



Issue Brief

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Reducing Pharmacy Fraud, Abuse and Waste: Promising Practices of States

Summary

Prescription drug expenditures constitute one of the fastest growing components of state Medicaid budgets, growing at almost 20 percent annually. As budgets tighten, states are looking for ways to reign in these expenditures. States are looking at administrative practices that increase program efficiency and maintain enrollees' access to appropriate medications. With state-of-the-art techniques now possible because of technological advances, data warehouses and decision support systems, states can better address fraud, waste, and abuse by:

- Enhancing prospective drug utilization review to prevent waste;
- Using technology at the point-of-sale to prevent abuse and errors;
- Using data and education to change provider prescribing behavior;
- Limiting the supply of medications a patient can receive from the pharmacy;
- Requiring providers and pharmacists to substitute generic drugs for brand-name when clinically appropriate, and cost-effective; and,
- Auditing claims data to profile both providers and clients to detect fraud, abuse, and waste.

Defining Fraud, Waste and Abuse

Fraud, waste, and abuse amounts to more than \$1 billion a year in Medicaid expenditures on pharmaceuticals.ⁱ Fraud, waste and abuse are defined as:

“**Fraud**’ means an intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to himself or to some other person. It includes any act that constitutes fraud under applicable Federal or State law.”ⁱⁱ

“**Waste**’ means the over-utilization of services not caused by criminally negligent actions; waste involves the misuse of resources.”

“**Abuse**’ means provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost to the Medicaid program, or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.”ⁱⁱⁱ

States have implemented a variety of strategies to prevent and detect fraud, waste, and abuse. Prevention strategies seek to avoid inappropriate expenditures (front-end strategy). Detection strategies seek to identify and recover lost resources (back-end strategy).

Drug Utilization Review

All states have the opportunity to prevent and detect fraud, waste, and abuse through established drug utilization review (DUR) programs. As a result of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), states were required to establish DUR programs to participate in the federal Medicaid pharmacy rebate program.^{iv} Each state's DUR program must contain three components: prospective DUR, retrospective DUR and educational outreach.^v Prospective DUR involves reviewing prescriptions before they are filled to prevent drug therapy problems (such as drug-drug interactions) and clinical abuse. Retrospective DUR involves reviewing claims data after prescriptions have been filled, specifically to identify fraud, waste, and abuse.

Both prospective DUR and educational outreach provide opportunities to increase the quality of care, as well as prevent fraud, waste, and abuse by ensuring that medications being prescribed are the most appropriate treatment for the consumer's condition. Retrospective DUR is designed specifically to assist in detecting the inappropriate prescription, provision, or use of pharmaceuticals.^{vi} Educational outreach is designed to enhance provider knowledge, and to change provider behavior.

Prevention of Pharmacy Fraud, Waste and Abuse

States recognize that preventing inappropriate expenditures from occurring in the first place is preferable to paying claims that later must be recouped. As a result, increased attention focuses on prevention activities.

Prospective DUR plays several roles in ensuring that a client receives the most appropriate care. Federal law requires that prospective DUR programs ensure each prescription is reviewed for potential problems related to "therapeutic duplication, drug-disease contraindications, drug-drug interactions... incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse."^{vii} The prevention of adverse reactions, unnecessary prescriptions and duplication of therapies not only protects the health of the patient but also prevents waste of prescription drug resources.

Some states use new information technology systems to detect fraud, waste, and abuse. Computer systems housed in pharmacies can provide electronic alerts at the point of sale (POS) that indicate the prescription may not be appropriate. Modeled after **Florida's** successful experience, **Michigan** contracts with a pharmacy benefit manager (PBM) for an electronic POS system. For each prescription, the system compares the claim to the consumer's history of claims seeking any potentially harmful drug interactions or other potentially negative effects. The POS system is tied to the preferred drug list (PDL), having a hard edit on all drugs on the PDL.^{viii}

The State of **Washington** recently implemented a program called Therapeutic Consultation Services (TCS)—also modeled after Florida—which takes advantage of both the technology of a POS system and a preferred drug list. For all states with a PDL, drugs on the list are selected by the state's Pharmaceutical and Therapeutics (P&T) Committee or DUR Board to be the best in their therapeutic class, based on their safety, clinical effectiveness and cost. In any PDL model, a beneficiary would ultimately have access to drugs that are not on the list if those drugs were deemed by the physician and pharmacist to be medically appropriate.^{ix} In Washington, if a pharmacist attempts to fill a prescription that is either not on the PDL

or is the fifth brand name prescription for a client in one month, the claim is stopped. Before a claim can be processed, the prescribing physician must discuss the recommended therapy with a consulting pharmacist from the state, who can assist the prescriber in choosing a more preferred therapy, if necessary. Washington has experienced dramatic shifts in utilization for those drugs already in the program, and the state also has noted the sentinel effect of altering prescribing patterns merely through the creation of the TCS initiative.^x

Systems like Washington's, where pharmacists must seek prior approval or find an alternative to filling the prescription as written, are known as *active* alert systems, which are enforced by "hard" edits in the system. Other states have implemented computerized warning systems by which claims are not necessarily blocked. Known as *passive* alert systems and enforced only by "soft" edits, these warnings—in the form of instant message conveyed via the POS system—allow pharmacists to override the warning and fill the prescription without consulting additional authorities. According to a Kaiser Family Foundation survey of state Medicaid pharmacy programs, those states with active systems reported a greater ability to change the pattern of drugs dispensed and, thus, to contain expenditures.^{xi}

One source of waste is the use of high-cost drug therapies when lower-cost therapies prove equally effective. Another way to reduce waste in prescription drug programs is to provide incentives for the use of generics or lower-cost alternative therapies. Many states have implemented programs that provide incentives to prescribers, pharmacists and consumers to use therapeutically equivalent medications that cost less.^{xii}

One way states motivate prescribers is through prior authorization programs, which most states have implemented to some degree in their Medicaid pharmacy programs.^{xiii} The level of prior authorization required by states differs dramatically. In some states, there are a handful of high cost drugs for which prescribers must obtain prior authorization. In other states, like **Washington, Michigan and Florida**, the state provides incentives for clinicians to prescribe generic or lower cost-alternatives by offering the opportunity to avoid prior authorization. In those three states, the Medicaid program instituted a PDL based on the therapeutic equivalence, safety, efficacy and cost of drugs in a particular drug class. All drugs not on the PDL are subject to prior authorization. Providers can avoid the additional administrative requirements of prior authorization by prescribing in accordance with the PDL. By allowing prescribers to avoid the additional administrative step of prior authorization, these states have shifted utilization away from higher cost treatments that do not provide a significantly better clinical outcome. Michigan has experienced significant cost savings, reducing its weekly Medicaid pharmacy expenditures by \$800,000.^{xiv}

The strongest requirements for generic substitution are found in **Massachusetts**. Because the cost of generics can be substantially less than that of brand name drugs, some states have required that pharmacists dispense the generic, unless the prescriber provides clinical justification for the brand name version.^{xv} Prior to November 2001, that was the case for Massachusetts' pharmacists. Today, however, regardless of the prescription, beneficiaries *must* receive generic equivalents when they are available.^{xvi} All brand name prescriptions are subject to prior authorization if a generic version is available.^{xvii}

Incentives for generic or low-cost substitution are not always directed solely towards the prescribing clinician. In states that do not mandate generic substitution, state officials have provided incentives to pharmacists by implementing differential dispensing fees based on whether prescriptions call for brand name or generic pharmaceuticals. In these states, higher fees are paid for dispensing generic over brand

drugs. At least four states (**Connecticut, Illinois, Iowa, and New York**) have implemented two-tiered dispensing fees.^{xviii}

In order to give Medicaid beneficiaries an incentive for choosing generic or lower-cost alternatives, some states charge differential co-payments for generic versus brand drugs. When generic equivalents are available, the beneficiary may be charged a higher co-payment for the brand than for the generic version.^{xix} Five states (**Indiana, Maine, Montana, New Hampshire, and New York**) currently charge differential co-payments.^{xx} While the differential co-payments are designed to affect change in utilization, pharmacies may not deny a prescription to a beneficiary based on his or her inability to pay. If the client does not pay, the pharmacy has to cover the cost. Thus, in many instances pharmacies view co-payments as rate reductions for their services, a perspective that can undermine this strategy.^{xxi}

Beyond encouraging the use of generic or lower-cost alternatives, states have found other ways to prevent waste in their prescription drug programs. In several states, prescription quantities are limited based on the type of medication. For drugs used on an acute basis, these states generally limit prescriptions to a 30- to 34-day supply. For longer-term, chronic or maintenance medications, limits are typically longer, often involving 90- to 100-day supplies.^{xxii} Supply limits, particularly for first-time prescriptions, can prevent the waste resulting from unused prescriptions. For example, a patient may receive a prescription for a new medication but realize during the course of treatment that the medication is not effective or results in unwanted side effects. If the patient discontinues use of the medication, the remainder of the prescription is wasted. Limiting the initial supply can minimize this kind of waste; **North Carolina** recently made this change in its policy, reducing the number of days for an initial prescription from a maximum of 100 days to a maximum of 34 days.

Educational Outreach

Many states have chosen to prevent wasteful and potentially harmful use of prescription drugs by educating the provider community on the most up-to-date drug therapies. **Michigan** implemented a counter detailing program in November, 2002, where pharmacists from the PBM visit physician offices and pharmacies to discuss the PDL, use of generics, prescribing patterns, and utilization patterns. In **Pennsylvania**, the state's Medical Society is under contract with the Department of Public Welfare (the agency in charge of administering the Medicaid program) to provide educational services to prescribing physicians. On their Web site (www.counterdetails.org), the medical society compiles all FDA warnings in a special "drug alerts" section. The program aims to provide Medicaid beneficiaries with improved health outcomes and to lower medical expenditures. The Center for Professional Drug Education at the Medical Society provides educational interventions as part of Pennsylvania's retrospective DUR. In addition, the Center provides educational materials to its members, such as charts comparing the costs of several drug therapies and a quarterly newsletter.^{xxiii} Changing prescribing patterns can be an effective way to improve quality and reduce costs.

Detecting Fraud, Waste and Abuse in Medicaid Pharmacy Programs

While prevention is the most desirable approach, fraud, waste and abuse still occur even with vigilant programs. States must consider ways they can detect fraud, waste and abuse to recover lost funds and to prevent future occurrences. Recent technological advances are improving states' ability to detect fraud, waste and abuse, and many have "paid for themselves" by increasing recoveries for fraudulent activities.

Profiling of both providers and clients can provide valuable information in the detection process. New electronic systems, such as Decision Support Systems (DSS) and Early Warning Systems, offer new ways

to gather and analyze data to detect fraud, waste and abuse.^{xxiv} These systems analyze potential overpayments or erroneous payments to providers through the application of standardized algorithms. Additionally, through sophisticated modeling techniques, analysts can identify patterns in the data that may indicate potential fraud, waste and abuse that is not readily apparent.

The State of **Washington** has implemented a DSS referred to as the Payment Review Program (PRP). The system provides analysts in the Medicaid agency with desktop access to several years of Medicaid claims data of value in detecting fraud, waste and abuse. For example, analysts decided to review all claims just below cost threshold because the State did not seek recoveries for wrongful payments under that dollar threshold. In a matter of minutes, analysts discovered a physician who regularly billed Medicaid at an amount just under that threshold each time he injected patients with a particular drug in his office. That drug cost the physician less than one percent of what he was billing Medicaid. By giving fraud, waste and abuse detectors in the state immediate access to claims data, Washington has increased significantly its capacity to run these algorithms and has reduced the average time for receiving the data from eight days to two minutes.^{xxv}

In addition to detecting these fraudulent behaviors through algorithms, Washington continues to implement more sophisticated statistical modeling techniques that allow Medicaid analysts to see patterns not readily apparent in the raw data. For example, the PRP can develop provider profiles that show the rate of prescriptions for a particular provider. These profiles benchmark that rate against all other similar providers in the Medicaid program. Often, results indicate a need for intervention through referrals to the state's Medicaid Fraud Control Unit. This agency not only seeks to recoup the full amount but also, in certain instances, seeks civil monetary penalties. As the state has found, interventions with a small number of providers can generate significant cost savings. Over the past three fiscal years, Washington reports it has saved over \$5 million through cost avoidance and recoveries as a result of the PRP.^{xxvi}

In addition to creating profiles of prescribers, some states generate profiles to track consumer use of prescription drugs. Client profiles can provide information to ensure that the client is receiving the most appropriate treatment and is not engaging in fraudulent or drug-abusing behavior. For example, states can review the number of pharmacies that clients are visiting. For those who visit multiple pharmacies, states can examine the prescriptions they are receiving at each pharmacy to determine whether there are duplicate prescriptions and whether a patient is receiving drugs that, in combination, are dangerous.

Along with their profiling efforts, many states perform audits on pharmacy claims, as well as on-site pharmacy audits to ensure that prescriptions are appropriate and are dispensed and billed correctly. **Tennessee** uses a vendor, ScripSolutions, to perform its on-site pharmacy audits, which include pre-visit claims audits. ScripSolutions identifies network pharmacies that meet certain criteria, such as high costs or a high number of prescriptions per member per month. For the pharmacies that meet certain criteria, ScripSolutions schedules an on-site review. Prior to the on-site audit, the auditor analyses claims and attempts to verify these claims while on-site. For example, the auditor may ask to review the hard copy of the prescription to determine whether it was filled appropriately or whether generic alternatives were offered when available. Auditors will also review the claim and reimbursement amount to ensure that they are consistent with the actual prescription filled. ScripSolutions performs these audits not only in ambulatory pharmacies but also in long-term care facilities.^{xxvii} These audits can serve two functions. First, the actual audit can uncover fraudulent behavior and lead to cost recoveries. Second, as pharmacies become aware of their possibly being audited, the threat of the audit may prevent fraud and abuse.

Considerations in Implementing Fraud, Waste and Abuse Prevention and Detection Programs

In implementing fraud and abuse prevention and detection programs, states must pay careful attention to the impact of their efforts beyond cost avoidance and recovery. Fraud, waste and abuse initiatives must neither adversely affect clinical outcomes nor block consumer access to appropriate prescription drugs. If needed medications are denied, the resulting increase in visits to doctors or emergency rooms could raise costs and clinical outcomes could suffer. As an implementation strategy, states also need to develop plans for evaluation of the clinical implications of new fraud, waste and abuse initiatives to ensure that their fraud, waste and abuse initiatives are not interfering with patient access and care. Florida produced quarterly reports analyzing how hospital and office visits changed after pharmacy management policies were implemented.^{xxviii}

States also must consider the additional administrative burden for providers when implementing these initiatives. While avoidance of additional administrative procedures can serve as an incentive for certain types of behaviors--offering generic equivalents, for example--prescribers and pharmacists may experience what they perceive to be unnecessary burdens. A claim may be blocked for an additional brand name medication even though the medication may be necessary and no generic alternative exists. Even when the claim is paid, added communication about denied claims is seen by providers as burdensome, and costly. States must ensure their mechanisms for fraud, waste and abuse control do not cause an undue number of these kinds of “false positives.”^{xxix} Additionally, building support and commitment from the provider community prior to implementing fraud, waste and abuse initiatives may ease implementation and increase the likelihood for long-term success.

States also must consider the implementation of their fraud, waste and abuse initiatives within the structure of their current delivery system. Many states provide care through one or several managed care programs. Many providers participate in both the fee-for-service and managed care systems. To ensure that fraud waste and abuse prevention and detection encompasses the entire Medicaid delivery system, the results of audits, investigations or profiles must be shared across programs.^{xxx}

Conclusion

As states continue their struggle with spiraling Medicaid costs, their ability to reduce fraud, waste and abuse may result in an effective approach that allows states to contain costs without reducing benefits and eligibility. As pharmacy expenditures continue to grow and increasingly become a larger portion of all Medicaid spending, control of fraud, waste and abuse specific to the pharmacy benefit may provide significant cost savings. Implementing and evaluating the policy choices will help states to understand the effects of new initiatives and to avoid sacrificing quality and access.

Additional Resources

“Strategies to Manage Improper Payments: Learning from Public and Private Sector Organizations,” GAO-02-69G <<http://www.gao.gov/new.items/d0269g.pdf>>.

“Guidance and Best Practices Relating to the States’ Surveillance and Utilization Review Functions,” Health Care Financing Administration <<http://cms.hhs.gov/states/fraud/surutil.pdf>>.

“Combating Health Care Fraud & Abuse: Technologies and Approaches for the 21st Century,” U.S. Department of Health and Human Services and U.S. Department of Justice <<http://cms.hhs.gov/states/fraud/tech1.pdf>>.

“Resource Guide of State Fraud & Abuse Systems,” Centers for Medicare and Medicaid Services
<<http://cms.hhs.gov/states/fraud/systmgde.pdf>>.

Endnotes

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- xi Schwalberg, R., H. Bellamy, M. Giffin, C. Miller, S. Schreiber Williams, L. Elam. (October 2001). *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights*. Kaiser Commission on Medicaid and the Uninsured. <<http://www.kff.org/content/2002/2225/2225.pdf>>
- xii In some states, such as Nevada and Montana, state officials have tried to reduce the cost of prescription drugs by suing manufacturers. These states claim that manufacturers manipulated the pricing system used in the federal rebate program such that states did not receive the level of rebates to which they were entitled. Several other states are considering litigation against manufacturers, as well. (From “States Fight to Control Drug Costs” by Andrew Caffrey, Scott Hensley and Russell Gold in *The Wall Street Journal*, posted on <http://senrs.com/states_fight_to_control_drug_costs.htm> Accessed October 1, 2002.)
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