DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

September 1, 2010

Report Number: A-01-10-00600

Susan Besio
Commissioner
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Dear Commissioner Besio:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Vermont's Compliance With the "Reimbursement of State Costs for Provision of Part D Drugs" Medicare Demonstration Project Requirements*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Curtis Roy, Audit Manager, at (617) 565-9281 or through email at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-10-00600 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

September 2010
A-01-10-00600

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended Title XVIII of the Social Security Act (the Act) by establishing Medicare Part D. Medicare Part D provides optional prescription drug coverage for individuals who are entitled to Medicare Part A or enrolled in Medicare 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.

Full-benefit dually eligible beneficiaries are eligible for benefits under both Medicare and Medicaid. Pursuant to Title I, section 103(c), of the MMA and upon the implementation of Medicare Part D on January 1, 2006, prescription drug coverage for these beneficiaries was transferred from Medicaid to Medicare Part D. Despite CMS's efforts to ensure a smooth transition to Medicare Part D, some full-benefit dually eligible beneficiaries did not enroll in or were not assigned to a Medicare Part D plan. As a result, some States paid for these beneficiaries' Medicare Part D drugs during the transition period.

To reimburse States for drug costs and related administrative costs incurred during the transition period, 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, as amended (codified at 42 U.S.C. § 1395b-1(a)(1)(A) and expressly made applicable to Medicare Part D in § 1860D-42(b) of the Act). On February 14, 2006, Vermont submitted its "Section 402 Demonstration Application" (Medicare demonstration application) to CMS. By submitting its Medicare demonstration application, Vermont agreed to pay for full-benefit dually eligible beneficiaries' drug claims overseen by the Department of Vermont Health Access (the State agency). The State agencies participation in the demonstration project covered drug claims with dates of service from January 1 through March 31, 2006, and related administrative costs from January 1 through September 1, 2006.

CMS reimbursed the State agency a total of $5,440,747 for Medicare demonstration project drug costs.

OBJECTIVES

Our objectives were to determine whether the State agency (1) complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually eligible beneficiaries and (2) claimed drug costs to both the Medicaid program and the Medicare demonstration project.

SUMMARY OF FINDINGS

The State agency complied with certain provisions of the Medicare demonstration project application when claiming drug costs for full-benefit dually eligible beneficiaries. For example, the State agency submitted claims only for drug costs incurred during the Medicare

demonstration project's effective dates and only claimed drug costs to the Medicare demonstration project.

However, the State agency claimed costs for drugs excluded from Medicare Part D reimbursement. Specifically, the State agency was reimbursed $70,027 for Benzodiazepines through the Medicare demonstration project. According to State agency officials, the State agency was improperly reimbursed for excluded Medicare Part D drugs through the Medicare demonstration project because of an administrative oversight.

RECOMMENDATIONS

We recommend that the State agency:

- refund $70,027 to the Federal Government and
- strengthen its internal controls to ensure that only allowable drugs are claimed from Medicare.

STATE AGENCY COMMENTS

In its written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Part D Prescription Drug Benefit

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended Title XVIII of the Social Security Act (the Act) by establishing Medicare Part D. Medicare Part D provides optional prescription drug coverage for individuals who are entitled to Medicare Part A or enrolled in Medicare 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.

Full-Benefit Dually Eligible Beneficiaries

Full-benefit dually eligible beneficiaries are eligible for benefits under both Medicare and Medicaid. Pursuant to Title I, section 103(c), of the MMA and upon the implementation of Medicare Part D on January 1, 2006, prescription drug coverage for these beneficiaries was transferred from Medicaid to Medicare Part D. CMS took numerous actions to ensure that full-benefit dually eligible beneficiaries continued to receive medications during the transition to Medicare Part D. For example, if a beneficiary did not choose a prescription drug plan by December 31, 2005, CMS randomly assigned the beneficiary to a plan. In addition, to facilitate enrollment of dually eligible beneficiaries at the point of sale, CMS implemented a new eligibility inquiry process for pharmacies to verify Medicare Part D plan assignments and employed contractors.

Despite CMS's efforts to ensure a smooth transition to Medicare Part D, some full-benefit dually eligible beneficiaries did not enroll in or were not assigned to a Medicare Part D plan. As a result, some States paid for these beneficiaries' Medicare Part D drugs during the transition period.

Medicare Part D Demonstration Project

To reimburse States for drug costs and related administrative costs incurred during the transition period, 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, as amended (codified at 42 U.S.C. § 1395b-1(a)(1)(A) and expressly made applicable to Medicare Part D in § 1860D-42(b) of the Act). The demonstration project permitted Medicare to fully reimburse States for full-benefit dually eligible beneficiaries' Medicare Part D drugs to the extent that the costs were not recoverable from a Medicare Part D plan.[1]

To participate in the demonstration project and receive reimbursement for their incurred costs, States were required to submit a signed "Section 402 Demonstration Application" (Medicare

[1]In addition, the demonstration project provided payments to States for low-income subsidy-entitled beneficiaries' (partial-benefit dually eligible beneficiaries) Medicare Part D drugs and for certain administrative costs.

demonstration application) to CMS. By submitting Medicare demonstration applications, States agreed to (1) require pharmacies to bill the Medicare Part D plan before relying on State payment (i.e., the State was the payer of last resort); (2) provide specific information to CMS on Medicare Part D drug claims and administrative costs; (3) ensure that claims submitted were for covered Medicare Part D drugs; (4) separate Medicare demonstration project claims from those payable under other programs; (5) submit claims only for drug costs (not including beneficiary cost sharing) and administrative costs incurred during the Medicare demonstration project's effective dates; (6) report to CMS the number of claims, beneficiaries, and expenditures on a timely basis; and (7) ensure that Medicare funding was not used as State Medicaid matching funds (State Medicaid Director Letter No. 06-001 (Feb. 2, 2006); CMS, Section 402 Demonstration Application Template: Reimbursement of State Costs for Provision of Part D Drugs).

CMS required States to submit Medicare demonstration project claims directly to its contractor, Public Consulting Group, which determined whether the claims were eligible for reimbursement. CMS then reimbursed States for eligible claims.

Vermont's Participation in the Medicare Part D Demonstration Project

On February 14, 2006, the Department of Vermont Health Access (the State agency) submitted its Medicare demonstration application to CMS. The State agency agreed to pay for full-benefit dually eligible beneficiaries' drug claims and for partial-benefit Medicare Part D enrollees entitled to assistance from Vermont's State Pharmaceutical Assistance Program. The State agencies participation in the demonstration project covered drug claims with dates of service from January 1 through March 31, 2006, and related administrative costs from January 1 through September 1, 2006.

The State agency processed drug claims for full-benefit dually eligible beneficiaries through its Medicaid point-of-sale system and claimed the amounts on its Forms CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Forms CMS-64), which CMS subsequently reimbursed at Vermont's Federal medical assistance percentage (FMAP).[2] CMS officials were aware that some States had submitted demonstration project costs previously claimed on the Forms CMS-64 and orally advised the States to appropriately adjust their Forms CMS-64 to remove claims paid by Medicare.

The State agency submitted Medicare demonstration project claims for drug costs incurred on behalf of full-benefit dually eligible beneficiaries to the Public Consulting Group and subsequently received reimbursement from CMS totaling $5,440,747.

[2]The FMAP determines the Federal share of the Medicaid program. During our audit period (January 1 through March 31, 2006), the FMAP for drug claims in Vermont was 58.49 percent.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the State agency (1) complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually eligible beneficiaries and (2) claimed drug costs to both the Medicaid program and the Medicare demonstration project.

Scope

The audit covered the State agency's 89,392 drug claims for full-benefit dually eligible beneficiaries submitted under the Medicare demonstration project from January 1 through March 31, 2006. We did not review the State agency's drug claims for partial-benefit dually eligible beneficiaries, nor did we determine whether pharmacies attempted to bill beneficiaries' Medicare Part D plans before relying on State payment.

The audit also covered the State agency's Medicare demonstration project drug costs for the period January 1 through March 31, 2006, claimed on the Forms CMS-64. CMS reimbursed the State agency a total of $5,440,747 for Medicare demonstration project drug costs. We reviewed only the State agency's claims for drug costs. We did not review whether the State agency complied with the Medicare demonstration project requirements for the State Pharmaceutical Assistance Program and administrative costs. We reviewed only those internal controls necessary to achieve our objectives.

We performed fieldwork at the State agency's offices in Williston, Vermont, from January 2010 through June 2010.

Methodology

To accomplish our objectives, we:

- reviewed applicable laws, regulations, and guidance;

- interviewed State agency officials to (1) obtain an understanding of their process for identifying and submitting full-benefit dually eligible beneficiary claims under the Medicare demonstration project and (2) determine whether they separated Medicare demonstration project claims from those payable under other programs;

- obtained from CMS a database of 89,392 drug claims for full-benefit dually eligible beneficiaries paid to the State agency under the Medicare demonstration project for the period January 1 through March 31, 2006;

- reviewed all claims paid to the State agency under the Medicare demonstration project to determine if the non covered drug category, Benzodiazepine, was reimbursed under Medicare Part D;

- reviewed a judgmentally selected sample of 30 drug claims paid to the State agency under the Medicare demonstration project to determine whether the dates of service were during the Medicare demonstration project's effective dates and any cost-sharing amounts (copayments) on the part of the beneficiary were not included in the claim;

- reviewed a judgmentally selected sample of 30 beneficiaries whose drug claims were paid under the Medicare demonstration project to determine whether these beneficiaries were dually eligible; and

- reviewed guidance issued by the State agency to the pharmacies, including guidance requiring them to submit Medicare Part D eligible drug claims to Medicare Part D plans before billing the State agency.

We conducted this performance audit 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 conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

The State agency complied with certain provisions of the Medicare demonstration project application when claiming drug costs for full-benefit dually eligible beneficiaries. However, the State agency claimed some costs for drugs precluded from Medicare Part D reimbursement.

MEDICARE DEMONSTRATION PROJECT DRUG CLAIMS

The State agency complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually eligible beneficiaries. Specifically, the State agency (1) provided specific information to CMS on Part D drug claims, (2) separated demonstration project claims from those payable under other programs, (3) submitted claims only for drug costs incurred during the demonstration project's effective dates, and (4) only claimed drug costs to the Medicare demonstration project.

MEDICARE DEMONSTRATION PROJECT DRUG COSTS

Pursuant to Section 1860D-4 (4)(b)(3)(C)(ii) of the MMA states that the United States Pharmacopeia (USP) shall develop a list of categories and classes reflecting any changes in therapeutic uses of and the additions of new covered Medicare Part D drugs. The USP does not include drug class Benzodiazepine in its comprehensive listing of approved Medicare Part D drugs. In addition, State Medicaid Directors Letter # 06-001, CMS stated that the Medicare demonstration project would not include reimbursement for drugs that were not allowable for Medicare Part D. Furthermore, the State's Medicare demonstration project application contains a provision stating it would not claim drugs that were unallowable to Medicare Part D.

The State agency claimed costs for drugs excluded from Medicare Part D reimbursement. Specifically, the State agency was reimbursed $70,027 for Benzodiazepines through the Medicare demonstration project. According to State agency officials, the State agency was improperly reimbursed for excluded Medicare Part D drugs through the Medicare demonstration project because of an administrative oversight.

RECOMMENDATIONS

We recommend that the State agency:

- refund $70,027 to the Federal Government and

- strengthen its internal controls to ensure that only allowable drugs are claimed from Medicare.

STATE AGENCY COMMENTS

In its written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

VERMONT

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
312 Hurricane Lane, Suite 201 [Fax] 802-879-5651
Williston VT 05495-2807
http://dvha.vermont.gov

August 24, 2010

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Inspector General, Region I
John F. Kennedy Building, Room 2425
Boston, MA 02203

Re: Report Number A-01-10-00600

Dear Mr. Armstrong

We have completed our review of the Office of Inspector General draft report entitled *Review of Vermont's Compliance With the "Reimbursement of State Costs for Provision of Part D Drugs" Medicare Demonstration Project Requirements*.

According to the findings, DVHA was in compliance with the provisions of the demonstration project with one exception whereby DVHA claimed costs for benzodiazepines which are excluded from Medicare Part D reimbursement. As stated in the draft report, our claims for full benefit duals were submitted, as required by CMS, to the CMS contractor Public Consulting Group who was responsible for determining which drugs were reimbursable by CMS. Notwithstanding the Public Consulting Group's responsibilities, the Department of Vermont Health Access concurs with the summary of findings and the recommendation put forth in this report and will reimburse the $70,027 to the Federal Government.

In terms of corrective action, since reimbursement of Medicare Part D claims paid during the demonstration project period was a one-time event we do not expect this discrepancy could recur. Additionally, our prescription benefit manager, MedMetrics Health Partners implemented system edits at the end of the demonstration project period that assure that DVHA reimburses only excluded Medicare Part D drugs for our full benefit dual population.

We appreciate the opportunity to respond to the OIG's findings in this matter.

Sincerely,

SUSAN W. BESIO

Susan W. Besio, Ph.D.
Commissioner