Increasing pressure on PBMs to identify fraudulent providers

How PBMs can use data, analytics and advanced technology to reduce their risk

In July 2017, the Justice Department arrested more than 400 people across the U.S. in a crackdown on healthcare fraud. The accused individuals were charged with billing Medicaid and Medicare for drugs that were never purchased, distributing unnecessary opioid prescriptions for cash and billing for false treatments.[1]

"Some doctors wrote out more prescriptions for controlled substances in one month than entire hospitals were writing," Andrew McCabe, acting FBI director said.[1] The fraud scheme cost the federal government $1.3 billion in fake Medicare and Medicaid billings.

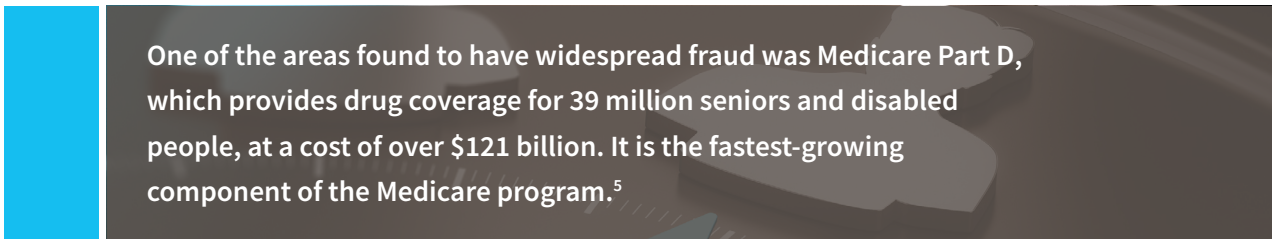
In October 2017, two pharmacists were charged in healthcare fraud schemes, allegedly defrauding Medicare, Tricare and major insurers out of more than $10 million. They took part in a conspiracy that employed improper contracts, kickbacks, mislabeled drugs and prescription forgeries, ultimately bilking millions of dollars from the federal health insurance program meant for America's military members and their families," said Jay Town, U.S. Attorney for the North district of Alabama.[2]

Unfortunately, those recent cases are just a few of the many schemes contributing to the billions of dollars lost each year through Medicare and Medicaid fraud and improper payments to providers, including pharmacists. The burden of catching that fraud is largely falling to Pharmacy Benefit Managers (PBMs).

A tempting target

The amount of money at stake and the tremendous volume of transactions make healthcare a natural target. In 2013 Medicaid doled out $415 billion; Medicare, nearly $600 billion.[3] No one knows for sure how much of that went to fraudulent claims, including prescription claims.

A report released in 2015 by the U.S. Government Accountability Office (GAO) said the Centers for Medicare and Medicaid Services (CMS) estimates that approximately $60 billion of American tax money, or more than 10% of Medicare's total budget, was lost to fraud, waste, abuse and improper payments in 2014.[4]



One of the areas found to have widespread fraud was Medicare Part D, which provides drug coverage for 39 million seniors and disabled people, at a cost of over $121 billion. It is the fastest-growing component of the Medicare program.[5]

Part D is administered by health insurers under contract with the federal government, but CMS is responsible for overseeing it and has made curtailing fraud a priority.

Preventing prescription drug fraud

CMS's strategy for ridding the system of fraud has been to move away from a pay-and-chase system to a preventive model. Identifying high-risk providers on the front end is easier than tracking and unraveling complicated transactions on the back end.

As part of its proactive approach, in 2019 CMS will publish a list of precluded prescribers who are no longer permitted to write prescriptions for Part D coverage. PBMs and retail pharmacies will be required to validate all prescription claims against that list.

Additionally, regulations in Title 42 CFR 455 for Medicaid Program Integrity put increasing pressure on PBMs to comply with screening and credentialing of the prescribers within their claims. Those claims represent about 75% of the more-than 3 billion prescriptions dispensed annually in the United States.[6]

PBMs must screen and monitor

CMS requires that PBMs ask important questions about each of the providers in their network:

Is the provider practicing with an expired license?

Has the provider been convicted of a felony?

Is the provider disbarred from participating in other programs or networks because of prior fraudulent activity?

Getting these answers is part of pre-enrollment screening to verify and disclose healthcare provider licensing and credentials. But PBMs' responsibility doesn't end there.

CMS requires PBMs to also do post-enrollment monitoring to comply with mandates, detect fraudulent provider activity and prevent improper payments to ineligible providers.

A variety of fraud schemes

Medicare Part D and Medicaid fraud is most often committed by organized crime groups and includes prescription schemes for both controlled and non-controlled substances. Part of the challenge for PBMs in detecting fraud is that those schemes can take so many different forms such as:

- Physicians who write prescriptions even though they've been disbarred from Medicare for previous violations
- Ineligible providers using false credentials to enroll in the system
- Physicians accepting kickbacks and bribes in exchange for prescribing drugs
- Pharmacies filling fake or forged prescriptions
- Pharmacies over-charging or billing for brand-name drugs but filling prescriptions with generics
- Providers, such as massage therapists or acupuncturists, writing prescriptions they don't have the authority to prescribe
- Identity theft of legitimately covered patients for criminal dispensing

Billions in improper payments

Fraud schemes involving Medicare Part D can be large and lucrative. Consider these examples:

- In 2015, more than 1,400 pharmacies were reported to have questionable billing practices. Some billed for extremely high numbers of prescriptions per patient and others billed for a high proportion of narcotic controlled substances. Collectively, they billed Part D $2.3 billion in 2014.[7]
- In April 2016, 24 Miami-area defendants were charged with defrauding Medicare of approximately $26 million in false claims through the Medicare Part D program.[8]
- In June 2016, in an unprecedented nationwide sweep, 301 individuals were charged with over $900 million in false billing. More than 60 of those who were arrested were charged with fraud related to Part D, according to the Justice Department.[9]

While big fraud cases get media attention, smaller schemes rarely get a mention. Hundreds, perhaps thousands more perpetrators continue to operate beneath the radar.

Using data for fraud detection

PBMs must identify potential fraud before it puts them at risk of regulatory non-compliance, affects their bottom line or jeopardizes patient safety. They're being called upon by CMS to step up their game to detect bad pharmacies and providers. They must look deeper at enrollment to eliminate bad players before they can commit fraud and be even more vigilant in monitoring.

The best fraud protection for PBMs lies in knowing their provider network. Data, analytics and cutting-edge technology now make that possible.

Working with the right data partner, PBMs are able to efficiently process searches and obtain critical information contained within massive data culled from hundreds of diverse sources to:

Verify and monitor healthcare provider licensing and credentials

Proactively uncover derogatory attributes linked to providers who then merit a closer look

Obtain risk scores and check indicators flagged for potential fraud

Protecting resources for the sick and elderly

Every dollar saved from fraud could be used to give people access to better health services, thereby saving and improving lives. Healthcare fraud hurts vulnerable people, diverting resources that should be going to the sick and elderly.

With data, analytics and advanced technology, suspected perpetrators of Medicare fraud are no longer able to hide. PBMs can reduce their risk of regulatory non-compliance. And taxpayers will see more of their money going to those who need care and less flowing to fraudulent providers, including pharmacies and pharmacists.

LexisNexis is a leader in data solutions and fraud prevention in the healthcare industry. The Provider Integrity Scan solution assists PBMs in verifying healthcare provider licensing and credentials, and detecting fraudulent or criminal provider activity.

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Our healthcare solutions combine proprietary analytics, science and technology with the industry's leading sources of provider, member, claims and public records information to improve cost savings, health outcomes, data quality, compliance and exposure to fraud, waste and abuse.

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