispensing (compared to peers)
- Increased dispensing/reimbursement of targeted high cost therapeutic classes or therapeutic classes with street value on the black market, i.e.:
 - Controlled substances
 - HIV drugs
 - Injectable specialty drugs
- Geographic prescription claim volume per capita, as compared to peers

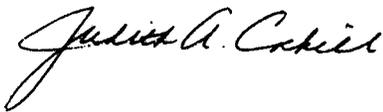
Second, the Academy appreciates the expanded data matching provisions provided for in Section 6402(a) of the Affordable Care Act. Section 6402(a) expands the "Integrated Data Repository" (IDR) at CMS that will incorporate data from all federal health care programs, including Medicare Parts A, B, C and D; Medicaid; CHIP; health-related programs administered by the Secretary of Veterans Affairs; health-related programs administered by the Department of Defense; Federal old-age survivors, and disability insurance benefits established under Title II of the Social Security Act; and the Indian Health Service and the Contract Health Service program. This provision establishes the ability to create a comprehensive database that reflects all claims involving federal government programs.

The Academy submits that it may be useful to link the claims data compiled in the IDR with the data compiled by the Medicare Drug Integrity Contractor (MEDIC) reporting infrastructure. The MEDIC database contains reports of fraud from private sector managed care organizations. To end the cycle of "paying and chasing" fraudulent activity, it will be important to ensure that there is a two-way communication of information between the public and private sectors with regard to fraudulent activity.

Fraud, waste and abuse are unacceptable within any health care program, especially within health care programs that are financed through taxpayer dollars. In a time of diminishing financial resources, it is more important than ever that Medicare providers, including Part D plan sponsors, are effectively able to combat suspected fraud. AMCP recognizes the seriousness of this problem and is supportive of efforts that would reduce the instance of fraudulent activity.

The Academy would be pleased to work with you to develop legislative language that addresses fraudulent activity in the Medicare Part D drug benefit. Thank you again for the opportunity to provide these written comments. Please do not hesitate to contact Lauren L. Fuller, Director of Legislative Affairs, at 703-683-8416 or lfuller@amcp.org if we may be of further assistance.

Sincerely,

A handwritten signature in cursive script that reads "Judy A. Cahill".

Judy A. Cahill
Executive Director

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cc: The Honorable John Lewis
Ranking Member