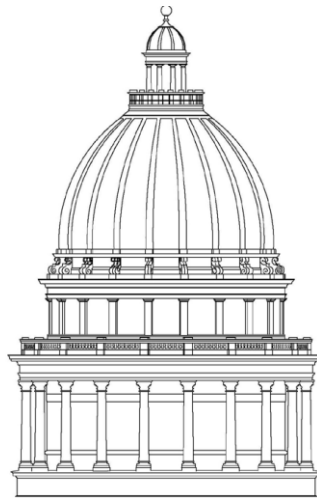


REPORT TO THE
UTAH LEGISLATURE

Number 2020-02



**A Performance Audit of
Medicaid's Pharmacy Benefit Oversight**

May 2020

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah



STATE OF UTAH

Office of the Legislative Auditor General

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Audit Subcommittee of the Legislative Management Committee

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Senator Karen Mayne • Senator Evan J. Vickers • Representative Brian S. King • Representative Francis D. Gibson

KADE R. MINCHEY, CIA, CFE
AUDITOR GENERAL

May 2020

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of Medicaid's Pharmacy Benefit Oversight** (Report #2020-02). An audit summary can be found located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

A handwritten signature in black ink that reads "Kade minchey". The signature is written in a cursive, slightly slanted style.

Kade R. Minchey, CIA, CFE
Auditor General



PERFORMANCE AUDIT

► AUDIT REQUEST

The Legislative Audit Subcommittee requested that we review the prescription drug costs for Medicaid and determine if there are possible savings, review Pharmacy Benefit Managers (PBMs) in the Medicaid market, and evaluate if Medicaid is providing effective oversight of the pharmacy benefits for their Accountable Care Organizations (ACOs).

► BACKGROUND

The Utah Department of Health Division of Medicaid and Health Financing (DOH, DOH Medicaid or Utah Medicaid) is charged with providing pharmacy benefits for its Medicaid population. Pharmacy benefits are administered to Medicaid recipients in two ways: through four separate Medicaid Accountable Care Organizations (ACOs), or directly through the DOH Medicaid program known as fee-for-service, or FFS. FFS utilizes the Medicaid Drug Rebate Program (MDRP), which is designed to offset federal and state prescription costs. Medicaid collects rebates for FFS and ACO prescription volume. Accordingly, most of the ACOs utilize a PBM to manage their claims and negotiate prescription prices for their plans.

Medicaid's Pharmacy Benefit Oversight



KEY FINDINGS

- ✓ Medicaid has full transparency of the net costs for prescription drugs, allowing them to provide effective care at the best rates.
- ✓ Savings could be realized by utilizing a statewide Preferred Drug List (PDL) for drugs with the lowest net cost to the state.
- ✓ Additional savings are available through increased oversight of ACOs and FFS pricing.

Medicaid's Ability to Prioritize Lowest-Net-Cost Drugs Could Lead to Savings

Medicaid has access to rebate information for all drugs covered, which can be used to compile the net cost of each drug after rebates. Utilization of this information through a statewide PDL for FFS and the ACOs could save the Medicaid program up to \$3.4 million a year.



RECOMMENDATIONS

- ✓ DOH should research and provide a report to the Legislature regarding the potential savings, benefits, and costs from creating a statewide Preferred Drug List (PDL).
- ✓ DOH should create a process to ensure pricing and rebates are processed correctly.
- ✓ DOH should take steps to provide better oversight of the Accountable Care Organizations (ACOs) to review cost trends, contract changes, and compliance.



REPORT SUMMARY

Additional Savings Can Be Realized Through Better Oversight

During our audit we found over 60,000 prescriptions that were over a single index that FFS uses to determine a drug's price. These overages total nearly \$400,000 in additional costs. DOH should provide additional oversight to ensure pricing and reimbursement are occurring according to policy. DOH should provide stronger oversight to ensure its projected cost to the state matches the actual cost.

DOH Could Provide More Oversight of Rate Setting and Rebates

We could not find evidence that Medicaid independently reviews ACO claims or spending data. Without tracking the trend changes, which may contribute

to capitated rate increases, DOH is unable to provide additional oversight steps to ensure costs are being managed. Providing oversight could ensure that ACOs are taking reasonable steps to control costs.

ACO PBMs Received \$1.5 Million From Spread Pricing

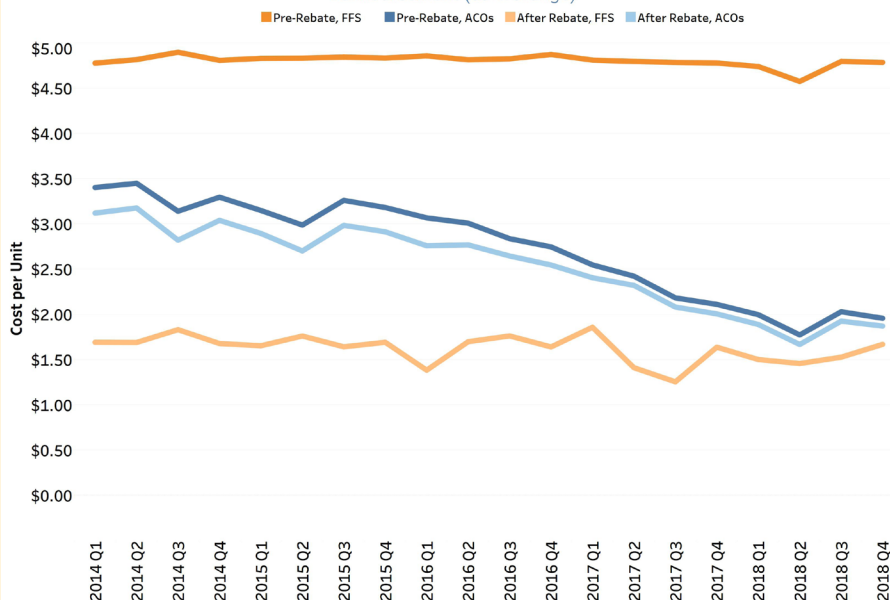
We analyzed spread by comparing pharmacy reimbursement costs at one pharmacy to the amount paid by the ACO for those claims. We would expect spread pricing to occur for HealthChoice because they utilize a traditional contract that employs spread pricing. However, Healthy U's contract is transparent and should not have any spread pricing. We found spread pricing occurred over a two-month period in 2018, which equaled 4 percent of all prescriptions.

ACOs Prioritize Prescriptions with Higher Net Costs to State

FFS has chosen the lowest-cost option after rebates are factored in, while the ACOs have chosen the option with the lowest upfront cost. The difference between the ACOs' net costs and FFS' net cost for this one drug equates to just over \$27,000 for 2018.

Figure 2.5 FFS Brand Compared to ACO Generic for a Single Drug

Net costs of brand drug is lower (light orange) compared to generic (light blue) despite high pharmacy reimbursement (dark orange)



REPORT TO THE UTAH LEGISLATURE

Report No. 2020-02

A Performance Audit of Medicaid's Pharmacy Benefit Oversight

May 2020

Audit Performed By:

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Chapter I

Introduction

The Utah Department of Health Division of Medicaid and Health Financing (DOH, DOH Medicaid, or Utah Medicaid) is charged with providing pharmacy benefits for its Medicaid population. We were asked by the Legislative Audit Subcommittee to audit the pricing structures of Medicaid's pharmacy costs and the oversight provided by Medicaid. Pharmacy benefits are administered to Medicaid recipients in two ways: through four separate Medicaid Accountable Care Organizations (ACOs), or directly through the DOH Medicaid program known as fee-for-service or FFS.

While three of the ACOs contract with pharmacy benefit managers (PBMs), Select Health, an ACO, contracts directly with manufacturers for prescription benefits. FFS receives primary rebates for prescription benefits that are established by the Centers for Medicare & Medicaid Services (CMS). FFS also contracts directly with manufacturers for supplemental rebates for prescription benefits from Medicaid's preferred drug list. We looked at the relationship between the PBMs and the ACOs that contract with PBMs and how PBMs affect ACOs prescription costs, as well as FFS direct relationships with manufacturers.

Pharmacy Costs Are Determined by Federal Pricing Controls and ACOs

FFS utilizes the Medicaid Drug Rebate Program (MDRP) which is designed to offset federal and state prescription costs. The MDRP is only available to state Medicaid agencies who collect rebates for FFS and ACO prescription volume. Accordingly, most of the ACOs utilize a PBM to manage their claims and negotiate prescription prices for their plans.

Utah Medicaid contracts with health plans, or ACOs, to provide medical services to Medicaid members. Members living in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties must choose an ACO. Members who live in any other county have the option to choose an ACO or the FFS network.

FFS receives primary prescription rebates that are established by the Centers for Medicare & Medicaid Services (CMS).

FFS contracts directly with manufacturers for supplemental rebates for prescription benefits from Medicaid's preferred drug list.

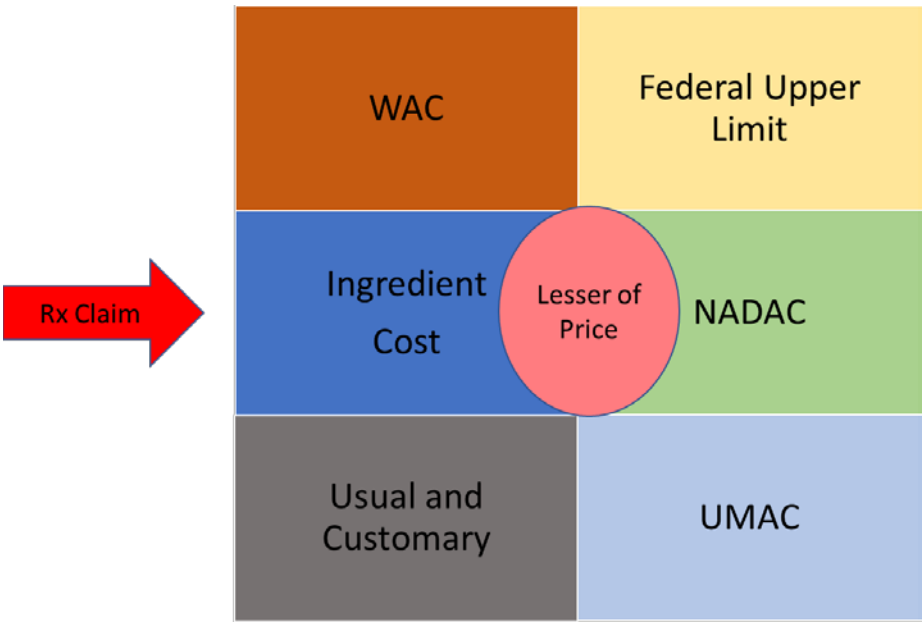
Each ACO is responsible for providing enrolled members with all services contracted. Medicaid pays a monthly fee for each member enrolled in an ACO. Each ACO may offer more benefits than the Medicaid scope of benefits but may not be more restrictive.

Fee-for-Service Receives Price Guarantees for Prescription Drugs

FFS utilizes a complex process designed to ensure the lowest drug cost. This will be further discussed in Chapter II, but, in short, it has two steps: First, FFS utilizes its access to protected rebate data to select drugs that have the lowest net cost to the state. FFS puts these drugs on its preferred drug list (PDL). FFS might pay more up front (at the pharmacy) than ACOs but when large rebates are factored in the final cost is often cheaper than ACOs, as discussed in Chapter II. Second, FFS utilizes what is called a lesser of logic formula. This formula compares a pharmacy claim to six points or indices, and the lowest price among the indices is submitted for reimbursement to the pharmacy. This process is called the lesser of logic determination. Figure 1.1 shows these six indices.

FFS utilizes its access to protected rebate data to select drugs that have the lowest net cost to the state.

Figure 1.1 Price Indices Used to Determine the Lowest Reimbursement for Drugs. FFS uses a lesser of logic model to ensure that the lowest price is paid on claims.



The six indices shown above are as follows:

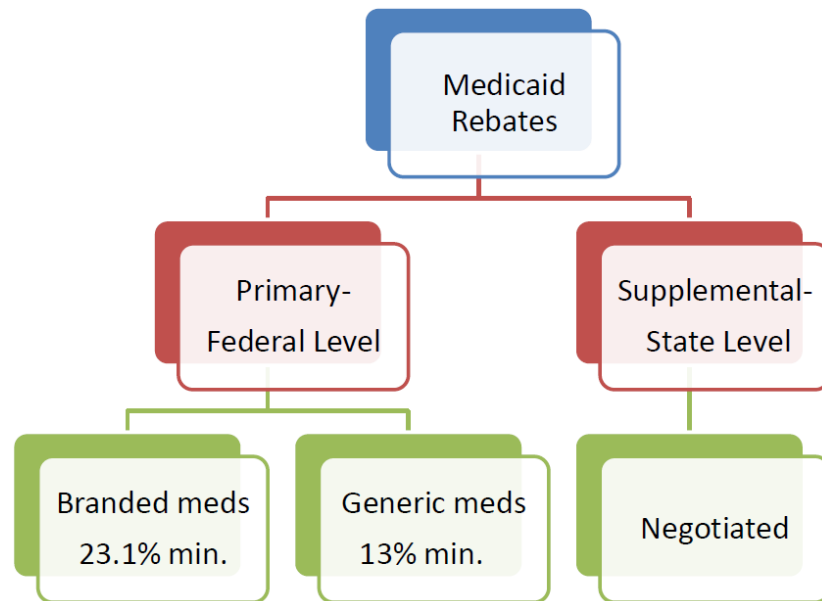
- **Federal Upper Limit:** A maximum allowable ingredient cost reimbursement established by the Federal government (CMS) for selected multiple source drugs.
- **Wholesale Acquisition Cost (WAC):** The list price for a drug. This is not a publicly known price, but payers can get access. Because Medicaid contracts directly with manufacturers, it has access to these prices.
- **National Average Drug Acquisition Cost (NADAC):** A publicly available price metric that approximates actual acquisition costs for drugs nationwide.
- **Utah Maximum Allowable Cost (UMAC):** A publicly available price ceiling established at the state level.
- **Ingredient Cost Submitted:** The initial cost submitted by the pharmacy.
- **Usual and Customary:** The price paid by the general public. A dispensing fee is not paid if Medicaid pays this rate.

Once a price is determined and the pharmacy is reimbursed, claims are submitted quarterly to Medicaid's rebate management contractor, Change Healthcare, who collects the rebates for Medicaid. Federal law provides for Medicaid departments in all states to receive substantial rebates which help control pharmacy costs. A rebate is an amount a manufacturer pays for a prescription which is generally a percentage of the average manufacturer price of the drug. Medicaid is guaranteed a minimum rebate percentage on brand and generic drugs. Figure 1.2 shows the two types of rebates Medicaid is eligible to receive.

FFS lesser of logic is based off six price indices: Federal Upper Limit, WAC, NADAC, UMAC, Ingredient Cost Submitted, and Usual and Customary.

Once a price is determined and the pharmacy is reimbursed, claims are submitted quarterly to Medicaid's rebate management contractor.

Figure 1.2 Total Medicaid Rebates are the Result of Federal and State Rebates. Federal law mandates that all primary rebates are at least 23% for branded drugs and 13% for generic drugs. The state also contracts for additional supplemental rebates.

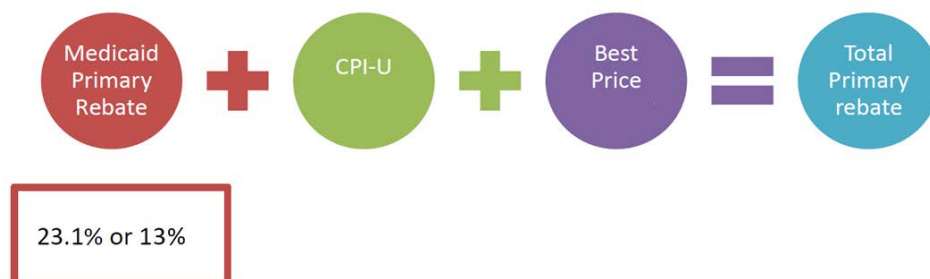


Federal law states that all covered drugs must receive a minimum primary rebate of 23.1 percent for brand drugs and 13 percent for generic drugs. In addition to primary rebates, Medicaid can also negotiate state-level supplemental rebates on various drugs; however, these rebates are not guaranteed or mandatory.

In addition to the guaranteed primary rebate percentage, federal statute requires that Medicaid receive additional price concessions to protect against inflation increases and receive the federally mandated best price. The best price mandate allows Medicaid to receive the lowest offered price to any other plan within the United States. Figure 1.3 shows that these are added to the Medicaid primary rebate.

Federal law states that all covered drugs must receive a minimum primary rebate of 23.1 percent for brand drugs and 13 percent for generic drugs.

Figure 1.3 Total Primary Rebate Is Determined by Three Components. The total primary rebate is a percentage discount from the average manufacturer's price of the drug.



The total primary rebate is calculated by adding the three components (CPI-U is defined as the consumer price index for all urban consumers) in Figure 1.3. As mentioned in Figure 1.2, Medicaid is also eligible to receive supplemental rebates. Figure 1.4 shows the inclusion of these rebates, which is the final step in determining the net drug cost.

Medicaid is also eligible to receive supplemental rebates.

Figure 1.4 Supplemental Rebates Allow for More Drug Cost Savings. The net drug cost is the true price of the drug that Medicaid pays for.



Supplemental rebates are a percentage of WAC or provide a guaranteed net price. Manufacturers may pay supplemental rebates to Medicaid for a specific drug's preferred status on the Medicaid Preferred Drug List. The cost after deducting primary and supplemental rebates is the net drug cost, which is the actual cost paid by Medicaid. In 2018, FFS and the ACOs spent a combined \$93.9 million on prescriptions after rebates.

Manufacturers may pay supplemental rebates to Medicaid for a specific drug's preferred status on the Medicaid Preferred Drug List.

PBMs are a central component in the prescription drug flow process.

Most ACOs Utilize PBMs To Control Drug Costs

PBMs are a central component in the prescription drug flow process. Since Medicaid receives primary rebates for prescription benefits that are established by CMS and is mandated to use the above-mentioned pricing indices, they will always be priced at or below these indices. Healthcare plans (plans) typically enter one of two types of contracts known as transparent or traditional which contract at rates different from the price indices. Figure 1.5 illustrates the centrality of the PBM in this process.

Figure 1.5 PBMs Play a Central Role in the Pharmacy World. PBMs negotiate rebates with manufacturers and then pass all or a portion of those rebates to the insurance plan.

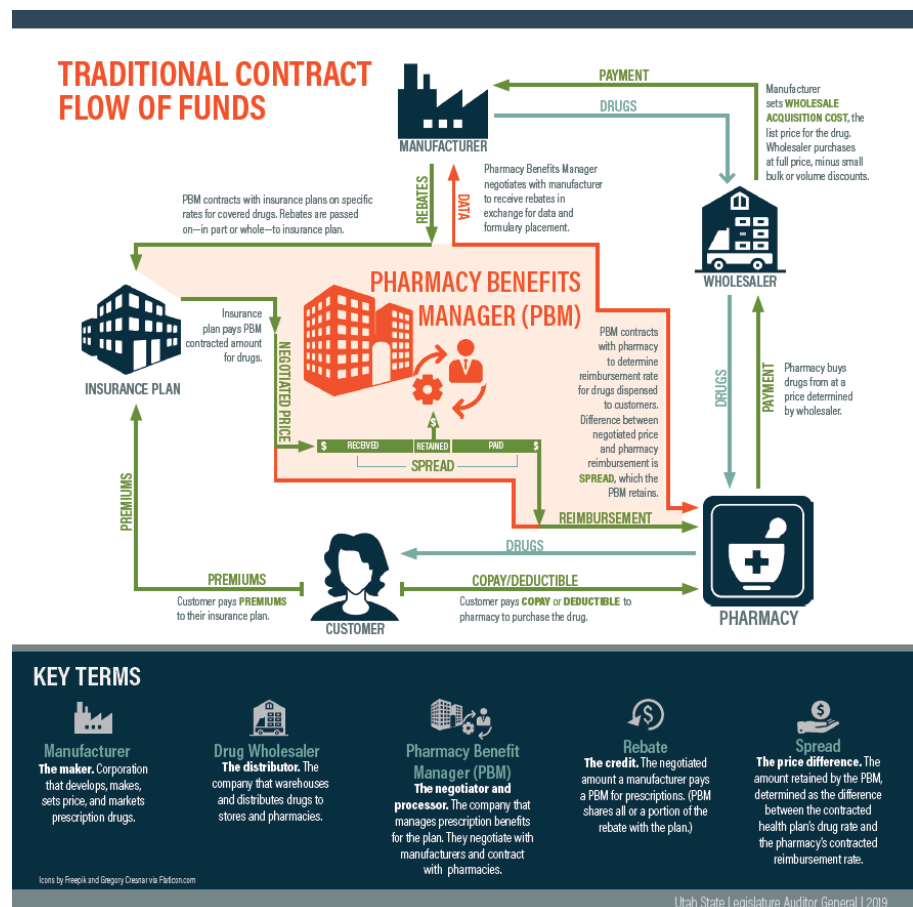


Figure 1.5 demonstrates the flow of prescription drugs, payments, and data for a traditional contract, which allows spread pricing. Spread is defined as the price difference between what the plan pays the PBM and what the PBM reimburses the pharmacy. A companion audit,

titled *A Performance Audit of PEHP's Pharmacy Benefit Manager*, was released in December 2019. The audit discussed the issue of spread pricing and the relationship between the PBM and manufacturers. We will discuss spread pricing in more depth in Chapter III.

Unlike traditional contracts, transparent (pass-through) contracts do not allow spread pricing. Instead they charge administrative fees and included the assurance that the amount paid for the prescription is the same as the amount reimbursed to the pharmacy.

ACOs pay PBMs to administer their claims and provide price guarantees that are based on the Average Wholesale Price of the drug, which is a different price point than the indices used by FFS. This rate difference will be discussed in more detail in Chapter II. One of the ACOs has a traditional contract with a PBM, whereas two ACOs have transparent contracts. The fourth ACO operates an internal PBM that allows for full transparency. PBMs engage in financial relationships with manufacturers, pharmacies, and healthcare plans.

Unlike traditional contracts, transparent (pass-through) contracts do not allow spread pricing.

Audit Scope and Objectives

We were asked to review the prescription drug costs for Medicaid and determine if there are possible savings, review PBMs in the Medicaid market, and evaluate if Medicaid is providing effective oversight of the pharmacy benefits for its ACOs.

- Chapter II: Medicaid's Ability to Access Protected Pharmacy Data Can Lead to Savings
- Chapter III: The Utah Medicaid Program Can Strengthen Its Oversight of ACO Pharmacy Practices

Chapter II

Medicaid's Ability to Access Protected Pharmacy Data Can Lead to Savings

The Utah Medicaid Program (Medicaid), under the Department of Health (DOH), has access to protected federal rebate information. As a result, Medicaid can prioritize the least expensive treatment options. Utilizing this information and creating a statewide Preferred Drug List (PDL) could result in significant savings to the Medicaid program. The amount of potential savings depends on several variables, but we believe it could be about \$3.4 million a year and potentially even higher (savings to the state would be lower based on the Federal Medical Assistance Percentage).

Potential savings were calculated by comparing the four accountable care organizations (ACOs) that contract with Medicaid to the costs of fee-for-service (FFS). Through this comparison, we found that FFS provides pharmacy benefits at a lower cost. In fact, the FFS per-unit cost after rebates from 2014 through 2018 increased by just under 5 percent, whereas ACO costs increased by over 9 percent. Because Medicaid FFS has access to the unit rebate amount (URA) of federal rebates, it can prioritize the lowest-cost prescription drugs; ACOs do not have URA access. We recommend that DOH study the benefits and costs of a statewide PDL, which would require ACOs to prioritize prescriptions that have the lowest cost to the state. In addition to considering the implementation of a statewide PDL, the Medicaid program should increase its oversight over the collection and accuracy of rebates and implementation of pricing structures.

Medicaid's Ability to Prioritize Lowest-Net-Cost Drugs Could Lead to Savings

Medicaid has access to protected rebate information known as URA, for all drugs covered, which can be used to compile the net cost¹ of each drug after rebates. Utilization of this information could save the Medicaid program millions of dollars. While our estimate has limitations, we believe the savings could amount to \$3.4 million a

¹ Net costs or final cost to the state = Total amount reimbursed to the pharmacy minus the rebate received

**Utilization of a
Statewide PDL could
result in \$3.4 million a
year in savings.**

We recommend the Medicaid program research and provide a report to the Legislature of potential savings, benefits, and costs of creating a statewide PDL.

FFS utilizes the lesser of six indices to determine reimbursement rates.

year. These savings could potentially be higher with additional supplemental rebates. Savings are achieved by Medicaid utilizing its ability to see rebate information to help manage Medicaid preferred drugs for ACOs and FFS, keeping costs low.

This valuable information gives the Medicaid program transparency into net cost to the state that is very rare in the pharmaceutical industry outside of state Medicaid agencies. The information allows Medicaid to create a PDL that prioritizes the lowest-net-cost drug. Utilizing the protected rebate information to prioritize the lowest-net-cost drug has contributed to FFS having lower drug costs when compared to the ACOs. We recommend the Medicaid program research and provide a report to the Legislature of potential savings, benefits, and costs of creating a statewide PDL.

Pharmacy Reimbursements Are Rising for All Plans

Three of the five Medicaid plans utilize a pharmacy benefit manager (PBM) to negotiate pricing of prescriptions. As discussed in Chapter I, FFS does not use a PBM; instead, it utilizes the lesser of six indices to determine reimbursement rates to pharmacies. FFS often has the lowest cost at the pharmacy due to these indices. Plans that rely on PBMs utilize the PBM to determine the price paid at pharmacies, rather than determining the reimbursement themselves. The price charged to the plan will be based on the pricing guarantees that are percentage discounts of the wholesale price. Figure 2.1 compares the prices paid at pharmacies for 24 prescriptions by FFS, the four ACOs, Public Employees Health Program (PEHP), the state average found in the All Payer claims database,² and GoodRx.³

² A database of all insurance plans' claims within Utah, as reported to the Department of Health

³ An online tool for consumers to search for the price of a certain prescription:
<http://www.goodrx.com>

Figure 2.1 Average Cost For 24 Drugs Across Medicaid Provider Compared to State Average. Based on a sample of highly utilized prescription drugs, FFS has the lowest cost (shown in red) 38 percent of the time. A blank in a data field means there was no comparable data to display.

Drug	FFS	HealthChoice	HealthyU	Molina	SelectHealth	All Payer	PEHP	Good Rx*
A	\$51.20	\$52.06	\$52.89	\$51.87	\$52.17	\$54.24	\$52.74	\$60.13
B	5.10**	5.65	8.53	3.77	13.21	11.01	8.93	
C	250.09	253.19	262.50	259.00	256.22	267.77	261.03	
D	2.61**	1.20	1.80	1.23	3.54	4.46	4.55	
E	5.01**	0.60	1.17	0.52	2.36	3.55	3.54	
F	5.08**	5.76	8.00	3.44	11.95	14.08	8.39	
G	72.58	71.42	73.82		72.33	81.05		
H	2.70**	7.61	7.92	2.77	8.70	11.39	10.72	
I	2.68**	2.04	3.88	2.30	4.45	6.08	3.81	
J	3.99**	4.14	8.36	2.93	16.06	12.73	7.77	12.24
K	2.62**	2.93	3.84	4.15	6.62	7.27	5.65	
L	261.74	270.30	274.81	266.89	273.12	277.69		333.92
M	140.23	137.95	142.10	138.51	139.18	141.41		151.25
N	313.83	321.14	327.31	316.63	319.23	319.70		
O	261.91	277.05	280.87	237.65	266.22	277.89	275.03	318.56
P	6,774.39	9,605.54	9,561.98	9,317.10	9,705.73	9,587.96	9,471.23	
Q	2,824.91	2,741.19	2,650.63	2,540.13	2,696.39	2,627.64	2,783.95	
R	12,928.69	13,299.58	12,996.27		13,154.00	13,132.19	12,830.40	13,116.20
S	7,324.63	7,421.11	7,287.20	6,982.54	7,336.09	7,362.98	7,246.17	
T	29,331.18		31,374.00		31,374.00	30,512.98		31,288.10
U	23,097.58		24,442.78		24,912.33	24,508.59	25,717.44	
V	250.76	256.73				\$264.56	246.92	
W	95.87	127.81	103.00	79.93	126.72	\$111.53	90.51	
X	\$281.82	\$296.71	\$273.97	\$276.41	\$263.60	\$293.71	\$306.05	

Source: Auditor Analysis of Medicaid Encounter claims, AllPayer Database claims, PEHP claims, and Good RX

Note: Prices paid to pharmacies do not include dispensing fees.

*Based on a point in time, not an average, for all of 2018

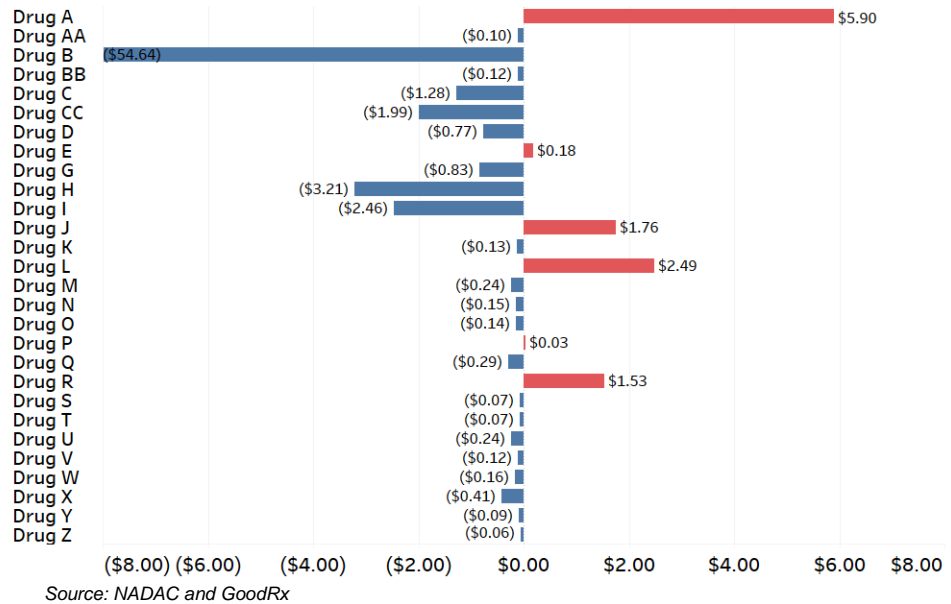
**May be priced at Gross Amount Due which would include an element of dispensing cost in price reported.

When comparing the prices negotiated across plans, FFS has the lowest rate 38 percent of the time. Numbers in Figure 2.1 and 2.2 do not reflect dispensing fees to compare negotiating power, not the final cost to the state. Dispensing fees are included later in the report as we seek to compare final costs. To further examine FFS pricing, Figure 2.2 compares average National Average Drug Acquisition Cost

FFS has the lowest reimbursement 38 percent of the time.

(NADAC) in December 2019 to the pharmacies' best price, as found on GoodRx in December 2019. We used these prices because NADAC is used nearly two-thirds of the time to determine FFS' cost paid at the pharmacy, and GoodRx is a cash price model.

Figure 2.2 Good Rx Compared to One of FFS Pricing Indices. The NADAC price is lower than GoodRx nearly 80 percent of the time. Red bars indicate GoodRx has better pricing, and blue bars indicates NADAC has better pricing.



Nearly 80 percent of the time NADAC is lower than GoodRx pricing.

On average, NADAC prices are lower than GoodRx's prices. The GoodRx price shown was the lowest price found and often applies only to specific pharmacies that may not be accessible to all members. GoodRx pricing at other pharmacies can be substantially higher than the price shown. However, when dispensing fees are factored in, FFS generally has a higher cost than the best GoodRx price. Dispensing fees were left out of Figure 2.2 in order to compare FFS' pricing to pharmacies' best price, not to the total cost after rebates. We will compare net cost to the state including dispensing fees later in the report.

Once rebates are factored, FFS pays the lowest for prescriptions.

Although the price paid at the pharmacy gives an idea of the initial drug cost, it does not include possible rebates and discounts that would impact the net cost of the drug. Once these rebates were factored into the cases we reviewed, FFS' net cost to the state was lower than GoodRx's net cost. Net costs, or the final cost to the state

once rebates are accounted for, will be discussed later in this chapter. Rebates account for a significant reduction in pharmacy costs.

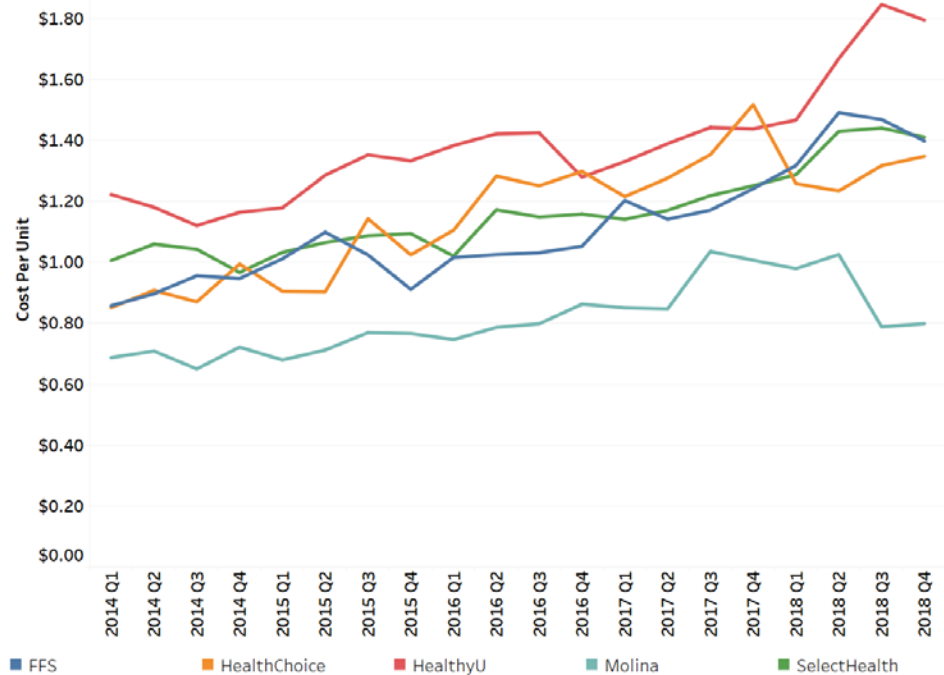
FFS is required by the Centers of Medicare and Medicaid Services to pay the average cost to dispense a prescription.⁴ This dispensing fee is paid to a pharmacy for the first prescription dispensed every 24 days for a specific member. About 15 percent of the time, FFS will pay no dispensing fee because the member is receiving more than one prescription at that pharmacy within 24 days. FFS pays \$9.99 for urban and \$10.15 for rural pharmacies per prescription while ACO plans paid between \$0.50 to \$1.46 in 2018 for dispensing fees.

To further analyze total costs to the state, we included dispensing fees with drug costs. While FFS often pays lower costs for drugs at the pharmacy due to its pricing model, it pays higher dispensing fees, which compensates for lower reimbursements. When dispensing fees are included, costs shift up for all plans but shift by a higher amount for FFS. Comparing pharmacy costs among FFS and the ACOs over time shows mostly an increasing cost trend. Figure 2.3 shows the trend of per-unit costs with dispensing fees for all four ACOs and FFS before rebates.

FFS pays a dispensing fee of \$9.99 for urban pharmacies and \$10.15 for rural pharmacies.

⁴ Average costs are determined based on surveys of pharmacies conducted by a CPA firm.

Figure 2.3 Pre-Rebate Costs Are Generally Rising Across All Plans. All plans have seen overall increases every year since 2014; however, Molina and HealthChoice saw decreases in 2018.



Source: Auditor Analysis of Medicaid Encounter Data

Figure 2.3 shows the cost per unit over time for each ACO. It is important to understand that not all ACOs have the same pricing agreements with PBMs, leading to higher or lower costs to the state. Additionally, the drug mix for each plan will impact the costs per unit. As will be discussed later, FFS has a higher brand utilization than the ACOs, increasing the per-unit costs at the pharmacy. This is due to Medicaid knowing federal statutory rebate amounts that significantly reduce the cost of brand drugs, sometimes below the costs of generics preferred by ACOs. Overall, FFS has had a similar trend to the other ACOs. Costs for ACOs largely depend on the plan's PBM, risk pool, and ultimately manufacturer costs. It is interesting to note that Molina had a sharp decline in costs in the second quarter of 2018, whereas Healthy U had a sharp increase during the same time. This was related to changes in members covered by each ACO, which we will discuss further in Chapter III.

FFS has a higher brand utilization than the ACOs, increasing the per-unit costs at the pharmacy.

Federal Rebates Control Rising Pharmacy Costs

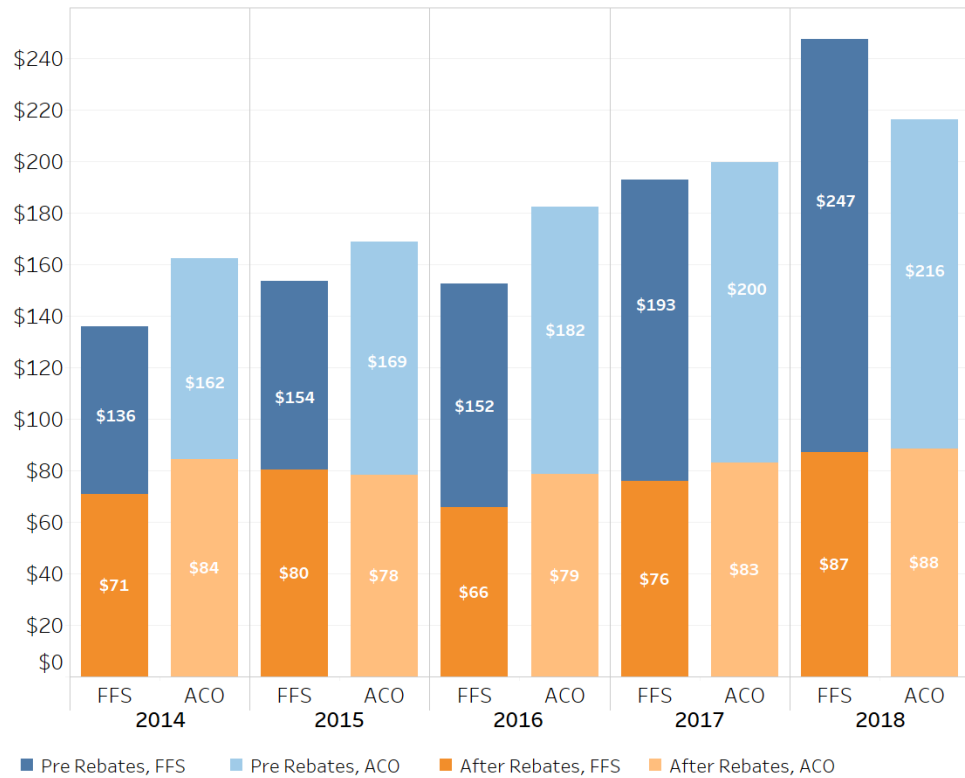
While initial pharmacy costs, or price paid at the pharmacy, has increased significantly (43 percent across all plans since 2014), net costs, or costs after rebates, have only increased by 8 percent for all claims. The net cost increases for FFS have been even lower because FFS has utilized its access to federal statutory rebate amounts to prioritize low net-cost drugs. FFS' net cost to the state has increased just under 5 percent, while ACOs' net costs have increased by just over 8 percent. We determined that the difference between FFS' and the ACO's net costs totals \$3.4 million. Our analysis was limited, in that we only looked at overall net costs and select treatment options. The Utah Medicaid program should conduct a full analysis reviewing ACO pricing and ACO PDLs to determine the benefit of utilizing a statewide PDL and provide a report to the Social Services Appropriations Subcommittee and any other pertinent Legislative committees.

FFS' Net Costs are Lower than the ACOs' Net Cost. FFS has the lowest net costs in large part because it has access to the amount of federal primary rebate, URA. After pharmacy claims are paid, Medicaid compiles and submits these claims to manufacturers quarterly, who then provide Medicaid a rebate, thus reducing the total cost of prescriptions. Medicaid collects these rebates for FFS and ACO volume. ACOs are unaware of the primary rebate amounts when prioritizing treatment options for its plans. This rebate information is very helpful because it allows Medicaid to analyze final drug costs and select the lowest cost option to the state for its PDL. With federal statutory rebates, the final costs of drugs are reduced significantly. When looking at per-unit costs after rebates, FFS' cost per unit is lower than the ACOs' combined average. Figure 2.4 shows the per member per month cost since 2014.

Net costs have increased by only 8 percent compared to 43 percent increase paid at the pharmacy.

Medicaid has access to final drug costs.

Figure 2.4 Most Years, FFS Has a Lower Per Member Per Month Cost Compared to ACOs. While total costs (costs before rebates) are increasing at a faster rate for FFS, rebates have kept the net costs lower.



Note: Excludes FFS carve out prescriptions and rebate but includes dispensing fees which is almost eight times higher FFS

Figure 2.4 shows that net costs are lower for FFS (dark orange) than for the ACOs (light orange). This analysis includes dispensing fees, which are nearly eight times higher for FFS due to requirements to pay dispensing fees based on the actual cost of dispensing prescriptions. One of the main reasons for this cost difference is that the Medicaid pharmacy director has access to protected rebate data, which can help generate estimates of future net cost. Although the ACOs have done a good job of obtaining lower initial costs, they do not have access to the federal rebate information that would allow them to selectively choose the lowest-cost drugs to the state for their PDL. ACOs can only estimate what would be the lowest cost to the plan. The following section discusses some examples of specific drugs where savings could be realized.

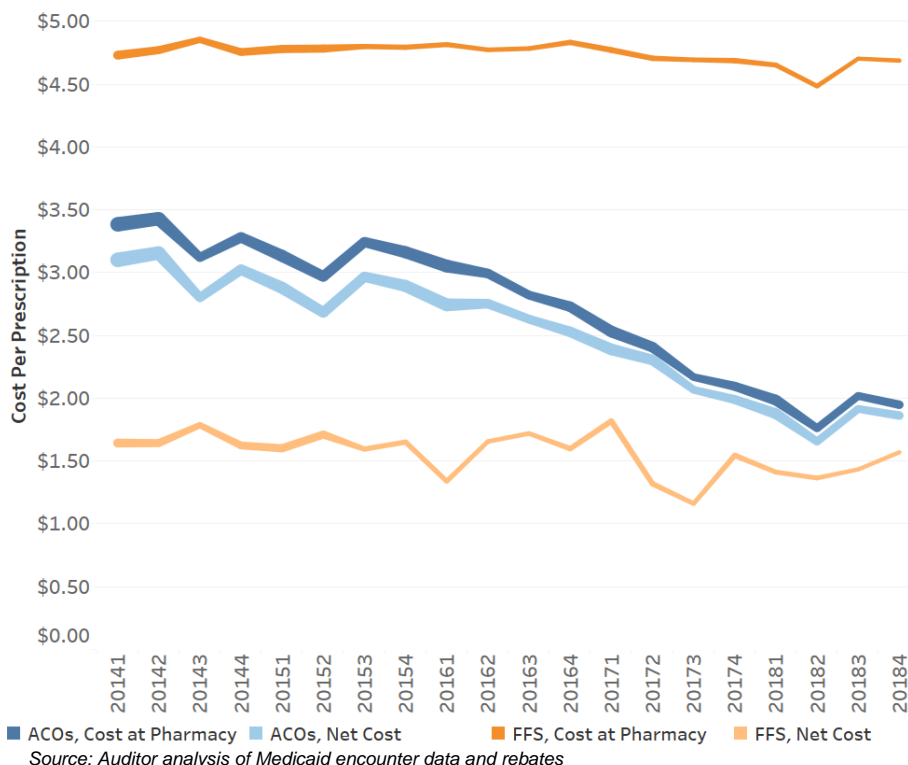
Despite higher costs at the pharmacy, FFS has utilized rebate information to achieve lower net costs.

ACOs Prioritize Prescriptions with Higher Net Costs to State

While ACOs have strived to keep costs at the pharmacies down, they have prioritized some drugs that have a higher net cost after rebates. This occurs because ACOs do not know the true net costs of drugs and are incentivized to reduce their costs at the pharmacy, not net costs to the state. ACOs are paid a capitated rate for a set time frame based on previous years' spending and population trends. ACOs are incentivized to keep their total costs at or below the capitated rate. Since DOH collects and keeps all primary rebates for FFS and ACOs, ACOs prioritize prescriptions with the lowest cost prior to rebates to keep their costs down. Figure 2.5 shows just one example of ACOs prioritizing a drug that would appear to have the lowest cost, given the information available to them. As the figure shows, FFS chose a drug with a much higher cost prior to rebates; however, once rebates are collected, the FFS drug choice has the lowest cost to the state.

ACOs do not know the true net cost to the state and are incentivized to reduce their costs at the pharmacy, rather than net costs to the state.

Figure 2.5 One Example of FFS Selecting the Lowest-Net-Cost for a Single Prescription. FFS has chosen the lowest-cost option after rebates are factored in, while the ACOs have chosen the option with the lowest upfront cost. Click the following link for additional examples, [Additional Examples Link](#).

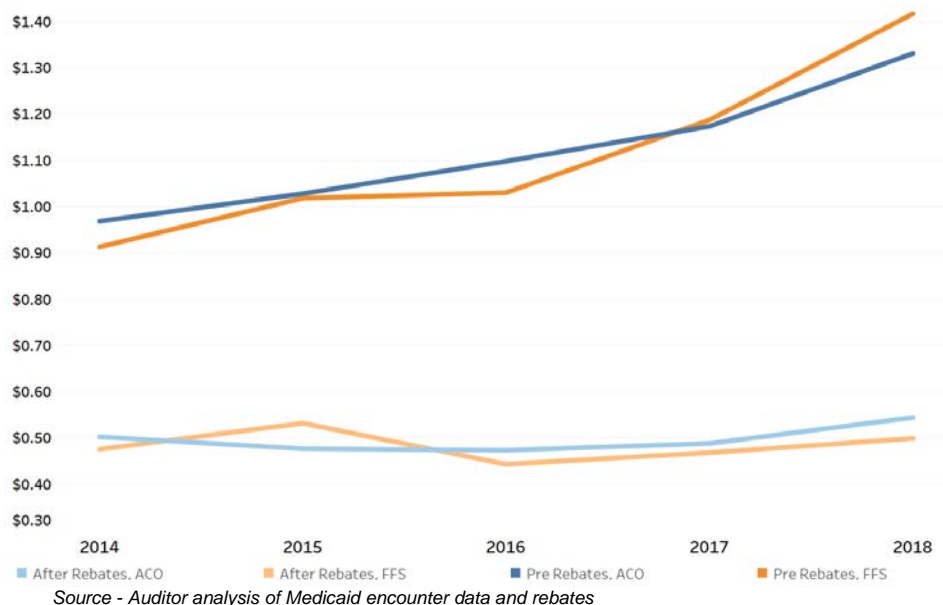


For additional examples
[CLICK HERE](#).

The difference between ACOs' net cost and FFS' net cost for a single drug equates to over \$27,000 for 2018.

Figure 2.5 shows an example of FFS' ability to select a brand drug with a lower net cost than the generic drug utilized by the ACOs. Despite the enormous difference in the initial price, where FFS' cost (dark orange) is much higher than the ACOs' (dark blue), once rebates are factored in, FFS' net cost (light orange) is lower than the ACOs' (light blue). The difference between the ACOs' net costs and FFS' net cost equates to just over \$27,000 for 2018. There are a number of brand drugs that FFS prefers over their generic equivalent because, despite the higher upfront cost, the high rebates result in lower net costs. Since the ACOs do not have this information they are incentivized to minimize pharmacy costs and not net costs to the state, resulting in a higher share of generic utilization. Figure 2.6 shows cost per unit for ACOs and FFS.

Figure 2.6 ACO's Post-Rebate Costs Were 16 Percent Higher than FFS' in 2018. From 2014-2018 FFS' net costs increased just under 5 percent, while the net costs for ACOs increased by over 9 percent. The cost difference between the ACOs and FFS in 2018 is nearly \$3.4 million.



The transparency FFS has to the Medicaid rebate data could allow for savings across the ACOs in addition to FFS. FFS has lower net costs, in large part, due to its access to URA. If ACOs were able to get to the same cost per unit as FFS, assuming ACOs' net costs (light blue) could match FFS' net costs (light orange), we estimate it could result in a savings of up to \$3.4 million. Our calculation is based on the difference between FFS' and ACOs' net costs in 2018. We

acknowledge our estimate has limitations in that it is not clear what pricing ACOs' would be able to receive and what drug makeup would be chosen. Additionally, if a statewide PDL was adopted, Medicaid would be able to collect additional supplemental rebates.⁵ This could result in even more savings, but those savings could be offset by increases to the capitated rate.

In our analysis we looked at net costs – the cost per unit with rebates included. While there is a difference in the cost per unit between ACOs and FFS, ACOs are paid based on a capitated rate which is influenced by the cost of prescriptions. We acknowledge that implementing a statewide PDL will likely increase ACO costs. This is due to two factors: increased utilization of brands and the possibility ACOs may not get the same pharmacy pricing (See Figure 2.1). Higher pharmacy costs could contribute to the state paying a higher capitated rate.

Realized savings through a uniform PDL would be the difference of the increased rebates collected by the state less the increase to the capitated rate. For this reason, we recommend that the Medicaid program conduct a detailed analysis to better understand potential savings. Medicaid should work with the ACOs to determine the potential benefits, savings, and additional costs of utilizing a uniform PDL. The findings of this analysis should then be reported to the Social Services Appropriations Subcommittee.

Additional Savings Can Be Realized Through Better Oversight

DOH has sufficiently managed its PDL, prioritizing the lowest-cost drugs after rebates. While this is encouraging and is keeping net costs down for the state, we believe DOH can provide stronger oversight over rebates and pricing. DOH can provide more audits and verification to ensure pricing is matching the lowest price index and rebates are billed and received correctly.

During our audit, we found over 60,000 prescriptions that were over NADAC, one index of FFS lesser-of logic that FFS uses to

Medicaid could collect additional supplemental rebates if a statewide PDL was adopted.

We found over 60,000 FFS prescriptions that appeared to be paid over NADAC.

⁵ Supplemental rebates are separate from federal mandated rebates, and states receive them by negotiating directly with manufacturers. Manufacturers provide a rebate in exchange for placement on a PDL.

DOH does not have a formal process to ensure the lowest price is paid.

Additional oversight should occur to ensure claims are not paid above the allowed charged.

determine a drug's price. These overages total just over \$300,000 in additional costs. While many of these differences could be explained, it is troubling that DOH does not have a process to ensure the logic is selecting the lowest price. FFS utilizes a process called "lesser of logic" to set the lowest price a pharmacy will be reimbursed. Additionally, DOH does not have a process to review these payments.

Currently, DOH has a contract with Change Healthcare (Change) to manage the lesser-of logic and collect rebates. Change ensures that the price paid at the pharmacy is the lowest of six different indices, as discussed in Chapter I. However, DOH does not have a formal process of ensuring that the lowest price is being selected. DOH would have to manually look up each claim to understand which index had been used to price a prescription. DOH is aware of this and is working with Change to include this information in DOH databases to allow for analysis.

Additionally, we found several examples of DOH reimbursing above the allowed charge. The DOH PDL assumes they will receive the correct rebate amount and pricing. DOH should provide additional oversight to ensure pricing and reimbursement is occurring according to policy. This control is important because higher prices paid at the pharmacy will lead to higher net costs.

As a final analysis, DOH should provide stronger oversight to ensure its projected cost⁶ to the state matches the actual cost. We are concerned that DOH does little verification or audit of claims receiving rebates. While we are unaware of any incorrect rebates, it is a substantial risk that DOH does not account for. For example, in 2018 alone, DOH received nearly \$138 million in rebates but did not sufficiently analyze or verify whether all available rebates were received. If errors amounted to 1 percent less in rebates, DOH would be missing out on over \$1 million in additional dollars.

Recommendations

1. We recommend the Department of Health research and provide a report to the Social Services Appropriations Subcommittee and any other pertinent legislative committees

⁶ Each month, DOH calculates per-unit final cost to the state. This cost factors in lesser-of logic and Medicaid rebate information.

regarding the potential savings, benefits, and costs from creating a statewide preferred drug list.

2. We recommend the Department of Health create a process to review lesser-of logic to ensure pricing is correct.
3. We recommend the Department of Health create a process to review claim-level rebate information to ensure rebates are processed correctly.

Chapter III

The Utah Medicaid Program Can Strengthen Its Oversight of ACO Pharmacy Practices

The Utah Medicaid Program (Medicaid) under the Department of Health relies on a capitated rate setting process to control the spending of accountable care organizations (ACOs). While the rate-setting process involves analysis to certify capitated rates are actuarially sound, it is not sufficient oversight over the ACO pharmacy programs. The capitated rate is a three-way contract between the Centers for Medicare & Medicaid Services, a state, and a health plan to provide comprehensive, coordinated care, where CMS and the state pay each plan a capitation payment, which is a monthly rate effective over a calendar year. The capitated rates are based on data which include ACO paid claims, trends, and data analysis methods. Drug and pharmacy cost increases can contribute to capitated rate increases. We found there are opportunities for DOH to improve its monitoring and oversight activities to control these trends.

We were asked to look at spread pricing amongst the ACOs. We found \$1.5 million in spread in calendar year 2018. Spread is the difference between the amount the pharmacy benefit manager (PBM) charges the health plan and the amount the PBM reimburses the pharmacy; this amount is typically retained by the PBM. Three of the four ACOs contract with a PBM to provide pharmacy services, but only one ACO (Health Choice) utilizes a contract where spread pricing is used. However, we found another ACO (Healthy U) that had spread pricing, even though its contract did not allow for it. This is concerning and is another example of how the Utah Medicaid program can bolster its oversight. Medicaid can ensure that reasonable steps are being taken to control costs and that PBMs follow contract requirements.

The capitated rate is a three-way contract between CMS, a state, and a health plan to provide comprehensive, coordinated care.

We found \$1.5 million in spread in calendar year 2018.

DOH Could Provide More Oversight of Rate Setting and Rebates

Medicaid relies on the actuarial company Milliman to set capitated rates.

Currently Medicaid relies on the actuarial company Milliman to set capitated rates that are actuarially sound and to evaluate trends in claims data. Medicaid uses these capitated rates as means to control spending. As discussed in Chapter II, capitated rates are a per member per month set amount that the ACOs receive to cover eligible medical services that a Medicaid recipient requires. We could not find evidence that Medicaid independently reviews ACO claims or spending data. Without tracking the trend changes that may contribute to capitated rate increases, DOH is unable to provide additional oversight steps to ensure costs are being managed. Providing oversight could assure that ACOs are taking reasonable steps to control costs.

An example of where Medicaid could bolster its oversight is shown in Chapter II. Figure 2.3 shows that Molina had a sharp decline in prescription costs in 2018, amounting to approximately 24 percent. At the same time, Healthy U experienced a sharp increase in costs of about 28 percent. These changes occurred because Molina lost a contract with the University of Utah. As a result, some of the patients that were with Molina moved to Healthy U, where they could continue with existing doctors and facilities. As a result, Molina's costs decreased, and Healthy U's increased. In this example, where wide fluctuation in costs occurred due to actions between two ACOs, we would expect the Medicaid program to be analyzing these trends and conducting analysis to ensure the greatest efficiency in cost is still being achieved. If costs are increasing, Medicaid should take corrective action where needed.

ACOs have little incentive to control cost trends in the long term.

Milliman does not reduce capitated rates if ACOs engage in practices that increase costs, such as poor contracts or unnecessary spending. Though Milliman reports it reviews provider contracting through an efficiency analysis, they do not use this efficiency analysis to reduce capitated rates. Therefore, DOH must assume the role of incentivizing the ACOs to control cost trends over the long term. One example of an ACO contract that appeared to unnecessarily increase costs occurred at Healthy U.

Healthy U procured a pharmacy contract that was not cost-effective. As a result, they did not receive 100 percent of supplemental

rebates from manufacturers and were charged at higher brand-drug rates for some generic drugs because generics were not strictly defined. Although Healthy U is in the process of correcting this contract moving forward, greater Medicaid oversight could have prevented this and kept costs lower. Therefore, especially in the case of Healthy U, a lack of contract oversight has led to increased pharmacy costs. Higher costs for ACOs can be a contributing factor of higher capitated rates and higher Medicaid spending.

DOH has access to the ACO plans, giving DOH the ability to compare pharmacy cost trends. We believe the Medicaid program should begin conducting analysis to ensure ACO pharmacy spending, as shown in Figure 2.1, is not increasing faster than statewide trends. While the capitated rate controls costs for the rate setting period, it does not control increases over time. We believe Medicaid should proactively monitor pharmacy costs, including trend analysis and contract monitoring. DOH should be working to oversee ACOs and ensure cost controls are in place to make certain high-quality care is provided at the lowest cost to the state.

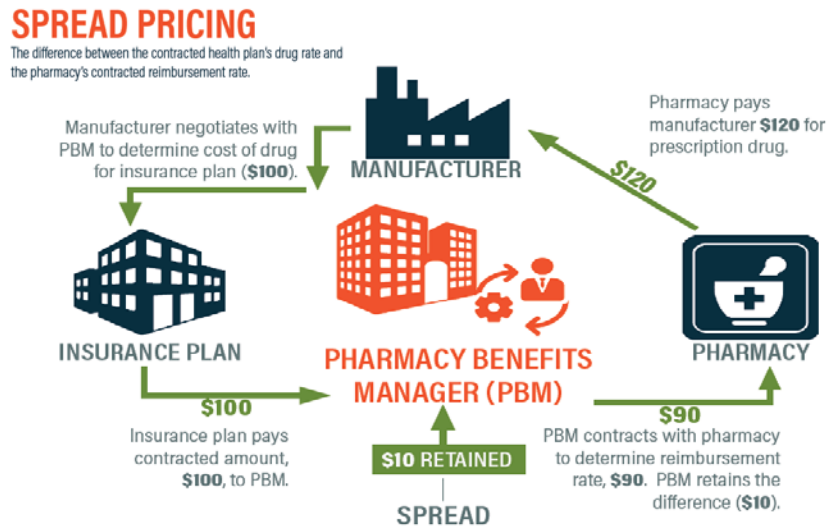
ACO PBMs Received \$1.5 Million From Spread Pricing

In traditional contracts, spread pricing is the result of two separate processes, both of which are controlled by the PBM. The PBM contracts with health care plans to provide covered drugs at specific rates. Independent of this transaction, PBMs contract with pharmacies to reimburse them at certain rates for drugs they dispense to consumers. As a result of these separate processes, the price difference between the health care plan's drug cost and the pharmacy's contracted reimbursement rate can lead to spread pricing, which is retained by the PBM. Figure 3.2 details the process of spread pricing.

DOH has access to the ACO plans, giving DOH the ability to compare pharmacy cost trends.

The price difference between the health care plan's drug cost and the pharmacy's contracted reimbursement rate can lead to spread pricing.

Figure 3.1 Spread Pricing Is a Major Revenue Source for PBMs. The price difference between what the plan pays and what is reimbursed to pharmacies is the spread amount the PBMs retain as revenue.



Icons by Freepik and Gregory Cresnar via FlatIcon.com

Utah State Legislature: Auditor General | 2019

Healthy U's contract is transparent and should not have any spread pricing. We found a spread of 1.4 percent in 2018.

We analyzed spread by comparing pharmacy reimbursement costs at one pharmacy to the amount paid by the ACO for those claims. Approximately 10 percent of Health Choice's claims and 18 percent of Healthy U's claims went through this specific pharmacy. We would expect spread pricing to occur for Health Choice because it utilizes a traditional contract that employs spread pricing. However, Healthy U's contract is transparent and should not have any spread pricing. A transparent contract removes spread pricing but is not necessarily more cost effective. See report 2019-13 *A Performance Audit of PEHP's Pharmacy Benefit Manager* for more information on transparent and traditional contracts. Figure 3.2 shows the spread amounts for Healthy U and Health Choice.

Figure 3.2 Two ACOs Showed Spread Pricing. Healthy U should not have any spread pricing due to the nature of their contract.

Healthy U



**Spread
Percent:**
1.4%

Health Choice



**Spread
Percent:**
6.5%

Total ACO Spread:
\$1.5 Million in CY 2018

We found spread pricing occurred over a two-month period in 2018 which equaled 4 percent of all prescriptions at Healthy U. Healthy U's contract states that its PBM will provide documentation, at Healthy U's request, of reimbursements to pharmacies. Healthy U is currently performing an audit on this PBM to determine the extent of spread pricing that may have occurred. However, DOH should provide oversight of all the ACOs and review contracts to ensure that they are not putting the state at risk due to increasing costs.

We found spread pricing occurred with Healthy U over a two-month period in 2018.

Recommendations

1. We recommend the Department of Health take steps to provide better oversight of the Accountable Care Organizations and review cost trends and contract changes.
2. We recommend the Department of Health provide oversight of contract compliance between Accountability Care Organizations and their Pharmacy Benefit Managers.

Agency Response



State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

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

Division of Medicaid and Health Financing

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

April 17, 2020

Kade Minchey, Auditor General
Office of the Legislative Auditor General
Utah State Capitol Complex
West Office Building, Suite W315
Salt Lake City, Utah 84114

Dear Mr. Minchey:

Thank you for the opportunity to respond to the audit titled *A Performance Audit of Medicaid's Pharmacy Benefit Oversight* (Report #2020-02). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe the results of our combined efforts will make a better, more efficient program.

We concur with the recommendations in this report. Our response describes the actions the Department plans to take to implement the recommendations. The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas needing improvement.

Sincerely,

Emma Chacon
Emma Chacon (Apr 17, 2020)

Emma Chacon for
Nathan Checketts
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing



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Division of Medicaid and Health Financing

Utah Department of Health

Response to Recommendations

We are including additional background information in our response to help others further understand the complex program areas addressed in the report, what steps have been taken by the Department and what additional steps still need to occur. Please see our specific responses to each audit recommendation directed to the Department may be found after the additional background section.

Background

Medicaid Drug Rebate Program (MDRP) vs Supplemental Rebates

In 1990, Congress created the Medicaid Drug Rebate Program (MDRP). *MDRP is a program that includes Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and participating drug manufacturers that helps to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients. Approximately 600 drug manufacturers currently participate in this program. All fifty states and the District of Columbia cover prescription drugs under the MDRP... The program requires a drug manufacturer to enter into, and have in effect, a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) in exchange for state Medicaid coverage of most of the manufacturer's drugs. When a manufacturer markets a new covered outpatient drug, it must also submit product and pricing data concerning the drug to CMS via the Drug Data Reporting for Medicaid (DDR) system.*¹ These rebates are generally referred to as “primary rebates.”

It is essential to understand the MDRP is managed by CMS. States do not directly contract with any manufacturers for these rebates.

“Secondary rebates” (AKA, “supplemental rebates”) are different from MDRP. They are available to a State through direct negotiation with manufacturers. For these secondary rebates, Utah has joined the Sovereign States Drug Consortium in order to leverage its purchasing power.

The Sovereign States Drug Consortium (SSDC) is an organization of 13 state Medicaid programs that have agreed to collectively solicit and evaluate offers from manufacturers for state supplemental and DME rebates. The SSDC, which started in 2006 with three charter states – Iowa, Maine and Vermont – is the only Medicaid rebate pool organized and managed by the states. The SSDC is also unique in that it is the only Medicaid rebate pool in which member states contract individually with manufacturers using their own state-specific Supplemental Rebate Agreements (SRAs). The SSDC enables the states to leverage the

¹ <https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html>

purchasing power of their collective over 10 million covered lives while providing each state with full ownership of its contracts.

The SSDC contracts with Change Healthcare to administer the rebate solicitation, negotiation and evaluation process. Each spring, Change Healthcare solicits offers for the pool from manufacturers for the following calendar year.²

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

Brand over Generic

Drug manufacturers, through the MDRP, have entered into rebate programs on many brand name products. This has resulted in Utah Medicaid receiving large rebates making the cost of some brand name drugs less expensive than their generic counterparts.

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

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

A listing of brand name products favored over the generic equivalent are available on Utah Medicaid's [website](#).

Professional Dispensing Fees

Effective April 1, 2016, CMS' Covered Outpatient Drug Rule ([CMS-2345-FC](#)), among other things, changed the term "estimated acquisition cost" (EAC) to "actual acquisition cost" (AAC) to *...require States to begin paying pharmacy providers based on the AAC of the drug. Additionally States will reimburse providers with a comparable dispensing fee...* The move to AAC required States to update their dispensing fees. Specifically, 42 CFR 447.518(d) requires States, with their State Plan amendment to move to AAC, to *provide adequate data such as a State or national survey of retail pharmacy providers or other reliable data other than a survey to support any proposed changes to either or both of the components of the reimbursement methodology.* Through RFP, Utah Medicaid contracted with Myers & Stauffer to conduct the survey. The results are available at this [link](#).

The professional dispensing fees prior to CMS' rule change were \$3.90 for urban and \$4.40 for rural pharmacies. Following CMS' rule change and professional dispensing fee survey, the

² [SSDC Medicaid Supplemental Drug Rebate Pool Fact Sheet](#)

professional dispensing fees following CMS' rule change were \$9.99 for urban and \$10.15 for rural pharmacies. While this appears a drastic increase, it was based on actual costs to dispense the drugs and Utah had no other choice to be compliant with the federal mandate.

To limit the potential to overuse the dispensing fee, UAC R414-60-7(3)(b) states *Medicaid will only pay one dispensing fee per 24 days per covered outpatient drug per pharmacy.*

ACO Rate Setting

ACO rate setting is complex; however, it can be boiled down to the need for capitated rates that are actuarially sound. Utah currently contracts with Milliman for actuary services and rate development for managed care rates. CMS defines actuarially sound as: *Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.* (See 42 CFR 438.4(a).) For rates to be approved by CMS, they need to *Have been developed in accordance with standards specified in §438.5 and generally accepted actuarial principles and practices... and Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under §438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under §438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.* (See 42 CFR 438.4(b)(1) and (9).)

The regulations allow for a range of rates to be developed and still be considered actuarially sound (e.g., rates at 85% medical loss ratio (MLR), rates at 90% MLR). As the various elements are considered by the actuaries, multiple rates are possible, within the regulatory constraints. Utah gives Milliman a target budget based on appropriations from the legislature. Base budget appropriations mandate consideration of increases for the ACOs as detailed in [UCA 26-18-405.5](#).

As Milliman develops rates, they are able to attest to rates being actuarially sound if the mandated considerations (e.g., base data, trend, non-benefit component, risk adjustments) are able to fall within the appropriations given by the legislature. If the appropriations are too high, then Medicaid would not be able to set rates up to the appropriation amount. If appropriations were too low, then Medicaid would need to seek additional funding from the legislature. If additional funding was not appropriated, Medicaid could not obtain CMS approval of the proposed rates and would not be able to get federal funding for those rates.

In summary, cost increases of the ACOs do not necessarily equate to an increase in capitated rates. Increases in costs, if no additional appropriations are available, could result in rates set to a lower MLR and not an increase in the capitated rates.

Utah Medicaid's Program Integrity

The creation of the Office of Inspector General for Medicaid Services (OIG) resulted in removing all program integrity funding and staff from Utah Medicaid. As stated in a recent OLAG audit, *OIG operations consist of three main activities: program integrity, performance audit, and special investigations. The OIG also devotes resources to provider education.*³

Utah Code, Title 63A, Chapter 13 denote the OIG's responsibilities. These responsibilities include, but are not limited to, the following:

- inspect and monitor the following in relation to the state Medicaid program:
 - the use and expenditure of federal and state funds;
 - the provision of health benefits and other services
- discovering and eliminating fraud, waste, and abuse of Medicaid funds
- obtain, develop, and utilize computer algorithms to identify fraud, waste, or abuse in the state Medicaid program
- audit, inspect, and evaluate the functioning of the division for the purpose of making recommendations to the Legislature and the department to ensure that the state Medicaid program is managed:
 - in the most efficient and cost-effective manner possible; and
 - in a manner that promotes adequate provider and health care professional participation and the provision of appropriate health benefits and services
- regularly advise the department and the division of an action that could be taken to ensure that the state Medicaid program is managed in the most efficient and cost-effective manner possible
- determine ways to:
 - identify, prevent, and reduce fraud, waste, and abuse in the state Medicaid program; and
 - balance efforts to reduce costs and avoid or minimize increased costs of the state Medicaid program with the need to encourage robust health care professional and provider participation in the state Medicaid program

³ https://olag.utah.gov/olag-doc/18_03rpt.pdf page i

Chapter II

Recommendation 1

We recommend the Department of Health research and provide a report to the Social Services Appropriations Subcommittee and any other pertinent Legislative committees of potential savings, cost, and other benefits in creating a statewide preferred drug list.

Department Response:

We concur with this recommendation.

Contact: Jennifer Strohecker, Director, Bureau of Healthcare Policy and Authorization, 801-538-6293

Implementation Date: Report submitted to Social Services Appropriations Subcommittee by July 1, 2021.

Recommendation 2

We recommend the Department of Health create a process to review lesser of logic to ensure pricing is correct.

Department Response:

We concur with this recommendation. The Department will also engage the OIG to assist in this effort.

Contact: Jennifer Strohecker, Director, Bureau of Healthcare Policy and Authorization, 801-538-6293

Implementation Date: January 1, 2021 to have discussions with OIG regarding program oversight in this area.

Recommendation 3

We recommend the Department of Health create a process to review claim level rebate information to ensure they are processed correctly.

Department Response:

We concur with this recommendation. We will finalize standard operating procedures and implement a process to review claim level rebate information to determine rebates are processed correctly. In addition, we will meet with the Office of Inspector General to clarify their role in

assisting the Department with this activity and modify our memorandum of understanding with the OIG to reflect that clarification.

Contact: Jennifer Strohecker, Director, Bureau of Healthcare Policy and Authorization, 801-538-6293

Implementation Date: January 1, 2021 to have discussions with OIG regarding program oversight in this area.

Chapter III

Recommendation 1

We recommend the Department of Health take steps to provide better oversight of the Accountable Care Organizations to review cost trends and contract changes.

Department Response:

We concur with this recommendation.

Milliman, through their rate-setting processes, develops cost trends. Those trends are reviewed with Department staff on a regular basis. In addition, the Division will meet with the Office of Inspector General to come to agreement on their role in assisting the Department with this activity. The Department will modify our memorandum of understanding with the OIG to reflect this discussion.

Contact: Gregory Trollan, Director, Bureau of Managed Health Care, 801-538-6358

Implementation Date: July 1, 2021

Recommendation 2

We recommend the Department of Health provide oversight of contract compliance between Accountability Care Organizations and their Pharmacy Benefit Managers.

Department Response:

The Department partially concurs with this recommendation

It is the primary responsibility of the Contractor to have oversight of its subcontractors. In addition, the State contract with Medicaid Accountable Care Organization states that the Contractor and its subcontractors are subject to audit by any state or federal auditor. It is important to note that the PBMs providing pharmacy services to three of the Medicaid ACO also provide these services to each plan's commercial and marketplace books of business.

We concur that the Department has oversight responsibility for its contracts. Currently, the Department does not have the necessary staff resources to conduct the level of oversight needed based on this recommendation. The Department will request assistance from the OIG.

Contact: Gregory Trollan, Director, Bureau of Managed Health Care, 801-538-6358

Implementation Date: July 1, 2021