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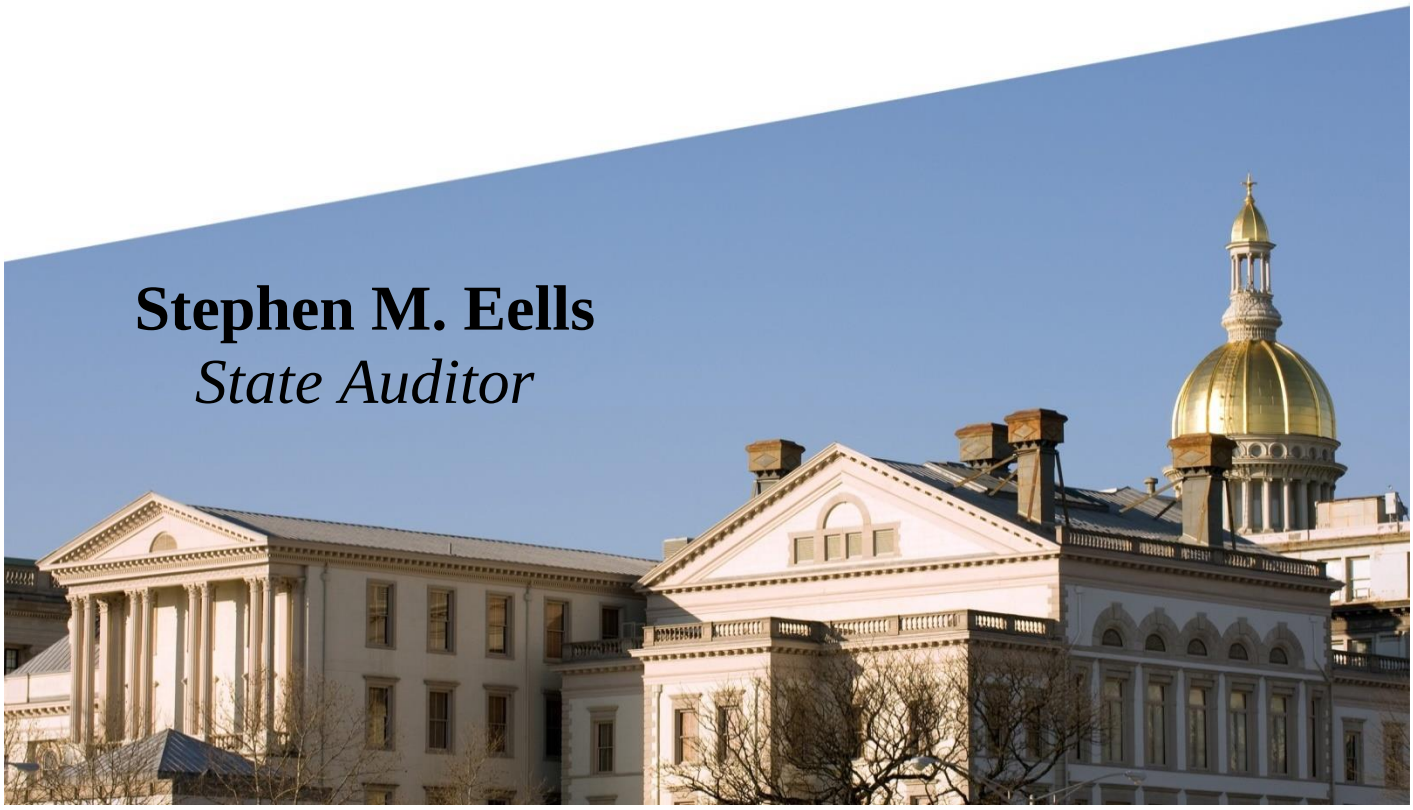
Department of Human Services
Division of Medical Assistance and Health Services
New Jersey FamilyCare, Medicaid Pharmacy Program

July 1, 2017 to February 29, 2020



Stephen M. Eells
State Auditor

NEW JERSEY STATE LEGISLATURE
Office of LEGISLATIVE SERVICES

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The Honorable Craig J. Coughlin
Speaker of the General Assembly

Ms. Peri A. Horowitz
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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, New Jersey FamilyCare, Medicaid Pharmacy Program for the period of July 1, 2017 to February 29, 2020. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells
State Auditor
July 1, 2020

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (division), New Jersey FamilyCare, Medicaid Pharmacy Program for the period July 1, 2017 through February 29, 2020. The Medicaid pharmacy program covers medically necessary Food and Drug Administration approved prescription drugs and over-the-counter medications for Medicaid beneficiaries. Our audit included a review of the fee-for-service (FFS) and managed care pharmaceutical process as it relates to pharmacy claims. Our audit did not include pharmacy claims for Medicaid and Medicare dual eligible beneficiaries. As of November 7, 2019, there were approximately 67,300 beneficiaries enrolled in FFS and 1.5 million beneficiaries enrolled in managed care. During calendar year 2019 as of November 7, there were 528,000 paid FFS pharmacy claims totaling $64.1 million and 16.8 million managed care pharmacy claims paid by the five contracted managed care organizations (MCOs) totaling $1.1 billion.

Objectives

The objectives of our audit were to determine whether adequate procedures and controls were in place to properly monitor FFS and managed care pharmacy claims and to prevent improper payments.

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. 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.

In preparation for our testing, we studied legislation, the administrative code, federal regulations, and policies of the division. Provisions we considered significant were documented and compliance with those requirements was verified by interviews with division personnel, observation, and through our review of the pharmacy claims. We also interviewed personnel from the division's fiscal agent for FFS and personnel from the five contracted MCOs to obtain an understanding of the program and the internal controls.

In addition, we assessed the reliability of the Medicaid pharmacy claims data in the Medicaid Shared Data Warehouse (SDW) by reviewing existing reconciliations prepared by the division and interviewing division personnel regarding the data. We determined that the claims data in the SDW is sufficiently reliable for the purpose of our audit findings and conclusions in this report.

However, we did not assess the accuracy of the claim information being entered, as all claims are initiated by the pharmacists where the medications are being dispensed.

A nonstatistical sampling approach was used. Our samples of Medicaid pharmacy claims were designed to provide conclusions on our audit objectives, as well as on internal controls and compliance. Sample populations were sorted and claims were judgmentally selected for testing.

Conclusions

We found the division had adequate procedures and controls in place to properly monitor FFS and managed care pharmacy claims and prevent improper payments. In making these determinations, we noted weaknesses in the internal controls meriting management's attention. We noted opportunities where improvements could be made to both the FFS and managed care pharmacy programs. We found FFS and managed care pharmacy claims for controlled dangerous substances in which the prescriptions were dispensed beyond the expiration date of the script. We also found the division needs to improve controls that monitor pharmacy claims for possible "doctor shopping", the excess accumulation of medication by a beneficiary, and high volume prescriptions per beneficiary on a single date of service. In addition, the division should ensure all social security numbers are validated so that only eligible individuals receive Medicaid pharmacy services. Furthermore, we made observations concerning the Medicaid pharmacy program monitoring and cost.

Background

New Jersey FamilyCare (Medicaid) is a program that provides health coverage for individuals and families with low incomes and limited resources. The federal government established Medicaid under Title XIX of the Social Security Act on July 30, 1965. States operate Medicaid programs in accordance with state rules and criteria that vary within the broad framework established by the federal government. The federal government requires states to provide a basic set of medical services to individuals eligible for Medicaid. Providing pharmaceutical services to Medicaid beneficiaries is one of the additional medical services that New Jersey has elected to provide. Beneficiaries who receive these services, are either enrolled in the fee-for-service (FFS) program or with a managed care organization (MCO).

FFS is the traditional health insurance program, in which healthcare providers bill Medicaid directly for their services and the FFS claims are processed through the division's fiscal agent that manages the FFS pharmacy program. FFS beneficiaries include those new to the program and not yet enrolled into a MCO, those in long-term care who are not enrolled in Managed Long Term Services and Supports, those in state institutions (psychiatric hospitals and developmental disability facilities), and those residing in Veterans Administration Homes.

Under managed care, beneficiaries enroll in one of the five MCOs contracted with the division to provide and manage healthcare services. For these beneficiaries, the division pays a capitation rate or monthly premium per beneficiary to the MCO in which they are enrolled. The division

relies on both the FFS fiscal agent and the MCOs to monitor the Medicaid pharmacy program based on policies and procedures set forth by the division.

Pharmacy claims are initiated at a pharmacy by the pharmacist, who enters the claim detail data into a Point of Sale (POS) system. That information is then electronically transmitted to the beneficiary's healthcare plan where it goes through claim processing edits to determine whether the claim is approved or denied.

Expired Prescriptions

Prescriptions were dispensed beyond the expiration date of the script.

We analyzed all approved pharmacy claims (excluding long-term care claims) in the SDW with service dates from July 1, 2017 through September 26, 2019, for prescriptions dispensed for the first time. Based on our analysis, we found 696 FFS claims totaling $59,000 and 47,467 managed care claims totaling $5.1 million for controlled dangerous substances, where the prescriptions appeared to have been dispensed beyond the expiration date of the scripts. On average, these prescriptions appeared to have been dispensed 34 days after they had expired for FFS claims and 29 days after they had expired for managed care claims.

For those controlled substances claims identified above, 206 FFS claims totaling $23,000 and 27,700 managed care claims totaling $3.4 million, were for Schedule II drugs. These are considered to have a high potential for abuse, with use potentially leading to severe psychological or physical dependence. As set forth by the New Jersey Administrative Code (N.J.A.C.) 13:45H Controlled Dangerous Substances, and per N.J.A.C. 13:45H-7.5 Manner of Issuance of Prescriptions, "all prescriptions for controlled substances, regardless of schedules, shall be presented to the pharmacist for filling within 30 days after the date when issued except when up to three separate prescriptions for a total of up to a 90-day supply of a Schedule II controlled substance are issued to a patient by a physician." We were unable to determine whether the prescription was to be filled beyond 30 days by reviewing the claim data. This can only be achieved by reviewing the actual prescription submitted by the prescribing provider to the pharmacy. In addition, it is the responsibility of the dispensing pharmacy to comply with these regulations and prevent the medication from being dispensed before it is allowed per the prescription.

In addition, our analysis identified non-controlled substance claims for that same period consisting of 681 FFS claims totaling $48,000 and 1,939 managed care claims totaling $43,000. These claims also appeared to have been dispensed beyond the prescription expiration date. Per N.J.A.C. 13:39-7.3, these claims have a valid prescription date good for one year beyond the date the script was written.

To determine whether the prescriptions were dispensed beyond their expiration date, we sorted the data by healthcare plans and drug schedules and judgmentally selected a sample of 155 controlled and non-controlled substance claims totaling $22,242. Items were selected to ensure the sample represented claims across all healthcare plans and drug schedules. We requested the division and MCOs to review the claims to determine if the prescriptions were dispensed beyond their expiration date. Based on their reviews, it was determined that 113 (73 percent) of the prescriptions totaling $16,174 were dispensed beyond their expiration date. There are no controls or edits in either the FFS or the managed care pharmacy programs that would prevent a claim from being dispensed based on the date the prescription was written. After bringing this to the division's and the FFS fiscal agent's attention, edits are being developed that will monitor dispensing dates of both controlled and non-controlled substances for FFS claims.

Recommendation

We recommend the division implement a control in the FFS pharmacy program that would prevent a prescription from being dispensed beyond its expiration date. Furthermore, we recommend the division require the MCOs implement a control to do the same in the managed care pharmacy program. In addition, the division should determine if payments for these expired prescriptions should be recovered.

Doctor Shopping

The division's monitoring of managed care pharmacy claims to determine if beneficiaries are using multiple prescribers and/or pharmacies to obtain controlled substances is inadequate.

Doctor shopping is a term referring to a practice in which beneficiaries visit multiple prescribers and/or pharmacies in an attempt to obtain more prescriptions for the same or similar drugs than a single prescriber would prescribe. It could indicate that a beneficiary is seeking drugs for an addiction, to divert for profit, or that the actual beneficiary's Medicaid identification number was stolen. Based on the managed care contract, MCOs must implement a lock-in program which restricts beneficiaries to a single pharmacy and/or other provider type for a reasonable period of time, if utilization of Medicaid services is at a frequency or amount that is not medically necessary. The MCO contract, when referring to the lock-in criteria, does not require the MCOs to lock-in a beneficiary to a prescribing provider, only to a specific pharmacy. The contract only gives them the option to lock-in to a specific provider. If the MCOs locked in a beneficiary to a specific provider in addition to a specific pharmacy, the risk of abuse of controlled substances could possibly be reduced.

Our analysis of the pharmacy claims data for controlled substances (excluding long-term care claims), found 29,063 managed care beneficiaries who were prescribed the same drug by five or more prescribers for a total of 36,336 instances amounting to $46.9 million for the period of July 1, 2017 through August 31, 2019. See the table below:

	Instances of beneficiaries receiving prescriptions for the same drug from				
Drug Schedule (Controlled Substances)	**5 to 10 providers**	**11 to 15 providers**	**16 to 20 providers**	**Over 20 providers**	**Total**
Schedule II - Most Abused					
Number of instances	19,620	1,145	53	8	**20,826**
Amount paid for prescriptions	$27,583,188	$1,848,557	$88,191	$13,500	**$29,533,436**
Schedule III - Less Abused					
Number of instances	2,410	65	1	-	**2,476**
Amount paid for prescriptions	$9,182,281	$411,879	$78	-	**$9,594,238**
Schedule IV - Potential Abuse					
Number of instances	12,090	221	15	2	**12,328**
Amount paid for prescriptions	$2,859,294	$21,843	$1,110	$207	**$2,882,454**
Schedule V - Controlled Sale by Pharmacy Only					
Number of instances	694	12	-	-	**706**
Amount paid for prescriptions	$4,839,431	$42,482	-	-	**$4,881,913**
Total					
Number of Instances	**34,814**	**1,443**	**69**	**10**	**36,336**
Amount paid for prescriptions	**$44,464,194**	**$2,324,761**	**$89,379**	**$13,707**	**$46,892,041**

There may be reasonable explanations for why a beneficiary is receiving prescriptions for the same medication by multiple prescribers. For example, the prescribing providers may all be within the same practice or the beneficiary moved multiple times during the period which required them to see a different provider. Therefore, we are unable to determine from the data analysis, which instances represent actual doctor shopping and which had legitimate explanations.

We judgmentally selected 71 instances totaling $221,800 across the five managed care healthcare plans, where it appeared that the beneficiaries utilized the highest number of prescribers and/or pharmacies to obtain their prescriptions. We then provided our sample to the division and the MCOs in which the beneficiaries were enrolled, to determine if they ever reviewed the beneficiaries for possible doctor shopping and to determine if they suspected that doctor shopping possibly occurred. Based on the reviews by the MCOs, they determined that 53 of the 71 beneficiaries sampled (75 percent) were not reviewed for possible doctor shopping prior to us providing the sample. However, even though they were not reviewed prior to our sample, the MCOs disagreed that doctor shopping took place. Reasons for such disagreement were due to prescribers being in the same practice, beneficiaries having multiple diagnoses that required them to see multiple specialists, or their lock-in program was not satisfied. In addition, 12 instances were noted totaling $36,500, that gives the appearance of possible doctor shopping for different reasons, however further review would be warranted. Three of these instances are provided below.

- A single beneficiary was prescribed Oxycodone-Acetaminophen 5-325 (opioid), a Schedule II drug which is defined by the United States Drug Enforcement Administration "as drugs with a high potential for abuse, with use potentially leading to severe psychological or

physical dependence", 71 times by 47 prescribers in which the beneficiary visited three pharmacies to have those prescriptions dispensed. The MCO agreed that doctor shopping took place and stated that the beneficiary was enrolled in their pharmacy lock-in program and provided notice on November 13, 2015. Even though they were placed in the lock-in program, they continued to see multiple prescribing providers and receive prescriptions.

- A beneficiary was prescribed the drug Lorazepam .5 mg tablet (benzodiazepines), a Schedule IV drug which has low potential for abuse, 30 times by 20 different prescribers and went to five different pharmacies to fill the prescriptions. The MCO agreed that doctor shopping took place and stated that letters were sent out on July 13, 2017 to six of the prescribing providers and again on January 2, 2019 to five other prescribing providers requesting them to review and provide feedback. Even after the letters were sent in 2017, the beneficiary continued to see multiple providers and was not placed in the lock-in program.

- A beneficiary was prescribed the drug Endocet 10-325 MG tablet (opioid), a Schedule II drug (high potential for abuse), 29 times by 9 different prescribers and went to three different pharmacies to fill the prescriptions. The MCO agreed that the beneficiary exhibited questionable behavior, placed the beneficiary in the lock-in program, and care management attempted to contact the beneficiary without success. This was only done after we had provided the sample to the MCOs.

If the MCOs locked in a beneficiary who utilized multiple prescribers for the same drug, to a specific prescriber, they could possibly reduce the risk of abuse of controlled substances. In addition, two of the five MCOs do not take into consideration the number of prescribers used by a beneficiary for the same drug when determining whether to place the beneficiary into the lock-in program. They only consider the number of pharmacies utilized. Furthermore, we found two of the five MCOs did not have their lock-in program approved by the division as required by the contract.

Recommendation

We recommend the division develop a lock-in program policy, with more restrictive criteria that includes prescribing providers, to be used by both the FFS and the managed care pharmacy programs.

Excess Accumulation of Medication

The division's monitoring of pharmacy prescriptions to prevent a beneficiary from receiving an excess accumulation of medication needs improvement.

The New Jersey Pharmacy Point of Sale (POS) system, through the use of a refill edit for the FFS and managed care pharmacy programs, will not allow a beneficiary to obtain the next fill until a

percentage of the previous fill has been utilized (utilization rate), unless a prescription dosage change or a prior authorization is given. This utilization rate for the FFS pharmacy program is 85 percent, and between 75 to 90 percent for the managed care pharmacy program depending upon which MCO the beneficiary is enrolled in. We noted there is no edit that considers the potential accumulation of medication from previous prescriptions that remain on hand when refilling those prescriptions based on the allowable utilization rate from the prior fill date, or for dosage changes in prescriptions.

For the period from January 1, 2017 through October 2, 2019, we analyzed all pharmacy claims for unit dose drugs (tablets, capsules, pills, etc.). Based on our analysis, we found 258 instances totaling $226,000 for FFS and 35,800 instances totaling $30 million for managed care, where beneficiaries received in excess of a 395-day supply of medication for a one-year period. Of those, 22 FFS instances totaling $2,000 and 2,662 of those managed care instances totaling $3.4 million, were for beneficiaries that received medication containing a controlled substance, which are drugs tightly controlled by the government because they may be abused or cause addiction. On average, the FFS beneficiaries received an extra 22-day supply while the managed care beneficiaries received an extra 28-day supply of medication over the initial 395 day supply allowed in our calculation. We estimate the excess accumulation of medication for these beneficiaries cost the FFS pharmacy program approximately $11,000, while also costing the managed care pharmacy program $1.8 million.

We sorted the data by healthcare plans and drug schedules and judgmentally selected a sample of 135 total instances. Items were selected to ensure the sample was representative across all healthcare plans and drug schedules. We then asked the division and the MCOs to review our sample to determine if the excess supply of medication should have been dispensed to the beneficiaries. Based on their reviews, it was determined that the excess amount of medication should not have been dispensed for 16 (12 percent) of the beneficiaries in question. In addition, the MCOs determined that 87 (64 percent) of the instances were acceptable as they were in compliance with the FFS and MCOs allowable utilization rates, 19 (14 percent) were acceptable due to a dosage change, and the remaining 13 sampled items were accepted for a variety of miscellaneous reasons. Although the majority of the sample items were acceptable, the failure to consider the accumulation of excess medications can result in additional costs to the program and excess controlled substances issued.

Recommendation

We recommend that the division enhance its monitoring of the dispensing of prescriptions to prevent a beneficiary from accumulating an excess amount of medication during a one-year period.

High Volume Prescriptions

The division's review of beneficiaries who are prescribed and dispensed a high volume of prescriptions needs improvement.

The division relies on the drug utilization review edits used by the division's FFS fiscal agent and the MCOs to monitor drug utilization within the pharmacy programs. These edits would not prevent or warrant a review of beneficiaries that are dispensed a high volume of prescriptions within a given time period. In addition, prescriptions are not normally reviewed to determine if the prescription was medically necessary unless a prior authorization is required.

We analyzed all pharmacy claims for the period of July 1, 2017 through September 26, 2019, to identify beneficiaries who were prescribed 10 or more prescriptions by a single prescriber on a single date of service. We found 1,178 instances totaling $727,000 for FFS and 20,213 instances totaling $10.5 million for managed care. These instances account for the first prescription written by a prescriber, not including any refills.

Using this analysis, we provided a judgmental sample, based on high volume and across all healthcare plans, of 110 instances to the division and the MCOs to review and determine whether all prescriptions were medically necessary. Based on their reviews, a determination could not be made on six of those instances due to limited data. For the remaining instances, the division and the MCOs determined that the prescriptions were necessary. Given the risk associated with the abuse and misuse of prescription drugs, particularly those containing controlled substances, the division should monitor and review beneficiaries that are prescribed and dispensed a high volume of prescriptions on a single date to determine if the prescriptions were medically necessary.

Other states have implemented limits on the number of prescriptions a beneficiary can receive per week or month (exclusions apply to certain groups of beneficiaries). Once certain thresholds are met, additional utilization management reviews take place.

Recommendation

We recommend the division implement a control that allows for a review of beneficiaries receiving a high volume of prescriptions within a given period, to verify whether the prescriptions are medically necessary.

Social Security Number (SSN) Verification

The division should ensure that all beneficiaries' information is accurate during the social security number validation process prior to acceptance into the Medicaid program.

The division uses county agencies throughout New Jersey and a state contract vendor to cross-reference a beneficiary's Medicaid application paperwork with documentation from the Social Security Administration (SSA), the New Jersey Department of Labor and Workforce Development, and other federal agencies to verify information for Medicaid eligibility. According to federal regulation 42 CFR 435.910 Use of Social Security Number, the agency must verify the SSN furnished by an applicant or beneficiary with SSA to ensure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

We matched the New Jersey Vital Statistics Death records to the pharmacy claims data in the SDW for the period of July 1, 2017 through October 21, 2019 and found 9,530 prescriptions for 265 managed care beneficiaries totaling $799,383, where the SSN matched, however the names did not. We reviewed the verification process for 25 (randomly selected) of the 265 beneficiaries and found that 10 (40 percent) were not verified with SSA. The division's policy is to accept the presence of a social security card in lieu of performing the federally required match. This policy is not in compliance with the federal regulation because it prevents the division from determining if any other SSNs were issued to the individual and increases the risk of pharmacy claims being paid for ineligible beneficiaries.

Recommendation

We recommend the division comply with federal regulation 42 CFR 435.910 and perform a social security number match with the Social Security Administration for all prospective beneficiaries to determine the validity of the social security number.

Utilization Reviews and Quality Management process of MCO Pharmacy Claims

The division needs a Utilization Review and Quality Management process for managed care pharmacy claims.

The Medicaid managed care contract requires that each MCO operate a drug utilization review program that complies with the requirements described in Section 1927 (g) of the Social Security Act. Although both the FFS and managed care pharmacy programs comply with the code, the FFS claims are subject to an additional prospective drug utilization review (PDUR) that differs from the MCOs' reviews. The FFS pharmacy program fiscal agent developed a Utilization Review and Quality Management process that would process managed care pharmacy claims through the same PDUR edits used when processing FFS claims. The purpose of this initiative

was to correct managed care claim inefficiencies prior to the division's actuary identifying them. This initiative was never implemented. According to the Utilization Review and Quality Management analysis completed by the division's FFS fiscal agent for the quarter ending June 30, 2016, a $7.7 million reduction in managed care pharmacy claims could have been achieved by the MCOs had the claims been processed using the same PDUR edits as the FFS pharmacy program.

Recommendation

We recommend the division require MCOs to use the same edits utilized in the FFS pharmacy program to possibly achieve a similar reduction in pharmacy claim payments.

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Pharmaceutical Services Manual

The Pharmaceutical Services Manual does not support current policies and procedures.

During the audit, it was brought to our attention that the Pharmaceutical Services Manual established by N.J.A.C. 10:51, currently in use by the division, is in need of updating. The last updates were made in December 2016, and even those did not reflect all changes that should have been made up to that point. The division has made changes in policy and procedures to their Medicaid pharmacy program with the guidance of the Centers for Medicare & Medicaid Services; however, the manual has remained the same. In addition, changes have also been made to the New Jersey Board of Pharmacy regulations, again with no changes to the manual.

Some changes consisted of minor wording changes, complete rewrite of sentences and paragraphs, the addition/deletion of sentences and paragraphs, and referencing to other regulations. Major changes consisted of adding new sections to address items such as; Definitions, State Upper Limits for Multi-Source Drugs, 340B Drugs, Professional Fee, Early Prescription Refills, Mandatory Generic Substitution of Brand-Name Multi-Source Drugs, Mandatory Generic Substitution of Brand-Name Multi-Source Drugs – Exceptions, Third Party Liability (TPL) Payments, Medicare Part B–Covered Prescription Drugs, Medicaid/NJ FamilyCare beneficiaries enrolled in the Medicare Part D Drug Benefit Program, and the NJ Prescription Monitoring Program (NJPMP). It is vital that the manual is regularly updated so the users consisting of the division, MCOs, and providers, have access to the most current policy and procedures.

Recommendation

We recommend the division review the proposed revisions and make the necessary changes that are required to bring N.J.A.C 10:51 up to date with current regulations, policies, and procedures.

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Observations

Expanding Access to the New Jersey Prescription Monitoring Program (NJPMP)

Access to the New Jersey Prescription Monitoring Program could provide the division with an additional monitoring tool for the division to identify potential instances of abuse.

Pursuant to N.J.S.A. 45:1-45, the NJPMP is a statewide database maintained by the Department of Law and Public Safety, Division of Consumer Affairs (DCA) that collects prescription data on Controlled Dangerous Substances (CDS) dispensed in outpatient settings in New Jersey, and by out-of-state pharmacies dispensing into New Jersey. Pharmacies are required to report this data to the NJPMP on a daily basis. Prescriptions must be reported to the database no more than one business day after the date the prescription is dispensed. The information contained in the database can help prescribers and pharmacists provide better care and identify signs that individuals may be abusing or diverting prescription medications for profit. In addition, fifteen other states share data with the NJPMP.

In accordance with DCA regulations, access to the NJPMP is granted to only prescribers, delegates, and pharmacists who are licensed by the State of New Jersey and whose licenses are in good standing with their respective licensing boards and who are directly providing healthcare to the recipients. Before issuing a prescription or dispensing a prescribed drug, qualified prescribers and pharmacists who have registered to use the NJPMP are able to access the NJPMP website and request the CDS prescription history of a patient.

Under current DCA regulations, prescribers, delegates, and pharmacists who are authorized to access the NJPMP must certify before each search that they are seeking data solely for the purpose of providing healthcare to new or current patients. Any prescribers or pharmacists who access or disclose NJPMP information for any purpose other than providing healthcare to a current patient or verifying the NJPMP's record of prescriptions issued by the prescriber, or who allow any other individuals to access the NJPMP using the prescriber's or pharmacist's own access codes, is subject to civil penalties and disciplinary action by the prescriber's or pharmacist's professional licensing board. Therefore, the staff of the state's Medicaid program, the third-party fiscal agent, and the MCOs who administer the states pharmacy program are not authorized access to NJPMP because they do not directly deliver healthcare to the recipients. Access to the NJPMP could be most useful when beneficiaries use cash to purchase prescriptions and bypass the healthcare plans. When cash is used, the drug utilization of beneficiaries cannot be monitored because these pharmacy claims are not processed through the Medicaid program. Therefore, statutory changes that would allow access to the NJPMP by licensed pharmacy staff of the FFS and managed care pharmacy programs could increase the ability of the division to monitor controlled *substance* utilization by beneficiaries. The data in the NJPMP is also valuable for avoiding therapeutic duplication and drug conflicts for Medicaid beneficiaries, which cannot be determined if the beneficiary pays cash.

Based on the website for the Office of New Jersey Coordinator for Addiction Responses and Enforcement Strategies, there have been 3,021 suspected overdose deaths and 3,990,809 opioid prescriptions dispensed during the period of January 1, 2019 through December 31, 2019. The NJPMP is an essential tool that could be used by the division to identify possible fraud and help mitigate the abuse and diversion of prescription drugs for profit within the Medicaid program.

FFS and Managed Care Pharmacy Program Cost Comparison

Comparing the costs of the FFS pharmacy program versus the managed care pharmacy program could prove beneficial to the division.

On July 1, 2011, the division began its mandatory enrollment of Medicaid FFS beneficiaries into the Medicaid managed care system. There are approximately 1.5 million beneficiaries enrolled in managed care under one of the five contracted MCOs and 67,300 beneficiaries enrolled in FFS. Since the transition, there has not been a comparison performed by the division to determine whether this change resulted in any cost savings to the Medicaid pharmacy program. We performed an analysis of the fiscal year 2019 paid pharmacy claims comparing the average cost per drug for 5,232 drugs paid by both the FFS and managed care programs. We found that the FFS program would have paid $84 million less than the amount paid by the MCOs. Our analysis did not factor in any additional cost such as capitation payments, administration cost, dispensing cost formulas, or pharmaceutical rebates.

At least three other states, West Virginia, Michigan, and California have performed cost comparisons and have decided to transition back to FFS from managed care due to the realization of cost savings in their pharmacy programs.

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Department of Human Services
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PHILIP D. MURPHY
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June 26, 2020

David J. Kaschak
Assistant State Auditor
Office of the State Auditor
125 South Warren Street
P.O. Box 067
Trenton, NJ 08625-067

Dear Mr. Kaschak:

The Department of Human Services (the Department) is in receipt of the Office of the State Auditor's draft audit report titled "Department of Human Services Division of Medical Assistance and Health Services New Jersey FamilyCare, Medicaid Pharmacy Program." We appreciate OSA's review and thank you for the opportunity to comment on the draft report.

Before addressing OSA's recommendations, we note that the Department has modified certain requirements regarding the frequency and quantity of prescription refills during the public health emergency to ensure that beneficiaries have appropriate access to medication and to limit in-person contact. These modifications are temporary and will cease when the public health emergency ends.

Please accept the following responses to the draft audit findings:

OSA Recommendation

"We recommend the division implement a control in the FFS pharmacy program that would prevent a prescription from being dispensed beyond its expiration date. Furthermore, we recommend the division require the MCOs to implement a control to do the same in the managed care pharmacy program. In addition, the division should determine if payments for these expired prescriptions should be recovered."

Response

The Department agrees that reviewing a prescription for validity prior to dispensing is an essential part of managing pharmacy services for Medicaid members. Under Division of Medical Assistance Health Services (DMAHS) regulations, prescriptions for non-controlled

medications may not be filled or refilled after one year from the date the original prescription was issued. N.J.A.C. 13:39-7.3. Prescriptions for controlled substances, regardless of schedules, must be presented to the pharmacist for filling within 30 days after the date issued, except when up to three separate prescriptions for a total of up to a 90-day supply of a Schedule II controlled substance are issued to a patient by a physician. N.J.A.C. 13:45H-7.5. The New Jersey Division of Consumer Affairs audits pharmacies for compliance with these regulations.

The Department concurs with OSA's recommendation that it implement a control in the FFS pharmacy program that would prevent a prescription from being dispensed beyond its expiration date. To that end, DMAHS has directed its vendor to develop an edit for the FFS pharmacy program to monitor the initial prescription written date submitted on a pharmacy claim. This point-of-sale (POS) edit will deny claims at the pharmacy if the date is older than 30 days for controlled substances Schedule II-V, and older than 12 months for all other drugs. The vendor has already begun work on this edit.

The Department also agrees that Medicaid Managed Care Organizations (MCOs) should implement a control to prevent a prescription from being dispensed beyond its expiration date in the managed care pharmacy program. Existing MCO contracts require MCOs to follow all applicable federal and State laws, regulations, codes and guidelines. DMAHS will ensure that MCO Pharmacy Directors implement edits like those being developed for the FFS pharmacy program to prevent the filling of expired prescriptions.

As recommended, DMAHS will consider whether payments for expired prescriptions can be recovered. Going forward, where DMAHS identifies or is made aware of the inappropriate filling of expired medications in a way suggesting intentional wrongdoing, it will refer these cases to the Medicaid Fraud Division in the Office of the State Comptroller, as appropriate.

OSA Recommendation

"We recommend the division develop a lock-in program policy, with more restrictive criteria that includes prescribing providers, to be used by both the FFS and the managed care pharmacy programs."

Response

The Department shares OSA's concern that, despite the current efforts of the program to manage these issues, members could be using multiple prescribers and pharmacies to obtain controlled substances inappropriately and agrees with OSA's recommendation to strengthen the lock-in program. DMAHS will review and approve all MCO lock-in programs. It will require MCOs to lock in members, not only for pharmacies, but also for prescribers when appropriate. DMAHS will modify MCO contracts as necessary to incorporate these changes.

As OSA notes in its report, there are often valid reasons for a member to use multiple prescribers, including prescribers being in the same practice, members having multiple diagnoses requiring treatment from multiple specialists, or a member moving multiple times during the period being reviewed. Accordingly, consideration as to whether to institute lock-in measures must be made at an individual patient level to ensure appropriate patient care.

OSA Recommendation

"We recommend that the division enhance its monitoring of the dispensing of prescriptions to prevent a member from accumulating an excess amount of medication during a one-year period."

Response

DMAHS agrees that members should not accumulate excess medication. DMAHS is considering systemic ways to account for accumulated prescription medication on hand prior to allowing a prescription refill. When developed, a system edit will only allow a refill if there is no more than one-month supply on hand from prior refills.

However, the estimated quantity on hand for any member varies depending on when the prescription was filled. A prescription dispensed during the last month of a review period for a drug may be exhausted during the first month of the following 12-month period. A member may fill a prescription on the last day of a review period, suggesting they have an excess quantity on hand, especially for those who fill for a 90-day supply. However, there will be fewer refills the following period. The Medicaid FFS pharmacy program currently applies an 85% rule for prescription renewals, in which a beneficiary must use 85% of an existing prescription prior to receiving any additional refills on the same prescription. Medicaid managed care pharmacy programs allow renewals of a prescription at either 85% to 90% utilization. These rules consider the needs of Medicaid recipients.

OSA Recommendation

"We recommend the division implement a control that allows for a review of members receiving a high volume of prescriptions within a given period, to verify whether the prescriptions are medically necessary."

Response

At the direction of DMAHS, the FFS vendor and the MCOs have developed multiple controls to prevent inappropriate medication utilization by our members. Existing prior authorization procedures focus on patient outcomes by ensuring members receive the most appropriate medication while reducing errors and unnecessary drug use. With the increased number of prescriptions used by a patient, the risk of adverse drug events, drug-drug interactions/conflicts, or therapeutic duplications is heightened. The drug utilization review (DUR) edits already in place reduce these risks and allow healthcare professionals to determine medical necessity, as well as to address any underlying polypharmacy or DUR issues.

It is also important to note that NJ licensed pharmacists are required under the Board of Pharmacy regulations to use their professional judgment to review each prescription prior to dispensing to protect the health and welfare of the patient. N.J.A.C. 13:39-7.13.

DMAHS shares OSA's concern regarding abuse and misuse of prescription drugs when not medically necessary. For this reason, the FFS and MCO pharmacy programs use DUR edits to

identify members where multiple prescribers are involved. DMAHS will consider OSA's recommendation to implement stronger controls concerning members receiving a high volume of prescriptions within a given period to determine if other system adjustments, such as additional edits or prior authorization requirements, would improve patient care.

OSA Recommendation

"We recommend the division comply with federal regulation 42 CFR 435.910 and perform a social security number match with the Social Security Administration for all prospective members to determine the validity of the social security number."

Response

DMAHS validates Social Security numbers on NJFC applications. Ten of the 25 randomly selected individuals did not have an electronic SSN verification but a paper verification. Although a paper copy of the applicant's SSN card is an allowable verification under regulation, DMAHS agrees that electronic verification is more efficient. Accordingly, since 2014, when the Affordable Care Act (ACA) was implemented, DMAHS has ensured that all eligibility determination agencies (EDAs) have the ability to electronically verify SSNs. DMAHS requires EDAs to attempt to verify all data elements electronically before paper documents can be requested. Seven out of the ten cases cited by OSA were for initial eligibility determinations prior to the implementation of the Affordable Care Act.

OSA Recommendation

"We recommend the division require MCOs to use the same edits utilized in the FFS pharmacy program to possibly achieve a similar reduction in pharmacy claim payments."

Response

The Department appreciates OSA's recommendation for consistency with edits used by the FFS and MCO pharmacy programs. The current MCO contracts already require that the DUR standards established by the MCOs shall be consistent with those established by the Medicaid Drug Utilization Review Board (DURB). FFS is also required to utilize DURB standards when establishing their DUR edits. Therefore, prospective drug utilization review requirements are similar for the MCO and FFS pharmacy programs.

MCOs use different pharmacy benefit management systems than FFS program, so these DURB standards may be processed differently. Medicaid's actuary, Mercer, analyzes MCO pharmacy claims for inefficiencies, including clinical edit utilization. Capitation payments are adjusted to prevent payment to MCOs for these inefficiencies.

OSA Recommendation

"We recommend the division review the proposed revisions and make the necessary changes that are required to bring N.J.A.C 10:51 up to date with current regulations, policies, and procedures."

Response

DMAHS agrees with OSA's recommendation and will update N.J.A.C. 10:51 as soon as practical.

OSA Observation

"Access to the New Jersey Prescription Monitoring Program could provide the division with an additional monitoring tool for the division to identify potential instances of abuse."

Response

The Department agrees with this observation. The Division of Consumer Affairs in the Office of the Attorney General controls access to the New Jersey Prescription Monitoring Program. DMAHS will continue to seek access to the PMP.

OSA Observation

"Comparing the costs of the FFS pharmacy program versus the managed care pharmacy program could prove beneficial to the division."

Response

The Department notes that a number of factors outside of a simple price comparison significantly impact total Medicaid pharmacy cost but are not tied to specific medications. These factors include managed care efficiency adjustments and pharmacy benefit manager rebates that serve to reduce monthly MCO capitation payments and result in net costs below what might be observed in claims data. The Division has considered the suggested analysis and found that that, dependent on a number of variables, such a shift could in fact result in increased cost the State. The Department appreciates the additional analysis performed by OSA and will consider its findings as it continually evaluates the most cost efficient way to administer the Medicaid pharmacy benefit.

Thank you again for the opportunity to review and respond to OSA's draft audit report. We welcome any opportunity to improve the NJ FamilyCare Pharmacy Program.

Sincerely,

Carole Johnson
Commissioner

c: Sarah Adelman, Deputy Commissioner
Jennifer Langer Jacobs, Assistant Commissioner
Allan Brophy, Director, Office of Auditing