



# MICHIGAN

OFFICE OF THE AUDITOR GENERAL

## AUDIT REPORT



THOMAS H. MCTAVISH, C.P.A.  
AUDITOR GENERAL

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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Michigan  
*Office of the Auditor General*  
**REPORT SUMMARY**

*Performance Audit*  
*Medicaid Pharmacy Services*  
*Medical Services Administration*  
*Department of Community Health*

Report Number:  
391-0116-12

Released:  
January 2013

*The federal government requires states to provide a basic set of medical services to people eligible for Medicaid. Providing pharmaceutical services to Medicaid recipients is one of the optional medical services that Michigan has elected to provide. The Department of Community Health's (DCH's) pharmaceutical drug claims totaled \$1.7 billion (\$0.6 billion General Fund/general purpose) during the period October 1, 2009 through June 30, 2012.*

***Audit Objective:***

To assess the effectiveness of DCH's efforts to identify and recover payments for pharmaceutical drugs covered by Medicare.

***Audit Conclusion:***

We concluded that DCH's efforts to identify and recover payments for pharmaceutical drugs covered by Medicare were moderately effective. We noted one reportable condition (Finding 1).

***Reportable Condition:***

DCH did not identify and recover Medicaid pharmaceutical drug payments made on behalf of beneficiaries who were Medicare eligible. We estimate that DCH could recover up to \$15.3 million (\$5.4 million General Fund/general purpose) in pharmaceutical claims that were originally paid by Medicaid but are the financial responsibility of Medicare (Finding 1).

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***Audit Objective:***

To assess the effectiveness of DCH's efforts to prevent Medicaid payments for pharmaceutical drugs prescribed by sanctioned or deceased service providers.

***Audit Conclusion:***

We concluded that DCH's efforts to prevent Medicaid payments for pharmaceutical drugs prescribed by sanctioned or deceased service providers were moderately effective. We noted two reportable conditions (Findings 2 and 3).

***Reportable Conditions:***

DCH did not always ensure that it notified the pharmacy benefits manager (PBM) when a provider was sanctioned (suspended, terminated, or excluded) and did not ensure that the PBM implemented sufficient controls to prevent payments to pharmacies for pharmaceutical drugs prescribed by sanctioned providers. In addition, DCH did not seek repayment from the pharmacy providers or the PBM

for \$712,000 (\$249,000 General Fund/general purpose) of payments made for pharmaceutical drugs prescribed by sanctioned Medicaid service providers (Finding 2).

DCH did not always ensure that it notified the PBM of deceased service providers. As a result, 324 pharmacies were reimbursed \$89,000 (\$31,000 General Fund/general purpose) for prescriptions written after the date of death of 82 deceased service providers (Finding 3).

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**Audit Objective:**

To assess the effectiveness of DCH's efforts to monitor the accuracy of drug manufacturer rebates calculated by its contracted PBM.

**Audit Conclusion:**

We concluded that DCH's efforts to monitor the accuracy of drug manufacturer rebates calculated by its contracted PBM were moderately effective. We noted one reportable condition (Finding 4).

**Reportable Condition:**

DCH needs to improve its monitoring of the PBM's calculation, invoicing, and tracking of drug manufacturer rebates (Finding 4).

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**Agency Response:**

Our audit report contains 4 findings and 5 corresponding recommendations. DCH's preliminary response indicates that it agrees with the recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: <http://audgen.michigan.gov>



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THOMAS H. MCTAVISH, C.P.A.  
AUDITOR GENERAL

January 17, 2013

Mr. James K. Haveman, Jr., Director  
Department of Community Health  
Capitol View Building  
Lansing, Michigan

Dear Mr. Haveman:

This is our report on the performance audit of Medicaid Pharmacy Services, Medical Services Administration, Department of Community Health.

This report contains our report summary; description of services; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; Medicaid expenditures and pharmacy expenditures by category, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's response subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

A handwritten signature in black ink that reads "Thomas H. McTavish".

Thomas H. McTavish, C.P.A.  
Auditor General



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## Description of Services

Medicaid is a program that helps certain individuals and families with low incomes and limited resources to pay for some or all of their medical bills. The federal government established Medicaid under Title XIX of the Social Security Act.

The federal government establishes regulations, guidelines, and policy interpretations that describe the broad framework within which states can tailor their individual Medicaid programs. The states operate Medicaid programs according to the respective state rules and criteria that vary within this broad framework. In Michigan, the Medical Services Administration, Department of Community Health (DCH), administers Medicaid.

Medicaid is a joint federal and state funding effort. The federal government matches the funds that each state spends on Medicaid according to the state's federal medical assistance percentage (FMAP). Michigan's FMAP ranged from 63.19% to 66.14% during our audit period.

The federal government requires states to provide a basic set of medical services to people eligible for Medicaid. Providing pharmaceutical services to Medicaid recipients is one of the optional medical services that Michigan has elected to provide. Approximately 1.3 million Michigan Medicaid beneficiaries\* receive pharmaceutical services through one of 14 managed care organizations (MCOs) and 574,000 beneficiaries receive pharmaceutical services through the Medicaid fee-for-service\* (FFS) program. MCOs are not required to pay for pharmaceutical drugs that treat certain medical conditions (referred to as carve-out drugs); instead the pharmacy benefits manager (PBM) receives and processes the claim through the FFS program.

DCH has been contracting with a PBM since July 2000 to administer various pharmaceutical services, such as pharmacy claims processing, drug utilization review\*, pharmacy provider enrollment, provider help line operation, manufacturer drug rebate\* administration, and prior authorizations for certain drugs. The PBM contract requires the use of a point-of-sale (POS) on-line pharmacy claims processing system. The POS

\* See glossary at end of report for definition.

system runs through a series of edit checks to verify the accuracy of the claim, and notification of approval or denial is sent back to the pharmacy. The DCH Pharmacy Management Division monitors the PBM's compliance with the contract.

The PBM processes payments to pharmacy providers and submits a paid claims file weekly to DCH for incorporation into the data warehouse. DCH utilizes the paid claims file to process a payment to the PBM. In addition, DCH uses the paid claims file to monitor the appropriateness of Medicaid FFS and carve-out prescription drug transactions.

Section 1927(a)(1) of the Social Security Act requires drug manufacturers to sign a rebate agreement with the Centers for Medicare and Medicaid Services in order to have their products covered for Medicaid beneficiaries. Michigan's contract with the PBM grants the PBM the authority to administer the federal and state supplemental drug manufacturer rebate program. The PBM negotiates the supplemental drug manufacturer rebates through a multiple-state pool to maximize DCH's rebate revenue. In addition, the PBM invoices the drug manufacturers for the rebate amount, monitors collection of the rebates, and resolves invoice disputes.

Federal regulations and the DCH Medicaid Provider Manual require that DCH utilize all identifiable financial resources prior to expending Medicaid funds for most healthcare services provided to Medicaid beneficiaries. Medicaid FFS beneficiaries may sometimes have other prescription drug coverage through private health plans, employers, noncustodial parents, State programs (such as workers' compensation), or federal programs (such as Medicare). These third parties have primary responsibility for paying Medicaid beneficiaries' prescription drug claims, and Medicaid will pay the portion of the claims that the third parties do not cover.

DCH's pharmaceutical drug claims totaled \$1.7 billion (\$0.6 billion General Fund/general purpose) during the period October 1, 2009 through June 30, 2012 (see supplemental information). Payments from DCH to the PBM for contract administration totaled \$7.1 million and \$6.8 million for fiscal years 2009-10 and 2010-11, respectively.

## Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

### Audit Objectives

Our performance audit\* of Medicaid Pharmacy Services, Medical Services Administration, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness\* of DCH's efforts to identify and recover payments for pharmaceutical drugs covered by Medicare.
2. To assess the effectiveness of DCH's efforts to prevent Medicaid payments for pharmaceutical drugs prescribed by sanctioned\* or deceased service providers.
3. To assess the effectiveness of DCH's efforts to monitor the accuracy of drug manufacturer rebates calculated by its contracted pharmacy benefits manager (PBM).

### Audit Scope

Our audit scope was to examine the records and processes of the Medical Services Administration related to pharmacy services for Medicaid's fee-for-service (FFS) beneficiaries. We excluded supplemental rebates on pharmaceutical drugs (as described in the methodology section) from our audit scope. 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. Our audit procedures, conducted from April through October 2012, covered selected activities during the period October 1, 2009 through July 31, 2012.

As part of our audit, we prepared a summary of Medicaid expenditures and pharmacy expenditures by category, presented as supplemental information. Our audit was not directed toward expressing a conclusion on this information and, accordingly, we express no conclusion on it.

\* See glossary at end of report for definition.

## Audit Methodology

We conducted a preliminary review of Medicaid pharmacy services' operations to formulate a basis for defining the audit objectives and scope. Our preliminary review included interviewing selected DCH personnel and the contracted PBM; reviewing applicable laws, rules, regulations, policies, procedures, manuals, contracts, the Michigan Medicaid State Plan, the DCH Medicaid Provider Manual, and other information; examining reports from other external audits; and obtaining an understanding of internal control\* over pharmacy services.

To accomplish our first objective, we reviewed Medicaid FFS pharmacy claims for beneficiaries who also had Medicare as other insurance coverage. We tested Medicare eligible claims for selected beneficiaries when the claim date of service was after the date that Medicare coverage was identified and entered into the Community Health Automated Medicaid Processing System (CHAMPS) to determine if the claim should have been paid by Medicaid. When we identified claims that appeared to be covered by Medicare but were paid by Medicaid, we determined if postpayment recovery was initiated and obtained.

To accomplish our second objective, we reviewed DCH's description of processes and interviewed DCH staff to obtain and clarify an understanding of the controls that existed to prevent Medicaid payments for drugs prescribed by sanctioned or deceased Medicaid service providers. We performed a comparison of prescribing providers with the DCH vital statistics death records to identify the extent of funds paid to pharmacies for prescriptions written after the date of death of the prescribing providers. We also performed a comparison of prescribing providers with DCH's sanctioned providers list to identify funds paid to pharmacies for prescriptions written by sanctioned providers.

To accomplish our third objective, we interviewed DCH staff to gain an understanding of the controls that were in place to ensure the accuracy of the rebate amount, invoicing to the drug manufacturers, and tracking of the rebate from the drug manufacturers. We obtained the DCH quarterly rebate reconciliation for the FFS rebates and verified the accuracy of the quantity reported and the federal unit rebate amount used for selected line items.

\* See glossary at end of report for definition.

The Centers for Medicare and Medicaid Services (CMS) allows states to enter into agreements with the drug manufacturers for supplemental rebates on pharmaceutical drugs. Michigan, along with nine other states and the District of Columbia, is a member of the National Medicaid Pooling Initiative (NMPI), which is administered by Michigan's PBM. The PBM negotiates supplemental rebates with the drug manufacturers on behalf of the states. The NMPI contract contains language exempting National Drug Code level pricing information from public disclosure. Because DCH cannot guarantee that any information it receives would not be subject to a Freedom of Information Act request, DCH does not have access to the supplemental unit rebate amounts. As noted in the audit scope section, we excluded supplemental rebates from the scope of our review.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit effort on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

#### Agency Responses and Prior Audit Follow-Up

Our audit report contains 4 findings and 5 corresponding recommendations. DCH's preliminary response indicates that it agrees with the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH to develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We released our prior performance audit of Selected Medicaid Pharmaceutical Drug Transactions, Medical Services Administration, Department of Community Health (39-115-04), in March 2006. Within the scope of this audit, we followed up 4 of the 7 prior audit recommendations. DCH complied with 1 of the 4 prior audit recommendations. We repeated 1 prior audit recommendation in Finding 2 of this audit report and rewrote the 2 other prior audit recommendations for inclusion in Findings 1 and 2 of this audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS,  
AND AGENCY PRELIMINARY RESPONSES

## **EFFECTIVENESS OF EFFORTS TO IDENTIFY AND RECOVER PAYMENTS FOR DRUGS COVERED BY MEDICARE**

### **COMMENT**

**Audit Objective:** To assess the effectiveness of the Department of Community Health's (DCH's) efforts to identify and recover payments for pharmaceutical drugs covered by Medicare.

**Audit Conclusion:** We concluded that DCH's efforts to identify and recover payments for pharmaceutical drugs covered by Medicare were moderately effective. Our assessment disclosed one reportable condition\* related to Medicaid recovery for Medicare eligible prescriptions (Finding 1).

### **FINDING**

#### **1. Medicaid Recovery for Medicare Eligible Prescriptions**

DCH did not identify and recover Medicaid pharmaceutical drug payments made on behalf of beneficiaries who were Medicare eligible. We estimate that DCH could recover up to \$15.3 million (\$5.4 million General Fund/general purpose) in pharmaceutical claims that were originally paid by Medicaid but are the financial responsibility of Medicare.

Medicare, the federal health insurance program for people who are age 65 or older or disabled, provides supplemental medical insurance for its enrollees that include certain pharmacy products. Federal law requires Medicaid to be the payer of last resort; therefore, if a beneficiary is dual eligible\*, Medicare coverage must pay first or deny payment prior to Medicaid picking up the cost of the pharmaceutical drug claim.

Beneficiary information is continually updated in the Community Health Automated Medicaid Processing System (CHAMPS) as it becomes available and uploaded daily to the pharmacy benefits manager's (PBM's) electronic point-of-sale (POS) system. The PBM's POS system denies claims when the beneficiary is eligible for and enrolled in Medicare. However, we noted that DCH was not always immediately notified when a beneficiary became eligible for Medicare and, therefore, the information was not uploaded to the PBM's POS system. As a result,

\* See glossary at end of report for definition.

the PBM allowed the claims to be paid because the beneficiaries were still listed in the POS system as being Medicaid eligible when the claims were presented for payment. After the claims were paid, the POS system was updated to reflect that the beneficiaries were, in fact, Medicare eligible at the date of service.

DCH stated that it does not have a process in place to identify and recover payments when a beneficiary is retroactively recorded as being Medicare eligible. DCH indicated that it is currently creating a query to identify claims for which the effective date of Medicare coverage is prior to the date eligibility was recorded in CHAMPS. DCH expected this query to be operational by December 2012 and, at that time, DCH could begin a more thorough review of the pharmaceutical claims.

### **RECOMMENDATION**

We recommend that DCH identify and recover Medicaid pharmaceutical drug payments made on behalf of beneficiaries who were Medicare eligible.

### **AGENCY PRELIMINARY RESPONSE**

DCH agrees that pharmaceutical drug payments made on behalf of beneficiaries who were Medicare eligible were not properly identified and recovered. DCH informed us that its Third Party Liability Division (TPL) is in the process of working with a Medicare contractor to attempt to recover Medicaid cost from Medicare for pharmaceutical products. TPL plans to begin submitting these claims for recovery through Medicare's Limited Income Newly Eligible Transition program (LI NET). LI NET is designed to eliminate any gaps in coverage for Medicaid beneficiaries transitioning to Medicare, or Medicare beneficiaries who become Medicaid eligible, by providing retroactive coverage. Medicaid programs that have paid prescription drug claims during these retroactive periods can submit these claims to LI NET for recovery. DCH indicated that the TPL is in the process of setting up the testing for the transmission of electronic files to LI NET. DCH also indicated that the TPL anticipates that the recovery of these pharmaceutical claims will begin in February 2013.

## **EFFECTIVENESS OF EFFORTS TO PREVENT MEDICAID PAYMENTS FOR DRUGS PRESCRIBED BY SANCTIONED OR DECEASED SERVICE PROVIDERS**

### **COMMENT**

**Audit Objective:** To assess the effectiveness of DCH's efforts to prevent Medicaid payments for pharmaceutical drugs prescribed by sanctioned or deceased service providers.

**Audit Conclusion:** **We concluded that DCH's efforts to prevent Medicaid payments for pharmaceutical drugs prescribed by sanctioned or deceased service providers were moderately effective.** Our assessment disclosed two reportable conditions related to payments for pharmaceutical drugs prescribed by sanctioned service providers and payments for pharmaceutical drugs prescribed by deceased service providers (Findings 2 and 3).

### **FINDING**

#### **2. Payments for Pharmaceutical Drugs Prescribed by Sanctioned Service Providers**

DCH did not always ensure that it notified the PBM when a provider was sanctioned (suspended, terminated, or excluded) and did not ensure that the PBM implemented sufficient controls to prevent payments to pharmacies for pharmaceutical drugs prescribed by sanctioned providers. In addition, DCH did not seek repayment from the pharmacy providers or the PBM for \$712,000 (\$249,000 General Fund/general purpose) of payments made for pharmaceutical drugs prescribed by sanctioned Medicaid service providers.

DCH and/or the U.S. Department of Health and Human Services sanctions Medicaid service providers for various reasons, including a conviction for a Medicaid related crime; Medicaid fraud; patient abuse; and license revocation due to professional incompetence, performance, or financial integrity. Federal law and the DCH Medicaid Provider Manual prohibit Medicaid payments for prescriptions written by sanctioned Medicaid service providers. In addition, the DCH Medicaid Provider Manual requires pharmacy providers to reimburse DCH for any such payments.

The DCH Program Policy Division publishes monthly cumulative listings of sanctioned Medicaid providers on its Web site, and updates are published in DCH Medicaid Policy Bulletins as additions and deletions are made to the list. Generally, once the bulletins are released, the Pharmacy Management Division, which is responsible for monitoring the PBM's compliance with the contract, requests that the PBM process a change to the business rule that will deny payment to pharmacies for pharmaceutical drugs prescribed by the identified sanctioned providers.

We reviewed 143 of 436 sanctioned providers from the cumulative list on DCH's Web site as of June 14, 2012 to determine if any pharmacies received payment for prescriptions written by the sanctioned providers subsequent to the date of sanction. We identified 16,818 paid fee-for-service (FFS) claims totaling \$712,000 (\$249,000 General Fund/general purpose) from October 1, 2009 through April 30, 2012 for 33 sanctioned providers. Additional detailed review of these FFS claims disclosed:

- a. DCH did not inform the PBM of the sanctioned status of two providers. These sanctioned providers were included on the cumulative list but not in the DCH Medicaid Policy Bulletins. Pharmacy Management Division staff indicated that they identify newly sanctioned providers primarily from the monthly DCH Medicaid Policy Bulletins and occasional notifications from other DCH areas. The Pharmacy Management Division then notifies the PBM, who is responsible for processing a change to the business rule that denies payment to pharmacies for prescriptions ordered by sanctioned providers. The PBM paid 1,000 claims totaling \$27,900 to these two sanctioned providers. The PBM informed us that it only makes changes to a business rule to deny payment to sanctioned providers when the PBM receives notification from DCH.
- b. DCH did not ensure that the PBM, once notified of the sanctioned providers, implemented controls to prevent payments for pharmaceutical drugs prescribed by sanctioned providers. The PBM paid 160 claims to pharmacies totaling \$7,500 for prescriptions ordered by 9 sanctioned providers after the PBM received notification from DCH that the provider was sanctioned. The PBM responded to DCH that the PBM updated the business rule; however,

payments were still processed to pharmacies for prescriptions prescribed by these sanctioned providers. In addition, the PBM responded that the pharmacy entered the incorrect prescribing provider in the POS system for 8 of the claims and that the actual prescribing provider was not sanctioned.

- c. DCH did not seek repayment from pharmacy providers or the PBM for payments made for pharmaceutical drugs prescribed by sanctioned providers. Although DCH may not receive timely notification of sanctioned providers, the DCH Medicaid Provider Manual states that a sanctioned provider is excluded from Medicaid participation even if that provider has not been included on Medicaid's list of sanctioned providers. The DCH Medicaid Provider Manual also states that any payment, even if unintentional, made to a sanctioned provider or a provider acting on an order or prescription from a sanctioned provider for dates of service on or after the date indicated on the sanctioned provider list must be refunded to Medicaid.

We reported the same issue in our prior audit. DCH agreed with our recommendation and informed us that DCH would seek repayment from pharmacies, as appropriate, for payments made for drugs prescribed by sanctioned providers.

## **RECOMMENDATIONS**

We recommend that DCH ensure that it notifies the PBM when a provider is sanctioned and ensure that the PBM implements sufficient controls to prevent payments to pharmacies for pharmaceutical drugs prescribed by sanctioned providers.

We again recommend that DCH seek repayment from the pharmacy providers or the PBM for the payments made for pharmaceutical drugs prescribed by sanctioned Medicaid service providers.

## **AGENCY PRELIMINARY RESPONSE**

DCH agrees that it did not always notify the PBM when a provider was sanctioned (suspended, terminated, or excluded) and did not ensure that the PBM implemented sufficient controls to prevent payments to pharmacies for pharmaceutical drugs by sanctioned providers:

- a. DCH agrees that it failed to notify the PBM of two providers identified on DCH's comprehensive sanctioned providers list but not published in a policy bulletin.

DCH indicated that it is streamlining the current sanctioned provider notification to a Web-based process to further improve the timely production of updates to its comprehensive provider sanctions/exclusions listing. As part of this process, DCH will be modifying its internal procedures to accommodate the new DCH sanctioned provider Web-based notifications. In addition, DCH indicated that it continues work toward its commitment to the Centers for Medicare and Medicaid Services (CMS) to restrict referring/prescribing providers to only those enrolled in Medicaid during 2013. Once promulgated, this policy will allow DCH to provide its PBM a prescriber reference file of CHAMPS active/enrolled prescribers. As a result, prescriptions written by sanctioned/excluded providers will automatically deny at the POS once the sanctioned/excluded prescriber's enrollment is inactivated in CHAMPS.

- b. DCH agrees that it did not appropriately monitor the PBM to ensure the sanctioned provider POS system edits were functioning as intended. DCH indicated that, subsequent to the audit, the PBM streamlined its sanctioned prescriber coding to minimize risk of manual errors. In addition, DCH informed us that it will update its internal procedures to routinely monitor sanctioned prescriber POS system edits to ensure they are functioning as intended.
- c. DCH agrees that it did not seek repayment from some pharmacy providers or the PBM for payments made for pharmaceutical drugs prescribed by sanctioned providers. DCH informed us that it will review the claims identified in the audit and recover payments from pharmacies or the PBM where appropriate and not cost prohibitive. In addition, DCH indicated that it will review existing Medicaid Provider Manual language for consistency and recommend modifications if necessary.

## FINDING

### 3. Payments for Pharmaceutical Drugs Prescribed by Deceased Service Providers

DCH did not always ensure that it notified the PBM of deceased service providers. As a result, 324 pharmacies were reimbursed \$89,000 (\$31,000 General Fund/general purpose) for prescriptions written after the date of death of 82 deceased service providers.

DCH contracts with the PBM to process pharmacy claims reimbursed through the FFS program. DCH's pharmaceutical drug claims totaled \$1.7 billion during the period October 1, 2009 through June 30, 2012. Section 333.17751(4) of the *Michigan Compiled Laws* states that a pharmacist shall not knowingly dispense a prescription after the death of the prescriber.

We performed a comparison of prescribing providers with the DCH vital statistics death records and identified 82 deceased providers with prescriptions filled between October 1, 2009 and June 7, 2012 which were written after the date of death of the prescribing provider. The following table summarizes our query of prescriptions filled by pharmacies that were written after the date of death of the prescribing provider:

Prescriptions Filled by Pharmacies That Were Written  
After the Date of Death of the Prescribing Provider

Length of Time	Prescriptions	
	Amount Paid to Pharmacies	Number of Prescriptions
Less than 31 days	\$16,097	276
31 - 90 days	15,207	456
91 - 180 days	7,322	206
181 - 365 days	15,801	303
Greater than 1 - 2 years	25,154	345
Greater than 2 - 3 years	8,375	139
Greater than 3 - 4 years	784	45
Greater than 4 - 5 years	250	37
Greater than 5 - 6 years	19	4
	<u>\$89,010</u>	<u>1,811</u>

The Provider Enrollment Section within DCH is responsible for identifying deceased providers. The Pharmacy Management Division is responsible for informing the PBM of deceased providers so that the PBM can update the business rule in the POS system to deny claims for the deceased providers. However, DCH did not have a process in place to notify the Pharmacy Management Division when the Provider Enrollment Section identified a deceased provider. The Pharmacy Management Division informed us that it was notified of only one prescribing provider's death during our audit period.

### **RECOMMENDATION**

We recommend that DCH ensure that it notifies the PBM of deceased service providers.

### **AGENCY PRELIMINARY RESPONSE**

DCH agrees that there are opportunities for improvement in its processes for notifying its PBM of deceased service providers. DCH informed us that the Pharmacy Management Division will work with the Provider Enrollment Section to develop a notification process for deceased providers so that it can provide more timely notification to its PBM vendor. In addition, DCH indicated that it continues work toward its commitment to CMS to restrict referring/prescribing providers to only those enrolled in Medicaid during 2013. Once promulgated, this policy will allow DCH to provide its PBM a prescriber reference file of CHAMPS active/enrolled prescribers. As a result, prescriptions written after a prescriber's date of death will automatically deny at the POS once the deceased prescriber's enrollment is inactivated in CHAMPS.

## **EFFECTIVENESS OF EFFORTS TO MONITOR THE ACCURACY OF DRUG MANUFACTURER REBATES**

### **COMMENT**

**Audit Objective:** To assess the effectiveness of DCH's efforts to monitor the accuracy of drug manufacturer rebates calculated by its contracted PBM.

**Audit Conclusion: We concluded that DCH's efforts to monitor the accuracy of drug manufacturer rebates calculated by its contracted PBM were moderately effective.** Our assessment disclosed one reportable condition related to the monitoring of drug manufacturer rebates (Finding 4).

## **FINDING**

### **4. Monitoring of Drug Manufacturer Rebates**

DCH needs to improve its monitoring of the PBM's calculation, invoicing, and tracking of drug manufacturer rebates. Without sufficient monitoring of the drug manufacturer rebates, DCH cannot ensure that the drug manufacturer rebates calculated, invoiced, and collected are accurate. During fiscal year 2010-11, DCH received \$364.0 million and \$146.0 million in FFS and managed care organization (MCO) rebates, respectively.

Section 1927 (a)(1) of the Social Security Act requires drug manufacturers to enter into rebate agreements with the federal government if the manufacturers intend for their drugs to be prescribed for beneficiaries of Medicaid and other programs. The Medicaid Drug Rebate Program is a partnership between CMS, state Medicaid agencies, and participating drug manufacturers that helps to offset the federal and state costs of most outpatient prescription drugs dispensed to Medicaid beneficiaries. A rebate is payment to DCH by drug manufacturers for prescribed drugs provided to beneficiaries and paid for by the federal programs. Each drug has a specific rebate amount, which is agreed upon by CMS and each drug manufacturer. DCH's PBM reports to CMS and DCH which FFS pharmaceutical drugs were obtained by beneficiaries.

Beginning March 23, 2010, Section 2501 of the Patient Protection and Affordable Care Act extended the prescription drug rebate program to Medicaid beneficiaries enrolled in MCOs. DCH receives pharmacy encounter data\* from each of the 14 MCOs and loads it into the data warehouse. DCH's contractor runs quarterly queries on the encounter data to create a file that is sent to the PBM and is used to invoice the drug manufacturers for MCO rebates.

\* See glossary at end of report for definition.

The PBM imports paid FFS pharmacy and physician administered claims and MCO pharmacy and physician administered encounters into its rebate subsystem. The PBM performs preinvoicing edits, applies CMS-established National Drug Code unit rebate amounts, compiles and mails rebate invoices to drug manufacturers, facilitates dispute resolution on DCH's behalf, tracks manufacturer rebate payments, and prepares and maintains historical rebate reports.

The PBM invoices the drug manufacturers for FFS and MCO rebates separately. Each drug manufacturer remits payment directly to DCH, and DCH provides the PBM with detailed payment documentation so that the PBM can monitor amounts invoiced and received from each drug manufacturer.

Our review disclosed:

- a. DCH did not thoroughly investigate significant differences between the amount DCH calculated and the amount that the PBM invoiced to the drug manufacturer for FFS rebates. DCH calculated rebates that were \$9.0 million, \$16.3 million, and \$17.4 million larger than the amount billed by the PBM to the drug manufacturers for the quarters ended September 30, 2011, December 31, 2011, and March 31, 2012, respectively.

DCH indicated that these differences are likely because of the physician administered outpatient drug claims. In its calculation, DCH is attempting to re-create the rebates invoiced; however, DCH's query of paid claims for physician administered drugs from the data warehouse for the quarter ended March 31, 2012 was double the query from CHAMPS that was sent to the PBM for use in its rebate calculation. DCH informed us that because of limited staff resources, DCH has been unable to follow up this discrepancy and identify the specific source of the difference. Because DCH has not identified the source of the differences, DCH could not be assured that the data provided to the PBM for rebate invoicing was accurate and complete.

- b. DCH did not have a process in place to verify the MCO rebates invoiced by the PBM. DCH performs an overall reasonableness test on the dollar value and volume of claims sent to the PBM for MCO rebate invoicing. However, DCH did not have procedures in place to recalculate the total rebates invoiced

to ensure accurate invoicing and collection of MCO rebates similar to the recalculation performed for the FFS rebates noted in part a.

DCH's contract with the PBM requires that the PBM perform specific duties related to rebate administration. To ensure that the PBM is properly executing the contract, DCH should monitor certain aspects of those duties.

### **RECOMMENDATION**

We recommend that DCH improve its monitoring of the PBM's calculation, invoicing, and tracking of drug manufacturer rebates.

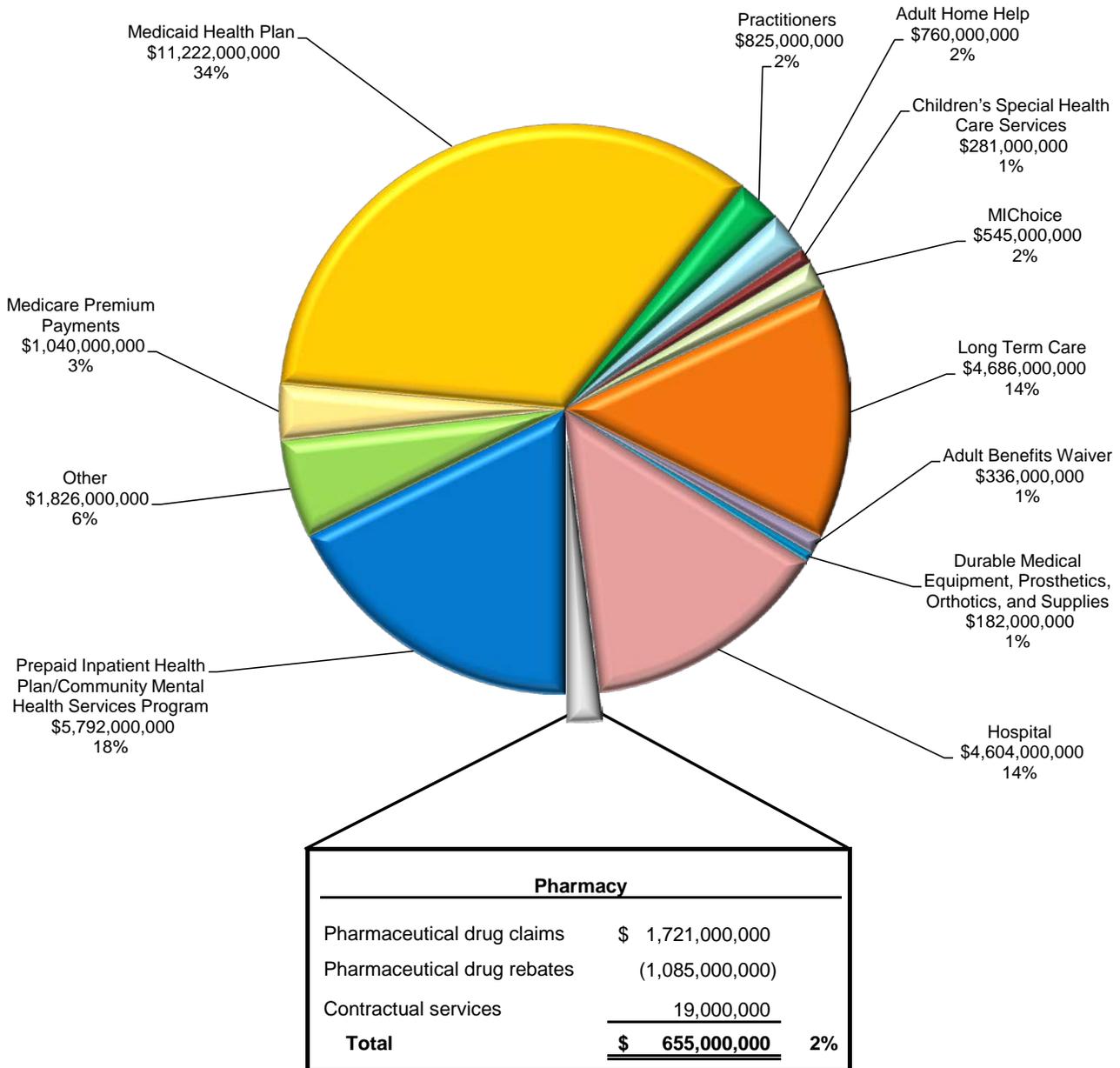
### **AGENCY PRELIMINARY RESPONSE**

DCH agrees that there are opportunities for improvement in its monitoring of the PBM's calculation, invoicing, and tracking of drug manufacturer rebates:

- a. DCH agrees that, due to limited staff resources, it was unable to thoroughly investigate the rebate variance between the amount DCH calculated and the amount the PBM invoiced. DCH informed us that it will thoroughly investigate the rebate variance within the physician administered drug claims for the quarters in question and implement corrective actions, if appropriate. In addition, DCH indicated that it will be increasing Pharmacy Management Division resources during 2013, so that future variances are investigated more timely.
- b. DCH agrees that it did not have a process in place to verify the MCO rebates invoiced by the PBM. As noted in the finding, DCH implemented an overall reasonableness check but did not have procedures to recalculate the total rebates invoiced. In addition, DCH informed us that it will implement internal procedures to validate MCO rebate invoicing.

# SUPPLEMENTAL INFORMATION

**MEDICAID PHARMACY SERVICES**  
 Department of Community Health (DCH)  
 Medicaid Expenditures and Pharmacy Expenditures by Category  
October 1, 2009 Through June 30, 2012



Source: Prepared by the Office of the Auditor General using data from the State's accounting system and DCH.

# GLOSSARY

## Glossary of Acronyms and Terms

beneficiary	A person who is enrolled in Medicaid who can receive medical services that are paid for with Medicaid funds.
CHAMPS	Community Health Automated Medicaid Processing System.
CMS	Centers for Medicare and Medicaid Services.
DCH	Department of Community Health.
drug utilization review	An annual federal requirement to promote patient safety and identify provider prescribing habits and dollars saved by avoidance of problems, such as drug-drug interactions, drug-disease interactions, therapeutic duplication, and overprescribing by providers.
dual eligible	Eligible for both Medicare and Medicaid insurances.
effectiveness	Success in achieving mission and goals.
fee-for-service (FFS)	The method of paying a medical provider for each service rendered.
FMAP	federal medical assistance percentage.
internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, goals, and objectives. Internal control includes the processes for planning, organizing, directing, and controlling program operations. It includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.

LI NET	Limited Income Newly Eligible Transition program.
manufacturer drug rebates	Negotiated rebates with drug manufacturers that afford state Medicaid programs the opportunity to reimburse pharmacy providers for drugs at discounted prices similar to those offered by drug manufacturers to other large purchasers.
MCO	managed care organization.
NMPI	National Medicaid Pooling Initiative.
PBM	pharmacy benefits manager.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
pharmacy encounter data	Managed care organization pharmacy claims.
POS	point-of-sale.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.

sanctioned provider

A provider who has been suspended, terminated, or excluded from furnishing, ordering, or prescribing items or services to Medicaid beneficiaries.

TPL

Third Party Liability Division.







