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Office of Legislative Services
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**Pharmaceutical Assistance to the Aged
and Disabled Program
Administered by: Department of Health
and Senior Services and Department
of Human Services**

July 1, 1998 to August 17, 1999

**Richard L. Fair
State Auditor**

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President of the Senate

The Honorable Jack Collins
Speaker of the General Assembly

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Enclosed is our report on the audit of the Pharmaceutical Assistance to the Aged and Disabled Program for the period July 1, 1998 to August 17, 1999. The program is administered by the Department of Health and Senior Services and the Department of Human Services.

If you would like a personal briefing, please call me at (609) 292-3700.

Richard L. Fair
State Auditor
January 14, 2000

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**Pharmaceutical Assistance to the Aged and Disabled Program
Administered by the Department of Health and Senior Services
and the Department of Human Services**

Scope

We have completed an audit of the Pharmaceutical Assistance to the Aged and Disabled Program (PAAD) administered by the Department of Health and Senior Services and the Department of Human Services for the period July 1, 1997 to August 17, 1999. This program's financial activities are accounted for in the state's General Fund and the Casino Revenue Fund.

Total expenditures of the program during the audit period were \$512 million. The prime responsibility of the Pharmaceutical Assistance to the Aged and Disabled Program is to provide prescription benefits to those New Jersey citizens who do not meet the qualifications for medical assistance under the federal Medical Assistance and Health Services Act. The Department of Health and Senior Services is responsible for establishing and monitoring the eligibility, and payment of claims of PAAD beneficiaries. The Department of Human Services, Division of Medical Assistance and Health Services is responsible for the billing and collection of the pharmaceutical manufacturers' rebates, and performing audits and investigations of beneficiaries and participating pharmacies. Revenues of the program totaled \$71 million during our audit period and the major component of revenue was pharmaceutical manufacturer rebates.

Objectives

The objectives of our audit were to determine whether financial transactions were related to the program, were reasonable and were recorded properly in the accounting system. We also tested for resolution of significant conditions noted in our prior audit report.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, administrative code, circular letters promulgated by the State Comptroller, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview and observation and through our samples of financial transactions. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and internal control.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Sample transactions were randomly selected.

To ascertain the status of findings included in our prior report, we identified corrective action, if any, taken by the agency and walked through the system to determine if the corrective action was effective.

Conclusions

We found that the financial transactions included in our testing were related to the program, were reasonable and were recorded properly in the accounting system. In making this determination, we noted certain internal control weaknesses and matters of compliance with laws and regulations meriting management's attention.

We also found that the agency has resolved the significant issue noted in our prior report.

Generic Drug Substitution

The adoption of a provision for a lower copayment for generic drugs could provide savings to individual beneficiaries, as well as program savings.

The Pharmaceutical Assistance to the Aged (PAA) Program provides prescription drug benefits to persons 65 years of age with an income of up to \$9,000 if single or \$12,000 if married. Eligible individuals above these income limits and the disabled are funded from the Casino Revenue Fund through the Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program, which provides prescription drug benefits to persons over 65 years of age, or disabled as defined by the Federal Social Security Act, with an income of up to \$18,151 if single or \$22,256 if married. An eligible person must pay to the pharmacy a \$5 copayment for each prescribed drug, whether it is a brand name drug or a generic drug substitution. The programs pay the rest of the cost. During fiscal year 1998 and fiscal year 1999, prescription claims paid by the programs totaled \$236 million and \$270 million, respectively.

The PAAD/PAA program does not currently have in effect a two tier co-payment schedule wherein the beneficiary pays one co-pay for brand name drugs and a lower co-pay for generic drugs. In Fiscal Year 1999 there were 880,000 prescriptions filled with brand named drugs, at a cost of \$33 million, that could have been filled with a generic equivalent.

The adoption of a two-tier co-payment schedule would provide economic benefits to the eligible residents as well as possible savings to the state, as the following chart indicates for various co-payment scenarios. While we acknowledge the program would incur additional costs to the state associated with the differential between the two co-pays, it is our opinion that the lower co-pay would provide a sufficient incentive to induce a number of beneficiaries to switch to generic prescriptions to cover any additional costs. In addition, we recognize that the generic will have an impact on the amount of the drug manufacturers' rebate paid to the program, but it is believed to be immaterial.

BRAND NAME DRUGS SUBSTITUTED WITH GENERIC DRUGS DURING FISCAL YEAR 1999	2,568,117
ADDITIONAL BRAND NAME DRUGS THAT COULD HAVE BEEN SUBSTITUTED	<u>880,777</u>
TOTAL POSSIBLE FISCAL YEAR 1999 GENERIC DRUG CLAIMS	<u>3,448,894</u>

FISCAL YEAR 1999
CO-PAY ALTERNATIVES

	<u>\$5/\$1 CO-PAY</u>	<u>\$5/\$3 CO-PAY</u>
SAVINGS TO BENEFICIARY WITH REDUCED CO-PAY FOR GENERIC DRUGS	\$4	\$2
POTENTIAL SAVINGS TO BENEFICIARIES (3,448,894 TIMES CO-PAY SAVINGS)	<u>13,795,576</u>	<u>\$6,897,788</u>
GENERIC CLAIM COSTS WITH REDUCED CO-PAY	\$15	\$13
SAVINGS PER CLAIM TO PROGRAM WITH GENERIC SUBSTITUTION (AVERAGE BRAND CLAIM COST OF \$38 MINUS GENERIC CLAIM COST)	\$23	\$25
ESTIMATED MAXIMUM PROGRAM SAVINGS WITH GENERIC SUBSTITUTION (880,777 BRAND NAME DRUGS TIMES SAVINGS PER CLAIM)	\$20,257,871	\$22,019,425
LESS: ESTIMATED INCREASED PROGRAM COSTS WITH REDUCED CO-PAY (2,568,117 GENERIC DRUG CLAIMS TIMES BENEFICIARY SAVINGS)	<u>\$10,272,468</u>	<u>\$5,136,234</u>
ESTIMATED MAXIMUM NET PROGRAM SAVINGS	<u>\$9,985,403</u>	<u>\$16,883,191</u>
MINIMUM DRUG SUBSTITUTIONS NEEDED TO COVER INCREASED PROGRAM COSTS (INCREASED PROGRAM COSTS DIVIDED BY PER CLAIM SAVINGS)	446,630	205,450

Recommendation

We recommend that the Department of Health and Senior Services propose such an incentive program for action by the legislature.

Auditee's Response

I cannot support the recommendation that the Department propose an incentive program to encourage substitution of generic drugs for brand name drugs by reducing the co-pay for generic drugs to \$1 from \$5.

- I would like to remind you that a similar proposal was considered two years ago and was rejected because of vigorous opposition. One of the concerns was that a patient should not make a medical decision regarding a prescription based on financial incentive. Additionally, you should be aware that the PAAD program was complimented by a national expert at a recent conference in Washington, because the program left the decision regarding a brand versus a generic drug to the prescriber. The point is that the generic vs. brand approach is contrary to good patient care.
- Your computations of savings on page 4 are well documented. However, the text should highlight the fact that over half of the 880,777 remaining brand name drug claims that could be substituted with generics would have to be, in order for there to be a net cost savings to the program. In order for a brand name drug to be dispensed where a generic substitution is available, the prescriber must write “Brand Medically Necessary” on the prescription in order for PAAD to pay for the brand name. If “Brand Medically Necessary” is not on the prescription, the pharmacist must automatically substitute the generic drug. Thus, it would appear that for the 880,777 brand name claims that could be substituted with generics, prescribing physicians who write “Brand Medically Necessary” have thought twice about prescribing a brand name, rather than allowing a generic to be substituted.
- Also, the maximum savings estimate assumes that all prescriptions for brand name drugs that have generic substitutes would be switched to generic drug if the co-pay were reduced to \$1. We have serious concerns that this will occur, given the comments about generic drug substitution rules and prescriber practices discussed above.

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Pharmaceutical Rebates

Brand name drugs' "consumer price index" as reported by pharmaceutical manufacturers should be independently verified.

As a condition of manufacturer participation in the Pharmaceutical Assistance to the Aged and Disabled Program (PAAD), New Jersey Statute 30:4D-35 requires manufacturers of pharmaceutical products to enter into an agreement with the Division of Medical Assistance and Health Services to provide a rebate to the state based on the amount of the manufacturers' pharmaceutical products purchased by the PAAD program. The statute also mandates the deduction of an element of the rebate known as the Consumer Price Index penalty (CPI). The Division of Medical Assistance and Health Services relies on each manufacturer to calculate and report the CPI for each drug purchased. DMAHS is unable to verify the propriety of the reported CPIs without performing on-site audits of the manufacturers.

The PAAD rebate program is modeled after the federal Medicaid drug rebate program for states. The federal Health Care Financing Administration (HCFA) provides DMAHS with the Medicaid rebate rates that includes the CPI and each drug's base rebate. The HCFA rate is a combined figure that does not disclose the value of its elements. DMAHS has been unsuccessful in obtaining each drug's rebate elements from HCFA due to privacy concerns. In addition, the unpredictability of pharmaceutical pricing make quarter-to-quarter comparisons impractical.

Independent verification of the CPI is needed to ensure the propriety of the CPI used in the calculation of the rebates. The lack of verification could result in the manufacturers inflating the CPI to reduce the rebate due to the PAAD program.

DMAHS estimates that the deduction of the reported CPI has reduced the rebates by \$69 million from \$344 million to \$275 million since the inception of the rebate program in fiscal year 1993 to March 31, 1999.

Recommendation

We recommend that the Division of Medical Assistance and Health Services continue to pursue sources that will allow them to independently verify the manu-

facturer reported CPI. Should the division be unable to obtain the data, they should conduct on-site audits at the manufacturers.

Auditee's Response

DMAHS continues to outreach the Health Care Financing Administration in Washington regarding the exchange of CPI Component information. As of September 15, 1999 no action had been taken.

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Outstanding Pharmaceutical Rebates

Outstanding disputed pharmaceutical manufacturer rebates have accumulated to \$22 million.

New Jersey Statute 30:4D-35 requires manufacturers of pharmaceutical products enter into an agreement with the Division of Medical Assistance and Health Services (DMAHS) to provide a rebate to the state based on the amount of the manufacturers' pharmaceutical products purchased by the PAAD program. Our audit of PAAD rebate revenues found \$22 million in outstanding disputed rebates that have accumulated since the inception of the rebate program in fiscal year 1993 to March 31, 1999. During our audit period, we found no evidence that DMAHS was actively pursuing to resolve these disputes. These outstanding balances represent the differences between the billed quarterly rebate and the amount that the manufacturer remits. Manufacturers remit less than they are billed because they do not agree with the drug usage amounts, or they fail to report the CPI for each of their drugs and DMAHS over-stated the bill by using the HCFA rate which includes the CPI.

As of the close of our field work, DMAHS had hired one staff person to work solely on resolving and collecting these outstanding balances.

Recommendation

We recommend that DMAHS continue its efforts to resolve and obtain collection of disputed rebates.

Auditee's Response

DMAHS has completed interviewing candidates for the Health Care Consultant position. A candidate was selected and we are preparing the paperwork for approval by the Governor's Office. With two staff

members dedicated to the PAAD Rebate Program we expect progress resolving outstanding disputes.

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Third Party Recovery Services

The Division of Medical Assistance and Health Services needs to reinstate or replace the contract for third party liability recovery services.

In accordance with N.J.A.C. 8:83-5.5d the Department of Health and Senior Services is required through the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) to recover benefits paid on behalf of a PAAD beneficiary who is found to have third party insurance coverage. The DMAHS Bureau of Third Party Liability contracted with Health Management Systems (HMS) to supplement their identification of beneficiaries with better prescription coverage and third party liability recovery activities. The contract period was from April 14, 1993 to April 13, 1996 with provisions for two one-year renewals. As of the expiration of the second one-year renewal in April 1998, the contract was terminated and a new contract was not sought.

HMS is not authorized to process, bill or collect on current claims. HMS is only authorized to continue to recover claims with service dates prior to the expiration of the contract. In fiscal year 1999 HMS collected \$1.2 million relating to these claims. This is \$2.2 million less than the average \$3.4 million collections for fiscal years 1996 to 1998.

As of the close of our field work, the Bureau of Third Party Liability had initiated a Request for Proposal for these recovery services.

Recommendation

We recommend that the Bureau of Third Party Liability be timely in securing third party liability recovery services.

Auditee's Response

The Bureau of Third Party Liability has extended the previous contract with Health Management Services until a new vendor is chosen and will advertise for a new vendor by publishing a Request for Proposal in early November 1999.

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