



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION V
233 NORTH MICHIGAN, SUITE 1360
CHICAGO, IL 60601

November 13, 2012

Report Number: A-05-12-00051

Mr. Joseph W. Keen
Vice President and Chief Compliance Audit Officer
United Healthcare Government Programs
9800 Health Care Lane MN006-W800
Minnetonka, MN 55343

Dear Mr. Keen:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Medicare Made Payments to United Healthcare of Wisconsin, Inc. Under Part D for Drugs That Were Already Covered Under Part C*. 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 <https://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jaime Saucedo, Audit Manager, at (312) 353-8693 or through email at

Page 2 – Mr. Joseph W. Keen

Jaime.Saucedo@oig.hhs.gov. Please refer to report number A-05-11-00051 in all correspondence.

Sincerely,

/Sheri L. Fulcher/
Regional Inspector General
for Audit Service

Enclosure

Direct Reply to HHS Action Official:

Timothy P. Love
Deputy Center Director
Centers for Medicare & Medicaid Services
Mail Stop C3-20-11
7500 Security Boulevard
Baltimore, MD 21244-1850

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE MADE PAYMENTS
TO UNITED HEALTHCARE
OF WISCONSIN, INC.
UNDER PART D FOR DRUGS
THAT WERE ALREADY
COVERED UNDER PART C**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Sheri L. Fulcher
Regional Inspector General**

**November 2012
A-05-11-00051**

Office of Inspector General

<https://oig.hhs.gov>

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

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act (BBA) of 1997, P.L. No. 105-33 established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, P.L. No. 108-173, revised Medicare Part C and renamed the program the Medicare Advantage (MA) program.

The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes monthly capitated payments to MA organizations for enrolled beneficiaries. MA organizations provide health care services to Medicare enrollees, including all medically necessary services that are allowable in the traditional Medicare fee-for-service program.

Title I of the MMA of 2003 amended Title XVIII of the Social Security Act by establishing the Medicare Part D voluntary prescription drug benefit for enrolled individuals. CMS contracts with prescription drug sponsors to provide the Part D benefit as a stand-alone drug plan. MA organizations provide this prescription drug coverage as part of an individual or group managed care plan, known as a Medicare Advantage Prescription Drug Plan (MA-PD). CMS provides a monthly prospective payment equal to the Part D plan's standardized bid, risk adjusted for health status, minus the monthly beneficiary premium. Part D excludes drugs covered under traditional Medicare, including drugs for beneficiaries in skilled nursing facilities (SNF) and inpatient hospitals or in the case of a MA-PD, drugs already covered by the MA organization's plan benefits.

Medicare Part D requires that for every prescription filled, drug sponsors must submit an electronic summary record, called the prescription drug event (PDE), to CMS. The PDE record contains information that CMS uses to reconcile monthly subsidy payments made to drug sponsors with actual program cost data. Within the PDE record, the gross drug costs and other payment data enable CMS to make payments to drug sponsors and administer the Part D benefit. PDE records are then stored in the Integrated Data Repository that also accumulates summary data used in payment reconciliation. While enrolled in a Medicare Part D prescription drug plan, most beneficiaries are responsible for certain costs which may include a monthly premium, an annual deductible, and coinsurance or copayments.

United Healthcare of Wisconsin, Inc., doing business as Evercare by United Healthcare (United) located in Minnetonka, Minnesota, is a MA organization that entered into contract number H5253 with CMS. For calendar year 2008, CMS made payments under this contract for United's seven MA and MA-PD plans. We reviewed all plans with institutional enrollment under contract H5253.

OBJECTIVE

Our objective was to determine whether Medicare Part D paid United for drugs for MA beneficiaries during SNF or inpatient hospital stays that were covered under Part C in 2008.

SUMMARY OF FINDING

The Medicare Part D program incurred drug costs for MA beneficiaries during SNF and inpatient hospital stays that were covered under Part C in 2008. Of the 999 institutionalized beneficiaries in United's contract H5253, 409 received Medicare SNF or inpatient hospital services during calendar year 2008. Of these 409 beneficiaries, 1,559 PDEs were submitted by United for 234 beneficiaries during their SNF or inpatient hospital stay. As a result, \$76,367 in Part D gross drug costs were incurred, which had an overpayment effect of \$53,439 to the Federal Government. Within the gross drug cost amount, patients paid \$1,505 in copayments that should have been paid by United had Medicare Part D not been billed for these drug costs. United attributed the duplicate payment amounts to a lack of knowledge of the beneficiary's status by pharmacies providing the drugs to the nursing facilities' resident population.

RECOMMENDATIONS

We recommend that United:

- refund to the Federal Government the \$53,439 identified in overpayments, and
- work with CMS to remove the 1,559 PDE records identified with Part D gross drug costs totaling \$76,367 from the Integrated Data Repository.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

United agreed with our finding and recommendations and agreed to remove the 1,559 PDE records from the Integrated Data Repository and to refund the \$53,439 to the Federal Government, which included \$1,505 to impacted beneficiaries.

United had inadvertently requested that we remove the words "inpatient hospital" from specific areas in our draft report. As an attachment to its response, United requested that we reincorporate the words "inpatient hospital" into our final report. We adjusted our report accordingly to reflect this request. With the exception of the highlighted attachment, United's comments are included in the Appendix.

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INTRODUCTION

BACKGROUND

Medicare Advantage Program

The Balanced Budget Act (BBA) of 1997, P.L. No. 105-33 established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, P.L. No. 108-173, revised Medicare Part C and renamed the program the Medicare Advantage (MA) program. Participating MA organizations include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for service plans.

The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, makes monthly capitated payments to MA organizations for enrolled beneficiaries. Except for hospice care, MA organizations provide managed health care covered services to Medicare enrollees, including all medically necessary services that are allowable in the traditional Medicare fee-for-service program. These services include Part D prescription drugs that the MA plan includes as part of its MA bid.

MA organizations cover skilled nursing care and inpatient hospital services furnished by Skilled Nursing Facility (SNF) and inpatient hospital providers. MA organizations pay SNF and inpatient hospital providers, typically a per diem rate, to supply a skilled level of care, including nursing care and physical, occupational, and speech therapies. These payments also cover drugs and biologicals furnished by the facility for use in the facility for the care and treatment of beneficiaries.

Medicare Part D Program

Title I of the MMA of 2003 amended Title XVIII of the Social Security Act by establishing the Medicare Part D voluntary prescription drug benefit for enrolled individuals. CMS contracts with prescription drug sponsors to provide the Part D benefit as a stand-alone drug plan. MA organizations provide this prescription drug coverage as part of an individual or group managed care plan, known as a Medicare Advantage Prescription Drug Plan (MA-PD).

CMS provides a monthly prospective payment equal to the Part D plan's standardized bid, risk adjusted for health status, minus the monthly beneficiary premium. Part D excludes drugs covered under traditional Medicare, including drugs for beneficiaries in SNFs and inpatient hospitals or in the case of a MA-PD, drugs already covered by the MA organization's plan benefits. Under Part D, each drug sponsor creates a list of covered drugs, known as a formulary. Certain drugs are excluded from Part D such as benzodiazepines, barbiturates, weight management drugs, and over-the-counter drugs.

Prescription Drug Events

Medicare Part D requires that for every prescription filled, drug sponsors must submit an electronic summary record, called the prescription drug event (PDE), to CMS. The PDE record contains information that CMS uses to reconcile monthly subsidy payments made to drug sponsors with actual program cost data. PDE records are then stored in the Integrated Data Repository that also accumulates summary data used in payment reconciliation. After year end, prospective payments are used in risk sharing calculations. In risk sharing, the prospective payments are compared to actual payments for the basic benefit that are reported on PDE records.

Gross Drug Costs

Within the PDE record, the gross drug costs¹ and other payment data enable CMS to make payments to drug sponsors and administer the Part D benefit. While enrolled in a Medicare Part D prescription drug plan, most beneficiaries are responsible for certain costs which may include a monthly premium, an annual deductible, and coinsurance or copayments.

United Healthcare of Wisconsin, Inc.

United Healthcare of Wisconsin, Inc., doing business as Evercare by United Healthcare (United) located in Minnetonka, Minnesota, is a MA organization that entered into contract number H5253 with CMS. For calendar year 2008, CMS made payments under this contract for United's seven MA and MA-PD plans. We reviewed all plans with institutional enrollment under contract H5253.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare Part D paid United for drugs for MA beneficiaries during SNF or inpatient hospital stays that were covered under Part C in 2008.

Scope

Our review covered all drugs paid by CMS for Medicare Part D beneficiaries while they were in SNF or inpatient hospital stays. We reviewed approximately \$6.8 million of calendar year 2008 gross drug costs related to United's 999 institutionalized beneficiaries in Medicare Part D, contract H5253. Of these 999 beneficiaries, 409 had Medicare SNF or inpatient hospital stays in 2008 and 234 had 1,559 PDEs during their stay.

¹ CMS's *Updated Instructions: Requirements for Submitting Prescription Drug Event Data*, April 27, 2006, section 7.2.3, defines gross drug costs as the sum of the following six PDE payment fields: covered plan paid amount, non-covered plan paid amount, patient pay amount, low income cost-sharing payment, other true out-of-pocket costs, and patient liability reduction due to other payer amount.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance regarding payments to MA organizations;
- interviewed MA organization officials to obtain an understanding of the organization's MA and Part D reimbursement system;
- identified 999 Medicare institutional beneficiaries under contract H5253 in calendar year 2008;
- identified 409 of the 999 institutionalized beneficiaries as having had a SNF or inpatient hospital stay in calendar year 2008;
- compared SNF and inpatient hospital claims with PDEs for these 409 beneficiaries to identify any PDEs on the days while in a SNF or inpatient hospital stay indicating a Medicare Part D payment; and
- quantified gross drug costs for any Medicare Part D payments for which Medicare Part C covered as part of the monthly capitated payment to United for enrolled MA beneficiaries.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

The Medicare Part D program incurred drug costs for MA beneficiaries during SNF and inpatient hospital stays that were covered under Part C in 2008.

FEDERAL REQUIREMENTS

Pursuant to the Social Security Act, § 1860D-2(e)(2)(B), implementing regulations at 42 CFR § 423.100, and Chapter 6, section 20.2 of the Prescription Drug Benefit Manual, Part D excludes drugs normally covered under traditional Medicare fee-for-service. This includes drugs for beneficiaries in SNFs and inpatient hospitals or in the case of a MA-PD, drugs already covered by the MA organization's plan benefits.

DUPLICATE GROSS DRUG COSTS

Of the 999 institutionalized beneficiaries in United's contract H5253, 409 received Medicare SNF or inpatient hospital services during calendar year 2008. Of these 409 beneficiaries, 1,559 PDE records were submitted by United for 234 beneficiaries during their SNF or inpatient hospital stay. As a result, \$76,367 in Part D duplicate gross drug costs were incurred, which had an overpayment effect of \$53,439 to the Federal Government. Within the gross drug amount, patients paid \$1,505 in copayments that should have been paid by United had Medicare Part D not been billed for these drug costs.

CAUSE OF DUPLICATE PAYMENTS

United attributed the duplicate payment amounts to a lack of knowledge of the beneficiary's status by pharmacies providing the drugs to the nursing facilities' resident population. United stated that in correlating payments, it relies on SNFs to properly inform the pharmacies regarding the current beneficiary status. Additionally, without access to the necessary information to make this determination, United did not want to improperly deny prescription drug transactions and interrupt members' access to necessary drugs.

RECOMMENDATIONS

We recommend that United:

- refund to the Federal Government the \$53,439 identified in overpayments, and
- work with CMS to remove the 1,559 PDE records identified with Part D gross drug costs totaling \$76,367 from the Integrated Data Repository.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

United agreed with our finding and recommendations and agreed to remove the 1,559 PDE records from the Integrated Data Repository and to refund the \$53,439 to the Federal Government, which included \$1,505 to impacted beneficiaries.

United had inadvertently requested that we remove the words "inpatient hospital" from specific areas in our draft report. As an attachment to its response, United requested that we reincorporate the words "inpatient hospital" into our final report. We adjusted our report accordingly to reflect this request. With the exception of the highlighted attachment, United's comments are included in the Appendix.

APPENDIX

APPENDIX: AUDITEE COMMENTS



Office of Inspector General (OIG) Audit
Corrective Action Plan (CAP)
October 17, 2012

Medicare Made Payments to UnitedHealthcare of Wisconsin Under Part D for Drugs That Were Already Covered Under Part C

OIG Findings – Duplicate Gross Drug Costs

DUPLICATE GROSS DRUG COSTS

Of the 999 institutionalized beneficiaries in United's contract H5253, 409 received Medicare SNF services during calendar year 2008. Of these 409 beneficiaries, 1,559 PDE records submitted by United for 234 beneficiaries during their SNF stay. As a result, \$76,367 in Part D duplicate gross drug costs were incurred, which had an overpayment effect of \$53,439 to the Federal Government. Within the gross drug amount, patients paid \$1,505 in copayments that should have been paid by United had Medicare Part D not been billed for these drug costs.

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OIG Recommendation:

We recommend that United:

- Refund to the Federal Government the \$53,439 identified in overpayments, and
- Work with CMS to remove the 1,559 PDE records identified with Part D gross drug costs totaling \$76,367 from the Integrated Data Repository.

United Response to Findings and Corrective Action Requirements:

United agrees with the OIG's findings that the 1,559 PDEs identified were in fact filled during the beneficiary's Part A stay. However, not all of these PDEs were filled during a SNF stay, some were filled during an inpatient hospital stay. United has reversed these claims within our systems and will submit the PDE deletions to remove the identified PDE records from the Integrated Data Repository.

In CMS guidance dated May 29, 2012, CMS notified Part D plan sponsors that CMS expects to perform the 2008 reopening sometime in the 1st Quarter of 2013 (SUBJECT: Additional Guidance on the Reopening of the Coverage Year 2006, 2007, and 2008 Part D Payment Reconciliations). Once CMS completes the 2008 Reopening and Payment Reconciliation in the 1st Quarter of 2013, CMS will automatically recoup the \$51,934 overpayment within the reconciliation. Since the \$1,505 in patient pay was not overpaid by CMS, these funds would not automatically go to CMS during the reconciliation. United proposes that the \$1,505 overpaid patient paid amount be refunded to the beneficiaries by United. As such, United would refund the full \$53,439 overpaid amount to the impacted parties.

United had inadvertently requested to remove "inpatient hospital" from the audit objective previously and after further review, United would like to include "inpatient hospital" stays as part of the objective since some of the PDEs identified by OIG were associated with hospital stays. United is requesting OIG to make changes to the attached PDF draft report on the highlighted sections of the report.