



Testimony before the Committee on Homeland Security and  
Governmental Affairs

United States Senate

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***“Oversight Challenges in the Medicare Prescription  
Drug Program”***

**Testimony of  
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342 Dirksen Senate Office Building**



Good afternoon, Mr. Chairman and members of the Subcommittee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections in Philadelphia at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). The Medicare Part D prescription drug program is large and complex with both Federal agencies and Federal contractors charged with protecting the integrity of the program. With approximately \$50 billion at risk in the program each year, it is important that all of us who have programmatic and oversight responsibilities work collaboratively to ensure that program vulnerabilities are identified and resolved.

Since the inception of the Part D program in 2006, OIG has developed a body of work to review program integrity and payment accuracy safeguards that are in place to protect the program from fraud, waste, and abuse. To date, OIG's work has demonstrated that the Part D program oversight by the Centers for Medicare & Medicaid Services (CMS), the Part D plan sponsors, and CMS's benefit integrity contractors has been limited. As a result, the program is vulnerable to fraud, waste, and abuse. There are opportunities to significantly enhance oversight of the Part D program, and on behalf of the Inspector General, I would like to thank you, Mr. Chairman, for holding today's hearing on this important topic.

After briefly describing the oversight role of the OIG and providing some background on the Medicare Part D program, I will summarize the Part D vulnerabilities we have identified and OIG recommendations to improve the integrity of the Part D program.

**I. OIG'S MISSION TO PROTECT THE MEDICARE AND MEDICAID PROGRAMS AND BENEFICIARIES**

OIG is an independent, nonpartisan agency committed to protecting the integrity of the more than 300 programs administered by HHS. OIG fights health care fraud, waste, and abuse through a nationwide network of investigations, audits, evaluations, and enforcement and compliance activities. OIG is comprised of more than 1,500 professionals who perform comprehensive health care oversight and enforcement activities, including:

- **Office of Investigations:** conducts criminal, civil, and administrative investigations of health care fraud, which result in convictions, civil and administrative actions, and monetary recoveries;
- **Office of Audit Services:** conducts and oversees audits of Medicare and Medicaid payments and operations; identifies improper payments and program vulnerabilities; and recommends audit disallowances and program improvements;

- Office of Evaluation and Inspections: conducts evaluations of the Medicare and Medicaid programs to identify program integrity vulnerabilities and make recommendations to prevent fraud, waste, and abuse and to promote economy, efficiency, and effectiveness; and
- Office of Counsel to the Inspector General: represents OIG in all civil and administrative fraud and abuse cases, and in connection with these cases, negotiates and monitors corporate integrity agreements; provides guidance to the health care industry to promote compliance; and provides legal support to OIG operations.

In FY 2009, OIG investigations resulted in \$4 billion in settlements and court-ordered fines, penalties, and restitution, and in 671 criminal actions. OIG audits resulted in almost \$500 million in receivables through recommended disallowances. OIG also produced equally important but less quantifiable gains in deterrence and prevention of fraud, waste, and abuse. OIG also has raised awareness of these critical issues among policy makers, government agencies, and the health care community at large. Moving forward, OIG is committed to building on our successes and achieving even greater results in protecting the integrity of government health care programs and the health and welfare of people served by them.

## **II. THE MEDICARE PART D PROGRAM**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the Medicare Part D prescription drug benefit. Effective January 1, 2006, Part D provides an optional outpatient prescription drug benefit to all Medicare beneficiaries. CMS administers the Part D program and contracts with private companies, known as plan sponsors, to provide Part D prescription drug coverage. Under Medicare Part D, beneficiaries can enroll in a stand-alone prescription drug plan that covers drugs only, or a Medicare Advantage prescription drug plan that integrates drug coverage with other health care services.

The MMA required an extremely short implementation schedule for the Medicare Part D prescription drug benefit. In the two years between the passage of MMA and the effective date of the program, CMS and its Part D plan sponsors conducted implementation activities, including the development of procedures, data systems, and infrastructure to carry out all the necessary functions. Beginning in November 2005, after expeditious and extensive planning, CMS began enrolling beneficiaries for the 2006 Part D plan year.

As the fifth year of the Part D program begins, there are approximately 27 million beneficiaries enrolled in the program. More than 60 percent of the beneficiaries, approximately 17 million, are in stand-alone plans. Since the inception of the program, Medicare has paid nearly \$200 billion, approximately \$50 billion each year, for the Part D program.

### **III. PART D PROGRAM INTEGRITY**

Within the Medicare program, the responsibility for ensuring integrity in the Part D program is shared between Part D plan sponsors, program integrity contractors, and CMS. The plan sponsors serve as the first line of defense against fraud in the Part D program and CMS requires that plan sponsors have compliance plans in place to protect the integrity of the program. CMS requires plan sponsors to include certain elements in their compliance plans. These elements include the designation of a compliance officer, the establishment of effective compliance training for employees and contractors, and the establishment of procedures for effective internal monitoring and auditing. CMS also requires compliance plans to have measures to detect, correct, and prevent fraud, waste, and abuse.

CMS contracts with Medicare Drug Integrity Contractors (MEDICs) to perform integrity functions such as identifying and investigating potential fraud, waste, and abuse in the Part D program. MEDICs, which are the cornerstone of CMS's program integrity efforts, are responsible for safeguard activities, including audits of plan sponsors' compliance plans and identifying fraud through innovative data analysis techniques.

As program administrator, CMS is ultimately responsible for safeguarding the Medicare Part D program. As such, CMS is statutorily required to perform financial audits of the Part D plan sponsors, which provide Part D benefits to Medicare beneficiaries. CMS also can conduct a number of other types of audits of plan sponsors, including bid audits, program audits, benefit integrity audits, and compliance plan audits.

In addition to plan sponsors, MEDICs, and CMS, the Office of Inspector General plays a critical role in combating fraud, waste, and abuse in Medicare Part D. Through its evaluations, audits, investigations, and enforcement actions, OIG has identified significant vulnerabilities in the Part D program and has made numerous recommendations to CMS to correct these vulnerabilities.<sup>1</sup> OIG also has performed targeted followup reviews to determine whether the vulnerabilities were addressed.

### **IV. STRENGTHENING PART D OVERSIGHT**

Overall, OIG's reviews of the Part D program indicate that CMS's program integrity efforts have been limited in scope and may not sufficiently protect the program. Lack of effective oversight exposes the Part D program and Medicare beneficiaries to a wide range of fraud, waste, and abuse, including inappropriate billings, payments for excluded drugs, drug diversion, improper bid submissions, excessive premiums, and illegal marketing schemes. The failure to address these vulnerabilities puts the scarce resources of the Medicare Trust Fund at risk. Below is a brief description of Part D program vulnerabilities identified through OIG's work.

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<sup>1</sup> See Attachment A for a list of OIG's completed, ongoing, and planned Part D work on program integrity, payment accuracy, cost controls, beneficiary protections and access, prescription drug pricing, and information technology systems.

**A. Early Challenges to Implementing a Comprehensive Safeguard Strategy**

An early review of Part D found that CMS implemented only limited safeguard activities and further development of these activities was needed. In fiscal year 2006, OIG found that while some of CMS's safeguards had been functioning since Part D enrollment began, other critical safeguards were implemented in limited capacity or had not yet been put in place.<sup>2</sup> We also found that CMS relied largely on complaints to identify potential fraud in Part D and not all of these complaints were investigated in a timely way. In addition, we found that no significant data analysis had been conducted specifically to detect or prevent fraud and abuse. One barrier to conducting data analysis was that CMS and its contractors lacked a centralized data repository that would enable proactive data monitoring.

**B. MEDICs Have Not Conducted the Full Range of Safeguard Activities Planned**

**i. MEDICs have relied mainly on external rather than proactive sources to identify fraud**

MEDICs play a key role in CMS's strategy to protect the Part D program from fraud, waste, and abuse. This is especially true in the area of using new and innovative techniques to monitor and analyze data to help identify fraud. Using data analysis tools to proactively detect fraud is one of the most important elements of CMS's safeguard strategies.

While proactive data analysis is a key element of MEDICs' responsibilities, OIG found in its October 2009 report that MEDICs identified most incidents of potential fraud through external sources, such as beneficiary complaints, rather than proactive methods.<sup>3</sup> Of the 4,194 potential fraud and abuse incidents MEDICs identified in 2008, 87 percent were identified through external sources and only 13 percent were identified through proactive methods, such as data analysis. In addition, of the 1,320 investigations MEDICs conducted, 96 percent involved incidents identified through external sources.

**ii. Limited data access has hindered MEDICs' fraud detection efforts**

CMS's strategy called for the use of data analysis to combat fraud and abuse. However, MEDICs reported that barriers hindered their ability to consistently conduct comprehensive data analysis to detect and prevent potential fraud and abuse. These barriers included delays in receiving access to the necessary CMS claims and Part D prescription drug event (PDE) data. MEDICs reported that they needed both PDE data

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<sup>2</sup> OIG, *CMS's Implementation of Safeguards During Fiscal Year 2006 to Prevent and Detect Fraud and Abuse in Medicare Prescription Drug Plans*, OEL-06-06-00280, October 2007.

<sup>3</sup> OIG, *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse*, OEI-03-08-00420, October 2009.

and Part B data to effectively identify and investigate potential fraud and abuse incidents. However, MEDICs did not receive access to PDE data until August 2007; nearly a year after their contracts began. Once they received access to PDE data, MEDICs found that there were significant limitations in the data and important variables were not available or were stored incorrectly. In addition, two MEDICs were not given access to Part B data (physician services) until the fall of 2008 and the third MEDIC did not receive access to Part B data before its contract ended.

In addition to limited access to data, MEDICs' lack of authority to directly obtain information, such as prescriptions and medical records from pharmacies, pharmacy benefit managers, and physicians hindered their ability to investigate potential fraud and abuse incidents. Also, MEDICs may not have been aware of some potential fraud and abuse incidents because plan sponsors are encouraged to refer potential fraud and abuse incidents to MEDICs but are not required to do so.

### **iii. MEDICs were not given approval to conduct compliance plan audits**

OIG also found that CMS did not give MEDICs approval to conduct audits of plan sponsors' compliance plans in 2008. During OIG's evaluation of the MEDICs, all three MEDICs indicated that they were prepared to conduct compliance plan audits in 2008 but were not given approval by CMS to do so. Between October and December 2008, two years after MEDICs' regional contracts began, the two remaining MEDICs did receive approval from CMS to begin 10 audits of plan sponsors' compliance plans. However, as of December 2009, CMS had not issued final reports on any of these compliance plan audits.

In November 2009, after the issuance of our evaluation report, CMS restructured the MEDIC program. There are now two instead of three MEDICs. One of these two MEDICs, the Compliance and Enforcement MEDIC, focuses solely on compliance activities of plan sponsors, including compliance plan audits and monitoring inappropriate agent/broker activity. The second MEDIC, the Benefit Integrity MEDIC, concentrates on fraud, waste, and abuse efforts including investigating potential fraud and conducting data and investigative analysis. As Part D program integrity efforts continue to evolve at CMS, OIG will continue its review to ensure the effectiveness of these efforts.

## **C. Sponsors' Compliance Plans Have Been Incomplete**

CMS requires that plan sponsors have compliance plans in place to protect the integrity of the program. An effective compliance plan helps plan sponsors protect the integrity of Medicare funds by preventing and detecting fraud, waste, and abuse. CMS requires plan sponsors to include certain elements in their compliance plans. These elements include the designation of a compliance officer, the establishment of effective compliance training for employees and contractors, and the establishment of procedures for effective internal monitoring and auditing.

OIG has conducted two evaluations, issued in December 2006 and October 2008, on Medicare Part D plan sponsors' compliance plans.<sup>4</sup> Plan sponsors are required to implement compliance plans in order to detect, correct, and prevent fraud, waste, and abuse. CMS's *Prescription Drug Benefit Manual* outlines specific requirements that sponsors' compliance plans must address to ensure that elements established by Federal regulation are met.

OIG's 2006 review found that while all plan sponsors had compliance plans, these plans did not fully address all of CMS's requirements and in some cases, contained only the broad outlines of a fraud and abuse plan and did not include descriptions of specific compliance and anti-fraud processes.

#### **D. CMS Has Not Finalized Audits of Plan Sponsors' Compliance Plans**

Because CMS has not finalized any audits of PDP sponsors' compliance plans, we do not know whether this key anti-fraud component is working at the plan level and what improvements plan sponsors can make to improve program safeguards. OIG recently completed an indepth audit of one plan sponsor's internal controls to detect, correct, and prevent fraud, waste, and abuse in the Part D program during 2007 and 2008.<sup>5</sup> This work highlights that audits of individual plan sponsors can provide important insights into how the Part D program is working at the plan level and what improvements plan sponsors can make to improve program safeguards.

In our audit, we found that although most of the plan sponsor's internal controls were adequate, it had several internal control weaknesses that compromised its ability to detect, correct and prevent fraud, waste, and abuse in the Part D program. The plan sponsor generally did not self-report potential fraud to the MEDICs as recommended by CMS guidance. While the plan sponsor had written procedures requiring the self-reporting of potential fraud to the MEDICs, the plan sponsor did not follow its own procedures. We also found that the plan sponsor paid claims for prescriptions written by physicians or other health care professionals who are excluded from Federal health care programs. Furthermore, the plan sponsor did not have a procedure in place to track complaints made against providers as recommended by CMS guidance. Based on these findings, OIG recommended that the plan sponsor strengthen its internal controls and establish and/or adhere to policies and procedures to address issues with payment accuracy and complaint tracking. In response to our work, the plan sponsor outlined a number of corrective actions it had implemented to address the vulnerabilities.

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<sup>4</sup> OIG, *Prescription Drug Plan Sponsors' Compliance Plans*, OEI-03-06-00100, December 2006 and *Oversight of Prescription Drug Plan Sponsors' Compliance Plans*, OEI-03-08-00230, October 2008.

<sup>5</sup> OIG, *Review of SilverScript Insurance Company's Internal Controls to Guard Against Fraud, Waste and Abuse for the Medicare Part D Program*, A-07-09-03124, January 2010.

### **E. Plan Sponsors Vary Widely in the Identification of Fraud**

Plan sponsors are the initial gatekeeper protecting the Part D program from fraud and abuse. Although CMS requires that sponsors have measures to detect and deter fraud and abuse, the specifics are left to each individual sponsor. However, CMS requires that plan sponsors conduct inquiries and initiate corrective actions if there is evidence of potential fraud and abuse. CMS recommends that after conducting inquiries, if plan sponsors identify potential fraud and abuse, sponsors should refer the incidents to CMS or MEDICs for further investigation.

In October 2008, OIG issued a report reviewing the extent to which plan sponsors identified potential fraud and abuse during the first 6 months of 2007.<sup>6</sup> We found that 24 of 86 sponsors of stand-alone plans did not identify any potential fraud and abuse incidents, either from internal efforts or complaints from external sources. For the 62 plan sponsors that identified fraud incidents, the number of incidents identified ranged from 1 to over 6,000. Ninety percent of all incidents were associated with only seven plan sponsors. We also found that not all plan sponsors that identified potential fraud and abuse incidents conducted inquiries, initiated corrective actions, or made referrals for further investigation.

Plan sponsors identified 26 different types of potential fraud and abuse, and of these, the most prevalent type was inappropriate billing. The second most prevalent type was "providing false information," e.g., misrepresentation of a beneficiary's plan enrollment, and the third most prevalent was doctor shopping, i.e., a beneficiary consulting a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for drugs. These types of suspicious behavior and potential abuse are consistent with the types of vulnerabilities that we have identified in other prescription drug benefit programs.

### **F. Payment Accuracy Vulnerabilities**

In addition to addressing the program integrity vulnerabilities identified above, it is critical that CMS strengthen its oversight of Part D payment accuracy. With costs for the Part D program approaching \$50 billion a year, it is imperative that Part D payments are made accurately and are based on the best data available. Each year, plan sponsors' bid amounts are the basis for determining the payments Medicare makes directly to plan sponsors. The bid amounts also determine the monthly premiums that beneficiaries will pay.

Medicare makes monthly payments to plan sponsors for providing Part D coverage to beneficiaries. These payments are based on estimates that sponsors provide in their approved bids. These estimates include sponsors' expected profits. After the close of the plan year, CMS must reconcile the monthly payments with sponsors' actual costs. This allows CMS to determine whether sponsors owe money to Medicare or if Medicare owes

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<sup>6</sup> OIG, *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse*, OEI-03-07-00380, October 2008.



money to sponsors. In addition, CMS must determine whether risk-sharing payments are required. Risk sharing requires the Federal Government to share in sponsors' unexpected profits and losses.

CMS's oversight is essential to reduce inaccuracies and errors in Part D sponsors' bids. Inaccuracies in sponsors' bids have resulted in Medicare paying higher payments and beneficiaries paying higher premiums than they should have. OIG has continually recommended that CMS strengthen its oversight and enforcement approach to hold plan sponsors accountable for their bids.

**i. The majority of Part D sponsors' bids in 2006 and 2007 overestimated the cost of providing the benefit**

OIG assessed the estimated reconciliation amounts that Part D sponsors would owe to or receive from Medicare for plan years 2006 and 2007.<sup>7</sup> In 2006, Part D sponsors owed Medicare more than \$4 billion. Although the overall net amount that sponsors owed in 2007 was substantially lower at only \$18 million, we continued to find that most Part D sponsors overestimated the costs of providing the benefit in their bids and made profits large enough to trigger risk sharing. In 2007, 71 percent of sponsors made unexpected profits large enough to trigger risk sharing. In total, they overestimated their bids by more than \$1 billion, which triggered risk-sharing payments of \$795 million to Medicare.<sup>8</sup>

These overestimates resulted in payments to sponsors by Medicare and by beneficiaries that were higher than they should have been. Although Medicare was able to recoup a portion of the amounts that were overpaid – because of risk-sharing requirements – there is no mechanism for seniors to recoup any of the money that they paid in higher premiums.

Based on these findings, we recommended that CMS ensure that sponsors' bids accurately reflect their costs of providing the benefit, and when sponsors fail to do so, that CMS hold sponsors more accountable for inaccuracies in the bids. We also recommended that CMS determine the appropriateness of any proposed changes to their methods of calculating risk sharing.

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<sup>7</sup> OIG, *Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006*, OEI-02-07-00460, October 2007, and *Medicare Part D Reconciliation Payments for 2006 and 2007*, OEI-02-08-00460, September 2009.

<sup>8</sup> The increased direct subsidy payments resulting from these overestimated bids were generally offset by reinsurance and low-income cost sharing subsidy payments that were too low, resulting in the lower net amount owed to Medicare.

**ii. CMS's Part D audit processes do not sufficiently ensure accountability**

The two audit mechanisms CMS has in place to ensure the accuracy of the bid, the bid audit and the financial audit, are largely ineffectual for detecting and correcting inaccuracies in the bid amounts.

The bid audit is focused on the actuarial assumptions that are used to calculate the bid amount. For plan years 2006 and 2007, one-quarter of all bid audits identified at least one material finding that, if corrected, would result in at least a 1-percent change in the bid amount or at least a 10-percent change in any bid element. However, the bid audits are not designed to result in adjustments to bid amounts. According to CMS staff, one reason that adjusting bid amounts as a result of bid audit material findings is problematic is because the audits are completed after contracts have already been signed with plan sponsors. Instead, CMS uses bid audits to influence the submission, review, and audit of future bid amounts.

Financial audits verify the accuracy of the financial data that plan sponsors submit with their bids. CMS is statutorily required to conduct a financial audit of at least one-third of plan sponsors annually. However, only 4 percent of the required financial audits of plan year 2006 had begun as of April 2008. CMS's delays in conducting required financial audits of plans increases the risk that inaccuracies in the financial data underlying bids will go undetected and affect future bids.

**V. RECOMMENDATIONS FOR IMPROVING OVERSIGHT**

Oversight of the newest benefit in Medicare, the Part D prescription drug program, is imperative. It requires focused attention and a commitment to remedying program vulnerabilities and ensuring bid and payment accuracy. Ensuring that the Medicare Part D program and its beneficiaries are paying appropriately for the benefit is imperative. The program needs systems in place to prevent, detect, and respond to fraud, waste, and abuse.

Below are specific recommendations that OIG believes will improve the oversight and integrity of the Medicare Part D program.

**A. CMS Should Implement a Comprehensive Program Integrity Plan That Includes Mechanisms to Ensure Oversight and Accountability**

OIG believes that CMS must set out a comprehensive program integrity plan that includes specific action items, target dates, and assigned staff for follow up. Having this comprehensive plan would address the broad coordination needed between different groups within CMS and contain details, deliverables, and timelines that would make it a useful management tool.

It also is crucial that audits are conducted in a timely manner and that mechanisms are established to hold plan sponsors accountable for the problems identified. While only financial audits are legislatively mandated, CMS established a comprehensive list of audits it expected to perform on plan sponsors. CMS needs to perform more of these audits and needs to perform these audits more timely. That way, vulnerabilities that exist at individual plan sponsors can be remedied quickly and detected problems can also serve as early warning flags for issues that CMS may need to address programwide.

CMS should also evaluate the performance of the plan sponsors by analyzing the number of fraud and abuse incidents identified, the number of inquiries and corrective actions initiated, as well as the number of fraud referrals made to law enforcement.

**B. CMS Should Ensure That MEDICs Conduct More Rigorous Oversight, Including Data Analysis, to Detect Potential Fraud, Waste, and Abuse**

Complaints from beneficiaries and others are a key part of detecting fraud. However, individual complaints tend to focus on one specific circumstance, which is why the work of the MEDICs is so important. MEDICs' ability to review all of the Part D prescription drug data and data from other Medicare programs allows for comprehensive analyses that can identify global problems, aberrancies, and outliers across the program. MEDICs need to perform more of these analyses as they allow for the identification of systemic vulnerabilities in the program.

MEDICs also should be provided with the legal authority to obtain critical information directly from pharmacies, pharmacy benefit managers, and prescribing physicians. Not being able to directly obtain prescriptions and related medical information can hinder the thoroughness and timeliness of MEDICs' investigations of potential fraud.

**C. CMS Should Ensure That Plan Sponsors are Implementing Effective Compliance Plans**

Our ultimate goal is to address fraud as early as we can in the process. That is why having comprehensive and successful compliance plans in place at the plan sponsors is so essential. They are able see the prescription drug data in real time. By constantly monitoring that data they can flag potentially fraudulent issues early on.

CMS, MEDICs, and plan sponsors need to perform innovative data analysis of claims and payment information and embrace proactive methods of fraud detection. Data metrics in conjunction with audit results can assist CMS in targeting their resources in the areas that are most vulnerable to fraud, waste, and abuse.

**VI. CONCLUSION**

Part D provides a valuable prescription drug benefit to Medicare beneficiaries and all of us who have programmatic and oversight responsibilities must be vigilant in safeguarding

the program. OIG recognizes the immense effort that CMS put forth to develop and administer the Part D benefit under such a tight timeframe. Now that the program is entering its fifth year, it is time to use the lessons and experiences from its initial years to focus on strengthening program integrity of Part D moving forward.

Protecting the Part D program from fraud, waste, and abuse will involve ongoing cooperation among a number of key partners, including CMS, plan sponsors, and MEDICs. OIG has conducted reviews of CMS's audit and oversight functions, on plan sponsors' identification of fraud and abuse, and MEDICs' abilities to detect, investigate, and refer fraud in the Part D program. All of the reviews have identified program vulnerabilities and opportunities to strengthen these key partners' efforts to combat Part D fraud and abuse.

CMS needs to ensure that there is adequate oversight of Medicare Part D payments and beneficiary costs. It also needs to make sure that plan sponsors are held accountable for the accuracy of their bid amounts and CMS needs a mechanism to address bid inaccuracies in the current benefit year and not just future years.

Our work in the Part D program continues. We are currently performing reviews on questionable billing patterns, plan sponsors training programs regarding fraud, the status and results of all audits of plan sponsors, Part D electronic prescribing initiatives, invalid prescriber identifiers on prescription drug data, payments made to excluded providers, reconciliation calculations, and Part D rebates and pharmacy discounts.

Clearly, there are many opportunities for CMS and its partners to strengthen Part D safeguards to ensure the integrity of the Part D program, and we stand ready to assist them in their efforts. I would be happy to answer any questions that the subcommittee may have.

## ATTACHMENT A

### Part D Reports Produced by HHS OIG

- *Review of SilverScript Insurance Company's Internal Controls to Guard Against Fraud, Waste and Abuse for the Medicare Part D Program*, A-07-09-03124, January 2010.
- *Midyear Formulary Changes in Medicare Prescription Drug Plans*, OEI-01-08-00540, December 2009
- *Medication Therapy Management Program: Controls Over Eligibility and Costs*, A-04-09-06106, December 2009
- *Review of Dual Eligibles' Part D Demonstration Project*, A-01-09-00601, October 2009
- *Medicare Part D E-Prescribing Standards: Early Assessment Shows Partial Connectivity*, OEI-05-08-00320, October 2009
- *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse*, OEI-03-08-00420, October 2009
- *Medicare Part D Reconciliation Payments for 2006 and 2007*, OEI-02-08-00460, September 2009.
- *Accuracy of Part D Plans' Drug Prices on the Medicare Prescription Drug Plan Finder*, OEI-03-07-00600, July 2009
- *Reimbursement of State Costs for Provision of Part D Drugs*, A-02-08-01007, July 2009
- *Medicare Part D Payments for Beneficiaries in Part A Skilled Nursing Facility Stays in 2006*, OEI-02-07-00230, June 2009
- *Effect of the Part D Coverage Gap on Medicare Beneficiaries Without Financial Assistance in 2006*, OEI-05-07-00610, March 2009
- *Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid*, OEI-03-07-00350, February 2009
- *Comparing Special Needs Plan Beneficiaries to Other Medicare Advantage Prescription Drug Plan Beneficiaries*, OEI-05-07-00490, December 2008
- *Centers for Medicare & Medicaid Services Audits of Medicare Part D Bids*, OEI-05-07-00560, November 2008
- *Oversight of Prescription Drug Plan Sponsors' Compliance Plans*, OEI-03-08-00230, October 2008
- *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse*, OEI-03-07-00380, October 2008
- *Marketing Materials for Medicare Prescription Drug Plans*, OEI-01-06-00050, September 2008
- *Review of Medicare Part D Contracting for Contract Year 2006*, A-06-07-00082, July 2008
- *Medicare Drug Subsidy Payments for Dual Eligibles*, A-05-02-00009, June 2008
- *Role of Nursing Homes and Long Term Care Pharmacies in Assisting Dual-Eligible Residents with Selecting Part D Plans*, OEI-02-06-00191, June 2008

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- *Availability of Medicare Part D Drugs to Dual-Eligible Nursing Home Residents*, OEI-02-06-00190, June 2008
- *Review of the Relationship Between Medicare Part D Payments to Local, Community Pharmacies and the Pharmacies' Drug Acquisition Costs*, A-06-07-00107, January 2008
- *Tracking Beneficiaries' True Out-of-Pocket Costs for the Part D Prescription Drug Benefit*, OEI-03-06-00360, December 2007
- *Generic Drug Utilization in the Medicare Part D Program*, OEI-05-07-00130, November 2007
- *Medicare Part D Prescription Drug Plan Sponsor Internet Web Sites: Content and Accessibility*, OEI-06-06-00340, October 2007
- *CMS's Implementation of Safeguards During Fiscal Year 2006 to Prevent and Detect Fraud and Abuse in Medicare Prescription Drug Plans*, OEI-06-06-00280, October 2007.
- *Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006*, OEI-02-07-00460, October 2007
- *Retail Pharmacy Participation in Medicare Part D Prescription Drug Plans in 2006*, OEI-05-06-00320, June 2007
- *Prescription Drug Plans Sponsors' Compliance Plans*, OEI-03-06-00100, December 2006
- *Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy*, OEI-03-06-00120, November 2006
- *Early Implementation of MMA: Status Report of the State Health Insurance Assistance Programs*, OEI-05-05-00190, March 2006
- *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006

### Part D Work Underway or Planned by HHS OIG

- Medicare Part D Reconciliation Calculations
- Medicare Part D Data Submitted by Sponsors for Reconciliations
- Medication Therapy Management Program
- Less-Than-Effective and Terminated Drugs in Part D
- Aberrant Part D Claims
- Medicare Prescription Drug Plans' Formulary Changes
- True Out-of-Pocket Costs for Part D
- Beneficiaries' Experiences With Low-Income Subsidies and Availability of Drug Benefits
- Duplicate Drug Claims for Hospice Beneficiaries
- Bid Submission by Part D Sponsors
- Administrative Costs Included in Bid Submissions
- Part D Sponsors' Audits of Pharmacies
- Disenrollment of Deceased Beneficiaries

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- E-Prescribing in Part D
- Oversight of Pharmacy Benefit Managers
- Oversight of Prescription Drug Event Data
- Part D Drug Claims With Inactive or Invalid Physician Identifier Numbers
- Medicare Part D Payments for Drugs Prescribed or Provided by Excluded Providers
- Investment Income Earned by Part D Plans
- Part D Pharmaceutical Manufacturer Rebates
- Alternative Calculation of Part D Rebates
- Drug Costs Paid by Part D Sponsors Under Retail Discount Generic Programs
- Medicare Part D Program Audit Overview
- Medicare Part D Sponsors' Internal Controls for Fraud, Waste, and Abuse
- Medicare Part D Price Concessions