Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAID FOR HIV DRUGS FOR DECEASED BENEFICIARIES

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Medicare Paid for HIV Drugs for Deceased Beneficiaries
OEI-02-11-00172

WHY WE DID THIS STUDY

Under the Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, known as sponsors, to provide prescription drug coverage to beneficiaries who choose to enroll. The Office of Inspector General (OIG) has had ongoing concerns about Medicare paying for drugs and services after a beneficiary has died.

Drugs that treat the human immunodeficiency virus (HIV) can be a target for fraud, waste, and abuse, primarily because they can be very expensive. Although this report focuses on HIV drugs, the issues raised are relevant to all Part D drugs.

HOW WE DID THIS STUDY

We based this study on an analysis of Prescription Drug Event (PDE) records for HIV drugs in 2012. Part D sponsors submit these records to CMS for each drug dispensed to beneficiaries enrolled in their plans. Each record contains information about the drug, beneficiary, pharmacy, and prescriber. We used the Beneficiary Enrollment Database, the Social Security Administration's Death Master File, and Accurint's Death Records to identify beneficiaries' dates of death.

WHAT WE FOUND

Medicare paid for HIV drugs for over 150 deceased beneficiaries. CMS's current practices allowed most of these payments to occur. Specifically, CMS has edits (i.e., systems processes) in place that reject PDE records for drugs with dates of service more than 32 days after death. CMS's practices allow payment for drugs that do not meet Medicare Part D coverage requirements. Most of these drugs were dispensed by retail pharmacies.

This review looked only at HIV drugs, which account for one-quarter of one percent of all Part D drugs in 2012. However, our findings have implications for all drugs because Medicare processes PDE records for all drugs the same way. Considering the enormous number of Part D drugs, a change in practice would affect all Part D drugs and could result in significant cost savings for the program and for taxpayers.

WHAT WE RECOMMEND

We recommend that CMS change its practice of paying for drugs that have a date of service within 32 days after the beneficiary's death. CMS should eliminate or—if necessary for administrative processing issues—shorten the window in which it accepts PDE records for drugs dispensed after a beneficiary's death. Such a change would prevent inappropriate payments for drugs for deceased beneficiaries and lead to cost savings for the program and for taxpayers. CMS concurred with our recommendation.

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OBJECTIVE

To determine the extent to which Medicare Part D paid for human immunodeficiency virus (HIV) drugs for deceased beneficiaries in 2012.

BACKGROUND

Medicare Part D provides an optional prescription drug benefit to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies, known as Part D sponsors, to provide drug coverage to beneficiaries who choose to enroll in the program.[1] In 2012, 37 million beneficiaries were enrolled in Part D.[2]

The Office of Inspector General (OIG) has had ongoing concerns about Medicare payments for drugs and services after a beneficiary has died. OIG has found that although CMS has some safeguards to prevent these improper payments, it continues to make some payments on behalf of deceased beneficiaries.[3] This raises questions about how effective the efforts of CMS and its contractors are in preventing improper payments and what opportunities exist for cost savings.

This report addresses payments on behalf of deceased beneficiaries for Part D drugs, specifically HIV drugs. HIV drugs are antiretroviral drugs that are the primary treatment of people living with HIV. These drugs can be a target for fraud, waste, and abuse, primarily because they can be very expensive. For example, one common HIV drug costs about $1,700 for a month's supply. Although the report focuses on HIV drugs, the issues raised are relevant to all Part D drugs because controls to prevent payments after death are not specific to HIV drugs.

Medicare Part D

Medicare Part D covers drugs prescribed for medically accepted indications.[4] Medicare beneficiaries have the option of enrolling in stand-alone prescription drug plans, or they may receive prescription drug coverage as a part of managed care plans. The managed care plans

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[1] 42 U.S.C. §§ 1395w-101(a)(1) and 1395w-112(b)(1).

[2] The Boards of Trustees, *Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, pp. 151 and 157. Accessed at http://downloads.cms.gov/files/TR2013.pdf on November 26, 2013.

[3] For example, OIG, *Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011* (OEI-04-12-00130), October 2013.

[4] 42 U.S.C. 1395w-102(e)(1).

(known as Medicare Advantage plans or Medicare Part C) also include medical benefits.

Most beneficiaries are responsible for certain costs under Part D, which may include a monthly premium, an annual deductible, and coinsurance.[5] However, certain low-income beneficiaries are eligible to receive assistance to pay some or all of these Part D costs.[6] These beneficiaries pay minimal or no co-pays for drugs.

CMS requires that Part D sponsors develop a network of pharmacies to dispense drugs to beneficiaries enrolled in their plans.[7] CMS requires these pharmacy networks to be geographically diverse and to include different types of pharmacies, such as retail pharmacies and long-term-care pharmacies.

Pharmacies submit claims to sponsors (or to sponsors' Pharmacy Benefit Managers) for drugs they dispense for beneficiaries. If the medication is never picked up, then the pharmacy must reverse the claim and return the drugs to stock.[8]

Sponsors then submit prescription drug event (PDE) records to CMS for all covered drugs that are dispensed to beneficiaries throughout the year.[9] These records include cost data as well as information about each drug, including the date of service, the pharmacy, and the beneficiary.

Payments to Sponsors

CMS makes monthly prospective payments to sponsors for each beneficiary enrolled in their plans. These payments are based on the bids that sponsors submit before the beginning of the plan year. Each bid estimates the sponsor's anticipated drug costs as well as its administrative costs.[10] CMS uses the approved bids to determine the premium amounts that beneficiaries pay and the monthly payments that it makes to each

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[5] 42 CFR §§ 423.293 and 423.104(d), (e), and (f).

[6] 42 CFR § 423.315(d).

[7] 42 CFR § 423.120.

[8] CMS, *Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 1, 2013, p. 144. Accessed at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/RateNotice.pdf on July 7, 2014.

[9] CMS, *2011 Regional Prescription Drug Event Technical Assistance Participant Guide*, p. 1-15. Accessed at http://www.csscoperations.com/internet/Cssc.nsf/files/PDEParticipantGuide%20cameraready%20081811.pdf/$FIle/PDEParticipantGuide%20cameraready%20081811.pdf on July 8, 2014.

[10] 42 CFR § 423.265(c)(1).

sponsor.[11] These monthly payments are for three subsidies—the direct subsidy, the low-income cost-sharing subsidy, and the reinsurance subsidy.[12]

- The **direct subsidy**, together with the beneficiary premium, is designed to cover the sponsor's cost of providing the benefit to each beneficiary.
- The **reinsurance subsidy** covers the Federal Government's share of drugs costs for beneficiaries who reach a certain cost threshold (known as catastrophic coverage), and
- The **low-income cost-sharing subsidy** covers the Federal Government's portion of the cost-sharing payment for certain low-income beneficiaries.

After the close of the plan year, CMS reconciles these monthly prospective payments with the actual costs incurred by the sponsors to determine at the end of the year whether CMS owes money to sponsors or sponsors owe money to CMS.[13] CMS determines each sponsor's actual costs based primarily on the PDE records that the sponsor submits.[14] If sponsors submit PDE records for drugs that should not have been covered by Part D, payments to sponsors may be too high. This is particularly an issue when the PDE records submitted are for beneficiaries who receive the low-income cost-sharing subsidy or who have reached the catastrophic coverage threshold, because the Federal Government is responsible for a larger share of their drug costs.[15]

Under current practice, CMS has edits (i.e., systems processes) in place that will not accept any PDE records for drugs with dates of service more than 32 days after the beneficiary's date of death.[16] However, according to CMS it is possible that—because of delays in receiving death information—it will accept a PDE with a date of service that is after the 32-day window. For this reason, beginning with contract year 2013, CMS began conducting additional analysis to identify and exclude these PDE

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[11] 42 CFR §§ 423.286 and 423.315(b).

[12] 42 CFR § 423.315. Also see, CMS, *2011 Regional Prescription Drug Event Technical Assistance Participant Guide*, pp. 1-16–1-18.

[13] 42 CFR § 423.343.

[14] CMS, *2011 Regional Prescription Drug Event Technical Assistance Participant Guide*, p. 1-15. Sponsors are also required to report direct and indirect remuneration, such as drug manufacturer rebates.

[15] Part D sponsors are also subject to risk sharing. Risk-sharing payments may also be inaccurate if PDE records for noncovered drugs are included in reconciliation. For more information about risk sharing, see 42 CFR § 423.336.

[16] See CMS, *2011 Regional Prescription Drug Event Technical Assistance Participant Guide*, p. 8-13.

records from the reconciliation process.[17] CMS has informational edits that alert Part D sponsors if the date of service on the PDE record is 32 or fewer days after the beneficiary's date of death.

This study focuses on PDE records submitted by sponsors for drugs dispensed after the beneficiary's date of death because these PDE records affect payments to sponsors and the overall cost of the Part D program. See Methodology section for more detailed information.

Related Work

A recent OIG report found that nearly 1,600 Part D beneficiaries had questionable utilization patterns for HIV drugs in 2012.[18] In total, Medicare paid $32 million for HIV drugs for these beneficiaries. These beneficiaries had no indication of HIV in their Medicare histories, received an excessive dose or supply of HIV drugs, received HIV drugs from a high number of pharmacies or prescribers, or received contraindicated drugs. These questionable patterns indicate that beneficiaries may be receiving inappropriate or unnecessary drugs. It may also indicate that a pharmacy is billing for drugs that a beneficiary never received, or that a beneficiary's identification number has been stolen.

Another OIG report looked at the extent to which CMS made monthly prospective payments in 2011 to Part C and D sponsors for deceased beneficiaries.[19] According to CMS policy, Medicare pays the sponsor the full payment for the month in which a beneficiary dies. OIG found that in 2011, CMS made monthly payments to Part C and D sponsors totaling $21 million for deceased beneficiaries in the months after death.

Lastly, another OIG report found that in 2006 and 2007 CMS paid $3.6 million in monthly prospective payments to certain Part D sponsors for deceased beneficiaries.[20] It found that although CMS had correctly stopped payments for the vast majority of deceased beneficiaries in 2006 and 2007, its systems did not always identify and prevent improper payments. In addition, CMS did not always recover on a timely basis the payments it had made on behalf of deceased beneficiaries.

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[17] CMS, *Reconciliation PDE Exclusion Process*, January 6, 2014.

[18] OIG, *Part D Beneficiaries with Questionable Utilization Patterns for HIV Drugs* (OEI-02-11-00170), August 2014.

[19] OIG, *Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011* (OEI-04-12-00130), October 2013.

[20] OIG, *Review of Medicare Payments to Prescription Drug Plans on Behalf of Deceased Enrollees* (A-05-09-00027), May 2011.

METHODOLOGY

This current study takes a different approach than the two previous studies that have identified Part D payments made on behalf of deceased beneficiaries. Whereas the other studies focused on monthly prospective payments, this study focuses on PDE records with dates of service after the beneficiary's date of death. Both the monthly payments and the prescription drug costs are factored into the amount that CMS ultimately pays for Part D.

Analysis of HIV Drugs

This study is based on an analysis of all PDE records for HIV drugs in 2012. Each record contains information about the drug and beneficiary, as well as the identification number for the pharmacy.

We first identified all PDE records for HIV drugs with dates of service from January 1 to December 31, 2012. To do this, we matched the Food and Drug Administration's (FDA) list of HIV drugs to First Databank and Red Book to identify the National Drug Codes (NDC) for HIV drugs.[21] In total, we identified 654 NDCs. Using these NDCs, we identified 3,177,937 PDE records for HIV drugs that were dispensed to 146,121 beneficiaries in 2012. These PDE records accounted for 0.26 percent of the 1.24 billion records for all Part D drugs dispensed that year. See Appendix A for a list of HIV drugs and their generic names.

Next, we took several steps to identify beneficiaries for whom HIV drugs were dispensed after their date of death. Using the Health Insurance Claims Number (HICN), we matched the PDE records to the Beneficiary Enrollment Database (EDB) to determine the beneficiary's date of the death. Next, we compared the beneficiary's date of death with the date of service on the PDE record.

For records where the date of service was after the date of death, we took additional steps to ensure the date of death listed in the EDB was accurate. Specifically, we consulted two additional sources—the Social Security Administration's Death Master File and Accurint's Death Records—to

[21] FDA, *Antiretroviral Drugs Used in the Treatment of HIV Infection*, August 2013. Accessed online at http://www.fda.gov/ForConsumers/byAudience/ForPatientAdvocates/HIVandAIDSActivities/ucm118915.htm on November 12, 2013. First Databank and Red Book contain both NDCs and drug names. We used both sources to ensure we had a comprehensive list of NDCs for HIV drugs.

verify the date of death.[22] If the dates of death did not match across the three sources, we took the latest date and used it in our analysis.

Next, we calculated the total number of HIV drugs dispensed after the date of death.[23] We then determined the number of beneficiaries and the total drug costs. We also calculated the difference between the date of service and the date of death. We determined the total number of drugs with dates of service that were within certain numbers of days after death and the total cost of these drugs.

Lastly, we identified the pharmacies that dispensed each of these drugs. To determine the type of each pharmacy, we matched the National Provider Identifiers (NPIs) on the PDE record to the database of the National Council for Prescription Drug Programs. This database contains descriptive information about each pharmacy, including the type of pharmacy (e.g., retail, long-term care, mail order).[24]

Limitations

We did not independently verify the accuracy of the PDE records, including the accuracy of the dates of service on the PDE records**.**

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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[22] Accurint is a LexisNexis data repository that contains more than 20 billion records from more than 10,000 data sources. Accurint's primary source for dates of death is SSA's Death Master File. Accurint also contains death information from obituaries and State death records. We matched beneficiaries' Social Security Numbers, first and last names, and dates of birth.

[23] For the purposes of this report, we considered a drug to be one PDE record.

[24] For the purposes of this report, we used the type that the pharmacy identified as its primary type.

FINDINGS

Medicare paid for HIV drugs for over 150 deceased beneficiaries as a result of CMS's current practices

In 2012, Medicare paid for 348 HIV drugs for 158 deceased beneficiaries. The total cost for these drugs was $292,381.[25] For each of these drugs, the date of service on the PDE record was after the beneficiary's death.

CMS's current practices allowed most of these payments to occur. Specifically, CMS has processing edits in place that should reject PDE records with dates of services that are more than 32 days after death. As Table 1 shows, all but 3 of the 348 drugs were dispensed within 32 days after death. About half the HIV drugs were dispensed within 7 days after death. A total of 142 drugs were dispensed between 8 and 20 days after death, while 24 drugs were dispensed between 21 and 32 days after.

Table 1: Number of Days After Death that the HIV Drugs Were Dispensed

Number of Days After Death	Number of Drugs*	Total Drug Costs
1 to 7 days	179	$151,433
8 to 20 days	142	$120,314
21 to 32 days	24	$18,183
33 days or more	3	$2,450
Total	**348**	**$292,381**

*For the purposes of this report, we considered a drug to be one PDE record.
Source: OIG analysis of Part D data, 2014.

CMS's practices allow payment for drugs that do not meet Medicare coverage requirements. Part D covers only drugs that are prescribed for medically indicated purposes. Drugs dispensed after death cannot be used for medically indicated purposes and therefore are not covered by Part D. According to CMS staff, the 32-day window is in place because some long-term-care pharmacies bill for Part D drugs once a month and inaccurately put this billing date, rather than the actual date of service, on the PDE record.

[25] This figure includes the amount paid by sponsors, by the Government, and on behalf of deceased beneficiaries.

Each of the 158 beneficiaries had between 1 and 6 drugs dispensed after the date of death; most beneficiaries had at least 2. The most common drugs dispensed for deceased beneficiaries were Norvir and Truvada.[26] See the text box below for examples of HIV drugs dispensed for deceased beneficiaries.

Examples of Drugs Dispensed After the Beneficiary's Death and Paid for by Medicare

- Medicare paid for three HIV drugs for a deceased beneficiary in Miami on two different dates after his death. The drugs cost a total of $7,160.
- Medicare paid for six HIV drugs for a deceased beneficiary in Michigan. The drugs were ordered by two different prescribers and cost $5,616.
- Medicare paid for four HIV drugs dispensed in Pennsylvania after a beneficiary's death. These drugs cost $4,414.
- Medicare paid for four HIV drugs for a deceased beneficiary in Florida. The drugs cost $3,452.

Most of these drugs were dispensed by retail pharmacies

Retail pharmacies dispensed 81 percent (283 of 348) of the HIV drugs for deceased beneficiaries.[27] In total, 124 pharmacies dispensed drugs for deceased beneficiaries. Of these, 106 were retail pharmacies, 8 were long-term-care pharmacies, and the remaining 10 were other types of pharmacies, such as clinics and mail-order pharmacies. See Table 2.

[26] Norvir and Truvada were also the most commonly dispensed HIV drugs among all Part D beneficiaries.

[27] Retail pharmacies dispensed 82 percent of all Part D drugs in 2009. See OIG, *Retail Pharmacies With Questionable Part D Billing*, (OEI-02-09-00600), May 2012.

Table 2: Types of Pharmacies That Dispensed HIV Drugs for Deceased Beneficiaries, 2012

Pharmacy Type	Number of Pharmacies	Number of HIV Drugs Dispensed After Beneficiaries' Deaths*	Percentage of HIV Drugs Dispensed After Beneficiaries' Deaths
Retail	106	283	81%
Long-Term Care	8	31	9%
Clinic	4	16	5%
Mail Order	2	4	1%
Specialty	1	4	1%
Other	3	10	3%
Total	**124**	**348**	**100%**

*For the purposes of this report, we considered a drug to be one PDE record.
Source: OIG analysis of Part D data, 2014.

The 8 long-term-care pharmacies dispensed a total of 31 HIV drugs for deceased beneficiaries. Of these, 20 drugs were dispensed within 7 days after death, 8 were dispensed between 8 and 20 days after death, and 3 were dispensed between 21 and 31 days after death. The small number of these drugs attributed to long-term-care pharmacies indicates that the billing practices of these pharmacies do not result in many claims for HIV drugs within 32 days after a beneficiary's death.

Furthermore, it is problematic if pharmacies are submitting their once-a-month billing date, rather than the actual date of service, on their PDE records. Sponsors are paid on the basis of PDE records, so it is important for these data to be accurate. Also, sponsors, CMS, and OIG use PDE records to detect and prevent fraud, waste, and abuse, and poor data can hinder these efforts.

CONCLUSION AND RECOMMENDATION

Our review focuses on HIV drugs; however, the findings have implications for all Part D drugs because Medicare processes PDE records for all drugs the same way. The findings show that CMS's current practice of permitting Medicare to pay for drugs with a date of service that is after a beneficiary's date of death has resulted in Medicare's inappropriately paying for drugs. Drugs for deceased beneficiaries are clearly not medically indicated, which is a requirement for Part D coverage.

This review looked only at HIV drugs, which account for one-quarter of one percent of all Part D drugs in 2012. A change in CMS's practice would affect all Part D drugs, not just HIV drugs. Considering the enormous number of Part D drugs, a change in practice could result in significant cost savings for the program and for taxpayers.

We recommend that CMS:

Change Its Practice of Paying for Drugs That Have a Date of Service Within 32 Days After the Beneficiary's Death

CMS should eliminate or—if necessary for administrative processing issues—shorten the window in which it accepts PDE records after a beneficiary's death. Having no window or a short window would prevent inappropriate payments for drugs for deceased beneficiaries and lead to cost savings for the program and for taxpayers.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendation that it change its practice of paying for drugs that have a date of service within 32 days after a beneficiary's death. CMS stated that it has had preliminary discussions with the industry to revisit the need for the 32-day window, which it had instituted because the date of service in some pharmacies reflects the date on which the prescription was billed, rather than the date on which the prescription was dispensed. CMS further stated that it will continue discussions with the industry with the goal of reducing the window to the absolute minimum, taking into consideration current industry billing practices and systems constraints.

CMS also stated that because many of the prescriptions identified by our study were filled at retail pharmacies, it will also "evaluate the potential use of additional PDE fields in the current editing logic of evaluating the relationship of the date of service to the date of death." Lastly, CMS stated that if OIG provides the PDE data for deceased beneficiaries, it will post these data for sponsors' review and, if necessary, correction. Any corrected or deleted PDE records would be considered in the reopening of the 2012 Part D reconciliation. (This reopening will adjust the final payment amounts that CMS made to sponsors for 2012.)

We support CMS's efforts to address this issue. As requested, we will provide CMS with a separate memorandum that includes the PDE records for deceased beneficiaries. The full text of CMS's comments is provided in Appendix B.

APPENDIX A

HIV Drugs

Brand Name	Generic Name
Multi-Class Combination Products	
Atripla	efavirenz, emtricitabine, and tenofovir disoproxil fumarate
Complera	emtricitabine, rilpivirine, and tenofovir disoproxil fumarate
Stribild	elvitegravir, cobicistat, emtricitabine, and tenofovir disoproxil fumarate
Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	
Combivir	lamivudine and zidovudine
Emtriva	emtricitabine, FTC
Epivir	lamivudine, 3TC
Epzicom	abacavir and lamivudine
Retrovir	zidovudine, azidothymidine, AZT, ZDV
Trizivir	abacavir, zidovudine, and lamivudine
Truvada	tenofovir disoproxil fumarate and emtricitabine
Videx EC	enteric coated didanosine, ddI EC
Videx	didanosine, dideoxyinosine, ddI
Viread	tenofovir disoproxil fumarate, TDF
Zerit	stavudine, d4T
Ziagen	abacavir sulfate, ABC
Nonnucleoside Reverse Transcriptase Inhibitors (NNRTIs)	
Edurant	rilpivirine
Intelence	etravirine
Rescriptor	delavirdine, DLV
Sustiva	efavirenz, EFV
Viramune (Immediate Release)	nevirapine, NVP
Viramune XR (Extended Release)	nevirapine, NVP

Source: FDA, *Antiretroviral Drugs Used in the Treatment of HIV Infection*, August 2013.

HIV Drugs - Continued

Brand Name	Generic Name
Protease Inhibitors (PIs)	
Agenerase	amprenavir, APV (no longer marketed)
Aptivus	tipranavir, TPV
Crixivan	indinavir, IDV
Fortovase	saquinavir (no longer marketed)
Invirase	saquinavir mesylate, SQV
Kaletra	lopinavir and ritonavir, LPV/RTV
Lexiva	fosamprenavir calcium, FOS-APV
Norvir	ritonavir, RTV
Prezista	darunavir
Reyataz	atazanavir sulfate, ATV
Viracept	nelfinavir mesylate, NFV
Fusion Inhibitors	
Fuzeon	enfuvirtide, T-20
Entry Inhibitors - CCR5 Co-Receptor Antagonist	
Selzentry	maraviroc
HIV Integrase Strand Transfer Inhibitors	
Isentress	raltegravir

Source: FDA, *Antiretroviral Drugs Used in the Treatment of HIV Infection*, August 2013.

APPENDIX B
Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 22 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Paid for HIV Drugs for Deceased Beneficiaries" (OEI-02-11-00172)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-referenced OIG draft report. The purpose of this report was to determine the extent to which Medicare Part D paid for human immunodeficiency virus (HIV) drugs for deceased beneficiaries in 2012. CMS appreciates OIG's concerns about Medicare paying for drugs and services after a beneficiary has died, and has implemented safeguards to address these vulnerabilities. For example, CMS has put into place processes to prevent payments made after a beneficiary's death and recover improper payments. Our response to the OIG recommendation follows.

OIG Recommendation

OIG recommends that CMS change its practice of paying for drugs that have a date of service within 32 days after the beneficiary's death. OIG stated that CMS should eliminate or, if necessary for administrative processing issues, shorten the window in which it accepts prescription drug event (PDE) data after a beneficiary's death. OIG believes that having no window or a short window would prevent inappropriate payments for drugs for deceased beneficiaries and lead to cost-savings for the program and for taxpayers.

CMS Response

CMS concurs. After reviewing this report, CMS has had preliminary discussions with the industry to revisit the need for a 32-day window, which was instituted because the date of service in some pharmacies reflects the date the prescription was billed, not the date the prescription was dispensed. CMS will continue discussions with the industry with a goal of reducing the margin to the absolute minimum given current industry billing practices and systems constraints. CMS will also evaluate the potential use of additional PDE fields in the current editing logic of evaluating the relationship of the date of service to the date of death since many of the prescriptions were filled at retail pharmacies. In addition, if OIG can provide the PDE data, CMS will post the data to the PDE website for sponsor review and if necessary, correction. Any corrected or deleted PDEs would be considered in the 2012 Part D reopening.

Thank you for the opportunity to review and comment on the draft OIG report.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Miriam Anderson served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Jenell Clarke-Whyte and Jason Kwong. Central office staff who provided support include Eddie Baker, Jr.; Mandy Brooks; Kevin Farber; David Graf; Meghan Kearns; and Christine Moritz.

Office of Inspector General

http://oig.hhs.gov

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