Summary of Results: Pharmacy Benefits Manager Navitus Health Solutions, LLC

Audits of Community First Health Plans, Parkland Community Health Plan, and Community Health Choice

January 8, 2021
OIG Report No. AUD-21-005

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS SERIES OF AUDITS

This report is not an audit report but summarizes the results and conclusions of three audits conducted by the OIG Audit and Inspections Division performed in accordance with generally accepted government auditing standards.

Texas MCOs are required to subcontract with a pharmacy benefits manager (PBM) to process prescription claims and perform other services. Of the 20 MCOs in Texas, 11 contracted with Navitus as their PBM. OIG audited three of those MCOs to determine whether the MCOs and Navitus administered the formulary, preferred drug list, and prior authorizations according to the contract and selected rules and statutes in the 2018 audit scope.

During 2018, the 11 MCOs that contracted with Navitus received $959,480,024, or 26 percent of the pharmacy capitation payments paid to MCOs. Those 11 MCOs also served 1,634,293 members, or 39 percent of the Medicaid and CHIP members in Texas.

RECOMMENDATIONS AND ACTION PLANS

In the three audits, OIG recommended that MCOs ensure that Navitus correctly reflects all VDP-approved formulary and preferred drug list items and follows adjudication requirements.

The MCOs agreed with the recommendations and expressed intent to work with Navitus to identify solutions by January 31, 2021, at the latest. The action plans developed are expected to provide a benefit to all MCOs served by Navitus.

OIG presented this summary report to the three MCOs and Navitus for review and comment on December 16, 2020. None had additional comments.

For more information, contact:
OIGAuditReports@hhsc.state.tx.us

SUMMARY OF RESULTS: PHARMACY BENEFITS MANAGER NAVITUS HEALTH SOLUTIONS LLC

Audits of Community First Health Plans, Parkland Community Health Plan, and Community Health Choice

WHAT THE OIG OBSERVED

Audits of three managed care organizations (MCOs) that contracted with Navitus to provide pharmacy benefit services concluded that the MCOs 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. However, in all three audits, Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations.

Because specific services, like formulary and preferred drug list adherence and the administration of certain prior authorizations processes, are performed consistently, the observations detailed can be reasonably applied to all MCOs that contract with Navitus. The table summarizes the results in each area of testing that are detailed in the report.

Aggregate of Results for the Three Audited MCOs

Area of Testing	Percentage Adhered
Formulary Adherence	97.2 percent
Preferred Drug List Adherence	98.8 percent
Prior Authorization Design and Performance	70.2 percent

The OIG Audit and Inspections Division observed that Navitus:

- Adhered to Medicaid and CHIP formularies for 97.2 percent of the formulary items and adhered to 98.8 percent of the preferred drug list items. However, for all three MCOs audited, Navitus:
  - Omitted or removed sooner than directed certain drug codes from its formularies
  - Omitted certain drug codes and preferred drug list statuses
  - Used incorrect status end dates for certain drug codes on preferred drug lists
  - Included some drug codes not listed on VDP's preferred drug list
- Did not always process prior authorizations and reject claims correctly, which resulted in instances of:
  - Not performing clinical and non-preferred prior authorizations as required
  - Incorrectly rejected claims
  - Communicating the incorrect rejection message to the member

These issues increased the risk that members served by all MCOs for which Navitus is contracted to administer pharmacy benefits may (a) experience delays in receiving prescriptions or not receive those prescriptions at all, (b) receive drugs without completing required prior authorizations or not being directed to preferred forms that are available, or (c) receiving a drug when not medically necessary or in the incorrect dosage. They also increased the risk that MCOs might pay higher prices for drugs than necessary or that it may bypass state rebates.

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INTRODUCTION

This report summarizes the results and conclusions of audits of three managed care organizations (MCOs) and selected pharmacy benefits delivered by their pharmacy benefits manager (PBM), Navitus Health Solutions, LLC (Navitus). This report also provides information related to the number of members served, the amount of capitation payments used to administer pharmacy benefit services, and the significance Navitus plays in providing services within Texas. The three audit reports issued by the Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit and Inspections Division in 2020 were:

- Community First Health Plans (Community First), Report No. AUD-20-020, August 26, 2020
- Parkland Community Health Plan (Parkland), Report No. AUD-20-023, August 31, 2020
- Community Health Choice, Report No. AUD-20-024, August 31, 2020

Of the 20 MCOs in Texas in 2018, the 3 audited MCOs are among 11 that contracted with Navitus as their PBM throughout 2018, which also included:

- Children's Medical Center Health Plan (Children's Medical)
- Cook Children's Health Plan (Cook Children's)
- Dell Children's Health Plan (Dell Children's)
- Driscoll Health Plan (Driscoll)
- El Paso Health Premier Plan (El Paso Health)
- FirstCare
- Scott and White RightCare (RightCare)
- Texas Children's Health Plan (Texas Children's)

While only 3 of the MCOs were audited, Navitus employed the same processes to manage pharmacy benefits for all 11 MCOs.

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 objective of the audits was to determine whether the MCOs and their subcontracted PBM, Navitus, administered the formulary, preferred drug list, and

prior authorizations[1] in accordance with the Uniform Managed Care Contract (UMCC), State of Texas Access Reform (STAR) Kids contract, Uniform Managed Care Manual (UMCM), and selected applicable state rules and statutes.

The audit scope included the Medicaid and Children's Health Insurance Program (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 and internal controls in place through the end of fieldwork in July 2020. Appendix A presents the methodology and criteria used in meeting the objectives for the three audit reports.

Background

HHSC contracts with MCOs to provide all covered, medically necessary services to its members, including prescription drugs. Under managed care, the MCOs receive 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 is required to subcontract with a PBM to process prescription claims[2] and perform other selected pharmacy-related services. A PBM is a third-party administrator of prescription drug programs,[3] and provides all pharmacy benefit services except for appeals of prior authorization determinations, which are addressed directly by the MCOs. MCOs work in conjunction with Navitus and other PBMs to provide pharmacy benefit services to Medicaid and CHIP managed care members. These pharmacy benefit services must comply with the UMCC and the UMCM, as well as applicable state rules and statutes, at a quality level that is acceptable and consistent with industry standard, custom, and practice.[4] During 2018, there were seven PBMs, including Navitus, fulfilling this role for the MCOs. 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.

[1] 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.

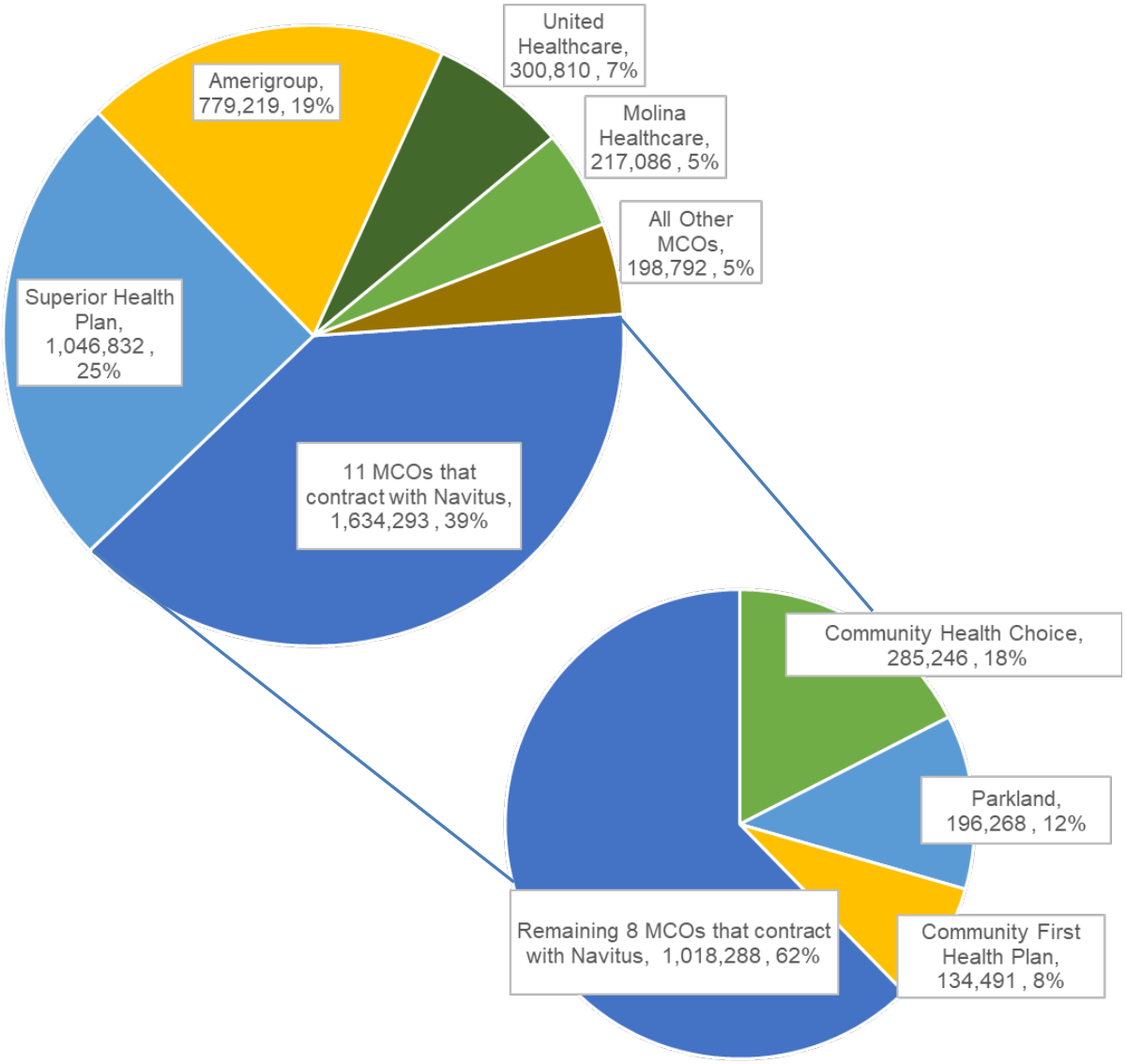
[2] Uniform Managed Care Contract, Attachment B-1, § 8.1.21.7, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

[3] Uniform Managed Care Contract, Attachment A, Article 2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

[4] Uniform Managed Care Contract, Attachment B-1, § 2.2, v. 2.24 (Sept. 1, 2017) through v. 2.25.1 (July 1, 2018).

As shown in Figure 1, the three MCOs audited comprise 38 percent of the 1,634,293 members in the MCOs with Navitus as the PBM. At a broader level, the 11 health plans that contract with Navitus as their PBM make up 39 percent of the nearly 4.2 million members in Texas. See Appendix B for details about each MCO's enrollment and financial reporting.

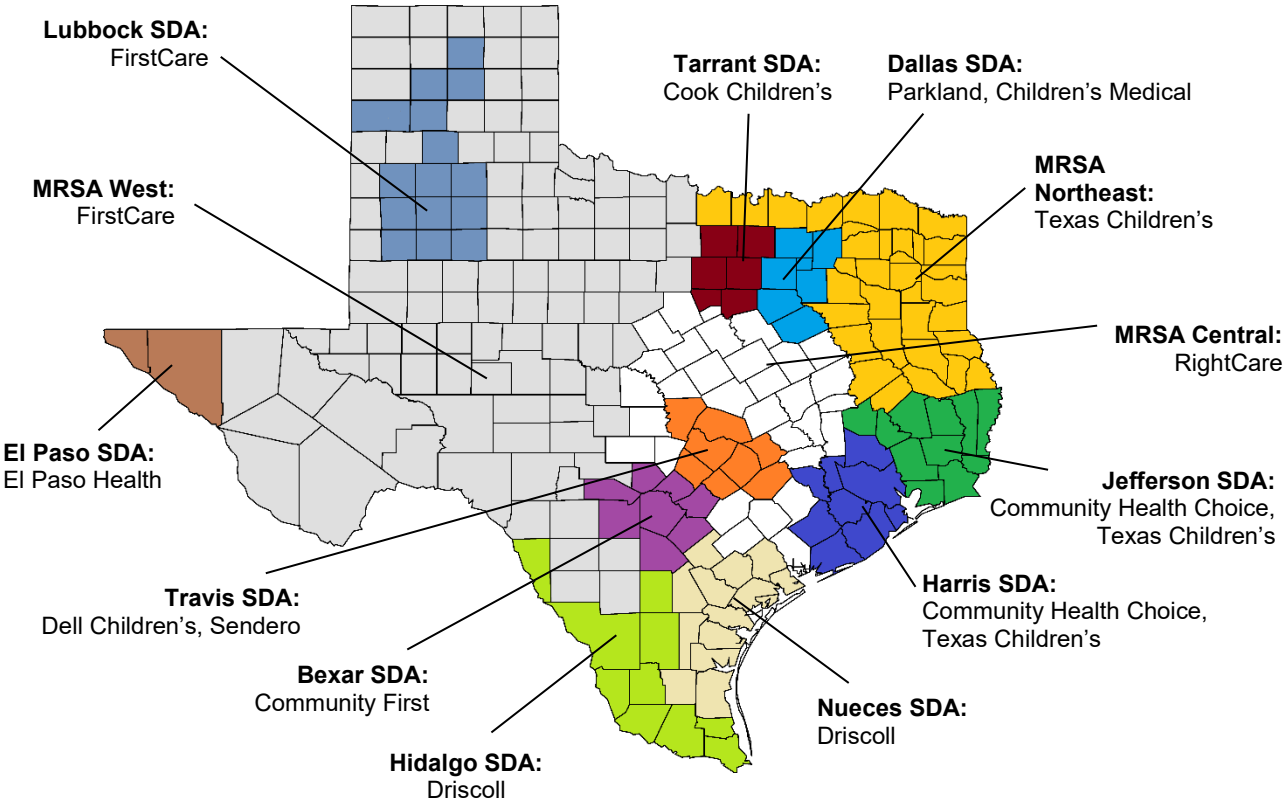
Figure 1: Member Enrollment by MCO



Source: HHSC Historical Medicaid Enrollment 2018

As shown in Figure 2, the three MCOs audited provide Medicaid and CHIP services in the Bexar, Dallas, Harris, and Jefferson service delivery areas (SDAs). The figure also shows the distribution of all the MCOs that contract with Navitus in the various SDAs and Medicaid Rural Service Areas (MRSAs). The 11 MCOs and Navitus provide services throughout Texas.

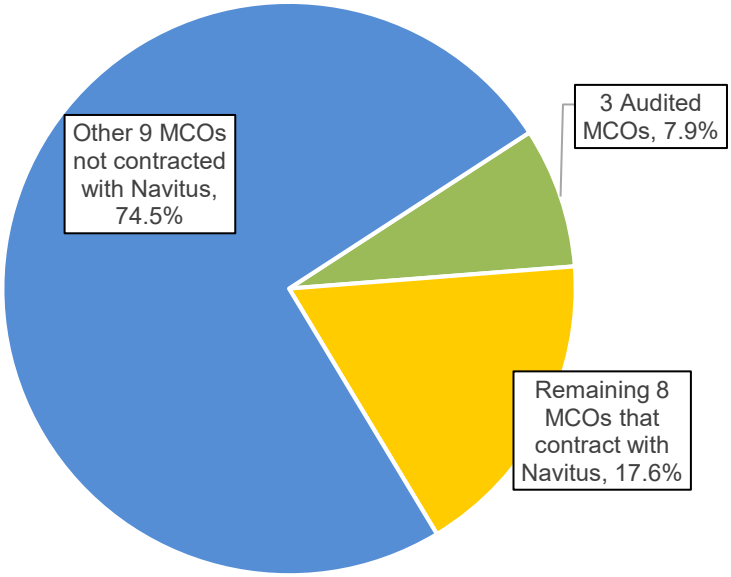
Figure 2: Map of Texas MCOs That Contract With Navitus



Source: HHSC Historical Medicaid Enrollment 2018

Figure 3 shows the relative share of pharmacy premiums among the three audited MCOs, the remaining eight MCOs that contract with Navitus, and all other MCOs providing Medicaid and CHIP services in Texas. The 11 MCOs that contract with Navitus received 25.5 percent of pharmacy premiums disbursed to all Texas MCOs. See Appendix B for details about each MCO's financial reporting.

Figure 3: Share of Pharmacy Premiums



Source: HHSC Financial Statistical Report 2018

Table 1 shows that the 11 MCOs that contract with Navitus represent the largest share of members (39 percent) but a smaller share of pharmacy capitation funds (26 percent) in Texas. This is because the MCOs that contract with Navitus serve, in addition to some STAR Kids members, mostly members in the STAR and CHIP programs which have lower capitation rates than the STAR+PLUS and STAR Health programs. See Appendix B for details about the PBMs and the MCOs with which they contract.

Table 1: Comparison of PBM Average Members Served and Total Pharmacy Capitation to Associated MCOs

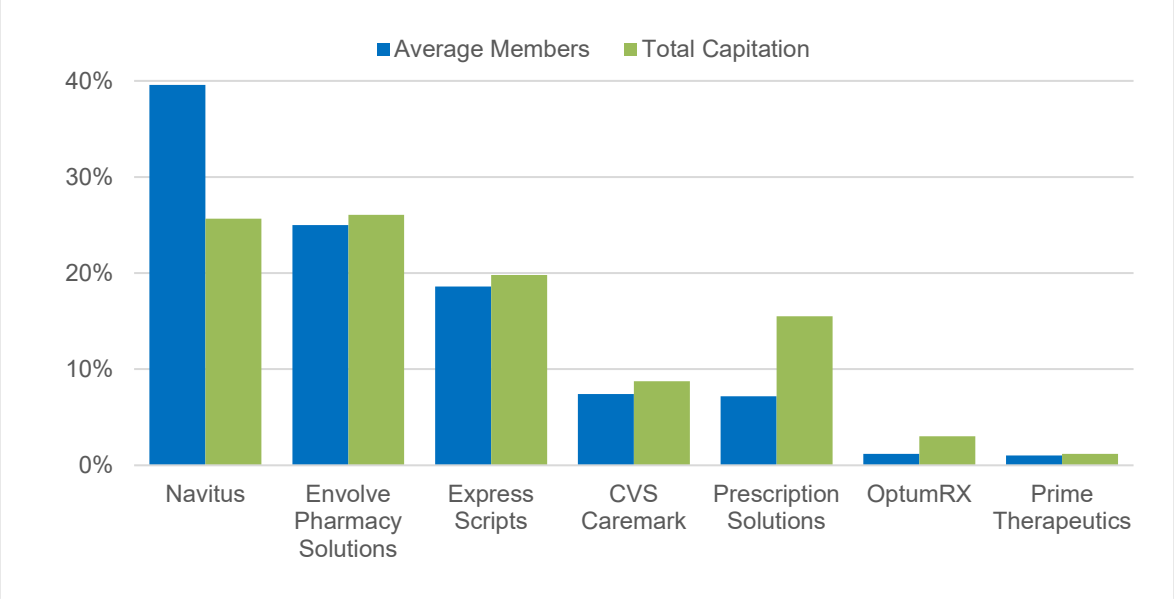
PBM	Average Members Served	Average Members	Pharmacy Capitation	Share of Capitation
Navitus[5]	1,646,438	39.4%	$ 963,689,078	25.7%
Envolve Pharmacy Solutions	1,046,832	25.1%	979,670,023	26.1%
Express Scripts	779,219	18.7%	744,631,138	19.8%
CVS Caremark	310,987	7.4%	328,500,033	8.7%
Prescription Solutions	300,810	7.2%	583,187,184	15.5%
OptumRX	49,796	1.2%	113,183,843	3.0%
Prime Therapeutics	42,951	1.0%	44,243,008	1.2%
Total	4,177,032	100.0%	$3,757,104,307	100.0%

Source: HHSC Historical Medicaid Enrollment 2018 and HHSC Financial Statistical Report 2018

[5] Navitus figures for average members served and pharmacy capitation include Sendero Health Plan, which discontinued serving Texas Medicaid and CHIP services during 2018.

Figure 4 shows the percentage of each PBM's average members side-by-side with its total pharmacy capitation to demonstrate that the two measures do not always directly correlate.

Figure 4: PBM Percentage of Average Members Served and Total Pharmacy Capitation



Source: HHSC Historical Medicaid Enrollment 2018 and HHSC Financial Statistical Report 2018

Navitus, by providing pharmacy benefit services to 11 of the 20 MCOs, has a significant role in providing services to Medicaid and CHIP members in Texas. As a result of the three audits and because specific services like formulary and preferred drug list adherence and the administration of certain prior authorizations processes are performed consistently, the observations detailed can be reasonably applied to all MCOs that contract with Navitus.

OBSERVATIONS

In processing prescription claims, individual claims transactions may be paid or rejected according to whether the claims are complete and meet certain criteria, such as member eligibility, drug existence in the corresponding formulary, and the requirement to complete prior authorization before dispensing. For context to observations within this summary report, Table 2 shows the total paid and rejected claims at each of the three audited MCOs. As shown, Community Health Choice had the largest number of claims in each of the categories.

Table 2: Number of Paid and Rejected Claims at the Three Audited MCOs

MCO	Paid Claims	Rejected Claims	Total Claims
Community First	1,114,917	476,595	1,591,512
Parkland	1,187,959	551,702	1,739,661
Community Health Choice	1,788,339	871,833	2,660,172

Source: OIG Audit and Inspections Division

Navitus generally adhered to formulary and preferred drug list requirements. Its adherence included maintaining drug codes, effective and ending dates, and drug statuses accurately. Navitus's process to timely monitor, identify, and code changes to the formulary and preferred drug list enabled it to substantively maintain accuracy across the large datasets.

However, in some cases, Navitus did not consistently and correctly update its formulary listing and its preferred drug list. Since Navitus follows the same process to complete formulary and preferred drug list updates on behalf of all 11 MCOs, the OIG Audit and Inspections Division expects adherence results to be consistent across all MCOs with Navitus as their PBM. In addition, Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations.

Table 3 summarizes the results in each area of testing that are detailed in the observations that follow. Prior authorization design and performance is an aggregated result based on testing across all three MCOs.

Table 3: Aggregate of Results for the Three Audited MCOs

Area of Testing	Percentage Adhered
Formulary Adherence	97.2 percent
Preferred Drug List Adherence	98.8 percent
Prior Authorization Design and Performance	70.2 percent

Source: OIG Audit and Inspections Division

FORMULARIES AND PREFERRED DRUG LISTS

The Medicaid and CHIP formularies are separate 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. Pharmacies may only fill prescriptions for drug codes, which are unique FDA-assigned 11-digit identifiers that appear on the Medicaid or CHIP formularies. The formularies are developed and updated by VDP based on additions or removals of drug codes, a drug manufacturer applying for new drug coverage, discontinued production of a drug, or discontinued coverage by Centers for Medicare and Medicaid Services (CMS). Each MCO and its PBM are required to adhere to and exclusively use the Medicaid and CHIP formularies[6] and provide members with access to all items listed on the formularies.[7] The UMCC requires MCOs to process formulary updates to a claims adjudication system within two business days of the VDP update files becoming available.[8] Navitus ensured compliance with this requirement by performing formulary updates five times per week.

In addition, MCOs are required to adhere to VDP's Medicaid preferred drug list,[9,10,11] which contains a subset of many, but not all, drugs on the formulary. 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 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 "preferred" must be adjudicated[12] as payable without a prior authorization[13] before the drug is dispensed to a member.[14] The preferred drugs are recommended for their effectiveness, clinical significance, cost effectiveness, and safety, and generally include drugs produced by manufacturers that have reached a state supplemental rebate agreement with HHSC.[15]

[6] 1 Tex. Admin. Code §§ 353.905(a) (Sept. 1, 2013) (Medicaid) and 370.701 (Mar. 1, 2012) (CHIP).

[7] 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).

[8] 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).

[9] Tex. Gov. Code § 533.005(a)(23)(B) (Sept. 1, 2017).

[10] 1 Tex. Admin. Code § 353.905(a) (Sept. 1, 2013).

[11] VDP maintains a preferred drug list for Medicaid (STAR and STAR Kids) only; drugs prescribed under CHIP are not subject to preferred drug list requirements.

[12] "Adjudicate" means to deny or pay a claim for services or drugs prescribed to a member by a health care provider.

[13] 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).

[14] Preferred drugs may still be subject to clinical prior authorization.

[15] Tex. Gov. Code § 531.072(b) (Jan. 1, 2016).

VDP provides the current listing of Medicaid and CHIP formularies and the preferred drug list that each PBM must maintain in its claims adjudication systems. PBMs must identify and adjust for additions, deletions, and changes in status from the previous published formularies and preferred drug lists to ensure that they adjudicate claims correctly. Since these formularies and preferred drug lists are consistent for all MCOs in Texas, Navitus used the same process for updating Medicaid and CHIP formularies and Medicaid preferred drug lists for all 11 MCOs. Given this uniformity in practice at Navitus, exceptions identified in the audits indicate the observations would be consistent at the other 8 MCOs served by Navitus.

Observation 1: Some Member Prescriptions May Be Incorrectly Adjudicated When Formularies and the Preferred Drug List Differ

Overall, Navitus's formularies matched 97.2 percent of VDP's formularies across both the Medicaid and CHIP programs. Similarly, Navitus's Medicaid 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 formulary and preferred drug list requirements. The sections that follow detail exceptions identified in the reconciliations.

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 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.

In aggregate, 904 of the Medicaid drug codes and 856 of the CHIP drug codes, or 2.8 percent of all drug codes, were incorrectly omitted or removed early from the Medicaid and CHIP formularies.

Table 4 shows the number of claims rejected and members affected as a result of drug codes not being included or removed early from Navitus's formularies.

Table 4: Total Claims Rejected Due to Formulary Exceptions

	Community First	Parkland	Community Health Choice	Total
Number of Incorrectly Rejected Claims for Formulary Exceptions	1,530	2,517	3,648	7,695
Members Affected	856	1,516	2,191	4,563
Estimated Value of Rejected Claims	$35,621	$53,456	$119,248	$208,325

Source: OIG Audit and Inspections Division

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. Based on additional evidence provided by Navitus, in some cases when a claim was rejected the member received an appropriate alternative drug.

In addition to the incorrectly rejected claims identified in Table 4, auditors identified 20,087 rejections affecting 12,448 members as potentially associated with formulary rejections. In these instances, 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[16] or those that were otherwise omitted as over-the-counter forms, despite their inclusion in VDP's formularies.

Navitus's Medicaid Preferred Drug Lists Drug Codes and Statuses Did Not Consistently Mirror Those on VDP's Preferred Drug Lists

Navitus did not always adhere to the preferred drug lists for all three MCOs. Specifically, Navitus:

- Omitted 176 drug codes from its Medicaid preferred drug list.
- Omitted status for 45 drugs in its Medicaid preferred drug list.
- Had incorrect status ending dates for 18 drugs on its Medicaid preferred drug list.
- Incorrectly included three drug codes on its Medicaid preferred drug list not included by VDP.

[16] Medi-Span is a prescription drug data application that Navitus uses, which classifies drugs based on generic product identifier.

Table 5 shows the paid and rejected claims and members affected by all four observations involving the preferred drug lists.

Table 5: Impacts From Preferred Drug List Observations Identified

	Community First	Parkland	Community Health Choice	Total
Number of Paid Encounters Incorrectly Processed	135	113	235	483
Number of Claims Incorrectly Rejected	39	29	96	164
Number of Members Affected	104	86	158	348

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 receive drugs without completing required prior authorizations or without being directed to preferred forms that are available. Including drug codes incorrectly on the preferred drug lists increases the risk that members experience delays in receiving drugs or do not receive needed drugs at all.

OIG Recommendations and Action Plans

In the audit reports, the OIG Audit and Inspections Division recommended the MCOs ensure that Navitus implements an appropriate method to add and update all VDP-approved formulary items and conduct periodic reviews to ensure their Medicaid and CHIP formularies are correctly reflected.

In response, the MCOs agreed with the observations presented and expressed intent to work with Navitus to identify solutions to address the observations and recommendations by the latest target implementation date of January 31, 2021. While the action plans were individually provided by each of the three MCOs, the actions set forth in cooperation with Navitus may provide a benefit to all MCOs and members served by Navitus.

PRIOR AUTHORIZATIONS

Certain prescriptions require prior authorization 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.

A non-preferred prior authorization applies to drugs identified as non-preferred on the 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. Non-preferred prior authorizations are not required for drugs listed as preferred, or those not listed at all, on the Medicaid preferred drug list.

A clinical prior authorization, which must be submitted prior to dispensing a drug, is based on evidence-based clinical criteria and nationally recognized peer-reviewed information. Clinical prior authorizations, which are established or authorized by VDP, may apply to an individual drug or a drug class on the formulary, including some preferred and non-preferred drugs. As applicable, 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. Drugs on Medicaid and CHIP formularies may be subject to clinical prior authorizations.

MCOs and their subcontracted PBMs must adopt prior authorization requirements that comply with the state's requirement to exclusively use VDP's formularies[17,18] and allow access by members to all non-preferred drugs on the Medicaid formularies.[19] MCOs must perform non-preferred prior authorizations as required by VDP.[20] MCOs are permitted to perform prior authorizations separately from or concurrently with other reviews but must not substitute any other types of reviews in place of required clinical and non-preferred prior authorizations.

[17] 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).

[18] Tex. Gov. Code § 533.005(a)(23)(A) (Sept. 1, 2017).

[19] 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).

[20] 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).

Observation 2: Claims May Be Incorrectly Paid or Rejected Due to Misapplied Prior Authorization Requirements

Overall, Navitus fully and correctly applied prior authorization requirements in 70.2 percent of sampled transactions across all three MCOs. However, Navitus did not consistently perform required clinical and non-preferred prior authorizations as required. In certain cases, Navitus incorrectly rejected claims or communicated the incorrect rejection message to the member. Table 6 summarizes the numbers sampled and observations identified in the testing.

Table 6: Summary of Results From Prior Authorization Testing

	Community First	Parkland	Community Health Choice	Total
Total Paid Claims Tested	60	60	60	180
Paid Claims With Errors	23	16	19	58
Paid Claim Error Rate	38.3%	26.7%	31.7%	32.2%
Total Rejected Claims Tested	15	15	15	45
Rejected Claims With Errors	5	2	2	9
Rejected Clam Error Rate	33.3%	13.3%	13.3%	20.0%

Source: OIG Audit and Inspections Division

Table 7 summarizes the various observations which appeared in either all MCOs audited or only one specific MCO.

Table 7: Breakdown of Issues for Each MCO

	Community First	Parkland	Community Health Choice
Non-Preferred Prior Authorizations Were Adjudicated Without Applying All Non-Preferred Requirements	X	X	X
Clinical Prior Authorizations Were Approved for All Doses on the Initial Request	X	X	X
Drugs Were Incorrectly Rejected as Non-Covered Drugs	X	X	X
A Non-Preferred Prior Authorization Was Adjudicated as Preferred		X	
A Preferred Drug Was Rejected as Non-Preferred		X	
A Drug Was Incorrectly Rejected as Requiring Prior Authorization Rather than Not Covered for a CHIP member			X

Source: OIG Audit and Inspections Division

Auditors observed the following three types of claims errors resulting from incorrectly programmed or adjudicated drug codes in all three audits:

- Certain non-preferred prior authorizations were adjudicated by applying some but not all non-preferred requirements.
- A few clinical prior authorizations tested for a specific drug were approved for all five monthly doses during the initial clinical review without subsequent clinical reviews being performed as required.
- Instances of drugs which were incorrectly rejected as non-covered drugs rather than requiring a prior authorization.

Two MCOs had one or more additional observations resulting from incorrectly programmed or adjudicated drug codes that were not identified in the other MCOs.

- A prior authorization tested at Parkland was incorrectly adjudicated as preferred with only the clinical prior authorization being performed.
- A preferred drug was incorrectly rejected at Parkland as non-preferred.
- A drug was incorrectly rejected at Community Health Choice as requiring prior authorization rather than as not covered for a CHIP member.

Table 8 shows the total paid and rejected claims and Medicaid and CHIP members affected by the observations identified at all three or individual MCOs.

Table 8: Impact of Observations Identified

	Community First	Parkland	Community Health Choice	Total
Number of Paid Encounters Incorrectly Processed	11,694	19,143	7,969	38,806
Number of Claims Incorrectly Rejected	26	133	34	193
Number of Members Affected	5,518	9,520	5,531	20,569

Source: OIG Audit and Inspections Division

Incorrectly approving or rejecting claims can result in a member (a) receiving a non-preferred drug when a preferred drug is available and may limit potential rebates to HHSC, (b) receiving a drug when not medically necessary or the incorrect dosage, (c) not receiving a non-preferred prior authorization when required, (d) not receiving a drug that may have been approved if the claim had adjudicated correctly, or (e) incorrectly communicating the reason for the rejected claim.

OIG Recommendations and Action Plans

In the audit reports, the OIG Audit and Inspections Division recommended the MCOs ensure that Navitus follows adjudication requirements for drug codes on the preferred drug list, complies with criteria that require additional clinical reviews on certain drug codes, and correctly programs and communicates rejection messages to members.

In response, the MCOs agreed with the observations presented and expressed intent to work with Navitus to identify solutions to address the observations and recommendations by the latest target implementation date of November 30, 2020. While the action plans were individually provided by each of the three MCOs, the actions set forth in cooperation with Navitus may provide a benefit to all MCOs and members served by Navitus.

CONCLUSION

This report provides a summary and overview of results and issues identified during audits of Community First, Parkland, and Community Health Choice that all subcontracted with Navitus for pharmacy benefits services in Texas Medicaid and CHIP. As a result of this series of audits, the three MCOs have identified corrective actions to address the findings and timelines for implementation which they projected as in progress.

The OIG Audit and Inspections Division observed that Navitus:

- Adhered to Medicaid and CHIP formularies for 97.2 percent of the formulary items and adhered to Medicaid preferred drug list for 98.8 percent of the preferred drug list items. Exceptions to adherence involved instances when it:
  - Omitted or removed sooner than directed certain VDP formulary drug codes from its formularies
  - Omitted certain drug codes and preferred drug list statuses
  - Used incorrect status end dates
  - Included some drug codes that were not included on VDP's preferred drug list

- Did not always process prior authorizations and reject claims correctly, which resulted in instances of:
  - Not performing clinical and non-preferred prior authorizations as required
  - Incorrectly rejected claims
  - Communicating the incorrect rejection message to the member

These observations increased the risk that members served by all MCOs for which Navitus was contracted to administer pharmacy benefits may have (a) experienced delays in receiving prescriptions or not receive those prescriptions at all, (b) received drugs without completed required prior authorizations or without being directed to preferred forms that are available, or (c) received a drug when not medically necessary or the incorrect dosage. The observations also increased the risk that MCOs might pay higher prices for drugs than necessary or bypass state rebates.

The OIG Audit and Inspections Division offered recommendations to the audited MCOs, which, if implemented, will ensure Navitus:

- Adds all VDP-approved formulary items.
- Correctly reflects all current VDP-approved formulary items in the Medicaid and CHIP formularies.
- Adds all approved preferred drug list line items with the appropriate designated preferred or non-preferred status.
- Correctly reflects all current drug codes 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.

The MCOs provided action plans indicating a cooperative approach with Navitus to review and adjust processes associated with the observations identified. Enhancing processes related to formulary and preferred drug list adherence and prior authorization performance may provide a benefit to all Texas MCOs and members served by Navitus.

The OIG Audit and Inspections Division presented this summary report to Community First, Parkland, Community Health Choice, and Navitus for review and comment on December 16, 2020. The three MCOs and Navitus had no additional comments.

The OIG Audit and Inspections Division thanks management and staff at HHSC VDP, the three audited MCOs, and Navitus for their cooperation and assistance.

Appendix A: Audit Methodology and Criteria

Methodology

This report is not an audit report but summarizes the results and conclusions of three audits conducted by the OIG Audit and Inspections Division that were performed in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States.

The OIG Audit and Inspections Division collected and consolidated information for this summary report from the three audit reports by reviewing:

- Medicaid and CHIP formularies
- Medicaid preferred drug list
- NaviGate 3D[21]-formulary and preferred drug list
- PA Intel and PA Accel screen shots[22]
- Audit Logs
- Prior authorization approval communication letters
- Clinical and preferred drug list criteria guidelines
- Encounter data and related claims data[23]

The OIG Audit and Inspections Division selected two points in time for which to request VDP's and Navitus's Medicaid and CHIP formularies. Auditors reconciled VDP's and Navitus's formularies to assess adherence and identify exceptions involving omitted drug codes,[24] and differences in drug code effective and termination dates.

The OIG Audit and Inspections Division selected three points in time for which to request VDP's and Navitus's preferred drug list. Auditors reconciled VDP's and Navitus's 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 180 prior authorizations and 45 rejected claims distributed equally across all three MCOs from which to assess compliance with prior authorization design and performance. A random and risk-based sample of 60 prior authorizations and 15 rejected claims was selected

[21] NaviGate 3D is the Navitus system used to update the formulary and preferred drug list.

[22] PA Intel and PA Accel are proprietary systems used by Navitus to adjudicate claims.

[23] "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.

[24] 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).

from each MCO for testing: (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. Additionally, drug code exceptions identified in the preferred drug list reconciliation were included in the sample selection process for non-preferred prior authorizations.

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)[25]
- 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)

[25] STAR Kids Contract criteria were applicable only to Community First.

Appendix B: Enrollment and Financial Reporting

Table B.1: MCOs, PBMs, Enrollment, and Capitation During 2018

PBM	MCO	Average Members Served	% of Members	Capitation ($ millions)	% of Capitation
Navitus - Audited	Community First Health Plans	134,491	3.22%	88.2	2.35%
Navitus - Audited	Parkland Community Health Plan	196,268	4.70%	81.9	2.18%
Navitus - Audited	Community Health Choice	285,246	6.83%	127.8	3.40%
	Subtotal of MCOs audited	616,005	14.75%	298.0	7.93%
Navitus	Children's Medical	9,405	0.23%	45.8	1.22%
Navitus	Cook Children's	140,778	3.37%	96.3	2.56%
Navitus	Dell Children's	27,403	0.66%	10.5	0.28%
Navitus	Driscoll	174,008	4.17%	121.4	3.23%
Navitus	El Paso Health	77,150	1.85%	35.0	0.93%
Navitus	FirstCare	92,337	2.21%	43.0	1.14%
Navitus	RightCare	45,528	1.09%	23.4	0.62%
Navitus	Texas Children's	451,678	10.81%	264.7	7.62%
	Subtotal of MCOs using Navitus not audited	1,018,288	24.38%	661.5	17.61%
	Subtotal of all 11 MCOs using Navitus	1,634,293	39.13%	959.5	25.54%
CVS Caremark	Aetna Better Health	91,489	2.19%	55.8	1.49%
Express Scripts	Amerigroup	779,219	18.65%	744.6	19.82%
Prime Therapeutics	Blue Cross and Blue Shield	42,951	1.03%	44.2	1.18%
CVS Caremark	Christus Health Plan[26]	2,412	0.06%	1.4	0.04%
OptumRX	Cigna-HealthSpring	49,796	1.19%	113.2	3.01%
CVS Caremark	Molina Healthcare	217,086	5.20%	271.2	7.22%
Navitus	Sendero Health Plan[27]	12,145	0.29%	4.2	0.11%
Envolve Pharmacy Solutions	Superior HealthPlan	1,046,832	25.06%	979.7	26.08%
Prescription Solutions	UnitedHealthcare	300,810	7.20%	583.2	15.52%
	Subtotal of MCOs not using Navitus	2,542,739	60.87%	2,797.6	74.46%
	Total for all MCOs	4,177,032	100.00%	3.757.1	100.00%

Source: HHSC Historical Medicaid Enrollment 2018 and HHSC Financial Statistical Reports 2018

[26] Christus discontinued providing Texas Medicaid and CHIP services on February 1, 2018.

[27] Sendero discontinued providing Texas Medicaid and CHIP services on May 1, 2018.

Appendix C: Report Team and Distribution

Report Team

OIG staff members who contributed to this summary report and the audit reports 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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- Pamela Hellstrom, Chief Compliance Officer

Navitus Health Solutions, LLC

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

Appendix D: OIG Mission, Leadership, and Contact Information

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:

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- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
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  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000