

# Audit Report

## Pharmacy Benefits Manager Navitus Health Solutions LLC

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### Community Health Choice



**Inspector  
General**

Texas Health  
and Human Services

**August 31, 2020  
OIG Report No. AUD-20-024**

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## HHS OIG

TEXAS HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

August 31, 2020

Audit Report

# PHARMACY BENEFITS MANAGER NAVITUS HEALTH SOLUTIONS LLC

## *Community Health Choice*

### WHY THE OIG CONDUCTED THIS AUDIT

HHSC paid Community Health Choice \$949.7 million in capitation payments to serve Medicaid and CHIP members during fiscal year 2018. Of that, \$127.8 million was related to pharmacy services. Community Health Choice provided pharmacy benefits to an average of 285,246 Medicaid and CHIP members through its PBM, Navitus, in fiscal year 2018.

The audit objective was to determine whether Community Health Choice and its subcontracted PBM, Navitus, administered formularies, preferred drug list, and prior authorizations in accordance with the UMCC, UMCM, and applicable rules and statutes. The audit scope included formularies, preferred drug lists, and pharmacy encounters and claims for fiscal year 2018.

### WHAT THE OIG RECOMMENDS

Community Health Choice should ensure Navitus (a) implements an appropriate method to add all VDP-approved formulary and approved preferred drug list items with the appropriate 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 criteria requirements for drug codes that require clinical and non-preferred prior authorizations.

### MANAGEMENT RESPONSE

OIG presented preliminary audit results, issues, and recommendations to Community Health Choice on August 11, 2020. Community Health Choice indicated it will work with Navitus to resolve identified issues. Community Health Choice's responses are included after each recommendation.

For more information, contact:  
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### WHAT THE OIG FOUND

Community Health Choice 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 Health Choice 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 Health Choice'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 72.0 percent of tested prior authorizations correctly. However, for the 21 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 incorrectly rejected claims or communicated the incorrect rejection message to the member.

### BACKGROUND

Community Health Choice 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) and Uniform Managed Care Manual (UMCM). 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 Health Choice, is required to subcontract with a Pharmacy Benefit Manager (PBM) to process prescription claims and perform other selected pharmacy-related services. A PBM is a third-party administrator of prescription drug programs.

Office of HHS Inspector General

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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 Health Choice, Inc. (Community Health Choice) and its pharmacy benefit manager (PBM), Navitus Health Solutions, LLC (Navitus).

The Texas Health and Human Services Commission (HHSC) paid Community Health Choice a total of \$949.7 million<sup>1</sup> in capitation payments to serve members of the Medicaid State of Texas Access Reform (STAR) program 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, \$127.8 million was the portion paid to Community Health Choice related to pharmacy services. Community Health Choice paid approximately 89 percent of those pharmacy capitation payments received from HHSC to Navitus for prescription expenses (\$108.8 million) and PBM administrative fees (\$5.2 million) during the same timeframe. Community Health Choice provided pharmacy benefits to an average monthly membership of 285,246 Medicaid and CHIP members during the 12-month period.

### Background

Community Health Choice 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 Health Choice, 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 Health Choice and ten other MCOs contracted with Navitus as their PBM to provide pharmacy benefit services. In

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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 Health Choice.

<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).

<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).

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 Health Choice. 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 Health Choice's Medicaid STAR 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 Health Choice'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 Medicaid preferred drug list. MCOs must approve a prior authorization

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

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 Health Choice's and Navitus's compliance with the Uniform Managed Care Contract (UMCC) 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 Health Choice and its subcontracted PBM, Navitus, administered the formulary, preferred drug list, and prior authorizations in accordance with the UMCC, 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 authorizations 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 Health Choice in a draft report dated August 11, 2020. In its management responses, Community Health Choice indicated it will work with Navitus to resolve identified issues. Community Health Choice'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)
- 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 Health Choice 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 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.<sup>11</sup> The OIG Audit and Inspections Division reviewed the extent to which Community Health Choice and Navitus met selected pharmacy benefit requirements.

Community Health Choice 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 21 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 incorrectly rejected claims for prior authorizations not required, or 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	72.0 %

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).

## 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 requires Community Health Choice 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 Health Choice's compliance with this requirement by performing formulary updates five times per week.

Both Community Health Choice and its PBM, Navitus, are required to adhere to and exclusively use the Medicaid and CHIP formularies.<sup>13</sup> Community Health Choice 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 Health Choice 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).

<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).

## 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.

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 Health Choice 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 number 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**

	Medicaid	CHIP
Total Rejected Claims in 2018	805,363	66,470
Number of Incorrectly Rejected Claims for Formulary Exceptions	3,160	488
Members Affected	1,882	309
Estimated Value of Rejected Claims	\$57,483.15	\$61,765.06

Source: OIG Audit and Inspections Division

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>15</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**

	Medicaid	CHIP
Total Rejected Claims with Drug Codes Not Retained	10,404	941
Number of Claims Potentially Associated with Formulary Rejections	8,148	861
Members Potentially Affected by Formulary Rejections	5,320	560

Source: OIG Audit and Inspections Division

### **Recommendation 1**

Community Health Choice 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.

### **Management Response**

*Community Health Choice agrees with OIG's findings that Navitus's Medicaid and CHIP formularies did not consistently include all NDCs on VDP formularies. The findings have been reviewed with Navitus's leadership.*

*As noted in the audit findings, Navitus uses Medi-Span as its drug data application, classifying drugs based on generic product identifier. Some of the NDC omissions were the results of MediSpan not recognizing the NDCs that were received on the daily VDP files. Additionally, Medi-Span is only able to provide pricing information for NDCs that are available in their database. Navitus would not be able to add these NDCs manually due to lack of appropriate pricing information.*

*Additionally, some of the NDC omissions were due to retroactive changes submitted on the formulary files produced by HHSC. Out of the 7296 transactions provided by OIG in the Formulary Impact Support Attachment, 2828 (38.8%) were*

<sup>15</sup> Medi-Span is a prescription drug data application that Navitus uses, which classifies drugs based on generic product identifier.

*due to retrospectively made changes to formulary files. Audit findings were pulled to look retroactively at data within Navitus' adjudication platform. Due to the retroactive nature of these file adds, Navitus is not able to produce non-existent claim documentation when the NDC was not setup in the adjudication platform until a later date. The back-date makes the claims which adjudicated at the time appear incorrect, however they adjudicated correctly based on the formulary at the time.*

*The audit report points to products rejecting incorrectly due to over-the-counter products not findings. Medi-Span controls all drug designation criteria, and provides updates on a weekly basis to Navitus. These updates include any changes to drug designation, including OTC or legend status of the NDC. This is due to Navitus' automated Medi-Span file review process not capturing the change of the product from legend status to OTC status, thus causing the NDC to reject once it was updated to OTC.*

*Some NDC omissions were due to Navitus' manual process to manage NDCs not recognized by Medi-Span. Navitus has a weekly manual process to review warehoused NDCs that are not recognized by Medi-Span and therefore not setup in Navitus' adjudication platform. These NDCs are added to formulary once Medi-Span availability has been confirmed. Navitus will continue to work to improve this manual process to account for more detailed review of these Medi-Span missing NDCs as well as implement monthly review of these files for any products that were omitted as a result of that review. Navitus will also look into automated processes that will capture these not yet recognized by Medi-Span NDCs instead of relying on a manual process to capture.*

#### Action Plan

- a) Navitus will review Medi-span file processes to ensure there is no gap in capturing and updating Medi-span changes as provided in the weekly file.*
- b) Navitus will pursue options for further system enhancements that enable VDP approved NDCs to adjudicate as requested based on real time Medi-Span drug designation, limiting dependency on manual intervention for these NDCs to process. Navitus is working with our internal IT partners to determine level of effort needed and will update policies and procedures. The solution will also be incorporated into automated and manual quality assurance practices.*

<b>Description of Activity</b>	<b>Timeline</b>	<b>Responsible Manager</b>
<i>Assessment of all processes that support Medi-span changes.</i>	<i>October 1<sup>st</sup> 2020</i>	<i>Navitus' Formulary Operations</i>
<i>Assessment of Solution Requirements</i> <ul style="list-style-type: none"> <li>• <i>Increased automation related to Medi-Span file review</i></li> <li>• <i>Impact of System enhancements</i></li> </ul>	<i>October 1<sup>st</sup> 2020</i>	<i>Navitus' Formulary Operations and IT-Client Operations</i>
<i>Initiate Project</i>	<i>30 days from completion of Assessment</i>	<i>Navitus' IT-Client Operations</i>
<i>Updates to policy and procedures</i>	<i>Upon implementation of the solution</i>	<i>Navitus' Formulary Operations and IT-Client Operations</i>
<i>Review and validate Navitus' system and process enhancements to comply with formulary requirements</i>	<i>January 2021</i>	<i>Director, Pharmacy Analytics Community Health Choice</i>

Responsible Manager*Director, Pharmacy Analytics, Community Health Choice*Target Implementation Date*January 2021***Auditor Comment**

The OIG Audit and Inspections Division appreciates the feedback provided by Community Health Choice in its management response letter, and respects Community Health Choice position on the reported issues. The OIG Audit and Inspections Division offers the following comments regarding Community Health Choice's management response for Issue 1.

During the audit, the OIG Audit and Inspections Division worked with VDP to evaluate the findings in the report. In addition, Community Health Choice and Navitus did not provide documentation to support assertions stated in the management responses. The OIG Audit and Inspections Division has reviewed the work supporting the report findings and stands by its conclusions.

## **PREFERRED DRUG LIST**

MCOs are required to adhere to VDP’s Medicaid preferred drug list,<sup>16,17,18</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>19</sup> before the drug is dispensed to a member.<sup>20</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 Health Choice 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 Health Choice 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>21</sup>

#### **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 at three points in time and

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<sup>16</sup> Tex. Gov. Code § 533.005(a)(23)(B) (Sept. 1, 2017).

<sup>17</sup> 1 Tex. Admin. Code § 353.905(a) (Sept. 1, 2013).

<sup>18</sup> VDP maintains a preferred drug list for Medicaid only; drugs prescribed under CHIP are not subject to preferred drug list requirements.

<sup>19</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).

<sup>20</sup> Preferred drugs may still be subject to clinical prior authorization.

<sup>21</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.

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**

	Medicaid
Number of Paid Encounters Incorrectly Processed	8
Number of Claims Incorrectly Rejected	3
Number of Members Affected <sup>22</sup>	6

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 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

<sup>22</sup> Number of members affected includes total unduplicated members for both paid encounters and reject claims.

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**

	Medicaid
Number of Paid Encounters Incorrectly Processed	209
Number of Claims Incorrectly Rejected	77
Number of Members Affected	139

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**

	Medicaid
Number of Paid Encounters Incorrectly Processed	18
Number of Claims Incorrectly Rejected	14
Number of Members Affected	11

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**

	Medicaid
Number of Claims Incorrectly Rejected	2
Number of Members Affected	2

Source: OIG Audit and Inspections Division

## **Recommendation 2**

Community Health Choice 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**

*Community Health Choice agrees with OIG's findings. The findings have been reviewed with Navitus' leadership.*

*Some of the NDCs omitted from PDL can be traced to NDCs not being available from Medi-Span which is outlined in issue #1. If a product is not recognized by Medi-Span, Navitus is unable to add to formulary and therefore unable to assign PDL status. Additionally, Medi-Span is only able to provide pricing information for NDCs that are available in their database. Navitus would not be able to add these NDCs manually due to lack of appropriate pricing information. Previously reported backdating issues due to retroactive file updates account for 19% of omissions. Retroactive file updates do not allow for appropriate audit reporting, as they adjudicated correctly at the time based on the information that was provided on the files.*

*Navitus contractually has two business days to update our adjudication platform with the daily file updates. For some of the findings, files were received Friday morning on 8/31/2018 and updated in Navitus' adjudication platform on Tuesday, 9/4/2018, fulfilling the two business day requirement (Monday 9/3/2018 was an observed Federal holiday). Claims submitted during that time period for these products would not have adjudicated at the correct PDL status that would have been effective on 9/4/2018.*

*Some of the findings were due to NDCs that were terminated from VDP files, therefore on the dates submitted in the audit, would not have shown up in Navitus' adjudication records as having PDL status.*

2b, c, d) Of the noted incorrect PDL effective dates, some of these removals were due to retroactive changes submitted on the formulary files produced by HHSC. Similarly noted in Issue #1, audit findings were pulled to look retroactively at data within Navitus' adjudication platform. Due to the retroactive nature of these file adds, Navitus is not able to produce nonexistent claim documentation when the NDC was not setup in the adjudication platform until a later date. This back-date makes the claims which adjudicated at the time appear incorrect, however they adjudicated correctly based on the formulary at that time.

Some of the findings were due to inactive NDCs on VDP files. As these products were inactive per VDP, no PDL status could be assigned to these products.

### Action Plan

- a) Navitus will review Medi-span file processes to ensure there is no gap in capturing and updating Medi-Span changes as provided in the weekly file.
- b) Navitus will pursue options for further system enhancements that enable VDP approved NDCs to adjudicate as requested based on real time Medi-Span drug designation, limiting dependency on manual intervention for these NDCs to process. Navitus is working with our internal IT partners to determine level of and will update policies and procedures. The solution will also be incorporated into automated and manual quality assurance practices.

<b>Description of Activity</b>	<b>Timeline</b>	<b>Responsible Manager</b>
Assessment of all processes that support Medi-span changes.	October 1 <sup>st</sup> 2020	Navitus' Formulary Operations
Assessment of Solution Requirements <ul style="list-style-type: none"> <li>• Increased automation related to Medi-Span file review</li> <li>• Impact of System enhancements</li> </ul>	October 1 <sup>st</sup> 2020	Navitus' Formulary Operations and IT-Client Operations
Initiate Project	30 days from completion of Assessment	Navitus' IT-Client Operations
Updates to policy and procedures	Upon implementation of the solution	Navitus' Formulary Operations and IT-Client Operations
Validate Navitus' system and process enhancements to comply with PDL requirements	01/01/2021	Director, Pharmacy Analytics Community Health Choice

### Responsible Manager

Director, Pharmacy Analytics, Community Health Choice

### Target Implementation Date

January 1, 2021

**Auditor Comment**

The OIG Audit and Inspections Division appreciates the feedback provided by Community Health Choice in its management response letter, and respects Community Health Choice's position on the reported issues. The OIG Audit and Inspections Division offers the following comments regarding Community Health Choice's management response for Issue 2.

During the audit, the OIG Audit and Inspections Division worked with VDP to evaluate the findings in the report. In addition, Community Health Choice and Navitus did not provide sufficient documentation to support the assertions stated in the management responses. The OIG Audit and Inspections Division has reviewed the work supporting the report findings and stands by its conclusions.

## **PRIOR AUTHORIZATIONS**

Certain prescriptions require prior authorization<sup>23</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 Health Choice and its subcontracted PBM, Navitus, must adopt prior authorization requirements that comply with the state's requirement to exclusively use VDP's formularies<sup>24,25</sup> and allow access by members to all non-preferred drugs on the Medicaid formularies.<sup>26</sup> MCOs must adhere to the Medicaid preferred drug list and perform non-preferred prior authorizations as required by VDP.<sup>27</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>28</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 independently so that each prior authorization (clinical and non-preferred) is checked for approval.<sup>29</sup>

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<sup>23</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>24</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).

<sup>25</sup> Tex. Gov. Code § 533.005(a)(23)(A) (Sept. 1, 2017).

<sup>26</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).

<sup>27</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).

<sup>28</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).

<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).

### Issue 3: Community Health Choice Did Not Ensure That Navitus Properly Approved and Rejected Claims

Community Health Choice 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 19 of 60 (32 percent) prior authorizations tested, clinical or non-preferred criteria was either not applied or not applied appropriately. Additionally, 2 of 15 (13 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>30</sup> as shown in Table 10.

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

	Number of Claims Tested	Number of Issues Identified
Paid Claims Tested	60	19
Rejected Claims Tested	15	2
Total Claims Tested	75	21

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>31,32</sup> for 17 (43 percent) of the 40 prior authorizations tested.<sup>33</sup> Before a non-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.

<sup>30</sup> Non -preferred–only prior authorizations testing included testing when the drug was also designated as preferred.

<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).

<sup>32</sup> VDP Texas Prior Authorization Program Preferred Drug List Criteria (July 27, 2017, Mar. 9, 2018, and July 26, 2018).

<sup>33</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.

Of the 17 non-preferred prior authorizations for which not all required non-preferred prior authorization criteria were correctly applied, 13 required only a non-preferred prior authorization and 4 required both non-preferred and clinical prior authorizations. Of the 13 claims that required only a non-preferred prior authorization:

- 11 had evidence that a preferred drug was previously tried
- 2 did not have evidence that a preferred drug was previously tried

The remaining four claims, which required both non-preferred and clinical prior authorizations, were for the drug Promethegan,<sup>34</sup> but neither the non-preferred requirements nor the clinical requirements for the prior authorizations were correctly applied. The four non-preferred prior authorizations included:

- 2 with evidence that a preferred drug was previously tried
- 2 without evidence that a preferred drug was previously tried

As a result, Promethegan was incorrectly paid as preferred without performing the non-preferred and clinical prior authorization requirements. Navitus did not correctly program Promethegan in its adjudication system and, as a result, 96 Promethegan claims in the amount of \$8,649.38 for 80 members were incorrectly adjudicated in 2018. Promethegan can be used as antihistamine, sedative, or anti-nausea drug.

The 17 prior authorizations for 14 drug codes were associated with 7,673 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>35</sup>

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

	Medicaid
Number of Drug Codes Affected	14
Total Paid Claims Processed Incorrectly	7,673
Total Number of Medicaid Members Affected	5,416

Source: *OIG Audit and Inspections Division*

<sup>34</sup> Drug code 00713052612.

<sup>35</sup> Table 11 includes results where neither non-preferred requirements nor Promethegan clinical requirements were applied correctly.

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

Two of 20 (10 percent) clinical prior authorizations tested, for Synagis,<sup>36</sup> were approved for all five monthly doses during the initial clinical review without evidence that clinical reviews for subsequent doses were performed, as required.<sup>37</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 Health Choice 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**

	Medicaid
Number of Drug Codes Affected	2
Total Paid Claims for Doses Following Initial Authorization	296
Total Number of Members Affected	98

Source: *OIG Audit and Inspections Division*

## A Drug Was Incorrectly Rejected as Requiring Prior Authorization Rather than Not Covered for a CHIP Member

For one of five (20 percent) rejected claims tested, Navitus incorrectly rejected Synagis,<sup>38</sup> for a CHIP member as requiring a prior authorization rather than “Product/Service Not Covered.”

Synagis claims were incorrectly rejected a total of two times in 2018 with an incorrect rejection message of “Prior Authorization Required” for two CHIP

<sup>36</sup> Drug code 60574411301.

<sup>37</sup> VDP Texas Prior Authorization Program Clinical Edit Criteria (Sept. 6, 2017, and Dec. 11, 2017).

<sup>38</sup> Drug code 60574411301.

members. Communicating the incorrect rejection message may delay the member from receiving an alternative drug that is a covered benefit.

### **A Drug Was Incorrectly Rejected as a Non-Covered Drug**

For one of 5 (20 percent) rejected claims tested, Navitus incorrectly rejected Orphenadrine,<sup>39</sup> a non-preferred drug that requires a prior authorization, for “Product/Service Not Covered.” Orphenadrine is used to relieve discomfort related with acute painful muscular skeletal conditions.

Orphenadrine claims were rejected a total of 32 times in 2018 with an incorrect rejection message of “Product/Service Not Covered” for 15 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**

	Medicaid
Total Incorrectly Rejected Claims	32
Number of Medicaid Members Affected	15

Source: *OIG Audit and Inspections Division*

### **Recommendation 3**

Community Health Choice 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>39</sup> Drug code 43386048024.

## **Management Response**

### ***3a: Non-Preferred Prior Authorizations Were Adjudicated Without Applying All Non- Preferred Requirement***

*Community Health Choice agrees with OIG's findings. The findings have been reviewed with Navitus' leadership.*

*The Preferred Drug List (PDL) criteria referenced for anti-nausea agents such as promethazine includes questions surrounding a different medication. Our automated criteria lookback did assess claim history for a trial of a preferred medication prior to approving a non-preferred medication, however this was asked in a different format than that referenced by VDP, this allowed for a more generous benefit for enrollees. Additionally, the audit assessed both manual and automated PA assessments. As a manual clinical review occurs, the clinical review agent assesses the criteria, and makes a clinical determination based on the associated criteria. The clinical review agent assesses the case, which includes demographics, claims history, and documentation provided by the prescriber. The clinical review agent will assess the medication including all formulary restrictions (including PDL criteria) and any clinical edits associated with the medication to come to their conclusion. This resulted in the audit report classifying 96 claims, and 80 members as impacted. This comprised of five prior authorizations identified by the OIG with issues. Navitus did change the automated questions to match a VDP's criteria on 3/1/2019.*

*Regarding the PDL criteria for Pulmicort suspensions, a member's age first dictates whether a claim would pay for a given member. The claim assessed in the audit report included a claim which paid based on the member's age. Navitus believes the question assessed in this edit is accurate, and allowed the claim to pay appropriately based on the member's age as the edit instructs.*

*Navitus agrees that the PDL questions for Otic antibiotics were asked in a different format. However, Navitus does believe that based on clinical experience, due to potential resistance to antibiotics, side effects, and adverse effects from medications, the outcome was appropriate. Otic antibiotics was associated with 348 claims and 311 members. This comprised of one prior authorization identified by the OIG with issues.*

*The stimulant case identified by the audit report as a potential issue surrounds how our automated criteria lookback assesses claim history. Our automated system assessed claim history for a trial of a preferred medication prior to approving a non-preferred medication, as well as the clinical edit associated with the medication. Stimulants were associated with 112 claims and 56 members. This comprised of one prior authorization identified by the OIG with issues.*

*Navitus agrees that the PDL questions for Epinephrine products were asked in a different format. This resulted in 921 claims and 757 members classified as impacted. This comprised of two prior authorizations identified by the OIG with issues.*

*As the PDL criteria for cough and cold medications, macrolides and ketolides (antibiotics), the audited cases required manual clinical reviews. As a manual clinical review occurs, the clinical review agent assesses the criteria, and makes a clinical determination based on the associated criteria. The clinical review agent assesses the case, which includes demographics, claims history, and documentation provided by the prescriber. The clinical review agent will assess the medication including all formulary restrictions (including PDL criteria) and any clinical edits associated with the medication to come to their conclusion. Navitus does not agree with this finding as a clinician review was completed.*

*Regarding an antiviral medication class the OIG identified as potential issues, Navitus agrees that the PDL questions were asked in a different format. However, Navitus believes that based on clinical experience, due to side effects and adverse effects from medications such as oseltamivir (Tamiflu), a medication commonly used to treat influenza and other viral infections, was an appropriate decision for this member noted in the audit.*

*The topical steroid case identified by the audit report as a potential issue surrounds how our automated criteria lookback assesses claim history. Our automated system assessed claim history for a trial of a preferred medication prior to approving a non-preferred medication. The PA criteria used by Navitus was in a different format than that referenced by VDP.*

*Navitus agrees a question was not asked on the automated lookback on two edits for Proventil and for oral antipsychotic medications. These comprise of three prior authorizations identified by the OIG with issues. Additionally, the audit assessed both manual and automated PA assessments. As a manual clinical review occurs, the clinical review agent assesses the criteria, and makes a clinical determination based on the associated criteria. The clinical review agent assesses the case, which includes demographics, claims history, and documentation provided by the prescriber. The clinical review agent will assess the medication including all formulary restrictions (including PDL criteria) and any clinical edits associated with the medication to come to their conclusion. Navitus believes this information was assessed during the manual review, however agrees the automated lookback did not assess the VDP format of the questions. The questions not asked will be edited to match the VDP required criteria by 10/1/2020.*

***3b: A Clinical Prior Authorization Was Approved for All Doses on the Initial Request***

*Community Health Choice agrees with OIG's findings. The findings have been reviewed with Navitus' leadership.*

*In order to prevent access to care issues for such a serious medical condition as respiratory syncytial virus (RSV), approving the necessary number of doses is appropriate in this scenario. The audit report states "...approving all five doses at once may have caused members to receive doses of Synagis when not medically necessary..." Navitus agrees the clinical documentation regarding history of an RSV infection, and the child's current weight is vital in order for this medication to be dispensed. This medication does have a limit on which pharmacies may dispense the medication (Limited Distribution), and both RSV history and weight are requirements in order to dispense. An appropriate clinician performs this assessment before dispensing from a pharmacy and stopping therapy should be warranted on the medical condition of the patient based on the prescriber's assessment of the individual prior to dosing. This may be interrupted for a number of reasons including contraction of RSV, but may also be due to a decline in health from underlying medical conditions and urgent need for surgical repair. Requiring documentation review could limit access to the medication and lead to inappropriate access to care issues and inappropriate delays in care.*

***3c: A Drug Was Incorrectly Rejected as Requiring Prior Authorization Rather than Not Covered for a CHIP Member***

*Community Health Choice agrees with OIG's findings. The findings have been reviewed with Navitus' leadership.*

***3d: A Drug Was Incorrectly Rejected as a Non-Covered Drug***

*Community Health Choice disagrees with this finding. Regarding orphenadrine, the formulary update process did have these claims process correctly at the time the claims were adjudicated. This NDC terminated 3/31/2013 from a VDP formulary update on 6/26/2012. After the NDC was no longer covered, the claims for this NDC rejected appropriately as a non-covered drug until the NDC was re-added on 6/4/2018. The effective date of this addition was 4/1/2013. This backdate makes the claims which adjudicated at the time appear incorrect, however they adjudicated correctly based on the formulary on the date of service.*

Action Plan

<b>Description of Activity</b>	<b>Timeline</b>	<b>Accountability</b>
<i>Implemented Medicaid Clinical Review Team</i>	<i>Completed in September 2019</i>	<i>Navitus' Clinical Prior Authorization</i>
<i>Manager for above team will have role expanded to include oversight on clinical edits</i>	<i>Completed in May 2020</i>	<i>Navitus' Clinical Prior Authorization</i>
<i>Updates to Affected Edits (Bronchodilators, Beta Agonist and Antipsychotics, Oral)</i>	<i>October 2020</i>	<i>Navitus' Clinical Prior Authorization</i>
<i>Issuing Corrective Action Plan to Navitus to address deficiencies with Synagis and non-preferred PA requirements.</i>	<i>August 2020</i>	<i>Community Health Choice's Compliance department</i>
<i>Assess and validate Navitus' correction of deficiencies with non-preferred and Synagis prior-authorization requirements.</i>	<i>November 2020</i>	<i>Director, Pharmacy Analytics Community Health Choice</i>

Responsible Manager

*Director, Pharmacy Analytics, Community Health Choice*

Target Implementation Date

*November 2020*

**Auditor Comments**

The OIG Audit and Inspections Division appreciates the feedback provided by Community Health Choice in its management response letter, and respects Community Health Choice's position on the reported issues. The OIG Audit and Inspections Division offers the following comments regarding Community Health Choice's management response for Issue 3.

During the audit, the OIG Audit and Inspections Division worked with VDP to evaluate the findings in the report. In addition, no further evidence was provided to support assertions stated in the management responses. The OIG Audit and Inspections Division has reviewed the work supporting the report findings and stands by its conclusions.

Specifically:

- Based on further review of Community Health Choice's responses related to Pulmicort (labeled 3a above), the OIG Audit and Inspections Division agrees that Pulmicort suspension was correctly approved based on the

member's age. However, Community Health Choice and Navitus did not provide documentation to support that it had established controls to ensure that all required non-preferred prior authorization criteria was programmed into Navitus's adjudication system and would be consistently applied if the member did not meet the age requirement for approval.

- Community Health Choice and Navitus indicated disagreement with prior authorization criteria in the response related to macrolides and ketolides (labeled 3a above). While Navitus provided evidence that certain prior authorization criteria were applied, the criteria applied did not align with required non-preferred prior authorization criteria for macrolides and ketolides.
- While Community Health Choice and Navitus asserted that the incorrect rejection messages occurred due to backdating, they did not provide documentation to support this assertion (labeled 3d above).

## 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 Health Choice 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 incorrectly rejected claims or 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 Health Choice 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 Health Choice, 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 Health Choice 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>40</sup> including administrative penalties.<sup>41</sup>

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

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<sup>40</sup> 1 Tex. Admin. Code § 371.1603 (May 1, 2016).

<sup>41</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>42</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>42</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
- Bennie Hookfin, Staff Auditor
- Erin Powell, Staff Auditor
- TiAnna Riddick, Staff Auditor
- Kathryn Wolf, Associate Auditor
- Karen Mullen, CGAP, Quality Control Reviewer
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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

### To Obtain Copies of OIG Reports

- OIG website: [ReportTexasFraud.com](http://ReportTexasFraud.com)

### To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: <https://oig.hhsc.texas.gov/report-fraud>
- Phone: 1-800-436-6184

### To Contact OIG

- Email: [OIGCommunications@hhsc.state.tx.us](mailto:OIGCommunications@hhsc.state.tx.us)
- Mail: Texas Health and Human Services  
Office of Inspector General  
P.O. Box 85200  
Austin, Texas 78708-5200
- Phone: 512-491-2000