



Office of Audit Services, Region III  
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Philadelphia, PA 19106-3499

July 30, 2010

Report Number: A-03-09-00021

Gregg A. Pane, MD, MPA, Director  
Commonwealth of Virginia  
Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219

Dear Dr. Pane:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Part D Drug Payments to Virginia for Service Dates January 1 Through March 8, 2006*. 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 Nicole Freda, Audit Manager, at (215) 861-4497 or through email at [Nicole.Freda@oig.hhs.gov](mailto:Nicole.Freda@oig.hhs.gov). Please refer to report number A-03-09-00021 in all correspondence.

Sincerely,

/Bernard Siegel/ for  
Stephen Virbitsky  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

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Centers for Drug and Health Plan Choice (CPC)  
Centers for Medicare & Medicaid Services  
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Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PART D DRUG  
PAYMENTS TO VIRGINIA FOR SERVICE  
DATES JANUARY 1 THROUGH  
MARCH 8, 2006**



Daniel R. Levinson  
Inspector General

July 2010  
A-03-09-00021

# ***Office of Inspector General***

<http://oig.hhs.gov>

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## **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 (MMA) of 2003 amended Title XVIII of the Social Security Act (the Act) by establishing the Medicare Part D prescription drug benefit. 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 entities known as Part D sponsors to provide prescription drug coverage for beneficiaries enrolled in the Part D program.

Part D sponsors submit a summary record called a prescription drug event (PDE) record every time a pharmacy dispenses a prescription for a beneficiary covered under Medicare Part D. The PDE record contains prescription drug cost and payment data that enables CMS to make payment and otherwise administer the Part D benefit.

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 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 that these beneficiaries continued to receive needed medications as they made the transition, some States found it necessary to provide assistance to these beneficiaries by paying for their Medicare Part D drugs.

To reimburse States for 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)(1)(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 Part D in section 1860D-42(b) of the Act). On February 14, 2006, Virginia submitted its "Section 402 Demonstration Application" to CMS. By submitting its application, Virginia agreed to pay for full-benefit dually eligible beneficiaries' Part D drug claims. Virginia's participation in the demonstration project covered drugs dispensed from January 1 through March 8, 2006. Virginia contracted with HMS to seek reimbursement for Medicaid claims from insurers who also provided coverage to Medicaid beneficiaries.

### OBJECTIVE

Our objective was to determine whether Virginia received payments from a Part D sponsor and from CMS under the Medicare Part D demonstration project for the same dispensing events.

### SUMMARY OF FINDING

For all 46 sampled claims, Virginia received Medicare Part D payment from both CMS and a Part D sponsor. CMS paid and Virginia's contractor recovered payments from the Part D sponsor for the same dispensing events. Based on our sample results, we estimate that Virginia

received \$168,500 in improper payments for the 3,443 claims that were reimbursed by CMS under the Part D demonstration project and also paid by the Part D sponsor.

## **RECOMMENDATIONS**

We recommend that Virginia work with CMS to:

- refund to the Medicare program the \$168,500 in improper Part D demonstration project payments identified in this audit and
- determine and resolve other improper Part D demonstration project payments received by Virginia for claims paid by other Part D sponsors.

## **VIRGINIA COMMENTS**

In its response to our draft report, Virginia concurred with our finding. Virginia stated that it reviewed all demonstration project claims and determined that HMS inadvertently billed and recovered \$286,388. Virginia said that it reported 50 percent of the recoveries, or \$143,194, to CMS on its Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64), and that it intended to reflect the remaining \$143,194 on its next CMS-64. Virginia's comments on our draft report are included as Appendix C. We excluded the attachment to Virginia's comments because it contained personally identifiable information.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Verifying Virginia's CMS-64 reports fell outside the scope of our audit. However, an adjustment to the CMS-64 would refund the payments to the Medicaid program, not to the Medicare program. Because the Medicare program reimbursed the drug claims under the Part D demonstration project, we continue to recommend that Virginia refund the payments to the Medicare program and we have clarified our recommendations accordingly.

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## INTRODUCTION

### BACKGROUND

#### **Medicare Part D Prescription Drug Benefit**

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 amended Title XVIII of the Social Security Act (the Act) by establishing the Medicare Part D prescription drug benefit. 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 entities known as Part D sponsors to provide prescription drug coverage for beneficiaries enrolled in the Part D program. Part D sponsors may offer drug coverage through more than one drug plan.

CMS pays Part D sponsors monthly prospective payments to provide Part D prescription drug coverage. These payments are based on estimates that Part D sponsors provide in their approved bids before the beginning of the plan year. After the close of the plan year, CMS must reconcile these payments to the Part D sponsors' actual costs to determine whether Part D sponsors owe money to Medicare or Medicare owes money to Part D sponsors. Sections 1860D-15(c)(1)(C) and (d)(2) of the Act and 42 CFR § 423.322 require Part D sponsors to submit to CMS certain information necessary to conduct these reconciliations. This information includes summary records called prescription drug event (PDE) records that Part D sponsors submit every time a pharmacy dispenses a prescription for a beneficiary covered under Medicare Part D. PDE records contain prescription drug cost and payment data, including the provider identification number, that enable CMS to pay Part D sponsors and otherwise administer the Part D benefit.

#### **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 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. 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 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 costs incurred during the transition period, CMS implemented the *Reimbursement of State Costs for Provision of Part D Drugs* Medicare demonstration project (Part D demonstration project) pursuant to section 402(a)(1)(A) of the Social Security

Amendments of 1967, as amended.<sup>1</sup> The Part D demonstration project permitted Medicare to reimburse States for full-benefit dually eligible beneficiaries' Part D drugs to the extent that those costs were not recoverable from a Part D sponsor and were not required Medicare cost sharing on the part of the beneficiary. To participate in the Part D demonstration project and receive reimbursement for their incurred costs, States were required to submit a signed Section 402 Demonstration Application to CMS.

### **Virginia's Participation in the Part D Demonstration Project**

On February 14, 2006, Virginia applied to participate in the Part D 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.

In 2007, we audited Virginia's compliance with the Part D demonstration project requirements.<sup>2</sup> Our audit found that Virginia complied with the requirements; however, our audit scope did not require that we determine whether Virginia also billed these claims to a Part D sponsor.

### **Virginia's Contractor**

Federal law mandates that Medicaid is to be the payer of last resort. Virginia contracts with HMS to seek reimbursement for Medicaid claims from insurers who also provided coverage to Medicaid beneficiaries. HMS collects recoveries from insurers and then provides a check to Virginia for Medicaid claims it has already paid on the beneficiary's behalf.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether Virginia received payments from a Part D sponsor and from CMS under the Medicare Part D demonstration project for the same dispensing events.

### **Scope**

Our audit covered the period January 1 through March 8, 2006. We judgmentally selected one Virginia provider identification number that appeared on PDE records because it represented a large number of payments in the database of matched claims that we reviewed. The provider identification number was a Federal tax identification number for Virginia. CMS reimbursed Virginia \$192,023 for 3,443 Part D demonstration claims that also had a Part D sponsor-

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<sup>1</sup> Demonstration provisions are codified at 42 U.S.C. § 1395b-1(a)(1)(A) and expressly made applicable to Medicare Part D in section 1860D-42(b) of the Act.

<sup>2</sup> *Review of Virginia's Compliance With the Reimbursement of State Costs for Provision of Medicare Part D Drugs Demonstration Project Requirements* (A-03-07-00001), issued October 4, 2007.

submitted PDE record for this tax identification number. The calculated payment recovered from the sponsor for these claims was \$168,500.

Our audit objective did not require an understanding or assessment of Virginia's overall internal control structure. We limited our review of internal controls to obtaining an understanding of the procedures Virginia used to bill Part D sponsors for Part D demonstration project claims.

We conducted our fieldwork at the Virginia Department of Medical Assistance Services offices in Richmond, Virginia, in August 2009.

## **Methodology**

To accomplish our objective, we:

- reviewed applicable laws, regulations, and guidance related to the Part D demonstration project and PDE records;
- discussed with Virginia Department of Medical Assistance officials Virginia's practices for billing Part D sponsors for Part D demonstration project claims;
- compared CMS's PDE records with Virginia's Part D demonstration project claims for the period January 1 through March 8, 2006 to identify providers with potential duplicate payments;
- identified a sampling frame of 3,443 PDE records using the Federal tax identification number that matched claims paid to Virginia under the Part D demonstration project and:
  - from the sampling frame, selected a random sample of 46 claims and
  - for each sampled claim, requested and reviewed payment documentation from the identified Part D sponsor; and
- identified the total dollar value of improper Part D demonstration project payments.

Appendix A provides a description of the sampling methodology and Appendix B details the sample results.

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 finding and conclusions based on our audit objective.

## **FINDING AND RECOMMENDATIONS**

For all 46 sampled claims, Virginia received Medicare Part D payments from both CMS and a Part D sponsor. CMS paid and Virginia's contractor recovered payments from the Part D sponsor for the same dispensing events. Virginia said its contractor had misidentified the claims as Medicaid claims and that it had reimbursed CMS by submitting adjustments for 50 percent of the recovered payments on its Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64).

Based on our sample results, we estimate that Virginia received \$168,500 in improper payments for the 3,443 claims that were reimbursed by CMS under the Part D demonstration project and also paid by the Part D sponsor.<sup>3</sup>

### **PART D DEMONSTRATION PROJECT REQUIREMENTS**

To participate in the Part D demonstration project and receive reimbursement for their incurred costs, States were required to submit a signed "Section 402 Demonstration Application" (Medicare demonstration application) to CMS. By submitting Medicare demonstration applications, States agreed to (1) require pharmacies to bill the 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 Part D drug claims and administrative costs; (3) ensure that claims submitted were for covered Part D drugs; (4) separate 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 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 Action Templates: Reimbursement of State Costs for Provision of Part D Drugs).

### **IMPROPER PAYMENTS**

For all 46 sampled claims, Virginia billed and received Medicare Part D payments from both the Part D sponsor and CMS. Pursuant to the Part D demonstration project requirements, Virginia required pharmacies to bill the Part D plan before relying on State payment. If the Part D sponsor could not be billed at the pharmacy, Virginia agreed to pay the claim through its Medicaid point-of-sale system and bill Medicare Part D (CMS) for the payment. Accordingly, Virginia paid the 46 claims in our sample through its point-of-sale system, billed CMS, and received Medicare payments under the Part D demonstration project.

Subsequently, Virginia's contractor misidentified the Part D demonstration claims as Medicaid claims and recovered payments from the Part D sponsor. The contractor submitted the recovered payments to Virginia. The Part D sponsor submitted PDE records to CMS using Virginia's Federal tax identification number in place of the provider identification number.

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<sup>3</sup> The total dollar value of improper payments reflects the calculated reimbursement to Virginia by the Part D sponsor.

Because sponsors were contractually obligated to pay for full-benefit dually eligible beneficiaries' Part D drugs, \$2,423 of the payments that Virginia received under the Part D demonstration project for the 46 sampled claims were improper.

At the time of our audit, Virginia could not support that it had refunded any of these improper payments to Medicare. Virginia stated that, in general, it reported 50 percent of the Medicare payments received from Part D sponsors on its Medicaid Forms CMS-64, even though it did not initially claim any amounts to Medicaid. Based on the documentation that Virginia provided, we were unable to determine whether any of the improper Part D demonstration payments described in this report were incorrectly submitted as Medicaid adjustments on the CMS-64.

Virginia also said that it billed other Part D sponsors, and refunded portions of other Part D demonstration claims on its CMS-64. However, because the PDE records were associated with claims submitted for other provider identification numbers, they fell outside the scope of this review. Therefore, we could not validate Virginia's statements.

Based on our sample results, Virginia received improper payments of \$168,500 for 3,443 claims that were reimbursed by CMS under the Part D demonstration project and also paid by the Part D sponsor.

## **RECOMMENDATIONS**

We recommend that Virginia work with CMS to:

- refund to the Medicare program the \$168,500 in improper Part D demonstration project payments identified in this audit and
- determine and resolve other improper Part D demonstration project payments received by Virginia for claims paid by other Part D sponsors.

## **VIRGINIA COMMENTS**

In its response to our draft report, Virginia concurred with our finding. Virginia stated that it reviewed all Part D demonstration project claims and determined that HMS inadvertently billed and recovered \$286,388. Virginia stated that it reported 50 percent of the recoveries, or \$143,194, to CMS on its CMS-64 and intended to reflect the remaining \$143,194 on its CMS-64 for the next quarter. Virginia's comments on our draft report are included as Appendix C. We excluded the attachment to Virginia's comments because it contained personally identifiable information.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Verifying Virginia's CMS-64 reports fell outside the scope of our audit. However, an adjustment to the CMS-64 would refund the payments to the Medicaid program, not to the Medicare program. Because the Medicare program reimbursed the drug claims under the Part D

demonstration project, we continue to recommend that Virginia refund the payments to the Medicare program and we have clarified our recommendations accordingly.

# **APPENDIXES**

## **APPENDIX A: SAMPLE DESIGN AND METHODOLOGY**

### **POPULATION**

The population represented prescription drug event (PDE) records with Virginia's Federal tax identification number used as a provider identification number that matched claims paid to Virginia under the Part D demonstration project.

### **SAMPLING FRAME**

The sampling frame was an Excel spreadsheet of 3,443 PDE records each of which matched one claim paid under the Part D demonstration project. The calculated value of matched claims totaled \$168,500 in demonstration project reimbursement.

### **SAMPLE UNIT**

The sampling unit was one individual line item identifying a PDE record matched to a Part D demonstration project claim.

### **SAMPLE DESIGN**

We used discovery sampling.

### **SAMPLE SIZE**

We selected 46 matched claims.

### **SOURCE OF RANDOM NUMBERS**

The source of the random numbers was the Office of the Inspector General, Office of Audit Services Statistical software. We used the random number generator for selecting the sample items.

### **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the matched claims in our sampling frame from 1 to 3,443. After generating 46 random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

All 46 items in the sample were in error; we have sufficient evidence to question the amount in the sample frame, and we are 90 percent confident that the error rate in the population is at least 95 percent.

## APPENDIX B: SAMPLE RESULTS

	<b>Sample Frame Size</b>	<b>Dollar Value of Sample Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Improper Payments</b>	<b>Value of Improper Payments</b>
<b>Total</b>	3,443	\$168,500	46	\$2,423	46	\$2,423

**APPENDIX C: VIRGINIA COMMENTS**

May 18, 2010

Mr. Stephen Virbitsky  
Regional Inspector General, Audit Services  
Department of Health & Human Services  
Office of Inspector General, Audit Services  
150 S. Independence Mall West, Suite 316,  
Philadelphia, Pennsylvania 19106-3499

Dear Mr. Virbitsky:

This is in reference to your letter dated April 20, 2010, concerning the audit of Medicare Part D drugs dispensed to full benefit dual eligible beneficiaries and paid for by the Virginia Department of Medical Assistance Services (DMAS) during the period January 1, 2006 through March 8, 2006. The results of your audit asserts that the DMAS received improper payments for Medicare Part D drugs dispensed during the period January 1, 2006 through March 8, 2006. This is DMAS' response to your findings and recommendations.

DMAS participated in the Medicare demonstration project under §402(a)(1)(A) of the Social Security Amendments of 1967 (codified at 42 U.S.C. § 1395b-1(a)(1)(A) expressly applicable to Part D at § 1860D-42(b)). DMAS paid for dually eligible recipient drug claims through its Medicaid point-of-sale system and CMS reimbursed DMAS for the claims at Virginia's Medicaid rate. DMAS contracted with Health Management Services (HMS) to seek reimbursement for Medicaid claims from insurers who also provided coverage to Medicaid beneficiaries.

The OIG requested information on 3443 claims totaling \$192,023. Of the total sample, 46 of those claims were reviewed to determine whether DMAS received payments from a Part D sponsor and from CMS under the Medicare Part D 402 demonstration project for the same dispensing events. The OIG's audit of these claims determined that DMAS received Medicare Part D payments from both the Part D sponsor and CMS. Based on the results of the 46 claims sampled, the OIG subsequently concluded that DMAS received improper payment for the entire sample of 3443 claims totaling \$192,023.

**OIG Recommendations**

**1) Refund to CMS the \$192,023 in improper Medicare Part D demonstration project payments identified in the audit**

DMAS' Response

Concur there were improper payments – DMAS sampled the entire population of claims submitted under the Medicare Part D 402 Demonstration Project to determine if improper payments were made as identified during the OIG audit. A total of 85,716 claims were processed for payment by DMAS totaling \$5,492,369. DMAS' contractor, HMS, improperly rebilled and recovered \$286,388 from third party payors.

Part D Sponsors are contractually obligated to pay for full-benefit dually eligible beneficiaries' Part D drugs. According to DMAS' Third-Party Liability Manager, HMS marked the Part D claims so that they would not be pursued with Part D carriers; however, the eligibility files coming from the carriers to HMS resembled other insurance records, not being distinctively marked as Part D. In addition, HMS was not in receipt of any information from DMAS showing which claims had been reimbursed by CMS so HMS could not close them to recovery. Thus, HMS inadvertently billed and recovered \$286,388 of Demonstration Project funds from third-party payors (see Attachment A).

We sampled the recovery checks sent to DMAS by HMS in connection with the audit and found the reimbursements were posted to the CMS-64 Report using a 50%/50% split between Federal and State funds, (see Attachment A).

Based on DMAS' review of the entire population of claims submitted and processed under the Medicare Part D 402 Demonstration Project and the subsequent review of claims rebilled and recovered by DMAS' contractor, we believe the amount due to CMS to settle this matter is:

HMS Recoveries and DMAS Payments to CMS:

HMS Third Party Recoveries	(\$ 286,388)
Recoveries refunded to CMS by DMAS via CMS-64 Reporting	<u>143,194</u>
Balance Due To/(From) DMAS:	<u>(\$ 143,194)</u>

The second payment is required because CMS refunded 100% of the original claim amounts to DMAS, not 50% as would be customary.

We recommend that DMAS reimburse CMS in the amount of \$143,194 for Demonstration Project drug related claims activity of the period January 1, 2006 to March 8, 2006. The amount due will be reflected in the CMS-64 for the quarter ending June 30, 2010.

**2) work with CMS to determine and resolve other improper demonstration project payments received by Virginia for claims paid by other Part D sponsors**

DMAS' Response

Concur – DMAS reviewed all claims received under the Part D demonstration project for the period January 1, 2006 to March 8, 2006 and determined that \$143,194 of improper payments are due to CMS. See DMAS' response to OIG Recommendation #1 above.

Please contact Karen Stephenson at 804-786-5592 should you have questions or need additional information.

Sincerely,

/Cynthia B. Jones/  
Acting Director

enclosure