

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PART D
MADE SOME INCORRECT
PAYMENTS TO
COMMUNITY INSURANCE
INC. FOR INSTITUTIONAL
BENEFICIARIES IN 2008**

*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**

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A-05-11-00042**

Office of Inspector General

<http://oig.hhs.gov>

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The designation of financial or management practices as questionable,
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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) 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 cost 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.

Community Health Insurance Company Inc. (Community) is a MA organization located in Mason, Ohio that entered into contract number H3655 with CMS. For calendar year 2008, CMS made payments under this contract for Community's 4 MA plans (2 individual plans with prescription drug coverage and 2 group plans with a single prescription drug plan). We reviewed Plan 13, the largest individual plan under contract number H3655 and the plan with the most institutionalized beneficiaries—the beneficiaries most likely to have a SNF stay.

OBJECTIVE

Our objective was to determine whether Medicare Part D paid Community for drugs for MA beneficiaries during SNF stays that should have been a covered service under MA in 2008.

SUMMARY OF FINDING

The Medicare Part D program incurred drug costs for MA beneficiaries during SNF stays that should have been covered under Part C in 2008. Of the 930 institutionalized beneficiaries in Community's Contract H3655, Plan 13, 192 received Medicare SNF services during calendar year 2008. Of these 192 beneficiaries, 244 PDEs were submitted by Community for 25 beneficiaries during their SNF stay. As a result, \$22,729 in Part D gross drug costs were incurred which had an overpayment effect of \$13,346 to the Federal Government. Within the gross drug cost amount, patients paid \$1,694 in co-payments that should have been paid by Community had Medicare Part D not been inappropriately billed for these drug costs. Community attributed the incorrect payment amounts to limited guidance from CMS and a lack of knowledge of the beneficiary's status by pharmacies providing the drugs to the nursing facilities' resident population.

RECOMMENDATIONS

We recommend that Community:

- refund to the Federal Government the \$13,346 identified in overpayments, and
- work with CMS to remove the identified duplicative 244 PDE records with Part D gross drug costs totaling \$22,729 from the Integrated Data Repository.

AUDITEE COMMENTS

In written comments on our draft report, Community disagreed with the dollar amount and the calculation of the overpayment. Community stated that our overpayment calculation was based on 100 percent of the amount covered by its Part D plan when CMS only pays plans 80 percent of the amount of claims incurred in the catastrophic level. Community provided calculation details and a schedule to show how it arrived at its computation of the overpayment amounts related to catastrophic claims, Low-Income Cost-Sharing Subsidy amounts, and beneficiary cost-sharing amounts. Community agreed to reimburse CMS for the incorrect duplicate overpayments when the report is finalized and based on its calculation, believed the overpayment amount to be \$13,346 of the \$22,729 in gross drug costs. Community's comments are included in their entirety in the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Community's submission of PDEs totaling \$22,729 in gross drug costs had an overpayment effect of \$13,346. Based on Community's comments to our report, we revised our finding to clarify the payment and reconciliation effects the incurrence of the 244 PDEs had on the Medicare Part D program and added a second recommendation to remove the identified duplicative PDE records from the Integrated Data Repository.

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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 services furnished by Skilled Nursing Facility (SNF) providers. MA organizations pay SNF 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 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.

Community Health Insurance

Community Health Insurance Company Inc. (Community) is a MA organization located in Mason, Ohio that entered into contract number H3655 with CMS. For calendar year 2008, CMS made payments under this contract for Community's 4 MA plans (2 individual plans with prescription drug coverage and 2 group plans with a single prescription drug plan). We reviewed Plan 13, the largest individual plan under contract number H3655 and the plan with the most institutionalized beneficiaries—the beneficiaries most likely to have a SNF stay.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare Part D paid Community for drugs for MA beneficiaries during SNF stays that should have been a covered service under MA in 2008.

Scope

Our review covered all drugs paid by CMS for Medicare Part D beneficiaries while they were in SNF stays. We reviewed approximately \$5.1 million of CY 2008 gross drug costs related to Community's 930 institutionalized beneficiaries in Medicare Part D, contract H3655, Plan 13. Of these 930 beneficiaries, 192 had SNF stays in 2008 and 25 had 244 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.

We performed our fieldwork from July 2010 through November 2010.

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 930 Medicare institutional beneficiaries in Plan 13 under contract H3655 in CY 2008;
- identified 192 of the 930 institutionalized beneficiaries as having had a SNF stay in CY 2008;
- compared SNF claims with PDEs for these 192 beneficiaries for possible duplicate payments; and
- identified and quantified gross drug costs for all duplicative PDE payments.

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 inappropriately paid Community for duplicate gross drug costs for MA beneficiaries during SNF stays that should have been 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 20.2.1 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 or in the case of a MA-PD, drugs already covered by the MA organization's plan benefits.

DUPLICATE GROSS DRUG COSTS

Of the 930 institutionalized beneficiaries in Community's Contract H3655, Plan 13, 192 received Medicare SNF services during calendar year 2008. Of these 192 beneficiaries, 244 PDEs were

submitted by Community for 25 beneficiaries during their SNF stay. As a result, \$22,729 in Part D gross drug costs were incurred which had an overpayment effect of \$13,346 to the Federal Government. Within the gross drug cost amount, patients paid \$1,694 in co-payments that should have been paid by Community had Medicare Part D not been inappropriately billed for these drug costs.

CAUSE OF INCORRECT PAYMENTS

Community attributed the incorrect payment amounts to limited guidance from CMS and a lack of knowledge of the beneficiary's status by pharmacies providing the drugs to the nursing facilities' resident population. Community 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, Community did not want to improperly deny prescription drug transactions and interrupt members' access to necessary drugs.

RECOMMENDATIONS

We recommend that Community:

- refund to the Federal Government the \$13,346 identified in overpayments, and
- work with CMS to remove the identified duplicative 244 PDE records with Part D gross drug costs totaling \$22,729 from the Integrated Data Repository.

AUDITEE COMMENTS

In written comments on our draft report, Community disagreed with the dollar amount and the calculation of the overpayment. Community stated that our overpayment calculation was based on 100 percent of the amount covered by its Part D plan when CMS only pays plans 80 percent of the amount of claims incurred in the catastrophic level. Community provided calculation details and a schedule to show how it arrived at its computation of the overpayment amounts related to catastrophic claims, Low-Income Cost-Sharing (LICS) Subsidy amounts and beneficiary cost-sharing amounts. Community agreed to reimburse CMS for the incorrect duplicate overpayments when the report is finalized and based on its calculation, believed the overpayment amount to be \$13,346 of the \$22,729 in gross drug costs. Community's comments are included in their entirety in the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

While Community's assessment may be accurate as it relates to how CMS pays plans for drug claims incurred in the catastrophic level in Part D, our identified PDEs relate to instances where drugs were dispensed for MA beneficiaries while in a covered SNF stay. As such, these instances should not be counted as Part D PDEs. Instead, CMS has already made monthly capitated payments to Community to provide health care services to Medicare enrollees, including

all medically necessary services that are allowable in the traditional Medicare fee-for-service program including drugs during a covered SNF stay.

While we agree with Community's overpayment computation of \$13,346 relative to catastrophic claims, LICS, and beneficiary cost-sharing amounts, the incorrect incurrence of the remaining \$9,383 as a Part D PDEs also has an impact on CMS's year-end reconciliation process for determining risk-sharing amounts such as the risk corridor payments as well as future Community Part D bids. The incorrect incurrence of these PDEs as Part D expenditures has the effect of incorrectly overstating Community's actual allowable costs used for computing the final risk corridor reconciliation that may translate into additional payments to Community as well as incorrectly overstating Community's historical actual allowable costs used for future Part D bids.

Community's submission of PDEs totaling \$22,729 in gross drug costs had an overpayment effect of \$13,346. Based on Community written comments to our report, we revised our finding to clarify the payment and reconciliation effects the submission of the 244 PDEs had on the Medicare Part D program and added a second recommendation to remove the duplicated PDE records from the Integrated Data Repository.

APPENDIX

APPENDIX: AUDITEE COMMENTS



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April 4, 2012

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Office of Inspector General, Office of Audit Services
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VIA HHS/OIG Delivery Server:

Re: Draft Report Number A-05-11-00042 entitled Medicare Part D Made Some Incorrect Payments to Community Insurance Inc. for Institutional Beneficiaries in 2008

Dear Ms. Fulcher:

WellPoint has reviewed the draft Audit Report from the U.S. Department of Health and Human Services, Office of Inspector General (OIG) entitled *Medicare Part D Made Some Incorrect Payments to Community Insurance Inc. for Institutional Beneficiaries in 2008*. WellPoint appreciates the opportunity to comment on the Findings and Recommendation in the draft Audit Report. As detailed below, WellPoint believes that the OIG overstated the amount of incorrect payments paid by the Centers for Medicare & Medicaid Services (CMS), and respectfully requests that the OIG revise the draft Audit Report to correct this before finalizing this report.

In addition, WellPoint notes that both the Executive Summary and the draft Audit Report contain confidential information regarding the amount of capitated payments paid by CMS to Community Insurance Inc. in 2008. While certain summary payment information is publicly disclosed by CMS pursuant to 42 C.F.R. Sections 422.504(n) and 423.505(o), we note that total contract capitated payment information is not publicly available. Accordingly, WellPoint requests that this confidential financial information be redacted from this report as this information is not a matter of public record.

Finding

The OIG asserts that the Medicare Part D program inappropriately paid Community \$22,729 for duplicate gross drug costs for Medicare Advantage beneficiaries during skilled nursing facility (SNF) stays that should have been covered under Medicare Advantage in 2008. Specifically, the OIG found that of the 930 institutionalized beneficiaries in Community's Medicare Advantage Contract H3655, Plan 13, 192 received Medicare SNF services during calendar year 2008. Of these 192 beneficiaries, Medicare Part D paid claims on 244 PDEs for 25 beneficiaries during their SNF stays, which the OIG determined resulted in an overpayment of \$22,729 in gross drug costs, \$1,694 of which was paid by Medicare beneficiaries in cost sharing.



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Response

While WellPoint agrees that there was an overpayment, WellPoint disagrees with the OIG's calculation. The OIG's calculation of \$22,729.32 was based on 100% of the amount covered by the Part D plan. However, CMS only pays plans for 80% of the amount of claims incurred in the catastrophic level. See 42 C.F.R. Section 423.329(c). Please see calculation details below, and on page 3 of this response:

- \$8,418.37 due to CMS related to the 80% of plan insured amount for catastrophic claims (80% of \$10,522.96 which is the amount paid to the Part D plan above the out-of-pocket threshold).
- \$3,233.76 due to CMS is for Low-Income Cost-Sharing Subsidy (LICS) amounts paid to the plan by CMS.
- \$1,694.05 refundable to 25 beneficiaries for amount paid to the pharmacies at point of sale.

Based on the calculations above, WellPoint agrees to an overpayment amount of \$13,346.18. WellPoint concurs with the OIG's recommendation to reimburse CMS for the incorrect payments, and, upon finalization of the OIG's Audit Report, will make arrangements with CMS to refund incorrectly paid LICS and reinsurance amounts. In addition, WellPoint has taken the appropriate steps to reimburse members overpaid cost sharing.

WellPoint notes that CMS acknowledged the difficulty Part D plans can have in distinguishing Part A versus Part D coverage for prescription drug claims for enrollees residing in long-term care facilities. See *Reminder on Long-Term Care Pharmacy Contracting*, from Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C&D Data Group, dated November 25, 2008. Accordingly, in 2009, CMS began sending Part D plans Long-Term Institutionalized Resident Reports twice annually. WellPoint believes that these additional measures should mitigate the risk of recurring overpayments.

We trust that the information provided includes the detail requested. If you have any questions regarding this communication, please contact me at 513-336-2541 or via email at edward.stubbers@wellpoint.com. Thank you in advance for your prompt attention and response to this matter.

Sincerely,

Edward L. Stubbers

Edward L. Stubbers, Esq.
Vice President of Compliance, Senior Business

H3655 OIG PDE Recalculation Summary

Data Element	Total Amount	Commentary	Payee	Payer	Repayment Needed?	Amounts Payable
Transaction Count	244	Removed 76 non-final PDEs	n/a	n/a	n/a	n/a
INGRDNT_COST_PD	\$ 21,624.82	Pharmacy billed ingredient cost; plan pays as fully insured risk	Pharmacy	Plan	No	\$ -
DSPNSNG_FEE_PD	\$ 1,104.50	Pharmacy billed dispensing fees; plan pays as fully insured risk	Pharmacy	Plan	No	\$ -
AMT_SALES_TAX	\$ -	Sales tax; non-factor	Pharmacy	Plan	No	\$ -
BELOW_OOP_THRHLD	\$ 12,200.43	Below catastrophic threshold; non-factor for reinsurance payments	Used for Accounting and Claim Calculation Purposes Only		No	\$ -
ABOVE_OOP_THRHLD	\$ 10,522.96	Catastrophic amounts; supports determination of claims for reinsurance refunds; amount payable is computed as reinsurance amount in	Used for Accounting and Claim Calculation Purposes Only		No	\$ -
REINSURANCE_AMT	\$ 8,418.37	80% of plan insured amount (ABOVE_OOP_THRESHOLD) for catastrophic claims	Plan	CMS	Yes	\$ 8,418.37
PATIENT_PAY_AMT	\$ 1,694.05	Amounts paid by members to the pharmacies; refundable	Pharmacy	Member	Yes	\$ 1,694.05
OTHER_TROOP_AMT	\$ -	Amounts paid by other plans; non-factor	Pharmacy	Other Plan	No	\$ -
LICS_AMT	\$ 3,233.76	LICS amounts paid to the plan by CMS; refundable	Plan	CMS	Yes	\$ 3,233.76
PLRO_AMT	\$ -	Amounts paid by other plans; non-factor	Pharmacy	Other Plan	No	\$ -
CVRD_D_PLAN_PAID	\$ 16,501.77	Amount absorbed by the plan; this is a statement of the financial risk paid by the plan	Used for Accounting and Claim Calculation Purposes Only		No	\$ -
NON_CVRD_PLAN_PAID	\$ 1,299.74	Amount absorbed by the plan; this is a statement of the financial risk paid by the plan beyond what is covered under a standard Part	Used for Accounting and Claim Calculation Purposes Only		No	\$ -
						<u>\$ 13,346.18</u>

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