AUDIT RECOMMENDATION STATUS REPORT

AUDIT NAME: Medicaid Prescription Drugs Performance Audit
AUDIT NUMBER: 1407P
DEPARTMENT: Health Care Policy and Financing
DATE OF STATUS REPORT: November 3, 2016

SUMMARY INFORMATION

Rec. Number	Department's Response	Original Implementation Date	Implementation Status	Revised Implementation Date (If applicable)
1a	Agree	November 2016	Not Implemented	March 2017
1b	Agree	November 2016	Not Implemented	March 2017
1c	Agree	November 2016	Not Implemented	March 2017
1d	Partially Agree	December 2015	Not Implemented	August 2017
2a	Agree	November 2016	Not implemented	September 2017
2b	Partially Agree	October 2015	Implemented and Ongoing	
3a	Agree	November 2016	Not Implemented	March 2017
3b	Agree	November 2016	Not Implemented	March 2017
3c	Partially Agree	October 2015	Implemented and Ongoing	
4	Agree	November 2016	Implemented	

DETAIL OF IMPLEMENTATION STATUS

Recommendation No. 1:

The Department of Health Care Policy and Financing should strengthen controls to enforce proper authorizations and payments for non-preferred, restricted, and emergency prescription drug claims in the Medicaid program by:

A. Implementing processes to keep its pharmacy benefits management system updated with current information on all drugs that require prior authorizations.

Current Implementation Status for Rec. 1A: Not Implemented.

Department's Update:

This process is still very manual in nature. The instances identified in this audit of drugs that needed to be denied for prior authorization have been corrected. The process to keep everything up to date is currently being manually maintained by the Department pharmacists. The transition to

the new pharmacy benefit management system (PBMS) in March 2017 will drastically improve this process moving forward as the new vendor has processes in place that will effectively address this issue, including a weekly review of new drugs entering the market, and any changes to drug classifications. This will inform the Department and vendor as to any changes that need to be made. There will also be more staff dedicated to help the Department maintain the controls in the adjudication system. New implementation date: March 2017.

B. Implementing functionality in its pharmacy benefits management system to eliminate the ability for pharmacies to override emergency fill authorizations and to clearly identify each prescription that is an emergency fill. Once this system functionality is implemented, the Department should monitor aggregate data on a routine basis for proper use of emergency fills.

Current Implementation Status for Rec. 1B: Not Implemented.

Department's Update:

This recommendation will be completed with the new PBMS. The transition was originally anticipated for November 2016 but is now expected in March 2017. The current PBMS vendor, XEROX, was approached to estimate the cost of this fix to disable the emergency fill authorization system override in the current system; it would require significant changes and the Department had to prioritize other changes while moving forward to the new systems. Therefore, this change will be corrected in the new system. New implementation date: March 2017.

C. Implementing a routine risk-based claims review process to identify and address improper prescription drug claims that do not have prior authorizations, and provide information to update the pharmacy benefits management system.

Current Implementation Status for Rec. 1C: Not Implemented.

Department's Update:

While working on the transition to the new PBMS, we are comprehensively working on the management of all drug edits and clinical criteria in the system. Currently, the Department pharmacy staff must identify a needed change and then that is sent in a request (transmittal) to XEROX to make the change. This process can take anywhere from five days to a couple of months. The vendor of the new PBMS, Magellan, is currently designing the management of the Prescription Drug List and other drug edits to be ready for implementation in the new system. Magellan will require a similar process to make system edits, but will have pharmacists and other staff to assist with the process and ensure that everything is correctly administered by the time of transition. In the meantime, there are weekly manual reviews of new drugs entering the marketplace to assess the need for additional controls. New implementation date: March 2017.

D. Reviewing the 5,154 prescription drug claims identified by this audit, which did not comply with state regulations, and recovering the questioned costs, as appropriate, from the pharmacies that received the funds.

Current Implementation Status for Rec. 1D: Not Implemented.

Department's Update:

The Department is still in the process of determining which of these drug claims were appropriate for payment and which ones need to be recovered. There are a certain percentage of prescriptions identified that would have met clinical criteria and would have been given a prior authorization. It is difficult to determine some of this information after the fact, and so the process is still ongoing. This determination will be a time-intensive process that will require the Department to contact the prescribers and/or seek medical records. Department resources have been focused on the Colorado Medicaid Management Innovation and Transformation project (COMMIT), (which includes the new PBMS) since early 2016; completion of this project must be given priority. Since the Department has not made a final determination on these claims, there have been no recoveries to date. New implementation date: August 2017.

Recommendation No. 2:

The Department of Health Care Policy and Financing should implement effective processes to ensure the appropriate utilization of prescription drugs by recipients and address overutilization within the Medicaid program by:

A. Implementing special restrictions over the prescription drugs that a recipient receives through Medicaid if he or she meets established overutilization criteria. The Department should consider implementing various types of restrictions, such as on the number of prescriptions, drug types, and/or drug combinations that the over utilizing recipient receives within a set time frame, and on the number of providers who can prescribe to the recipient through Medicaid.

Current Implementation Status for Rec. 2A: Not Implemented.

Department's Update:

The Department generates quarterly lists of clients meeting overutilization criteria and sends clients letters with a description of the overutilization and a request to contact their Regional Care Collaborative Organization (RCCO) for assistance. The Department also sends a list of clients who meet overutilization criteria to each RCCO for clinical review and program enrollment. Program enrollment may include a verification of a medical home, information and referral, and/or intensive case management, and care coordination. RCCOs are required to report client outreach activities to the Department; these activities are also discussed in monthly RCCO operations meetings to inform care initiatives and program improvement. RCCOs may also identify prescriber issues upon clinical review and provide outreach to in-network prescribers.

The utilization management vendor, QHealth Solutions, is responsible for generating the quarterly lists of clients meeting overutilization criteria. The Department did not pull quarterly lists during the 2015 six-month vendor transition. However, the RCCOs continued to provide client outreach to previously enrolled clients, as well as to RCCO-identified clients during this time.

The ability to restrict a client to specific providers (often referred to as "lock-in") required significant changes to Medicaid Management Information System (MMIS). The Department is currently undergoing a large-scale multi-system transition. The transition from MMIS to interChange will allow for enhanced systems capabilities, including lock-in. On October 11, 2016,

the Department postponed the interChange go-live date from November 2016 to March 2017. We now anticipate that lock-in capabilities will be available as early as March 2017, although more likely later in 2017, depending on the prioritization of critical systems changes and implementation. New implementation date: September 2017.

B. Analyzing the claims paid for the 17 recipients who appeared to over utilize prescription drugs through Medicaid, notifying the recipients' prescribers of potential overutilization, and based on the results of the analyses, referring the recipients to the Department's Drug Utilization Review Program and to law enforcement for investigation, as appropriate.

Current Implementation Status for Rec. 2B: Implemented and Ongoing.

Department's Update:

This recommendation has been implemented and is ongoing. The Drug Utilization Review (DUR) Program sent out letters to notify these prescribers of the patients who were still identified as overutilizers in September 2015. Not all of these patients were accessible at this time because they had already reduced their dosing drastically or they were not actively eligible Medicaid members at this time. The DUR program has started monitoring overprescribing criteria every quarter, and so prescribers are notified via letter of these instances on a regular basis beginning in September 2015. The Department has also been implementing opioid overutilization restrictions. An initial limit of daily milligrams of morphine equivalents was implemented in February 2016 and will continue to be monitored for further decreases to the total daily limit. The systemic limit monitors all opioid prescriptions that are given to a patient. It calculates a daily morphine equivalent for all prescriptions that a patient cannot go over. The system requires a prior authorization for anyone to be allowed any prescription that would put them over the limit.

Recommendation No. 3:

The Department of Health Care Policy and Financing should strengthen controls to detect and prevent health care provider fraud, abuse, and misuse related to prescription drugs in the Medicaid program by:

A. Implementing system controls, such as in the Medicaid Management Information System (MMIS) and pharmacy benefits management system, to automatically deny claims originating from excluded providers and terminated providers. This should include updating both MMIS and the pharmacy benefits management system to include National Provider ID's for all Medicaid providers and requiring pharmacies to enter these IDs for all claims.

Current Implementation Status for Rec. 3A: Not Implemented.

Department's Update:

Once revalidation (which includes risk assessment) is completed and the Department has implemented the new MMIS system, all providers must have a valid National Provider Identification (NPI) and the NPI must be included on all claims. No excluded or terminated providers should be paid through the new system. The risk assessment will include monthly checks of the List of Excluded Individuals/Entities (LEIE), System for Award Management (SAMS),

Social Security Administration Death Master File, and the Colorado Department of Regulatory Agencies (for licensure). New implementation date: March 2017.

B. Implementing a periodic review of prescription drug claims data to identify those originating from excluded and terminated providers, and recovering payments for the claims, as appropriate. This should include recovering payments for those unallowable claims identified by the audit, as appropriate.

Current Implementation Status for Rec. 3B: Not Implemented.

Department's Update:

Once the provider enrollment and screening rules are fully implemented via the new MMIS system, all prescribing providers must be enrolled and active in MMIS. The fiscal agent, Hewlet Packard Enterprise, will take over the monthly checks of all providers against the List of Excluded Individuals/Entities (LEIE) and System for Award Management (SAM). A monthly check of the federal Centers for Medicare and Medicaid Services (CMS) list of providers terminated by other states will be performed by the Audit Information Management Section. Excluded or terminated providers will be removed from active status and pharmacies should not receive verification by PBMS for a prescription issued by a non-active prescribing provider. Implementation of the requirement for prescribing providers to enroll and the new PBMS is expected to prevent payments to a pharmacy for prescriptions written by excluded or terminated providers. The Department is currently investigating the possibility of recovering the payments from the prescribing provider. New implementation date: March 2017.

C. Implementing routine processes to identify high risk prescribers using comprehensive risk criteria, periodically reviewing these prescribers' prescription drug claims, and referring them to the State's Medicaid Fraud and Control Unit for investigation, as appropriate, when their prescribing practices appear fraudulent.

Current Implementation Status for Rec. 3C: Implemented and Ongoing.

Department's Update:

This recommendation has been implemented and is ongoing. The Drug Utilization Review program continues to monitor this on a quarterly basis. The retrospective drug utilization review criteria are specific to high and mis-utilization of opioid, psychotropic and stimulant medications routinely. Other criteria come up from time to time when another prescribing issue is identified as a possible problem. If fraudulent practices or potential fraudulent practices are identified, those prescribers are referred to the Medicaid Fraud Control Unit for investigation.

Recommendation No. 4:

The Department of Health Care Policy and Financing should implement internal controls and oversight of its fiscal agent to ensure it complies with federal regulations to bill for and collect interest when manufacturers are past due in paying prescription drug rebates. The Department

should collect unpaid interest from the drug manufacturers identified in the audit, refund the federal portion of the interest to the federal government, as appropriate, and ensure its fiscal agent billed manufacturers for interest correctly between April 2014 and April 2015.

Current Implementation Status for Rec. 4: Implemented.

Department's Update:

This recommendation has been implemented. The fiscal agent, Xerox State HealthCare, calculated the interest and billed the manufacturers. The Department increased its oversight of the fiscal agent by reviewing the interest due and the interest paid on a quarterly basis to ensure that the fiscal agent is calculating and invoicing drug rebate interest. As of August 19, 2016, $3,894.63 in interest has been paid by drug manufacturers for 2QTR2014 through 2QTR2015 and the applicable amounts have been shared with the Centers for Medicare and Medicaid Services. Please note that it's common for the number of drug units and/or the federal unit rebate amounts to change retroactively; this in turn would impact the amount of rebate due and any interest calculations. So the interest due for this time period (April 2014 and April 2015) is now different from the figure identified during the audit.
