Medicaid Prescription Payments

Report Number 2018-05

July 14, 2020

Utah Office of
Inspector General

Gene Cottrell
Inspector General

July 14, 2020

To: Utah Department of Health

Please see the attached report, Medicaid Prescription Payments, Report 2018-05. An Executive Summary is included at the inception of this report. An explanation of the audit's objectives and scope is located on page 6 of this report.

Sincerely,

Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Justin Harding, Chief of Staff, Office of Governor Gary R. Herbert
J. Stuart Adams, President of the Utah Senate
Brad Wilson, Speaker of the Utah House of Representatives
Joseph Miner, MD, MSPH, Executive Director, Utah Department of Health
Nathan Checketts, MPA, Deputy Director, Medicaid & Health Financing
Emma Chacon, Medicaid Division Operations Director
Eric Grant, Medicaid Assistant Division Director
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EXECUTIVE SUMMARY

The Utah Office of Inspector General (UOIG) initiated an audit of the Utah Medicaid pharmacy program and non-controlled prescription drug claims.

Utah Rule 414-60-4(2), in accordance with Subsection 58-17b-606(4), states:

When a multi-source A-rated legend drug is available in the generic form, Medicaid will only reimburse for the generic form of the drug unless:

(a) reimbursing for the non-generic brand-name legend drug will result in a financial benefit to the State; or

(b) the treating physician demonstrates a medical necessity for dispensing the non-generic, brand-name legend drug.[1]

UOIG retrieved all paid non-controlled prescription drug claims for January 2018-March 2018 from the data warehouse. During that 3-month period, there were 586,726 claims that totaled an estimated $51 million. Of those claims, 228,008, or 38.87%, initially appeared to pay both brand name and generic versions for the exact same drug, totaling an estimated $9.5 million dollars. The data included both Accountable Care Organizations (ACO's) and Fee-for-Service (FFS) claims.

Audit Objectives:

- Determine if prescription claims paid properly according to both Federal and State policy.
- Determine Utah Medicaid's adherence to pharmacy policy and procedures.

Audit Findings:

- Claim Review Limitations Exist.
- Inaccurate or Incomplete Prescription Claims Data Found in the Medicaid Data Warehouse.
- Standard Operating Procedures and Training Have Improved.

Utah Medicaid Pharmacy Program policy and procedures are functioning with no significant risk of fraud and abuse. Recommendations to address waste and better business practices are outlined within this audit report.

UOIG later determined from the sample, no claims paid both brand name and generic version for the same drug. However, UOIG found claims data that indicated claims paid non-preferred. UOIG was not able to determine if all claims were paid properly with inaccurate and incomplete data in the data warehouse and with limited information available to UOIG. UOIG cannot conduct future independent audits with these limitations.

[1] Utah Administrative Code retrieved September 21, 2018 from https://rules.utah.gov/publicat/code/r414/r414-60.htm#T4

This was not an audit of Utah Medicaid pharmacy providers, prescribing providers or recipients of prescription drugs. Therefore, the potential of fraud, waste and abuse could be occurring within the provider and recipient community that is not within the scope of this audit.

INTRODUCTION

BACKGROUND

The Utah Office of Inspector General (UOIG) initiated an audit of the Utah Medicaid pharmacy program and non-controlled prescription drug claims.

Utah Rule 414-60-4(2), in accordance with Subsection 58-17b-606(4), states:

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UOIG retrieved all paid non-controlled prescription drug claims for January 2018-March 2018 from the data warehouse. During that 3-month period, there were 586,726 claims that totaled an estimated $51 million. Of those claims, 228,008, or 38.87%, initially appeared to pay both brand name and generic versions for the exact same drug, totaling an estimated $9.5 million dollars. The data included both Accountable Care Organizations (ACO's) and Fee-for-Service (FFS) claims.

Drug pricing and rebates, drug preferred status, prior authorization (PA), and use of "Dispense As Written" language are factors used in determining payment of FFS prescription drugs. Each of these terms are discussed below.

Pricing and Rebates

Utah Medicaid bases pricing for FFS prescription drugs on the net cost after primary and secondary rebates. Utah Medicaid only covers prescription medications that are eligible to be paid for with federal funds. For a prescription medication to be eligible for coverage, the manufacturer must participate in the federal drug rebate program.[3] Sometimes pharmaceutical manufacturers also offer a secondary rebate in order for their drug to be a preferred medication. Rebates and pricing are complex. Utah Medicaid stated UOIG could not have access to pricing information and therefore UOIG could not determine proper payment of claims based on pricing.

[2] Utah Administrative Code retrieved September 21, 2018 from https://rules.utah.gov/publicat/code/r414/r414-60.htm#T4

[3] Utah Medicaid Pharmacy Services Provider Manual, January 2018, 4-2, p6 retrieved July 9, 2019 from https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Pharmacy/Archive/2018/Pharmacy1-18.pdf and Utah Code 58-17b-606 retrieved July 9, 2019 from https://le.utah.gov/xcode/Title58/Chapter17B/58-17b-S606.html

Preferred Status

Medicaid uses many tools including the Preferred Drug List (PDL)[4] and the Brand over Generic (BOG) list,[5] to encourage the use of less expensive, clinically efficacious and cost effective therapies. The Pharmacy and Therapeutics (P&T) Committee advises the Drug Utilization Review Board (DURB) and the Division of Medicaid Health Financing (DMHF) in choosing preferred agent(s) for each selected class of drugs based on safety and clinical efficacy. The DURB provides evaluation of criteria for drug coverage within the Medicaid program. If the brand name version has a lower price, if there is a a drug shortage of the generic or if there is no generic version available on the market, the brand name would pay, barring any other exceptions later addressed in this report. Placement on the PDL is also based on recommendations from the P&T committee and DURB, for instance, certain drugs need to have a long acting formula and other drugs need a formula appropriate for children.

Prior Authorization (PA)

The January 2018 Pharmacy Provider Manual states:

> Non-preferred medications require prior authorization from the prescriber and must satisfy one of the following:
>
> - The member has had a trial and failure of at least one (1) preferred agent in the drug class.
> - There is evidence of a potential drug interaction between the member's current medication regimen and the preferred drug(s).
> - There is evidence of a contraindication that prevents the member from using the preferred drug(s).
> - There is objective clinical evidence that the member is at high risk of adverse events due to a therapeutic interchange with a preferred drug.[6]

Dispense As Written (DAW) Code "1"

"If a prescriber writes "dispense as written" on a prescription for a non-preferred psychotropic drug, the pharmacy may submit a Dispense As Written (DAW) Code of "1" on the claim. Submitting the DAW code will allow the claim to bypass the prior authorization requirement for the non-preferred drug psychotropic drug at the point-of-sale.

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[4] Example of PDL list- Retrieved July 8, 2019 from https://medicaid.utah.gov/pharmacy/PDL/files/PDL%20Archive/2018/Utah%20Medicaid%20PDL%20(01-01-18).pdf

[5] Example of Brand Over Generic List retrieved July 9, 2019 from https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Pharmacy/Attachments/Brand_Over_Generic_Drugs.pdf

[6] Utah Medicaid Pharmacy Services Provider Manual, January 2018, retrieved July 9, 2019 from https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Pharmacy/Archive/2018/Pharmacy1-18.pdf Section 4-4 page 8

NOTE: The DAW Code will not allow claims for the brand-name version of multisource drugs to process, even though the brand-name version of the drug is listed as non-preferred and the prescriber writes "dispense as written" on the prescription. If a Medicaid member needs the brand-name version that is listed as non-preferred, a prior authorization request must be submitted to Utah Medicaid"[7]

UOIG identified, in the data, 18,628 claims submitted with the DAW "1" code for non-controlled psychotropic prescription drugs totaling approximately $6.4 million.

DAW "1" coded prescriptions on file with the pharmacy were not reviewed to verify if specific "dispense as written" wording was used according to policy.

OBJECTIVE AND SCOPE

Audit Objectives:

- Determine if prescription claims paid properly according to both Federal and State policy.
- Determine Utah Medicaid's adherence to pharmacy policy and procedures.

Audit Scope:

January 2018 through March 2018 non-controlled prescription drug claims.

Audit Scope Limitations:

Utah Medicaid stated UOIG could not have access to pricing information. Therefore , if a drug was preferred or non-preferred based on pricing reasons, UOIG relied on Utah Medicaid self-reporting. Restricted access to pricing leads UOIG to rely on data to determine proper payment of claims. As you will see in finding two of this report, UOIG found missing or inaccurate prescription claims data in the data warehouse. UOIG cannot rely on prescription claims data in the data warehouse and therefore cannot conduct independent claim reviews.

UOIG chose to review non-controlled substances because controlled substances are heavily regulated by both the Federal and Utah governments and claims are continually monitored by Utah Medicaid. Therefore, for the scope of this audit, controlled substance claims,[8] such as opioids, were not included. This audit is only a review of a portion of Utah Medicaid policy and procedures relating to non-controlled prescription drug claims.

[7] Utah Medicaid Pharmacy Services Provider Manual, January 2018, retrieved August 29, 2018 from https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Pharmacy/Archive/2018/Pharmacy1-18.pdf

[8] See DEA explanation of controlled substances retrieved July 9, 2019 from https://www.dea.gov/controlled-substances-act

METHODOLOGY

Researched Federal, State and local Utah Medicaid pharmacy policy and procedures for non-controlled prescription drug claims.

Discussed pharmacy policy and procedures with Utah Medicaid management and staff.

Communicated with Medicaid's contracted pharmacy benefit administrator, Change HealthCare (CHC), to understand processes and procedures.

Extracted and analyzed data from the data warehouse for all non-controlled prescription drug claims paid January 2018- March 2018. Researched non-controlled prescription drug claims that paid both generic version and brand name version for the same drug.

Accessed the Utah CHC Point of Sale (POS) system to review adjudicated claims to determine why claims paid both brand name and generic version for the same drug and if there was a PA or other exception for the claim.

Examined claims with Medicaid staff to determine why claims paid both brand name and generic version for the same drug.

FINDING 1: CLAIM REVIEW LIMITATIONS EXIST

The four Utah Accountable Care Organizations (ACOs), Medicaid agencies in other states and throughout the private sector, have the advantage of reviewing claims real-time and are able to run test claims prior to the pharmacy submitting a prescription drug claim to Medicaid.

Utah Medicaid has the capability to view real-time claims; however, they do not have the ability to see specific claim details for a recipient in real-time. One recipient may have several claims processing all at once. The specific claim details do not populate per recipient, therefore, if the recipient has several claims processing at the same time, Medicaid staff must click on every claim to research the one in question. The ability to see all claim status by recipient could save time for the pharmacy, provider, recipient and Utah Medicaid staff.

Utah Medicaid also cannot run test claims. Several Medicaid staff spend as much as five hours a day trouble shooting calls on claims that are not processing correctly. Sometimes several scenarios are run to figure out why the claim is not being accepted causing extra, perhaps unnecessary, time spent by the pharmacy, Medicaid staff and the recipient.

At times claims are paid with a manual over-ride. Utah Medicaid receives a weekly over-ride report. When that report is reviewed an improper payment may be found. If the improperly paid claim is not discovered right away, if at all, that could result in waste of Medicaid funds. Testing claims beforehand results in reducing manual over-rides, reduces the need to review reports after claims pay, avoids reprocessing improperly paid claims and significantly reduces the risk of loss of Medicaid funds.

Inquiries into why a claim is not processing causes wasted time and money for pharmacies as well as Utah Medicaid. Pharmacies submit claims to a switch company, which routes the claims to the appropriate payer. Utah Medicaid staff state that if the claim is rejected the pharmacy pays a small fee to the switch company. Medicaid testing the claim beforehand avoids the rejected claim fee for the pharmacy. Labor costs are reduced for the pharmacy provider and eliminate the need for staff to spend extra time waiting on the phone and chasing down the cause for the rejection. It is a benefit for all parties involved to work together to administer the Medicaid program with the most cost-effective and efficient practices.

A higher concern is that of a recipient not able to receive a prescription because there is a problem processing the claim outside of Medicaid operating hours. There are instances where even though there is a PA for a specific drug for a patient the system rejects the claim. System edits, such as refill too soon, dose increase limitations and patient eligiblity for other Medicaid plans, may cause the claim to reject.

Claims that require a PA could be tested beforehand to ensure the recipient will not go without the needed medication outside of Medicaid operating hours and provides better care to Medicaid recipients.

These enhanced capabilities:

- reduce claim submission errors thus ensuring claims would pay properly before adjudication and eliminate the need for claim reprocessing;
- decrease the need to review reports to discover improperly paid claims;
- increase staff productivity in reduction of sorting through every live claim to find the one claim detail in question;
- reduce time spent by both Medicaid staff and pharmacies when trouble shooting why a claim is not paying;
- avoid fees paid by pharmacy providers for a rejected claim; and
- assure the recipient will receive the medication when needed.

In addition to the above claim review limitations, Medicaid staff report CHC software portals are cumbersome and outdated compared to the private sector. Medicaid staff use multiple portals to perform essential job functions. For instance, one portal is used for PA's, one portal for rejected claims and one portal for paid claims. Use of multiple portals results in an inefficient use of time and could result with inaccurate data. Current software portals do not interface and can have redundant information. Staff who have previously worked in the private sector indicate they were able to work more efficiently with better and condensed software portals.

Some report reviews are necessary but medicaid staff stated some of the reports are not meeting the needs of the users, are non-efficient, are sent in pdf format and are untimely. Staff indicated the need to have the over-ride report more quickly rather than weekly so as to catch improperly paid claims in a timely manner. Also, staff requested to have more data fields and filter capabilities with other reports. Requesting a change to a report can be costly, one recent request to add additional data fields cost Utah Medicaid $5,200. Discussing software and report needs with staff, then working with the vendor to implement those requested capabilities, could result in cost savings and improve staff morale.

RECOMMENDATIONS

1.1 We recommend Medicaid contract with a third party vendor to create the ability, like that of Utah's ACO's, other states' Medicaid agencies and the private sector, to review all claim details in real-time by member.

1.2 We recommend Medicaid contract with a third party vendor to create the ability, like that of Utah's ACOs, other states' Medicaid agencies and the private sector, to run test claims before adjudication.

1.3 We recommend Medicaid contract with a third party vendor to update and improve software portals.

1.4 We recommend Medicaid contract with a third party vendor to provide updated reporting capabilities, that are timely and user friendly.

1.5 We recommend consistent and timely review of claim over-rides to ensure prescription claims are paid according to Utah Medicaid policy.

FINDING 2: INACCURATE OR INCOMPLETE PRESCRIPTION CLAIMS DATA FOUND IN THE MEDICAID DATA WAREHOUSE

UOIG reviewed claims data from the Medicaid data warehouse. UOIG initially ran data that showed claims paid both brand and generic for the same drug. UOIG provided a sample of those claims to Medicaid for review. Utah Medicaid explained that even though the drug name was the same, each drug had a unique National Drug Code (NDC). Payment for prescription drugs is based on the NDC and not the name of the drug. Utah Medicaid also provided information on data fields that included additional information such as Preferred (P) and Non-Preferred (NP) status. Upon merging original data with new fields UOIG found no claims paid both brand and generic when the specific NDC was added, however the new data pull, which added P/NP status, resulted in more questionable claims. For example:

- Data fields listing P/NP status were blank.
    - Out of the 228,008 claims there were 60,190 that were missing P/NP indicators completely. If UOIG added the P/NP data field with the initial data pull, those 60,190 claims would not have appeared in the data because that field did not have any data populated. Out of the 228,008 claims there were 18,081 FFS claims and 42,109 ACO claims that had no data indicating if it was P/NP. Medicaid stated the fields with blank data could indicate a drug did not have PDL status. However, there are over 4,000 psychotropic FFS claims that are drugs listed on the PDL that are missing P/NP status. UOIG review could not rely on that field information and those claims had to be researched one by one and with the aid of Medicaid staff to determine if the claims paid properly.

- Data fields indicated claims paid NP.
    - There were 10,234 FFS and 14,889 ACO claims that had NP indicators. UOIG had to rely on Utah Medicaid to research why those claims paid NP. Utah Medicaid found the FFS claims were actually paid properly and do not know why the claims show NP in the data. UOIG cannot rely on the FFS published PDL list to see if the drug is preferred because the PDL list shows the drug name and usually does not list P/NP status at the NDC level. Although the drug name shows NP on the PDL, the NDC may actually be preferred. Also, ACO's may have different P/NP status than FFS. UOIG has to rely on the P/NP field in the data warehouse to show the proper P/NP status. While UOIG is aware that ACO's may have different P/NP status than FFS claims, all data in the data warehouse should still accurately reflect this status.

- PA data was either missing or inaccurate.
    - According to Utah Medicaid's review of NP claims, some had a PA to explain the reason the claim paid. However, there was no PA information in the data warehouse. Also, fields that did have PA information, such as the PA effective date, were not populated with the actual PA effective date and UOIG was told by

Medicaid staff that having a PA effective date in the data did not mean there was an actual PA on the claim and that the PA effective date listed in the data could be incorrect.

- UOIG does not have access to over-ride and exception notes in the data warehouse.
    - Medicaid revealed some of the above questionable claims paid with an over-ride or exception. UOIG does not have access to the data which notes the reason for the exception and over-ride and therefore UOIG would not know the reason why the claim paid based on an over-ride or exception.

- ACO's paid claims that were carve-out drugs[9] that should have been paid FFS.
    - There are 830 claims for carve-out drugs that should have been paid FFS. The carve-out drugs can be expensive. ACO costs are higher because the ACO paid for drugs that were supposed to be paid FFS. This could potentially increase the dollar amount ACO's request from Medicaid.

It is important to note that the 228,008 claims reviewed were the claims that appeared paid both brand and generic for the same drug. The numbers listed in this finding could be higher had UOIG looked at all 586,726 FFS and ACO claims for P/NP status and PA information.

UOIG and Utah Medicaid staff took significant time to research claims and had to retrieve the information in the CHC POS system because the information was missing or inaccurate in the data warehouse. Although Utah Medicaid pharmacy staff were very willing and helpful in researching claims this resulted in extra time and research for both UOIG and Utah Medicaid staff.

Missing information in the reviewed data sample did not appear to affect whether a claim adjudicated properly. However, missing or inaccurate data information made it impossible for UOIG to review claims independent of Medicaid staff. In order for the UOIG to maintain independence in performing audits of the Utah Medicaid program, all fields must contain complete and accurate data. Complete and accurate data also saves time for Medicaid staff by giving them the ability to review claims in a reliable report rather than researching individual claims in the CHC POS system.

Regardless of whether the claim is ACO or FFS, all data in the warehouse should show complete and accurate information.

[9] Utah Medicaid Pharmacy Services Provider Manual, January 2018, 4-2, p13 retrieved July 9, 2019 from https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Pharmacy/Archive/2018/Pharmacy1-18.pdf

RECOMMENDATIONS

2.1 Utah Medicaid needs to research why claims data fields in the data warehouse are missing information or have inaccurate information. Data should indicate accurate P/NP status and if NP status is indicated there should be PA information, over-ride exception or other notes indicating the reason the claim paid even though the status is NP. Going forward we recommend Utah Medicaid ensure all prescription claims data in the data warehouse for both ACO and FFS claims has complete and accurate information.

2.2 We recommend Utah Medicaid, after the conclusion of this audit, discuss and coordinate with UOIG to provide data and information that will allow independent audits. We also recommend continual collaboration going forward.

FINDING 3: STANDARD OPERATING PROCEDURES AND TRAINING HAVE IMPROVED

During the scope of this audit, UOIG discovered that one individual staff member was responsible for maintenance of the weekly drug file. The weekly drug file is a critical task in the pharmacy department. The weekly drug file is a list of new drugs sent to Medicaid by third party vendor CHC. Medicaid must review those drugs and ensure they are coded per policy, and then return the file to CHC by the end of the business day it is received. CHC then uploads the appropriate coding for those drugs into the POS system. Untimely filing of this report or incorrect information means prescription drugs are not coded correctly per policy which then causes the claim to pay improperly. UOIG posed the question of what would happen if that staff member were not able to perform that task, such as taking time off or becoming ill.

The staff member performing that task indicated other staff would perform the work for the weekly drug file, if needed. However, there was not a written procedure or training during the scope of this audit. Other staff indicated they were not comfortable performing that critical task.

Utah Medicaid has since established a written standard operating procedure and training for review and submission of the weekly drug file. Additionally, Utah Medicaid implemented the control of another staff member double checking the file for accuracy.

Although certain other standard operating procedures and cross training were not in effect during the scope of the audit, current Medicaid pharmacy procedures provide consistency in staff training and enable staff to perform one another's duties.

RECOMMENDATIONS

3.1 Continue regular staff training and development of standard operating procedures.

3.2 Provide cross training to enable staff to comfortably perform one another's duties.

APPENDIX A :
UTAH MEDICAID PREFERRED DRUG LIST FOOTNOTES

Utah Medicaid Preferred Drug List Explanations

Last Modified September 1, 2018

Explanations

Drugs not listed on the PDL are covered via regular pharmacy provider manual policy.

A drug listing on the PDL consists of 3 columns on one line. From left to right, these are the Brand/Generic indicator, the drug name, and the date that listing was last updated. The general convention used for the PDL is that the more generic the listing is, the broader the listing encompasses. For example, if there are several strengths and dosage forms available for a particular drug within a class, a simple listing of the generic name would indicate that all generic strengths, dosage forms, and formulations for that drug in that class are implied. The same principle applies to branded drugs. In some cases, formulations of a drug may fall in multiple classes - for example some contraceptives and some topical preparations. When the strength and/or dosage form is included in a listing, that narrows the listing to those particular strengths and/or dosage forms. A comma may be used to delineate multiple strengths, dosage forms, or formulations.

For example:

Drug ER indicates that only the ER formulation is part of that listing.

Drug, ER indicates that both the immediate release and ER formulations are part of that listing.

- If a footnote symbol is in the class name, the notation applies to the entire class; if a footnote symbol is after a drug name, the notation applies to that drug specifically.
- If a footnote symbol is before a strength, dosage form, or formulation, only those preceding the notation are covered by the notation.
- Unless otherwise noted, over-the-counter (OTC) products are not included on the PDL. A complete listing of covered OTC products can be found in the OTC reference.
- If a brand and generic have the same status (i.e. both are preferred or both are non-preferred). The generic name will be in parentheses ().
- Information in brackets [] indicates important notes about a drugs (i.e. specified strengths or formulations that are part of, or excluded from that drug's status).
- Within a drug class, "failure" on a preferred drug must be on a drug with a similar dosage form and use/indication to the requested drug where possible.
- For non-preferred combination products, if the separate single ingredient products are preferred, those must be tried before the non-preferred product will be approved
- For non-preferred drugs that have a dosage form or indications/general usage that are similar to a preferred drug, the similar drug must be failed before the non-preferred drug will be approved.
- For non-preferred drugs that have a preferred strength or dosage form on the PDL, the preferred strength or dosage form must be tried before the non-preferred strength will be approved.
- Kits - Utah Medicaid does not generally reimburse for dosing kits. Unless a product is only available in a kit, this form must be used prior to requesting a PA for a kit.
- The dosage form is generally not included in a listing unless a drug is available in more than one dosage form and they do not all have the same status (preferred or non-preferred).
- If multiple dosage forms of a drug are available, but the drug is only listed once (i.e. preferred or non-preferred), it is implied that all dosage forms fall under that listing.
- New changes made in the current release of the PDL have the date highlighted in yellow.
- Non-preferred Drugs require a Prior Authorization effective 5/15/2009.
- If a non-preferred drug requires a clinical prior authorization, the clinical PA form AND the non-preferred PA form must be submitted.
- If a new formulation of a listed drug comes to market, unless otherwise noted, that new formulation is included in the simple listing for that drug.
- The date column indicates the date that listing was last updated. This may include changes to the status (preferred/non-preferred) or a change to the way the drug is listed. A date older than the release of a new form of a drug does not mean the newer form is excluded from that listing.
- For information pertaining to the Tobacco Cessation Program please refer to: https://medicaid.utah.gov/tobacco-cessation-program. Additional information can be found at http://www.health.utah.gov/umb/TobaccoCessationBenefits.pdf.

[10]

[10] Retrieved 9-26-18 from https://medicaid.utah.gov/pharmacy/PDL/files/PDL%20Key.pdf

Utah Medicaid Preferred Drug List Footnotes

Last Modified May 1, 2019

Symbols and Footnotes		
*	Clinical PA required	PA Critera Forms
**	Clinical PA required in some cases - see specific PA criteria for details	
†	Brand Required Over Generic.	Refer to Brand Over Generic (BOG) reference in the Resource Library
‡	Quantity Limits Apply.	Drug Criteria and Limits Attachment to the Pharmacy Manual
#	Listed on the 90-day supply list	Utah Medicaid 90-Day Supply Medication List
##	Must be dispensed directly to the provider, not the patient	
^	Added to reference before dates were tracked	
^^	Part of more than one PDL drug class	
¶	Indicates that additional pertinent information can be found in the center area between preferred and non-preferred drugs	
J	Covered under the medical benefit using the appropriate J code	
Q	Covered under the medical benefit using the appropriate Q code	
§	Step Therapy required. Must fail another preferred agent first	
§§	Pursuant to HB 437, passed during the 2016 General Session, Utah Medicaid began placing psychotropic drugs on the Preferred Drug List (PDL) effective July 1, 2016. For the purposes of the Preferred Drug List, psychotropic medications are defined as atypical antipsychotics, anti-depressants, anti-convulsants/mood stabilizers, anti-anxiety medications, and attention deficit hyperactivity disorder (ADHD) stimulants. Non-preferred psychotropic medication classes listed on the PDL may bypass the non-preferred drug prior authorization if a prescriber writes "dispense as written" on a prescription and the pharmacy submits a Dispense As Written (DAW) Code of "1" on the claim. Note: In accordance with UCA 58-17b-606 (4) and (5), the DAW Code will not allow claims for the brand-name version of multisource drugs to bypass the prior authorization requirement, even if the brand-name version of the drug is listed as non-preferred and the prescriber writes "dispense as written" on the prescription. An exception to this is in the case that a brand-name drug is listed on the Brand Over Generic reference; in that case, the DAW Code will only override the brand-name drug. Note: In order for a prescription to be eligible for the pharmacy to submit the DAW Code of "1" to bypass the edit for a non-preferred medication the prescriber must write "dispense as written" on the physical prescription. Check boxes or pre-printed forms that include "dispense as written" are not acceptable substitutes for the prescriber writing "dispense as written" on the prescription. Electronic prescriptions must state "dispense as written" as either a note or as part of the prescription drug order to satisfy this requirement. Verbal orders that include "dispense as written" must be reduced to writing on the prescription by the pharmacist accepting the verbal order and documented in the member's medical record.	
***	The following meter NDCs are covered through Medicaid: Abbott 99073-0711-43 99073-0709-14 99073-0708-05 57599-8814-01 57599-5175-01 True Metrix 56151-1490-02 56151-1470-02 56151-0888-80 Abbott meters may also be billed to the manufacturer using the following: RxBIN: 610020 Group number: 99992432 ID: ERXUTMED Free for Medicaid members Diabetic test supplies are not covered for Nursing Home clients. Non-preferred products must be billed through DME.	

Utah Medicaid Preferred Drug List Key

Last Modified May 1, 2019

Key

Selected Abbreviations

Drug Name		Dosage Form	
amph	amphetamine	aug	augmented
apap	acetaminophen	cap	capsule
asa	aspirin	chw	chewable
bac	bacitracin	con	concentrate
bp	benzoyl peroxide	crm	cream
but	butalbital	emul	emulsion
caf	caffeine	inj	injection
damph	dextroamphetamine	liq	liquid
dhe	dihydroergotamine	lot	lotion
dmph	dexmethylphenidate	loz	lozenge
ee	ethinyl estradiol	neb	nebulization solution
hc	hydrocortisone	ODT	orally disintegrating tablet
hctz	hydrochlorothiazide	oint	ointment
ibu	ibuprofen	shmp	shampoo
mph	methylphenidate	SL	sublingual
poly	polymyxin	sol	solution
sa	sulfacetamide	sup	suppository
ss	sodium sulfacetamide	susp	suspension
tac	triamcinolone	syp	syrup
		tab	tablet

Brand/Generic		Salt Form	
B	Brand	buty	butyrate
BG	Both Brand and Generic	dip	dipropionate
G	Generic	Fe	iron
		Fl	fluoride
		HCl	hydrochloride
		mag	magnesium
		Na	sodium
		$NaHCO_3$	sodium bicarbonate
		$NaPO_4$	sodium phosphate
		pam	pamoate
		str	Strontium

GLOSSARY OF TERMS

Term	Description
ACO	Accountable Care Organization- Medicaid contracted health care entitity organized to provide health benefits for Medicaid members in order to manage cost, utilization and quality of services. ACO's accept a set per member per month (capitation) payment for services. The objectives of these contracts are to reduce Medicaid program and costs, and improve health plan performance and health care quality and outcomes.
BOG	Brand Over Generic-List that indicates which brand name drugs are preferred over the generic version
CHC	Change HealthCare- Utah Medicaid's Pharmacy Benefit Manager
DAW	Dispense as Written- Pharmacies submit a DAW code when entering a claim which indicates why the pharmacist used a certain brand name or generic drug. There are 9 codes. The code that is utilized for psychotropic drugs to bypass the PA requirement is DAW "1". See Appendix A pg 2 for further information on DAW "1" use.
DURB	Drug Utilization Review Board (See Page five for further understanding)
P&T	Pharmacy and Therapeutics Committee - advises on the safety and efficacy of a drug
PA	Prior Authorization
PDL	Preferred Drug List
POS	Point of Sale- Pharmacy claims processing system which Utah pharmacies utilize to submit electronic claims, currently administered by CHC
UOIG	Utah Office of Inspector General

MANAGEMENT RESPONSE

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

JOSEPH K. MINER, MD, MSPH, FACPM
Executive Director

Division of Medicaid and Health Financing

NATE CHECKETTS
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

June 23, 2020

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

Thank you for the opportunity to respond to the audit titled *Medicaid Prescription Payments* (Report 2018-05). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe the results of our combined efforts will make a better, more efficient program.

We concur with several of the recommendations in this report, as noted below. The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas needing improvement.

Sincerely,

Emma Chacon
Emma Chacon (Jun 23, 2020 16:41 MDT)

Emma Chacon
Operations Director,
Medicaid and Health Financing

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Response to Recommendations

The Department is including additional background information in this response to assist other readers to further understand the complex program areas addressed in the report, what steps have been taken by the Department and what additional steps still need to occur. The Department's specific responses to each audit recommendation are stated below.

Background

Extracting Claims Data from the Data Warehouse

Medicaid pharmacy data comes from a variety of sources. Extraction and interpretation of this data requires a level of technical expertise combined with an expert level of familiarity with the data structure. Department staff initially consulted with UOIG to assist in the accuracy of the data accessed by the OIG. The Department was not given access to the final data set used by the auditors. In addition, the Department was unable to replicate the results produced by the auditors. Following is an example:

On Page 1 and repeated on Page 3, the report notes a base of 586,726 claims. The Department was only able to find 573,670 claims meeting the criteria anticipated to have been used by the UOIG. The claims identified by the Division were 55% ACO and 45% FFS claims.

Accountable Care Organization (ACO) vs Fee-for-Service (FFS) Pharmacy Coverage

Given the stated audit objectives, it appeared appropriate to only include FFS data in this report. If the intent of the audit objectives was to cover FFS and ACO pharmacy claims, then specific criteria for both types of claims is warranted. On May 15, 2020, the Department provided following information to the UOIG:

> The contracts with the ACOs (Section 4.1.2(A)) state: "The Contractor shall administer Covered Services, when Medically Necessary, in a manner that is no more restrictive than the state Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in state statutes and regulations, the State Plan, and other state policies, procedures, and administrative rules." This means that ACOs cannot be more restrictive than FFS in their pharmacy benefit coverage; however, ACO's pharmacy coverage is not expected to "match" FFS coverage. Because of this, ACO's have the flexibility and authority to establish their own reimbursement methodology, adjudication edits, preferred/non-preferred status, brand over generic policy, etc. Accordingly, brand/generic assignment or preferred/non-preferred status may be different between and among FFS and the four ACO pharmacy plans. To evaluate ACO pharmacy claims against FFS coverage policy is inaccurate and may result in a misrepresentation of facts.
>
> If the OIG intends to review both FFS and ACO pharmacy claims, we suggest the two be distinctly reviewed independently. For example, one of the current audit objectives is to "determine why there are paid claims for both the brand name and generic version for the same drug." The potential coverage differences between FFS and ACOs is a great example of an area that FFS and ACOs coverage likely diverge. UCA 58-17b-606(5) states: "The Department of Health pharmacists may override the generic mandate provisions of Subsection (4) if a financial benefit will accrue to the state." FFS has brand over generic coverage based

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on its understanding of the net cost of the brand drugs compared to the generic equivalent. The ACOs financial interests may not align with the State's as they do not receive the benefit of primary rebates. As such, ACOs tend to select coverage of drugs that result in a financial benefit to them. (Note: Not all brand drugs have a generic equivalent.)

Overall, under the methodology and contractual requirements, differences between preferred/non-preferred status or brand/generic assignment is expected. Thus, our recommendation is to exclude ACO claims from this analysis because a "difference" is expected.

ACO Rate Setting

In Finding 2, the auditor states, *ACO costs are higher because the ACO paid for drugs that were supposed to be paid FFS. This could potentially increase the dollar amount ACO's request from Medicaid.* Cost increases of the ACOs do not directly equate to an increase in capitated rates. The most significant impact on rates is current state law in section 26-18-405.5. Increases in costs, if no additional appropriations are available, could result in rates set to a higher medical loss ratio (MLR) and not an increase in ACO capitated rates.

Medicaid Drug Rebate Program (MDRP) vs Supplemental Rebates

"Primary rebates" are managed by CMS through the Medicaid Drug Rebate Program (MDRP). States do not directly contract with any manufacturers for these rebates.

"Secondary rebates" ("supplemental rebates") are different from MDRP. They are available to a State through direct negotiation with manufacturers. Utah is part of the Sovereign States Drug Consortium in order to leverage its purchasing power for secondary rebates.

With the exception of secondary rebates negotiated directly with manufacturers, Utah Medicaid does not negotiate with manufacturers related to its pharmacy program.

Finally, it is important to note Section 1927 of the SSA (42 USC 1396r-8) protects and makes confidential the pricing and rebate information.

Brand over Generic

FFS Medicaid programs are eligible for primary and supplemental rebate programs ensuring the Medicaid programs receive the best price for pharmaceuticals 38 U.S. Code § 8126. Primary rebates are mandatory under 42 U.S. Code § 1396r–8 and managed by CMS through the Medicaid Drug Rebate Program (MDRP). In order to be eligible for FFS Medicaid programs, drug manufacturers must participate in the MDRP, guaranteeing primary rebates to State pharmacy programs.

Drug manufacturers, through the MDRP, have entered into rebate agreements on most brand name and generic drug products. The complex formulas used to calculate primary rebates can often result in a net cost to Medicaid for a branded drug being less than its generic equivalent.

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Utah Medicaid refers to the Pharmacy Practice Act, UCA 58-17b-606(4) and (5) in relation to the above when determining coverage policy:

> (4) When a multisource legend drug is available in the generic form, the Department of Health may only reimburse for the generic form of the drug unless the treating physician demonstrates to the Department of Health a medical necessity for dispensing the nongeneric, brand-name legend drug.
> (5) The Department of Health pharmacists may override the generic mandate provisions of Subsection (4) if a financial benefit will accrue to the state.

A listing of brand name products favored over the generic equivalent is available on the Utah Medicaid website.

Utah Medicaid ACOs are excluded from the above stated rules and ACOs do not participate in the MDRP. While Medicaid is able to invoice manufacturers for primary rebates for claims processed through ACOs, the ACOs do not have access to rebate information and cannot use such information to guide coverage decisions. In addition, ACOs are allowed to create and manage their own Preferred Drugs lists.

Therefore, the Department requested ACO data be excluded from the report. Inclusion of ACO data, program assessment and evaluation, and interpretation of results throughout the report may contribute to confusion for the reader and misrepresentation of the Audit Objectives and Summary Findings.

The audit objectives stated on Page 1 in the Executive Summary are: "Determine if prescription claims paid properly according to both Federal and State Policy. Determine Utah Medicaid's adherence to pharmacy policy and procedures."

The audit objectives appear to limit the scope to FFS claims evaluation. If the UOIG desired to find if "claims paid properly" then FFS claims are the only claims the agency adjudicates and the only claims appearing to meet this objective. This conclusion is strengthened by the desire to determine Medicaid's adherence to pharmacy policy and procedures as the ACO's are not subject to all of the FFS policies as noted earlier in the Background.

If conclusions were made due to ACO claims inclusion, it would be expected to find differences as each plan may have a different preferred drug list (PDL), more or fewer prior authorization (PA) requirements, etc. FFS and individual ACO plans are not expected to follow the same brand/generic coverage preference. In addition, differences should be expected when comparing the five plans (FFS and 4 ACO's) against each other.

Finding 1: Claim Review Limitations Exist

At the bottom of Page 7, the last two paragraphs indicate a recipient may not be able to get their prescription if there is a problem processing the claim outside of Medicaid operating hours. On May 20, 2020, the Department asked UOIG staff if they had any specific examples of recipients being unable to receive their medications on weekends or holidays. Agency staff further noted the 72-hour emergency fill policy was

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established to address these potential situations.[1] UOIG staff did not respond with any specific examples.

Recommendation 1.1

We recommend Medicaid contract with a third party vendor to create the ability, like that of Utah's ACO's, other states' Medicaid agencies and the private sector, to review all claim details in real-time by member.

Department Response: We concur with this recommendation. For several months prior to the release of the audit report, the Department was in the process of developing a Request for Proposal for the POS Pharmacy Benefit Administration (PBA) services. This RFP was released by State Purchasing on June 5, 2020. This RFP will allow the agency to replace its current system which has been in place since 2012. Medicaid has detailed dozens of system requirements, including those noted in this recommendation, and will evaluate prospective vendors against RFP requirements. At the close of the solicitation period, Medicaid will award the RFP to the top candidate. The new POS Contract is anticipated to go live in calendar year 2021.

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Upon implementation of the new Point of Sale system.

Recommendation 1.2

We recommend Medicaid contract with a third party vendor to create the ability, like that of Utah's ACOs, other states' Medicaid agencies and the private sector, to run test claims before adjudication.

Department Response: Please see Recommendation 1.1

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Upon implementation of the new Point of Sale system.

Recommendation 1.3

We recommend Medicaid contract with a third party vendor to update and improve software portals.

Department Response: Please see Recommendation 1.1

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Upon implementation of the new Point of Sale system.

---

[1] Reference: UAC R414-60-5(2), https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/72HourSupply.pdf and an Amber Sheet from May 2010 (https://medicaid.utah.gov/pharmacy/library/files/Amber%20Sheets/Amber%20Sheets%202010/Amber18.2.pdf)

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Recommendation 1.4

We recommend Medicaid contract with a third party vendor to provide updated reporting capabilities, that are timely and user friendly.

Department Response: Please see Recommendation 1.1

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Upon implementation of the new Point of Sale system.

Recommendation 1.5

We recommend consistent and timely review of claim over-rides to ensure prescription claims are paid according to Utah Medicaid policy.

Department Response: We concur with this recommendation. The agency has an established, weekly process to perform consistent and timely review of claim over-rides. This process has been in place for approximately two years.

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Previously implemented.

Finding 2: Inaccurate or Incomplete Prescription Claims Data Found in the Medicaid Data Warehouse

As mentioned above in the Background section, given that both ACO and FFS claims were included in the OIG review it is unclear what data the OIG believes is inaccurate or incomplete. ACO data may be different given the differences in coverage (e.g., PDL, PA). The Department was not given access to a copy of the final dataset used by OIG to be able to identify if data is inaccurate or incomplete. The audit provides one example that may be applicable to FFS claims but not to ACO claims. No other specifics are provided in the audit report.

Recommendation 2.1

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Utah Medicaid needs to research why claims data fields in the data warehouse are missing information or have inaccurate information. Data should indicate accurate P/NP status and if NP status is indicated there should be PA information, over-ride exception or other notes indicating the reason the claim paid even though the status is NP. Going forward we recommend Utah Medicaid ensure all prescription claims data in the data warehouse for both ACO and FFS claims has complete and accurate information.

Department Response: We concur with this recommendation as it relates to FFS claims. As noted above, staff have already researched the issues noted in the audit and are working with the current POS vendor on a correction. ACO claims do not lend themselves to these recommendations. ACOs submit pharmacy encounter data to the State using National Council for Prescription Drug Programs (NCPDP) standard file format and requirements noted would be impractical to implement for their data.

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: The Department will implement, to the extent possible, as part of the new POS system noted in Recommendations 1.1 through 1.4.

Recommendation 2.2

We recommend Utah Medicaid, after the conclusion of this audit, discuss and coordinate with UOIG to provide data and information that will allow independent audits. We also recommend continual collaboration going forward.

Department Response: We concur with this recommendation. As noted in the Background section, obtaining data in the data warehouse is complicated and, related to pharmacy data, requires some level of industry knowledge to understand and interpret the data. At any time the UOIG requires data to conduct an audit, the Department offers the expertise of our data analytics staff and other program experts to conduct a peer review of the data to assist the OIG. Due to the complexity of Medicaid data the Department instituted an internal process for peer review of data which has proven to be very beneficial.

The agency will continue to assist the UOIG, when needed, in obtaining data and information and as otherwise required in UCA 63A-13-302 and 303.

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Completed and as required in the future

Finding 3: Standard Operating Procedures and Training Have Improved

Recommendation 3.1

Continue regular staff training and development of standard operating procedures.

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Department Response: We concur with this recommendation. This process is currently in place and maintained by internal policies and procedures.

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Previously implemented.

Recommendation 3.2

Provide cross training to enable staff to comfortably perform one another's duties.

Department Response: We concur with this recommendation. Staffing expansion began in April 2019, enabling more cross coverage and cross training. These processes are currently in place and maintained by internal policies and procedures.

Contact: Jennifer Strohecker, Bureau Director, Bureau of Healthcare Policy and Authorization, 801-538-6293
Implementation Date: Previously implemented.

Signature:

Email: echacon@utah.gov

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EVALUATION OF MANAGEMENT RESPONSE

The UOIG appreciates Utah Medicaid concurs with all recommendations in this Medicaid Prescription Payments (2018-05) audit report.

Extracting Claims Data

In the response, Utah Medicaid stated the Department was not given access to the final data set and was unable to replicate the results produced by the UOIG auditors. The number of adjudicated claims can vary greatly when extracting claims data at a different time period. The difference in the number of claims was roughly only 13,000, when compared to the original 586,726 claims, which is to be expected given the data was pulled by Medicaid a year later. The findings and recommendations of this audit were based on adjudicated claim detail at that time. The difference in the number of claims is inconsequential to the findings and recommendations in this audit. However, UOIG did provide the data parameters and structured query language(SQL's) used to pull the data to Utah Medicaids data analyst in December of 2018. UOIG also provided a number of specific claims, including all data parameters, to Utah Medicaid staff which site examples of missing or inaccurate data cited in the report. UOIG worked extensively with the program experts from Medicaid regarding data parameters, interpretations and expectancies. It is incumbent upon the audited entity to provide complete and accurate data during the course of the audit, not to troubleshoot the auditor at the conclusion of the audit.

ACO vs FFS Pharmacy Coverage

UOIG starts an audit by extracting all adjudicated claims data. UOIG begins with a larger universe of data. This data is used to confirm or deny expected assumptions and then compares that information to program expections. UOIG subsequently filters out the data needed for specific audit objectives. The UOIG initial data included all FFS and ACO prescription claims adjudicated as of August 23, 2018. UOIG acknowledges there is a difference between ACO and FFS claim reimbursements, which is the precise reason the findings specifically separated ACO and FFS claims. UOIG has access to all ACO and FFS claims therefore all claims were included to obtain a full picture. Regardless of the different reimbursement ACO and FFS policy, the recommendations are for Utah Medicaid to remedy the claims data in the data warehouse to reflect complete and accurate data information for both ACO and FFS claims. While UOIG did not review the ACO claim adjudication process during the scope of this audit, the findings and recommendations regarding data in the data warehouse still apply.

ACO rate setting

Utah Medicaid stated cost increases for ACOs do not directly equate to an increase in capitated rates, however, ACOs are still paying claims erroneously which potentially results in a higher medical loss ratio (MLR).

Brand over Generic

Utah Medicaid referred to the list of brand name products favored over generic equivalent and provided a link. That list, as well as the FFS preferred drug list, state the drug name. When the UOIG first pulled data we saw that drugs paid both brand and generic which we then referenced the data to those lists. UOIG understood the difference between ACO and FFS preferred status so we focused on those claims that appeared improperly paid when referenced back to the FFS lists provided on the Medicaid website. In some cases the list stated that a drug was non-preferred yet the data showed the claim paid preferred. When using those lists provided on the website, UOIG and providers cannot make an accurate determination by drug name alone whether a drug is preferred.

Finding 1:

UOIG relied on several Utah Medicaid staff stating that even with the 72-hour emergency fill policy there are still possible instances where a recipient may be unable to receive their medications after hours.

Finding 2:

Utah Medicaid stated it is unclear what data is inaccurate or incomplete and stated they were not given access to the final data set. As noted previously in the audit report and above, Utah Medicaid was provided claims data on several occasions throughout the audit. Specific examples of inaccurate and incomplete data for both FFS and ACO claims were provided as well as discussed with Utah Medicaid staff and Medicaid's data analytics specialist. UOIG extracted data on May 28, 2020. A sample of the subsequent data revealed that details have been updated and do not reflect the same claim detail from the original findings and data previously provided to Utah Medicaid. For some claims, the specific field that indicated whether a drug was preferred, non-preferred or was blank has since been updated and populated with information that was different or missing in the original data. This progress shows that claim details can be corrected, however, for FFS claims, there are still examples where claim detail indicates non-preferred, is blank and has no prior authorization information.

Utah Medicaid stated it would be impractical to implement the recommendations for ACO data. However, some ACO claims data in the data warehouse did populate complete and accurate information originally, which indicates it is possible to implement the recommendations for ACO data as well.

Due to the very specific nature of the pharmacy program, UOIG did consult with Utah Medicaid staff and Medicaid's data analytics specialist on several occasions on the best way to obtain and analyze the data. Per Utah Code 63A-13-201, UOIG was created as an independent entity to inspect and monitor the Utah Medicaid program.[11] Government auditing is essential in providing accountability to legislators, oversight bodies, those charged with governance, and the public.

[11] Retrieved July 13, 2020 from https://le.utah.gov/xcode/Title63A/Chapter13/63A-13-S201.html?v=C63A-13-S201_2019051420190514

The UOIG audit team adheres to the Generally Accepted Government Auditing Standards (GAGAS) also known as the Yellow Book. GAGAS engagements provide an independent, objective, nonpartisan assessment of the stewardship, performance, or cost of government policies, programs, or operations.[12] In all matters relating to the GAGAS engagement, auditors and audit organizations must be independent from an audited entity. [13] UOIG appreciates the assistance and cooperation from Utah Medicaid, however, in order to fulfill our mandate and maintain independence, UOIG must rely on data extracted from the data warehouse to be complete and accurate for all claims.

[12] Retrieved July 13, 2020 from https://www.gao.gov/assets/700/693136.pdf section 1.05
[13] Retrieved July 13, 2020 from https://www.gao.gov/assets/700/693136.pdf section 3.18

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

Jennifer Kay
Auditor III

Neil Erickson
Audit Manager

UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts, and services in order to identify root problems contributing to fraud, waste, and abuse within the system and make recommendations for improvement to Medicaid management and the provider community.

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