



MAY 07 2009

Region IX
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Report Number: A-09-08-00056

David Maxwell-Jolly, Ph.D.
Director
Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, California 95814

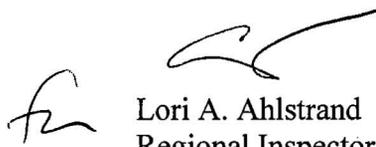
Dear Dr. Maxwell-Jolly:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled “Review of California’s Compliance With Demonstration Project Requirements for Reimbursement of State Costs for Provision of Medicare Part D Drugs (Claims Processed Through the Medicaid Management Information System).” We will forward a copy of this report to the HHS action official noted below.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. 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. Please refer to report number A-09-08-00056 in all correspondence.

Sincerely,


Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Mr. Jonathan Blum, Acting Director
Center for Drug and Health Plan Choice (CPC)
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW.
314-G, HHH Building
Washington, DC 20201

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF CALIFORNIA'S
COMPLIANCE WITH
DEMONSTRATION PROJECT
REQUIREMENTS FOR
REIMBURSEMENT OF STATE
COSTS FOR PROVISION OF
MEDICARE PART D DRUGS**

**CLAIMS PROCESSED THROUGH THE MEDICAID
MANAGEMENT INFORMATION SYSTEM**



Daniel R. Levinson
Inspector General

May 2009
A-09-08-00056

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 Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

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 Medicare Part D. 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 prescription drug plans and Medicare Advantage plans to offer prescription drug benefits to eligible individuals.

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 the 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 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.

To reimburse States for drug costs and related administrative 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 Act. On February 15, 2006, California submitted its "Section 402 Demonstration Application" (Medicare demonstration application) to CMS. By submitting its Medicare demonstration application, California agreed to pay for full-benefit dually eligible beneficiaries' drug claims overseen by the Department of Health Care Services (the State agency). The State agency's participation in the demonstration project covered drug claims with dates of service from January 1 through March 31, 2006.

In May 2006, CMS drafted guidance specifying that States should not claim demonstration project costs on Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64). The guidance also specified that if a claim for any demonstration project costs had already been reported on the CMS-64, the State must make a decreasing adjustment to a subsequent CMS-64 to remove those costs.

CMS reimbursed the State agency a total of \$61,147,661 for Medicare demonstration project drug costs. The State agency processed claims totaling \$55,769,874 through its Medicaid Management Information System (MMIS) and included this amount on its CMS-64s. The remaining claims totaling \$5,377,787 were processed through a separate system. For this audit, we limited our review to the \$55,769,874 of claims that the State agency processed through the MMIS. We plan to review the remaining \$5,377,787 in another audit.

OBJECTIVES

Our objectives were to determine whether the State agency (1) complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually

eligible beneficiaries and (2) claimed drug costs to both the Medicaid program and the Medicare demonstration project.

SUMMARY OF RESULTS

For the \$55,769,874 in drug claims processed through the MMIS, the State agency complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually eligible beneficiaries. For example, the State agency ensured that claims were for covered Part D drugs and for drug costs incurred during the demonstration project's effective dates.

However, the State agency claimed drug costs to both the Medicaid program and the Medicare demonstration project. In most cases, the State agency made a decreasing adjustment to the CMS-64 in the same quarter or the following quarter. However, the State agency did not adjust some drug costs claimed on the CMS-64s for the first and second quarters of 2006 until the fourth quarter of 2007. We are not making any recommendations in this report because the demonstration project has ended and the State agency adjusted the CMS-64s to remove all demonstration project costs before the start of our fieldwork.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Part D Prescription Drug Benefit.....	1
Full-Benefit Dually Eligible Beneficiaries	1
Medicare Part D Demonstration Project	1
California’s Participation in the Medicare Part D Demonstration Project	2
OBJECTIVES, SCOPE, AND METHODOLOGY	3
Objectives	3
Scope	3
Methodology	3
RESULTS OF AUDIT	4

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 Medicare Part D. 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 prescription drug plans and Medicare Advantage plans to offer prescription drug benefits to eligible individuals.

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 the 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. For example, if a beneficiary did not choose a prescription drug plan by December 31, 2005, CMS randomly assigned the beneficiary to a plan. In addition, to facilitate enrollment of dually eligible beneficiaries at the point of sale, CMS implemented a new eligibility inquiry process for pharmacies to verify Part D plan assignments and employed contractors.

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 drug costs and related administrative 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 Act.¹ The demonstration project permitted Medicare to fully reimburse States for full-benefit dually eligible beneficiaries' Part D drugs to the extent that the costs were not recoverable from a Medicare Part D plan.²

To participate in the 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

¹Demonstration 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.

²In addition, the demonstration project provided payments to States for low-income subsidy-entitled beneficiaries' (partial-benefit dually eligible beneficiaries) Part D drugs and for certain administrative costs.

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 Template: Reimbursement of State Costs for Provision of Part D Drugs).

CMS required States to submit demonstration project claims directly to its contractor, Public Consulting Group, which determined whether the claims were eligible for reimbursement. CMS then reimbursed States for eligible claims.

In addition, in May 2006, CMS drafted guidance specifying that States must separately identify and claim all demonstration project costs only through the demonstration project reconciliation process. States were advised not to claim demonstration project costs on Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (CMS-64). The guidance also specified that if a claim for any demonstration project costs had already been reported on the CMS-64, the State must make a decreasing adjustment to a subsequent CMS-64 to remove those costs and claim them directly through the demonstration project reconciliation process.

California's Participation in the Medicare Part D Demonstration Project

On February 15, 2006, California, through the Department of Health Care Services (the State agency), submitted its Medicare demonstration application to CMS. California agreed to pay for full-benefit dually eligible beneficiaries' drug claims. The State agency's participation in the demonstration project covered drug claims with dates of service from January 1 through March 31, 2006.

The State agency processed the majority of drug claims for full-benefit dually eligible beneficiaries through its Medicaid Management Information System (MMIS) and claimed the amounts on its CMS-64s, which were subsequently reimbursed at California's Federal medical assistance percentage (FMAP).³ The State agency submitted demonstration project claims to the Public Consulting Group and subsequently received reimbursement from CMS totaling \$61,147,661. Subsequently, the State agency made adjustments to the CMS-64s to remove demonstration project costs.

³The FMAP determines the Federal share of the Medicaid program. During our audit period (January 1 through March 31, 2006), the FMAP for drug claims in California was 50 percent.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the State agency (1) complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually eligible beneficiaries and (2) claimed drug costs to both the Medicaid program and the Medicare demonstration project.

Scope

The audit covered the State agency's Medicare demonstration project drug costs for the period January 1 through March 31, 2006, claimed on the CMS-64s. CMS reimbursed the State agency a total of \$61,147,661 for these costs, representing 672,996 drug claims. The State agency processed 641,482 claims totaling \$55,769,874 through its Medicaid Management Information System (MMIS) and included this amount on its CMS-64s. The remaining 31,514 claims totaling \$5,377,787 were processed through a separate system.⁴

For this audit, we limited our review to the \$55,769,874 of claims that the State agency processed through the MMIS. We plan to review the remaining \$5,377,787 in another audit. We did not review whether the State agency complied with demonstration project requirements for claiming administrative costs. In addition, we did not determine whether pharmacies attempted to bill beneficiaries' Medicare Part D plans before relying on State payment. We reviewed only those internal controls necessary to achieve our objectives.

We performed fieldwork from April through October 2008 at the State agency offices in Sacramento and Rancho Cordova, California.

Methodology

To accomplish our objectives, we:

- reviewed applicable laws, regulations, and guidance;
- interviewed State agency officials to (1) obtain an understanding of their process for identifying and submitting full-benefit dually eligible beneficiary claims under the demonstration project and (2) determine whether they separated demonstration project claims from those payable under other programs;
- obtained from CMS a database of 672,996 drug claims for full-benefit dually eligible beneficiaries paid to the State agency under the demonstration project for the period January 1 through March 31, 2006;

⁴These claims were for full-benefit dually eligible beneficiaries residing in facilities run by the Department of Developmental Services.

- obtained the State agency's decreasing adjustments to the CMS-64s for prescribed drugs related to the Medicare demonstration project costs;
- reconciled the total dollar amount of drug claims that the State agency reported on its CMS-64s to the decreasing adjustments reported on its CMS-64s;
- reviewed a judgmentally selected sample of 28 drug claims paid to the State agency under the demonstration project to determine whether (1) the dates of service were during the demonstration project's effective dates, (2) the drugs were covered by Medicare Part D, and (3) any cost-sharing amounts (copayments) on the part of the beneficiary were not included in the claim;
- reviewed a judgmentally selected sample of 23 beneficiaries whose drug claims were paid under the demonstration project to determine whether these beneficiaries were dually eligible;
- reviewed guidance issued by the State agency to the pharmacies, including guidance requiring them to submit Part D-eligible drug claims to Part D plans before billing the State agency; and
- reviewed the State agency's procedures to ensure that Medicare funding under the demonstration project 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 objectives.

RESULTS OF AUDIT

For the \$55,769,874 in drug claims processed through the MMIS, the State agency complied with certain provisions of the Medicare demonstration application when claiming drug costs for full-benefit dually eligible beneficiaries. Specifically, the State agency (1) provided specific information to CMS on Part D drug claims; (2) ensured that claims submitted were for covered Part D drugs; (3) separated demonstration project claims from those payable under other programs; (4) submitted claims only for drug costs incurred during the demonstration project's effective dates; (5) reported to CMS the number of claims, beneficiaries, and expenditures on a timely basis; and (6) ensured that Medicare funding was not used as State Medicaid matching funds.

However, the State agency claimed drug costs to both the Medicaid program and the Medicare demonstration project. In most cases, the State agency made a decreasing adjustment to the CMS-64 in the same quarter or the following quarter. However, the State agency did not adjust some drug costs claimed on the CMS-64s for the first and second quarters of 2006 until the fourth quarter of 2007. We are not making any recommendations in this report because the

demonstration project has ended and the State agency adjusted the CMS-64s to remove all demonstration project costs before the start of our fieldwork.