New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Department of Human Services
Division of Medical Assistance and Health Services
Medicaid Pharmacy Program

July 1, 2008 to February 10, 2012

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State Auditor

New Jersey State Legislature

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The Honorable Sheila Y. Oliver
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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Pharmacy Program for the period of July 1, 2008 to February 10, 2012. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells
State Auditor
May 7, 2012

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (division), Medicaid Pharmacy Program for the period July 1, 2008 through February 10, 2012. The Medicaid Pharmacy Program covers medically necessary Food and Drug Administration approved prescription drugs and over-the-counter medications for Medicaid recipients. Our audit included a review of the fee-for-service pharmaceutical process as it relates to retail pharmacy claims, long-term care pharmacy claims, physician administered injectable drugs, and all HIV/AIDS medications including those for recipients in managed care organizations. Our audit did not include a review of medication dispensing fees for Medicaid recipients in long-term care facilities, which were reviewed as part of our audit completed in October 2008. As of October 1, 2011, all Medicaid recipients covered under fee-for-service were transferred into managed care organizations, excluding those in long-term care facilities and institutions. During fiscal year 2011, there were 6.1 million Medicaid fee-for-service retail pharmacy claims totaling $568.6 million. Additionally, there were 1.1 million Medicaid pharmacy claims for those in long-term care facilities amounting to $54.4 million for the same year.

Objectives

The objective of our audit was to determine whether controls are adequate to prevent improper payments of fee-for-service retail pharmacy claims, long-term care pharmacy claims, physician administered injectable drugs, and HIV/AIDS medications.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. In preparation for our audit, we studied legislation, the administrative code, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our review of the claims. We also interviewed agency personnel to obtain an understanding of the program and the internal controls.

Both statistical and non-statistical sampling approaches were used. Our tests were designed to provide conclusions about the controls in place to prevent improper payments of fee-for-service retail and long-term care pharmacy claims, physician injectable drug claims, and HIV/AIDS medication claims. Retail pharmacy populations were sorted and judgmentally selected for testing.

Conclusions

We found that the division has adequate controls in place to prevent improper payments of fee-for-service retail pharmacy claims and HIV/AIDS medications; however, controls over long-term care pharmacy claims and physician administered injectable drugs are inadequate. In making these determinations, we noted opportunities where the division could improve controls. An estimated annual savings of $4 million could be achieved if the division did not batch long-term care pharmacy claims and instead subjected them to a proper edit review process prior to dispensing. The division should recover overpayments from prescribers for physician administered injectable medications. Medicaid recipients receiving HIV/AIDS medications should be matched to the statewide HIV/AIDS registry to avoid improper payments. The division should also monitor the payment of claims for HIV/AIDS medications to prevent the improper payment for the dispensing of excess drugs caused by early refills.

Long-Term Care Pharmacy

The division is not effectively monitoring long-term care pharmacy claims.

Long-term care (LTC) facilities and state institutions typically have contracts with LTC pharmacies to ensure the safety and convenient access to drugs for their residents. LTC pharmacies provide services to chronically disabled individuals requiring 24 hour nursing care. These services differ from the retail pharmacy setting in that retail pharmacies provide services to recipients that reside in the community. LTC pharmacies, as well as retail pharmacies, submit all Medicaid pharmacy claims to the state fiscal agent through the Point of Sale (POS) System. This system checks claim information and data validity against requirements called edits. An "edit" is a condition, set by the state, applied to a claim that determines whether the claim is ultimately paid or denied, and is used to prevent the processing of improper payments. All pharmacy claims are subject to the edit process. When a pharmacy claim is processed, it may trigger edits that have one of three dispositions: pay and report to the state, pay and give a message to provider, or deny. Medicaid retail pharmacy prescriptions are entered into the state's POS system and individually reviewed through a series of edits prior to being dispensed and paid or denied. However, LTC pharmacy prescriptions are processed differently; they are batched daily and not subjected to the individual claim edit review process prior to dispensing. The claim is paid and reported to the state with edit notations. This LTC pharmacy claim process bypasses a proper initial review. The division has decided to not deny long-term claims with conflicts or other irregularities, but to pay and report possible errors. As noted in our audit report issued in April 2008, pay and report edits are not a useful monitoring tool, since the division does not perform a payment review on these claims.

Based on our analysis of 10 edits (see Appendix) pertaining to pharmacy claims, we calculated a 66 percent denial rate for retail pharmacy claims processed during fiscal year 2011. Because of inherent differences between the retail pharmacy and LTC populations, management asserts that this denial rate should be reduced by 20 percentage points for LTC claims. If this adjusted denial rate of 46 percent is reflective of the entire 71,900 LTC pharmacy claim population processed with one of the 10 edits for fiscal year 2011, we estimate that 33,300 claims would have been denied resulting in an annual savings of approximately $3.2 million.

During fiscal year 2011, there were an additional 53,400 LTC pharmacy claims processed, totaling $3 million, that triggered an early refill edit. We performed a separate test of early refill edits to determine the effect of having this edit set as a pay and report disposition rather than a deny disposition. In the retail pharmacy setting this edit will not permit a prescription to be refilled until 85 percent of the medication has been utilized. However, in the LTC setting there are instances where a claim would have to be filled prior to the 85 percent utilization. We reviewed 171 claims and noted 50 exceptions, a 29 percent error rate, where the pharmacies could not properly support the early refill. Projecting the statistical lower limit (24 percent) to the total population, 12,561 claims would have been denied resulting in a $706,000 savings. There is no monitoring process that ensures the LTC pharmacy claims are being sufficiently reviewed.

Recommendation

We recommend the LTC pharmacies not batch claims and instead utilize the POS system as intended, thus allowing claims to be properly reviewed prior to dispensing. We further recommend the division review all other pay and report edits to determine if those dispositions should be changed.

Injectable Drugs

Discrepancies in units of measure for injectable drugs have caused inaccurate billings.

Injectable drugs administered by physicians are reimbursed by Medicaid. Beginning in June 2008, the unit of measure for these drugs changed from the Healthcare Common Procedure Coding System to the National Drug Code (NDC) system. This change in coding has caused inaccuracies in the billing for Medicaid claims mainly because the providers' billing systems do not utilize the proper NDC coding, allowing injectable drugs to be billed in the wrong unit of measure. Claims processed during the period July 1, 2009 through March 17, 2011 amounted to 32,000, with reimbursements totaling $9.2 million. We sampled 100 claims totaling $173,000 during this same period and noted 11 percent in overpayments amounting to $18,000. Applying this error percentage to the total dollar amount of reimbursed injectable drug claims of $9.2 million, we estimate overpayments of $1 million have occurred. Although the division has taken measures to reduce inaccurate billings, the division needs to review the amount of overpayments and recover these amounts.

Recommendation

We recommend that the division recover overpayments made to providers for injectable drugs.

HIV/AIDS Medication

HIV/AIDS Registry

The division should utilize the HIV/AIDS Registry to determine that eligible recipients are receiving medications.

The Division of HIV/AIDS Services at the Department of Health and Senior Services (DHSS) is required to maintain a registry of individuals in New Jersey with HIV/AIDS, in accordance with New Jersey Administrative Code 8:57-2. Various state programs, such as the Pharmaceutical Assistance to the Aged and Disabled Program, the Senior Gold Program, and the AIDS Drug Distribution Program, routinely match their recipients to the registry to

determine that individuals receiving the medications are eligible. Medicaid does not perform such a match. During fiscal year 2010 there were 3,758 Medicaid recipients with claims for HIV/AIDS medication totaling $58.3 million. We matched these Medicaid recipients to the HIV/AIDS registry as of January 2012. We identified 82 Medicaid recipients who were not listed on the registry. They had claims totaling $745,000. We noted that 19 of these recipients had related claims dating back to 2009 and three date back as far as 2002.

Early Refills

The division needs to monitor the refills of HIV/AIDS medications to prevent excess distributions.

The New Jersey pharmacy Point of Sale (POS) system, through the use of the early refill edit, will not permit a prescription to be refilled until 85 percent of the medication has been utilized. We noted instances where both fee-for-service and Managed Care Organizations (MCO) Medicaid recipients consistently refill at 85 percent utilization, thus allowing them to accumulate an additional two month supply of the medication in a given year.

During the period of July 1, 2008 through June 30, 2011, 5,334 fee-for-service and MCO Medicaid recipients received HIV/AIDS medication totaling $170.4 million. Our review of the three years disclosed 439 instances where recipients received a 420 day supply of medication for a one year period. The amount for the 14th month supply totaled $648,000. We have referred these instances to the division for further review. Since all fee-for-service Medicaid recipients were transferred to the MCOs in October 2011 and HIV/AIDS medications are a direct cost to the Medicaid program, the division needs to adequately monitor how these pharmaceutical claims are being processed by the MCOs.

Recommendation

We recommend the division utilize the services of DHSS to verify that Medicaid recipients receiving HIV/AIDS medications are on the HIV/AIDS Registry, after their first pharmacy claim, to avoid improper payments. The division should follow-up to determine why recipients were not placed on the registry. We also recommend that the division monitor, more closely, the payment of claims for HIV/AIDS medications to prevent the improper payment of excess medications.

Appendix

Fiscal Year 2011 Claim Edits for LTC

Description of Edits	# of Claims	Paid Amount
Possible Therapeutic Class Duplication	16,331	$628,218
Duplication of HIV Medications	243	$38,433
Daily Dose Exceeds Recommended Limits	3,242	$33,865
Daily Quantity Exceeded *	6,083	635,845
Prior Authorization Required for Work First New Jersey/General Assistance Drug Coverage	281	$42,050
Possible Severe Drug-Drug Interaction	2,032	$170,606
Prior Authorization Required (Specific Drugs)	22,969	$3,493,603
Maximum Allowable Cost (MAC) Override	6	$234
Daily Dosage Quantity Standard Exceeded	20,677	$1,906,509
Total:	71,864	$6,949,363

* Includes two edits

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April 26, 2012

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Dear Mr. Termyna:

This is in response to your letter of January 4, 2012 to Commissioner Velez concerning the Office of Legislative Services (OLS) draft audit report entitled **"Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Pharmacy Program".** Your letter provides an opportunity to comment on the draft audit report.

The objective of the audit was to determine whether controls are adequate to prevent improper payments of fee-for-service retail pharmacy claims, long-term care pharmacy claims, physician administered injectable drugs, and HIV/AIDS medications.

The draft audit report concluded that DMAHS has adequate controls in place to prevent improper payments of fee-for-service retail pharmacy claims and HIV/AIDS medications; however, controls over long-term care pharmacy claims and physician administered injectable drugs are inadequate. As outlined below in response to the audit findings, we will be implementing improved controls for long-term care pharmacy claims and physician-administered injectable drugs.

Long-Term Care Pharmacy:

Recommendation:

The LTC pharmacies should not batch claims but instead utilize the POS system as intended, thus allowing claims to be properly reviewed prior to dispensing. The Division should review all other pay and report edits to determine if those dispositions should be changed.

Response:

The proposed State Fiscal Year 2013 budget includes a requirement that all drug utilization review (DUR) standards currently applied to retail pharmacy claims by the Division also be applied to long-term-care pharmacy claims. This proposed policy change would require that all long-term-care pharmacies submit nursing facility and institutional pharmacy claims in "real time," meaning that DUR standards would be applied during claims processing prior to prescriptions being dispensed. As is now true for retail claims, this change would provide the Division the opportunity to deny those pharmacy services considered inappropriate based on current standards. As part of the development phase of this project, all POS Edits will be revisited to determine their appropriate disposition, including Pay and Report Edits.

Injectable Drugs:

Recommendation:

The Division should recover overpayments made to providers for injectable drugs.

Response:

Revised billing procedures for physician-administered drugs were implemented for claims with service dates on or after June 8, 2009. Reimbursement for these procedures required proper reporting of the National Drug Code (NDC), Unit of Measure and Metric Quantity for the actual NDC used to administer an injectable medication.

In addition, the Division established an interactive website for providers to determine coverage and the correct Unit of Measure for the NDC being billed. To support the Division's decision to more effectively monitor the billing of physician-administered drugs, staff also established over 4,500 maximum daily dosage standards to determine when these claims were being overbilled.

With these safeguards in place, the Division is in the process of completing a recycle of prior paid claims with service dates on or after June 1, 2009 through October 31, 2011. A claim detail report was sent to providers requesting that they provide corrected Metric Quantities for the NDCs billed on claims determined by the Division to have been overpaid. With this information, the Division will generate claim adjustments to recover the overpayments. The Division anticipates that the recovery of overpayments will be completed by May 31, 2012.

HIV/AIDS Medication:

Recommendation:

The Division should utilize the services of the Department of Health and Senior Services (DHSS) to verify that Medicaid recipients receiving HIV/AIDs medications are on the HIV/AIDS Registry, after their first pharmacy claim, to avoid improper payments. The Division should follow-up to determine why recipients were not placed on the Registry. The Division

should also monitor, more closely, the payment of claims for HIV/AIDs medications to prevent the improper payment of excess medications.
Response:

DMAHS believes that current procedures applied to fee-for-service (FFS) claims are effective in validating a diagnosis of HIV/AIDS. All FFS claims for HIV drugs are subject to a "First Fill Edit" that is used to confirm a diagnosis of HIV/AIDS based on laboratory test results received from the prescriber. Once verified by the Molina Medical Exception Unit, continued use of the HIV drug is authorized by the State.

For those beneficiaries enrolled in managed care, the HMO Medical Directors are required to certify that a member has a diagnosis of HIV/AIDS before the State provides payments to the HMO for HIV drugs.

The Division along with its HMOs will work with FFS and HMO network providers to utilize the HIV/AIDS Registry to the fullest extent possible to ensure that DHSS has been appropriately notified of those beneficiaries with HIV/AIDS. In addition, the Division will retrospectively apply the aforementioned "First Fill Edit" to HMO encounter claims to further ensure the appropriateness of HIV therapy.

DMAHS's experience indicates that a primary reason for excessive distribution of medications is the "auto-filling" of prescriptions by pharmacies. In response to this concern and in order to minimize the excessive distribution of HIV drugs, the Division intends to propose a regulatory change that would require all prescription refill requests to be initiated only by the beneficiary or the prescriber, essentially disallowing the process of pharmacy "auto-filling."

If you have any questions or require additional information, please do not hesitate to contact me or Richard Hurd at 609-588-2550.

Sincerely,

Valerie Harr
Director

VH:H
c: Jennifer Velez
Richard J. Hurd
Thomas Lind, MD