

**Performance Audit No. 16-02**

# **A Performance Audit of Medicaid Prescription Drug Controls**

**August 17, 2016**



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UTAH STATE AUDITOR**

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# Executive Summary

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## Section 1: Pharmacy Claims Data Indicates Control Weaknesses And Database Errors

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The Division of Health Care Financing (DHCF) final pharmacy claims data appears to reflect both inappropriate payment for prescription drugs and database errors (see Appendix A). This section consists of the following three findings:

**Finding 1: Pharmacy Claims Data Indicates Payment For Prescriptions Written By Deceased Prescribers.** According to the DHCF Data Warehouse final pharmacy claims data, DHCF appears to have paid for 59 prescriptions that were written after the death of 11 prescribers, including some prescriptions that were written more than eight months after the prescriber’s death.

**Finding 2: Pharmacy Claims Data Indicates Payment For Prescriptions Dispensed To Deceased Recipients.** According to the DHCF Data Warehouse final pharmacy claims data, DHCF appears to have paid for 52 prescriptions that were dispensed subsequent to the death of the 25 recipients to whom the prescriptions were prescribed. In addition, some prescriptions appear to be *written* after the death of the recipient.

**Finding 3: Pharmacy Claims Data Indicates Payment For Prescriptions Written By Ineligible Prescribers.** According to the DHCF Data Warehouse final pharmacy claims data, DHCF appears to have authorized payment for 234 prescriptions —including 51 prescriptions for opioids—written by prescribers not enrolled to prescribe to Medicaid recipients. Additionally, according to the DHCF Data Warehouse final pharmacy claims data, Medicaid appears to have authorized payment for 138 prescriptions written by two prescribers that were sanctioned by DHCF.

## **Section 2: The Client Restriction Program Needs Improvement**

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The Utah Medicaid Client Restriction Program (CRP), which is intended to minimize recipient overutilization, does not always effectively identify and prioritize the review of recipients qualifying for restriction or objectively evaluate client utilization. This section consists of the following five findings:

**Finding 4: Pharmacy Claims Data Indicates Payment To Unassigned Providers.** According to the DHCF Data Warehouse final pharmacy claims data, about 19 percent of restricted recipients appear to have received prescriptions written or dispensed by an unassigned provider, contrary to DHCF policy and administrative rule. DHCF appears to have authorized payment for both (1) prescriptions written by unassigned prescribers and (2) prescriptions filled at unassigned pharmacies.

**Finding 5: Client Restriction Program Reviews Indicate Areas For Improvement.** Almost a quarter of evaluated CRP reviews conducted had inaccuracies and/or lack of documentation identified in a quality control review. Enhanced quality control may help improve CRP reviewer consistency and compliance with policy.

**Finding 6: Inconsistent Restriction Reviews May Allow Overutilization To Continue.** DHCF CRP reviewers manually adjusted the vast majority of sampled restriction initial review summaries, resulting in almost 25 percent of the reviewed recipients no longer qualifying for restriction according to restriction criteria A – E (see Section 2 Introduction). Additionally, some reviewer decisions appear to be made inconsistently and contrary to policy. Some CRP reviewers did not appear to consider concurrent prescribing in restriction decisions, which may allow recipients with drug seeking behaviors to continue to receive controlled substances funded by Medicaid.

**Finding 7: SURS Reports Exclude Some High-Risk Recipients.** DHCF Surveillance and Utilization Review System (SURS) reports do not appear to fully account for all Medicaid recipients who may be at risk for overutilization and potential fraud. Additionally, the SURS reports do not appear to be consistent with established restriction criteria and policy.

**Finding 8: The CRP Does Not Always Review And Restrict High-Risk Recipients.** Even assuming the SURS reports were programmed and generated correctly, restriction reviews do not always account for the highest-risk recipients. In addition, CRP reviewers appear to spend a considerable amount of time working on affordable care organization (ACO) related matters, limiting the number of CRP fee-for-service (FFS) reviews. CRP staff also do not appear to account for the frequency with which recipients appear on the SURS reports during the review process.

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# Background

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On July 30, 1965, the United States Congress enacted Title XIX of the *Social Security Act* to enable each state

to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care . . . .<sup>1</sup>

This program is known as Medicaid,<sup>2</sup> and is defined as “medical assistance provided under a State plan approved under title XIX of the [*Social Security Act*].”<sup>3</sup> Medicaid is “jointly financed by the Federal and State governments and administered by States”<sup>4</sup> under the direction of the Centers for Medicare and Medicaid Services (CMS) within the United States Department of Health and Human Services.<sup>5</sup> Utah statute designates the Department of Health (DOH) as the “single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.”<sup>6</sup> Within DOH, the Division of Health Care Financing (DHCF) is “responsible for implementing, organizing, and maintaining the Medicaid program” in accordance with state and federal law.<sup>7</sup>

For state fiscal year (SFY) 2015, Utah’s Medicaid expenditures totaled over \$2.4 billion,<sup>8</sup> which reflects a sharing of federal and state funds based on an adjusted Federal medical assistance percentage<sup>9</sup> of 70.50% and a state percentage of 29.50%.<sup>10</sup> In addition, the average number of members per month (“Average Member Months”) enrolled in Utah Medicaid over SFY 2015 was

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<sup>1</sup> Social Security Amendments of 1965, Pub. L. No. 89-97, § 1901, 79 Stat. 286, 343-344 (1965); 42 CFR 430.0.

<sup>2</sup> Utah Admin. Code R414-1-2(16).

<sup>3</sup> 42 CFR 400.200. Federal regulation defines the “State plan” as “a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.” 42 CFR 430.10.

<sup>4</sup> 42 CFR 430.0.

<sup>5</sup> Utah Admin. Code R414-1-2(6).

<sup>6</sup> Utah Code 26-18-3(1).

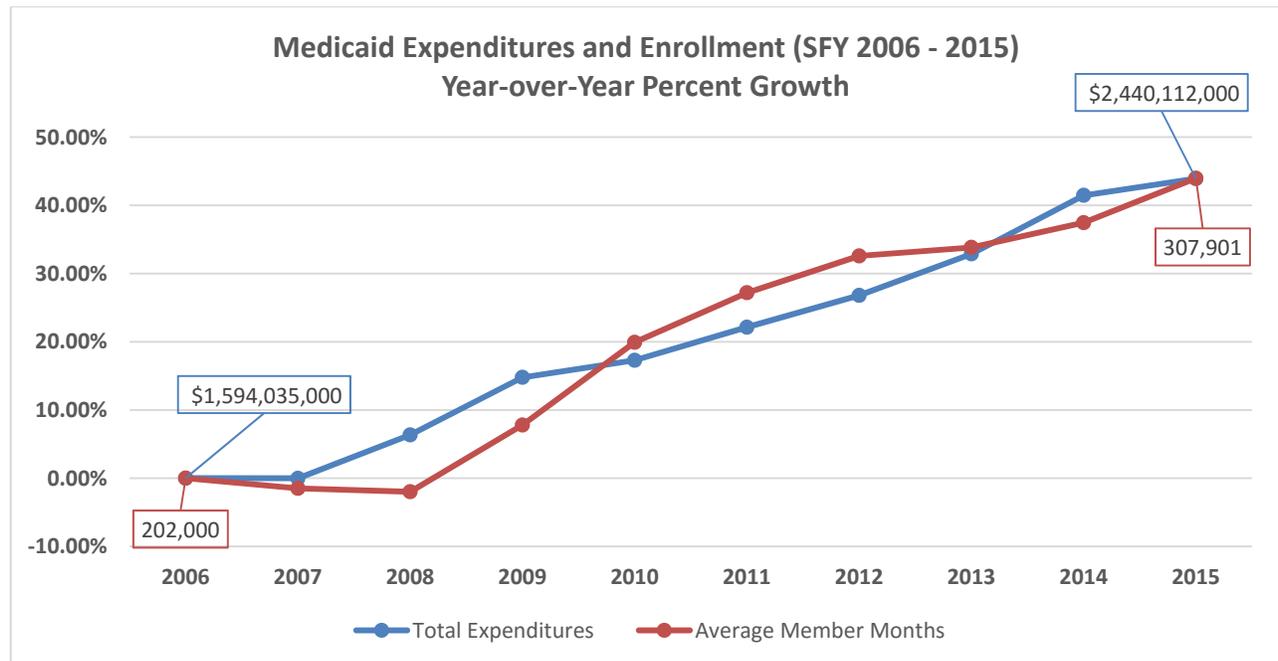
<sup>7</sup> Utah Code 26-18-2.1. DHCF is also referred to as the Division of Medicaid and Health Financing (DMHF).

<sup>8</sup> State of Utah, 2015 COMPREHENSIVE ANNUAL FINANCIAL REPORT, pgs. 166-167.

<sup>9</sup> “[T]he term ‘Federal medical assistance percentage’ for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum . . . .” 42 U.S.C. §1396d(b).

<sup>10</sup> 2015 UTAH ANNUAL REPORT OF MEDICAID & CHIP, pg. 8. The 2015 Annual Report adjusted the Federal medical assistance percentage to reflect the difference between the federal and state fiscal years.

307,901.<sup>11</sup> Over the last 10 state fiscal years, both total Medicaid expenditures and enrollment grew on average 4.4 percent from year-to-year (see chart below).



Source: OSA Analysis of CAFR and Medicaid Annual Report Data.

The figure below displays the statewide Medicaid enrollment composition for SFY 2015.

Category of Assistance	Total Retention
Adult (Ages 19-64)	13.0%
Children	59.1%
PCN <sup>12</sup>	5.9%
Pregnant Women	6.1%
The Elderly (Ages 65+)	3.8%
Visually Impaired and People with Disabilities	12.1%
<b>Statewide Total</b>	<b>100.0%</b>

Source: 2015 UTAH ANNUAL REPORT OF MEDICAID & CHIP, pg. 30.

Since federal regulation permits a state Medicaid agency to “enter into a comprehensive risk contract” with a Managed Care Organization (MCO),<sup>13</sup> Utah law authorized the use of MCOs to replace the “fee-for-service delivery model with one or more risk-based delivery models.”<sup>14</sup> MCOs

<sup>11</sup> 2015 UTAH ANNUAL REPORT OF MEDICAID & CHIP, pg. 23.

<sup>12</sup> Utah Medicaid policy states that the Primary Care Network (PCN) is “authorized under a federal waiver of Medicaid regulations approved by” CMS and that the PCN “covers the cost of primary care medical services for uninsured adults who do not qualify for coverage under any other category of Medicaid and who are not covered by or do not have access to affordable employer-sponsored health insurance, student health insurance, Medicare or the Veterans Administration Health Care System. PCN has a limited scope of service that is designed to provide basic primary care, emergency care and pharmacy services to eligible individuals.” Medicaid Policy 900.

<sup>13</sup> 42 CFR 438.6(b)(1).

<sup>14</sup> Utah Code 26-18-405(1).

are referred to as Accountable Care Organizations (ACOs) in Utah,<sup>15</sup> and four currently operate statewide:

- Health Choice Utah
- Healthy U
- Molina Healthcare of Utah
- SelectHealth Community Care<sup>16</sup>

Utah Medicaid recipients in 13 counties are required to select an ACO while Medicaid recipients in the remaining 16 counties have the option to choose either an ACO or the “Fee for Service Network.”<sup>17</sup> DHCF defines “Fee-for-Service” as “Medicaid covered services that are billed directly to and paid for directly by Medicaid based on an established fee schedule” and a “Fee-for-Service Medicaid Member” as “[a] member who is not enrolled in an MCO; or is enrolled in an MCO, but the service that is needed is a carve-out service covered directly by Medicaid.”<sup>18</sup> Approximately 80 percent of Medicaid recipients are enrolled with ACOs while the remaining 20 percent constitute the fee-for-service population.

## Medicaid Pharmacy Program

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“Prescribed drugs”<sup>19</sup> are among the many services provided in the Utah Medicaid State Plan.<sup>20</sup> The Utah Medicaid Pharmacy Program reimburses for prescribed drugs “for Medicaid eligible, categorically and medically needy individuals.”<sup>21</sup> Utah Administrative Rule limits coverage to pharmacy services “prescribed by a Utah licensed health care provider *lawfully permitted* to issue the prescription” and requires that “[t]he pharmacy filling the prescription must be enrolled as a Utah Medicaid provider.”<sup>22</sup> Among the prescriptions paid for by DHCF are opioids, which include pain relief medications such as hydrocodone, oxycodone, and codeine.

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<sup>15</sup> Utah Code 26-36a-103(1). Utah Medicaid Policy defines an ACO as, “A group of health care providers that have entered into a formal arrangement to assume collective responsibility for the care of a specific group of patients and that receive financial incentives to improve the quality and efficiency of health care.”

<sup>16</sup> Utah Department of Health, 2015 ANNUAL REPORT OF MEDICAID & CHIP, pg. 41.

<sup>17</sup> Recipients in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties are required to choose an ACO. Recipients in Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne counties are free to choose an ACO or the Fee for Service Network. Utah Department of Health, MEDICAID MEMBER GUIDE, pgs. 8-9.

<sup>18</sup> UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 12. “Carve-out services” are services not included in an ACO contract.

<sup>19</sup> Federal regulation defines “prescribed drugs” as “simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are—(1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; (2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and (3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist’s or practitioner’s records.” 42 CFR 440.120(a).

<sup>20</sup> Utah Admin. Code R414-1-6(2)(r).

<sup>21</sup> Utah Admin. Code R414-60-1(1); R414-60-2(1).

<sup>22</sup> Utah Admin. Code R414-60-3 (emphasis added).

## Opioid Death Rate Statistics

Both the Utah DOH and the Centers for Disease Control and Prevention (CDC) recognize Methadone, oxycodone (e.g. OxyContin), and hydrocodone (e.g. Vicodin) as among the most common prescription drugs associated with overdose deaths. All three are opioids and are classified as schedule II controlled substances.<sup>23</sup>

Utah had the third highest opioid pain reliever<sup>24</sup> death rate per 100,000 residents in the United States in 2014.<sup>25</sup> In addition, over the last five years, Utah has consistently held among the highest per capita opioid death rate when compared with the six surrounding states.

Opioid Death Rate per 100,000					
	2010	2011	2012	2013	2014
Arizona	7.02	5.88	5.95	5.18	5.62
Colorado	4.49	6.04	5.71	5.66	6.57
Idaho	4.47	4.42	3.38	4.09	3.92
Nevada	14.44	14.21	13.66	11.29	10.14
New Mexico	7.43	7.97	10.84	11.61	13.91
<b>Utah</b>	<b>10.82</b>	<b>12.67</b>	<b>14.15</b>	<b>14.2</b>	<b>14.68</b>
Wyoming	7.27	6.51	5.9	6.35	6.85

Source: CDC Wide-ranging Online Data for Epidemiologic Research (CDC WONDER) Data.

In addition, opioid pain reliever deaths constitute the vast majority of all prescription drug deaths in Utah over the last five years.

	Opioid Deaths	Total Prescription (Rx) Drug Deaths	Percent Of Rx Deaths By Opioids
<b>2010</b>	299	357	83.75%
<b>2011</b>	357	435	82.07%
<b>2012</b>	404	507	79.68%
<b>2013</b>	412	512	80.47%
<b>2014</b>	432	518	83.40%

Source: CDC WONDER Data.

In March 2016, the Utah Legislature and Governor issued a concurrent resolution declaring that “the Utah drug overdose death rate represents a public health emergency,” and strongly urged “Utah’s Department of Health, Department of Human Services, and Department of Public Safety to direct appropriate resources to reducing the number of drug overdose deaths in Utah.”<sup>26</sup>

<sup>23</sup> Utah Code 58-37-4(2)(b)(i)(A)(X), -4(2)(b)(i)(A)(XIV), -4(2)(b)(ii)(O). A schedule II controlled substance “has a high potential for abuse” and/or “may lead to severe psychological or physical dependence.” 21 U.S.C. § 812(b). See Appendix B for more information regarding the *Controlled Substances Act* and the controlled substance schedules.

<sup>24</sup> In this report, opioid pain relievers (“opioids”) include the following ICD-10 codes: T40.2 (other opioids), T40.3 (methadone), and T40.4 (other synthetic narcotics). National Institute on Drug Abuse, National Institutes of Health. See Appendix C for additional prescription drug code methodology.

<sup>25</sup> Utah ranked third out of all 50 states plus the District of Columbia and was in the top ten from 2010 through 2014.

<sup>26</sup> H.R. Con. Res. 004, 2016 General Session.

# **Section 1: Pharmacy Claims Data Indicates Control Weaknesses And Database Errors**

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## **Section 1 Introduction: Pharmacy Claims Data And Regulatory Obligations**

According to the Division of Healthcare Financing (DHCF), final claim indicators in DHCF's Data Warehouse identify final, paid pharmacy claims, but a database error may inaccurately identify some accountable care organization (ACO) claims as final, paid claims when in reality they were not (see Appendix A). Since, according to DHCF, this database error does not affect FFS claims, and Findings 1 – 4 each include FFS pharmacy claims, any control weaknesses identified therein are likely not affected by this database error.

Each of the pharmacy claims highlighted in Findings 1 – 3 may represent fraudulent or abusive behavior to the extent they are final, paid claims as indicated in DHCF's Data Warehouse. Federal Medicaid program integrity regulations define fraud as "intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person."<sup>27</sup> In addition, abuse is defined as,

provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary 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.<sup>28</sup>

## **DHCF Is Federally Required To Investigate Any Questionable Practices**

Federal regulations not only require that DHCF have methods, criteria, and procedures to identify *and* refer suspected fraud and abuse cases to law enforcement,<sup>29</sup> but also require DHCF to "conduct a preliminary investigation" into "any questionable practices" identified "to determine whether there is sufficient basis to warrant a full investigation."<sup>30</sup> Thus, even if the behaviors discussed in Findings 1 – 3 represent errors made by physicians or pharmacists, they would likely constitute "questionable practices" worthy of at least a preliminary investigation.

If "the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program," DHCF is federally required to

- (1) refer cases of suspected provider fraud or abuse to the Medicaid Fraud Control Unit,<sup>31</sup>

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<sup>27</sup> 42 CFR 455.2 (It also "includes any act that constitutes fraud under applicable Federal or State law").

<sup>28</sup> 42 CFR 455.2.

<sup>29</sup> 42 CFR 455.13.

<sup>30</sup> 42 CFR 455.14.

<sup>31</sup> According to the Utah Medicaid Provider Manual, the Medicaid Fraud Control Unit (MFCU) is the "official state Medicaid fraud control unit in the Utah Office of the Attorney General, certified by the federal government, to investigate and prosecute complaints of abuse and neglect of patients, and Medicaid fraud under state laws as required by 42 CFR 1007.7 through 1007.13. The MFCU has statewide prosecutorial authority." UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 14.

- (2) refer beneficiaries believed to have defrauded the Medicaid program to an appropriate law enforcement agency, *and*
- (3) conduct a full investigation of the abuse of any beneficiary believed to have abused the Medicaid program.<sup>32</sup>

Utah Medicaid’s state plan and applicable administrative rule state that DHCF “has established and will maintain methods, criteria, and procedures that meet” these and other federal requirements “for prevention and control of program fraud and abuse.”<sup>33</sup>

## **The Utah False Claims Act Requires DHCF To Investigate And Refer Suspected Violations For Investigation And Prosecution**

In addition to federal requirements, the *Utah False Claims Act* (UFCA) prohibits actions such as the concealment or failure to disclose events with the intent to obtain Medicaid benefits to which the individual is not otherwise entitled, kickbacks or bribes related to Medicaid benefits, and false Medicaid benefits claims.<sup>34</sup> It is possible that behaviors identified in Findings 1 – 3 (e.g. writing prescriptions after a prescriber’s death) could involve actions prohibited by UFCA. In the event of suspected violations of UFCA, statute states that DOH is responsible for

- (1) Investigating and prosecuting suspected civil violations of UFCA *or* referring such suspected violations to the attorney general for investigation and prosecution; and
- (2) Promptly referring suspected criminal violations of UFCA to the attorney general for criminal investigation and prosecution.<sup>35</sup>

To the extent that pharmacy claims data highlighted in Findings 1 – 3 of this report are final, paid claims, prescriptions highlighted in Findings 1 – 3 may have been written and/or dispensed in violation of state and federal laws, rules, and/or regulations, and it is possible that provider and/or recipient violations of UFCA may have occurred in each instance.

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<sup>32</sup> 42 CFR 455.15 (emphasis added). Federal regulation requires that a “full investigation” continue until (1) “Appropriate legal action is initiated”; (2) “The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse”; or (3) “The matter is resolved between the agency and the provider or beneficiary.” 42 CFR 455.16. Furthermore, a resolution may include, but is not limited to, the following: “(1) Sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action; (2) Suspending or terminating the provider from participation in the Medicaid program; (3) Imposing other sanctions provided under the State plan.” 42 CFR 455.16(c).

<sup>33</sup> Utah Medicaid State Plan, pg. 62; Utah Admin. Code R414-1-15. The Utah Medicaid State Plan outlines that the Bureau of Coverage and Reimbursement Policy “monitors and manages the utilization of Medicaid’s fee-for-service programs, and performs federally mandated reviews to identify and pursue action in cases of fraud and abuse” and that the bureau engages in the “post-payment analysis of claims.” Utah Medicaid State Plan, pg. 194/914.

<sup>34</sup> Utah Code 26-20-3(3), -4(2), -7. Criminal penalties for these and other listed violations range from a class B misdemeanor to a second degree felony, depending on the dollar amounts involved. Utah Code 26-20-9. Civil penalties may also apply. Utah Code 26-20-9.5.

<sup>35</sup> Utah Code 26-20-13(2). Furthermore, any violation of UFCA that “comes to the attention of any state government officer or agency shall be reported to the attorney general or [DOH].” Utah Code 26-20-13(5).

# **Finding 1 Pharmacy Claims Data Indicates Payment<sup>36</sup> For Prescriptions Written By Deceased Prescribers**

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According to the Division of Health Care Financing (DHCF) Data Warehouse final claim indicators, DHCF appears to have paid for 59 prescriptions that were *written* after the death of 11 prescribers, including some prescriptions that were written more than eight months after the prescriber’s death. Almost 30 percent of these posthumously issued prescriptions were for controlled substances,<sup>37</sup> which may increase the risk of prescription drug abuse and indicate Medicaid fraud.<sup>38</sup> DHCF should ensure that it does not pay for prescriptions written after the death of the prescriber.<sup>39</sup> Additionally, DHCF should scrutinize each of the 59 prescriptions to determine if each claim was a validly paid, final claim.<sup>40</sup> To the extent that these claims are validly paid, final claims, DHCF should also investigate and refer any cases of suspected fraud or abuse to proper authorities in accordance with federal regulation and state law.

## **Pharmacy Claims Data Indicates Payment For 59 Prescriptions Written Subsequent To Deaths Of 11 Prescribers**

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According to the DHCF Data Warehouse final paid claim indicators, DHCF appears to have authorized payment for 59 prescriptions written subsequent to the death of the 11 prescribers. Figure 1.1 below displays the prescription details for each of the deceased prescribers.

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<sup>36</sup> Data in this finding represent final, paid Medicaid pharmacy claims according to DHCF’s Data Warehouse final claim indicators for prescriptions dispensed from July 1, 2014 through March 15, 2016. For more information on final claim indicators and potential data limitations, see Appendix A.

<sup>37</sup> See Appendix B for more information regarding controlled substances and federal drug schedules.

<sup>38</sup> Congress found, among other findings, that the “improper use of controlled substances [has] a substantial and detrimental effect on the health and general welfare of the American people.” 21 U.S.C. §801(2). See Appendix B for more information regarding controlled substances and federal drug schedules.

<sup>39</sup> DHCF pharmacy claims data contains both a prescribed date and a dispense date for each prescription drug claim. According to DHCF, the prescribed date is the date upon which the prescriber wrote the prescription and the dispense date (“service begin date”) is the date upon which the prescription was dispensed at a Medicaid-eligible pharmacy. For the purposes of this report, claims with a prescribed date that is subsequent to the prescriber’s death date are considered “prescriptions written after death.”

<sup>40</sup> Since, according to DHCF, the database error described in Appendix A does not affect FFS claims, and this finding includes FFS pharmacy claims, any control weaknesses identified herein are likely not affected by this database error.

**Figure 1.1 Prescriptions (Rx) Written By Deceased Prescribers**

Deceased Prescriber	# of Rx Written After Death	# of Controlled Substance Prescriptions	# of Patients	Time Elapsed Between Death and Latest Rx Written (Days)
A	19	1	9	138
B	17	7	8	47
C	5	2	4	28
D	5	0	3	35
E	4	4	1	94
F	3	1	2	20
G	2	0	1	253
H	1	1	1	215
I	1	0	1	16
J	1	0	1	50
K	1	1	1	30

Source: OSA analysis of DHCF pharmacy claims and OVRS death data.

While it is unlawful to dispense prescriptions written subsequent to the death of the prescriber indicated on the prescription<sup>41</sup> and administrative rule prohibits DHCF payment for such prescriptions,<sup>42</sup> state statute permits death certificates to be filed with the Office of Vital Records and Statistics (OVRS) within 15 days after the person’s death.<sup>43</sup> As a result, it may be unrealistic for DHCF to proactively deny payment<sup>44</sup> for prescriptions written by deceased prescribers *before* OVRS receives a particular prescriber’s death certificate. However, over half of all the prescriptions identified within this finding appear to be written more than 15 days after death, which suggests that DHCF controls could have proactively accounted for<sup>45</sup> most of the prescriptions we identified. Figure 1.2 shows the timeline detail for these prescriptions.

<sup>41</sup> See Utah Code 58-17b-501(10); 58-1-308(2)(c); 58-1-102(7). Additionally, this type of activity appears suspect since federal law requires Medicaid-covered prescriptions for out-patient drugs that are written (and non-electronic) to “be executed on a tamper-resistant pad” and both state and federal law prohibit refills for schedule II controlled substance prescriptions. 42 U.S.C. §1396b(i)(23); 21 U.S.C. §829(a); Utah Code 58-37-6(7)(f)(i)(A).

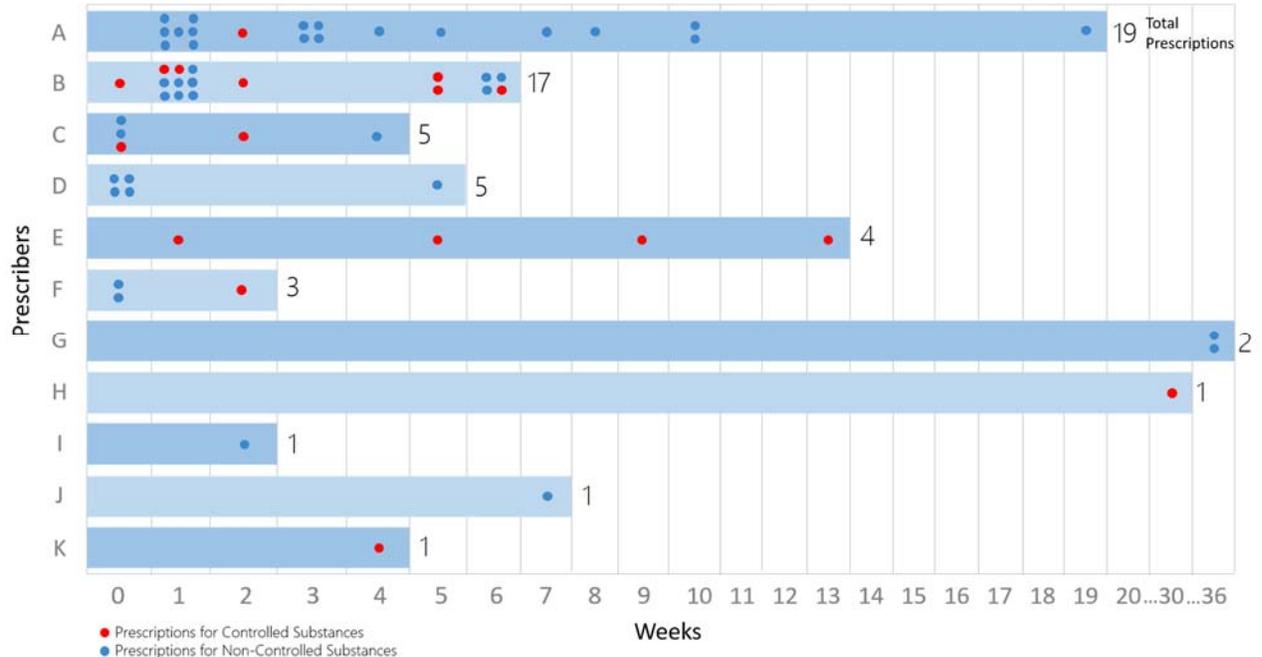
<sup>42</sup> Utah Administrative Rule limits coverage under Utah Medicaid Pharmacy Program to pharmacy services “prescribed by a Utah licensed health care provider *lawfully permitted to issue the prescription.*” Utah Admin. Code R414-60-3 (emphasis added).

<sup>43</sup> Utah Code 26-2-13(1)(a); Utah Admin. Code R436-10-1(6). “Death certificates are registered with [OVRS] using the Electronic Data Entry Network (EDEN). Once a death certificate is registered, information from it may be shared with other [DOH] information systems according to existing agreements.” Utah Medicaid Death Notification Policy.

<sup>44</sup> DHCF requires that all pharmacy claims be submitted electronically through the POS system, which “accepts standardized claims for pharmacy services to be submitted through an electronic data exchange.” UTAH MEDICAID PROVIDER MANUAL, Section II: Pharmacy Manual, pg. 28; UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 60. In addition, the POS system “provides pharmacists with the capability to submit pharmacy claims electronically. It enables pharmacies to immediately determine Medicaid member eligibility, verify drug coverage, and have ‘real time’ claim processing.” UTAH MEDICAID PROVIDER MANUAL, Section II: Pharmacy Manual, pg. 28.

<sup>45</sup> Even if DHCF’s POS system denied payment for that particular prescription, a Medicaid recipient could pay cash to have an invalid prescription dispensed, which is likely still prohibited by the Utah *Pharmacy Practice Act*. See Utah Code 58-17b-501(10).

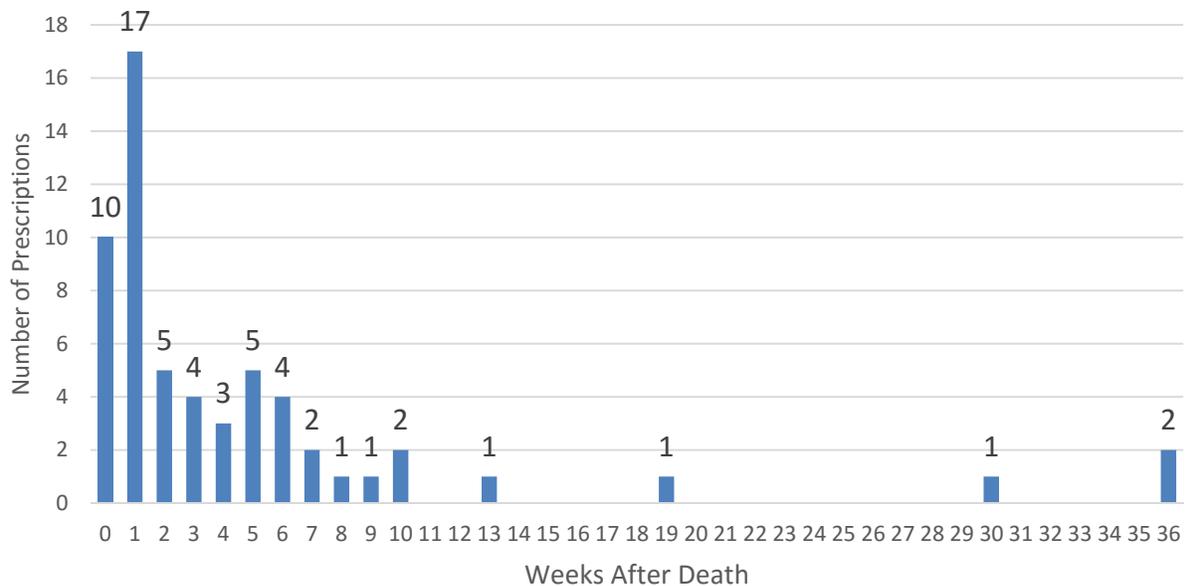
**Figure 1.2 Timing Of Prescriptions Written By Deceased Prescribers**



Source: OSA analysis of DHCF pharmacy claims and OVRs death data.

Figure 1.3 displays the aggregate count of all prescriptions prescribed per week across all deceased prescribers.

**Figure 1.3 Time Elapsed And Number Of Prescriptions Prescribed After Death**



Source: OSA analysis of DHCF pharmacy claims and OVRs death data.

Seventeen of the 59 prescriptions written by deceased prescribers were for controlled substances. Seven of the 11 prescribers had prescriptions for controlled substances written after their deaths and 11 Medicaid recipients received those drugs, totaling 17 prescriptions (see Figure 1.4).

**Figure 1.4 Prescriptions For Controlled Substances Written By Deceased Prescribers**

Prescription Drug (Brand/Common Name)	Rx Count	Drug Schedule <sup>46</sup>	Prescriber Count
Hydrocodone-Acetaminophen (Vicodin)	5	II	5
Oxycodone HCl	5	II	3
Methylphenidate HCl (Ritalin)	4	II	1
Morphine Sulfate	2	II	1
Zolpidem Tartrate (Ambien)	1	IV	1

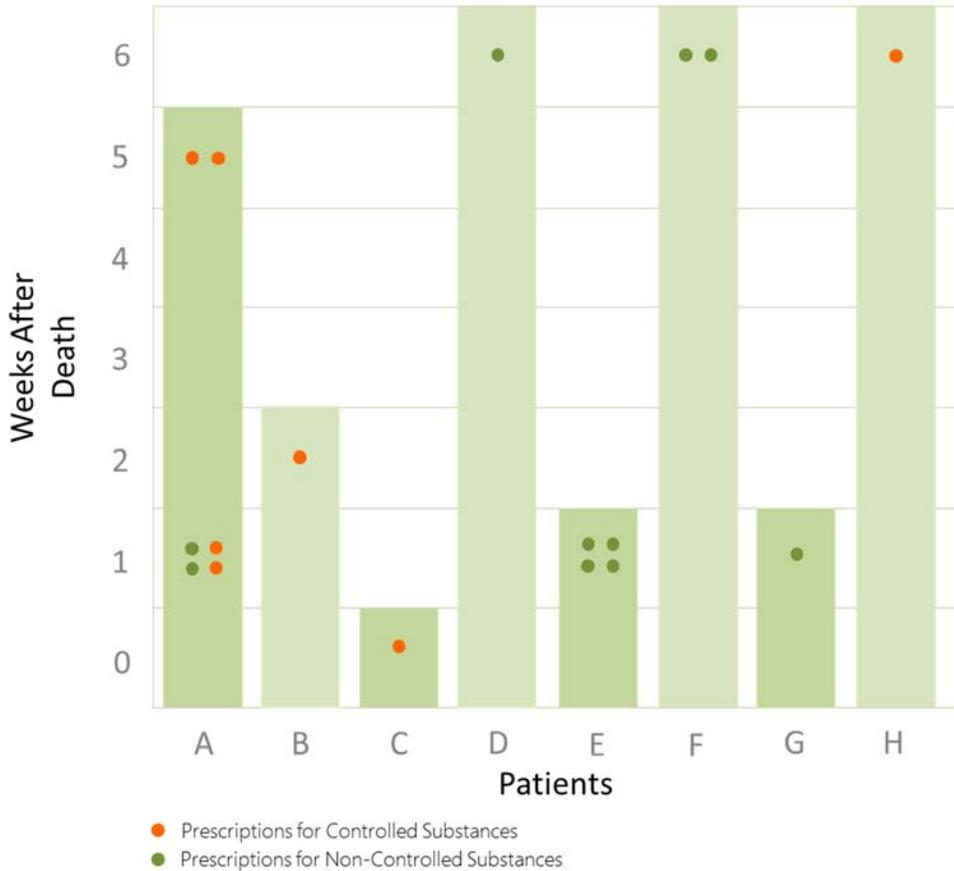
Source: OSA analysis of DHCF pharmacy claims and OVRs death data.

**One patient received four prescriptions for the same schedule II drug written after the prescriber’s death.** Prescriber E was credited with writing four prescriptions, averaging one per month, following Prescriber E’s death. Each prescription was written exactly 29 days after the previous prescription and each prescription was dispensed on the same day the prescription was written. The last prescription written and dispensed occurred 94 days after this prescriber’s death.

**Seventeen prescriptions appear to be written after Prescriber B’s death, including seven for controlled substances.** Six of the prescriptions were for schedule II controlled substances while one other was for a schedule IV controlled substance. The schedule II controlled substances included prescriptions for three potent pain medications: oxycodone, morphine, and hydrocodone. Some of these prescriptions were written up to six weeks after Prescriber B’s death. Overall, eight of this prescriber’s patients appear to have received at least one prescription after the death of the prescriber—four of whom were prescribed at least one controlled substance. One of these patients received four schedule II controlled substances, the last of which was written 39 days after the prescriber’s death. Figure 1.5 shows a timeline of prescriptions written after this prescriber’s death.

<sup>46</sup> The federal *Controlled Substances Act* assigns controlled substances to one of five schedules. While schedule II drugs have a “currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions,” they have a “high potential for abuse” which “may lead to severe psychological or physical dependence.” In contrast, schedule IV drugs have a “currently accepted medical use in treatment in the United States,” but a “low potential for abuse” which “may lead to limited physical dependence or psychological dependence relative” to drugs in schedules I, II, and III. 21 U.S.C. §812(b). See Appendix B for more information regarding controlled substance schedules.

**Figure 1.5 Prescriptions To Recipients After Prescriber B's Death**



Source: OSA analysis of DHCF pharmacy claims and OVRs death data.

## Writing Prescriptions Without A Valid License Is Illegal

The Utah Division of Occupational and Professional Licensing (DOPL) within the Department of Commerce is charged with administering and enforcing occupational licensing laws, including those within the *Utah Medical Practice Act*.<sup>47</sup> This act generally requires a license for any individual that writes a prescription to any person in Utah.<sup>48</sup> Additionally, while the Utah Medicaid Pharmacy Program reimburses for prescribed drugs, applicable Utah Administrative Rule limits Medicaid coverage to pharmacy services “prescribed by a Utah licensed health care provider *lawfully permitted to issue the prescription*.”<sup>49</sup> Thus, DHCF is restricted to paying for prescriptions written by prescribers validly licensed at the time the prescription is written.<sup>50</sup>

<sup>47</sup> Utah Code 58-1-103; 58-17b; 58-67.

<sup>48</sup> Utah Code 58-67-301(1); 58-67-102(12)(a)(1).

<sup>49</sup> Utah Admin. Code R414-60-1(1), -2(1), -3 (emphasis added).

<sup>50</sup> Since the Utah *Pharmacy Practice Act* requires that all prescriptions contain the “date of issuance,” and federal regulation requires that “[a]ll prescriptions for controlled substances shall be dated as of, and signed on, the day when issued,” the *prescribed date* is the operative data point to assess whether an individual prescriber was validly

Since the *Division of Occupational and Professional Licensing Act* mandates that a license “automatically expires” upon the death of a DOPL-licensed prescriber,<sup>51</sup> DHCF should not authorize payment for prescriptions written by deceased prescribers because DHCF may reimburse only those prescriptions written by individuals with a valid DOPL-issued license at the point in time at which they wrote the prescription. Furthermore, several Utah laws declare that the underlying conduct involved with writing and dispensing prescriptions written subsequent to the death of the prescriber is potentially criminal in nature.<sup>52</sup>

ACO prescriptions written after the death of the prescriber may have been improperly reimbursed; however, DHCF pharmacy claims data does not always appear to accurately reflect whether ACO pharmacy claims are final, paid claims. Thus, DHCF should determine whether each of the ACO claims identified in this finding were validly paid, final claims and implement controls to detect and prevent such claims from being paid.

## **DHCF Does Not Use Death Reports To Review Pharmacy Claims**

DHCF currently employs a death notification system to receive and use “real-time” death notification data to recover “reimbursements for claims submitted after a member/provider has expired.” Among other sources, this system reviews data from the Department of Health Master Person Index (DOHMPI), Office of Vital Records and Statistics (OVRs), and Electronic Death Entry Network (EDEN) to generate monthly reports that compare dates of death to payment records. Although the system is intended to “reduce the number of claims received and Medicaid payments made subsequent to a death,” DHCF does not use a death report for *pharmacy claims*, which likely limits DHCF’s ability to both prevent and investigate claims for prescriptions written after the prescriber’s death.

Given the potentially fraudulent, abusive, and perhaps even criminal conduct associated with dispensing prescriptions written after a prescriber’s death, DHCF should proactively avoid the payment of claims for prescriptions written subsequent to a prescriber’s death. Additionally, DHCF should investigate each prescription that appears<sup>53</sup> to be written unlawfully after the death of the prescriber as well as ensure that DHCF authorizes payment only for prescriptions written by eligible prescribers (see Finding 3).

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licensed to prescribe a medication later dispensed and paid for by DHCF. Utah Code 58-17b-602(1); 21 CFR 1306.05(a).

<sup>51</sup> Utah Code 58-1-308(2)(c); 58-1-102(7); 58-1-101. DOPL issues licenses with a two year renewal cycle. Utah Code 58-67-303(1)(a).

<sup>52</sup> Utah Code 26-20-3 to -7 (*Utah False Claims Act*); 58-17b-501(10) (*Pharmacy Practice Act* unlawful conduct provisions); 58-1-501(1) (*Division of Occupational and Professional Licensing Act* unlawful conduct provisions); 58-37-8(3)(a) (*Utah Controlled Substances Act* prohibited acts provisions). The violations listed in the aforementioned statutes are punishable as anywhere from a Class B misdemeanor to a second degree felony. Utah Code 26-20-9; 58-17b-504; 58-67-503(1); 58-1-502(1); 58-37-8(3)(b), (c). Specific civil penalties may also result from violations of the *Utah False Claims Act*. Utah Code 26-20-9.5.

<sup>53</sup> See Appendix A for data limitations.

## Recommendations

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1. We recommend that DHCF review pharmacy claims identified within this finding to determine whether they are final, paid claims within the DHCF Data Warehouse.
2. We recommend that DHCF ensure that the ACOs are properly preventing payment for claims for prescriptions written after the prescriber's death.
3. We recommend that DHCF monitor and proactively avoid the payment of claims for prescriptions written subsequent to a prescriber's death.
4. We recommend that DHCF investigate each validly paid, final prescription credited to a prescriber who was deceased before the prescription was written and refer cases to the appropriate authority, as needed.
5. We recommend that DHCF take action in accordance with federal regulation to
  - a. identify individuals engaged in questionable practices or potentially fraudulent or abusive conduct;
  - b. investigate any questionable practices and/or potentially fraudulent or abusive conduct to the extent necessary to resolve concerns; and
  - c. refer cases of fraud and abuse to law enforcement or MFCU, as necessary.
6. We recommend that DHCF ensure that suspected civil and criminal violations of the *Utah False Claims Act* are referred promptly to the attorney general for investigation and possible prosecution.

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## **Finding 2      Pharmacy Claims Data Indicates Payment For Prescriptions Dispensed<sup>54</sup> To Deceased Recipients<sup>55</sup>**

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According to the Division of Health Care Financing (DHCF) Data Warehouse final claim indicators, DHCF appears to have paid for 52 prescriptions that were dispensed subsequent to the death of the 25 recipients to whom the prescriptions were prescribed. Some of these 52 prescriptions were controlled substance prescriptions,<sup>56</sup> which may increase the risk of prescription drug abuse and Medicaid fraud. In addition, some prescriptions appear to have been *written* after the death of the recipient. DHCF should scrutinize each of the 52 prescriptions to determine if each claim was a validly paid, final claim.<sup>57</sup> To the extent that these claims are valid, DHCF should ensure that it does not pay for prescriptions dispensed or written after the death of the recipient.

### **Pharmacy Claims Data Reflects Prescriptions Potentially Dispensed And/Or Written To Deceased Recipients**

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According to DHCF Data Warehouse final claim indicators, DHCF appears to have authorized payment for 52 prescriptions that were dispensed subsequent to the death of the 25 recipients to whom the prescriptions were prescribed. Included among these 52 prescriptions were eight prescriptions for controlled substances. Figure 2.1 shows the details of the prescriptions that appear to have been dispensed after each recipient's death.

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<sup>54</sup> DHCF pharmacy claims data contains both a prescribed date and a dispense date for each prescription drug claim. According to DHCF, the prescribed date is the date upon which the provider wrote the prescription and issued it to the recipient and the dispense date is the date upon which the prescription was dispensed at a Medicaid-eligible pharmacy. For the purposes of this report, claims with a dispense date that is subsequent to the recipient's death date are considered "prescriptions dispensed after death."

<sup>55</sup> Data in this finding represent final, paid pharmacy claims according to DHCF's Data Warehouse final claim indicators for prescriptions dispensed from July 1, 2014 through March 15, 2016. For more information on final claim indicators and potential data limitations, see Appendix A.

<sup>56</sup> See Appendix B for more information regarding controlled substances and federal drug schedules.

<sup>57</sup> Since, according to DHCF, the database error described in Appendix A does not affect FFS claims, and this finding includes FFS pharmacy claims, any control weaknesses identified herein are likely not affected by this database error.

**Figure 2.1 Prescriptions (Rx) Potentially Dispensed To Deceased Recipients**

Recipient	# of Rx Dispensed After Death	Days After Death Most Recent Rx Dispensed	Days After Death Final Rx Was Written*	# of Rx for Controlled Substances
A	1	32	32	1
B	1	6	-	0
C	2	5	-	0
D	1	7	6	1
E	13	69	28	0
F	2	23	-	0
G	1	2	-	0
H	1	1	-	1
I	1	7	-	0
J	2	10	-	0
K	1	2	-	0
L	1	1	-	0
M	1	24	-	0
N	1	2	-	0
O	2	1	-	0
P	1	4	-	1
Q	1	15	-	0
R	2	2	-	0
S	4	5	5	1
T	3	1	-	1
U	2	4	-	0
V	1	6	-	1
W	1	2	2	1
X	5	25	-	0
Y	1	7	-	0

\*Blanks represent prescriptions that were written before the death of the recipient but not dispensed until after the death of the recipient.  
 Source: OSA analysis of DHCF pharmacy claims and OVRs death data.

Five of the recipients shown in Figure 2.1 not only appear to have been dispensed prescriptions after death, but also had a total of seven new prescriptions *written* subsequent to their death. For example, a new prescription for 90 pills of oxycodone/acetaminophen (the generic brand of Percocet) was written to and dispensed for Medicaid Recipient A 32 days after death.

**DHCF appears to have authorized payment for 13 prescriptions *dispensed* after Recipient E’s death.** Ten of these 13 prescriptions that appear to have been dispensed after the recipient’s death should have been prevented by DHCF, including three prescriptions that were *dispensed* 69

days after death.<sup>58</sup> Although this recipient did not have any controlled substance prescriptions *dispensed* after death, two prescriptions were *written* for this recipient 28 days after the recipient’s death.

**Recipient T died of a prescription drug overdose and appears to have had a controlled substance prescription *dispensed* one day after death.** Recipient T also had two other prescriptions for non-controlled substances that appear to have been dispensed one day after the recipient’s death.

**Recipient W appears to have been written and dispensed a new prescription for 240 tablets of Endocet (same drug type as Percocet) two days after death.** Due to the high<sup>59</sup> tablet count, this prescription may have had an attached valid diagnosis code of terminal cancer or other qualifying diagnosis. However, it is unclear why this prescription was written and dispensed after the recipient died.

Additionally, among the 25 recipients for whom prescriptions appear to have been dispensed after death, DHCF authorized payment for eight controlled substance prescriptions dispensed to eight recipients (see Figure 2.2). Three of these eight prescriptions appear to also have been written after the recipients’ death (see Figure 2.2).

**Figure 2.2 Type Of Controlled Substances Potentially Dispensed For Deceased Recipients**

Drug Name (Common/Brand Name)	Rx Dispensed After Death	Drug Schedule	New Prescriptions Written After Death
Clonazepam	1	IV	0
Fentanyl	2	II	0
Oxycodone HCl	2	II	1
Oxycodone w/ Acetaminophen (Percocet)	2	II	2
Zolpidem Tartrate (Ambien)	1	IV	0

Source: OSA analysis of DHCF pharmacy claims and OVRS death data.

While most prescriptions for deceased recipients were dispensed before DHCF could reasonably prevent the dispensing, nearly 35 percent of these prescriptions should have been prevented (see Finding 1). For example, one of the controlled substances in Figure 2.2 could have reasonably been identified because it was dispensed 32 days after the death of the recipient. This prescription was for 90 tablets of oxycodone/acetaminophen (the generic form of Percocet).

<sup>58</sup> Utah statute permits death certificates to be filed with the Office of Vital Records and Statistics (OVRS) within 15 days after the person’s death. Utah Code 26-2-13(1)(a); Utah Admin. Code R436-10-1(6). However, 10 of the 13 prescriptions referenced here were dispensed more than 15 days subsequent to the recipient’s death. See Finding 1 for further information regarding OVRS and death data reporting.

<sup>59</sup> DHCF requires a valid diagnosis code and/or prior authorization for a prescription of more than 180 tablets for short-acting opioids.

DHCF should scrutinize each of the 52 prescriptions noted in Figure 2.1 that appear have been dispensed for 25 deceased recipients. DHCF should also investigate each of these claims to determine whether they are final, paid claims. Additionally, DHCF is likely required to investigate the prescribers who wrote prescriptions for deceased recipients (see Section 1 Introduction).

## **DHCF Should Cover Prescriptions Only For Eligible Medicaid Recipients**

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Applicable administrative rule restricts the Utah Medicaid Pharmacy Program to covering prescription drugs for only eligible Medicaid recipients.<sup>60</sup> Since deceased individuals are not eligible for Medicaid,<sup>61</sup> DHCF should not reimburse prescriptions written or dispensed subsequent to the death of any individual. Furthermore, statute prohibits writing and dispensing prescriptions subsequent to the death of the recipient, and the use or distribution of such prescriptions is potentially criminal in nature.<sup>62</sup>

Similar to prescriptions written after the death of the prescriber (see Finding 1), prescriptions dispensed subsequent to the death of the recipient appear to be fraudulent, abusive, or otherwise criminal in nature (see Section 1 Introduction). In each case, DHCF appears to have authorized payment for an unauthorized individual to redeem the prescription. In addition, as mentioned in Finding 1, DHCF does not use a death report for *pharmacy claims*, which likely leaves DHCF ill-equipped to both prevent and seek repayment for deceased recipient pharmacy claims. DHCF should implement controls to prevent payment for prescription drugs dispensed subsequent to the death of a Medicaid recipient. Additionally, DHCF should investigate each prescription written and dispensed after the death of a Medicaid recipient (see Section 1 Introduction).

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<sup>60</sup> Utah Admin. Code R414-60-1(1), -2(1).

<sup>61</sup> Utah Medicaid Policy 207; see 42 CFR 435.403(d).

<sup>62</sup> Utah Code 26-20-3 to -7 (*Utah False Claims Act*); 58-17b-501 (*Pharmacy Practice Act* unlawful conduct provisions); 58-1-501(1) (*Division of Occupational and Professional Licensing Act* unlawful conduct provisions); 58-37-8(3)(a) (*Utah Controlled Substances Act* prohibited acts provisions). The violations listed in the aforementioned statutes are punishable as anywhere from a Class B misdemeanor to a second degree felony. Utah Code 26-20-9; 58-17b-504; 58-67-503(1); 58-1-502(1); 58-37-8(3)(b), (c). Specific civil penalties may also result from violations of the *Utah False Claims Act*. Utah Code 26-20-9.5.

## Recommendations

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1. We recommend that DHCF review pharmacy claims identified within this finding to determine whether they are final, paid claims within the DHCF Data Warehouse.
2. We recommend that DHCF ensure that the ACOs are properly preventing payment for claims for prescriptions written or dispensed subsequent to a recipient's death.
3. We recommend that DHCF monitor and proactively avoid the payment of claims for prescriptions written or dispensed subsequent to a recipient's death.
4. We recommend that DHCF investigate each prescription written or dispensed after the death of the recipient and refer cases to the appropriate authority, as needed.
5. We recommend that DHCF take action in accordance with federal regulation to
  - a. identify individuals engaged in questionable practices or potentially fraudulent or abusive conduct;
  - b. investigate any questionable practices and/or potentially fraudulent or abusive conduct to the extent necessary resolve concerns; and
  - c. refer cases of fraud and abuse to law enforcement or MFCU, as necessary.
6. We recommend that DHCF ensure that suspected civil and criminal violations of the *Utah False Claims Act* are referred promptly to the attorney general for investigation and possible prosecution.

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## **Finding 3**

# **Pharmacy Claims Data Indicates Payment For Prescriptions Written By Ineligible Prescribers<sup>63</sup>**

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According to the Division of Health Care Financing (DHCF) Data Warehouse final claim indicators, DHCF appears to have authorized payment for 234 prescriptions—including 51 prescriptions for opioids—written by prescribers not enrolled<sup>64</sup> in the Utah Medicaid Program to prescribe to Medicaid recipients (hereinafter referred to as “ineligible prescribers”). About 63 percent of the controlled substances that appear to be prescribed by ineligible prescribers were written by one ineligible prescriber.

Additionally, according to the DHCF Data Warehouse final claim indicators, DHCF appears to have authorized payment for 138 prescriptions written by two prescribers sanctioned<sup>65</sup> by DHCF. DHCF rule and policy prohibits payment for claims of services provided by prescribers both not enrolled with and sanctioned by DHCF. DHCF payment for prescriptions written by sanctioned prescribers may, in some cases, fund illegal prescriptions from unlicensed prescribers.

DHCF should scrutinize each of the prescriptions listed in this finding to determine which claims were validly paid, final claims.<sup>66</sup> Additionally, DHCF should strengthen payment controls to ensure payment for prescriptions written or dispensed only by providers eligible to provide Medicaid services.

### **Prescriptions May Have Been Written By Ineligible Prescribers**

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According to the DHCF Data Warehouse final claim indicators, DHCF appears to have paid for 234 prescriptions written in state fiscal year (SFY) 2015 by potentially ineligible prescribers. Almost 22

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<sup>63</sup> As used in this finding, the term “provider” refers to both prescribers and pharmacies. The terms “ineligible prescriber” and “ineligible pharmacy,” as used within this finding, refer to prescribers and pharmacies, respectively, that are not enrolled as providers in the Utah Medicaid Program—even if appropriately enrolled as providers with an ACO or otherwise validly licensed to provide services. Prescriber data in this finding represent final, paid pharmacy claims according to DHCF’s Data Warehouse final claim indicators for prescriptions written from July 1, 2014 through June 30, 2015. Pharmacy data in this finding represent final, paid pharmacy claims according to DHCF’s Data Warehouse final claim indicators for prescriptions dispensed from July 1, 2014 through June 30, 2015. For more information on final claim indicators and potential data limitations, see Appendix A.

<sup>64</sup> DHCF does not have complete documentation to indicate whether all “limited enrollment” prescribers are in fact eligible to prescribe, nor does DHCF appear to have documentation to indicate whether prescribers not enrolled with Medicaid are in fact under contract with a particular ACO. See Appendix A for more information.

<sup>65</sup> Utah administrative rule allows DHCF to “implement administrative sanctions against providers who abuse or improperly apply the benefit program.” Utah Admin. Code R414-22-1(1). As used in this finding, the term “sanctioned prescriber” means any prescriber against whom DHCF has implemented administrative sanctions.

<sup>66</sup> Since, according to DHCF, the database error described in Appendix A does not affect FFS claims, and this finding includes FFS pharmacy claims, any control weaknesses identified herein are likely not affected by this database error.

percent of these prescriptions were for opioids. In comparison, it appears that only eight percent of all prescriptions written by Medicaid prescribers in SFY 2015 were opioid prescriptions.

The Utah Medicaid Provider Manual, which is incorporated by reference into DHCF's administrative rule,<sup>67</sup> requires that providers be enrolled in the Utah Medicaid Program to receive coverage of services they provide to any Medicaid recipient. Enrollment is contingent on compliance with applicable state and federal law and satisfaction of all rules and requirements outlined in the Utah Medicaid Provider Manual.<sup>68</sup> Additionally, although ACOs enter into contracts with legally authorized providers to provide health care services to ACO enrollees, DHCF-ACO contracts<sup>69</sup> require that each ACO also enroll each participating provider in the Utah Medicaid Program.<sup>70</sup> Consequently, payment to ineligible providers is contrary to DHCF rule and policy, and—in the case of ACO providers not enrolled in the Utah Medicaid Program—contractual obligations. Furthermore, since enrollment as a Medicaid provider requires an applicant to satisfy all of the credential requirements specific to each provider type in addition to completion of the Utah Medicaid Provider agreement, ineligible providers may present an unnecessary risk to DHCF and Medicaid recipients.<sup>71</sup>

A total of 48 ineligible prescribers<sup>72</sup> appear to have written prescriptions for 121 different Medicaid recipients. One ineligible prescriber appears to have written a recipient two 25-day prescriptions of oxycodone, totaling 600 pills. A distribution of how many prescriptions were written by each prescriber is shown in Figure 3.1.

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<sup>67</sup> Utah Admin. Code R414-1-5(35).

<sup>68</sup> UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 20.

<sup>69</sup> Our analysis involved a review of the model ACO contract.

<sup>70</sup> For contracts beginning on or after July 1, 2018, recent federal regulation also requires states to enroll all ACO providers. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,497, 27,498, 27,890 (May 6, 2016) (codified at 42 CFR pt. 438).

<sup>71</sup> UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 20.

<sup>72</sup> While most of these prescribers were prescribing for ACO recipients, none were enrolled in the Utah Medicaid Program according to rule, policy, or contract.

**Figure 3.1 Summary Of Prescriptions Per Ineligible Prescriber**

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Prescription Count	Number of Prescribers
1	23
2	7
3	5
4	1
5	1
6	2
8	3
11	2
12	1
16	1
27	1
60	1

Source: OSA analysis of pharmacy claims data for SFY 2015.

Additionally, DHCF final claims data appears to indicate payment for four prescriptions dispensed from two ineligible pharmacies. One prescription appears to have been reimbursed for \$80,000 and two other prescriptions appear to have been reimbursed for \$16,000 each.

**Pharmacy Claims Data Indicates Payment For 51 Prescriptions For Opioids Written By Ineligible Prescribers**

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Opioids were the most common type of drug that appears to have been prescribed by ineligible prescribers. In SFY 2015, ineligible prescribers appear to have prescribed a total of 51 prescriptions for opioids<sup>73</sup> totaling 6,148 pills. The next most common drug group prescribed (which includes antibiotics) comprised 17 total prescriptions. Oxycodone and Vicodin, both narcotics, were the most commonly prescribed schedule II prescriptions, accounting for more than 72 percent of all schedule II drugs prescribed by ineligible prescribers. Figure 3.2 below shows the percent of the total prescriptions for different types of controlled substances.

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<sup>73</sup> These 51 prescriptions were classified as “Analgesics – Opioids,” but only 47 were schedule II controlled substances.

**Figure 3.2 Percent Of Total Prescriptions For Controlled Substances**

	Number of Prescriptions (234)	Percent of Total (234)
<b>Total Controlled Substance Prescriptions</b>	60	26%
Opioids	51	22%
Oxycodone	21	9%
Vicodin	13	6%

Source: OSA analysis of DHCF pharmacy claims data for SFY 2015.

Of the 51 opioid prescriptions, 47 were schedule II opioid prescriptions. Opioids were the only schedule II controlled substances prescribed by ineligible prescribers. The details for each schedule II drug are described in Figure 3.3 below.

**Figure 3.3 Schedule II Drugs Prescribed By Ineligible Prescribers**

Generic Brand Name (Common/Brand name)	Prescription Count	Total Pill Count
Oxycodone HCL	21	2,910
Hydrocodone-Acetaminophen (Vicodin)	13	2,175
Morphine Sulfate	6	208
Oxycodone w/ Acetaminophen (Percocet)	4	195
Hydromorphone HCL (Dilaudid)	2	300
Methadone HCL	1	120

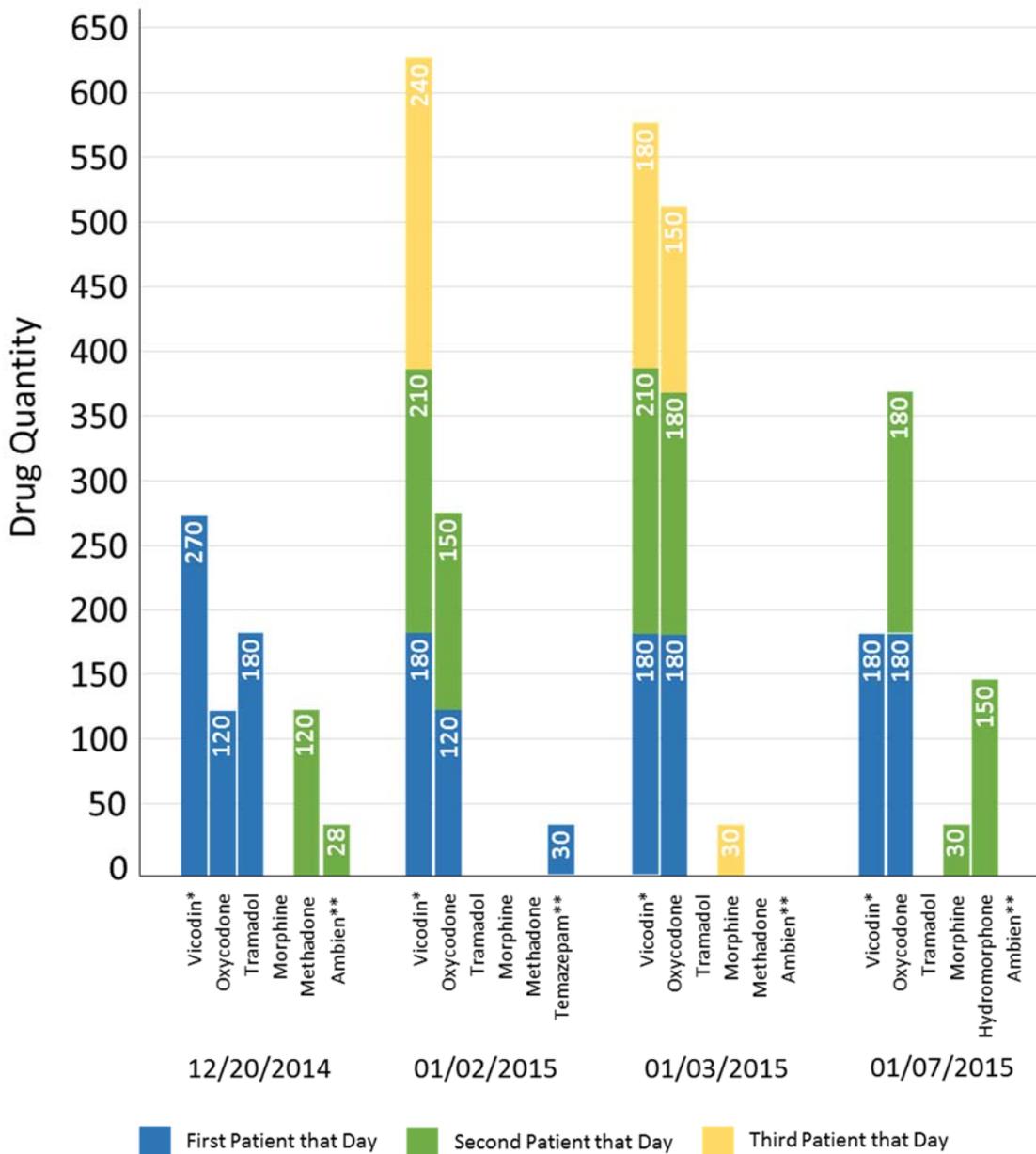
Source: OSA analysis of pharmacy claims data for SFY 2015.

**One Ineligible Prescriber Appears To Have Written 38 Prescriptions For Controlled Substances**

According to DHCF Data Warehouse final claims indicators, one ineligible prescriber<sup>74</sup> (Prescriber A) prescribed 63 percent of the 60 controlled substance prescriptions identified in this finding. Nearly all of the oxycodone and generic form of Vicodin prescriptions were written by this prescriber during this prescriber’s period of ineligibility. This prescriber regularly prescribed up to three different types of opioids to a single person on a single day.

<sup>74</sup> While this prescriber may have been enrolled in an ACO, this prescriber was not enrolled in the Utah Medicaid Program.

**Figure 3.4 Partial Timeline For Prescriber A's Ineligible Prescriptions<sup>75</sup>**



\*Vicodin is the common brand name of hydrocodone-acetaminophen.  
 \*\*These prescriptions are *sedatives*. Ambien is the common brand name of zolpidem.  
 Source: OSA analysis of pharmacy claims data for SFY 2015.

In total, DHCF final claims data indicates payment for 38 controlled substances prescribed by Prescriber A in 27 days. Figure 3.5 shows the details of Prescriber A's controlled substance prescriptions.

<sup>75</sup> This timeline shows data for only four of the ten days during which Prescriber A was not eligible to prescribe.

**Figure 3.5 Prescriber A’s Total Prescriptions For Controlled Substances**

Drug Class	Generic Drug Name (common name)	Total Prescriptions	Total Pills
Opioid	Oxycodone HCl	15	2,160
Opioid	Hydrocodone-Acetaminophen (Vicodin)	11	2,130
Opioid	Morphine Sulfate	4	148
Opioid	Hydromorphone HCl	2	300
Opioid	Tramadol HCl <sup>76</sup>	2	240
Opioid	Methadone HCl	1	120
Muscle Relaxant	Carisoprodol	1	90
Sedative	Temazepam	1	30
Sedative	Zolpidem Tartrate (Ambien)	1	28
<b>Total</b>		<b>38</b>	<b>5,246</b>

Source: OSA analysis of pharmacy claims data for SFY 2015.

Payment for services delivered by ineligible providers is contrary to Medicaid rule and policy, and may present a risk of Medicaid benefit misuse or prescription drug abuse. DHCF should restrict payment of prescriptions to those written or dispensed by only providers enrolled in Medicaid. Additionally, DHCF should scrutinize each of the claims from potentially ineligible providers to determine if they are final, paid claims.

### **Additional Prescriptions Appear To Have Been Written By Sanctioned Prescribers**

Although Medicaid rules prohibit reimbursement of claims for services to sanctioned prescribers, according to the DHCF Data Warehouse final claim indicators, DHCF paid for 138 prescriptions<sup>77</sup> written by two sanctioned prescribers who were sanctioned at the time the prescriptions were written. These 138 prescriptions were written for 40 different recipients and included 72 controlled substance prescriptions. The most common drug prescribed was a generic form of Suboxone, which is used to help transition patients away from a reliance on opioids.

Utah administrative rule allows DHCF to “implement administrative sanctions against providers who abuse or improperly apply the benefit program.”<sup>78</sup> Among various other specified grounds

<sup>76</sup> Effective August 18, 2014, the Drug Enforcement Administration placed 2-[(dimethylamino)methyl]-1-(3-methoxyphenyl)cyclohexanol (tramadol) into schedule IV of the *Controlled Substances Act*. Since these two prescriptions of tramadol were prescribed after August 18, 2014, they were both controlled substances at the time prescribed by this ineligible provider.

<sup>77</sup> Although some of the prescriptions were ACO claims, “[o]nce a provider is suspended or terminated, [DHCF] shall only pay claims for services provided prior to the suspension or termination.” Utah Admin. Code R414-22-7(1).

<sup>78</sup> Utah Admin. Code R414-22-1(1).

for sanctioning listed within rule, DHCF “may sanction a Medicaid provider who has a current restriction, suspension, or probation from DOPL or another state's equivalent agency.”<sup>79</sup> Available sanctions for violating specified rules “are

- (1) Termination from participation in the Medicaid program; or
- (2) Suspension of participation in the Medicaid program.”<sup>80</sup>

Furthermore, “[o]nce a provider is suspended or terminated, [DHCF] *shall only* pay claims for services provided prior to the suspension or termination.”<sup>81</sup>

Federal regulation also mandates that affordable care organizations (ACO) “may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128a of the [*Social Security Act*].”<sup>82</sup> In addition, ACOs are required to “comply with any additional requirements established by the State,”<sup>83</sup> which includes the Utah Medicaid ACO contractual requirement that ACOs conduct regular screenings to ensure that ACO prescribers are not restricted.

A DHCF sanction may result from the revocation or suspension of a prescriber’s license to practice medicine, in which case the prescriber may not lawfully prescribe medication. Since DHCF payment for prescriptions written by sanctioned prescribers may fund illegal prescriptions from unlicensed prescribers, DHCF should deny payment for services provided by sanctioned prescribers.

Given the potentially fraudulent, abusive, and perhaps even criminal conduct associated with ineligible and/or sanctioned providers writing prescriptions or dispensing prescription drugs (see Section 1 Introduction), we recommend that DHCF restrict payment of prescriptions to only prescriptions written and dispensed by eligible providers.

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<sup>79</sup> Utah Admin. Code R414-22-4(24).

<sup>80</sup> Utah Admin. Code R414-22-5.

<sup>81</sup> Utah Admin. Code R414-22-7(1) (emphasis added).

<sup>82</sup> 42 CFR 438.214(d). Sections 1128 and 1128a of the *Social Security Act* address criminal activity and penalties associated with federal health care programs.

<sup>83</sup> 42 CFR 438.214(e).

## **Recommendations**

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1. We recommend that DHCF review pharmacy claims identified within this finding to determine whether they are final, paid claims within the DHCF Data Warehouse.
2. We recommend that DHCF ensure that the ACOs properly prevent payment for claims for prescriptions written or dispensed by ineligible providers.
3. We recommend that DHCF restrict payment of prescriptions to those written or dispensed by only eligible Medicaid providers.
4. We recommend that DHCF deny payment for services provided by sanctioned providers.
5. We recommend that DHCF ensure that ACOs properly enroll providers in the Utah Medicaid Program.

## **Section 2: The Client Restriction Program Needs Improvement**

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## Section 2 Introduction: *The Client Restriction Program*

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The federal *Social Security Act* requires a state Medicaid plan to

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care . . . .<sup>84</sup>

Regulations enacted under this provision of the *Social Security Act*<sup>85</sup> require Medicaid agencies to implement “a statewide surveillance and utilization control program that . . . [s]afeguards against unnecessary or inappropriate use of Medicaid services and against excess payments” and “[p]rovides for the control of the utilization of all services provided under the plan.”<sup>86</sup>

Federal regulations also permit states to “lock-in” Medicaid recipients who overutilize services:

If a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only.<sup>87</sup>

A state may impose these restrictions only if (1) the beneficiary is given “notice and opportunity for a hearing” before restrictions are imposed; (2) the beneficiary has reasonable access “to Medicaid services of adequate quality”; and (3) “[t]he restrictions do not apply to emergency services.”<sup>88</sup>

Utah Department of Health (DOH) administrative rule references the two aforementioned federal regulations as requiring the establishment of the Client Restriction Program (CRP), which “promotes the appropriate use of quality medical services by identifying and correcting overutilization of services.”<sup>89</sup> According to administrative rule, DOH “may require a client to participate in the [CRP] based on the client’s overutilization of services” following proper notification.<sup>90</sup> During the restriction period, restricted recipients are “locked-in to one Primary

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<sup>84</sup> 42 U.S.C. § 1396a(a)(30)(A).

<sup>85</sup> 42 CFR 456.1(b)(1).

<sup>86</sup> 42 CFR 456.3. Federal regulations also require the state Medicaid agency to “[m]onitor the statewide utilization control program” and “[t]ake all necessary corrective action to ensure the effectiveness of the program,” among other requirements. 42 CFR 456.4(a).

<sup>87</sup> 42 CFR 431.54(e).

<sup>88</sup> 42 CFR 431.54(e).

<sup>89</sup> Utah Admin. Code R414-29-1.

<sup>90</sup> Utah Admin. Code R414-29-3(1). Administrative rule defines “overutilization” as “the use of medical services at a frequency or amount that is above what is medically necessary.” Utah Admin. Code R414-29-2(1). *See also*, Utah Medicaid Policy 603-5 (“When a client abuses the benefits of the medical program by continually going to multiple

Care Provider who can authorize specialty providers as needed and are also locked-in to one pharmacy.”<sup>91</sup> According to the Division of Health Care Financing (DHCF), providers other than the assigned providers to whom the recipient is restricted “will *not* receive payment for the services rendered to a restricted member.”<sup>92</sup> A restricted Medicaid recipient is required to “continue participation in the [CRP] until the client has demonstrated he is not overutilizing services.”<sup>93</sup>

The CRP review process takes into account the following guidelines to determine a recipient’s eligibility for restriction:

- **Criterion A:** “Four or more Primary Care Providers (PCPs), non-affiliated, within the past 12 months of Medicaid eligibility, and/or four or more specialists seen outside a normal range of utilization.”
- **Criterion B:** “Four or more pharmacies accessed for abuse potential medications within the past 12 months of Medicaid eligibility.”
- **Criterion C:** “Three or more providers (non-affiliated) prescribing abuse potential medications in a two-month period.”
- **Criterion D:** “Six or more prescriptions filled for abuse potential medications in a two-month period.”
- **Criterion E:** “Five or more non-emergent [emergency room] visits within the past 12 months.”
- **Criterion F:** “Diagnosis or confirmed extenuating circumstances”; “[c]oncurrent prescribers”; “PCP patterns (i.e., clear pattern of utilizing PCP)”; “[o]ther utilization patterns”; “[l]imited access to care in rural areas”; and “limited benefits for PCN clients.”<sup>94</sup>

According to DOH restriction policy, meeting one or more of the restriction criteria A – F “over a 12-month period in which the member has Medicaid eligibility, may mean that a member is misusing their Medicaid benefit.” Also, a review for possible restriction “may be initiated by a complaint from a clinician or pharmacy or law enforcement or through automated claims surveillance.” To account for and track Medicaid recipient eligibility for a restriction review, DOH pulls data from the DHCF Data Warehouse to generate monthly Surveillance and Utilization Review System (SURS) reports, although these reports account for and quantify only criteria A – E. The CRP reviewers use SURS reports to prioritize cases for review, and then perform reviews using utilization data generated in an initial review summary (see Finding 6 and Appendix E).

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providers or seeking multiple prescriptions from different pharmacies, a restriction may be placed limiting which provider or what pharmacy an individual may use.”).

<sup>91</sup> Federal law requires that hospital emergency departments “provide for an appropriate medical screening examination” for “any individual” requesting examination or treatment for a medical condition. 42 U.S.C. § 1395dd(a). However, DHCF policy requires that the assigned Primary Care Provider approve emergency department providers “when a prescription is written for a restricted member.” UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pgs. 46.

<sup>92</sup> UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pgs. 16, 46 (emphasis added).

<sup>93</sup> Utah Admin. Code R414-29-7(1).

<sup>94</sup> The CRP manager developed these criteria after consulting restriction criteria literature and practices developed in other states. For a comparison against the restriction program criteria, if any, for the six surrounding states, see Appendix D. For further explanation regarding the restriction review process, see Appendix E.

## **Finding 4      Pharmacy Claims Data<sup>95</sup> Indicates Payment To Unassigned Providers<sup>96</sup>**

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According to the Division of Health Care Financing (DHCF) Data Warehouse final claim indicators, about 19 percent of restricted recipients appear to have improperly received prescriptions written or dispensed by an unassigned provider, contrary to DHCF policy and administrative rule.<sup>97</sup> DHCF appears to have authorized payment for both (1) prescriptions written by unassigned prescribers and (2) prescriptions dispensed at unassigned pharmacies. During state fiscal year (SFY) 2015, DHCF appears to have authorized payment for 609 prescriptions written by unassigned prescribers and 465 prescriptions dispensed at unassigned pharmacies. DHCF should scrutinize each of these claims to determine if they were final, paid claims.<sup>98</sup> To the extent that these claims are final, paid claims, DHCF should correct controls to prevent restricted recipients from going to unassigned providers.

### **Pharmacy Claims Data Indicates Prescriptions Written By Unassigned Prescribers In SFY 2015**

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According to the DHCF Data Warehouse final claim indicators, DHCF authorized payment for 609 prescriptions that appear to have been written by unassigned prescribers in SFY 2015. These prescriptions include 320 prescriptions written for controlled substances totaling about 12,000 pills. Figure 4.1 shows an overview of the prescriptions written by unassigned prescribers—the highest number of which were for the generic form of Percocet, an opioid used to manage pain.

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<sup>95</sup> Data in this finding represent final, paid Division of Health Care Financing (DHCF) pharmacy claims according to DHCF's Data Warehouse final claim indicators for prescriptions dispensed from July 1, 2014 through June 30, 2015. See Appendix A for more information on final claim indicators.

<sup>96</sup> As used in this finding, the term "provider" refers to both prescribers and pharmacies. More specifically, the term "unassigned provider" refers to providers to whom a particular restriction client is *not* restricted. In other words, DHCF rule and policy do not allow restricted recipients to visit prescribers or fill prescriptions at pharmacies other than those specific prescribers and/or pharmacies explicitly assigned to provide services to the recipient. Although our analysis may include some emergency department providers, DHCF policy requires that the assigned PCP approve these prescribers "when a prescription is written for a restricted member." UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 46.

<sup>97</sup> UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 46; Utah Admin. Code R414-29-2, R414-1-5(35).

<sup>98</sup> Since, according to DHCF, the database error described above does not affect FFS claims, and this finding include FFS pharmacy claims, any control weaknesses identified herein are likely not affected by this database error.

**Figure 4.1 Summary Of Prescriptions Written By Potentially Unassigned Prescribers**

# of Recipients Filling Prescriptions Written By Unassigned Prescribers	170
# of Prescriptions Written	609
# of Controlled Substance Prescriptions	320
Cumulative Controlled Substance Prescription Pill Count	12,245
Highest # of Prescriptions By Drug (Count)	Percocet* (78)
Highest Pill Count By Drug (Count)	Percocet* (2,902)

\*Common name for oxycodone w/ acetaminophen.  
 Source: OSA analysis of pharmacy claims data for SFY 2015.

Approximately 73 percent of the 12,245 controlled substance pills prescribed by unassigned prescribers were opioids.<sup>99</sup> A generic form of Percocet was the most prescribed drug by unassigned prescribers, in both number of prescriptions and number of pills. In total, 39 different recipients received the generic form of Percocet totaling 78 prescriptions for 2,902 pills, including one recipient who received 770 of those pills from 13 prescriptions.

Figure 4.2 displays various totals for controlled substance prescriptions and pills prescribed by unassigned prescribers.

**Figure 4.2 Types Of Prescriptions Written By Unassigned Prescribers**

Controlled Substance	# of Prescriptions Written	# of Pills Prescribed <sup>100</sup>
Oxycodone w/ Acetaminophen (Percocet)	78	2,902
Hydrocodone-Acetaminophen (Vicodin)	62	2,713
Oxycodone HCl	27	2,124
Tramadol HCl	18	625
Morphine Sulfate	6	418
Oxymorphone HCl	2	120
Hydromorphone HCl	3	68
Fentanyl	3	48 patches

Source: OSA analysis of pharmacy claims data for SFY 2015.

<sup>99</sup> Additionally, 42.38 percent of the total pills prescribed by unassigned prescribers, including non-controlled substances (21,168), consisted of opioids prescribed by unassigned prescribers.

<sup>100</sup> Except as otherwise indicated, these totals do not include any drug form other than tablets or capsules.

# Pharmacy Claims Data Indicates Payments For Prescriptions Dispensed At Unassigned Pharmacies In SFY 2015

According to final claim indicators within DHCF’s Data Warehouse, DHCF appears to have authorized payment for 465 prescriptions dispensed at unassigned pharmacies ineligible to receive payment for pharmacy services provided to restricted recipients in SFY 2015. These dispensed prescriptions included 272 prescriptions for controlled substances totaling about 13,000 pills. Figure 4.3 shows an overview of the prescriptions dispensed at unassigned pharmacies.

**Figure 4.3 Summary Of Prescriptions Dispensed At Unassigned Pharmacies**

# of Recipients That Received Prescriptions Dispensed at Unassigned Pharmacies	90
# of Prescriptions Dispensed	465
# of Controlled Substance Prescriptions	272
Cumulative Controlled Substance Prescription Pill Count	13,029
Highest # of Prescriptions By Drug (Count)	Oxycodone (47)
Highest Pill Count By Drug (Count)	Oxycodone (4,446)

Source: OSA analysis of pharmacy claims data for SFY 2015.

About 78 percent of the 13,029 controlled substance pills that appear to have been dispensed at unassigned pharmacies were opioids.<sup>101</sup> In total, 21 different recipients had oxycodone prescriptions dispensed at unassigned pharmacies totaling 47 prescriptions for 4,446 pills. Among prescription drugs dispensed at unassigned pharmacies, oxycodone appeared to be dispensed more than *any* other prescription drug. One recipient received 14 prescriptions for Oxycodone that she had dispensed at two potentially unassigned pharmacies for a total of 1,120 pills.

Figure 4.4 displays totals for controlled substance prescriptions and pills dispensed at unassigned pharmacies.

<sup>101</sup> Additionally, 50 percent of the total pills dispensed at potentially unassigned pharmacies, including non-controlled substances (20,286), consisted of opioid prescriptions dispensed at potentially unassigned pharmacies.

**Figure 4.4**      **Types Of Controlled Substance Prescriptions  
Dispensed At Unassigned Pharmacies**

Controlled Substance (Brand/Common Name)	# of Prescriptions Dispensed	# of Pills Dispensed <sup>102</sup>
Acetaminophen w/ Codeine (Tylenol and Codeine)	1	60
Buprenorphine (Suboxone)	5	20 patches
Buprenorphine HCl-Naloxone HCl Dihydrate (Suboxone)	1	60 films
Fentanyl	1	10 patches
Hydrocodone-Acetaminophen (Vicodin)	42	1,801
Hydromorphone HCl	4	291
Morphine Sulfate	14	713
Oxycodone HCl	47	4,446
Oxycodone w/ Acetaminophen (Percocet)	43	1,877
Oxymorphone HCl	6	360
Tramadol HCl	8	600

Source: OSA analysis of pharmacy claims data for SFY 2015.

Failure to implement cost and restriction controls—particularly when restrictions should be in place—may increase both DHCF costs and the risk of controlled substance abuse among the high-risk population of DHCF’s restricted recipients.

### **DHCF Should Not Pay For Prescriptions Written By Or Dispensed At Unassigned Providers For Restricted Recipients**

While prescriptions written by unassigned prescribers or dispensed at unassigned pharmacies do not necessarily represent an illegal use of controlled substances, DHCF’s administrative rule and policy prohibits the payment of prescriptions written by unassigned prescribers or dispensed at unassigned pharmacies<sup>103</sup>. However, according to final claim indicators, it appears that DHCF paid for dozens of recipients to receive prescriptions for controlled substances written by or dispensed at unassigned providers. Additionally, federal regulation not only requires state Medicaid agencies to “implement a statewide surveillance and utilization control program” but also to “monitor the statewide utilization control program” and “[t]ake all necessary corrective action to ensure the effectiveness of the program.”<sup>104</sup>

<sup>102</sup> Except as otherwise indicated, these totals do not include any drug form other than tablets or capsules.

<sup>103</sup> UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 46; Utah Admin. Code R414-29-2, R414-1-5(35).

<sup>104</sup> 42 CFR 456.3, 456.4(a)(1), (2).

DHCF's restriction program is designed to prevent certain recipients from having prescriptions written or dispensed outside of a designated provider list in order to decrease overutilization and potential abuse and/or fraud. DHCF should correct the system edits in its payment system to prevent restricted recipients from getting prescriptions (1) written by unassigned prescribers and (2) dispensed at unassigned pharmacies. Additionally, since it is DHCF's responsibility to allow payments for prescriptions written by or dispensed at only assigned providers, DHCF should scrutinize each of the claims described in this finding to determine if they were validly paid, final claims.

## **Recommendations**

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1. We recommend that DHCF review pharmacy claims identified within this finding to determine whether they are final, paid claims within the DHCF Data Warehouse.
2. We recommend that DHCF ensure that the ACOs are properly preventing payment for claims for prescriptions (1) written by an unassigned prescribers and (2) dispensed at unassigned pharmacies.
3. We recommend that DHCF correct its payment system to prevent payment for prescriptions (1) written by unassigned prescribers and (2) dispensed at unassigned pharmacies.

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## Finding 5 Client Restriction Program Reviews Indicate Areas For Improvement

Some fee-for-service (FFS) Medicaid recipients were not selected for restriction despite qualifying evidence following Client Restriction Program (CRP) reviews.<sup>105</sup> For example, the CRP manager documented that one reviewer admitted to incorrectly removing a restricted recipient from restriction (see Recipient 1 below). Almost a quarter of evaluated CRP reviews conducted had inaccuracies and/or lack of documentation identified in a quality control review.<sup>106</sup> Enhanced quality control may help improve CRP reviewer consistency and compliance with policy.

### Inadequate Restriction Controls May Contribute To Overutilization And Public Safety Risks

The CRP did not restrict three potentially high-risk recipients FFS recipients during state fiscal year (SFY) 2015 despite recipient behaviors consistent with overutilization identified within the review documentation. The CRP has a responsibility to identify and restrict recipients who demonstrate high-risk behaviors. Among these recipients removed from or not selected for restriction, two still met at least one or more of restriction criteria A – E<sup>107</sup> subsequent to the review and any accompanying reviewer adjustments. Figure 5.1 shows the criteria values for these three recipients who appear to have met restriction criteria and demonstrated behaviors consistent with overutilization yet were not restricted or were removed from restriction.

**Figure 5.1 Some FFS Recipients Not Selected For Restriction Showed Signs Of Overutilization In Review<sup>108</sup>**

	Initial Review Summary Criterion Values					Reviewer Adjusted Criterion Values				
	A	B	C	D	E	A	B	C	D	E
Recipient 1	5	2	3	6	3	1	1	1	4	2
Recipient 2	0	2	3	12	7	1	2	3	7	5
Recipient 3	0	3	4	6	0	1	3	3	3	0

\*\*Cells with red text indicate values that exceed DHCF-established limits for criteria A – E.

Source: OSA analysis of restriction reviews conducted in SFY 2015.

**Recipient 1** initially met three of restriction criteria A – E, but the CRP reviewer adjusted down all three values. As a result of these modifications, the recipient no longer met any of restriction

<sup>105</sup> The CRP team reviewed 1,679 Medicaid recipients for restriction during state fiscal year (SFY) 2015.

<sup>106</sup> This reflects an analysis of only electronically documented quality control reviews for four of the six months from January 1, 2015 through June 30, 2015. The substance of the quality control reviews for the other two months could not be analyzed due to lack of clear documentation.

<sup>107</sup> Note: The SURS reports, initial review summaries, and reviewer changed criterion values do not include a numeric value for criterion F. See Section 2 Introduction for more information on criterion F.

<sup>108</sup> The Section 2 Introduction defines criteria A through E.

criteria A – E. However, the reviewer noted a Controlled Substance Database (CSD) report<sup>109</sup> suggesting drug-seeking behavior and reflective of a history of cash purchases for controlled substances. Despite these indicators of overutilization, the reviewer removed this recipient from restriction. This recipient appeared on the next three SURS reports, meeting three of criteria A – E on two occasions, yet was not again reviewed.

The CRP manager later reviewed the documentation for this review and realized that the reviewer had documented a CSD report indicative of drug abuse yet removed the recipient from restriction. The CRP manager documented that the reviewer admitted the decision to not continue restriction for Recipient 1 was made in error. DHCF has since also acknowledged that this recipient was removed from restriction in error and that the reviewer responsible for the error was subsequently subjected to discipline.

**Recipient 2** initially met three of restriction criteria A – E and still met the same three criteria after adjustments were made by the reviewer, yet was not restricted by the CRP reviewer. The reviewer acknowledged that the recipient exceeded the prescription limits in multiple periods and that there were numerous instances of emergency room visits for non-emergent care. The reviewer called the recipient and suggested that the recipient use an urgent care instead of the emergency room for non-emergent visits and documented that the recipient “would look into the urgent cares.” The CRP reviewer agreed to follow up with the recipient in three months.

**Recipient 3** initially met two of restriction criteria A – E, but after reviewer adjustments met only one criterion. The reviewer discounted four prescribers (criterion C) to three because the CRP reviewer believed two of the prescribers were affiliated with the same radiology department, though it is unclear in the reviewer documentation whether these two prescribers were affiliated with *one another*.<sup>110</sup>

As reflected in the examples noted above, CRP reviewer departures from established restriction criteria may result in the removal or exclusion of otherwise high-risk Medicaid recipients from the restriction program, which is specifically intended to prevent overutilization of Medicaid services. CRP restriction reviewers should more closely adhere to restriction criteria, especially in cases where drug-seeking or abusive behavior is indicated in the initial criteria summary, CSD reports, and/or diagnosis documentation. The CRP should more thoroughly review and document any departures from established criteria.

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<sup>109</sup> Restriction reviewers occasionally request individual Division of Occupational and Professional Licensing (DOPL) controlled substance database reports to assess recipient utilization patterns. See Utah Code 58-37f-301(2)(g). The Utah Controlled Substances Database (CSD) is administered by DOPL and contains specific data “regarding every prescription for a controlled substance dispensed in the state to any individual other than an inpatient in a licensed health care facility.” Utah Code 58-37f-201(1), (5); 58-1-102(5).

<sup>110</sup> The Division of Health Care Financing restriction policy allows for a CRP reviewer to count a prescriber as “affiliated” (i.e., count two prescribers as one) with an authorized PCP *if* the other prescriber “would normally be either ‘on call’ for the PCP or is working in the same office,” but *not* if they are merely “working in the same health network, building or clinic.”

## Quality Control Reviews Indicate Restriction Review Errors

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The CRP manager documented inaccuracies and/or lack of documentation for almost one out of every four CRP restriction reviews selected for a quality control review from January 1, 2015 through June 30, 2015, calling into question the overall accuracy and consistency of CRP reviews and reviewer adjustments made during these reviews (see Finding 6). Quality control review documentation included concerns such as:

- Inconsistent consideration of emergent/non-emergent diagnoses
- Personal, anecdotal reasoning used to come to a decision
- Incomplete review of all required information
- Inadequate justification for restriction decision
- Restriction decisions contrary to data
- Duplicative entries
- Conflicting information and substantiation
- Consideration of information outside the past twelve months of utilization

Accurate restriction reviews are important when considering the potential impact the CRP has on recipient access to controlled substances. Such inaccuracies may result in inappropriate restriction decisions.

While the CRP is not necessarily responsible for managing recipient cases, it does have the authority and responsibility to impose restrictions on recipients who demonstrate risks associated with overutilization and abuse of Medicaid benefits. Failure to effectively perform these duties may increase the risk of misusing Medicaid funds and may contribute to the current drug overdose public health emergency in Utah.

Additionally, the CRP manager audited only 12.8 percent of all restriction reviews conducted from January 1, 2015 through June 30, 2015.<sup>111</sup> As a result, over 87 percent of reviews were conducted by only one CRP reviewer, which reflects a risk of subjectivity because reviewers are given a significant amount of discretion. Additionally, there is limited additional oversight over the manager. The CRP manager's audits include looking at four components of the review: (1) the accuracy of the changes to the initial review summary, (2) the accuracy of Medicaid Managed Care System (MMCS) documentation, (3) the accuracy of the CSD review, and (4) the accuracy and completeness of the overall review documentation. The CRP should strengthen its quality control process to ensure that appropriate and necessary restriction decisions are made.

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<sup>111</sup> This percentage reflects all quality control reviews—both electronic and otherwise—conducted during the full six month period.

## **Recommendations**

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1. We recommend that the CRP review its process, procedures, and systems to ensure reviews reflective of CRP restriction criteria and policy.
2. We recommend that CRP reviewers adhere to established DHCF restriction criteria, especially in cases where drug-seeking or abusive behavior is evident in the initial criteria summary, DOPL reports, pharmacy claims data, and/or diagnosis documentation.
3. We recommend that CRP reviewers improve documentation for reviews and restriction decisions.
4. We recommend that DHCF strengthen the CRP reviewers' quality control process to ensure that appropriate and necessary restriction decisions are made consistently to protect Medicaid funds.

## **Finding 6**

# **Inconsistent Restriction Reviews May Allow Overutilization To Continue**

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The Division of Healthcare Financing’s (DHCF) Client Restriction Program (CRP) reviewers manually adjusted the vast majority of sampled restriction initial review summaries, resulting in almost 25 percent of the reviewed recipients no longer qualifying for restriction according to restriction criteria A – E.<sup>112</sup> Additionally, some reviewer decisions appear to be made inconsistently and contrary to policy.

Some CRP reviewers did not appear to consider concurrent prescribing<sup>113</sup> behavior in restriction decisions, which may allow recipients with drug seeking behaviors to continue to receive controlled substances funded by Medicaid. The CRP should ensure that reviewer actions are consistent, justifiable, and in compliance with DHCF policy.

### **DHCF’s CRP Review Process Is Intended To Address High Utilization Among Medicaid Recipients**

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The CRP uses monthly Surveillance Utilization Review System (SURS) reports as a way to determine those Medicaid recipients who should be restricted. The CRP claims to analyze the SURS report by each criterion individually in a descending manner, beginning with criterion E (which involves emergency room visits). After ranking the values for criterion E, the CRP reviewer claims to research each Medicaid recipient that meets criterion E to determine if a review is needed. However, according to DHCF practice, a review is not conducted if the individual

- (1) is an ACO member,
- (2) is no longer eligible for Medicaid,<sup>114</sup>
- (3) is already restricted,
- (4) was recently reviewed, or
- (5) is a dual-eligible Medicare recipient.

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<sup>112</sup> Note: The SURS reports, initial review summaries, and reviewer changed criterion values do not include a numeric value for criterion F. For more information see Section 2 Introduction.

<sup>113</sup> The CRP manager defined “concurrent prescribing” as “simultaneous” prescribing behavior or instances in which the date upon which one prescription is dispensed overlaps with the days supplied for a prior prescription for a drug of the same class.

<sup>114</sup> Our audit scope did not include a review of recipient eligibility, so it is possible that some Medicaid recipients identified within this section of the report were classified as ineligible on a particular month’s SURS report and were therefore exempted from review by the restriction staff. Since the restriction staff only recently began documenting the SURS ranking process, only two of the 11 SURS reports reviewed in our analysis included restriction staff documentation regarding why certain Medicaid recipients on these two SURS reports were not reviewed. However, since Medicaid eligibility may fluctuate month to month, a recipient’s inclusion on multiple SURS reports may still warrant a restriction review, regardless of an exemption during one particular month. This appears to be the case with the three “ineligible” Medicaid recipients in the limited restriction staff documentation we received.

Once the restriction reviewer has ranked the criterion E values, the restriction reviewer then ranks criterion D (which involves the number of prescriptions dispensed for abuse potential medications) in a descending manner and completes the same process. This is then repeated for criteria A – C.

After the restriction reviewers complete this SURS report review process, they then assign an acuity score to each recipient on the SURS report. This acuity score indicates the number of criteria the Medicaid recipient met on that month’s SURS report. After each Medicaid recipient on the SURS report is given an acuity score, the SURS report is ranked descending by acuity score. The restriction reviewers then identify recipients that either had a review completed that month or were not considered eligible for a review.

Once the CRP reviewers use the SURS report to identify a recipient who meets criteria and is eligible for restriction, a reviewer should complete an in-depth review of that recipient’s Medicaid utilization over the past 12 months of Medicaid eligibility. Initially, the reviewer generates an initial review summary that shows the point-in-time values for restriction criteria A – E. Then the reviewer researches specific claims and their corresponding diagnosis codes to better understand the recipient’s utilization. Using this additional information, the reviewer adjusts values generated in the initial review summary based on the reviewer’s interpretation of the claims. The CRP reviewer theoretically uses these adjusted values to make the final decision to restrict, to remove from restriction, or not to restrict the recipient.

Appendix E includes process maps documenting the review methodology for the CRP reviewers as well as the overall restriction program practice.

## **CRP Reviewers Manually Modified 94 Percent Of Sampled Reviews**

CRP reviewers appear to frequently adjust recipient indicators on the initial review summary, potentially affecting restriction decisions for certain recipients. In over 24 percent of sampled cases, reviewers downgraded initial review summary values below the restriction threshold for criteria A – E. While adjusting key indicators may be appropriate in certain instances, some of the adjustments in the sample were done inconsistently and, in many cases, without documented justification. Below are examples of reviews we sampled in which criteria appear to have been inappropriately modified in a manner that resulted in a decision to not restrict the recipient reviewed.

**A CRP reviewer subjectively reduced a recipient’s “pharmacies accessed” total from seven to two.** Based on the reviewer’s own judgment, the reviewer adjusted the value because “[t]he pharmacies were exceeded to 7 but 5 were only used one time so that brings them down to 2.” This position is contrary to DHCF’s restriction policy, which allows for restriction if “[f]our or more pharmacies [were] accessed for abuse potential medications within the past 12 months of Medicaid eligibility.” Since DHCF policy does not otherwise indicate that pharmacies used only

once may be discounted, this reviewer made an adjustment contrary to policy. Additionally, it does not appear that similar considerations exist for all recipients.

**A CRP reviewer improperly reduced the number of primary care providers (PCP) used by a recipient in a 12-month period from 13 to one.** The reviewer documented that six providers were urgent care providers, while the remainder were a variety of specialists (e.g., pulmonologist, allergist, podiatrist, and mental health provider). The reviewer adjusted the value of this criterion, reasoning that “[u]sing urgent care is an appropriate way to avoid using the [emergency room] for urgent but not emergent care. I have reduced the Provider Count to one (1) for the PCP.”

While DHCF policy is clear that the reviewer must “not count Urgent Care providers,” the seven remaining providers that this recipient visited who were not urgent care providers would appear to still meet the criteria of “[f]our or more PCPs, non-affiliated, within the past 12-months of Medicaid eligibility, and/or four or more specialists seen outside a normal range of utilization.”<sup>115</sup> Therefore, the reviewer in this case made an adjustment contrary to policy.

**A CRP reviewer adjusted down the initial review summary value for criterion C in a manner inconsistent with policy for a recipient.** The initial review summary indicated two separate two-month periods when the recipient exceeded criterion C with a total of four prescriptions for controlled substances during each two-month span. However, the reviewer adjusted this value down to two, which resulted in this recipient no longer meeting any restriction criteria. The reviewer’s documentation states that “[t]here are 2 prescribers from the same clinic so I am only going to count them as 1 and there is [*sic*] also 2 new prescribers that are in . . . the same clinic.”

This position appears contrary to DHCF’s restriction policy, which allows for a reviewer to count a prescriber as “affiliated” (i.e., count two prescribers as one) with an authorized PCP *if* the other prescriber “would normally be either ‘on call’ for the PCP or is working in the same office,” but *not* if they are merely “working in the same health network, building or clinic.” In this case, the documentation is at the very least insufficient to justify counting two prescribers from the same clinic as one single provider. Absent evidence that two of the prescribers were either on call or working in the same office for each of the other two prescribers, this adjustment appears contrary to policy.

In each of these three cases, reviewers reduced initial review summary values such that the recipients no longer met criteria A – E for restriction. Each of these three cases appear to demonstrate inconsistent or improper application of restriction policies. Additionally, each of the three adjustments resulted in an individual not qualifying for restriction despite evidence suggesting overutilization outlined in DHCF policy. The CRP reviewers should adhere more closely to policy and restrict recipients whose actions may increase the risk of Medicaid abuse.

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<sup>115</sup> For additional information regarding the CRP calculation of criterion A, see Finding 7.

## **Some Reviews Did Not Account For Evidence Of Concurrent Prescribing**

Restriction criterion F requires that CRP reviewers take into account “[c]oncurrent prescribing” when determining whether to restrict Medicaid recipients. However, in two of the sampled fee-for-service (FFS) reviews the CRP reviewer declined to restrict the recipient despite documentation within the review material of concurrent prescribing. For example, the review documentation for one of these two FFS recipients read:

The [CSD report] shows that [the recipient] paid cash for prescriptions from 12 additional prescribers. . . . However, [the recipient] also regularly uses [Pharmacy X] and pays cash. . . . There is concurrent prescribing found on the [CSD report]. . . . Use of services does not meet criteria in any area so [the recipient] will be removed from the program. Because of the positive [CSD report] I am setting a follow up review.

This review identified multiple risks for fraudulent behavior and overutilization, including (1) paying cash for some prescriptions while using Medicaid to pay for others, (2) concurrent prescribing, and (3) visiting excessive number of prescribers. However, this recipient was removed from the restriction program because the recipient did not “meet criteria” despite a policy requiring the restriction reviewer to consider concurrent prescribers. The CRP should more consistently utilize the concurrent prescriber consideration within criterion F as a part of their restriction review process to identify potential overutilization and fraud in Medicaid.

## **Recommendations**

1. We recommend that the CRP reviewers adhere to DHCF policy for restricting recipients who are overutilizing Medicaid services.
2. We recommend that the CRP reviewers more consistently consider concurrent prescribing as a part of their restriction review process to identify potential overutilization and fraud among Medicaid recipients.

## Finding 7 **SURS Reports Exclude Some High-Risk Recipients**

The Division of Healthcare Financing (DHCF) Surveillance and Utilization Review System (SURS) reports do not appear to fully account for all Medicaid recipients who may be at risk for overutilization and potential fraud. For example, two fee-for-service (FFS) recipients were not identified on the SURS report despite each visiting an emergency room (ER) more than 35 times in 12 months. Additionally, the SURS reports do not appear to be consistent with established restriction criteria and policy.

### **Some High-Risk Recipients Do Not Appear On Overutilization Reports**

The CRP reviewers use SURS reports to identify Medicaid recipients eligible for the restriction program. However, the SURS report does not capture all high-risk recipients who meet restriction program criteria A – E.<sup>116</sup> Our analysis of 141 recipients reviewed during state fiscal year (SFY) 2015 indicated five FFS recipients who exceeded the restriction criteria yet were not included on any SURS reports published during SFY 2015, which covered recipient utilization from July 1, 2013 through May 31, 2015.<sup>117</sup> It is unclear why these recipients were not included in the SURS reports. A summary of those five recipients and their utilization from our review sample is seen in Figure 7.1 below, with criteria values exceeding the threshold in bold.

**Figure 7.1 Summary Of Five Recipients Not On SURS Report**

	<i>Initial Review Summary Criterion Values</i>					<i>Reviewer Changed Criterion Values</i>				
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
<i>Recipient 1</i>	0	2	1	4	<b>7</b>	1	2	1	4	<b>6</b>
<i>Recipient 2</i>	0	1	2	<b>7</b>	0	1	1	2	<b>7</b>	0
<i>Recipient 3</i>	0	1	2	3	<b>48</b>	1	1	1	3	<b>48</b>
<i>Recipient 4</i>	3	2	<b>3</b>	5	<b>35</b>	2	2	<b>3</b>	4	<b>26</b>
<i>Recipient 5</i>	0	2	<b>3</b>	3	4	1	2	<b>3</b>	3	4

Source: OSA sample of restriction reviews conducted in SFY 2015.

These five recipients met or exceeded at least one criterion threshold (A – E), indicating that they should have been identified on a SURS report due to their high utilization. Recipients 3 and 4 are particularly troubling considering the exceptionally high values they had for criterion E, indicating

<sup>116</sup> Note: The SURS reports, initial review summaries, and reviewer changed criterion values do not include a numeric value for criterion F. For more information, see Section 2 Introduction and Finding 6.

<sup>117</sup> Our analysis did not include the SURS report that covered utilization through June 30, 2015 because it was released in July 2015, and our analysis excluded SURS reports released outside of SFY 2015. Additionally, for our overall SURS report analysis as reflected in this finding, we otherwise excluded the final SURS report released in SFY 2015 (June 9, 2015) because DHCF could have reviewed such individuals through the release of the next SURS report released on July 9, 2015, which runs into state fiscal year 2016.

copious ER visits. These examples demonstrate possible perpetuation of Medicaid fraud, abuse, and/or overutilization that may continue undetected or unreported. DHCF should update the SURS report in order to accurately and completely identify high-risk, high-utilizing Medicaid recipients.

**Improper Program Coding On SURS Reports May Allow Continued Medicaid Abuse**

Programming inconsistencies in the SURS report coding may allow some high-risk behaviors to continue undetected, in addition to potentially skewing the prioritization of cases selected for review (see Finding 8). Figure 7.2 shows six examples of inconsistencies between SURS report criteria and DHCF’s restriction policy:

**Figure 7.2 DHCF Policy vs. SURS Report Programming**

DHCF Policy	SURS Report Programming
Criterion A includes a single value that sums the total number of both PCPs and specialists.	The field representing Criterion A totals the number of providers that do not have a designated specialty.
Criterion C represents the total number of prescribers of abuse potential drugs for a rolling <i>two-month</i> period.	The field representing Criterion C totals the number of prescribers of abuse potential drugs for a <i>12-month</i> period.
Criterion D represents the total number of prescriptions for abuse potential drugs for a rolling <i>two-month</i> period.	The field representing Criterion D totals the number of prescriptions for abuse potential drugs for a <i>12-month</i> period.
Restriction policy states: “DO NOT count any claims (paid or unpaid) relating to inpatient hospital stays.”	The field representing Criterion D is programmed to include both inpatient and outpatient prescription claims.
Criterion E is intended to count only non-emergent ED visits.	The field representing Criterion E totals all ED visits, both emergent and non-emergent.
Restriction policy states: “Two (2) Months: 60 days” (resulting in one month counted as 30 days).	When calculating monthly totals, the SURS report is programmed to count a calendar month, which can vary from 28-31 days in length.

Source: OSA analysis of DHCF policy and practice.

As mentioned in Finding 6, the CRP reviewers use three different sets of data in the restriction process: (1) SURS reports; (2) the initial review summaries; and (3) the CRP reviewer edits. The SURS reports are generated monthly from the DHCF Data Warehouse and are intended to capture recipients who meet at least one restriction program criteria A – E.

Once a review is deemed necessary, the CRP reviewer generates the initial review summary, which shows the point-in-time values for the five restriction criteria. In contrast, the SURS report shows only the past 12 months of data from the date published and could therefore be out of date compared to the initial review summary. Finally, the reviewer adjusts the initial review

summary according to further analysis of the claims and diagnoses data and adjustments (see Finding 6), which are then used as a basis for making a final restriction decision.

Because of the aforementioned inconsistencies, the SURS report may result in inefficient prioritization of reviews for the CRP reviewers. For example, Recipient 6 was reviewed due to the recipient’s inclusion on a SURS report, but during the review the reviewer found that the recipient did not meet any criteria, potentially due to differences in the data sources used. Figure 7.3 compares the Recipient 6’s values from all three reports.

**Figure 7.3 Recipient 6’s Report Values Comparison**

Report	Criterion A	Criterion B	Criterion C	Criterion D	Criterion E
SURS Report	10	1	0	0	2
Initial Review Summary	0	1	2	2	1
CRP Reviewer Edits	1	1	2	2	1

Source: OSA analysis of SURS reports and restriction review reports and documentation.

DHCF should correct programming codes for the SURS report to accurately fit the restriction program criteria in order to correctly report overutilization and to increase efficiency within the restriction review process.

**Recommendations**

1. We recommend that DHCF improve its process for identifying recipients who overutilize Medicaid services to better identify and prioritize for review recipients at the highest risk for overutilization.
2. We recommend that DHCF review and update SURS report programming in order to accurately and completely identify high-risk, high-utilizing Medicaid recipients.

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## **Finding 8      The CRP Does Not Always Review And Restrict High-Risk Recipients<sup>118</sup>**

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Even assuming the Surveillance Utilization Review System (SURS) reports were programmed and generated correctly (see Finding 7), restriction reviews do not always account for the highest-risk recipients. In addition, Client Restriction Program (CRP) reviewers appear to spend a considerable amount of time working on affordable care organization (ACO) related matters, limiting the number of CRP fee-for-service (FFS) reviews. CRP staff also do not appear to account for the frequency with which recipients appear on the SURS reports during the review process.

### **Current CRP Review Process Does Not Evaluate Most High-Risk Recipients**

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The CRP did not review the majority of recipients determined to be high-risk in state fiscal year (SFY) 2015. The CRP uses the monthly SURS report as a way to determine those recipients who are eligible for restriction. CRP staff claim to not review recipients who are:

- Currently restricted
- Recently reviewed and not restricted
- Not currently eligible for Medicaid
- Enrolled in an ACO
- Dual eligible Medicare recipients.

Our analysis excludes ACO recipients, recipients restricted during SFY 2015, and dual eligible Medicare recipients. However, our audit scope did not include a review of recipient eligibility, so it is possible that some Medicaid recipients identified within this section of the report were classified as ineligible on a particular month's SURS report and were therefore exempted from review by the restriction staff.<sup>119</sup> Lastly, recently reviewed recipients who were not restricted but whose continued utilization qualifies them for inclusion on a SURS report may pose a high risk of potential fraud, waste, or abuse.

It does not appear that the CRP always reviews all of the highest-risk recipients (as determined by the acuity score<sup>120</sup> or the individual criteria scores). For example, many of the cases reviewed for restriction have lower acuity scores than recipients not reviewed. Figure 8.1 shows the number of recipients reviewed by acuity score.

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<sup>118</sup> The analysis represented in this finding accounted for 11 SURS reports released in SFY 2015, which excludes the final SURS report released in SFY 2015 (June 9, 2015) because DHCF could have reviewed such individuals through the release of the next SURS report released on July 9, 2015, which runs into SFY 2016.

<sup>119</sup> Since the restriction staff only recently began documenting the SURS ranking process, only two of the 11 SURS reports reviewed in our analysis included restriction staff documentation regarding why certain Medicaid recipients on these two SURS reports were not reviewed.

<sup>120</sup> The acuity score is the number of criteria A – E that a particular recipient meets on a given SURS report. However, the acuity score does not reflect a numeric value for criterion F.

**Figure 8.1 Recipients Identified And Reviewed By Acuity Score**

Acuity Score	Not Reviewed in SFY 2015 <sup>121</sup>	Reviewed in SFY 2015	Total	Recipients Reviewed
1	12,439	337	12,776	2.64%
2	1,558	266	1,824	14.58%
3	174	122	296	41.22%
4	28	15	43	34.88%
5	3	2	5	40.00%

Source: OSA analysis of restriction reviews and SURS reports.

While the CRP claims to also prioritize recipients for review based on individual criteria rather than just acuity score, our analysis shows that the CRP does not always appear to review recipients based on the intensity of each individual criterion score. Our analysis of the five individual criterion scores within the SURS reports revealed the following for reviews conducted in SFY 2015:<sup>122</sup>

- **Criterion A:** The CRP reviewed only 18 percent of the cases with an individual criterion A value of at least twice the policy limit. One SURS report indicated that one recipient received services from 14 different PCPs and did not have a review completed in SFY 2015.
- **Criterion B:** The CRP reviewed 39 percent of the cases that accessed at least twice the criterion limit for pharmacies. One SURS report indicated that one recipient received services from 17 different pharmacies and did not have a review completed in SFY 2015.
- **Criterion C:** The CRP reviewed 59 percent of the cases that received abuse potential medications from at least twice the criterion limit for prescribers. One SURS report indicated that one recipient received abuse potential medications from 11 different prescribers and did not have a review completed in SFY 2015.
- **Criterion D:** The CRP reviewed only 45 percent of the cases that had at least twice the criterion limit of prescriptions for abuse potential medications. One SURS report indicated that one recipient received 38 prescriptions for abuse potential medication and did not have a review completed in SFY 2015.
- **Criterion E:** The CRP reviewed 55 percent of the cases that had at least twice the criterion limit for emergency room visits. One SURS report indicated that one recipient visited the emergency room 26 times and did not have a review completed in SFY 2015.

While the individual criterion and acuity scores do not indicate all risks, the CRP does not seem to consistently review cases with high acuity scores or high individual criterion scores. The CRP should ensure that it prioritizes and reviews recipients who demonstrate the highest risks of overutilization.

<sup>121</sup> These individuals were also not reviewed in SFY 2014.

<sup>122</sup> These individuals were also not reviewed in SFY 2014.

## **CRP Reviewers Appear To Spend Considerable Time Working With ACOs**

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The CRP appears to spend considerable time working with ACOs in lieu of conducting reviews for FFS recipients. During SFY 2015, each CRP reviewer completed on average about two reviews (including ACO audits and FFS reviews) per day. The CRP reviewers responded to approximately 35,920 ACO restriction forms in state fiscal year 2015, which involves responding to questions, preparing data for reviews, and receiving requests for reviews and CSD reports. Additionally, the CRP was requesting and reviewing CSD reports at the request of the ACOs, notwithstanding the ACOs' ability to request and review CSD reports on their own. During the course of the audit, the bureau director was made aware of this practice and subsequently asked the ACOs to complete CSD requests and reviews on their own.

While some communication with the ACOs is necessary, any time and resources spent on the ACO restriction forms may unnecessarily prevent the CRP reviewers from conducting more reviews of high-utilizing FFS clients for which the CRP reviewers are solely responsible. According to ACO-DHCF contracts, the ACOs "shall be responsible for screening its Enrollees to determine whether or not the Enrollee should be placed into the Restriction Program." The CRP reviewers should focus their efforts on conducting more FFS reviews to curb high utilization in FFS recipients.

## **Review Prioritization Process Does Not Consider Ongoing Trends Of Medicaid Misuse**

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In SFY 2015, the CRP reviewed only 188 (3.69%) of the 5,092 recipients who appeared on six or more SURS reports. DHCF should identify recipients who are regularly included on monthly SURS reports. Figure 8.2 shows the total number of recipients who were on six or more SURS reports and the number of recipients reviewed subsequent to those SURS reports.

**Figure 8.2 Frequency Of SURS Reports For Medicaid Recipients<sup>123</sup>**

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SURS Reports	Total Recipients	Recipients Reviewed	Percentage
6	1,151	62	5.39%
7	930	41	4.41%
8	893	37	4.14%
9	798	19	2.38%
10	444	14	3.15%
11	876	15	1.71%
<b>TOTAL (6+)</b>	<b>5,092</b>	<b>188</b>	<b>3.69%</b>

Source: OSA analysis of restriction reviews and SURS reports.

Neglecting to account for recipients who consistently appear on SURS reports may allow for recipients to continue engaging in high-risk behaviors that go undetected on a repeated, monthly

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<sup>123</sup> The analysis represented in Figure 8.2 counted recipient reviews made only subsequent to a recipient's inclusion on six SURS reports, not before.

basis, which may result in potentially fraudulent use of Medicaid services and funds. The CRP reviewers should include the frequency of recipient inclusion on SURS reports in their review prioritization process to ensure that the highest-risk individuals are reviewed. To the extent any additional reviews based on newly prioritized cases indicate potentially fraudulent behavior,<sup>124</sup> we recommend that the CRP investigate and refer such cases to proper authority, as permitted by state and federal privacy and reporting laws and regulations.

## **Recommendations**

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1. We recommend that the CRP identify and review recipients who demonstrate the highest risk of program abuse.
2. We recommend that the CRP reviewers prioritize their efforts on more fee-for-service reviews to curb high utilization in fee-for-service recipients.
3. We recommend that the CRP reviewers include the frequency of recipient inclusion on SURS reports in their review prioritization process to ensure that the highest-risk individuals are being reviewed.
4. We recommend that the CRP investigate and refer any potentially fraudulent activities identified during its review process to appropriate authority, as permitted by state and federal privacy and reporting laws and regulations.

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<sup>124</sup> See Section 1 Introduction for additional information regarding state and federal investigation and referral requirements.

## Appendix A      **Audit Scope, Methodology, And Limitations**

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*A Performance Audit of Medicaid Prescription Drug Controls* was conducted in an effort to evaluate existing controls to prevent fraud, waste, and abuse within the Utah Medicaid Pharmacy Program. The scope of the audit, which was narrowed based on a risk assessment conducted as part of the initial phases of the audit, included an evaluation of Division of Health Care Financing (DHCF) monitoring of the following:

- Provider fraud, waste, and abuse
- Recipient fraud, waste, and abuse

To this end, field work for this audit—which occurred from January 2016 to June 2016—included but was not limited to the following:

- Analysis of applicable federal and state statute, administrative rules, and program policies and procedures
- Analysis of Department of Health Office of Vital Records and Statistics (OVRs) death certificate data for deaths that occurred in Utah from July 1, 2012 through February 29, 2016
- Analysis of the Center for Disease Control and Prevention (CDC) Wide-ranging Online Data for Epidemiologic Research (WONDER) Mortality database for *Multiple Cause of Death Data, 1999-2014*<sup>125</sup>
- Analysis of the DHCF pharmacy claims data for all final, paid claims as indicated by final claim indicators in DHCF's Data Warehouse for prescriptions dispensed from July 1, 2014 through March 15, 2016
- Analysis of restriction program review documentation for staff reviews conducted during state fiscal year (SFY) 2015
- Analysis of Medicaid recipients enrolled in the Client Restriction Program during SFY 2014 and 2015 and associated restricted providers
- Analysis of the Medicaid Management Care System (MMCS) Restriction Reviews Completed Report for SFY 2014 and 2015
- Analysis of Surveillance and Utilization Review System (SURS) reports with a period review end date of June 30, 2014 through April 30, 2015
- Analysis of all enrolled providers that were eligible to prescribe at any point during SFY 2015
- Analysis of all pharmacies that were eligible to bill DHCF at any point during SFY 2015
- Analysis of all providers sanctioned by DHCF during SFY 2015
- Analysis of DHCF Data Warehouse tables including drug classification, provider enrollment, and identification information from DHCF's Data Warehouse

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<sup>125</sup> See Appendix C for more additional methodological information regarding this database and our use of the database.

The audit scope did not include a review of recipient eligibility, so it is possible that some Medicaid recipients identified within Section 2 of this report were classified as ineligible on a particular month's SURS report and were therefore exempted from review by the restriction staff. Since the restriction staff only recently began documenting the SURS ranking process, only two of the 11 SURS reports reviewed in our analysis included restriction staff documentation regarding why certain Medicaid recipients on these two SURS reports were not reviewed. However, since Medicaid eligibility may fluctuate month to month, a recipient's inclusion on multiple SURS reports may still warrant a restriction review, regardless of an exemption during one particular month. This appears to be the case with the three "ineligible" Medicaid recipients in the limited restriction staff documentation we received.

## **Final Claim Indicator Error Limitation**

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In coordination with DHCF, we used specifically suggested final claim indicators to identify final, paid Medicaid pharmacy claims housed within the Medicaid Data Warehouse for both fee-for-service (FFS) and accountable care organization (ACO) pharmacy claims. All pharmacy claims discussed in Findings 1 – 4 of this report appear to be final, paid claims according to these final claim indicators as reflected in DHCF's Data Warehouse.

During our survey work and field work, our understanding—as confirmed by DHCF—was that DHCF's Data Warehouse accurately and completely reflected actual payment of pharmacy claims according to the final claim indicators. After concluding our analysis, and as a result of our audit, DHCF raised the concern that one specific final claim indicator ("FinalClaimInd") may inaccurately identify some ACO pharmacy claims as final, paid claims when such claims may have been voided and not paid. DHCF can neither explain the cause nor the extent of this error. Additionally, it is unclear whether DHCF can systematically identify each individual error. As a result of this error, any conclusions or recommendations in this report are reflective of data *only* as represented within DHCF's Pharmacy Claims Data Warehouse.

ACO pharmacy claims we report may be reflective of actual payment for pharmacy claims contrary to applicable law, rule, or policy as detailed in Findings 1 – 4, to the extent these claims are indeed final, paid claims. Additionally, because each claim currently appears to be a final, paid claim, each claim should be reviewed to determine the validity of the final claim indicators.

Since, according to DHCF, the database error described above does not affect FFS claims, and Findings 1 – 4 each include FFS pharmacy claims, any control weaknesses identified therein are likely not affected by this database error.

## Other Data Limitations In Specific Findings

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In addition to the database final claim indicator error, data in Findings 3 and 4 have specific limitations discussed below.

### **Finding 3: Provider Enrollment Limitations**

DHCF does not have complete documentation to indicate whether all “limited enrollment” prescribers are in fact eligible to prescribe. Although there may be limited information in the enrollment tables, we believe that DHCF’s provider eligibility controls do not completely detect prescriptions written by or dispensed from providers not enrolled in the Utah Medicaid Program.

### **Finding 4: Restriction Data Limitations**

DHCF does not appear to have accurate recipient restriction information. DHCF could not readily provide a database for all restriction patients and the providers to whom they were restricted during SFY 2015. However, after working with DHCF for approximately six months and after four separate restriction database iterations, we conclude that the final restriction database received represents the most complete and accurate data available. While there may be inaccuracies within the database that DHCF created and errors or inconsistencies in the methodology that DHCF suggested, we believe that DHCF lacks sufficient controls to ensure that restricted recipients are truly restricted to each assigned prescriber and pharmacy.

Due to the sensitive nature of Social Security numbers, all Social Security numbers were deleted from our working papers upon completion of our final report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Appendix B Schedules Of Controlled Substances

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On October 27, 1970, the United States Congress enacted the *Controlled Substances Act* (CSA) within Title II of the *Comprehensive Drug Abuse Prevention and Control Act of 1970*.<sup>126</sup> The CSA defines a “controlled substance” as “a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V” of the CSA.<sup>127</sup> The CSA lists findings for each schedule that are required to be made with respect to each drug or other substance listed therein.<sup>128</sup> The required findings “for each of the schedules are as follows:

(1) SCHEDULE I.—

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has no currently accepted medical use in treatment in the United States.

(C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

(2) SCHEDULE II.—

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.

(C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

(3) SCHEDULE III.—

(A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

(4) SCHEDULE IV.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

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<sup>126</sup> Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, § 100, 84 Stat. 1236, 1242 (1970).

<sup>127</sup> 21 U.S.C. §§ 802(6), 812(a).

<sup>128</sup> 21 U.S.C. § 812(b).

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

(5) SCHEDULE V.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.”<sup>129</sup>

The CSA lists the specific drugs assigned to each of the five schedules, which are updated and republished annually.<sup>130</sup> For illustrative purposes, the chart below includes some of the specific drugs found within each of the five schedules.

Schedule	Controlled Substance (Examples of Brand Names)
<b>I</b>	Ecstasy, heroin, marijuana, LSD
<b>II</b>	Fentanyl, hydrocodone, oxycodone, methadone, methylphenidate (Ritalin)
<b>III</b>	Anabolic steroids, ketamine, testosterone
<b>IV</b>	Alprazolam (Xanax), diazepam (Valium), tramadol, zolpidem (Ambien)
<b>V</b>	Codeine preparations – 200 mg/(100 ml or 100 gm) (Robitussin A-C), Pregabalin (Lyrica)

Source: OSA analysis of U.S. Department of Justice Drug Enforcement Administration list of controlled substances.<sup>131</sup>

<sup>129</sup> 21 U.S.C. § 812(b).

<sup>130</sup> 21 U.S.C. § 812(a), (c).

<sup>131</sup> See also, 21 U.S.C. § 812(c).

## Appendix C ICD-10 Codes For Prescription Drug Overdose Death Data

The National Institute on Drug Abuse (NIDA) at the National Institutes of Health (NIH) publishes data representing national overdose deaths from select prescription and illicit drugs. NIDA draws upon source material and analyses from the National Center for Health Statistics (NCHS) within the Centers for Disease Control and Prevention (CDC) and CDC Wide-ranging Online Data for Epidemiologic Research (WONDER)<sup>132</sup> data, which is based on specific International Classification of Diseases, 10<sup>th</sup> Revision (ICD-10) codes.<sup>133</sup>

Using the same methodology and ICD-10 codes that NIDA used to assemble its national overdose death data, our office queried the CDC WONDER Mortality database for *Multiple Cause of Death Data, 1999-2014* with the following specific ICD-10 codes for the underlying cause of death and the multiple causes of death:

### *Underlying Cause of Death*

Unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14)
X40 (Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics)
X41 (Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified)
X42 (Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified)
X43 (Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system)
X44 (Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances)
X60 (Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics)
X61 (Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified)
X62 (Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified)
X63 (Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system)
X64 (Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances)
X85 (Assault by drugs, medicaments and biological substances)
Y10 (Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent)

<sup>132</sup> CDC WONDER (CDC Wide-ranging Online Data for Epidemiologic Research) “is a web application that makes many health-related data sets available to the worldwide public health community.” It “manages nearly 20 collections of public-use data for U.S. births, deaths, cancer diagnoses, Tuberculosis (TB) cases, vaccinations, environmental exposures, and population estimates, among many other topics.”

<sup>133</sup> Note: The U.S. Department of Health and Human Services maintains and distributes the International Classification of Diseases, 10th Revision (ICD-10-CM). 45 CFR 162.1002(c)(2); 45 CFR 160.103.

Unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14) (continued from previous page)
Y11 (Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent)
Y12 (Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent)
Y13 (Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent)
Y14 (Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent)

Source: CDC WONDER Data.

### Multiple Causes of Death: Prescription Drugs

Prescription Drugs ICD-10 codes (T36-T39, T40.2-T40.4, T41-T43.5, and T43.8-T50.8)	
T36.0 (Penicillins)	T44.3 (Other parasympatholytics [anticholinergics and antimuscarinics] and spasmolytics, not elsewhere classified)
T36.1 (Cefalosporins and other beta-lactam antibiotics)	T44.4 (Predominantly alpha-adrenoreceptor agonists, not elsewhere classified)
T36.2 (Chloramphenicol group)	T44.5 (Predominantly beta-adrenoreceptor agonists, not elsewhere classified)
T36.3 (Macrolides)	T44.6 (Alpha-adrenoreceptor antagonists, not elsewhere classified)
T36.4 (Tetracyclines)	T44.7 (Beta-adrenoreceptor antagonists, not elsewhere classified)
T36.5 (Aminoglycosides)	T44.8 (Centrally acting and adrenergic-neuron-blocking agents, not elsewhere classified)
T36.6 (Rifamycins)	T44.9 (Other and unspecified drugs primarily affecting the autonomic nervous system)
T36.7 (Antifungal antibiotics, systemically used)	T45.0 (Antiallergic and antiemetic drugs)
T36.8 (Other systemic antibiotics)	T45.1 (Antineoplastic and immunosuppressive drugs)
T36.9 (Systemic antibiotic, unspecified)	T45.2 (Vitamins, not elsewhere classified)
T37.0 (Sulfonamides)	T45.3 (Enzymes, not elsewhere classified)
T37.1 (Antimycobacterial drugs)	T45.4 (Iron and its compounds)
T37.2 (Antimalarials and drugs acting on other blood protozoa)	T45.5 (Anticoagulants)
T37.3 (Other antiprotozoal drugs)	T45.6 (Fibrinolysis-affecting drugs)
T37.4 (Anthelmintics)	T45.7 (Anticoagulant antagonists, vitamin K and other coagulants)
T37.5 (Antiviral drugs)	T45.8 (Other primarily systemic and haematological agents)
T37.8 (Other specified systemic anti-infectives and antiparasitics)	T45.9 (Primarily systemic and haematological agent, unspecified)
T37.9 (Systemic anti-infective and antiparasitic, unspecified)	T46.0 (Cardiac-stimulant glycosides and drugs of similar action)

Prescription Drugs ICD-10 codes (T36-T39, T40.2-T40.4, T41-T43.5, and T43.8-T50.8) (continued from previous page)	
T38.0 (Glucocorticoids and synthetic analogues)	T46.1 (Calcium-channel blockers)
T38.1 (Thyroid hormones and substitutes)	T46.2 (Other antidysrhythmic drugs, not elsewhere classified)
T38.2 (Antithyroid drugs)	T46.3 (Coronary vasodilators, not elsewhere classified)
T38.3 (Insulin and oral hypoglycaemic [antidiabetic] drugs)	T46.4 (Angiotensin-converting-enzyme inhibitors)
T38.4 (Oral contraceptives)	T46.5 (Other antihypertensive drugs, not elsewhere classified)
T38.5 (Other estrogens and progestogens)	T46.6 (Antihyperlipidaemic and antiarteriosclerotic drugs)
T38.6 (Antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified)	T46.7 (Peripheral vasodilators)
T38.7 (Androgens and anabolic congeners)	T46.8 (Antivaricose drugs, including sclerosing agents)
T38.8 (Other and unspecified hormones and their synthetic substitutes)	T46.9 (Other and unspecified agents primarily affecting the cardiovascular system)
T38.9 (Other and unspecified hormone antagonists)	T47.0 (Histamine H2-receptor antagonists)
T39.0 (Salicylates)	T47.1 (Other antacids and anti-gastric-secretion drugs)
T39.1 (4-Aminophenol derivatives)	T47.2 (Stimulant laxatives)
T39.2 (Pyrazolone derivatives)	T47.3 (Saline and osmotic laxatives)
T39.3 (Other nonsteroidal anti-inflammatory drugs [NSAID])	T47.4 (Other laxatives)
T39.4 (Antirheumatics, not elsewhere classified)	T47.5 (Digestants)
T39.8 (Other nonopioid analgesics and antipyretics, not elsewhere classified)	T47.6 (Antidiarrhoeal drugs)
T39.9 (Nonopioid analgesic, antipyretic and antirheumatic, unspecified)	T47.7 (Emetics)
T40.2 (Other opioids)	T47.8 (Other agents primarily affecting the gastrointestinal system)
T40.3 (Methadone)	T47.9 (Agent primarily affecting the gastrointestinal system, unspecified)
T40.4 (Other synthetic narcotics)	T48.0 (Oxytocic drugs)
T41.0 (Inhaled anaesthetics)	T48.1 (Skeletal muscle relaxants [neuromuscular blocking agents])
T41.1 (Intravenous anaesthetics)	T48.2 (Other and unspecified agents primarily acting on muscles)
T41.2 (Other and unspecified general anaesthetics)	T48.3 (Antitussives)
T41.3 (Local anaesthetics)	T48.4 (Expectorants)
T41.4 (Anaesthetic, unspecified)	T48.5 (Anti-common-cold drugs)
T41.5 (Therapeutic gases)	T48.6 (Antiasthmatics, not elsewhere classified)
T42.0 (Hydantoin derivatives)	T48.7 (Other and unspecified agents primarily acting on the respiratory system)

Prescription Drugs ICD-10 codes (T36-T39, T40.2-T40.4, T41-T43.5, and T43.8-T50.8) (continued from previous page)	
T42.1 (Iminostilbenes)	T49.0 (Local antifungal, anti-infective and anti-inflammatory drugs, not elsewhere classified)
T42.2 (Succinimides and oxazolidinediones)	T49.1 (Antipruritics)
T42.3 (Barbiturates)	T49.2 (Local astringents and local detergents)
T42.4 (Benzodiazepines)	T49.3 (Emollients, demulcents and protectants)
T42.5 (Mixed antiepileptics, not elsewhere classified)	T49.4 (Keratolytics, keratoplastics and other hair treatment drugs and preparations)
T42.6 (Other antiepileptic and sedative-hypnotic drugs)	T49.5 (Ophthalmological drugs and preparations)
T42.7 (Antiepileptic and sedative-hypnotic drugs, unspecified)	T49.6 (Otorhinolaryngological drugs and preparations)
T42.8 (Antiparkinsonism drugs and other central muscle-tone depressants)	T49.7 (Dental drugs, topically applied)
T43.0 (Tricyclic and tetracyclic antidepressants)	T49.8 (Other topical agents)
T43.1 (Monoamine-oxidase-inhibitor antidepressants)	T49.9 (Topical agent, unspecified)
T43.2 (Other and unspecified antidepressants)	T50.0 (Mineralocorticoids and their antagonists)
T43.3 (Phenothiazine antipsychotics and neuroleptics)	T50.1 (Loop [high-ceiling] diuretics)
T43.4 (Butyrophenone and thioxanthene neuroleptics)	T50.2 (Carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics)
T43.5 (Other and unspecified antipsychotics and neuroleptics)	T50.3 (Electrolytic, caloric and water-balance agents)
T43.8 (Other psychotropic drugs, not elsewhere classified)	T50.4 (Drugs affecting uric acid metabolism)
T43.9 (Psychotropic drug, unspecified)	T50.5 (Appetite depressants)
T44.0 (Anticholinesterase agents)	T50.6 (Antidotes and chelating agents, not elsewhere classified)
T44.1 (Other parasympathomimetics [cholinergics])	T50.7 (Analeptics and opioid receptor antagonists)
T44.2 (Ganglionic blocking drugs, not elsewhere classified)	T50.8 (Diagnostic agents)

Source: CDC WONDER Data.

*Multiple Causes of Death: Opioids*

Opioid pain relievers includes other opioids, methadone, other synthetic narcotics. ICD-10 codes (T40.2-T40.4)
T40.2 (Other opioids)
T40.3 (Methadone)
T40.4 (Other synthetic narcotics)

Source: CDC WONDER Data.

# Appendix D Restriction Program Criteria Comparison With Surrounding States

Federal Medicaid regulations permit state agencies to “lock-in” Medicaid recipients that overutilize services. Such regulations state:

If a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only.<sup>134</sup>

However, “[t]he agency may impose these restrictions only if the following conditions are met:

- (1) The agency gives the beneficiary notice and opportunity for a hearing (in accordance with procedures established by the agency) before imposing the restrictions.
- (2) The agency ensures that the beneficiary has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality.
- (3) The restrictions do not apply to emergency services furnished to the beneficiary.”<sup>135</sup>

The chart below displays the lock-in procedure for the Medicaid restriction program, if any, for Utah and its six surrounding states.

	AZ	CO	ID	NV	NM	UT	WY
<b>Restriction Program?</b>	No	Yes	Yes	Yes	Yes	<b>Yes</b>	Yes
<b>Designated Pharmacies</b>	N/A	1	1	1	Multiple	<b>1</b>	1
<b>Designated Providers</b>	N/A	1	1	1	Multiple	<b>1</b> <sup>136</sup>	Multiple

Source: OSA analysis of statutes, rules, and policies for Utah and six surrounding states.<sup>137</sup>

Each state can restrict Medicaid recipients based on risks defined in individual state Medicaid policies. Criteria evaluated by Medicaid programs in surveyed states include the use of multiple primary care providers (PCP), pharmacies, or providers, or excessive use of specific prescriptions (Rx) or emergency departments (ED).

<sup>134</sup> 42 CFR 431.54(e).

<sup>135</sup> 42 CFR 431.54(e).

<sup>136</sup> Medicaid policy states that restricted recipients are “locked-in to one Primary Care Provider *who can authorize specialty providers as needed* . . . .” UTAH MEDICAID PROVIDER MANUAL, Section I: General Information, pg. 16.

<sup>137</sup> 10 Colorado Code of Regulations 2505-10-8.075.2; Idaho Admin. Code r.16.03.09.011.11, r.16.03.09.910; Nevada Division of Health Care Financing and Policy, MEDICAID SERVICES MANUAL, pg. 492; Code of New Mexico Rules R. 8.308.22.9.E(2); Utah Medicaid Policy 603-5; Code of Wyoming Rules R. 29-9; and Wyoming Department of Health, MEDICAID PHARMACY PROVIDER MANUAL, pg. 22.

The table below displays the specific criteria or guidelines for the Medicaid restriction program, if any, for Utah and its six surrounding states.

Criteria	CO	ID	NV*	NM	UT	WY
<b>PCP</b>		Use of multiple providers; excessive provider visits; unnecessary use of providers		Frequently changing PCPs	<b>Four or more PCP within last 12 months or four or more specialists</b>	
<b>Pharmacy</b>	Three or more pharmacies during a quarter	Use of multiple pharmacies	More than one pharmacy in the past 60 day period	Simultaneous use of multiple pharmacy providers	<b>Four or more pharmacies within the last 12 months</b>	Multiple pharmacies within a designated time period
<b>Provider</b>		Use of multiple prescribing physicians	More than three physicians in the past 60 day period		<b>Three or more in a two-month period</b>	Multiple prescribers within a designated time period
<b>Rx</b>	Use of three or more Rx in the same therapeutic category during a quarter; 16 or more Rx during a quarter	Use of multiple controlled substances; overlapping Rx drugs of the same therapeutic class	Dispensed quantity per Rx of controlled substances appears excessive		<b>Six or more Rx filled in a two-month</b>	
<b>ED Visit</b>		Frequent use of ED facilities for non-emergent conditions	Recipient has utilized ED for receiving controlled substances	Regular use of ED services for inappropriate, non-emergency care	<b>Five or more non-emergent ED visits within last 12 months</b>	
<b>Other</b>	By referral, review or other analysis that indicates other overutilization	Determination of abusive use of drugs or unnecessary or abusive use of Medicaid services; demonstrated abusive patterns or drug-seeking behavior as referred by a medical professional or PCP; diagnosis of drug abuse and/or withdrawal	Recipient has been diagnosed with a drug dependency related condition; recipient has other noted drug seeking behavior(s)	Overutilization of services; frequently seeking unauthorized care; habitually non-compliant and missed appointments	Diagnosis; confirmed extenuating circumstances; concurrent prescribers; PCP patterns; limited access to care in rural areas; limited benefits for PCN clients	Pursuant to a referral from another state's Medicaid program

\*In Nevada, once a recipient "has filled ten or more controlled substance prescriptions in the past 60 day period (includes controlled substance pharmaceuticals given in the emergency room)," the clinical review proceeds with the criteria listed in the chart above.

Source: OSA analysis of statutes, rules, and policies for Utah and six surrounding states.<sup>138</sup>

<sup>138</sup> 10 Colorado Code of Regulations 2505-10-8.075.4; Idaho Admin. Code r.16.03.09.913; Nevada Division of Health Care Financing and Policy, MEDICAID SERVICES MANUAL, pgs. 492-493; Code of New Mexico Rules R. 8.301.5.11; Utah Department of Health, RESTRICTION CRITERIA, pgs. 2-3; Code of Wyoming Rules R. 29-9; and Wyoming Department of Health, MEDICAID PHARMACY PROVIDER MANUAL, pg. 22.

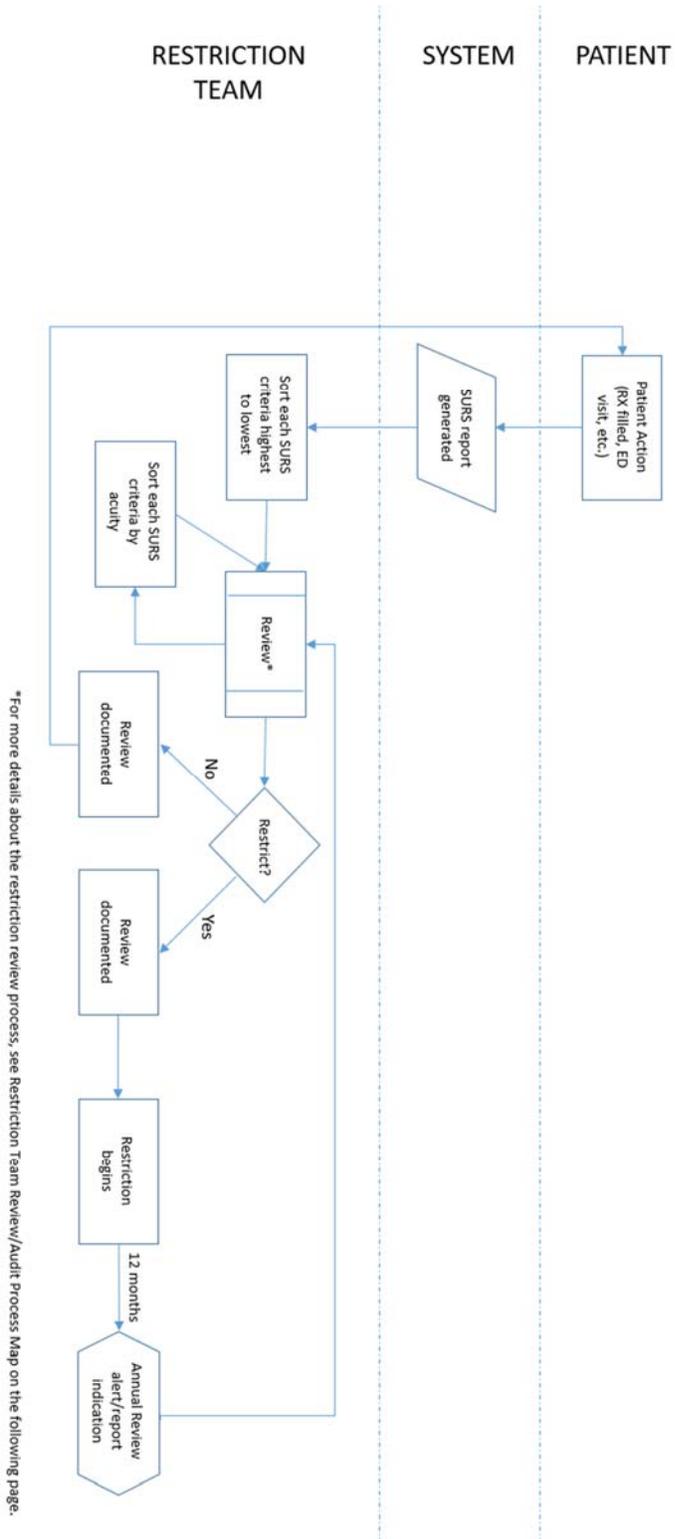
## **Appendix E    Restriction Team Process Maps**

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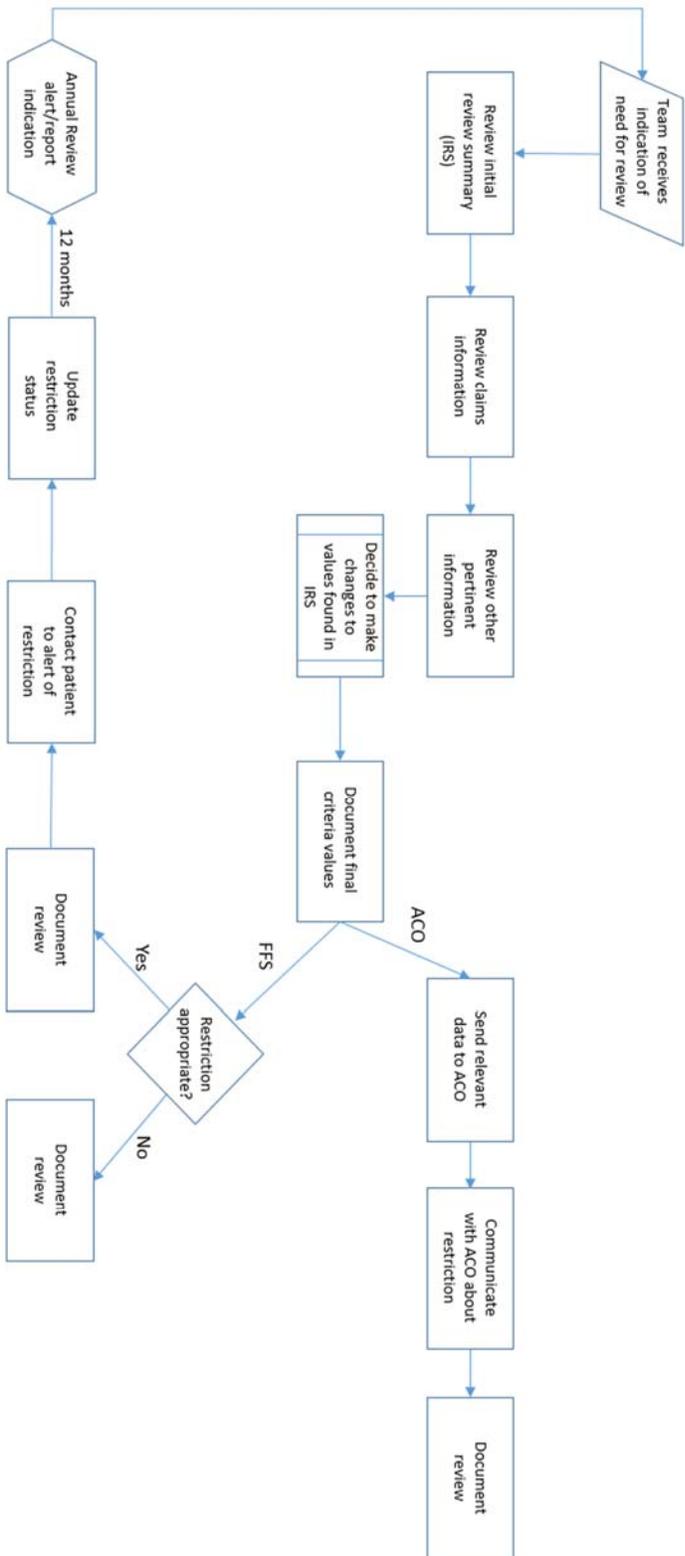
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We created two process maps relating to the Division of Healthcare Financing’s (DHCF) Client Restriction Program (CRP): (1) a high-level map detailing the restriction process and the involved constituents and (2) a more detailed map showing the process of a single review/audit. We created these maps using information learned from conversations with CRP staff, observations of restriction staff, and DHCF policy.

# Restriction Process Map



# Restriction Team Review/Audit Process Map



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# **DHCF Response**

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**State of Utah**

GARY R HERBERT  
*Governor*

SPENCER J. COX  
*Lieutenant Governor*

**Utah Department of Health  
Executive Director's Office**

Joseph K. Miner, M.D., M.S.P.H., F.A.C.P.M.  
*Executive Director*

Robert T. Rolfs, M.D. M.P.H.  
*Deputy Director  
Chief Medical Officer*

Nate Checketts  
*Deputy Director  
Director, Medicaid and Health Financing*

August 11, 2016

John Dougall, State Auditor  
Office of the State Auditor  
Utah State Capitol Complex  
East Office Building, Suite E310  
P.O. Box 142310  
Salt Lake City, Utah 84114-2310

Dear Mr. Dougall:

Thank you for the opportunity to respond to the audit entitled "A Performance Audit of Medicaid Prescription Drug Controls" (Report No. 2016-02). We appreciate the effort and professionalism of both you and your staff in this review. Likewise, our staff have spent time collecting information for your review, answering questions, and implementing changes to improve the program. We believe that the results of our combined efforts will make Medicaid a better, more efficient program.

We concur with the recommendations in this report and will use the recommendations to strengthen the policies, procedures, and internal controls of the program. Our responses describe the actions the Department of Health is taking to implement the recommendations. The Department is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need to be improved.

Sincerely,

A handwritten signature in blue ink that reads "Nate Checketts".

Nate Checketts  
Deputy Director, Department of Health  
Division Director, Medicaid and Health Financing

*Response to Recommendations*

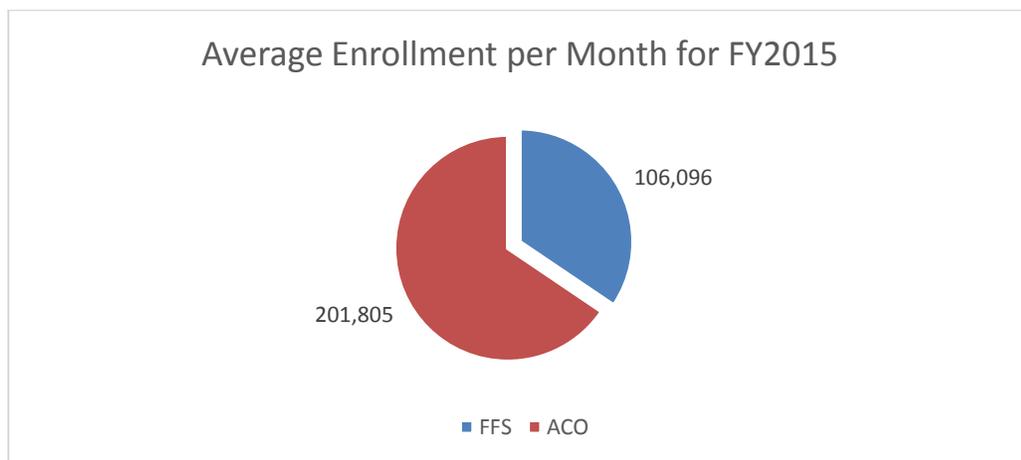
**Overview**

The goal of the Utah Medicaid program is to provide access to quality, cost effective health care for eligible Utahans. In order to provide this access to care, Utah Medicaid employs two different delivery systems: fee for service and managed care. The payment models for the two delivery systems are significantly different.

In the fee for service (FFS) delivery system, providers submit medical claims directly to the Division of Medicaid and Health Financing (DMHF) to seek payment for services performed. Providers receive a payment for each allowable service performed (such as an office visit, a test, or a procedure).

In the managed care delivery system, DMHF transfers the full financial risk for contracted services to a managed care plan. DMHF pays the managed care plans a monthly rate for each enrolled recipient (capitation), whether or not the recipient seeks care during the month. The goal in the managed care delivery system is that the managed care plan will manage program cost, utilization, and quality<sup>1</sup>.

As stated in the audit report, Utah Medicaid refers to contracted managed care entities for physical health services as Accountable Care Organizations (ACOs). During state fiscal year (SFY) 2015, Medicaid recipients in four counties were required to enroll in an ACO and receive their physical health care through that ACO. Medicaid recipients in the other counties may voluntarily enroll in an ACO or they may receive services through the FFS delivery system. As a result, an average of 66 percent of Medicaid recipients received their physical health services through an ACO during SFY 2015. Mandatory enrollment was expanded to nine additional counties during SFY 2016, resulting in more than 80 percent of Medicaid recipients receiving their physical health services through an ACO.



<sup>1</sup> CMS website <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>

Because the payment models for FFS and ACOs are significantly different, the resulting data for each payment type is also very different. For FFS, providers submit claims directly to DMHF and payments are paid through the Medicaid Management Information System (MMIS). Thus, the resulting data in the Medicaid data warehouse includes all of the detailed information for each paid claim.

For ACOs, DMHF makes monthly capitated payments to the ACOs. Detailed information for each paid capitation is stored in the Medicaid data warehouse. When an ACO enrolled recipient receives services, the ACO pays the providers for the services performed. Therefore, the most detailed information and related controls for claims paid by the ACOs exist in the ACOs' respective payment systems.

ACOs send encounter information (high level claim information) for claims paid by their respective systems to DMHF to facilitate monitoring of utilization and quality, and as support for rate setting purposes. However, this information does not reflect what DMHF paid the ACO because DMHF paid the ACO a capitated rate per recipient not a payment per service provided. Therefore, it is important to distinguish between FFS paid claims and submitted ACO encounters when analyzing data in the Medicaid data warehouse.

In addition to the distinction between the FFS and managed care delivery systems, there is an important distinction that should be made between Medicaid health care providers and Medicaid prescribers. The concept of enrolling Medicaid prescribers and requiring a limited level of disclosure and screening for prescribers is a component of the Patient Protection and Affordable Care Act (ACA). Prior to ACA, only Medicaid health care providers were screened and enrolled. As such, Utah Medicaid system controls to address risks associated with provider payments were originally designed for these types of providers. Due to the limited level of disclosure and screening required by ACA for prescribers, prescribers are enrolled with Utah Medicaid differently than providers. Additionally, because payments for prescriptions are made to pharmacies rather than to prescribers, certain payment controls designed for providers do not apply to prescribers.

## **Section 1**

### **Background**

DMHF has a data sharing agreement with the Department's Office of Vital Records and Statistics (OVRS) whereby death records are uploaded to Medicaid's data warehouse for use in identifying both providers and recipients that are deceased. These death records are loaded into the Medicaid data warehouse on a weekly basis. During the audit review period, these records were used in the creation of a monthly surveillance and utilization report<sup>2</sup> (SURS) that matched the death records with enrolled providers and eligible Medicaid recipients. The monthly SURS was used to close contracts of deceased providers and to reverse claims and capitations for deceased recipients.

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<sup>2</sup> DMHF utilizes surveillance and utilization reports (SURS) to address various different surveillance and utilization processes. Thus, there are multiple different SURS reports generated.

During the audit period, the majority of claims and capitations were being properly reversed. However, this audit correctly pointed out a weakness in our process related to reversing pharmacy claims. We contract with a vendor to process point-of-sale pharmacy claims and our process did not include reversing claims processed by this pharmacy vendor. As discussed in our responses below, we have addressed this identified weakness in our process.

#### Finding 1

We concur with the recommendations made to address the assertion that DMHF appears to have paid for prescriptions dispensed after the prescriber's death. For this portion of the audit, the auditors reviewed prescriptions dispensed from July 1, 2014 through March 15, 2016. During that time frame, 2,295,975 FFS pharmacy claims were processed totaling \$223,571,915 and 2,181,044 pharmacy encounters were submitted by ACOs.

Of the 59 prescriptions identified in this finding, 11 were FFS and 48 were ACO encounters. We reviewed these 59 claims and determined that both the MMIS paid claims as well as the submitted ACO encounters represented final, paid claims.

We reversed the claim payments in our pharmacy vendor's system for the 11 identified FFS claims. We also notified the ACOs of the 48 encounters identified and requested that they reverse the related pharmacy claims in their systems and adjust the encounter data submitted to DMHF.

In addition, we modified the SURS to run weekly rather than monthly to minimize the lag between the prescriber's date of death and DMHF action to close the prescriber's contract. We also modified the report to ensure that the related pharmacy claims paid and pharmacy encounters submitted subsequent to a prescriber's death are identified. We are drafting a new Standard Operating Procedure (SOP) for staff to use when prescribers are identified on the report. The SOP will document the process to close prescriber contracts and to reverse the FFS pharmacy claims identified on the report. Additionally, it will document the steps that should be taken to notify the ACOs of the encounters identified on the SURS to ensure they take the appropriate action in their respective systems.

The Department contracts with the Utah Office of Inspector General (OIG) to perform program integrity functions for the Medicaid program. These program integrity functions include preliminary investigations into any identified questionable practices; full investigations if the results of the preliminary investigation provide sufficient reason to believe that fraud or abuse has occurred; and referral to appropriate law enforcement entities, if fraud or abuse is substantiated by the full investigation. We referred the detail for the 59 prescriptions identified in this finding to the OIG to conduct initial investigations. We requested that sufficient work be performed to determine the cause of each error, which could include fraud, data entry errors made at the pharmacy, improper refill processes employed by the pharmacy, etc. Finally, we requested monthly reporting on the status of each investigation and the related outcomes.

### Finding 2

We concur with the recommendations made to address the assertion that DMHF appears to have paid for prescriptions dispensed after the Medicaid recipient's death. For this portion of the audit, the auditors reviewed prescriptions dispensed from July 1, 2014 through March 15, 2016. As discussed in the response to Finding 1, during that time frame, 2,295,975 FFS pharmacy claims were processed totaling \$223,571,915 and 2,181,044 pharmacy encounters were submitted by ACOs.

Of the 52 prescriptions identified in this finding, 35 were FFS and 17 were ACO encounters. We reviewed these 52 claims and determined that both the MMIS paid claims as well as the submitted ACO encounters represented final, paid claims.

We reversed the claim payments in our pharmacy vendor's system for the 35 identified FFS claims. We also notified the ACOs of the 17 encounters identified and requested that they reverse the related pharmacy claims in their systems and adjust the encounter data submitted to DMHF.

In addition, we modified the SURS generated to match the death dates of recipients to run weekly rather than monthly to minimize the lag between death date and the DMHF action to reverse claim payments and capitations. We also modified the report to ensure that the related pharmacy claims paid and pharmacy encounters submitted subsequent to a recipient's death are identified. We are drafting a new SOP for staff to use when recipients are identified on the SURS. It will document the steps that should be taken to reverse the related pharmacy claims. In addition, it will document steps that should be taken to notify the ACOs of the encounters identified on the SURS to ensure they take the appropriate action in their respective systems.

As discussed in the response to Finding 1, the Department contracts with the OIG to perform program integrity functions for the Medicaid program. We referred the detail for the 52 prescriptions identified in this finding to the OIG to conduct initial investigations. We requested that sufficient work be performed to determine the cause of each error, which could include fraud, data entry errors made at the pharmacy, improper refill processes employed by the pharmacy, etc. Finally, we requested monthly reporting on the status of each investigation and the related outcome.

### Finding 3

We concur with the recommendations made to address the assertion that DMHF appears to have authorized payment for 234 prescriptions written by prescribers not enrolled in the Utah Medicaid program. For this portion of the audit, the auditors reviewed prescriptions written during SFY 2015. During that time frame, 1,481,552 FFS pharmacy claims were processed totaling \$139,640,779 and 1,221,304 pharmacy encounters were submitted by ACOs.

Of the 234 prescriptions identified in this finding, 28 were FFS and 206 were ACO encounters. We reviewed these 234 claims and determined that both the MMIS paid claims as well as the submitted ACO encounters represented final, paid claims.

The 28 FFS prescriptions identified were written by five prescribers. We reviewed the enrollment detail in our provider enrollment system for the five prescribers. In addition, since we contract with a vendor to process our point-of-sale pharmacy claims, we reviewed the enrollment information in our contracted vendor's system for these five prescribers. We noted some discrepancies between the enrollment data in our provider enrollment system versus the enrollment data in the vendor's system. We will work to identify the cause of the discrepancy and make the necessary correction to ensure the enrollment data is consistent and accurate in both systems.

We submitted the 206 encounters identified to the respective ACOs and requested that they perform a detailed review of the prescriber enrollment data in their systems to determine if the prescriber was appropriately enrolled in the ACOs' systems. Since the prescribers were not enrolled in the DMHF provider enrollment system, this is a contract violation. Therefore, we will request that the ACOs void the related encounter data to prevent its use in future rate setting. Additionally, if the prescribers were not properly enrolled in the ACOs' systems, we will work with the ACOs to ensure that the related claims are reversed in their payment systems.

Of the 138 prescriptions related to sanctioned providers, 76 were FFS claims and 62 were ACO encounters. We reviewed the enrollment history of the two sanctioned providers and found that they were dually enrolled as both a Medicaid health care provider and a Medicaid prescriber. When the sanction was applied to the enrollment record, the dual enrollment was not addressed and only the Medicaid health care provider enrollment contract was closed. We will develop an SOP to ensure prescriber enrollment is also closed when closing sanctioned provider contracts.

In addition, we will reverse the claim payments in our pharmacy vendor's system for the 76 identified FFS claims for the sanctioned providers. We will also notify the ACOs of the 62 encounters identified and request that they reverse the related pharmacy claims in their systems and adjust the encounter data submitted to DMHF.

## **Section 2**

### **Background**

Federal regulations require that each Medicaid agency implement a statewide surveillance and utilization control program<sup>3</sup> to:

- Safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments;
- Assess the quality of the services;
- Provide for the control of the utilization of all services provided under the plan; and
- Provide for the control of the utilization of inpatient services.

Federal regulations allow Medicaid agencies to restrict beneficiaries for a reasonable period of time to receive services from designated providers if they have utilized Medicaid services at a

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<sup>3</sup> 42 CFR 456.3 – Statewide surveillance and utilization control program.

frequency or amount that is not medically necessary. These restrictions may only be imposed if the following conditions<sup>4</sup> are met:

- The agency gives the beneficiary notice and opportunity for a hearing before imposing the restrictions;
- The agency ensures that the beneficiary has reasonable access to Medicaid services of adequate quality; and
- The restrictions do not apply to emergency services furnished to the beneficiary.

The Utah Medicaid program has elected to implement a program that restricts recipients to designated providers as allowed by 42 CFR 431.54. DMHF has established a restriction program for FFS recipients. DMHF's ACO contracts allow the ACOs to operationalize their own restriction programs as long as they comply with related federal regulations, state administrative rules, and the contract. On average during SFY 2015, there were 174 FFS recipients and 375 ACO recipients on restriction.

#### Finding 4

We concur with the recommendations made to address the assertion that restricted recipients appear to have received prescriptions written or dispensed by an unassigned provider. Of the 465 prescriptions dispensed at unassigned pharmacies, 115 were FFS and 350 were ACO encounters. Of the 609 prescriptions written by unassigned prescribers, 107 were FFS and 502 were ACO encounters. We have reviewed these claims and determined that both the MMIS paid claims, as well as the submitted ACO encounters represented final, paid claims.

As discussed in the background of this section, ACOs are contractually permitted to operationalize their own restriction programs. In reviewing the detail of the prescriptions identified in this finding, we noted that ACOs employ some practices that resulted in recipients reviewed in the audit appearing as though they were restricted, when they actually were not. For example, one ACO entered a physician name in the temporary provider section of the restriction record for some recipients. However, these recipients were not actually in the Client Restriction Program (CRP). In addition, one ACO allows recipients in its program to utilize providers other than the locked-in provider to obtain medications that are not controlled substances. For example, if the recipient is in need of an antibiotic after an urgent care visit after hours, the ACO allows the restricted recipient to obtain the antibiotic from any pharmacy. We will work with the ACOs to ensure they discontinue these practices. We will also work with the ACOs to better document the operational differences allowed under their programs. Both steps will improve the reliability of the data generated for audits and other reporting.

We reviewed the details of the FFS prescriptions identified in the finding, and noted that the primary reason for the identified errors related to prescriptions written by unassigned prescribers resulted from pharmacies' ability to enter information into the point-of-sale system that resulted in pharmacy claims for restricted recipients bypassing the lock-in controls established. We have submitted a change request to the pharmacy vendor to modify the system to eliminate the pharmacies' ability to enter information that bypasses the lock-in controls.

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<sup>4</sup> 42 CFR 431.54(e)

The primary reason for the identified errors related to prescriptions dispensed at unassigned pharmacies was the result of our current operational procedure and programming in the MMIS system. When recipients are locked-in to a specific pharmacy that is not part of a retail chain, the locked-in pharmacy is identified in the system using the provider contract ID. Each pharmacy provider has a unique contract ID. However, when the locked-in pharmacy is part of a retail pharmacy chain, all locations share one Tax ID. These pharmacies also share the same computer system with the necessary controls to prohibit inappropriate dispensing of controlled substances. Therefore, Utah Medicaid believes it is appropriate for a restricted recipient to be allowed to fill a prescription at any chain location. However, because the MMIS lists only one location, it appears as though prescriptions have been dispensed by an unassigned pharmacy. We will review this policy and system programming to determine what changes need to be made to ensure policy and practice are aligned.

#### Finding 5

We concur with the recommendations made to address the assertion that CRP reviews indicate areas for improvement. CRP has SOPs that describe the criteria CRP reviewers evaluate when making restriction determinations. The Section 2 Introduction segment of the audit report outlines the six criteria (A-F) used in the restriction determination process. The evaluation process requires a significant amount of professional judgment. As such, initial derived values for criteria A-E may be modified when the reviewer considers other factors such as diagnosis, that are not evaluated in the automated process that derives the initial values. In addition, the CRP reviewers are required to consider criterion F which can also impact the overall restriction determination.

We will review the CRP processes, procedures, and systems to ensure reviews are reflective of documented restriction criteria. We have existing SOPs that provide guidance to CRP staff on applying the six criteria to aid in reducing the subjectivity of reviews. In addition, we have developed a documentation template and are in the process of drafting a related SOP to assist reviewers in adequately documenting all judgmental modifications of the derived values for criteria A-E. The SOP will describe how to document the impact of criterion F in the restriction determination. CRP staff will be trained and tested on the new SOP, once adopted.

CRP currently employs a quality control process that includes 100 percent review of all FFS restriction determinations made by CRP reviewers who are not skilled professional medical personnel (SPMP)<sup>5</sup>. In addition, the CRP manager reviews at least 10 percent of all restriction determinations. We are evaluating the current quality control process used by the CRP team to identify improvements that can be made to provide additional assurance that restriction determinations are accurate.

#### Finding 6

We concur with the recommendations made to address the assertion that inconsistent restriction reviews may allow over-utilization to continue. As noted in the audit, DMHF makes manual modifications to a significant percentage of the initially derived values for criteria A-E. The CRP team utilizes a surveillance and utilization report (SURS) to derive the initial values and that report has been programmed to over-capture recipients to help ensure that recipients are not

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<sup>5</sup> See 42 CFR 432.50 for definition of skilled professional medical personnel.

erroneously excluded from evaluation. Due to the broad nature of the SURS used by CRP and due to the fact that it is not possible to automate the medical necessity considerations that are used in the restriction determination process, modifications to a significant percentage of the initial derived criterion values are to be expected. The report is simply a tool used to help identify recipients that should be considered for possible restriction.

As stated in the response to Finding 5, we have developed a documentation template and are in the process of drafting a related SOP to assist reviewers in adequately documenting all judgmental modifications of the derived values for criteria A-E. In addition, the SOP will describe how to document the impact of criterion F in the restriction determination. CRP staff will be trained and tested on the new SOP, once adopted. Existing policies will also be reviewed with staff regularly to help ensure staff proficiency in all aspects of the process and to help ensure consistency among reviews.

Concurrent prescribing is currently considered as part of the restriction review process, however, documentation of this consideration is not consistent. The above mentioned template and SOP will help provide consistency in documenting the modifications of the derived values for the six criteria and should provide clear documentation of the restriction determination made by the CRP reviewer.

#### Finding 7

We concur with the recommendations made to address the weaknesses identified in the SURS used by the CRP to identify recipients that should be considered for restriction. As stated in the response to Finding 6, the intent of the programming for the SURS was to over-capture recipients to help ensure that recipients are not erroneously excluded from evaluation. We appreciate the work performed by the auditors that has identified some weaknesses in the report's programming. These weaknesses have allowed some high-risk recipients to be excluded. We are reviewing the SURS programming to identify the reason recipients were excluded and once identified we will make the appropriate corrections to the programming. We have already made other adjustments to the report that have improved the identification of recipients who over-utilize Medicaid services. We will continue to evaluate the report programming, as well as the sorting processes used by CRP to identify additional enhancements that can be made to improve our ability to accurately identify recipients at the highest risk for over-utilization.

#### Finding 8

We concur with the recommendations made to address the assertion that restriction reviews do not always account for the highest-risk recipients. We are drafting SOPs related to prioritizing recipients for review that will include the frequency of inclusion on the SURS as one of the prioritization factors. All modifications to the SOPs, as discussed in the responses to Section 2, as well as the modifications that have been and will continue to be made to the SURS, will help ensure that the highest-risk individuals will be identified and reviewed.

CRP currently performs restriction determinations for FFS clients. CRP must also respond to restriction forms submitted by the ACOs. Responding to ACO restriction forms is necessary to ensure payment for services that are carved out of the ACO contracts is prevented for restricted

recipients. Additionally, CRP reviews ACO restriction determinations to provide some assurance that the determinations are being performed correctly and to help ensure that ACOs are not inappropriately restricting individuals in order to receive the enhanced monthly rate DMHF pays ACOs for restricted recipients. We will continue to review work performed by the CRP team to identify efficiencies that would free up time to perform additional FFS reviews.

As stated in the response to Finding 1, DMHF contracts with the OIG to perform program integrity functions on behalf of DMHF. To the extent allowed by the state and federal privacy and reporting laws and regulations, both CRP and the ACOs have referred instances of potential fraud identified during their respective review processes. However, the referral process is not well documented. We will develop SOPs to better document the referral process. We will work with the OIG to ensure that referrals from the CRP team are properly reviewed according to the federal program integrity regulations.