TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

PHARMACY BENEFIT MANAGERS

Inspection of Program Integrity Activities

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HHSC OIG

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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WHY THE OIG CONDUCTED THIS INSPECTION

The OIG conducted an inspection to determine the program integrity activities pharmacy benefit managers (PBMs) use to detect fraud, waste, and abuse (FWA) of Medicaid-funded prescriptions. The inspection focused on the following objective:

- Determine how PBMs detect overbilling, unauthorized refills, and unauthorized drug substitutions.

In fiscal year 2017, Texas Medicaid paid approximately $3.47 billion in pharmacy capitation payments to managed care organizations (MCOs). In 2012, the Uniform Managed Care Contract was amended to require MCOs to use a PBM to process prescription claims. As subcontractors, direct oversight of PBM program integrity activities is the responsibility of the MCOs. Further, PBMs are responsible for oversight of their contracted pharmacies and their program integrity activities.

A Texas State Auditor's Office report recommended that HHSC obtain greater assurance about the effectiveness of the MCOs' PBM internal controls and compliance with state requirements. In order to assess specific program integrity controls and compliance of the six Texas Medicaid PBMs, the OIG selected two PBMs to determine how FWA is detected in processing prescription claims. The inspection focused on program integrity activities that two PBMs used in fiscal year 2017.

View the report online at https://oig.hhsc.texas.gov/

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

WHAT THE OIG FOUND

The two PBMs selected by OIG rely on three program integrity activities to detect FWA in overbilling, unauthorized refills, and unauthorized drug substitutions in Medicaid-funded prescriptions. The three program integrity activities are: a.) Edit Checks of Submitted Prescription Claims, b.) Daily Prepayment Review of Covered Prescription Claims, and c.) Audit of Paid Prescription Claims.

These specific program integrity activities are not required in the managed care contract. Therefore, any observations made are not an indication of non-compliance with rules, statutes, HHSC guidance, or contract requirements. The report refers to the two inspected PBMs as PBM A and PBM B.

Both PBMs stated their prepayment review activities review 100 percent of all claims and are intended to identify claims prone to FWA. However, when requested, PBM A did not provide policies and procedures, training manuals, or other documentation for their program integrity activities. PBM B provided policies and procedures, but those did not identify or describe the prepayment review or daily activities performed.

The OIG made the following observations:

- Select PBMs are unable to provide complete results of their prepayment review process.
- As a result of audit program integrity activity, each PBM recovered less than one percent of paid Medicaid prescription claims.

PBM A cannot identify adjustments to Texas Medicaid prescription claims to report cost avoidance from their prepayment review. As a result, cost savings or avoidance was not available for analysis by the OIG. PBM B was only able to provide fourth quarter prepayment review results for the inspection scope of fiscal year 2017. Without annual recovery amounts or documented policies and procedures, a complete analysis could not be performed. The inspection cannot report on the results of their prepayment review program integrity activity.

PBM A's program integrity audits resulted in recovery of $450,157, which is 0.06 percent of the total Medicaid paid claims. PBM B's program integrity audits resulted in recovery of $1,215,675, which is 0.14 percent of the total paid claims. PBMs' management asserted the limited percentage of claims audited is the result of the effectiveness of the edit checks and daily prepayment review. The inspection focused on activities specific to the detection of overbilling, unauthorized refills, and unauthorized drug substitutions. Although edit checks and daily prepayment reviews enhance integrity, auditing is the only activity the PBMs could provide complete results specific to the inspection objectives.

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I. PURPOSE AND OBJECTIVES

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Inspections and Investigations Division conducted an inspection to determine the program integrity activities pharmacy benefit managers (PBMs) use to detect fraud, waste, and abuse (FWA) of Medicaid-funded prescriptions. The inspection focused on the following objective:

- Determine how PBMs detect overbilling, unauthorized refills, and unauthorized drug substitutions.

II. BACKGROUND

In fiscal year 2017, Texas Medicaid paid approximately $3.47 billion in pharmacy capitation payments to MCOs.[1] Prior to 2012, HHSC Vendor Drug Program (VDP) paid Texas Medicaid pharmacy benefits through a fee-for-service model. In 2012, per Texas Government Code, Section 533.005(a)(23), the Uniform Managed Care Contract (UMCC) was amended to state, "The MCO [managed care organization] must use a PBM to process prescription claims."[2] PBMs provide the following services for Texas Medicaid MCOs: (a) offering a network of pharmacy providers to its members, (b) processing prescription claims, (c) adhering to a formulary and preferred drug list, (d) adhering to prior authorization requirements, and (e) proper reimbursement of pharmacy providers. As subcontractors, direct oversight of PBM program integrity activities is the responsibility of the MCOs. Further, PBMs are responsible for oversight of their contracted pharmacies and their program integrity activities.

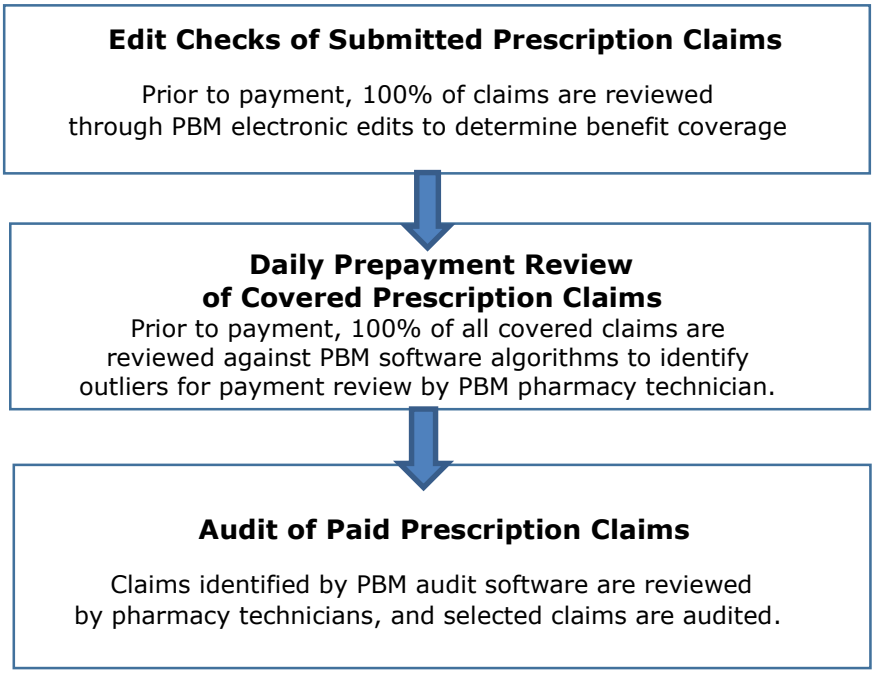
A Texas State Auditor's Office (SAO) report, *Medicaid Managed Care Contract Processes at the Health and Human Services Commission*, recommended that HHSC obtain greater assurance about the effectiveness of the MCOs' PBM's internal controls and compliance with state requirements.[3] SAO gave this recommendation a "priority" issue rating. The rating means the issue presents risks which, if not addressed, could critically affect the entity's ability to administer the program. The SAO report indicates that there is a greater need for assurance because the agreed upon procedures HHSC has approved are limited. One example from the SAO report is the lack of audit trail of claims the PBM paid to pharmacies.

In order to assess specific program integrity controls and compliance of the six Texas Medicaid PBMs, the OIG selected two PBMs to determine how FWA is detected in processing prescription claims.[4] The inspection focused on program

[1] https://hhs.texas.gov/reports/2018/08/rider-60-prescription-drug-benefit-administration-medicaid-chip-other-health-related-services
[2] UMCC, Section 8.1.21.7
[3] October 2016, Report No. 17-007: http://www.sao.texas.gov/reports/main/17-007.pdf
[4] See Appendix A, Data Sources, for more information on the selection of the two PBMs.

integrity activities the two PBMs used in fiscal year 2017. As outlined in Figure 1, the OIG found that the two PBMs rely on three program integrity activities to detect FWA in overbilling, unauthorized refills, and unauthorized drug substitutions in Medicaid-funded prescriptions.

Figure 1: Program Integrity Activities Process Flow for Select Texas Medicaid PBMs



1) **Edit Checks of Submitted Prescription Claims:** Once a pharmacy submits a prescription to a PBM to verify benefit coverage, PBM claims processing system edit checks are initiated. Edit checks are electronic tests performed in real time designed to ensure pharmacy claims meet specific billing criteria prior to payment approval. Examples include, but are not limited to: valid client Medicaid identification number, valid national drug code number, maximum drug quantity limitations, and maximum refill limitations. If a claim is denied for coverage due to edit checks, the claim is not processed and the prescription is not filled.

2) **Daily Prepayment Review of Covered Prescription Claims:** This is a process that electronically scans all covered claims using algorithms to identify claims for potential review prior to payment. PBM pharmacy technicians analyze each of those identified claims. The PBMs refer to these claims as outliers; they are generally high dollar claims. The technician, based on professional judgment, may accept the outlier claim for payment or may call the pharmacy to discuss concerns. Based on the technician's call with the pharmacy, the claim may be accepted or adjusted. Both PBMs stated their systems do not collect the number

or dollar amount of paid claims corrected during prepayment review. However, adjusted claims do result in cost avoidance because the dollar amount of the claim is modified prior to payment.

3) **Audit of Paid Prescription Claims:** PBMs use a separate software application to manage pharmacy audits. The software identifies pharmacy claims for potential audit. Pharmacy technicians, again using professional judgement, review the identified claims to determine which to select for audit. Audits are the only activity that compare the pharmacy claim to the prescription to ensure the pharmacy billed the correct quantity, refill, drug, and other requirements set by the PBM.

The PBM edit check and prepayment review activities reviewed by OIG do not meet the VDP definition of audit. The HHSC VDP Pharmacy Provider Procedure Manual describes audits as comparing claim transactions to documentation on the corresponding prescription, invoice, pharmacy daily log, pharmacy delivery log, etc.[5] Audits occur after the PBM pays pharmacy claims. Overpayments are recovered through credits or offsets from subsequent payments.

[5] Texas Vendor Drug Program, Pharmacy Provider Procedure Manual – Audits, Page 2 – May 2018
https://www.txvendordrug.com/sites/txvendordrug/files/docs/manuals/audits.pdf

III. INSPECTION RESULTS

The PBMs detect overbilling, unauthorized drug refills, and unauthorized drug substitutions using audits of paid prescription claims. However, the inspection could not evaluate the edit checks of submitted prescription claims or daily prepayment review of covered prescription claims program activities due to limited information available from the PBMs.

The inspection could not assess the effectiveness of edit checks because PBMs could not provide the number or dollar amount of claims not processed. Also, PBMs stated that their claims processing systems have limited capability to report adjusted claim information.

The PBMs stated their prepayment review activities review 100 percent of all claims and are intended to identify claims prone to FWA. However, when requested, one PBM did not provide policies and procedures, training manuals, or other documentation for their program integrity activities. The other PBM provided policies and procedures, but those did not identify or describe the prepayment review or daily activities performed. As a result, the daily prepayment review activity could not be evaluated.

The audit program activity does detect and recovers a limited amount of FWA from overbilling, unauthorized drug refills, and unauthorized drug substitutions. The PBMs provided dollar amounts recovered as a result of their audit program integrity activity. Of the three program activities, this is the only activity that compares the claim to prescription to ensure accurate billing, refills, and drug.

These specific program integrity activities are not required in the managed care contract. Therefore, any observations made are not an indication of non-compliance with rules, statutes, HHSC guidance, or contract requirements. The observations will refer to the two inspected PBMs as PBM A and PBM B.

Observation 1: Select PBMs are unable to provide complete results of their prepayment review process.

PBM A cannot identify adjustments to Texas Medicaid prescription claims to report cost avoidance from their prepayment review process. During interviews, this PBM stated they plan to add this functionality in the future. They have not determined an implementation timeframe. As a result, cost savings or avoidance was not available for analysis by the OIG. Therefore, the inspection cannot report on the results of their prepayment review program integrity activity.

PBM B implemented their prepayment review process on June 1, 2017, and prior to this date were processing Texas Medicaid claims without prepayment reviews. As a result, they did not recover any amounts from prepayment reviews for the first three quarters of the inspection period, but recovered $95,111 in the last quarter. Furthermore, PBM B did not provide policies and procedures related to prepayment reviews. Without annual recovery amounts or documented policies and procedures, a complete analysis cannot be performed.

Both PBMs use algorithms to identify prescription claims for potential prepayment review. Both PBMs stated the prepayment review process is a significant program integrity activity because this process reviews all covered claims prior to payment. Because PBMs were unable to provide annual total savings as a result of the activity and unable to provide policies and procedures, inspectors were unable to assess this activity.

The prepayment review program integrity activity, shown in Table 1, may result in adjustment of pharmacy claims prior to payment. If adjustments were made and tracked by PBMs, they would reflect cost avoidance. In addition, these program integrity activities do not compare pharmacy claims against prescriptions to detect overbilling, unauthorized refills, and unauthorized drug substitutions.

PBM A and PBM B paid pharmacies a total of over $1.68 billion for 19.8 billion Texas Medicaid prescriptions claims.

Table 1: FY 2017 PBMs Medicaid Daily Prepayment Review Activities

Texas Medicaid FY 2017	**PBM A**		**PBM B**	
	Claims	**Dollars**	**Claims**	**Dollars**
Covered and Accepted by Claims System	PBM does not track.		PBM does not track.	
Identified as High Risk for Potential Prepayment Review	PBM does not track specific to MCOs.		2,198,203	$210,875,391
Identified Risk for Errors - Corrected by Prepayment Review	PBM does not track specific to MCOs.		167	$95,111

Source: Non-audited data self-reported by PBM - Dollar amounts rounded to nearest whole dollar

Observation 2: As a result of audit program integrity activity, each PBM recovered less than one percent of paid Medicaid prescription claims.

Audits are the only program integrity activity performed by the PBMs, which ensures paid pharmacy claims are supported by prescriptions.

PBM A's program integrity audits resulted in recovery of $450,157, which is 0.06 percent of the total Medicaid paid claims. Table 2 shows the amounts and percentages for the program integrity audits.

Table 2: FY 2017 PBM A Medicaid Audit Activities

Texas Medicaid FY 2017	PBM A	
	Claims	Dollars
Total Audited	11,021	$7,336,832
% of Paid Claims Audited	0.11%	0.90%
Total Recoveries	*	$450,157
% Recoveries of Paid Claims	*	0.06%
% Recoveries of Audited Claims	*	6.14%

** Cannot calculate because not all audited claims have errors which resulted in a recovery.*
Source: Non-audited data self-reported by PBM - Dollar amounts rounded to nearest whole dollar

PBM B's program integrity audits resulted in recovery of $1,215,675, which is 0.14 percent of the total Medicaid paid claims. Table 3 below shows the amounts and percentages for the program integrity audits

Table 3: FY 2017 PBM B Medicaid Audit Activities

Texas Medicaid FY 2017	PBM B	
	Claims	Dollars
Total Audited	47,161	$40,643,858
% of Paid Claims Audited	0.48%	4.64%
Total Recoveries	1,930	$1,215,675
% Recoveries of Paid Claims	0.02%	0.14%
% Recoveries of Audited Claims	4.09%	2.99%

Source: Non-audited data self-reported by PBM - Dollar amounts rounded to nearest whole dollar

PBMs' management asserted the reason for the limited percentage of claims audited is the result of the effectiveness of the edit checks and daily prepayment review program integrity activities. The inspection focused on program integrity activities specific to the detection of overbilling, unauthorized refills, and unauthorized drug substitutions. Although the edit checks and prepayment daily reviews enhance program integrity, auditing is the only program activity the PBMs could provide complete program integrity results specific to the inspection objectives.

IV. CONCLUSION

The OIG Inspections and Investigations Division completed an inspection to determine the program integrity activities PBMs use to detect FWA of Medicaid-funded prescriptions. The inspection focused on determining how PBMs detect overbilling, unauthorized refills, and unauthorized drug substitutions.

Both PBMs that were reviewed rely on three program integrity activities to detect FWA in overbilling, unauthorized refills, and unauthorized drug substitutions in Medicaid-funded prescriptions. The three program integrity activities are: Edit Checks of Submitted Prescription Claims; Daily Prepayment Review of Covered Prescription Claims: and Audit of Paid Prescription Claims.

These specific program integrity activities are not required in the managed care contract. Therefore, any observations made are not an indication of non-compliance with rules, statutes, HHSC guidance, or contract requirements.

The OIG Inspections and Investigations Division made the following observations:

- Select PBMs are unable to provide complete results of their prepayment review process.
- As a result of audit program integrity activity, each PBM recovered less than one percent of paid Medicaid prescription claims.

PBM A does not distinguish Texas Medicaid prescription claims from those of other pharmacy benefit providers prior to payment. As a result, cost savings or avoidance was not available for analysis by the OIG. Annual recovery amounts were not available for PBM B. Without annual recovery amounts or documented policies and procedures, a complete analysis could not be performed. The inspection cannot report on the results of their prepayment review program integrity activity.

PBM A's program integrity audits resulted in recovery of $450,157, which is 0.06 percent of the total paid claims. PBM B's program integrity audits resulted in recovery of $1,215,675, which is 0.14 percent of the total paid claims. PBMs' management asserted the reason for the limited percentage of claims audited is the result of the effectiveness of the edit checks and daily prepayment review program integrity activities.

The OIG Inspections and Investigations Division thanks VDP and both PBMs for their assistance and cooperation during the course of this inspection.

V. APPENDICES

Appendix A: Detailed Methodology

Selection of PBMs

The two PBMs were selected for inspection based on an analysis of claims data.

Data Collection and Analysis

The inspectors developed questionnaires requesting details of the PBM program integrity activities used to detect FWA in processing prescription claims specific to overbilling, unauthorized refills, and unauthorized drug substitutions. The team also conducted on-site visits and interviews with the two selected PBMs, as well as follow-up conference calls.

Standards

The OIG Inspections and Investigations Division conducts inspections of the Texas Health and Human Services programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of FWA. Inspections typically result in observations and may result in recommendations to strengthen program effectiveness and efficiency. The OIG Inspections and Investigations Division conducted the inspection in accordance with Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this OIG Inspections Division report include:

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- Troy Neisen, Manager for Inspections
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- Leslie Gibson, Inspector
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- Karin Hill, Director, Internal Audit
- Grace Windbigler, Director, Managed Care Compliance & Operations Division, Medicaid and CHIP Services
- Priscilla Parrilla, Director, Vendor Drug Program

Appendix C: OIG Mission and Contact Information

Inspector General Mission

The mission of the OIG is to prevent, detect, and deter FWA through the audit, review, 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
- Anita D'Souza, OIG Chief Counsel and Chief of Staff
- Christine Maldonado, Chief for Operations and Workforce Leadership
- Olga Rodriguez, Chief Strategy Officer
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections and Investigations
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Knobloch, Assistant Deputy IG for Medical Services

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- Phone: 1-800-436-6184

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