Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE MEDICARE DRUG DISCOUNT CARD PROGRAM SPONSOR PUBLIC SECTOR PARTNERS

Daniel R. Levinson
Inspector General

July 2006
A-06-05-00062

Office of Inspector General

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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

July 10, 2006

Report Number: A-06-05-00062

Greg MacGilpin
PBM Senior Project Manager
Public Sector Partners, Inc.
100 Century Drive
Worcester, Massachusetts 01606

Dear Mr. MacGilpin:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Report on the Medicare Drug Discount Card Program Sponsor Public Sector Partners." A copy of this report will be forwarded to the HHS action official noted below 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 the HHS action 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-05-00062 in all correspondence.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
For Audit Services

Enclosures

Direct Reply to HHS Action Official:

Cynthia Moreno
Director, Plan Oversight and Accountability Group
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850

EXECUTIVE SUMMARY

BACKGROUND

Medicare Drug Discount Card Program and Transitional Assistance

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), section 1860D-31(a)(1), established a drug discount card program to provide eligible individuals with access to prescription drug discounts and transitional assistance (TA) subsidies. The program began in June 2004 and ended in December 2005 or when the beneficiary enrolled in the Medicare Part D drug program, whichever occurred first. However, if enrolled by December 2005, a beneficiary could have used the drug discount card through May 2006.

Sections 1860D-31(h)(4) and (8) of the MMA required drug discount card sponsors to pass on negotiated prices to beneficiaries and ensure that beneficiaries were not charged more than the lower of the negotiated prices or the usual and customary prices.

The MMA, section 1860D-31(d)(2)(C), also required sponsors to provide a beneficiary's TA balance to the pharmacy when a prescription was filled. Beneficiaries received a maximum TA subsidy of $600 per year for 2004 and 2005; the amount was prorated for 2005 based on when they enrolled in the program. Beneficiaries who enrolled in 2004 received the entire $600, regardless of the month they enrolled.[1] The Centers for Medicare & Medicaid Services (CMS) added any amount not used in 2004 to the 2005 benefit.

To recoup claimed expenditure payments to the pharmacies, sponsors withdrew funds from the Payment Management System. All claim expenditures and withdrawals should have been reported to the CMS on the Transitional Assistance Monthly Expense and Reconciliation Report.

The MMA, section 1860D-2(e)(2)(A), excludes specific drugs and drug classes from the definition of "covered Part D drug." Any drug or class of drugs that is excluded should not have been purchased with TA funds. In August 2005, CMS issued a memo directing all drug discount card sponsors to determine whether they had used TA funds to pay for excluded drugs. The memo requested that drug discount card sponsors repay CMS for any funds used for excluded drugs.

Some drug manufacturers that participated in the Medicare drug discount card program offered an additional benefit that they referred to as a "wrap-around" program. This benefit covered the cost of certain drugs after beneficiaries reached their TA fund limits.

Public Sector Partners

Public Sector Partners, Inc. (PSP), a health care management organization in Worcester, Massachusetts, offered a drug discount card to eligible Medicare beneficiaries. CMS paid PSP an annual enrollment fee of $30 per eligible TA beneficiary in addition to the TA subsidy it paid.

[1]All individuals whose applications were received in December 2004 were officially enrolled in January 2005. However, those individuals received the full TA entitlement for 2004 and 2005.

PSP submitted approximately $27 million in claims to CMS for TA expenditures from June 2004 through May 2005. In September 2005, PSP reimbursed CMS $181,519 for excluded drugs that it identified based on the criteria CMS used in its August 2005 memo to sponsors.

IntegriGuard

CMS contracted with IntegriGuard, LLC, to audit Medicare drug discount card programs. The program safeguard contractor reviewed a variety of issues, including enrollment, TA fund limits, and excluded drugs. We met with IntegriGuard and reviewed some of their work papers in an effort to understand the program and develop audit areas.

Transition to Medicare Part D

During our audit, PSP indicated that it might participate in the Part D program in the future. CMS requires prescription drug plan (PDP) sponsors in the Part D program to ensure that:

- beneficiaries have access to drugs at negotiated prices,
- payments for beneficiaries and claims submitted to CMS are correct, and
- statutorily excluded drugs are not included in the program.

OBJECTIVES

Our objectives were to determine whether PSP complied with Federal requirements to (1) ensure that beneficiaries did not exceed their TA limits, (2) apply TA funds only to covered drugs, (3) pass on negotiated prices to beneficiaries and offer the lower of the negotiated prices or the usual and customary prices, and (4) support the expenditures and withdrawals it reported to CMS.

SUMMARY OF FINDINGS

PSP properly supported the expenditures it made on behalf of beneficiaries and the withdrawals from the Payment Management System. However, PSP did not have proper procedures in place to ensure that it always complied with Federal requirements to:

- ensure that beneficiaries did not exceed their TA fund limits,
- apply TA funds only to covered drugs, and
- pass on negotiated prices to beneficiaries and charge the lower of the negotiated prices or the usual and customary prices.

Additionally, PSP mistakenly believed that its edits identified all excluded drugs.

As a result, CMS overpaid PSP $420,875 for beneficiaries who exceeded their TA limits and $231,260 for excluded drugs for the period July 12, 2004, through May 31, 2005.

RECOMMENDATIONS

We recommend that PSP:

- reimburse CMS for the $420,875 by which it exceeded TA fund limits;

- determine whether the amount PSP reimbursed CMS for excluded drugs included any of the $231,260 in TA funds identified in the audit and reimburse the difference; and

- implement policies and procedures, if it continues as a PDP sponsor in Part D, to ensure that it (1) does not pay for statutorily excluded drugs with CMS funds and (2) offers negotiated prices to beneficiaries.

PUBLIC SECTOR PARTNERS' COMMENTS

In its written comments on our draft report, PSP agreed that errors had occurred, but it did not agree with all of the causes we identified. PSP stated that it had worked with CMS to correct its procedures and had reimbursed CMS for the errors we identified.

Regarding TA funds, PSP stated that it did not allow beneficiaries to exceed their limits. The error, PSP said, occurred because it mistakenly identified funds it was owed from manufacturers for their wrap-around programs as amounts owed by CMS, and it withdrew those amounts from the Payment Management System. PSP reimbursed CMS $436,363 for this error.

PSP stated that it paid for excluded drugs because it did not effectively update its claims processing system and that it reimbursed CMS $181,519. However, PSP did not address the difference in the amount of funds we identified for excluded drugs and the amount it reimbursed CMS.

PSP stated that it did not always pass on negotiated prices to beneficiaries and charge the lower of the negotiated prices or the usual and customary prices because of two system errors. PSP stated that it corrected the errors and reimbursed CMS $159,500. PSP said that it also reimbursed beneficiaries $21,603 because they paid higher copayments than they should have paid.

PSP's comments are included in the appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We agree that the steps PSP took to reimburse CMS are sufficient to address all of the errors we identified except for those related to excluded drugs. We continue to believe that PSP should determine whether the amount it reimbursed CMS for excluded drugs included any of the $231,260 in TA funds we identified and reimburse the difference.

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INTRODUCTION

BACKGROUND

Medicare Drug Discount Card Program and Transitional Assistance

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), section 1860D-31(a)(1), established a drug discount card program to provide eligible individuals with access to prescription drug discounts and transitional assistance (TA) subsidies. The program began in June 2004 and ended in December 2005 or when the beneficiary enrolled in the Medicare Part D drug program, whichever occurred first. However, if enrolled by December 2005, a beneficiary could have used the drug discount card through May 2006. The Medicare Part D program went into effect January 1, 2006. Like the drug discount card program, Medicare Part D provides discount drug coverage to Medicare-eligible individuals.

Under the drug discount card program, the Centers for Medicare & Medicaid Services (CMS) provided TA subsidies to low-income Medicare beneficiaries whose prescription drugs were not covered by Medicaid or another insurance plan. Eligible beneficiaries were entitled to $600 per year in 2004 and 2005; funds not used during 2004 were rolled over into 2005. Individuals who enrolled in 2004 were eligible for the entire $600 subsidy, regardless of when they enrolled in the program.[1] Beneficiaries who enrolled in 2005 received a prorated subsidy based on the date they enrolled. When applying TA toward the purchase of prescription drugs, beneficiaries who had incomes at or below 100 percent of the poverty level paid a 5-percent coinsurance payment, and those with incomes between 101 and 135 percent of the poverty level paid a 10-percent coinsurance payment.

In addition, Medicare paid the annual drug discount card program enrollment fee, if any, a sponsor charged for eligible beneficiaries.

Centers for Medicare & Medicaid Services Requirements

CMS required drug discount card sponsors to:

- obtain manufacturer discounts or rebates on brand name and generic drugs and share the savings with beneficiaries;
- enroll all eligible Medicare beneficiaries who applied to their programs and resided in their service areas;
- administer the TA program for all drug card program enrollees who applied for subsidies and met eligibility requirements;

[1]All individuals whose applications were received in December 2004 were officially enrolled in January 2005. However, those individuals received the full TA entitlement for 2004 and 2005.

- provide access to discounts on at least one brand name or generic prescription drug in each of the therapeutic drug classes, groups, and subgroups of prescription drugs Medicare beneficiaries commonly need; and

- charge CMS an annual enrollment fee of no more than $30 per beneficiary.

Federal Requirements

The MMA, sections 1860D-31(h)(4) and (8), required drug discount card program sponsors to pass on negotiated rates to beneficiaries and ensure that beneficiaries were not charged more than the lower of the negotiated prices or the usual and customary prices. Negotiated prices take into account manufacturer rebates, pharmacy discounts, and pharmacy dispensing fees. Manufacturers base rebates on a periodically updated published price that includes the wholesale acquisition cost (WAC) and the average wholesale price. The usual and customary price is what the pharmacy normally charges for the drug if the beneficiary does not have insurance.

The MMA, section 1860D-31(d)(2)(C), also required sponsors to provide a beneficiary's TA balance to the pharmacy when a prescription was filled.

To recoup claimed expenditure payments to pharmacies, sponsors withdrew funds from the Payment Management System. All claim expenditures and withdrawals should have been reported to CMS on the Transitional Assistance Monthly Expense and Reconciliation Report (TAMER).

The MMA, section 1860D-2(e)(2)(A), excludes specific drugs and drug classes from the definition of "covered Part D drug." Any drug or class of drugs that is excluded should not have been purchased with TA funds. In August 2005, CMS issued a memo directing all drug discount card sponsors to determine whether they had used TA funds to pay for excluded drugs. The memo requested that sponsors repay CMS for any funds used for excluded drugs.

If patients qualified for TA subsidies, they may also have been eligible for what drug manufacturers referred to as their "wrap-around" programs. Manufacturers offered the wrap-around programs to drug card program participants to provide additional savings after they used all of their TA subsidies. When beneficiaries reached their TA limits and were prescribed drugs that qualified for a wrap-around program, the sponsors would pay for the drugs and manufacturers would reimburse the sponsors quarterly for the cost of the drugs less any copayment amount, which beneficiaries paid.

Public Sector Partners

Public Sector Partners, Inc. (PSP), a health care management organization in Worcester, Massachusetts, offered a drug discount card to eligible Medicare beneficiaries. CMS

paid PSP an annual enrollment fee of $30 per eligible TA beneficiary in addition to the TA subsidy CMS paid.

IntegriGuard

CMS contracted with IntegriGuard, LLC, to audit Medicare drug discount card programs. The program safeguard contractor reviewed a variety of issues, including enrollment, TA fund limits, and excluded drugs. We met with IntegriGuard and reviewed some of its work papers in an effort to understand the program and develop audit areas.

Transition to Medicare Part D

During our audit, PSP indicated that it might participate in the Part D program in the future. CMS requires prescription drug plan (PDP) sponsors in the Part D program to ensure that:

- beneficiaries have access to drugs at negotiated prices,
- payments for beneficiaries and claims submitted to CMS are correct, and
- statutorily excluded drugs are not included in the program.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether PSP complied with Federal requirements to (1) ensure that beneficiaries did not exceed their TA limits, (2) apply TA funds only to covered drugs, (3) pass on negotiated prices to beneficiaries and offer the lower of the negotiated prices or the usual and customary prices, and (4) support the expenditures and withdrawals it reported to CMS.

Scope

For the period June 2004 through May 2005, PSP submitted TA expenditure claims to CMS totaling approximately $27 million. We limited our review of the drug discount card program to claims paid with TA subsidies.

We reviewed the drug prices PSP negotiated with drug manufacturers and pharmacies for July 2004 (the second full month of the program) and May 2005 (the most current month that data were available when we started the audit). To determine whether PSP offered beneficiaries the prices negotiated with drug manufacturers and pharmacies, we repriced the negotiated prices PSP claimed on 200 sampled claims by using the pricing methodology set forth in its contracts.

We did not rely on IntegriGuard's work because it (1) did not cover the same period as our review, (2) incorrectly applied CMS's November 4, 2004, list of excluded drugs to all claims and did not use all the July 12, 2004, list to determine excluded drugs, and (3) did

not include negotiated prices in its review. IntegriGuard also incorrectly accounted for rollovers of beneficiaries' funds from 2004 to 2005. Additionally, in its report to CMS, IntegriGuard did not recommend that PSP reimburse CMS for funds used to pay for excluded drugs and excess TA.

Further, our methodology for analyzing TA limits was different from IntegriGuard's methodology. For example, IntegriGuard used Social Security numbers to determine beneficiaries' TA totals. We used member identification numbers because it is possible for two beneficiaries—a husband and wife, for example—to share the same Social Security number. The Social Security numbers in PSP's database do not include beneficiary identification codes, which are less likely to be duplicated.

As part of our audit, we:

- relied on the enrollment information IntegriGuard provided,

- used PSP's payment data and did not perform a detailed review of PSP's internal controls because the audit objectives did not require it, and

- could not review the $181,519 PSP reimbursed CMS for excluded drugs to determine whether it was included in the $231,260 in excluded drugs we identified.

We performed the audit at the PSP office in Worcester, Massachusetts.

Methodology

To meet our objectives, we:

- met with IntegriGuard and reviewed some of its work papers in an effort to understand the program and develop audit areas;

- interviewed PSP officials to obtain an understanding of how PSP processed claims and recorded expenditures and cash withdrawals on the TAMER;

- obtained PSP's bank records and Payment Management System drawdown information to compare them to the amounts recorded as withdrawals on the TAMER;

- obtained the claim information to compare it to the expenditures recorded on the TAMER;

- reviewed PSP's policies and procedures regarding TA;

- selected the months of July 2004 and May 2005 to reprice a sample of claims, and reviewed an unrestricted random sample of 100 claims for each of the 2 months;

- reviewed the contracts between PSP and CMS, manufacturers, pharmacies, and other entities;

- analyzed all claims during the period June 2004 through May 2005 to determine whether the drugs on the claims were excluded drugs and whether beneficiaries exceeded their TA fund limits; and

- determined whether PSP's expenditures and withdrawals from the Payment Management System for the period June 2004 through May 2005 reconciled to the information in the CMS system.

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

FINDINGS AND RECOMMENDATIONS

PSP properly supported the expenditures it made on behalf of beneficiaries and the withdrawals from the Payment Management System. However, PSP did not have proper procedures in place to ensure that it always complied with Federal requirements to:

- ensure that beneficiaries did not exceed their TA fund limits,

- apply TA funds only to covered drugs, and

- pass on negotiated prices to beneficiaries and charge the lower of the negotiated prices or the usual and customary prices.

Additionally, PSP mistakenly believed that its edits identified all excluded drugs.

As a result, CMS overpaid PSP $420,875 for beneficiaries who exceeded their TA limits and $231,260 for excluded drugs for the period July 12, 2004, through May 31, 2005. In September 2005, PSP reimbursed CMS $181,519 for excluded drugs for the period June 2004 through September 2005.

TRANSITIONAL ASSISTANCE LIMITS

Federal Requirements

The MMA, section 1860D-31(g)(2)(A), limited the TA subsidy amount a qualified beneficiary could receive to $600 during 2004 and $600 during 2005. CMS prorated the amount for 2005 based on the date the beneficiary enrolled in the program. Beneficiaries who enrolled in 2004 received the entire $600, regardless of the month they enrolled. CMS added any TA amount not used during 2004 to the 2005 benefit.

Transitional Assistance Limits Exceeded

For the period June 2004 through May 2005, PSP allowed 1,565 beneficiaries to exceed their TA fund limits. For 2004, the amount exceeding the TA fund limits ranged from $2 to $3,634 for 1,215 beneficiaries. For 2005, the amount exceeding the TA fund limits ranged from $4 to $3,544 for 430 beneficiaries. Some beneficiaries exceeded their TA fund limits in both years.

Inadequate Procedures

PSP did not have adequate procedures in place to ensure that beneficiaries did not exceed their TA fund limits as required by the MMA. Also, PSP did not have procedures in place to account for beneficiaries who qualified for manufacturers' wrap-around programs. This allowed PSP to inappropriately charge both CMS and drug manufacturers for claims. Because beneficiaries became eligible for the wrap-around programs after they had exhausted their TA funds, they exceeded their TA fund limits when PSP billed CMS for their claims.

Excess Transitional Assistance Funds

Because PSP did not have adequate procedures in place to limit beneficiaries to their TA fund limits, PSP overpaid $420,875 for 1,565 beneficiaries. Specifically, PSP paid:

- $283,294 for 1,215 beneficiaries who exceeded their TA fund limits in 2004 and
- $137,581 for 430 beneficiaries who exceeded their TA fund limits in 2005.

EXCLUDED DRUGS

Federal Requirements

The MMA, section 1860D-2(e)(2)(A), excludes specific drugs and drug classes from the definition of "covered Part D drugs." Regulations (CFR § 403.802) define covered Part D drugs and state which drugs are included and excluded. Any drug that falls into one of the excluded classes of drugs cannot be purchased with TA funds.

In July 2004, CMS issued a list of two classes of excluded drugs; in November 2004, it issued an updated list that covered all classes of excluded drugs as of December 2004. CMS based the lists on the National Drug Code (NDC), which identifies each drug by a specific code. On August 29, 2005, CMS issued a memo directing all drug discount card sponsors to determine whether they had used TA funds to pay for excluded drugs. The memo specified which list to use for the appropriate periods and requested that sponsors repay CMS for any TA funds reimbursed for excluded drugs.

Transitional Assistance Funds Used for Statutorily Excluded Drugs

From July 12, 2004, to May 31, 2005, PSP charged CMS for 10,955 claims for drugs that were statutorily excluded from the drug discount card program and for which payment should not have been made.

Incorrect Data Used to Identify Excluded Drugs

PSP used the Generic Product Identifier (GPI), which lists brand-name drugs and their generic equivalents under single codes, to determine whether the MMA excluded a drug. Because PSP used the GPI, it was not able to identify all the drugs in the statutorily excluded categories.

Charged for Statutorily Excluded Drugs

Because PSP used the GPI to identify excluded drugs on claims, CMS overpaid PSP $231,260 for 10,955 claims. Based on the guidelines that CMS issued to the sponsors on August 29, 2005, the breakdown of claims PSP submitted to CMS for statutorily excluded drugs is:

- $41,978 for 1,943 claims made from July 12 through December 3, 2004; and
- $189,282 for 7,545 claims made from December 4, 2004, through May 31, 2005.

In September 2005, PSP reimbursed CMS $181,519 for excluded drugs that it identified based on the criteria CMS used in its August 2005 memo to sponsors.

NEGOTIATED PRICES

Federal Requirements

The MMA, sections 1860D-31(h)(4) and (8), required sponsors to pass on negotiated rates to beneficiaries and ensure that beneficiaries were not charged more than the lower of the negotiated prices or the usual and customary prices.

Federal regulations (42 CFR § 403.806(d)(6)) required sponsors to pass on a share of any discounts, rebates, or other price concessions to beneficiaries through negotiated prices. PSP's contracts with drug manufacturers specified the amount of the rebates that PSP should have passed on to the beneficiaries and what amount it should have kept.

Negotiated Prices Not Passed On to Beneficiaries

PSP did not always comply with the Federal requirements and PSP contracts to pass on negotiated prices to the beneficiaries and charge the lower of the negotiated prices or the usual and customary prices. The contracts specifically stated the amount of the rebate that should have been passed on to the beneficiaries. Of the 200 claims we reviewed, 32 had the following errors related to negotiated prices:

- Thirty-one claims totaling $2.77 did not include the correct amount of the manufacturer's rebate as required by the contracts.

- On one claim, PSP used incorrect pricing information and charged the beneficiary $11.15 more than the lower of the negotiated price or the usual and customary price.

Inadequate Procedures

PSP did not have adequate procedures in place to ensure that it complied with the MMA's requirements to pass on negotiated prices to beneficiaries and charge the lower of the negotiated prices or the usual and customary prices. Specifically, PSP did not update its system to calculate drug rebates on individual claims using the correct WAC. In some instances, the WAC PSP used to calculate the rebate on a claim was a year old while the WAC used to calculate the rebate from manufacturers was more current. As a result, beneficiaries did not receive the rebate amounts to which they were entitled.

Claims Billed Incorrectly

While the dollar amounts of these errors are not material, these problems could become material if PSP continues as a Part D provider.

RECOMMENDATIONS

We recommend that PSP:

- reimburse CMS for the $420,875 by which it exceeded TA fund limits;

- determine whether the amount PSP reimbursed CMS for excluded drugs included any of the $231,260 in TA funds identified in the audit and reimburse the difference; and

- implement policies and procedures, if it continues as a PDP sponsor in Part D, to ensure that it (1) does not pay for statutorily excluded drugs with CMS funds and (2) offers negotiated prices to beneficiaries.

PUBLIC SECTOR PARTNERS' COMMENTS

In its written comments on our draft report, PSP agreed that errors had occurred, but it did not agree with all of the causes we identified. PSP stated that it had worked with CMS to correct its procedures and had reimbursed CMS for the errors we identified.

Regarding TA funds, PSP stated that it did not allow beneficiaries to exceed their limits. The error, PSP said, occurred because it mistakenly identified funds it was owed from manufacturers for their wrap-around programs as amounts owed by CMS, and it

withdrew those amounts from the Payment Management System. PSP reimbursed CMS $436,363 for this error.

PSP stated that it paid for excluded drugs because it did not effectively update its claims processing system and that it reimbursed CMS $181,519. However, PSP did not address the difference in the amount of funds we identified for excluded drugs and the amount it reimbursed CMS.

PSP stated that it did not always pass on negotiated prices to beneficiaries and charge the lower of the negotiated prices or the usual and customary prices because of two system errors. PSP stated that it corrected the error and reimbursed CMS $159,500. PSP said that it also reimbursed beneficiaries $21,603 because they paid higher copayments than they should have paid.

PSP's comments are included in the appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We agree that the steps PSP took to reimburse CMS are sufficient to address all of the errors we identified except for those related to excluded drugs. We continue to believe that PSP should determine whether the amount it reimbursed CMS for excluded drugs included any of the $231,260 in TA funds we identified and reimburse the difference.

APPENDIX

PUBLIC SECTOR PARTNERS, INC.

100 Century Drive ♦ Worcester, MA 01606
Tel: 508-793-1191 • Fax: 508-793-1199

June 19, 2006

Mr. Gordon L. Sato
Regional Inspector General
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Mr. Sato,

The following is Public Sectors Partners' response to your request for written comments on your Report Number A-06-00062; ***Report on The Medicare Drug Discount Card Program Sponsor Public Sector Partners.*** Also enclosed are supporting documents that are referenced in this response.

Public Sector Partners, Inc. (PSP), simultaneous with the Office of Inspector General (OIG) audit, conducted its own review of PSP's Prescription Drug Discount Card procedures and systems for the period from June 1, 2004 through November 11, 2005. As a result of PSP's internal review, PSP initiated a conference call with the Center for Medicare and Medicaid Services (CMS) on November 28, 2005. Participants in the call included Rosalind M. Abankwah, Account Manager, CMS Discount Card, and Jennifer Shapiro, Director, CMS Discount Card. The purpose of the call was to discuss PSP's internal review, present its findings and recommendations, and request CMS' recommendation and direction. This process included the correction of procedures and identification of reimbursements through that date. Beyond that time, PSP has continued to monitor its results. References to this internal review are included in PSP's response, outlined below, to the OIG's audit conducted for the period June 1, 2004 through May 31, 2005.

The following is Public Sector Partners response to the "Findings and Recommendations" section referred to in the document entitled "Report on the Medicare Drug Discount Card Program Sponsor Public Sector Partners."

Where the report states:

"...PSP did not have proper procedures in place to ensure that it always complied with Federal requirements to:

- *ensure that beneficiaries did not exceed their TA funds limits"*

  PSP did have adequate procedures in place to administer the benefit properly such that beneficiaries did not receive more than their CMS-approved Transitional

Assistance (TA) benefit. The error that PSP made was not in extending the TA benefit provided to members, but in its reporting of TA fund utilization for reimbursement from CMS. From the beginning of the program until June 19, 2005, PSP incorrectly included in its CMS funding request funds due to PSP for the Manufacturers' Wrap Extended Benefit program. The Manufacturers' Wrap Extended Benefit program was an additional benefit in which PSP contracted with several manufacturers to offer generous subsidies to low-income Discount Cardholders on various products after their TA benefit was exhausted.

To be clear, PSP's calculation of the benefits extended to members was always correct at the point of sale. Unfortunately, however, PSP's reporting mechanism for the total funds due from CMS inadvertently included funds due to PSP from participating manufacturers to reimburse PSP for this Extended Benefit. PSP's reporting process was corrected on June 19, 2005. The reporting error was a topic on the agenda during PSP's conference call with CMS on November 28, 2005 and PSP requested CMS direction on its resolution at that time.

As a result of PSP's internal review, PSP reimbursed CMS on Feb 16, 2006 for over-payment in the amount of $436,363.22, which was actually due from manufacturers to fund the Manufacturers' Extended Benefit Program. (A copy of cancelled check # 6713 dated 2/16/06 is attached).

The additional payment amount of $15,488.22 in excess of the OIG calculation of $420,875 was identified by PSP's internal review and represents the period between the Audit end date of May 31, 2005 and the time the reporting problem was corrected on June 19, 2005.

- *apply TA funds only to covered drugs,"*

PSP made its best efforts to properly administer the TA benefit in accordance with applicable laws and regulations. For the implementation of the program in April 2004, PSP developed a list of Excluded Drugs that it believes met the program requirements. However, PSP did not effectively update the Excluded Drug list defined in its claims processing system to reflect the interim lists that were provided by CMS in July and November, 2004.

PSP took great care to translate the Excluded Drug list in the CMS Published Guidance of August 29, 2005 and updated its claims processing system to properly reflect and reject each defined Excluded Drug item.

Further, as part of PSP's internal review, PSP reviewed TA claims for Excluded Drug products, again using the August 2005 List. PSP identified that $181,519.35 of TA funds had been expended for Excluded Drugs. On September 28, 2005, PSP reimbursed CMS for that amount and accompanied the remittance with

supporting documentation. (A copy of cancelled check # 6142, dated 9/28/06, is attached).

- *...and pass on negotiated prices to beneficiaries and charge the lower of the negotiated prices or the usual and customer prices."*

  Over the course of the Discount Card program, PSP encountered two price calculation issues. Both were system-based, occurring in the manner in which PSP set up the calculation of point-of-sale rebate pricing. In one case, there was a problem with procedures used in updating our Rebate Lists, and, in the other, an error in pricing very low-cost generic claims (which was affected by the rebate calculation methodology.) PSP reviewed all claim system processing and procedures that caused any incorrect pricing and made corrections in the claims processing system to price all claims consistently and correctly.

  As part of its internal review, PSP did a full review of TA reimbursements from CMS and co-pays paid by beneficiaries that may have been incorrect due to any pricing issues. All process and system corrections were made by November 11, 2005. This topic was also discussed in the conference call that PSP initiated with CMS on November 28, 2005 to seek CMS direction.

  Based on our conversation with CMS, PSP reimbursed CMS on Feb 2, 2006 for incorrect pricing reimbursed with TA funds $159,500.11 covering the period from June 1, 2004 through the correction of all process errors November 11, 2005 and accompanied the remittance with supporting documentation. (A copy of cancelled check # 6713, dated 2/16/06, is attached).

  Further, based on the results of PSP's internal review, in February 2006, PSP sent reimbursements to beneficiaries who paid higher co-pays than they should have.. The total of this reimbursement was $21,603.35 and covered the period from June 1, 2004 through the correction of all process errors November 11, 2005.

"...Additionally, PSP mistakenly believed that its edits identified all excluded drugs."

PSP assumes this comment refers to the above statement that PSP did not have systems in place to ensure that it applied TA funds only to covered drugs. Please see PSP's response above on this topic.

In closing, PSP believes that it made every reasonable effort to comply with CMS regulations and guidance in the implementation and management of the Medicare-approved Prescription Drug Discount Card. Unfortunately, over the course of the benefit, PSP found that some issues occurred that resulted in non-compliance. PSP's

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Management sincerely hopes that it is clear that PSP immediately acted in good faith to correct any compliance issues that were identified by the OIG or through PSP's own investigation. Furthermore, PSP hopes that it is clear to the OIG that PSP took the necessary steps to reimburse CMS and/or PSP's Prescription Drug Discount Cardholders for these errors.

Thank you for the opportunity to reply to the findings of your audit. Please feel free to contact Cheryl Lazzaro at (508) 793-1168 if you have any questions or would like additional information.

Sincerely,

Robert D. Wakefield, Jr.
Chief Executive Officer

Enclosures

Office of Inspector General Note: Pages 5 through 9 of Public Sector Partners' Comments was not included in the report. These pages were copies of checks it sent to CMS to reimburse funds PSP owed CMS.