

# Audit Report

## Pharmacy Benefits Manager Navitus Health Solutions LLC

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### Community First Health Plans



**Inspector  
General**

Texas Health  
and Human Services

**August 26, 2020  
OIG Report No. AUD-20-020**

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## HHS OIG

TEXAS HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

August 26, 2020

Audit Report

# PHARMACY BENEFITS MANAGER NAVITUS HEALTH SOLUTIONS LLC

## *Community First Health Plans*

### WHY THE OIG CONDUCTED THIS AUDIT

HHSC paid Community First \$502.8 million in capitation payments to serve Medicaid and CHIP members during fiscal year 2018. Of that amount, \$88.2 million was paid to Community First related to pharmacy services. Community First provided pharmacy benefits to an average of 134,491 Medicaid and CHIP members through its PBM, Navitus, in fiscal year 2018.

The audit objective was to determine whether Community First and its subcontracted PBM, Navitus, administered formularies, preferred drug list, and prior authorizations in accordance with the UMCC, STAR Kids contract, UMCM, and applicable rules and statutes. The audit scope included formularies, preferred drug lists, and pharmacy encounters and claims for the period from September 1, 2017, through August 31, 2018.

### WHAT THE OIG RECOMMENDS

Community First should ensure Navitus (a) implements an appropriate method to add all VDP-approved formulary and approved preferred drug list line items with the appropriate designated preferred or non-preferred status, (b) implements periodic reviews to ensure all current drug codes are correctly reflected in the formularies and Medicaid preferred drug list, and (c) complies with the VDP requirements for drug codes that require additional clinical reviews and requirements for non-preferred prior authorizations.

### MANAGEMENT RESPONSE

OIG presented preliminary audit results, issues, and recommendations to Community First on August 6, 2020. Community First indicated it will work with Navitus to resolve identified issues. Community First's responses are included after each recommendation.

For more information, contact:  
[OIG.AuditReports@hhsc.state.tx.us](mailto:OIG.AuditReports@hhsc.state.tx.us)

### WHAT THE OIG FOUND

Community First and Navitus generally adhered to formulary and preferred drug list requirements, which helped Navitus to ensure that it administered pharmacy benefits to Medicaid and CHIP members as required. Overall, Navitus's formularies matched 97.2 percent of Vendor Drug Program (VDP) formularies for the Medicaid and CHIP programs, and its preferred drug lists matched 98.8 percent of VDP's preferred drug lists. However, Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations.

Specifically, Community First did not ensure that Navitus always:

- Adhered to Medicaid and CHIP formularies because Navitus omitted certain drug codes from its drug formularies. By not including all drug codes listed on VDP's Medicaid and CHIP formularies, Navitus increased the risk that members would either experience delays in receiving prescriptions or not receive those prescriptions at all. Navitus incorrectly omitted 2.7 percent of drug codes from the Medicaid formulary it used to administer Community First's prescription benefits, and it incorrectly omitted 2.9 percent of drug codes from its CHIP formulary.
- Adhered to Medicaid preferred drug list because Navitus omitted certain drug codes and status information, used incorrect status end dates, and included some drug codes that were not listed for a total of 1.2 percent of drug codes on VDP's preferred drug list. Omitting drug codes with preferred status can result in paying higher prices for pharmaceuticals or bypassing state rebates. Conversely, omitting drug codes with non-preferred status can cause members to inappropriately receive items without completing required prior authorizations.
- Processed prior authorizations and reject claims correctly, which resulted in not correctly performing clinical and non-preferred prior authorizations as required. Overall, Navitus conducted 62.7 percent of tested prior authorizations correctly. However, for the 28 of 75 prior authorizations and rejected claims tested, Navitus did not perform required clinical and non-preferred prior authorizations as required, and in some cases, communicated the incorrect rejection message to the member.

### BACKGROUND

Community First is a managed care organization (MCO) contracted by The Texas Health and Human Services Commission (HHSC) to provide all covered, medically necessary services to its members, including prescription drugs. MCOs operate under requirements set forth in the Uniform Managed Care Contract (UMCC), STAR Kids contract, and Uniform Managed Care Manual (UMCM). Under the managed care model, the MCO receives monthly capitation payments for each member enrolled.

Each Texas Medicaid State of Texas Access Reform (STAR) program and Children's Health Insurance Program (CHIP) MCO, including Community First, is required to subcontract with a Pharmacy Benefits Manager (PBM) to process prescription claims and perform other selected pharmacy-related services. A PBM is a third-party administrator of prescription drug programs.

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## INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division conducted an audit of selected pharmacy benefits delivered by Community First Health Plans, Inc. (Community First) and its pharmacy benefit manager (PBM), Navitus Health Solutions, LLC (Navitus).

The Texas Health and Human Services Commission (HHSC) paid Community First a total of \$502.8 million<sup>1</sup> in capitation payments to serve members of the Medicaid State of Texas Access Reform (STAR) program, Medicaid STAR Kids program (STAR Kids), and Children's Health Insurance Program (CHIP) populations in state fiscal year 2018, which is the period from September 1, 2017, to August 31, 2018. Of that amount, \$88.2 million was the portion paid to Community First related to pharmacy services. Community First paid approximately 103 percent of those pharmacy capitation payments received from HHSC to Navitus for prescription expenses (\$88.2 million) and PBM administrative fees (\$2.6 million) during the same timeframe. Community First provided pharmacy benefits to an average monthly membership of 134,491 Medicaid and CHIP members during the 12-month period.

### Background

Community First is a managed care organization (MCO) contracted by HHSC to provide all covered, medically necessary services to its members, including prescription drugs. Under managed care, the MCO receives a capitation payment for each member enrolled, based on historical expenses by populations served. Capitation payments are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member per month rates based on members' associated risk groups. These capitation payments include federal and state funds, and both medical and pharmacy payments.

Each Texas Medicaid and CHIP MCO, including Community First, is required to subcontract with a PBM to process prescription claims<sup>2</sup> and perform other selected pharmacy-related services. A PBM is a third-party administrator of prescription drug programs.<sup>3</sup> Community First and ten other MCOs contracted with Navitus as

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<sup>1</sup> This capitation amount includes premiums for medical, pharmacy, delivery of supplemental payments, and investment income earned by Community First.

<sup>2</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.7, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.7, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>3</sup> Uniform Managed Care Contract, Attachment A, Article 2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment A, Article 2, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

their PBM to provide pharmacy benefit services. In addition to the requirement to process prescription claims, Navitus administers all pharmacy benefits services except for appeals of prior authorization determinations which are addressed directly by Community First. See Appendix A for details about the MCOs and their PBMs.

Pharmacies are required to enroll with the HHSC Vendor Drug Program (VDP) to become eligible to serve as a vendor for Medicaid and CHIP programs. The PBMs then contract with those VDP-enrolled pharmacies to dispense prescriptions to Medicaid and CHIP managed care members. For example, Navitus contracts with a network of pharmacies to dispense prescriptions to Community First's Medicaid STAR, STAR Kids, and CHIP managed care members. VDP provides guidance to the MCOs, their PBMs, and pharmacies in administering pharmacy benefit services, including lists of drugs available to Medicaid and CHIP members as pharmacy benefits and related authorization requirements.

## Key Concepts

Key components of Community First's and Navitus's administration of pharmacy benefit services include:

- **Formulary:**  
A listing of drugs, vitamins and minerals, and home health supplies available to Medicaid or CHIP members as pharmacy benefits. In Texas, MCOs are required to adhere to the Medicaid and CHIP formularies. VDP maintains separate Medicaid and CHIP formularies. Pharmacies can only fill prescriptions for drug codes, which are unique 11-digit identifiers, on the Medicaid and CHIP formularies unless approval was obtained from VDP. Some drugs on the Medicaid formulary are subject to one or both types of prior authorization, non-preferred and clinical.
- **Preferred Drug List:**  
A listing of drugs that a Texas Medicaid member can receive without a non-preferred prior authorization. VDP maintains a preferred drug list for Medicaid only; drugs prescribed under CHIP are not subject to preferred drug list requirements. The preferred drug list is a subset of the formulary and includes drugs produced by manufacturers that have reached a state supplemental rebate agreement with HHSC.<sup>4</sup> Drug manufacturers pay these state supplemental rebates to HHSC, which are then shared between the state and Centers for Medicare and Medicaid Services (CMS).
- **Non-Preferred Prior Authorization:**  
An authorization that applies to drugs identified as non-preferred on the

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<sup>4</sup> Tex. Gov. Code § 531.072(b) (Jan. 1, 2016).

Medicaid preferred drug list. MCOs must approve a prior authorization request from the prescribing provider before the prescription can be filled and the corresponding claim adjudicated.<sup>5</sup> Non-preferred prior authorizations are not required for drugs listed as preferred, or those not listed at all, on the Medicaid preferred drug list.

- **Clinical Prior Authorization:**

A drug review process authorized by VDP that is conducted by an MCO or their PBM prior to dispensing a drug. An authorization is based on evidence-based clinical criteria and nationally recognized peer-reviewed information. Clinical prior authorizations may apply to an individual drug or a drug class on the formulary, including some preferred and non-preferred drugs. Drugs under Medicaid and CHIP may be subject to clinical prior authorizations.

This audit focused on Community First's and Navitus's compliance with the Uniform Managed Care Contract (UMCC), STAR Kids contract, and the Uniform Managed Care Manual (UMCM) requirements related to adherence to (a) Medicaid and CHIP formularies, (b) the Medicaid preferred drug list, and (c) clinical and non-preferred prior authorization processes.

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

## **Objective and Scope**

The audit objective was to determine whether Community First and its subcontracted PBM, Navitus, administered the formulary, preferred drug list, and prior authorizations in accordance with the UMCC, STAR Kids contract, UMCM, and selected applicable state rules and statutes.

The audit scope included the Medicaid and CHIP formularies and Medicaid preferred drug list in effect for 2018, pharmacy claims that required prior authorizations for the period from September 1, 2017, through August 31, 2018, and related activities in place through the end of fieldwork in July 2020 and included a review of related significant controls and control components.

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<sup>5</sup> "Adjudicate" means to deny or pay a claim for services or drugs prescribed to a member by a health care provider.

## Methodology

The OIG Audit and Inspections Division collected information for this audit through discussions and interviews with responsible staff at Navitus and VDP and through request and review of the following information:

- Medicaid and CHIP formularies
- Medicaid preferred drug list
- NaviGate 3D<sup>6</sup>-formulary and preferred drug list
- PA Intel and PA Accel screen shots<sup>7</sup>
- Audit Logs
- Prior authorization approval communication letters
- Clinical and preferred drug list criteria guidelines
- Encounter data and related claims data<sup>8</sup>

The OIG Audit and Inspections Division selected two points in time for which to request the VDP and Navitus Medicaid and CHIP formularies. Auditors reconciled the VDP and Navitus formularies to assess adherence and identify exceptions involving omitted drug codes,<sup>9</sup> and differences in drug code effective and termination dates.

The OIG Audit and Inspections Division selected three points in time for which to request the VDP and Navitus preferred drug list. Auditors reconciled the VDP and Navitus preferred drug lists to assess adherence and identify exceptions between drug codes, drug code effective and termination dates, and preferred drug list status type.

The OIG Audit and Inspections Division sampled a total of 60 prior authorizations and 15 rejected claims from which to assess compliance with prior authorization design and performance. A random and risk-based sample of 20 prior authorizations and 5 rejected claims was selected for the following testing areas: (a) drug codes that require both a clinical and non-preferred prior authorization, (b) drug codes that require only clinical prior authorizations, and (c) drug codes that require only non-preferred prior authorizations.<sup>10</sup> Additionally, drug code exceptions identified in the preferred drug list reconciliation were included in the sample selection process for non-preferred prior authorizations.

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<sup>6</sup> NaviGate 3D is the Navitus system used to update the formulary and preferred drug list.

<sup>7</sup> PA Intel and PA Accel are proprietary systems used by Navitus to adjudicate claims.

<sup>8</sup> “Encounter” means a covered service or group of covered services delivered by a provider to a member during a visit between the member and provider.

<sup>9</sup> The Medicaid and CHIP formularies and Medicaid preferred drug lists are developed and updated by VDP based upon additions or removals of National Drug Codes (NDCs).

<sup>10</sup> Non-preferred-only prior authorization testing included testing when the drug was also designated as preferred.

The OIG Audit and Inspection Division presented preliminary audit results, issues, and recommendations to Community First in a draft report dated August 6, 2020. In its management responses, Community First indicated it will work with Navitus to resolve identified issues. Community First's responses are included after each recommendation.

## Criteria

The OIG Audit and Inspections Division used the following criteria to evaluate the information provided:

- Texas Government Code §§ 531.072 (2016) and 533.005 (2017)
- 1 Texas Administrative Code §§ 353.905(a) (2013) and 370.701 (2012)
- Uniform Managed Care Contract, Attachment A, v. 2.24 (2017) through v. 2.25.1 (2018)
- Uniform Managed Care Contract, Attachment B-1, v. 2.24 (2017) through v. 2.25.1 (2018)
- STAR Kids Contract, Attachment A, v. 1.5 (2017) through v. 1.6 (2018)
- STAR Kids Contract, Attachment B-1, v. 1.5 (2017) through v. 1.6 (2018)
- Uniform Managed Care Manual, Chapter 2.2, v. 2.8 (2016)
- Uniform Managed Care Manual, Chapter 3.21, v. 2.1 (2015)
- VDP Texas Prior Authorization Program Clinical Edit Criteria (2017)
- VDP Texas Prior Authorization Program Preferred Drug List Criteria (2017 and 2018)

## Auditing Standards

### GAGAS

The OIG Audit and Inspections Division conducted this audit in accordance with generally accepted 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 the issues and conclusions based on our audit objectives. The OIG Audit and Inspections Division believes the evidence obtained provides a reasonable basis for our issues and conclusions based on our audit objectives.

## AUDIT RESULTS

Community First works in conjunction with its subcontracted PBM, Navitus, to provide pharmacy benefit services to Medicaid and CHIP managed care members. These pharmacy benefit services are required to be performed in compliance with the UMCC, STAR Kids contract, and the UCMCM, as well as applicable state rules and statutes, at a quality level that is acceptable and consistent with industry standard, custom, and practice.<sup>11</sup> The OIG Audit and Inspections Division reviewed the extent to which Community First and Navitus met selected pharmacy benefit requirements.

Community First and Navitus generally adhered to formulary and preferred drug list requirements. However, in some cases, Navitus did not consistently and correctly update its formulary listing and its preferred drug list. As a result, Navitus may have incorrectly rejected claims for prescriptions that should have been accepted, caused members to experience delays in receiving prescriptions or not receive those prescriptions at all, or paid higher prices or reduced state rebates for drugs.

In addition, Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations. Specifically, for 28 of 75 prior authorizations and rejected claims tested, Navitus did not perform required clinical and non-preferred prior authorizations as required, and in some cases, Navitus communicated an incorrect rejection message to the member. Table 1 summarizes the results in each area of testing that are detailed in the issues that follow.

**Table 1: Summary of Results**

Area of Testing	Percentage Adhered
Formulary Adherence	97.2 %
Preferred Drug List Adherence	98.8 %
Prior Authorization Design and Performance	62.7 %

*Source: OIG Audit and Inspections Division*

The OIG Audit and Inspections Division assessed the reliability of data provided by Navitus by tracing encounter data to Navitus's claim system and interviewing relevant Navitus personnel knowledgeable about the systems and data. The OIG Audit and Inspections Division determined that the data was sufficiently reliable for the purposes of this audit.

<sup>11</sup> Uniform Managed Care Contract, Attachment B-1, § 2.2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 2.3, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

## FORMULARY

The Medicaid and CHIP formularies are listings of drugs, vitamins and minerals, and home health supplies that are established by VDP and available to Medicaid and CHIP members as pharmacy benefits. They are developed and updated by VDP based upon additions or removals of drug codes, a drug manufacturer applying for new drug coverage, discontinued production of a drug, or discontinued coverage by CMS. The UMCC and STAR Kids contract require Community First to process formulary updates to a claims adjudication system within two business days of the VDP update files becoming available.<sup>12</sup> Navitus ensured Community First's compliance with this requirement by performing formulary updates five times per week.

Both Community First and its PBM, Navitus, are required to adhere to and exclusively use the Medicaid and CHIP formularies.<sup>13</sup> Community First and Navitus must provide members with access to all items listed on the formularies.<sup>14</sup>

VDP provides the current listing of Medicaid and CHIP formularies that each PBM must maintain in its claims adjudication systems. Each daily update potentially contains changes to the formularies that include both additions of drug codes or adjustments to termination dates to remove drug codes. These incremental differences from the previous formularies must be identified and adjusted within the claims adjudication system to continue adherence with the established formularies. Any changes not incorporated can create a mismatch between the formularies established by VDP and those administered by the PBM.

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### Issue 1: Community First Did Not Always Ensure That Navitus Adhered to the Medicaid and CHIP Formularies

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Overall, Navitus's formularies matched 97.2 percent of VDP's formularies across both the Medicaid and CHIP programs. As a result, in most cases, Navitus correctly adjudicated claims for those programs. The sections that follow detail exceptions identified in the reconciliations.

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<sup>12</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.14, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.14, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>13</sup> 1 Tex. Admin. Code §§ 353.905(a) (Sept. 1, 2013) and 370.701 (Mar. 1, 2012).

<sup>14</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.1, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.1, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

## Navitus's Medicaid and CHIP Formularies Did Not Consistently Include All Drug Codes on VDP Formularies

The OIG Audit and Inspections Division compared the Navitus Medicaid and CHIP formularies with VDP's Medicaid<sup>15</sup> and CHIP formularies at two points in time to determine whether the correct drug codes were included on the Navitus formulary and to determine whether drug codes were added or removed as required by changes to the VDP formulary. In some cases, drug codes were incorrectly excluded from the Navitus formularies because the drug codes (a) were omitted or (b) were removed sooner than indicated by VDP.

As a result, 2.7 percent of drug codes were incorrectly omitted or removed early from the Medicaid formulary, and 2.9 percent of drug codes were incorrectly omitted or removed early from the CHIP formulary. Table 2 summarizes the differences identified.

**Table 2: Drug Code Exceptions for Medicaid and CHIP Formularies**

	Medicaid	CHIP
Number of Drug Codes on Formulary in 2018 (Average)	33,828	29,738
Number of Drug Codes Incorrectly Omitted	801	758
Number of Drug Codes Incorrectly Removed Early	103	98
Total Drug Codes Affected	904	856

Source: OIG Audit and Inspections Division

By not including all drug codes listed on VDP's Medicaid and CHIP formularies, Navitus increases the risk that Community First members will either experience delays in receiving prescriptions or not receive those prescriptions at all. Based on additional evidence provided by Navitus, in some cases when a claim was rejected the member received an appropriate alternative drug. Table 3 shows the numbers of claims rejected and members affected as the result of drug codes not being included in Navitus's formularies.

**Table 3: Total Claims Rejected Due to Formulary Exceptions**

	STAR	STAR Kids	CHIP
Total Rejected Claims in 2018	351,060	84,447	41,088
Number of Incorrectly Rejected Claims for Formulary Exceptions	1,201	160	169
Members Affected	698	65	93
Estimated Value of Rejected Claims	\$25,008.94	\$4,779.77	\$5,832.36

Source: OIG Audit and Inspections Division

<sup>15</sup> Both STAR and STAR Kids programs use the same Medicaid formulary and thus have the same exceptions. The number of incorrectly rejected claims and members affected will vary for each program in subsequent tables.

In addition to the incorrectly rejected claims identified in Table 3, additional rejections were identified. OIG auditors could not determine whether those claims were correctly rejected because Navitus's claims adjudication system did not retain the corresponding drug codes. Navitus has attributed these rejections to drug codes not registered with Medi-Span<sup>16</sup> or those that are otherwise omitted as over-the-counter forms, despite their inclusion in the VDP formularies.

Table 4 shows (a) the number of claims rejected for any reason for which Navitus did not retain the drug code number, (b) those which were potentially associated with formulary exceptions, and (c) the number of members affected by these claims potentially rejected due to formulary exceptions.

**Table 4: Total Rejected Claims for Drug Codes Not Retained by Navitus**

	STAR	STAR Kids	CHIP
Total Rejected Claims with Drug Codes Not Retained	3,834	2,798	524
Number of Claims Potentially Associated with Formulary Rejections	3,054	1,541	452
Members Potentially Affected by Formulary Rejections	1,972	381	287

Source: OIG Audit and Inspections Division

### **Recommendation 1**

Community First should ensure that Navitus:

- Implements an appropriate method to add and update all VDP-approved formulary items.
- Implements periodic reviews to ensure all current VDP-approved formulary items are correctly reflected in the Medicaid and CHIP formularies.

<sup>16</sup> Medi-Span is a prescription drug data application that Navitus uses, which classifies drugs based on generic product identifier.

## **Management Response**

### **Action Plan**

*CFHP will work with Navitus to identify solutions around:*

- a) A more comprehensive Medi-Span file review to capture changes when proposed by Medi-Span to ensure adjudication platforms are updated timely.*
- b) System enhancements to allow for VDP approved NDCs to adjudicate as required based on drug designation on VDP's formulary files.*

### **Responsible Manager**

*Director of Clinical Pharmacy Services*

### **Target Implementation Date**

*October 1, 2020 for assessment of solution requirements (Comprehensive Medi-Span file reviews and system enhancements). Project will then commence 30 days from completion of assessment of solutions followed by policy and procedure updates. CFHP will perform quarterly reviews for documentation of successful Medi-Span and VDP formulary file loads beginning January 1, 2021.*

## **PREFERRED DRUG LIST**

MCOs are required to adhere to VDP's Medicaid preferred drug list,<sup>17,18,19</sup> which contains a subset of many, but not all, drugs on the formulary. The preferred drug list is arranged by drugs in various therapeutic classes that are designated as either "preferred" or "non-preferred" according to their specific, unique drug codes. Drugs identified on the preferred drug list as "non-preferred" may be subjected to non-preferred prior authorization review. Preferred drugs must be adjudicated as payable without a prior authorization<sup>20</sup> before the drug is dispensed to a member.<sup>21</sup> Preferred drugs are recommended for their effectiveness, clinical significance, cost effectiveness, and safety. The Medicaid preferred drug list is published every January and July.

VDP provides the Medicaid preferred drug list that must be maintained by claims adjudication systems. Each published update contains additions and deletions from the preferred drug list, as well as changes in status between preferred and non-preferred designations. Community First must ensure that Navitus identifies and adjusts for differences from the previous published preferred drug list to maintain adherence. If Navitus does not make those required updates, it may adjudicate claims incorrectly. The process Navitus used for Medicaid preferred drug list updates was performed concurrently with formulary updates.

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### **Issue 2: Community First Did Not Always Ensure That Navitus Adhered to the Medicaid Preferred Drug List**

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Overall, Navitus's preferred drug lists matched 98.8 percent of VDP's preferred drug lists. As a result, Navitus correctly filled and adjudicated most claims based on preferred drug list requirements. The sections that follow detail exceptions identified in the reconciliations.<sup>22</sup>

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<sup>17</sup> Tex. Gov. Code § 533.005(a)(23)(B) (Sept. 1, 2017).

<sup>18</sup> 1 Tex. Admin. Code § 353.905(a) (Sept. 1, 2013).

<sup>19</sup> VDP maintains a preferred drug list for Medicaid only; drugs prescribed under CHIP are not subject to preferred drug list requirements.

<sup>20</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.2, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>21</sup> Preferred drugs may still be subject to clinical prior authorization.

<sup>22</sup> Criteria considered in the reconciliations included the drug codes identified in the preferred drug lists, as well as the drug statuses and effective and ending dates during the scope.

## Navitus Omitted Drug Codes From Its Medicaid Preferred Drug List

The OIG Audit and Inspections Division compared Navitus's Medicaid preferred drug list with VDP's Medicaid preferred drug list<sup>23</sup> at three points in time and determined that Navitus incorrectly omitted some drug codes from its preferred drug lists. Navitus has attributed these differences to drug codes not registered with Medi-Span or which were updated subsequent to the effective dates directed by VDP. Table 5 summarizes the omissions.

**Table 5: Drug Code Omissions for Navitus's Medicaid Preferred Drug Lists**

Medicaid	
Total Average Number of Drug Codes on preferred drug lists during 2018	19,493
Number of Drug Codes Incorrectly Omitted (September 1, 2017)	41
Number of Drug Codes Incorrectly Omitted (March 1, 2018)	55
Number of Drug Codes Incorrectly Omitted (August 31, 2018)	63
Number of Additional Drug Codes Incorrectly Omitted for all three dates tested	17

Source: OIG Audit and Inspections Division

Omitting drug codes with preferred status can result in paying higher prices for drugs or bypassing state rebates. Conversely, omitting drug codes with non-preferred status can cause members to inappropriately receive drugs without completing required prior authorizations or deferral to preferred forms that are available. Table 6 shows the numbers of encounters, rejected claims, and members affected as the result of drug codes not included in Navitus's preferred drug lists.

**Table 6: Encounters and Rejected Claims Affected for Omitted Drug Codes**

	STAR	STAR Kids
Number of Paid Encounters Incorrectly Processed	1	0
Number of Claims Incorrectly Rejected	0	0
Number of Members Affected <sup>24</sup>	1	0

Source: OIG Audit and Inspections Division

## Navitus Omitted Status for Some Drugs in Its Medicaid Preferred Drug List

In some instances, Navitus included drug codes but excluded the drug's preferred or non-preferred status during part of the fiscal year. These 45 drug codes lacked designation as preferred or non-preferred during the first of the three individual

<sup>23</sup> Both STAR and STAR Kids programs use the same Medicaid preferred drug list and thus have the same exceptions. The number of incorrectly rejected claims and members affected will vary for each program in subsequent tables.

<sup>24</sup> Number of members affected includes total unduplicated members for both paid encounters and reject claims.

reconciliations performed, which were resolved prior to the subsequent reconciliation.

Omitting a drug's status during part of the fiscal year can have a similar impact to omitting a drug code altogether. Omitting drug codes with preferred status can result in paying higher prices for drugs or bypassing state rebates. Conversely, omitting drug codes with non-preferred status can cause members to inappropriately receive drugs without completing required prior authorizations or deferral to preferred forms that are available. Table 7 shows the encounters, rejected claims, and members affected during the omitted period.

**Table 7: Encounters and Rejected Claims Affected for Missing Status**

	STAR	STAR Kids
Number of Paid Encounters Incorrectly Processed	104	25
Number of Claims Incorrectly Rejected	29	7
Number of Members Affected	79	16

Source: *OIG Audit and Inspections Division*

### Navitus Had Incorrect Status Ending Dates on Its Medicaid Preferred Drug List

Navitus had a status ending date for 18 drug codes that differed from the ending dates in the VDP preferred drug list. Differences in ending dates cause mismatches in how long Navitus retains the preferred or non-preferred status of the affected drug codes on its preferred drug list. These differences in ending dates were identified in the first of the three individual reconciliations performed and were resolved prior to the subsequent reconciliation. Differences in expiration dates of drug codes between Navitus's and VDP's preferred drug lists can cause Navitus to incorrectly adjudicate claims during those exception periods. Table 8 shows the encounters, rejected claims, and members affected during these intervals.

**Table 8: Encounters and Rejected Claims Affected as a Result of Ending Date Differences**

	STAR	STAR Kids
Number of Paid Encounters Incorrectly Processed	5	0
Number of Claims Incorrectly Rejected	1	0
Number of Members Affected	6	0

Source: *OIG Audit and Inspections Division*

### Navitus Identified Drug Codes on Its Medicaid Preferred Drug List Not Included by VDP

Lastly, Navitus identified three drug codes as non-preferred that were not included in the preferred drug lists published by VDP. These incorrectly included drug codes were identified in the first of the three individual reconciliations performed. By classifying these drug codes as non-preferred, Navitus required prior authorizations

that should not have been required. This increases the risk that members experience delays in receiving drugs, or do not receive needed drugs at all. Table 9 shows the rejected claims and members affected by these exceptions.

**Table 9: Rejected Claims Affected for Drug Codes Not Included by VDP**

	STAR	STAR Kids
Number of Claims Incorrectly Rejected	2	0
Number of Members Affected	2	0

Source: *OIG Audit and Inspections Division*

## **Recommendation 2**

Community First should ensure that Navitus:

- Implements an appropriate method to add all approved preferred drug list line items with the appropriate designated preferred or non-preferred status.
- Implements periodic reviews to ensure all current drug codes are correctly reflected in the Medicaid preferred drug list.

## **Management Response**

### Action Plan

*CFHP will work with Navitus to identify solutions around:*

- a) A more comprehensive Medi-Span file review to capture changes when proposed by Medi-Span to ensure adjudication platforms are updated timely and accurately.*
- b) System enhancements to allow for VDP approved NDCs to adjudicate as required based on drug designation on VDP's formulary files.*
- c) CFHP will perform quarterly reviews for documentation of successful Medi-Span file loads and successful VDP formulary file loads into the Navitus claims adjudication system.*

### Responsible Manager

*Director of Clinical Pharmacy Services*

### Target Implementation Date

*October 1, 2020 for assessment of solution requirements (Comprehensive Medi-Span file reviews and system enhancements). Project will then commence 30 days from completion of assessment of solutions followed by policy and procedure updates. CFHP will perform quarterly reviews for documentation of successful Medi-Span and VDP formulary file loads beginning January 1, 2021.*

## **PRIOR AUTHORIZATIONS**

Certain prescriptions require prior authorization<sup>25</sup> in order to be filled and dispensed to Medicaid and CHIP members, and for the claims to be adjudicated. A prescription may require authorization because of its non-preferred status or because of its clinical status. Some prescriptions are subject to both non-preferred and clinical prior authorizations. To obtain a prior authorization, the prescribing provider must submit a prior authorization request to Navitus and receive Navitus's approval.

Community First and their subcontracted PBM, Navitus, must adopt prior authorization requirements that comply with the state's requirement to exclusively use VDP's formularies<sup>26,27</sup> and allow access by members to all non-preferred drugs on the Medicaid formularies.<sup>28</sup> MCOs must adhere to the Medicaid preferred drug list and perform non-preferred prior authorizations as required by VDP.<sup>29</sup> MCOs are permitted to perform prior authorizations separately from or concurrently with other reviews. However, MCOs must not substitute any other types of reviews in place of required clinical and non-preferred prior authorizations.

In addition, certain drugs prescribed under Medicaid or CHIP require clinical prior authorization because the member must meet certain medical or conditional requirements before the drug is approved. MCOs are not permitted to impose more stringent clinical prior authorization requirements than those specified by VDP without approval by HHSC or the Drug Utilization Review Board.<sup>30</sup>

Additionally, a requested drug could be subject to both a clinical and non-preferred prior authorization. The MCO must process all edits concurrently and

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<sup>25</sup> A "prior authorization" is an authorization from the Medicaid or CHIP program for the delivery of certain services. It must be obtained prior to providing the service and may remain valid for up to a year after approval.

<sup>26</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.8.1, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.9.1, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>27</sup> Tex. Gov. Code § 533.005(a)(23)(A) (Sept. 1, 2017).

<sup>28</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.1, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.1, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>29</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.2, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>30</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.2, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

independently so that each prior authorization (clinical and non-preferred) is checked for approval.<sup>31</sup>

### **Issue 3: Community First Did Not Ensure That Navitus Properly Approved and Rejected Claims**

Community First did not ensure that Navitus consistently performed required clinical and non-preferred prior authorizations as required, and in some cases Navitus incorrectly rejected claims or communicated the incorrect rejection message to the member.

Specifically, for 23 of 60 (38 percent) prior authorizations tested, clinical or non-preferred criteria was either not applied or not applied appropriately. Additionally, 5 of 15 (33 percent) rejected claims tested were incorrectly rejected. The 60 prior authorizations and 15 rejected claims included 20 prior authorizations and 5 rejected claims each for (a) drug codes that require both a clinical and non-preferred prior authorization, (b) drug codes that require only clinical prior authorizations, and (c) drug codes that require only non-preferred prior authorizations.<sup>32</sup>

**Table 10: Summary of Results from Prior Authorization Testing**

	Number of Claims Tested	Number of Issues Identified
Paid Claims Tested	60	23
Reject Claims Tested	15	5
Total Claims Tested	75	28

Source: *OIG Audit and Inspections Division*

#### **Non-Preferred Prior Authorizations Were Adjudicated Without Applying All Non-Preferred Requirements**

Navitus did not correctly apply all required non-preferred prior authorization criteria<sup>33,34</sup> for 22 (55 percent) of the 40 prior authorizations tested.<sup>35</sup> Before a non-

<sup>31</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract, Attachment B-1, § 8.1.17.2, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>32</sup> Non-preferred-only prior authorization testing included testing when the drug was also designated as preferred.

<sup>33</sup> Uniform Managed Care Contract, Attachment B-1, § 8.1.21.2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018) and STAR Kids Contract Attachment B-1, § 8.1.17.2, v. 1.5 (Sept. 1, 2017) through v. 1.6 (Mar. 1, 2018).

<sup>34</sup> VDP Texas Prior Authorization Program Preferred Drug List Criteria (July 27, 2017, Mar. 9, 2018, and July 26, 2018).

<sup>35</sup> Two sets of 20 prior authorizations were tested: those for drugs that required both clinical and non-preferred prior authorizations, and those for drugs that required only non-preferred prior authorizations.

preferred drug can be approved several requirements must be met, including determining whether the member had recently received a preferred form of the drug, and experienced treatment failure, a documented allergy, or contraindication with the preferred drug. For 16 (73 percent) of the 22 prior authorizations for which all required non-preferred prior authorization criteria were not applied, Navitus determined that the members previously tried a preferred drug prior to approving a non-preferred prior authorization but did not provide sufficient evidence to demonstrate that other required non-preferred prior authorization requirements were applied. However, for the remaining six prior authorizations, there was no evidence that a preferred drug was tried prior to approving the non-preferred drug.

In addition, two of the six non-preferred prior authorizations tested, for the drugs Promethazine<sup>36</sup> and Promethegan,<sup>37</sup> also required a clinical prior authorization, but clinical requirements were not applied. As a result, Promethazine and Promethegan were incorrectly paid as preferred without performing the non-preferred and clinical prior authorization requirements. Navitus did not correctly program Promethazine and Promethegan in its adjudication system. Navitus incorrectly adjudicated and paid 38 Promethazine and Promethegan claims in the amount of \$2,876.19 for 29 members in 2018. Promethegan and Promethazine can be used as antihistamine, sedative, or anti-nausea drugs.

The 22 prior authorizations for 18 drug codes were associated with 11,493 claims processed without all requirements being applied as required. Approving non-preferred prior authorizations without applying required criteria can result in members receiving drugs when a preferred drug is available or may limit potential rebates to HHSC. Table 11 shows the number of drug codes affected, the paid claims processed on those drug codes, and the members affected due to this issue.<sup>38</sup>

**Table 11: Impact of Prior Authorization Requirements Not Being Applied**

	STAR	STAR Kids
Number of Drug Codes Affected	17	15
Total Paid Claims Processed Incorrectly	9,342	2,151
Total Number of Medicaid Members Affected	4,704	747

Source: *OIG Audit and Inspections Division*

<sup>36</sup> Drug code 45802075930.

<sup>37</sup> Drug code 00713052612.

<sup>38</sup> Table 11 includes results where non-preferred requirements, and Promethazine and Promethegan clinical requirements were not applied.

## A Clinical Prior Authorization Was Approved for All Doses on the Initial Request

One of 20 (5 percent) clinical prior authorizations tested, for Synagis,<sup>39</sup> was approved for all five monthly doses during the initial clinical review without evidence that clinical review for subsequent doses was performed, as required.<sup>40</sup> Synagis is administered during the respiratory virus season, and authorizations for Synagis are approved as monthly doses for up to five months. Synagis is used in infants and children to prevent respiratory syncytial virus–track infections and serious lung diseases, and a clinical review is required prior to each administration in order to ensure that the drug is still needed, and to verify that the correct dosage is administered.

According to Navitus, it approves all five doses to limit the administrative burden of review for each dose requested throughout the virus season. Approving all five doses on the initial request prevented Community First or Navitus from performing clinical criteria review that is required for subsequent Synagis doses. Approving all five doses at once without ensuring clinical review prior to subsequent doses may have caused members to receive doses of Synagis when not medically necessary, and it increased the risk that infants and young children were administered incorrect dosages. Table 12 shows the drug codes affected, total number of paid claims for doses beyond initial authorization, and Medicaid members affected due to this issue.

**Table 12: Impact of Prior Authorization Approved for All Doses on Initial Request Without Subsequent Review**

	STAR	STAR Kids
Number of Drug Codes Affected	2	2
Total Paid Claims for Doses Following Initial Authorization	99	102
Total Number of Members Affected	27	28

Source: *OIG Audit and Inspections Division*

<sup>39</sup> Drug code 60574411301/6057441401.

<sup>40</sup> VDP Texas Prior Authorization Program Clinical Edit Criteria (Sept. 6, 2017, and Dec. 11, 2017).

## Drugs Were Incorrectly Rejected as Non-Covered Drugs

Navitus incorrectly rejected 5 of 15 (33 percent) rejected claims tested, for Orphenadrine,<sup>41</sup> Fluticasone Propionate,<sup>42</sup> Cetrizine HCL,<sup>43</sup> and Proair HFA,<sup>44</sup> for “Product/Service Not Covered” when they are actually non-preferred drugs that require a prior authorization. Orphenadrine is used to relieve discomfort related with acute painful muscular skeletal conditions. Fluticasone Propionate and Cetrizine HCL can be used for managing nasal symptoms of allergic rhinitis. Proair HFA is used to treat or prevent bronchospasm for patients with obstructive airway disease.

Orphenadrine claims were rejected a total of 13 times in 2018 with an incorrect rejection message of “Product/Service Not Covered” for 5 STAR members. Fluticasone Propionate, Cetrizine HCL, and Proair HFA were collectively rejected a total of 13 times in 2018 with an incorrect rejection message of “Product/Service Not Covered” for 7 STAR Kids members. Communicating the incorrect rejection message may result in a member not receiving a drug that may have been approved if the claim had been adjudicated correctly. Table 13 shows the total rejected claims and Medicaid members affected due to this issue.

**Table 13: Impact of Non-Preferred Drug Rejected as Not Covered**

	STAR	STAR Kids
Total Incorrectly Rejected Claims	13	13
Number of Medicaid Members Affected	5	7

Source: *OIG Audit and Inspections Division*

## **Recommendation 3**

Community First should ensure that Navitus:

- Follows adjudication requirements for preferred drug list drug codes.
- Complies with the VDP clinical criteria requirements for drug codes that require additional clinical reviews on subsequent doses.
- Correctly programs and communicates rejection messages to members.

<sup>41</sup> Drug code 43386048024.

<sup>42</sup> Drug codes 00054327099/60505082901.

<sup>43</sup> Drug code 54838057280.

<sup>44</sup> Drug code 59310057922.

## **Management Response**

### **Action Plan**

*CFHP will work with Navitus to identify solutions around:*

- a) System enhancements to allow for VDP approved NDCs to adjudicate as required by VDP in terms of preferred status and non-preferred status.*
- b) Programming appropriate rejection codes to pharmacies based on VDP formulary status.*

*Additionally, CFHP will update the Synagis clinical criteria to require a renewal PA for each subsequent dose of Synagis. This change will be made effective for the 2020-2021 Synagis season which starts this November. CFHP will then ensure Navitus adequately trains all Prior Authorization Pharmacists and notifies pharmacies and providers of this new change prior to the start of this year's Synagis season.*

### **Responsible Manager**

*Director of Clinical Pharmacy Services*

### **Target Implementation Date**

#### ***Adjudicated Non-PDL PAs Without VDP-Required Questions***

*The questions not asked will be edited to match the VDP required criteria by 10/1/2020.*

#### ***Synagis PA was Approved for All Doses***

*CFHP will ensure PA requirements for Synagis are updated to include renewal PA criteria by the start of this year's Synagis season on 11/1/2020.*

## CONCLUSION

Overall, Navitus's formulary and preferred drug list matched VDP's formulary and preferred drug list 97.2 percent and 98.8 percent, respectively. Additionally, Navitus processed the majority of prior authorizations and rejected claims tested appropriately.

However, Community First did not ensure that Navitus always:

- Adhered to Medicaid and CHIP formularies because Navitus omitted certain VDP formulary drug codes from its formularies.
- Adhered to the Medicaid preferred drug list because Navitus omitted certain drug codes and preferred drug list status, used incorrect status end dates, and included some drug codes that were not listed on VDP's preferred drug list.
- Processed prior authorizations and reject claims correctly, which resulted in not performing clinical and non-preferred prior authorizations as required, and in some cases, Navitus communicated the incorrect rejection message to the member.

These issues increase the risk that members may (a) experience delays in receiving prescriptions or not receive those prescriptions at all, or (b) receive drugs without completed required prior authorizations. They also increase the risk that Community First might pay higher prices for drugs than necessary or that it may bypass state rebates.

The OIG Audit and Inspections Division offered recommendations to Community First, which, if implemented, will ensure Navitus:

- Implements an appropriate method to add all VDP-approved formulary items.
- Implements periodic reviews to ensure all current VDP-approved formulary items are correctly reflected in the Medicaid and CHIP formularies.
- Implements an appropriate method to add all approved preferred drug list line items with the appropriate designated preferred or non-preferred status.
- Implements periodic reviews to ensure all current drug codes are correctly reflected in the Medicaid preferred drug list.
- Follows adjudication requirements for preferred drug list drug codes.

- Complies with the VDP clinical criteria requirements for drug codes that require additional clinical reviews on subsequent doses.
- Communicates rejection messages to members correctly.

For instances of noncompliance identified in this audit report, Medicaid and CHIP Services may consider tailored contractual remedies to compel Community First to meet contractual requirements related to formulary and preferred drug list adherence, and prior authorization processing. In addition, audit findings in this report may be subject to OIG administrative enforcement measures,<sup>45</sup> including administrative penalties.<sup>46</sup>

The OIG Audit and Inspections Division thanks management and staff at Community First and Navitus for their cooperation and assistance during this audit.

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<sup>45</sup> 1 Tex. Admin. Code § 371.1603 (May 1, 2016).

<sup>46</sup> Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

## Appendix A: MCOs and Their PBMs in 2018

PBM	MCO	Average Members per Month
Navitus	Community First	134,491
Navitus	Community Health Choice	285,246
Navitus	Children's Medical Center	9,405
Navitus	Cook Children's	140,778
Navitus	Driscoll Health Plan	174,008
Navitus	El Paso Health	77,150
Navitus	FirstCare	92,337
Navitus	Parkland	196,268
Navitus	Scott and White (RightCare)	45,528
Navitus	Dell Children's Health Plan	27,403
Navitus	Texas Children's	451,678
Navitus	Sendero Health Plan <sup>47</sup>	12,145
CVS Caremark	Aetna Better Health	91,489
CVS Caremark	Christus Health Plan	2,412
CVS Caremark	Molina Healthcare	229,560
Envolve Pharmacy Solutions	Superior Health Plan	1,055,956
Express Scripts	Amerigroup	792,928
OptumRx	Cigna-HealthSpring	51,639
Prescription Solutions	United Healthcare	305,838
Prime Therapeutics	Blue Cross Blue Shield	42,951

Source: HHS Medicaid and CHIP SFY 2018 Historical Medicaid Enrollment

<sup>47</sup> Sendero Health Plan discontinued as MCO for Texas Medicaid and CHIP programs beginning May 1, 2018.

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## Appendix B: Report Team and Distribution

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### Report Team

OIG staff members who contributed to this audit report include:

- Audrey O’Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
- Kacy VerColen, CPA, Assistant Deputy Inspector General of Audit and Inspections
- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Anton Dutchover, CPA, Audit Director
- Marcus O. Horton, CIA, CFE, CRMA, CCSA, Audit Project Manager
- Kristyn Scoggins, CGAP, Audit Project Manager
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- Erin Powell, Staff Auditor
- TiAnna Riddick, Staff Auditor
- Kathryn Wolf, Associate Auditor
- Karen Mullen, CGAP, Quality Control Reviewer
- Mo Brantley, Senior Audit Operations Analyst

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- Katherine Scheib, Deputy Associate Commissioner, Medicaid and CHIP Services

Community First Health Plans, Inc.

- Theresa Scepaniski, Interim Chief Executive Officer
- Dr. Priti Mody-Bailey, Chief Medical Officer
- Dr. Patricia Favila, Director of Clinical Pharmacy Services
- Susan Lomba, Chief Compliance and Quality Officer

Navitus Health Solutions, LLC

- Carmen Backman, Vice President, Government Programs
- Gayle Fisher, Senior Director, Strategic Accounts and Contract
- Lori Dodge, Manager, Client Audits

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## Appendix C: OIG Mission, Leadership, and Contact Information

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The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Investigations and Reviews

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