DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
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OCT 4 2007

Report Number: A-03-07-00001

Patrick W. Finnerty, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Mr. Finnerty:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Virginia's Compliance With the 'Reimbursement of State Costs for Provision of Medicare Part D Drugs' Demonstration Project Requirements." Because this report contains no recommendations, no response is necessary. We will forward a copy of this report to the HHS action official noted below.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after this report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-03-07-00001 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Mr. James T. Kerr, Consortium Administrator
Consortium for Medicare Health Plans Operations
26 Federal Plaza, Mailstop 38-3811
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF VIRGINIA'S COMPLIANCE WITH THE "REIMBURSEMENT OF STATE COSTS FOR PROVISION OF MEDICARE PART D DRUGS" DEMONSTRATION PROJECT REQUIREMENTS

Daniel R. Levinson
Inspector General

October 2007
A-03-07-00001

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 amended Title XVIII of the Social Security Act by establishing the Medicare Part D prescription drug benefit which provides optional prescription drug coverage for individuals who are entitled to Medicare Part A or enrolled in Part B. The Centers for Medicare & Medicaid Services (CMS), which administers Medicare, contracts with private prescription drug plans and Medicare Advantage plans to offer prescription drug benefits to eligible individuals.

With the implementation of Medicare Part D on January 1, 2006, prescription drug coverage for full benefit dual eligible (dual eligible) beneficiaries was transitioned from Medicaid coverage to the new Medicare prescription drug benefit. Some States, however, found it necessary to provide additional funding assistance to its dual eligible population in order to facilitate their transition into Medicare Part D. To reimburse States for drug costs incurred on behalf of dual eligible beneficiaries during the transition, CMS implemented the "Reimbursement of State Costs for Provision of Part D Drugs" Medicare demonstration project pursuant to section 402(a)(l)(A) of the Social Security Amendments of 1967 (codified at 42 U.S.C. section 1395b-1(a)(1)(A) and expressly made applicable to Part D in section 1860D-42(b)). This voluntary demonstration project permitted Medicare to reimburse States for dual eligible beneficiaries' Part D drugs to the extent that those costs were not recoverable from a Medicare Part D plan. In addition, the demonstration project also provided payments to States for low-income subsidy-entitled (non-full benefit dual eligible) beneficiaries' Part D drugs and for certain administrative costs incurred by States.

OBJECTIVE

Our objective was to determine whether the Commonwealth of Virginia (Virginia) complied with the CMS "Reimbursement of State Costs for Provision of Part D Drugs" demonstration project requirements related to reimbursed drug claims for full benefit dual eligible beneficiaries.

RESULTS OF AUDIT

Virginia complied with CMS's demonstration project requirements related to reimbursed drug claims for dual eligible beneficiaries. Virginia utilized its Medicaid payment system to separate the demonstration claims from those payable under its Medicaid program. Virginia also utilized its Medicaid system to properly identify beneficiaries as being dually eligible for both Medicare and full Medicaid benefits and to appropriately pay claims through the demonstration project. Virginia ensured that all claims reimbursed through the demonstration project were within its approved demonstration period of January 1 through March 8, 2006. We are not submitting recommendations to Virginia.

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INTRODUCTION

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Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 amended Title XVIII of the Social Security Act by establishing the Medicare Part D prescription drug benefit which provides optional prescription drug coverage for individuals who are entitled to Medicare Part A or enrolled in Part B. The Centers for Medicare & Medicaid Services (CMS), which administers Medicare, contracts with private prescription drug plans and Medicare Advantage plans to offer prescription drug benefits to eligible individuals.

As defined by the MMA, Medicare Part D covered drugs are: drugs available only by prescription, used and sold in the United States, and used for a medically accepted indication; biological products; insulin; and vaccines. The definition also includes medical supplies associated with the injection of insulin (e.g., syringes, needles, alcohol swabs, and gauze). Certain drugs or classes of drugs or their medical uses are excluded by law from Medicare Part D coverage. While these drugs or uses are excluded from basic Medicare Part D coverage, drug plans may choose to include them as part of supplemental benefits, not covered by Medicare. Some States may also choose to cover these excluded drugs through their Medicaid programs.

Full Benefit Dual Eligible Beneficiaries

Full benefit dual eligible (dual eligible) beneficiaries are eligible for both Medicare and comprehensive Medicaid benefits. Pursuant to Title I, Sec. 103(c) of the MMA and with the implementation of Medicare Part D on January 1, 2006, prescription drug coverage for dual eligible beneficiaries transitioned from Medicaid to Medicare Part D.

To ensure that dual eligible beneficiaries continued to receive needed medications during the transition, CMS took numerous actions to prevent a lapse in prescription drug coverage. For example, if dual eligible beneficiaries did not choose a prescription drug plan by December 31, 2005, CMS randomly assigned them to one (auto-assignment). CMS implemented a new eligibility inquiry process for pharmacies to verify Part D plan assignments and employed contractors to facilitate enrollment at the point-of-sale.

Despite CMS's best efforts to promote a smooth transition to Medicare Part D, some dual eligible beneficiaries presented at pharmacies and were not enrolled in a Part D plan or a Part D plan could not be billed. Therefore, some States found it necessary to provide assistance to dual eligible beneficiaries during the transition period by paying for these beneficiaries' Medicare Part D drugs.

Demonstration Project

To reimburse States for drug costs incurred on behalf of dual eligible beneficiaries during the transition, CMS implemented the "Reimbursement of State Costs for Provision of Part D Drugs"

Medicare demonstration project pursuant to section 402(a)(l)(A) of the Social Security Amendments of 1967 (codified at 42 U.S.C. section 1395b-1(a)(1)(A) and expressly made applicable to Part D in section 1860D-42(b)). This voluntary demonstration project permitted Medicare to reimburse States for dual eligible beneficiaries' Part D drugs to the extent that those costs were not recoverable from a Medicare Part D plan. In addition, the demonstration project also provided payments to States for low-income subsidy-entitled (non-full benefit dual eligible) beneficiaries' Part D drugs and for certain administrative costs incurred by States.

To participate in the demonstration and receive reimbursement for their incurred costs, States submitted applications to CMS. The application included requirements for participation. By submitting applications, States agreed to: 1) require pharmacies to bill the Part D plan first before relying on State payment (the State was the payer of last resort); 2) provide information on Part D drug claims and administrative costs incurred in a specified format; 3) ensure that claims submitted were for Part D drugs; 4) separate claims from those payable under other programs, such as the State Medicaid program; 5) submit claims only for drug costs (not including beneficiary cost sharing) and administrative costs incurred during the demonstration effective dates; 6) report to CMS on the number of claims, beneficiaries, and expenditures on a timely basis; and 7) ensure Medicare funding was not used for the Medicaid State match.

Virginia's Participation in the Demonstration Project

On February 14, 2006, Virginia applied to participate in the demonstration project. By participating, Virginia agreed to pay for dual eligible beneficiaries' drug claims that should have been paid under Medicare Part D. Virginia processed these drug claims through its Medicaid point-of-sale system. CMS subsequently reimbursed Virginia for these drug claims at Virginia's Medicaid rate.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Commonwealth of Virginia (Virginia) complied with the CMS "Reimbursement of State Costs for Provision of Part D Drugs" demonstration project requirements related to reimbursed drug claims for full benefit dual eligible beneficiaries.

Scope

The audit covered Virginia's approved demonstration period, January 1 through March 8, 2006. At the time of our audit, CMS approved reimbursement of 81,159 drug claims totaling $5,249,206 for dual eligible beneficiaries. We reviewed only those internal controls necessary to achieve our objective.

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, and guidance;

- held discussions with CMS officials about the Federal requirements and guidance regarding the demonstration project;

- interviewed Virginia Department of Medical Assistance officials to obtain an understanding of Virginia's Medicaid drug program, the process used to identify dual eligible beneficiaries, and the process to prepare and submit claims under the demonstration project;

- obtained the reimbursed claims file for dual eligible beneficiaries for claims paid under the demonstration project for the period January 1 through March 8, 2006;

- obtained the Quarterly Medical Assistance Expenditures (CMS-64) for prescribed drugs for the first and second calendar quarters of 2006;

- compared all claims reimbursed under the demonstration project to all prescribed drug claims paid under the CMS-64 for the first and second calendar quarters of 2006 to ensure that claims were not paid more than once;

- reviewed a judgmentally selected sample of 30 claims paid under the demonstration project to ensure that the claim dates of service were during the demonstration project period, the drug was a covered Part D drug, and any cost sharing amounts on the part of the beneficiary were not included on the claim to Medicare;

- reviewed a judgmentally selected sample of 30 beneficiaries whose claims were paid under the demonstration project and reviewed Virginia's methodology to classify the beneficiaries as dual eligible;

- obtained and reviewed guidance issued by Virginia to the pharmacies; and

- reviewed Virginia's procedures to ensure that Medicare funding under the demonstration was not used as State Medicaid matching funds.

We performed fieldwork at the Virginia Department of Medical Assistance Services offices in Richmond, Virginia.

We conducted our review in accordance with generally accepted government auditing standards.

RESULTS OF AUDIT

Virginia complied with CMS's demonstration project requirements related to reimbursed drug claims for dual eligible beneficiaries. Virginia utilized its Medicaid payment system to separate the demonstration claims from those payable under its Medicaid program. Virginia also utilized its Medicaid system to properly identify beneficiaries as being dually eligible for both Medicare and full Medicaid benefits and to appropriately pay claims through the demonstration project. Virginia ensured that all claims reimbursed through the demonstration project were within its approved demonstration period of January 1 through March 8, 2006. We are not submitting recommendations to Virginia.