



Testimony

Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

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MEDICARE PART D

Instances of Questionable Access to Prescription Drugs

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Chairman Carper, Ranking Member Brown, and Members of the Subcommittee:

Thank you for the opportunity to discuss the results of our investigation of fraud and prescription drug abuse in Medicare Part D. Prescription drug abuse is a serious and growing public health problem. According to the Centers for Disease Control and Prevention, drug overdoses, including those from prescription drugs, are the second leading cause of deaths from unintentional injuries in the United States, exceeded only by motor vehicle fatalities. Unlike addiction to heroin and other drugs that have no accepted medical use, addiction to some controlled substances can be unknowingly financed by insurance companies and public programs, such as Medicare Part D.

My statement today summarizes our report,¹ describing indications of doctor shopping in the Medicare Part D program for 14 categories of frequently abused prescription drugs.² The objectives of the forensic audit and related investigation were to (1) determine the extent to which Medicare beneficiaries obtained frequently abused drugs from multiple prescribers, (2) identify examples of doctor shopping activity, and (3) determine the actions taken by the Centers for Medicaid & Medicare Services (CMS) to limit access to drugs for known abusers. To meet the objectives, we analyzed Medicare Part D claims for calendar year 2008 to identify potential doctor shoppers. To identify examples, we chose a nonrepresentative selection of 10 beneficiaries based on a number of factors, including the number of prescribers.

We conducted this forensic audit from May 2010 to October 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related

¹ GAO, *Medicare Part D: Instances of Questionable Access to Prescription Drugs*, [GAO-11-699](#) (Washington, D.C.: Sept. 6, 2011).

² According to the Drug Enforcement Administration, doctor shopping generally refers to visits by an individual to several doctors, each of whom writes a prescription for a controlled substance. The individual will visit several pharmacies, receiving more of the drug than intended by any single physician, typically for the purpose of abuse.

investigative work in accordance with standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Some Medicare Beneficiaries Received Prescriptions from Five or More Medical Practitioners to Obtain the Same Class of Frequently Abused Drugs

Our analysis found that about 170,000 Medicare beneficiaries received prescriptions from five or more medical practitioners for the 12 classes of frequently abused controlled substances and 2 classes of frequently abused noncontrolled substances in calendar year 2008.³ This represented about 1.8 percent of the Medicare Part D beneficiaries who received prescriptions for these 14 classes of drugs during the same calendar year. These individuals incurred approximately \$148 million in prescription drug costs⁴ for these drugs,⁵ much of which is paid by the Medicare program. We also found the following:

- Most of these 170,000 Medicare beneficiaries who were prescribed prescriptions from five or more practitioners were eligible for Medicare Part D benefits based on a disability. Specifically, approximately 120,000 Medicare beneficiaries (about 71 percent) were eligible for Medicare Part D benefits based on a disability.
- Of these 170,000 beneficiaries, approximately 122,000 beneficiaries (72 percent) received a Medicare Low-Income Cost-Sharing (LICS) subsidy.⁶

³ We selected the 14 classes of drugs and the five or more prescribers threshold based on our review of drug diversion literature and prior GAO work and discussions with a criminal investigator whose recognized expertise is in drug diversion and with an official representing state prescription drug monitoring programs.

⁴ Medicare Part D is financed from general revenues, beneficiary premiums, and state contributions for Medicare beneficiaries who are also eligible for Medicaid. A beneficiary premium is set to cover approximately 25 percent of the cost of standard drug coverage.

⁵ The \$148 million in prescription costs represents about 5 percent of total Medicare Part D prescription costs for these 14 classes of highly abused drugs. The prescription drug costs included in this study do not include related costs associated with obtaining prescriptions, such as the corresponding visits to the doctor's office and emergency room. These costs are billed separately from the prescription drug claims.

⁶ When Medicare Part D was established, it replaced Medicaid as the primary source of drug coverage for beneficiaries with coverage under both programs—referred to as dual-eligible beneficiaries. Part D provides substantial premium and cost-sharing assistance through the LICS for dual-eligible beneficiaries and other low-income beneficiaries. The amount of the subsidy for premiums, deductibles, co-payments, and catastrophic coverage varies depending on income and resources.

- Of the 14 classes of frequently abused drugs analyzed, hydrocodone and oxycodone were the most prevalent. These drugs represented over 80 percent of the instances of potential doctor shopping we identified.

In some cases, beneficiaries may have a justifiable reason for receiving prescriptions from multiple medical practitioners, such as visiting specialists or several prescribers in the same medical group. However, our analysis of Medicare Part D claims found that about 600 Medicare beneficiaries received prescriptions from 21 to 87 medical practitioners in the same year. In these situations, there is heightened concern that these Medicare beneficiaries may be seeking several medical practitioners to support and disguise an addiction.⁷

Our analysis of Medicare Part D claims did not focus on all prescription drugs, but instead targeted 12 classes of frequently abused controlled substances and 2 classes of frequently abused noncontrolled substances, as shown in table 1. Our analysis does have certain limitations based on the data. Specifically, for at least 5.8 percent of the Part D claims, the data submitted to CMS contained blank or invalid prescriber identification values. Because these claims were not included in our analysis, we potentially understated the total number of unique prescribers for each beneficiary who received a prescription for all the claims paid.

Table 1: Fourteen Frequently Abused Prescription Drugs Classes

Prescription drug classes	Other names	DEA schedule ^a	Description
Amphetamine derivatives	Adderall	II	Non-narcotic stimulant
Benzodiazepines ^b (e.g., Diazepam, Alprazolam, Lorazepam, Clonazepam, Temazepam, and Triazolam)	Valium, Xanax, Klonopin, Ativan, Restoril, and Halcion	IV	Non-narcotic depressant
Carisoprodol	Soma	Not scheduled	Muscle relaxant
Codeine with Acetaminophen	Tylenol with Codeine	III	Narcotic painkiller
Fentanyl	Duragesic and Actiq	II	Narcotic painkiller
Hydrocodone combinations	Lorcet, Lortab, Norco, and Vicodin	III	Narcotic painkiller
Hydromorphone	Dilaudid	II	Narcotic painkiller

⁷ Our threshold of visiting five or more practitioners excludes those who successfully doctor shop by visiting fewer than five practitioners on a regular basis. For example, a Medicare beneficiary can regularly receive overlapping prescriptions of abused drugs by visiting as few as two practitioners.

Prescription drug classes	Other names	DEA schedule ^a	Description
Meperidine	Demerol	II	Narcotic painkiller
Methadone ^c	Methadose and Dolophine	II	Narcotic painkiller
Methylphenidate	Ritalin, Concerta, and Methylin	II	Non-narcotic stimulant
Morphine	MS Contin, Roxanol, Avinza, and Kadian	II	Narcotic painkiller
Non-Benzodiazepine sleep aids (e.g., Zolpidem, Zopiclone, and Zaleplon)	Ambien, Sonata, and Lunesta	IV	Non-narcotic sedative
Oxycodone	OxyContin, Roxicodone, Percocet, Endocet, and Roxicet	II	Narcotic painkiller
Tramadol	Ultram and Ultracet	Not scheduled	Non-narcotic painkiller

Sources: National Institutes of Health and Drug Enforcement Administration.

^aThe Drug Enforcement Administration (DEA) classifies controlled substances in schedules I through V. Schedule I drugs—including heroin, marijuana, and hallucinogens such as LSD—have a high potential for abuse and no federally accepted medical use. Schedule II drugs have a high potential for abuse and may lead to severe physical or psychological dependence but have a currently accepted medical use. Drugs on schedules III through V have medical uses and successively lower potentials for abuse and dependence.

^bPart D plans are not required to cover benzodiazepines. However, some plans choose to cover these drugs as an added benefit.

^cMethadone is also used for the treatment of narcotic withdrawal and dependence.

Table 2 shows the breakout by drug class for the approximately 170,000 Medicare Part D beneficiaries who were prescribed the same class of drug by five or more medical practitioners. Because Medicare Part D beneficiaries may be receiving multiple classes of prescription drugs from five or more medical practitioners, certain beneficiaries may be counted in more than one prescription drug class. As shown in table 2, hydrocodone and oxycodone were the two prescription drug classes that were most prescribed by multiple medical practitioners. According to the Department of Justice (DOJ), doctor shopping is the primary method to obtain highly addictive prescription opioids (e.g., hydrocodone and oxycodone) for illegitimate use.⁸

⁸ DOJ, *National Prescription Drug Threat Assessment 2010 (NPDTA 10)* (Johnstown, Pa.: February 2010).

Table 2: Number of Medicare Part D Beneficiaries Who Received 1 of 14 Prescription Drug Classes from Five or More Prescribers in 2008

	DEA controlled	Number of prescribers					Total	Total prescription cost
		5-10	11-15	16-20	21-50	51+		
Amphetamine derivatives (e.g., Adderall)	Y	881	9	3	2		895	\$1,040,395
Benzodiazepine (e.g., Valium and Xanax)	Y	2,437	17	4	2		2,460	\$372,822
Carisoprodol (e.g., Soma)	N	3,026	51	4	2		3,083	\$592,751
Codeine with Acetaminophen (e.g., Tylenol with Codeine)	Y	1,500	21	4			1,525	\$244,930
Fentanyl (e.g., Duragesic)	Y	5,043	24	8	2		5,077	\$19,124,853
Hydrocodone (e.g., Vicodin and Lortab)	Y	92,801	3,553	700	335	5	97,394	\$18,949,677
Hydromorphone (e.g., Dilaudid)	Y	2,453	77	13	8		2,551	\$1,236,678
Meperidine (e.g., Demerol)	Y	149	8				157	\$90,236
Methadone (e.g., Dolophine and Methadose)	Y	3,414	9				3,423	\$859,208
Methylphenidate (e.g., Ritalin and Concerta)	Y	740	2	1			743	\$488,759
Morphine (e.g., MS Contin and AVINZA)	Y	6,354	33	4			6,391	\$9,311,773
Non-Benzodiazepine sleep aids (e.g., Ambien and Lunesta)	Y	4,496	15				4,511	\$2,917,465
Oxycodone (e.g., Oxycontin and Percodan)	Y	54,183	1,974	440	235	5	56,837	\$91,681,281
Tramadol (e.g., Ultram and Ultracet)	N	4,346	134	33	14		4,527	\$1,037,423
Total		181,823	5,927	1,214	600	10	189,574	\$147,948,251

Sources: GAO and DEA.

Notes: The totals do not necessarily represent unique beneficiaries. A single beneficiary could have been prescribed more than one class of drug by more than one prescriber. The number of unique beneficiaries represented in this table is 170,029. The maximum number of prescribers from which a beneficiary received 1 of the 14 classes of prescription drugs was 87. The total beneficiary counts for oxycodone and hydrocodone represent 2.8 percent and 1.8 percent of all beneficiaries receiving that class of drug, respectively.

Examples of Doctor Shopping in Medicare Part D

We obtained additional information on 10 of the Medicare Part D beneficiaries that showed indications of doctor shopping. In each of the 10 cases, we found evidence that the beneficiary was acquiring highly abused drugs through doctor shopping. We also found that in each example physicians were not aware that their patients were receiving drugs prescribed by other prescribers. DEA's definition of doctor shopping specifies an individual receiving more of a drug than intended by any single physician. In several examples physicians stated that they would not have prescribed the drugs if they were aware that the patient was receiving the same class of drugs from other sources. Table 3 highlights 3 of the 10 examples of doctor shopping for prescription drugs, including controlled substances, in the Medicare Part D program. We referred

these beneficiaries to the Medicare Part D fraud contractor, as appropriate, for further investigation.⁹

Table 3: Examples of Doctor Shopping of Prescription Drugs in Medicare Part D

Example	State	Class of prescription drug(s)	Case details
1	CA	Fentanyl	<ul style="list-style-type: none"> <li data-bbox="662 638 1503 688">• The beneficiary received prescriptions for a total of 1,397 fentanyl patches and pills (a 1,758-day supply) from 21 different prescribers in 2008. <li data-bbox="662 699 1503 827">• One physician who treated the beneficiary prescribed fentanyl for lower back pain. The beneficiary did not inform the physician that he was seeing other doctors. The physician stated that he would not have prescribed any controlled substances had he known they were being prescribed by other doctors. <li data-bbox="662 837 1503 1094">• Another physician who treated the beneficiary from March 2008 through August 2008 stated that the beneficiary did not disclose that he was seeing other doctors and that she would not have prescribed any controlled substances had she known they were being prescribed by other doctors. In August 2008, the physician received an alert letter^a from the state prescription drug monitoring program (PDMP) informing her that within a 4-month period the beneficiary had received 33 prescriptions for controlled substances from 10 different prescribers. After the PDMP alerted the physician of these multiple prescribers, the physician informed the beneficiary that she would no longer treat him as a patient.

⁹ CMS guidance directs Part D plans to refer cases of potential fraud directly to the Medicare Part D fraud contractor.

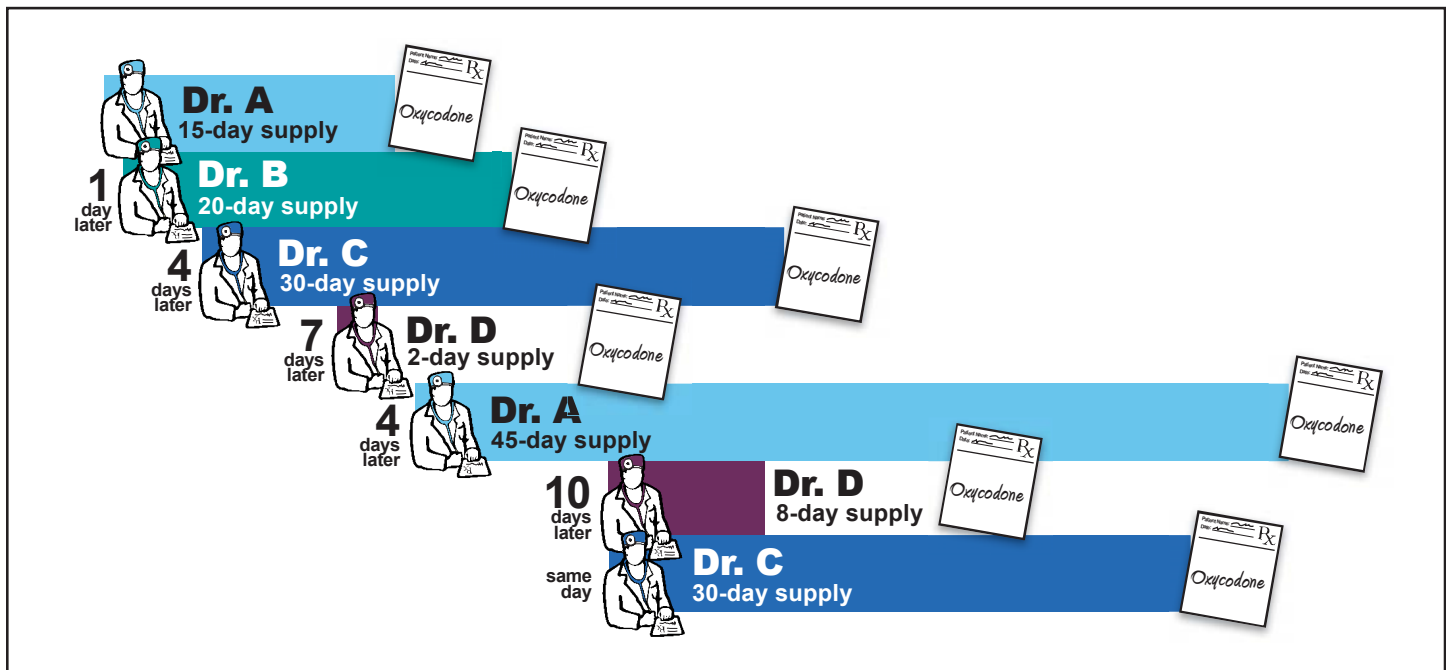
Example	State	Class of prescription drug(s)	Case details
2	GA	Oxycodone	<ul style="list-style-type: none"> The beneficiary received prescriptions for a total of 3,655 oxycodone pills (a 1,679-day supply) from 58 different prescribers in 2008. The beneficiary received a prescription for at least 1 of the 14 selected drugs from at least 66 different prescribers, and she filled her prescriptions at 45 different pharmacies in 2008. A pharmacy discovered that the beneficiary was forging a prescription from a physician. The pharmacy has noted in its system that its store and other pharmacies in the chain should refuse to fill controlled substances prescriptions for this beneficiary. Another pharmacy refused to fill a prescription for the beneficiary, after believing that the beneficiary tried to fill a forged prescription at the store. The beneficiary has not returned to the store since that refusal. A physician who frequently treated the beneficiary was repeatedly asked for early refills of Oxycontin prescriptions. After the physician would no longer prescribe Oxycontin, the beneficiary's medical visits to him ceased. The beneficiary did not inform the physician about seeing other physicians. The physician would not have prescribed any controlled substances had he known they were being prescribed by other physicians. Another physician stated that he was suspicious of the beneficiary's need for the drugs because (1) the beneficiary stated a desire for Oxycontin because of an allergy to other drugs and (2) the beneficiary refused to see a specialist despite his repeated directions. The beneficiary quit seeing the physician after the physician refused to prescribe any more narcotics. The physician was not aware of any attempted forgeries, but stated that he would not be surprised because it is easy to forge prescriptions in Georgia. The physician stated that Georgia has no requirements that prescriptions be written on any type of special security paper and that an individual can simply print or copy a prescription at home using a personal computer and regular computer paper.
3	TX	Hydrocodone	<ul style="list-style-type: none"> The beneficiary received prescriptions for a total of 4,574 hydrocodone pills (a 994-day supply) from 25 different prescribers in 2008. A previous physician stated that the beneficiary was obligated to inform him about receiving other prescriptions for controlled substances. The physician stated that he did not know that other physicians were prescribing narcotics to the beneficiary. The physician stated that it was medically unnecessary, and possibly dangerous, to consume the amount of narcotics obtained by the beneficiary. Had he been informed that the beneficiary was receiving narcotics from other doctors, the physician would have ceased prescribing the drugs.

Source: GAO.

^aPrescribers can receive alert letters from state PDMPs and from Part D plan sponsors.

Figure 1 illustrates the doctor shopping activity from example 2. This beneficiary received a 150-day supply of oxycodone in just 27 days by obtaining seven prescriptions from four different prescribers.

Figure 1: Medicare Part D Beneficiary Visits Four Doctors to Obtain Oxycodone



Source: GAO analysis of Medicare Part D claims data for calendar year 2008.

Systems Are in Place to Identify Inappropriate Drug Use, but Measures to Stop the Activity Are Limited

CMS requires Part D plans to perform retrospective drug utilization review (DUR) analysis to identify prior inappropriate or unnecessary medication use and provide education, such as alert letters, to the prescribers involved. By analyzing historical prescription claims data, the drug plans can identify individuals who are likely obtaining excessive amounts of highly abused drugs or potentially seeking such drugs from multiple medical practitioners. However, according to CMS Part D program officials, federal law does not authorize Part D plans to restrict the access of these individuals, leaving little recourse for preventing known doctor shoppers from obtaining hydrocodone, oxycodone, and other highly abused drugs.

Officials from the Part D plan sponsors we interviewed stated that controls in place in the Medicaid program and in some private sector plans could be used to better restrict the dispensing of abused drugs to individuals identified as doctor shoppers through detecting a pattern of abuse during retrospective analysis. Such programs employ a restricted

recipient program, or “lock-in” program, where prescription drug plans restrict beneficiaries who have been identified as drug abusers to one prescriber, one pharmacy, or both for receiving prescriptions. However, as mentioned, CMS Part D program officials’ interpretation of federal law prevents such a program from being implemented.

Further, effective retrospective DURs require prescription drug plans to be able to share information about individuals identified as doctor shoppers with other Part D plans, as appropriate. Even if a restricted recipient program were implemented, according to CMS officials, Medicare Part D plan sponsors are not allowed to share beneficiary information with other plans. As a result, a Medicare Part D plan sponsor cannot forewarn another Medicare Part D plan sponsor when an identified doctor shopper has left its plan and enrolled in another. Because Medicare Part D beneficiaries can change prescription drug plans on at least a yearly basis, beneficiaries may be able to switch plans and continue their doctor shopping activity. Thus, to prevent known doctor shoppers from circumventing a restricted recipient program, a mechanism would also need to be established that allows CMS or its fraud contractor to inform the new plan of the doctor shopping activities of the beneficiary. Without such notification, beneficiaries will be able to bypass a restricted recipient program merely by switching prescription drug plans.

Recommendations for Executive Action

In our report, we recommended that the Administrator of CMS should review our findings, evaluate the existing DUR program, and consider additional steps, such as a restricted recipient program for Medicare Part D that would limit identified doctor shoppers to one prescriber, one pharmacy, or both for receiving prescriptions. We stated that CMS should consider the experiences from Medicaid and private sector use of such restricted recipient programs, including weighing the potential costs and benefits of instituting the control. We also stated that along with a restricted recipient program, CMS should consider facilitating the sharing of information on identified doctor shoppers among the Part D drug plan sponsors so that those beneficiaries cannot circumvent the program by switching prescription drug plans. Finally, we stated that in considering such controls, CMS should seek congressional authority, as appropriate.

CMS Comments and Our Evaluation

In response to a draft of our report, CMS agreed with our overall recommendation to improve efforts to curb overutilization in Part D, but disagreed that a restricted recipient program is necessarily the appropriate control for the Part D program. CMS also stated that it is

undertaking an additional evaluation of data on potential overutilization to identify potential solutions and that it will issue program guidance to Part D sponsors on any best practices and develop an internal monitoring strategy. We support CMS looking into both enhanced point-of-sale and retrospective controls and related actions to address overutilization and questionable access to specific drugs. We believe that a restricted recipient program should be part of CMS's assessment. It can be used for known abusers identified by retrospective DURs while not jeopardizing legitimate patient access to care.

CMS also stated that GAO provided no evidence that a restricted recipient program would be more effective than existing DUR requirements. Our intent was not to prescribe a restricted recipient program as the only solution, but instead for CMS to consider utilizing it along with other existing controls. As previously discussed, Part D plan sponsor officials we interviewed stated that a restricted recipient program could better restrict the dispensing of abused drugs. CMS also provided a written statement to this Subcommittee in 2009 asserting that a restricted recipient program, or "lock-in" program, is a proven mechanism in the Medicaid program to minimize misuse.¹⁰ Thus, we continue to believe a restricted recipient program warrants further consideration.

Chairman Carper, Ranking Member Brown, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact

For further information regarding this testimony, please contact me at (202) 512-6722 or kutzg@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

¹⁰ *A Prescription for Waste: Controlled Substance Abuse in Medicaid*, Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, 111th Cong. (2009) (posthearing Questions for the Record Submitted to Penny Thompson, Deputy Director, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, from Senator Tom Carper).

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