



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

October 2, 2008

Report Number: A-02-08-01008

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, New York 12237

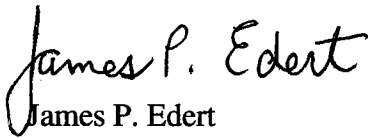
Dear Dr. Daines:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of New York State's Compliance With the 'Reimbursement of State Costs for Provision of Medicare Part D Drugs' Demonstration Project Requirements." We will forward a copy of this report to the HHS action official noted below.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please direct them to the HHS action official noted on the following page. Please refer to report number A-02-08-01008 in all correspondence.

Sincerely,


James P. Edert
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Abby L. Block, Consortium Administrator
Consortium for Medicare Health Plans Operations
200 Independence Avenue, SW
Mail Stop 325-H-01
Washington, DC 20201

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF NEW YORK STATE'S
COMPLIANCE WITH THE
"REIMBURSEMENT OF STATE
COSTS FOR PROVISION OF
MEDICARE PART D DRUGS"
DEMONSTRATION PROJECT
REQUIREMENTS**



Daniel R. Levinson
Inspector General

October 2008
A-02-08-01008

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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 by establishing the Medicare Part D prescription drug benefit which provides optional prescription drug coverage for individuals who are entitled to Medicare Part A or enrolled in Part B. The Centers for Medicare & Medicaid Services (CMS), which administers Medicare, contracts with private prescription drug plans and Medicare Advantage plans to offer prescription drug benefits to eligible individuals.

With the implementation of Medicare Part D on January 1, 2006, prescription drug coverage for full benefit dual eligible (dual eligible) beneficiaries was transitioned from Medicaid coverage to the new Medicare prescription drug benefit. Some States, however, found it necessary to provide additional funding assistance to its dual eligible population in order to facilitate their transition into Medicare Part D. To reimburse States for drug costs incurred on behalf of dual eligible beneficiaries during the transition, 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 (codified at 42 U.S.C. section 1395b-1(a)(1)(A) and expressly made applicable to Part D in section 1860D-42(b)). This voluntary demonstration project permitted Medicare to reimburse States for dual eligible beneficiaries’ Part D drug costs to the extent that those costs were not recoverable from a Medicare Part D plan. In addition, the demonstration project also provided payments to States for low-income subsidy-entitled beneficiaries’ (non-full benefit dual eligible) Part D drug costs and for certain administrative costs incurred by States.

OBJECTIVE

Our objective was to determine whether New York State (New York) complied with the CMS “Reimbursement of State Costs for Provision of Part D Drugs” demonstration project requirements related to reimbursed drug claims for full benefit dual eligible beneficiaries.

RESULTS OF AUDIT

New York complied with CMS’s demonstration project requirements related to reimbursed drug claims for dual eligible beneficiaries. New York utilized its Medicaid payment system to separate the demonstration claims from those payable under its Medicaid program. New York also utilized its Medicaid system to properly identify beneficiaries as being dually eligible for both Medicare and full Medicaid benefits and to appropriately pay claims through the demonstration project. New York ensured that all claims reimbursed through the demonstration project were within its approved demonstration period of January 1 through March 31, 2006. We are not submitting recommendations to New York.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Prescription Drug, Improvement, and Modernization Act of 2003	1
Full Benefit Dual Eligible Beneficiaries	1
Demonstration Project	1
New York’s Participation in the Demonstration Project	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology.....	3
RESULTS OF AUDIT	4

INTRODUCTION

BACKGROUND

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 amended Title XVIII of the Social Security Act by establishing the Medicare Part D prescription drug benefit which provides optional prescription drug coverage for individuals who are entitled to Medicare Part A or enrolled in Part B. The Centers for Medicare & Medicaid Services (CMS), which administers Medicare, contracts with private prescription drug plans and Medicare Advantage plans to offer prescription drug benefits to eligible individuals.

As defined by the MMA, Medicare Part D covered drugs are: drugs available only by prescription, used and sold in the United States, and used for a medically accepted indication; biological products; insulin; and vaccines. The definition also includes medical supplies associated with the injection of insulin (e.g., syringes, needles, alcohol swabs, and gauze). Certain drugs or classes of drugs or their medical uses are excluded by law from Medicare Part D coverage. While these drugs or uses are excluded from basic Medicare Part D coverage, drug plans may choose to include them as part of supplemental benefits, not covered by Medicare. Some States may also choose to cover these excluded drugs through their Medicaid programs.

Full Benefit Dual Eligible Beneficiaries

Full benefit dual eligible (dual eligible) beneficiaries are eligible for both Medicare and comprehensive Medicaid benefits. Pursuant to Title I, Sec.103(c) of the MMA and with the implementation of Medicare Part D on January 1, 2006, prescription drug coverage for dual eligible beneficiaries transitioned from Medicaid to Medicare Part D.

To ensure that dual eligible beneficiaries continued to receive needed medications during the transition, CMS took numerous actions to prevent a lapse in prescription drug coverage. For example, if dual eligible beneficiaries did not choose a prescription drug plan by December 31, 2005, CMS randomly assigned them to one (auto-assignment). CMS implemented a new eligibility inquiry process for pharmacies to verify Part D plan assignments and employed contractors to facilitate enrollment at the point-of-sale.

Despite CMS's best efforts to promote a smooth transition to Medicare Part D, some dual eligible beneficiaries, when presenting prescriptions at pharmacies, were determined not to be enrolled in a Part D plan or a Part D plan could not be billed. Therefore, some States found it necessary to provide assistance to dual eligible beneficiaries during the transition period by paying for these beneficiaries' Medicare Part D drugs.

Demonstration Project

To reimburse States for drug costs incurred on behalf of dual eligible beneficiaries during the transition, 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 (codified at 42 U.S.C. section 1395b-1(a)(1)(A) and expressly made applicable to Part D in section 1860D-42(b)). This voluntary demonstration project permitted Medicare to reimburse States for dual eligible beneficiaries' Part D drug costs to the extent that those costs were not recoverable from a Medicare Part D plan. In addition, the demonstration project also provided payments to States for low-income subsidy-entitled beneficiaries' (non-full benefit dual eligible) Part D drug costs and for certain administrative costs incurred by States.

To participate in the demonstration and receive reimbursement for their incurred costs, States submitted applications to CMS. The application included requirements for participation. By submitting applications, States agreed to: 1) require pharmacies to bill the Part D plan first before relying on State payment (the State was the payer of last resort); 2) provide information on Part D drug claims and administrative costs incurred in a specified format; 3) ensure that claims submitted were for Part D drugs; 4) separate claims from those payable under other programs, such as the State Medicaid program; 5) submit claims only for drug costs (not including beneficiary cost sharing and administrative costs incurred during the demonstration effective dates 6) report to CMS on the number of claims, beneficiaries, and expenditures on a timely basis; and 7) ensure Medicare funding was not used for the Medicaid State match.

New York's Participation in the Demonstration Project

On February 3, 2006, New York applied to participate in the demonstration project.¹ By participating, New York agreed to pay for dual eligible beneficiaries' drug claims that should have been paid under Medicare Part D. New York processed these drug claims through its Medicaid claims processing system. CMS subsequently reimbursed New York for these drug claims at New York's Medicaid rate.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective was to determine whether New York State (New York) complied with the CMS "Reimbursement of State Costs for Provision of Part D Drugs" demonstration project requirements related to reimbursed drug claims for full benefit dual eligible beneficiaries.

Scope

The audit covered New York's approved demonstration period, January 1 through March 31, 2006. At the time of our audit, CMS approved reimbursement of 1,220,131 drug claims totaling \$117,095,637.43 for dual eligible beneficiaries. We reviewed only those internal controls necessary to achieve our objective.

We performed fieldwork at the New York State Department of Health's headquarters in Albany, NY from April 2008 through August 2008.

¹ New York's participation in the demonstration project was retroactive to the implementation of Medicare Part D on January 1, 2006.

Methodology

To accomplish our objective, we:

- reviewed applicable laws, regulations, and guidance;
- interviewed New York State Department of Health officials to obtain an understanding of New York's Medicaid drug program, the process used to identify dual eligible beneficiaries and the process used to prepare and submit claims under the demonstration project;
- obtained the reimbursed claims file for dual eligible beneficiaries for claims paid under the demonstration project for the period January 1 through March 31, 2006;
- obtained the CMS Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64) for prescribed drugs, for all four quarters in 2006;
- compared all claims reimbursed under the demonstration project to all prescribed drug claims paid under the CMS-64 for all four quarters of 2006 to ensure that claims were not paid more than once;
- reviewed a judgmentally selected sample of 30 claims paid under the demonstration project to ensure that the claims dates of service were during the demonstration project period, the drug was a covered Part D drug, and any cost sharing amounts on the part of the beneficiary were not included on the claim to Medicare;
- reviewed a judgmentally selected sample of 30 beneficiaries whose claims were paid under the demonstration project and reviewed New York's methodology to classify the beneficiaries as dual eligible;
- obtained and reviewed guidance issued by New York to the pharmacies;
- obtained and reviewed the methodology of the State Medicaid payment rate for pharmacy products to ensure the reimbursement amount under the demonstration project was limited to the Medicaid payment rate; and
- reviewed New York's procedures to ensure that Medicare funding under the demonstration was not used as State Medicaid matching funds.

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 findings and conclusions based on our audit objective.

RESULTS OF AUDIT

New York complied with CMS demonstration project requirements related to reimbursed drug claims for dual eligible beneficiaries. New York utilized its Medicaid payment system to separate the demonstration claims from those payable under its Medicaid program. New York also utilized its Medicaid system to properly identify beneficiaries as being dually eligible for both Medicare and full Medicaid benefits, to ensure that only claims for dual eligible beneficiaries were submitted for the demonstration project, and to appropriately pay claims through the demonstration project. New York ensured that all claims reimbursed through the demonstration project were within its approved demonstration period of January 1 through March 31, 2006. We are not submitting recommendations to New York.