MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF

SELECTED MEDICAID PHARMACEUTICAL DRUG TRANSACTIONS

MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

March 2006

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

39-115-04

"...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

Audit report information may be accessed at:
http://audgen.michigan.gov

Michigan

Office of the Auditor General

REPORT SUMMARY

Performance Audit

Selected Medicaid Pharmaceutical Drug Transactions

Medical Services Administration
Department of Community Health

Report Number:
39-115-04

Released:
March 2006

Providing pharmaceutical services to Medicaid recipients is one of the optional medical services that Michigan has elected to provide. The Department of Community Health (DCH) began contracting with a pharmacy benefits manager (PBM) in April 2000 for various pharmaceutical services. DCH paid $1.6 billion for 31.6 million pharmacy claims processed by its PBM during the period October 1, 2002 through September 30, 2004. DCH paid its PBM $17.8 million during that same two-year period for contract administration.

Audit Objective:

To assess the effectiveness of DCH's efforts in monitoring its contracted PBM's performance to ensure that Medicaid is the payer of last resort for selected pharmaceutical drug transactions.

Conclusion:

DCH's efforts were not effective in monitoring its contracted PBM's performance to ensure that Medicaid is the payer of last resort for selected pharmaceutical drug transactions.

Material Conditions:

The material conditions in our report disclosed $55.1 million in Medicaid payments comprised of known overpayments of $15.2 million and questionable payments of $39.9 million.

DCH did not sufficiently monitor its PBM to ensure that the PBM had effective controls to prevent and detect when pharmacy providers billed Medicaid for certain pharmacy claims that pharmacy providers should have billed to Medicare. In addition, DCH did not recover from the pharmacy providers or the PBM the associated Medicaid payments made for pharmacy claims that Medicare should have paid. (Finding 1)

As a result, DCH overpaid $15.2 million ($6.7 million of State General Fund/general purpose funding) in Medicaid fee-for-service pharmacy claims for a specific pharmacy product that "dual eligible" beneficiaries' Medicare benefits should have paid during the period July 1, 2000 through September 30, 2004. DCH may also have overpaid some portion of another $10.4 million in questionable Medicaid fee-for-service pharmacy claims for other pharmacy products that are sometimes eligible for Medicare payment.

DCH did not sufficiently monitor and investigate Medicaid fee-for-service prescription drug payments processed by its PBM to help ensure that Medicaid is the payer of last resort. Also, DCH did not determine the appropriateness of questionable third party payment amounts,

did not determine if its Third Party Liability (TPL) section had recovered inappropriate Medicaid payments made for pharmacy claims, and did not determine the amounts for which the PBM or pharmacy providers may be liable. (Finding 2)

As a result of DCH's insufficient monitoring, DCH could not ensure that Medicaid was the payer of last resort for questionable prescription drug claims totaling approximately $29.5 million ($13.0 million of State General Fund/general purpose funding).

Reportable Condition:
DCH did not ensure that postpayment audits conducted at pharmacy providers included a review of billings to and amounts collected from third parties for Medicaid fee-for-service prescription drug claims (Finding 3).

Noteworthy Accomplishments:
In November 2003, The Lewin Group reported that Michigan had the second lowest per member per month Medicaid pharmacy cost of any state. In September 2004, the U.S. Department of Health and Human Services' Office of the Inspector General reported that Michigan ranked first out of 42 states in having the lowest reimbursement rates in three categories of drugs. DCH informed us that per capita pharmacy expenditures in the Michigan Medicaid Program decreased 0.7% from fiscal year 2002-03 to 2003-04, while the national per capita amount of pharmacy expenditures increased 11.3%.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Audit Objective:
To assess the effectiveness of DCH's efforts to prevent and detect Medicaid payments for pharmaceutical drugs prescribed by service providers excluded (sanctioned) from participating in Medicaid.

Conclusion:
DCH efforts were moderately effective in preventing and detecting Medicaid payments for pharmaceutical drugs prescribed by service providers excluded (sanctioned) from participating in Medicaid.

Reportable Condition:
DCH needs to improve its controls to prevent and detect Medicaid fee-for-service payments for pharmaceutical drugs prescribed by sanctioned Medicaid service providers. In addition, DCH needs to seek repayment from the pharmacy providers or the PBM for the pharmaceutical drugs prescribed by sanctioned Medicaid service providers. (Finding 4) The finding disclosed $92,504 in inappropriate Medicaid payments for drugs prescribed by the sanctioned Medicaid service providers.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Agency Response:
Our report contains 4 findings and 7 corresponding recommendations. DCH's preliminary responses indicate that it agrees with all 7 of our recommendations.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~

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

Michigan Office of the Auditor General
201 N. Washington Square
Lansing, Michigan 48913

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

Scott M. Strong, C.P.A., C.I.A.
Deputy Auditor General

STATE OF MICHIGAN
OFFICE OF THE AUDITOR GENERAL
201 N. WASHINGTON SQUARE
LANSING, MICHIGAN 48913
(517) 334-8050
FAX (517) 334-8079

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

March 3, 2006

Ms. Janet Olszewski, Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the performance audit of Selected Medicaid Pharmaceutical Drug Transactions, Medical Services Administration, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; 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 responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

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

AUDITOR GENERAL

This Page Left Intentionally Blank

TABLE OF CONTENTS

SELECTED MEDICAID PHARMACEUTICAL DRUG TRANSACTIONS
MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

Description of Agency

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. Michigan's percentage was 58.84% through June 30, 2004. Starting July 1, 2004, the percentage changed to 55.89% for the remainder of fiscal year 2003-04.

The federal government requires states to provide a basic set of medical services to people eligible for Medicaid. The states have the option of providing medical services in addition to the basic services. Providing pharmaceutical services to Medicaid recipients is one of the optional medical services that Michigan has elected to provide. The Medical Services Administration is responsible for administering the pharmaceutical benefits for Medicaid's approximately 500,000 fee-for-service* beneficiaries*.

DCH began contracting with a pharmacy benefits manager (PBM) in April 2000 to administer various pharmaceutical services, such as pharmacy claims processing, drug utilization review*, postpayment audits of the pharmacy providers, provider help line operation, manufacturer drug rebate* administration, and prior authorizations for certain drugs. The PBM was contractually required to implement a "point-of-sale" on-line pharmacy claims processing system by July 1, 2000. One objective of the PBM's on-line claims processing system is to improve DCH's pharmacy management through accurate and timely reporting of pharmacy costs, trends, and action plans.

* *See glossary at end of report for definition.*

The PBM processes payments to pharmacy providers and provides a paid claims file weekly to DCH for incorporation into the Medicaid Management Information System (MMIS). DCH uses MMIS to process a payment back to the PBM based on that data. DCH stores data from the paid claims file in its data warehouse and can perform various ad hoc queries for use in monitoring the appropriateness of Medicaid fee-for-service prescription drug claims.

Federal regulations and the DCH Medicaid Provider Manual require Medicaid to be the payer of last resort. Medicaid fee-for-service beneficiaries 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 contract with the PBM stipulates that the PBM is responsible for ensuring that Medicaid is the payer of last resort. The contract also states that the PBM shall be liable for the actual amount of all overpayments caused by the PBM for which full recovery from the pharmacy providers cannot be made. DCH retains responsibility for Medicaid policy and prescription drug coverage decisions and is ultimately accountable for the disbursement of State and federal Medicaid funds and the enforcement of applicable Medicaid laws and regulations.

The PBM processed payments totaling $1.6 billion to pharmacy providers for 31.6 million Medicaid fee-for-service prescription drug claims during the period October 1, 2002 through September 30, 2004. Payments from DCH to the PBM for contract administration totaled $7.8 million and $10.0 million in fiscal years 2002-03 and 2003-04, respectively.

As of September 2004, DCH dedicated 301 full-time equated positions to its Medicaid efforts. Michigan's Medicaid expenditures totaled $7.3 billion for fiscal year 2003-04.

Audit Objectives

Our performance audit* of Selected Medicaid Pharmaceutical Drug Transactions, Medical Services Administration, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness* of DCH's efforts in monitoring its contracted pharmacy benefits manager's (PBM's) performance to ensure that Medicaid is the payer of last resort for selected pharmaceutical drug transactions.

2. To assess the effectiveness of DCH's efforts to prevent and detect Medicaid payments for pharmaceutical drugs prescribed by service providers excluded (sanctioned) from participating in Medicaid.

Audit Scope

Our audit scope was to examine the program and other records of the Medical Services Administration related to the administration of pharmaceutical benefits for Medicaid's fee-for-service beneficiaries. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Audit Methodology

We performed our initial audit procedures between June and December 2004. We performed additional audit procedures between March and June 2005, primarily in response to new information provided by DCH during that time period. Our audit procedures included an examination of Medicaid pharmaceutical records and activities primarily for the period October 1, 2002 through September 30, 2004. To accomplish our audit objectives, we reviewed federal regulations, State statutes, Medicaid policies and procedures, audit reports from other states, and publications and periodicals on the topics of Medicaid and pharmaceutical drugs. In addition, we interviewed Medicaid management and staff.

** See glossary at end of report for definition.*

In connection with our first objective, we reviewed Medicaid fee-for-service pharmacy claims for beneficiaries who also had other insurance coverage. We interviewed DCH personnel to determine what the monitoring efforts were over DCH's PBM to ensure that Medicaid was the payer of last resort for pharmacy claims for those beneficiaries. Through these interviews, we also obtained an understanding of the PBM's on-line system used to process pharmacy claims and the controls involved with third party billings. Using data in DCH's data warehouse, we examined third party billing data and determined that there were 4.4 million Medicaid fee-for-service pharmacy claims totaling $204 million in which pharmacy providers had recorded a third party payment amount of $0 or some other nominal amount. We further analyzed these claims and discussed them with DCH staff to determine the appropriateness of the payment amounts recorded from the third parties. In addition, we assessed the effectiveness of the postpayment audits conducted at the pharmacy providers in identifying inappropriate payment amounts from third parties.

In connection with our second objective, we interviewed DCH staff to obtain an understanding of the controls that existed to prevent and detect Medicaid payments for drugs prescribed by sanctioned Medicaid service providers. In connection with these controls, we reviewed DCH's timeliness in updating the listing of sanctioned Medicaid service providers that it provided to its PBM. Through our interviews with DCH staff, we also determined if DCH's PBM had implemented controls in its on-line pharmacy claims processing system that would prevent claims from being paid by Medicaid when a sanctioned Medicaid service provider had prescribed the drugs. Using pharmacy claim data in DCH's data warehouse, we determined if there were pharmacy claims paid by Medicaid that a sanctioned provider had prescribed and then assessed the appropriateness of these claims.

We use a risk-based approach when selecting activities or programs to be audited. Accordingly, our audit efforts are focused on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. By design, our limited audit resources are used to identify where and how improvements can be made. Consequently, our audit reports are prepared on an exception basis. To the extent practical, we add balance to our audit reports by presenting noteworthy accomplishments for exemplary achievements identified during our audits.

Agency Responses

Our report contains 4 findings and 7 corresponding recommendations. DCH's preliminary responses indicate that it agrees with all 7 of our 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 Department of Management and Budget Administrative Guide procedure 1280.02 require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFORTS TO ENSURE THAT MEDICAID IS THE PAYER OF LAST RESORT

COMMENT

Audit Objective: To assess the effectiveness of the Department of Community Health's (DCH's) efforts in monitoring its contracted pharmacy benefits manager's (PBM's) performance to ensure that Medicaid is the payer of last resort for selected pharmaceutical drug transactions.

Conclusion: DCH's efforts were not effective in monitoring its contracted PBM's performance to ensure that Medicaid is the payer of last resort for selected pharmaceutical drug transactions. Our review disclosed two material conditions*:

- DCH did not sufficiently monitor its PBM to ensure that the PBM had effective controls to prevent and detect when pharmacy providers billed Medicaid for certain pharmacy claims that pharmacy providers should have billed to Medicare. In addition, DCH did not recover from the pharmacy providers or the PBM the associated Medicaid payments made for pharmacy claims that Medicare should have paid. (Finding 1)

- DCH did not sufficiently monitor and investigate Medicaid fee-for-service prescription drug payments processed by its PBM to help ensure that Medicaid is the payer of last resort. Also, DCH did not determine the appropriateness of questionable third party payment amounts, did not determine if its Third Party Liability (TPL) section had recovered inappropriate Medicaid payments made for pharmacy claims, and did not determine the amounts for which the pharmacy providers or the PBM may be liable. (Finding 2)

In addition, we noted a reportable condition* related to postpayment audits (Finding 3).

Noteworthy Accomplishments: DCH informed us that it administers several strategies to help reduce Medicaid prescription drug costs. These strategies include requiring pharmacy providers to select drugs from a preferred drug list, utilizing maximum allowable cost drug pricing, participating in a multi-state drug purchasing pool, collecting manufacturer drug rebates pursuant to federal regulations, requiring

* *See glossary at end of report for definition.*

prior authorization for selected drugs, performing drug utilization reviews and counter-detailing, and requiring beneficiary copayments.

In November 2003, The Lewin Group published a study entitled, "Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System." The study was commissioned by the State of Arizona and was funded by the Center for Health Care Strategies, Inc. (CHCS). A comparison of federal fiscal year 2001-02 Medicaid pharmacy costs by state (Table II-1) shows Michigan as having the second lowest per member per month cost of any state. The study can be found on the Internet at <http://www.chcs.org/usr_doc/RxCarveout.pdf>.

In September 2004, the U.S. Department of Health and Human Services' (HHS's) Office of the Inspector General (OIG) issued a report entitled, "Variation in State Medicaid Drug Prices." To assess the extent to which state Medicaid programs vary in pharmacy reimbursement for the same drugs, OIG staff analyzed fiscal year 2000-01 reimbursement data for 28 drugs from 42 states. Table D of the report ranks selected states in four drug categories: all 28 drugs, single source drugs, Innovator (brand name) multisource drugs, and non-Innovator (generic) multisource drugs. In each of the first three categories, Michigan ranked first out of the 42 states in having the lowest reimbursement rates. In the fourth category, Michigan ranked third. The report can be found on the Internet at <http://oig.hhs.gov/oei/reports/oei-05-02-00681.pdf>.

DCH also informed us that per capita pharmacy expenditures in the Michigan Medicaid Program decreased 0.7% from fiscal year 2002-03 to 2003-04, while the national per capita amount of pharmacy expenditures increased 11.3%.

FINDING

1. Medicaid Overpayments for Medicare Eligible Prescriptions

   DCH did not sufficiently monitor its PBM to ensure that the PBM had effective controls to prevent and detect when pharmacy providers billed Medicaid for certain pharmacy claims that pharmacy providers should have billed to Medicare. In addition, DCH did not recover from the pharmacy providers or the PBM the associated Medicaid payments made for pharmacy claims that Medicare should have paid.

   As a result, DCH overpaid $15.2 million ($6.7 million of State General Fund/general purpose funding) in Medicaid fee-for-service pharmacy claims for a specific

pharmacy product that "dual eligible" beneficiaries' Medicare benefits should have paid during the period July 1, 2000 through September 30, 2004. DCH may also have overpaid some portion of another $10.4 million in questionable Medicaid fee-for-service pharmacy claims for other pharmacy products that are sometimes eligible for Medicare payment.

Medicare, the federal health insurance program for people who are age 65 or older or disabled, provides supplemental medical insurance for its enrollees that includes certain pharmacy products. As of September 2004, there were 8,097 Medicaid beneficiaries who were dual eligible for both Medicaid and Medicare and had obtained prescription drugs paid 100% by Medicaid. Federal law requires Medicaid to be the payer of last resort. DCH should ensure that its PBM has implemented effective controls to prevent Medicaid fee-for-service payments for prescriptions that beneficiaries' Medicare benefits would cover and should immediately recover related Medicaid overpayments. Medicare claims are generally 100% federally funded.

Our review of Medicaid fee-for-service pharmacy claims for dual eligible beneficiaries disclosed:

a. We identified $10.4 million in Medicaid fee-for-service pharmacy claims for a specific pharmacy product during the period July 1, 2000 through August 31, 2003 that pharmacy providers should have billed to Medicare. DCH informed us that the PBM did not have an edit in its on-line claims processing system prior to September 1, 2003 to require pharmacy providers to bill Medicare for eligible beneficiaries' prescription claims for this pharmacy product.

b. Although the new edit was effective September 1, 2003, our review identified an additional $4.8 million in Medicaid fee-for-service pharmacy claims for this same product during the period September 1, 2003 through September 30, 2004 that pharmacy providers should have billed to Medicare but had continued to bill Medicaid because of an error in the PBM's on-line claims processing system. DCH stated that the error was identified and corrected in October 2004.

c. DCH did not analyze an additional population of questionable pharmacy claims for other products eligible for Medicare reimbursement, under certain conditions, submitted between October 1, 2002 and September 30, 2004.

Pharmacy providers billed 100% of these claims, which also totaled $10.4 million, to Medicaid even though the beneficiaries were also eligible for Medicare. Additional analysis would help DCH to identify if there were more instances in which pharmacy providers should have billed Medicare instead of Medicaid. DCH informed us that it could not perform the additional analysis because of limitations with the information captured in its data warehouse and because of complex Medicare coverage laws. DCH also informed us that it felt additional analysis was not necessary because the claims for these products were subject to cost avoidance edits in the PBM's on-line claims processing system. Considering the errors noted in this finding, we question whether DCH's reliance on these cost avoidance edits was sufficient to ensure Medicaid was the payer of last resort.

Although the DCH Medicaid Provider Manual allows DCH to initiate an adjustment with the pharmacy providers to obtain money paid for services that did not comply with Medicaid coverage, billing, and/or reimbursement policies, DCH had not initiated any such adjustments. Also, the contract with the PBM states that the PBM shall be liable for the actual amount of all overpayments caused by the PBM for which full recovery from the pharmacy providers cannot be made.

DCH informed us that it would not seek recovery from the pharmacy providers for the overpayments, but rather that it planned to rebill for these claims directly to Medicare. Federal regulations require Medicare billings to occur between 15 and 27 months from the dates of service. Therefore, DCH's recovery efforts will be limited to the most recent 27-month period when it initiates the first billing to Medicare. With this recovery approach, DCH would forego collecting the $8.8 million (58%) it overpaid between July 1, 2000 and March 30, 2003 if it began submitting billings to Medicare by July 1, 2005. DCH has the authority to pursue recovery of the $8.8 million from the pharmacy providers who processed the inappropriate claims and/or the PBM for the errors noted in its on-line claims processing system that allowed the inappropriate claims. At the conclusion of our audit fieldwork, DCH had not recovered any of the Medicaid overpayments and had not recorded in the State's accounting records a related liability to the federal government or amounts due from the pharmacy providers or the PBM to the State for the Medicaid overpayments made to the pharmacy providers.

RECOMMENDATIONS

We recommend that DCH sufficiently monitor its PBM to ensure that the PBM has effective controls to prevent and detect when pharmacy providers bill Medicaid for certain pharmacy claims that pharmacy providers should bill to Medicare.

We also recommend that DCH seek to immediately recover from the pharmacy providers or the PBM the associated Medicaid payments made for pharmacy claims that Medicare should pay.

AGENCY PRELIMINARY RESPONSE

DCH agrees with the finding and the first recommendation and agrees in principle with the second recommendation that it should seek to recover any inappropriate payments. DCH will take steps to improve its monitoring activities over Medicaid fee-for-service payments processed by its PBM. DCH will ensure that it regularly reviews monthly reports submitted by the PBM that identify the number of requests to its Clinical Call Center for overrides for Medicare-covered drugs. DCH will also regularly review payments made for drugs that are potentially covered by Medicare on a sample basis and, for the selected sample, the PBM will be required to provide DCH with copies of the documentation showing that Medicare rejected the claim.

With respect to the second recommendation, DCH indicated that it recovered nearly $3.2 million of the overpayment described in item b. of the finding directly from Medicare subsequent to the completion of the audit fieldwork. DCH also indicated that, for the Medicaid claims it paid that are outside of the 27-month billing period allowed by federal regulations, it is continuing to pursue recovery of those claims directly with Medicare. However, DCH further indicated that it would not be appropriate to pursue recoveries from the pharmacies or the PBM for the remaining portion of the overpayment because the claims and payments were processed in accordance with DCH specifications in effect when the services were rendered.

For the other population of approximately $10.4 million described in item c. of the finding, DCH agrees that potentially some portion of the amount paid could have been covered by Medicare, but DCH indicated that it does not have the resources or system capability that would be necessary to retroactively and individually analyze the propriety of these claims. DCH stated that it is very important to

recognize that Medicare's coverage of drugs and related products under Medicare Part B is very restricted and that there is no published list of products that are always covered. While DCH acknowledges limitations in its monitoring activities, DCH stated that the PBM has assured it that the PBM's on-line claims processing system edits claims against a list of drug categories that includes products covered conditionally by Medicare Part B. DCH indicated that it updates the list periodically as Medicare guidelines change or as drugs/products come on the market.

DCH indicated that the PBM utilized point-of-sale editing and phone authorizations to help ensure that Medicaid payment for the covered products was appropriate during the audit period. DCH also indicated that, to improve the documentation of this process, at DCH's direction in fall 2004, the PBM began requiring pharmacies to submit a denial from Medicare before paying claims for products on the list when the pharmacy reported that Medicare did not make a payment.

OFFICE OF THE AUDITOR GENERAL EPILOGUE

In accordance with federal regulations, DCH has up to 27 months to file claims with Medicare for eligible services. Also, in accordance with State and federal statute of limitation laws, DCH has up to 6 years to collect inappropriate Medicaid claims it paid from the pharmacy providers and/or its PBM.

FINDING

2. Monitoring of Third Party Insurance Payments for Medicaid Prescription Drug Claims

DCH did not sufficiently monitor and investigate Medicaid fee-for-service prescription drug payments processed by its PBM to help ensure that Medicaid is the payer of last resort. Also, DCH did not determine the appropriateness of questionable third party payment amounts, did not determine if its TPL section had recovered inappropriate Medicaid payments made for pharmacy claims, and did not determine the amounts for which the pharmacy providers or the PBM may be liable.

As a result of DCH's insufficient monitoring, DCH could not ensure that Medicaid was the payer of last resort for questionable prescription drug claims that may have been the responsibility of beneficiaries' other insurance during the period October 1, 2002 through September 30, 2004.

The DCH Medicaid Provider Manual states that third party insurance payments are to be reviewed on a postpayment audit basis (see Finding 3) and that failure to bill Medicaid the total due less the amount paid by another insurance may be construed as fraud under the Medicaid False Claim Act. Also, DCH's contract with the PBM states that the PBM shall be liable for the actual amount of all overpayments caused by the PBM for which full recovery from the pharmacy providers cannot be made. DCH efforts regarding improper payments should consider the federal Improper Payment Information Act of 2002, which expanded the federal government's efforts to identify and reduce improper payments in the government's programs and activities and is intended to improve the integrity of the government's payments and the efficiency of its programs and activities.

We identified 26,857 Medicaid fee-for-service beneficiaries who had prescription drug coverage from other insurance providers throughout the period October 1, 2002 through September 30, 2004. During this period, DCH paid $29.5 million ($13.0 million of State General Fund/general purpose funding) for claims that we identified as potentially being the responsibility of beneficiaries' other third party insurance. The PBM's on-line claims processing system had built-in edits designed to require pharmacy providers to bill existing third parties before billing Medicaid. The PBM's claims processing system required pharmacy providers to manually record certain claim information. Because the PBM cannot predetermine the amount covered by third party insurance, pharmacy providers could have recorded incorrect payment amounts received from third party insurers and then proceeded to submit a Medicaid claim to the PBM for payment of any remaining amount. DCH informed us that its TPL section had a process in place to generate postpayment billings to third party insurers for certain pharmacy claims during our audit period and that the process included billing for claims in which pharmacy providers had originally recorded nominal third party payment amounts of less than $2. Postpayment audits conducted at pharmacy providers did not include a review of the accuracy of third party payment information recorded by the pharmacy providers (see Finding 3).

The PBM provided Medicaid fee-for-service prescription drug claim and payment data to DCH that indicated payment amounts from existing third party insurers of either $0 or nominal amounts ranging between $.01 and $5 for 4.4 million claims totaling $204 million during the period October 1, 2002 through September 30, 2004. DCH staff informed us that they considered some third party payment amounts of $5 or less toward Medicaid beneficiaries' prescriptions to be

questionable. After considering various factors that DCH informed us could explain some of the nominal third party payment amounts, we narrowed our review to 391,500 of the more questionable claims totaling $29.5 million. DCH could not readily verify the appropriateness of these claims or determine if it had recovered any of the $29.5 million in Medicaid payments through its postpayment billing process for these claims. Data from the PBM showed a third party payment amount of $0 for 369,000 (94%) of the 391,500 claims with Medicaid costs totaling $28.5 million (97%).

Our review of claim information from DCH's data warehouse for the 391,500 claims and DCH's efforts to monitor the appropriateness of data submitted for these and other claims by the PBM disclosed:

a. The PBM's system edits designed to ensure that Medicaid is the payer of last resort were not activated for 305,800 (78%) of the 391,500 claims totaling $23.4 million (79%) because either DCH had not yet identified existing third parties at the time the PBM processed the claims ($11.3 million) or DCH had not provided the PBM with the necessary coding information to identify all third parties ($12.1 million). DCH informed us that it is not always immediately aware of Medicaid beneficiaries' existing third party insurance coverage, and in those circumstances, it retroactively enters the date coverage began when the third party is identified. DCH also informed us that it did not provide all of the coding information to the PBM to identify third parties because it wanted to minimize unnecessary disruptions in Medicaid beneficiaries' access to care that can result when pharmacy providers are required to bill third parties.

b. Neither TPL section staff nor staff responsible for administering the pharmacy program reviewed any of the postpayment billings related to the 391,500 claims. As a result, DCH could not determine what amounts, if any, it had collected from third parties relative to these claims. For the 391,500 claims, DCH informed us that its TPL section had an automated process that electronically billed one particular third party insurer for some of the claims and that DCH staff manually generated a postpayment billing for some of the claims. DCH informed us that it billed for approximately 307,000 (78%) of the 391,500 claims on a postpayment basis totaling $23.9 million and that most of these billings occurred electronically. DCH did not have sufficient data that we could analyze to determine when the electronic postpayment billings occurred, the reasons the TPL section generated the postpayment billings, or how much

money DCH recovered. DCH informed is that it did not generate a postpayment billing to third party insurers for approximately 84,500 (22%) of the 391,500 claims totaling $5.6 million.

DCH staff responsible for administering the pharmacy program should reconcile amounts received from third party providers with amounts billed by the TPL section. This reconciliation process would allow DCH to determine which pharmacy providers had recorded incorrect third party payment information, how often the PBM's on-line claims processing system allowed these inappropriate Medicaid payments, and the appropriateness of the amounts submitted to DCH on a postpayment basis. DCH could then pursue appropriate sanctioning procedures against those pharmacy providers who incorrectly recorded nominal third party payment amounts and hold the PBM liable for not preventing the inappropriate Medicaid payments.

c. DCH's monitoring did not prevent or detect when the PBM submitted summary claims data that was not accurate or clearly was not consistent with other information DCH included in its data warehouse. DCH stores the summary claims data in its data warehouse and can use the information to generate ad hoc queries to monitor the appropriateness of Medicaid fee-for-service prescription drug claims. We noted:

(1) DCH's monitoring did not detect when, subsequent to a software change in August 2003, the PBM began combining copayment amounts paid by beneficiaries with payments recorded from third parties and transferring that information to DCH as a single amount. As a result, DCH could not distinguish between amounts recorded by pharmacy providers as copayments from beneficiaries and nominal amounts recorded as payments from third parties. We had initially identified an additional estimated $29.5 million in Medicaid claims in which DCH's data warehouse indicated that third parties had paid only nominal amounts, but DCH later informed us that these questionable amounts were more likely appropriate copayments from beneficiaries that the PBM had erroneously combined in the payments from third parties data field.

(2) DCH informed us that third parties had actually made payments totaling $169,000 (1%) for 6,400 (2%) of the 369,000 claims identified earlier in the finding; however, subsequent to the software change in August 2003,

the PBM had erroneously transferred data that indicated no third party payment amounts for those claims. DCH informed us that it had requested the PBM to send the correct data for those claims after we had already analyzed the data that existed in DCH's data warehouse.

(3) The PBM submitted summary data in which the other coverage code data field was blank, indicated "not specified," or indicated "no other coverage identified" in 331,000 (85%) of the 391,500 claims for which we identified a third party by using other coding data available in DCH's data warehouse. The pharmacy providers manually entered the other coverage code information into the PBM's on-line claims processing system.

Accurate and consistent data recorded in the PBM's on-line claims processing system that is appropriately transferred to DCH should help DCH perform useful data claims analyses to help maintain the integrity of Medicaid fee-for-service prescription drug payments; identify pharmacy providers with suspect or unusual billing practices; and determine the appropriate course(s) of action, including on-site reviews of pharmacy providers' billing records when appropriate.

(4) Over 2,000 pharmacy providers Statewide had processed the 369,000 Medicaid claims with third party payment amounts of $0. DCH needs to determine a methodology to identify the most likely circumstances that would warrant further investigation for those questionable claims.

At the request of the Department of Attorney General, DCH investigated one pharmacy during the period October 1, 2002 through September 30, 2004 that had recorded a third party payment amount of $0 and billed the entire cost of the prescription drug to Medicaid on seven different occasions. DCH's investigation confirmed that the pharmacy had circumvented the PBM's system edits designed to ensure that Medicaid is the payer of last resort and had overbilled Medicaid when the beneficiary had other prescription drug insurance coverage. DCH referred the pharmacy back to the Department of Attorney General for possible Medicaid fraud. A pharmacist at that pharmacy explained that multiple third party carrier identification numbers in the beneficiary's data profile

provided by DCH made it difficult for the pharmacy to identify which third party to bill and admitted that the billing to Medicaid was inappropriate.

RECOMMENDATIONS

We recommend that DCH sufficiently monitor and investigate Medicaid fee-for-service prescription drug payments processed by its PBM to help ensure that Medicaid is the payer of last resort.

We also recommend that DCH seek to immediately determine the appropriateness of questionable third party payment amounts, immediately determine if its TPL section has recovered any inappropriate Medicaid payments made for pharmacy claims, and immediately determine the amounts for which the pharmacy providers or the PBM may be liable.

AGENCY PRELIMINARY RESPONSE

DCH generally agrees with the finding and the first recommendation and agrees in principle with the second recommendation that it should determine the amount of inappropriate payments made on behalf of beneficiaries who had third party coverage.

DCH will take steps to improve its monitoring activities. DCH stated that it has implemented certain improvements to ensure that its systems reflect more current and up-to-date third party coverage information and that it has initiated action to correct the deficiencies cited as examples in item c. of the finding.

DCH indicated that, to improve its monitoring activities, it has instructed both the PBM and the postpayment audit subcontractor to review billings to and amounts collected from third parties for Medicaid fee-for-service prescription drug claims when the audit subcontractor conducts audits of the pharmacy providers. The pharmacies to be audited will be selected by the audit subcontractor in consultation with DCH, and the audit findings will be communicated directly to both the PBM and DCH. Also, DCH will review, on a sample basis, the propriety of payments made for any claims paid on behalf of a beneficiary coded as having other insurance. As part of this review, DCH will monitor the accuracy of claim information submitted by the PBM and stored in DCH's data warehouse. DCH stated that in September 2005, DCH and the PBM made the necessary corrections to ensure that the beneficiary copayment and other insurance amounts paid by

third parties are separately identified and captured in separate fields in DCH's data warehouse.

DCH indicated that the system improvements include the October 2004 implementation of an edit in the PBM's on-line claims processing system that will identify and reject claims when the third party payment amount appears questionable in relationship to the ingredient cost of the drug. DCH also indicated that the need for this edit was identified by DCH and the PBM prior to the audit. DCH further indicated that it has taken steps to ensure that the PBM is furnished with up-to-date third party coverage information on a timely basis. DCH stated that the daily updates reflect changes in the beneficiaries' eligibility and the weekly updates reflect changes to the third party coverage information. DCH also stated that it has made several changes to the coordination-of-benefits processes to ensure that Medicaid is the payer of last resort. DCH further stated that in December 2005, DCH required pharmacies to begin using more specific carrier codes and that these codes are posted to DCH's TPL Web site and that the PBM's on-line claims processing system now edits against this list and rejects any inappropriate claim submitted for a beneficiary that has other insurance on the TPL file.

With respect to the second recommendation, DCH indicated that it does not have the system capability required to individually analyze each claim to determine with certainty the appropriateness of the $29.5 million in claims identified in the audit. DCH acknowledged that it did not individually analyze the appropriateness of these payments on a claim-by-claim basis. DCH informed us that it billed through its TPL section approximately 78% of the claims totaling $23.9 million relating to this population to third party carriers; however, DCH stated that it could not and did not determine the extent of the recoveries realized from these billings. To address this deficiency in the future, DCH indicated that it implemented a new Post-Payment Recovery System (PPRS) in April 2005 and that PPRS was actually under development prior to the audit. DCH stated that implementation of PPRS allows for more accurate claim adjudication by carriers; has provided DCH with the ability to adjudicate recoveries by claim line, to submit bills to carriers in a more timely manner, and to post recoveries from carriers to DCH's data warehouse; and has greatly enhanced DCH's ability to monitor its TPL recovery process.

To further enhance its ability to identify and pursue recoveries from appropriate third parties, DCH will work to introduce legislation to enhance its ability to locate

and utilize third party health insurance information. The proposed legislation would ensure that DCH operates its cost savings and recovery efforts from a complete universe of available insurance information rather than the current subset of the information it receives from voluntary data exchanges with third parties and individual reporting.

OFFICE OF THE AUDITOR GENERAL EPILOGUE

In accordance with State and federal statute of limitation laws, DCH has up to 6 years to collect inappropriate Medicaid claims it paid from the pharmacy providers and/or its PBM.

FINDING

3. Postpayment Audits

DCH did not ensure that postpayment audits conducted at pharmacy providers included a review of billings to and amounts collected from third parties for Medicaid fee-for-service prescription drug claims.

Without postpayment reviews of third party payment amounts, DCH could not verify the appropriateness of third party payments for Medicaid fee-for-service prescription drug claims it questioned or effectively discourage improper claim submissions. DCH's Program Investigation Section is responsible for investigating possible Medicaid fraud and abuse. Program Investigation Section staff informed us that they had not investigated more pharmacy providers because the issue had not been identified in the postpayment audits.

DCH's contract with the PBM stipulates that the PBM shall maintain an aggressive pharmacy provider audit and monitoring program that deters fraudulent claim submissions and educates participating pharmacy providers on the correct procedures for program guidelines. However, the subcontractor that the PBM had contracted with to conduct the postpayment audits informed us that neither DCH nor the PBM had required the subcontractor to review billings to or amounts collected from third parties.

RECOMMENDATION

We recommend that DCH ensure that postpayment audits done at pharmacy providers include a review of billings to and amounts collected from third parties for Medicaid fee-for-service prescription drug claims.

AGENCY PRELIMINARY RESPONSE

DCH agrees with the finding and the recommendation. DCH indicated that it has instructed both the PBM and the postpayment audit subcontractor to review billings to and amounts collected from third parties for Medicaid fee-for-service prescription drug claims when the audit subcontractor conducts audits of the pharmacy providers. The pharmacies to be audited will be selected by the audit subcontractor in consultation with DCH, and the audit findings will be communicated directly to both the PBM and DCH.

EFFORTS REGARDING SANCTIONED MEDICAID SERVICE PROVIDERS

COMMENT

Audit Objective: To assess the effectiveness of DCH's efforts to prevent and detect Medicaid payments for pharmaceutical drugs prescribed by service providers excluded (sanctioned) from participating in Medicaid.

Conclusion: DCH efforts were moderately effective in preventing and detecting Medicaid payments for pharmaceutical drugs prescribed by service providers excluded (sanctioned) from participating in Medicaid. We noted a reportable condition related to drugs prescribed by sanctioned Medicaid service providers (Finding 4).

FINDING

4. Drugs Prescribed by Sanctioned Medicaid Service Providers

DCH needs to improve its controls to prevent and detect Medicaid fee-for-service payments for pharmaceutical drugs prescribed by sanctioned Medicaid service providers. In addition, DCH needs to seek repayment from the pharmacy providers or the PBM for the pharmaceutical drugs prescribed by sanctioned Medicaid service providers.

From October 1, 2002 through September 8, 2004, DCH paid 1,798 Medicaid fee-for-service claims totaling $92,504 to 185 pharmacy providers for drugs prescribed by 17 Medicaid service providers that DCH and/or HHS had excluded (sanctioned) from participating in Medicaid.

DCH and/or HHS 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. The DCH Medicaid Provider Manual requires pharmacy providers to reimburse DCH for any such payments.

Language in the contract between DCH and the PBM requires the PBM to implement controls in its on-line claims processing system to reject claims submitted by pharmacy providers that sanctioned Medicaid providers had prescribed. The contract with the PBM also states that the PBM shall be liable for the actual amount of all overpayments caused by the PBM for which full recovery from the pharmacy providers cannot be made. DCH publishes semiannual cumulative listings and monthly updates of sanctioned Medicaid providers on its Web site. Pharmacy providers rely on DCH's publication of these listings to manually determine which Medicaid service providers DCH and/or HHS has sanctioned.

We identified 354 sanctioned Medicaid service providers listed on DCH's Web site during the six-month period from March through August 2004. Of the 354 sanctioned Medicaid service providers, 17 (5%) had continued to prescribe drugs after DCH and/or HHS had sanctioned them. Neither DCH nor its PBM had identified any of these occurrences. Our further review of the drug prescribing activities of these 17 providers and of the controls to prevent or detect such activities during the period of October 1, 2002 through September 30, 2004 disclosed:

a. DCH did not ensure that its PBM had implemented controls in its on-line claims processing system that would prevent a pharmacy provider from billing DCH for a prescription written by a sanctioned Medicaid service provider. The PBM stated that such controls are feasible and acknowledged that it had not implemented them because DCH had not provided the PBM with listings of

sanctioned providers and the PBM did not review the listings on DCH's Web site.

b. DCH did not publish all of the semiannual cumulative listings and monthly updates of sanctioned Medicaid service providers on its Web site. We determined that DCH had published only 2 (50%) of the 4 semiannual cumulative listings and 4 (20%) of the 20 monthly updates on its Web site during the period October 1, 2002 through September 30, 2004. This resulted in 2 of the 17 providers being added to the Web site listings approximately 3 months and 10 months after HHS had sanctioned them. These sanctioned providers wrote 16 and 64 prescriptions, respectively, totaling $4,529 between the dates HHS sanctioned them and the dates DCH included them on the Web site listing of sanctioned Medicaid service providers.

   In addition, DCH did not publish a monthly update to indicate that 1 of the 17 Medicaid service providers had been reinstated to participate in Medicaid until 5 months after the effective date of the reinstatement. At the time of our review, DCH had reinstated a second provider 8.5 months earlier but had not yet published a listing of sanctioned Medicaid service providers to reflect this.

RECOMMENDATIONS

We recommend that DCH improve its controls to prevent and detect Medicaid fee-for-service payments for pharmaceutical drugs prescribed by sanctioned Medicaid service providers.

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

AGENCY PRELIMINARY RESPONSE

DCH agrees with the finding and both recommendations. DCH indicated that it publishes its list of newly sanctioned providers through the issuance of a provider bulletin and that it issues paper copies and posts these bulletins to DCH's Web site. DCH also indicated that it is creating a reference file that combines federal Drug Enforcement Agency and Medicaid provider identification numbers and that the combination of this provider identification information will facilitate DCH's efforts to more effectively and timely issue its updated sanctioned provider publication.

DCH further indicated that reinstatements of previously sanctioned providers are published at the same time as the list of sanctioned providers, which results in the more timely publication of providers that have been reinstated.

DCH will seek repayment from pharmacies, as appropriate, for payments made for drugs prescribed by sanctioned providers.

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.
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.
effectiveness	Program success in achieving mission and goals.
fee-for-service	The method of paying a medical provider for each service rendered.
HHS	U.S. Department of Health and Human Services.
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 pharmaceutical manufacturers to other large purchasers.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
MMIS	Medicaid Management Information System.

OIG	Office of Inspector General.
PBM	pharmacy benefits manager.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
PPRS	Post-Payment Recovery System.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
TPL	Third Party Liability.

This Page Left Intentionally Blank

This Page Left Intentionally Blank


STATE OF MICHIGAN
OFFICE of the AUDITOR GENERAL