DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

September 25, 2006

Report Number: A-06-06-00014

Gena Gilliam
aClaim, Inc.
1540 H Wade Hampton Blvd.
Greenville, South Carolina 29609

Dear Ms. Gilliam:

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 aClaim, Inc." 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-06-06-00014 in all correspondence.

Sincerely,

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.
Mail Stop C4-23-07
Baltimore, Maryland 21244-1850

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE MEDICARE DRUG DISCOUNT CARD PROGRAM SPONSOR ACLAIM, INC.

Daniel R. Levinson
Inspector General

September 2006
A-06-06-00014

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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.

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 amount 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 made to the pharmacies, sponsors withdrew funds from 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 any funds used for excluded drugs.

AClaim, Incorporated

AClaim, Inc. (aClaim), a pharmacy benefit manager in Greenville, South Carolina, offered a drug discount card to eligible Medicare beneficiaries.

[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.

Transition to Medicare Part D

CMS requires prescription drug plan (PDP) sponsors in the Medicare Part D drug program to ensure that:

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

During our audit, aClaim indicated that it did not plan to participate in the Part D program. However, if aClaim decides to participate, CMS will require it to follow the above requirements.

OBJECTIVES

Our objectives were to determine whether aClaim 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, (4) support the expenditures and withdrawals it reported to CMS, and (5) ensure that beneficiaries were enrolled when aClaim filed their claims.

SUMMARY OF FINDINGS

AClaim properly supported the expenditures it made on behalf of beneficiaries and the withdrawals from the Payment Management System. For the 45 claims reviewed for enrollment, all of the beneficiaries were enrolled at the time of the service. However, aClaim 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.

As a result, CMS overpaid aClaim $792 for beneficiaries who exceeded their TA limits and $8,008 for excluded drugs for the period July 12, 2004, through July 31, 2005. AClaim identified $4,988 it paid for excluded drugs using the guidelines in the August 29, 2005, memo from CMS. However, it did not provide any documentation to show that it refunded this amount to CMS.

RECOMMENDATIONS

We recommend that aClaim:

- reimburse CMS for the $792 by which it exceeded TA fund limits;

- determine whether the amount aClaim reimbursed CMS for excluded drugs included any of the $8,008 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 the beneficiaries.

ACLAIM'S COMMENTS

In its written comments on our draft report, aClaim did not agree with any of our findings or recommendations.

AClaim's comments are included in their entirety in the Appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We reviewed additional TA documentation aClaim provided and do not agree with aClaim's assertion that only three beneficiaries exceeded their TA fund limits. We did, however, reduce the amount aClaim should reimburse CMS from $3,712 to $792.

We believe that our audit finding regarding excluded drugs is correct and that aClaim should reimburse CMS the $8,008 in excluded drugs identified in the audit.

TABLE OF CONTENTS

Page

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 for 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 funds 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 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.

AClaim, Incorporated

AClaim, Inc. (aClaim), a pharmacy benefits manager in Greenville, South Carolina, offered a drug discount card to eligible Medicare beneficiaries.

Transition to Medicare Part D

CMS requires prescription drug plan (PDP) sponsors in the Medicare Part D drug program to ensure that:

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

During our audit, aClaim indicated that it did not plan to participate in the Part D program. However, if aClaim decides to participate, CMS will require it to follow the above requirements.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether aClaim 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, (4) support the expenditures and withdrawals it reported to CMS, and (5) ensure beneficiaries were enrolled when aClaim filed their claims.

Scope

For the period June 2004 through May 2005, aClaim submitted TA expenditure claims to CMS totaling approximately $7.3 million. We limited our review of the drug discount card program to claims paid with TA subsidies

We reviewed the drug prices aClaim 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 aClaim offered beneficiaries the prices negotiated with drug manufacturers and pharmacies, we repriced the negotiated prices aClaim claimed on 200 sampled claims by using the pricing methodology set forth in its contracts. As part of our audit, we:

- did not perform a detailed review of aClaim's internal controls because the audit objectives did not require it,
- used aClaim's payment data, and
- reviewed the enrollment data aClaim provided.

We performed the audit at aClaim's office in Greenville, South Carolina.

Methodology

To perform our audit we:

- obtained aClaim bank records 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 aClaim'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 a judgmental sample of 45 claims to determine whether the beneficiaries were enrolled in the drug discount card program when the prescriptions were filled;

- reviewed the contracts between aClaim and CMS, manufacturers, and pharmacies; and

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

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

FINDINGS AND RECOMMENDATIONS

AClaim properly supported the expenditures it made on behalf of beneficiaries and the withdrawals from Payment Management System. For the 45 claims we reviewed for enrollment, all of the beneficiaries were enrolled when the prescriptions were filled. However, aClaim 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.

As a result, CMS overpaid aClaim $792 for beneficiaries who exceeded their TA limits and $8,008 for excluded drugs for the period July 12, 2004, through July 31, 2005. AClaim identified $4,988 it paid for excluded drugs using the guidelines in the August 29, 2005, memo from CMS; however, it did not provide any documentation to show that it repaid this amount to CMS.

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 amount not used during 2004 to the 2005 benefit.

Transitional Assistance Limits Exceeded

For the period June 2004 through July 2005, aClaim allowed 4 beneficiaries to exceed their TA fund limits. For 2004, the amount exceeding the TA fund limits was $115 for 1 beneficiary. For 2005, the amount exceeding the TA fund limits ranged from $65 to $507 for 3 beneficiaries. No beneficiaries exceeded their TA fund limits in both 2004 and 2005.

Inadequate Procedures

AClaim did not have adequate procedures in place to ensure that beneficiaries did not exceed their TA fund limits as required by the MMA.

Excess Transitional Assistance Funds

Because aClaim did not have adequate procedures in place to limit beneficiaries to their TA funds limits, aClaim overpaid $792 for 4 beneficiaries. Specifically, aClaim paid:

- $115 for 1 beneficiary who exceeded their TA fund limits in 2004 and
- $677 for 3 beneficiaries who exceeded their TA funds 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 drug." 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 used for excluded drugs.

Transitional Assistance Funds Used for Statutorily Excluded Drugs

From July 12, 2004, to July 31, 2005, aClaim charged CMS for 329 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

AClaim paid for excluded drugs because its edits were not based on the NDC. Instead, aClaim used the following third-party information: restriction codes, therapeutic category codes, Generic Product Identifier codes, and RX/OTC indicators. By not initially using the NDC codes to identify excluded drugs, aClaim was not able to identify all of the drugs that were statutorily excluded from the program.

Charged for Statutorily Excluded Drugs

Because aClaim did not use the NDC to ensure that it excluded unallowable drugs, CMS overpaid aClaim $8,008 for 329 claims. Based on the guidelines that CMS issued to the drug card sponsors on August 29, 2005, the breakdown of claims aClaim submitted to CMS for statutorily excluded drugs is:

- $4,762 for 178 claims made from July 12 through December 3, 2004; and
- $3,246 for 151 claims made from December 4, 2004, through July 31, 2005.

AClaim identified $4,988 it paid for excluded drugs using the guidelines in the August 29, 2005, memo from CMS; however, it did not provide any documentation to show that it refunded this amount to CMS.

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. AClaim's contracts with drug manufacturers specified the amount of the rebates that aClaim should have passed on to the beneficiaries and what amount it should have kept.

Negotiated Prices Were Not Passed On to Beneficiaries

AClaim did not always comply with the Federal requirements and aClaim 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 245 claims we reviewed, 13 had the following errors related to negotiated prices:

- Three claims totaling $23.21 did not include the correct amount of the manufacturer rebate as required by the contracts.

- On six claims, aClaim used incorrect pricing information and charged the beneficiary $57.49 more than the lower of the negotiated price or the usual and customary price.

- For two claims, aClaim used incorrect pricing data.

- For two claims, the rebate amount in the contract with one manufacturer was different from the amount listed by aClaim.

Inadequate Procedures

AClaim did not have adequate procedures in place to ensure that it complied with MMA's requirement to pass on negotiated prices to beneficiaries and charge the lower of the negotiated prices or the usual and customary prices.

Claims Billed Incorrectly

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

RECOMMENDATIONS

We recommend that aClaim:

- reimburse CMS for the $792 by which it exceeded TA fund limits;

- determine whether the amount aClaim reimbursed CMS for excluded drugs included any of the $8,008 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 the beneficiaries.

ACLAIM'S COMMENTS

In its written comments on our draft report, aClaim did not agree with any of our findings or recommendations.

AClaim stated that it conducted its own review to determine the amount by which it had exceeded TA fund limits and determined that only three beneficiaries had exceeded their TA fund limits. Therefore, aClaim stated that the amount by which beneficiaries exceeded their TA fund limits totaled $157.83 but did not indicate whether it would refund this amount.

AClaim stated that our determination that the NDC was not used to ensure that it excluded unallowable drugs was incorrect. AClaim stated that its "adjudication system requires an NDC-specific record for processing prescription claims for drug exclusions." AClaim said that "Medicare did not provide vendors with standard drug identifiers or NDC's until November 2004. Many of the intended exclusions were still not identified in the supplied file and remained unidentified until August 2005. Medicare's failure to provide specific information needed by processors for the accurate processing of prescription claims should not be viewed as a failure by processors to implement programs to exclude products not intended for payment by Medicare." AClaim stated that "NO PRESCRIPTION CLAIMS for NDC's excluded by Medicare were paid by aClaim after receipt of the NDC data from Medicare." AClaim said that, based on the information we provided, it "over-reimbursed" Medicare $5,107.26.

AClaim also stated that it would not participate in the Part D program in the future. AClaim's comments are included in their entirety in the Appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Based on additional TA documentation aClaim provided after we completed our draft report, we still do not agree with aClaim's assertion that only three beneficiaries exceeded their TA fund limits. However, we changed our finding to reflect claim reversals and information from CMS that included TA amounts for beneficiaries who had moved from one sponsor to another. The original enrollment data did not indicate whether a beneficiary had transferred to aClaim from another sponsor. The additional data showed the day the beneficiary enrolled in the drug card program, not with a particular sponsor. Thus, some beneficiaries were entitled to more TA funds than the original data had indicated. Therefore, we changed our recommendation, reducing the amount aClaim should reimburse CMS for exceeding TA fund limits from $3,712 to $792.

We believe that our audit finding regarding excluded drugs is correct. We based our analysis of the data on guidance CMS issued to drug card sponsors on August 29, 2005. In this guidance, CMS directed "all Medicare-endorsed prescription drug discount card sponsors to perform a review of excluded drugs which were paid for using Federal transitional assistance (TA) funds and refund the improper TA drawn-down to the

Division of Payment Management (DPM) in the Health and Human Services Program Support Center." The drug card sponsors were supposed to have used the drug lists published on July 12, 2004; November 4, 2004; and August 5, 2005. Because our audit period ended on July 31, 2005, we used the lists for July 12, 2004, and November 4, 2004, to determine the amount that had been paid for excluded drugs. Therefore, we believe that aClaim should reimburse CMS the $8,008 in excluded drugs we identified in the audit.

APPENDIX

1540-H Wade Hampton Blvd. • Greenville,SC 29609

July 20, 2006

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

RE: Report Number A-06-06-00014

Dear Mr. Sato:

We are in receipt of the above reference report and respectfully submit the following regarding the "validity of the facts and reasonableness of the recommendations" contained in the report.

1. "Summary Of Findings":

Your report states that aClaim 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.

aClaim asserts that it did have proper procedures in place to ensure compliance with Federal requirements and that there were a statistically insignificant number of occurrences during the course of its participation in the program that resulted in improper adjudication.

We reinvestigated the TA fund expenditures for all of the beneficiaries supplied in the file enclosed with the above referenced report. We have attached files for each beneficiary which the report stated received more than $ 0.13 in excessive TA Funds. The attached spreadsheet contains a complete listing of each transaction processed for

each beneficiary and the balance available when presented. Each tab within the worksheet represents an individual beneficiary from the file provided. aClaim had only three beneficiaries, throughout the entire program that EXCEEDED their allotted TA funds. None of these three were included in the spreadsheet provided with your report. aClaim's policies and procedures ensured that ONLY three program errors, in the calculation of TA funds, occurred during the entire course of the Medicare Discount Drug Card Program.

In keeping with industry standards, aClaim adjudicates prescription claims using dollar amounts rounded to five (5) decimal places. The differences calculated by the auditor's that resulted in overages of $ 0.13 or less are the result of mathematical rounding. Of the 1,813 cases reported as exceeding the TA allotment, 800 were reported by the auditor's as being overpaid by $ 0.01. Additionally, 1,793 of the reported cases were shown as being overpaid by less than $ 00.11. aClaim's system calculated the available balance for each beneficiary prescription upon presentation for adjudication, using five decimal place dollar fields. Rounding dollar fields on each claim to two decimal places inevitably produces totals that are erroneously inflated.

The statement under "Charged for Statutorily Excluded Drugs" that "aClaim did not use the NDC to ensure that it excluded unallowable drugs…" is incorrect. aClaim's adjudication system requires an NDC specific record for processing prescription claims for drug exclusions. When the Medicare Discount Drug Card program began in June 2004, vendors were instructed to use the list posted in the final legislation to identify exclusions. This list contained only a generic description of drug categories that were intended to be excluded under the Medicare Discount Drug Card Program. Prescription claims processing standards dictate that adjudication of drug eligibility be based on nationally published/available code sets, i.e. NDC, GPI (MediSpan copyrighted classification), Third Party Exclusion Codes, etc. Medicare did not provide vendors with standard drug identifiers or NDC's until November 2004. Many of the intended exclusions were still not identified in the supplied file and remained unidentified until August 2005. Medicare's failure to provide specific information needed by processors for the accurate processing of prescription claims should not be viewed as a failure by processors to implement programs to exclude products not intended for payment by Medicare. aClaim used all means available to identify the drug products intended for exclusion on the list provided. aClaim used Medispan's GPI and Third Party Exclusion Codes to identify specific NDC numbers to exclude where appropriate and available. There were no commercially/universally available standard elements to identify some of the descriptions supplied in the Final Rule, for example, "agents when used for the symptomatic relief of cough and cold" and "prescription mineral products". There were also combination products, later identified by Medicare and excluded by NDC, which contained traces of excluded drugs like barbiturates which were not labeled by standard coding methodology that would allow processors to identify the inclusion of the excluded product. aClaim enlisted the assistance of First Databank personnel, prior to the June 2004 program startup in its efforts to comply with the excluded drug stipulations. Medispan's GPI was chosen for the identification of individual NDC's within a drug classification because of the specificity this method provided. aClaim's adjudication,

while allowing identification of drugs through means other than the NDC, uses only NDC's as the criteria for drug exclusion adjudication. NO PRESCRIPTION CLAIMS for NDC's excluded by Medicare were paid by aClaim after receipt of the NDC data from Medicare.

The statement made under the heading "Negotiated Prices Were Not Passed On to Beneficiaries is not substantiated by any data. Specifically:

> Three claims totaling $ 23.21 did not include the correct amount of the manufacturer rebate as required by contracts.
>
> For two claims, aClaim used incorrect pricing data.
>
> For two claims, the rebate amount in the contract with one manufacturer was different from the amount listed by aClaim.

None of the above mentioned errors were pointed out during the on-site audit and data to support these allegations was not included with the receipt of the above referenced report. aClaim has no knowledge of any instances in which the accusations stated above occurred in the processing of prescriptions for the Medicare Program.

The statement that "On six claims, aClaim used incorrect pricing information and charged the beneficiary $57.49 more that the lower of price was discussed with the auditors during the on-site visit. It was explained that due to a programming change, one of the parameters which edited Medicare Discount Drug Card claims to ensure that the lower of negotiated or the usual and customary price was charged was found to be malfunctioning. It was aClaim's policies and procedures that caused this error to be promptly detected. The malfunction allowed beneficiaries to be charged the negotiated price, without regard to the U&C submitted. This was discovered by aClaim and immediately remedied. The error in programming only affected prescription claims processed during a 26-hour window of time.

Based on the information supplied, aClaim disputes and does not intend to reimburse CMS for the $ 3,712 which was claimed to have exceed TA fund limits. aClaim's documentation proves that there were only three (3) cases during the entire course of the program where beneficiaries were allowed to exceed TA fund limits. The last three tabs on the spreadsheet supplied, detail these the expenditures for these (3) beneficiaries. The amount which aClaim allowed to exceed TA Fund limits for these three beneficiaries totals $ 157.83.

aClaim has included a review of the excluded drugs tables supplied with the above referenced report. As discussed above, aClaim took reasonable care and used due diligence in identifying drugs which were intended to be excluded from payment in the Medicare Prescription Drug Card Program. aClaim processed ZERO claims for excluded NDC's once this data was provided. The attached spreadsheets outline the AVAILABLE STANDARD drug categorization for drugs claimed in the report to have been paid in

error, prior to the issuance of NDC numbers by Medicare. The highlighted cells represent drugs which aClaim acknowledge it did in fact, allow to be processed and should have been excluded using available technology. Un-highlighted cells represent drugs in classifications did NOT violate any of the "exclusions" listed in the Final Legislation and therefore were paid – in good faith – by aClaim. Based on the data supplied by the Auditor, aClaim over-reimbursed Medicare in the amount of $5,107.26.

The difference between the amount due by aClaim for TA Fund limit overages and the excluded drug payment by aClaim totals $ 4,949.43. Please advise how these funds will be forwarded to aClaim.

aClaim, is not now and will not in the future be a participant in Medicare Part D, or any other prescription drug program offered under the US Department of Health and Human Services. The recommendation by the auditor for aClaim to implement changes is unfounded and unnecessary.

Sincerely,

Gena Harbert Gilliam
President
aClaim, Inc.

enclosure: CD – password = same as provided to aClaim with report