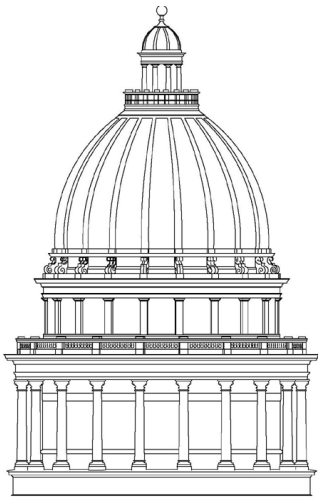
REPORT TO THE

UTAH LEGISLATURE

Number 2010-14



A Follow-up of Utah Medicaid's Implementation of Audit Recommendations

December 2010

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH
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AUDITOR GENERAL

December 2010

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Follow-up of Utah Medicaid's Implementation of Audit Recommendations (**Report #2010-14). A digest is found on the blue pages 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,

John M. Schaff

John M. Schaff, CIA
Auditor General

JMS:KRM/lm

Digest of
A Follow-up of Utah Medicaid's Implementation of Audit Recommendations

This report presents an in-depth follow-up to two Medicaid audits, *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* (Report 2009-12) and *A Performance Audit of Utah Medicaid Managed Care* (Report 2010-01). We conducted this follow-up work at the request of the Health and Human Services Appropriations Subcommittee with the approval of the Legislative Audit Subcommittee. This report is broken out into two subsequent chapters, one for each report. Both of the previous reports had six chapters, which are discussed in more detail below.

Chapter II Follow-up of Report 2009-12: A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program

Management Controls Over Medicaid Cost Avoidance Are Progressing Slowly. Utah Medicaid has made some improvements in its practices and policies dealing with prior authorizations and provider enrollment, two critical areas in avoiding Medicaid fraud, waste, and abuse. However, implementation of management oversight to ensure these policies and practices are functioning correctly is still in-process.

Cost Recovery Effort Improvements Are Not Yet Operational. Efforts are underway to improve cost recovery of inappropriately paid Utah Medicaid funds. Currently, Program Integrity is working on improving its tracking of recovery data and its return on investment. A critical recommendation in Chapter IV that also is important to Chapter V is the introduction of a new analytical tool that can systematically review all claims for fraud, waste, and abuse. DOH reports that this tool should be operational in September 2011.

Independence for Oversight Functions Has Improved, But Is Still Inadequate. The DOH has taken steps to improve the independence of the oversight function for the department; however, independence is still not satisfactory. Three of the four recommendations in Report 2009-12, Chapter VI have been addressed by DOH management but independence concerns persist. Consequently, we designated these recommendations as partially implemented, since the department's action to date has not provided the level of independence necessary for Internal Audit and Program Integrity.

Chapter III Follow-up of Report 2010-01: A Performance Audit of Utah Medicaid Managed Care

Managed Care Cost Reductions Have Been Achieved, But More Are Possible. Report 2010-01 found that managed care cost reductions were possible. The report recommendations were aimed at helping Utah Medicaid realize these cost savings. Implementation of some recommendations has been slow, but Utah Medicaid implementation to date appears to have led to some cost control.

Managed Care Oversight Must Be an On-going Effort. It appears that Utah Medicaid has made some improvement in its oversight of the managed care programs, though more work needs to be done. Utah Medicaid can still do more to develop and implement cost-saving measures in its managed care plans.

Medicaid Must Continue to Implement Cost-Saving Options. In addition to the cost savings that were identified through the health plans, the prior report indicates that Utah Medicaid could be more proactive in developing cost-saving programs proven to be cost effective in other states. Some implementation has occurred in this area and new programs are being developed.

REPORT TO THE

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Report No. 2010-14

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December 2010

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Chapter I
Introduction

This report presents an in-depth follow-up to two Medicaid audits, *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* (Report 2009-12) and *A Performance Audit of Utah Medicaid Managed Care* (Report 2010-01). We conducted this follow-up work at the request of the Health and Human Services Appropriations Subcommittee with the approval of the Legislative Audit Subcommittee. This report is broken out into two subsequent chapters, one for each report.

This report follows-up to two previous audits on Utah Medicaid. The first was released in August 2009 and the second in January 2010.

Follow-up of *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program*

Our first report, issued in August 2009, focused on what was then known as the Bureau of Program Integrity (BPI), whose function was to identify and recover inappropriate payments from provider fraud, waste, or abuse. In response to our concerns of the independence of BPI and the internal auditors, the Department of Health (DOH) created the Office of Internal Audit and Program Integrity (OIAPI), which now encompasses both Program Integrity and the DOH internal audit function.

The August 2009 report found that improvements were needed to the controls over Medicaid fraud, waste, and abuse.

We found that improvements have been made in the areas of cost recovery and avoidance, although most report recommendations are still in the process of being completely implemented. Despite the creation of OIAPI, we continue to have concerns regarding the independence of Program Integrity and Internal Audit.

Follow-up of *A Performance Audit of Utah Medicaid Managed Care*

Our second report, issued in January 2010, focused mainly on the Bureau of Managed Health Care, which oversees the contracted managed health care plans utilized by Utah Medicaid. We found that little oversight has been provided to these plans and substantial savings were possible by increased controls.

The January 2010 report found that substantial savings are achievable in Utah's Medicaid Managed Care Programs.

The audit also looked at other ways of implementing cost-saving options by reducing utilization of services or finding low-cost alternatives. Again, we found that most recommendations had some work done, but were still in the process of being implemented.

This report categorizes DOH's progress in fulfilling recommendations in five ways. We define the progress as:

- Implemented – The recommendation has been completed in the manner intended.
- In progress – The department has begun making the necessary improvements, but they have not yet been completed. They intend to continue working towards implementation.
- Partially implemented – The department has taken steps toward implementing the recommendation, but has not fully completed it. They have no intention to take further action.
- Not implemented – Either the department has decided not to implement or they are awaiting some other action to take place.
- On hold – The department has not yet started implementation due to circumstances beyond their control.

Audit Scope and Objectives

We were asked to perform an in-depth follow-up on two reports: *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* and *A Performance Audit of Utah Medicaid Managed Care*. The scope of this audit was to:

- Follow up on the implementation status of recommendations.
- Identify areas where further improvements can be made.

Chapter II
Follow-up of Report 2009-12: A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program

The recommendations in our August 2009 report dealing with fraud, waste, and abuse controls in Utah's Medicaid program are in various stages of implementation, but most are still in process. Below is a summary of the status of each our recommendations.

- Implemented = 5
- In process = 16
- Partially implemented = 4

Recommendations are in various stages of implementation. Of note, the recommended replacement of the outdated fraud, waste, and abuse analytical tool has not been purchased.

Our report covered three primary areas of controls, as follows:

- Cost avoidance
- Cost recovery
- Independence of oversight functions

Cost avoidance improvements have been made; however, most of these improvements deal with improved policies and training. Many of the necessary management controls to ensure that policies are followed and necessary actions are taken are still in the process of being implemented.

Some cost recovery improvements have been made in the form of better performance measures and improved tracking ability. However, a significant obstacle to effective implementation of our cost recovery recommendations is the cost recovery operation's reliance on an inadequate fraud, waste, and abuse analytical tool. The existing tool was last updated in 1987 and although we recommended replacement, to date a new tool has not been purchased.

Independence of the oversight functions at the Department of Health (DOH) appears to have been technically implemented by placing the Program Integrity operation directly under departmental management. However, the intent of our recommendations may have

We continue to question if the oversight functions at DOH have sufficient independence. A report scheduled to be released in December 2010 will further address this concern.

been lost because of other departmental actions that we believe undermined full independence. Audit and Program Integrity independence may ultimately be possible only by completely removing the function from the department.

Management Controls over Medicaid Cost Avoidance Are Progressing Slowly

Utah Medicaid has made some improvements in its practices and policies relating to prior authorizations and provider enrollment, two critical areas in avoiding Medicaid fraud, waste, and abuse. However, implementation of management oversight to ensure these policies and practices are correctly functioning is still in progress.

Cost avoidance issues were addressed in Chapters II and III of Report 2009-12. Chapter II: "Prior Authorization Is Not Adequately Controlling Utilization" addressed issues dealing with the need for improved management control of over-utilization of Medicaid Program provided services. Chapter III: "More Controls Needed with Provider Enrollment" addressed need for improved management controls to reduce fraudulent or abusive providers within the Medicaid Program.

Improved Prior Authorization Program Still Needs Management Oversight

The oversight control to ensure prior authorization nurses are not inappropriately approving procedures is not yet fully implemented.

Utah Medicaid has made encouraging changes to its prior authorization program. However, improved oversight control of the program's prior authorization nurses is still in the process of being implemented. Failure to provide this oversight means that prior authorization nurses' decisions are still not being reviewed to prevent inappropriate and costly claim decisions. This control weakness was noted in our August 2009 report.

Figure 2.1 lists the recommendations related to prior authorization issues, recommendation status, and a brief explanation. Greater details on selected issues follow the figure.

Figure 2.1 Prior Authorization Recommendations' Status (Chapter II). Three of the six recommendations have been implemented. The other recommendations, dealing primarily with oversight, have not been fully implemented, though progress is being made.

Recommendation	Status	Explanation
We recommend that BPI establish clear guidelines for when a prior authorization request should be reviewed by the appropriate utilization review committee.	Implemented	The guidelines have been implemented, but the control to ensure prior authorization nurses are following the guideline has not yet been put in place.
We recommend that BPI management ensure prior authorization nurses receive regular training on how to review prior authorization requests.	Implemented	Improved training has occurred and is ongoing.
We recommend that BPI management ensure prior authorization nurses present the following to the appropriate UR committee: a. Non-covered procedures that do not have established criteria b. Requests for procedures that may require an exception to policy	In process	The management control to ensure the control is functioning has not yet been implemented, but the process to monitor the control has been put in place.
We recommend that the HCF* establish criteria for the following circumstances: a. Procedures for which HCF does not agree with InterQual criteria b. Common prior authorization requests, such as circumcision	In process	HCF has written many new policies for medical procedures. However, some are still outstanding.
We recommend that more management oversight be given to the prior authorization process. The prior authorization manager should regularly monitor prior authorization nurses to ensure adherence to statute, administrative rule, HCF policy, and established criteria when evaluating a prior authorization request.	In process	More management oversight has been given to the prior authorization process; however, adequate monitoring procedures are still being developed and implemented.
We recommend that the HCF adequately document all changes to policy.	Implemented	It appears new changes to policy are being documented. Utah Medicaid should be diligent to ensure this continues.

**Health Care Financing is now know as the Division of Medicaid and Health Financing*

Three recommendations have been implemented and another three are still in the process of being implemented.

Figure 2.1 shows that five of the six recommendations were directed at improving management oversight and control over prior authorization nurse decisions. We originally found that very little

oversight was occurring and prior authorization nurses had the ability to unilaterally approve procedures outside of Medicaid policies. These decisions resulted in the state being charged for and paying inappropriate claims.

To correct this control weakness, management has reclassified two positions to provide oversight of the nurses and review cases the nurses are approving to determine if the approval process is being correctly followed. Utah Medicaid management has hired for these two positions and reportedly should have a tracking process in place by January 2011.

Improved Provider Enrollment Process Needs Additional Controls

A new policy was drafted to increase oversight of provider enrollment. However, some clarifications are needed to strengthen the oversight.

We are encouraged by the new policy that has been developed and implemented to improve controls over provider enrollment. To further improve the provider enrollment and oversight process three more items need strengthening, specifically:

- More scrutiny can be given to providers under disciplinary action where the need for that provider is not critical
- Automating of provider disenrollment should be instituted
- Legislative Amendments made to the controlled substance database now allows Program Integrity to obtain information by individual. Future tests may show a need to also give Program Integrity the ability to obtain information by provider.

Figure 2.2 lists the 2009 report's recommendations related to improving provider enrollment controls, their recommendation status, and a brief explanation. A more detailed explanation of some of the recommendations follows the figure.

Figure 2.2 2009 Report's Status of Recommendations Related to Provider Enrollment and Oversight (Chapter III). Two of the four recommendations have been implemented, one recommendation is partially implemented and the other recommendation is in the process of being implemented.

Recommendation	Status	Explanation
We recommend that HCF determine the feasibility of putting provider enrollment in the Bureau of Program Integrity.	Implemented	Change was discussed, but provider enrollment was left in Medicaid.
We recommend that provider enrollment develop its own standards and policies for enrolling new providers to ensure they are properly precluding fraudulent and other high-risk providers.	Implemented	Four providers have been removed and three applicants denied due to more stringent criteria.
We recommend that provider enrollment consider provider need when considering providers with disciplines, for providers not automatically precluded by policy.	In process	Policy allows for committee to consider provider need, but no providers have been excluded because of this clause.
We recommend that the Legislature consider the merits of extending access of the controlled substance database to BPI. If access is granted, BPI should develop and institute controls to ensure providers are billing Medicaid correctly and that prescriptions are appropriate in regards to frequency and dosage.	Partially Implemented	Access was given to Program Integrity to obtain information by individual. Future tests may show a need for Program Integrity to also obtain information by provider.

The next few pages discuss, in more detail, some of the areas that still need additional strengthening or further work to ensure full implementation of the recommendations.

Provider Enrollment Policy Has Been Strengthened, but More Review Scrutiny Over Providers Still Needed. Based on our recommendations, HCF made a number of changes to provider enrollment policy that we believe have strengthened its ability to exclude providers who are at higher risk for fraud, waste, and abuse as well as providers who have sanctions regarding patient abuse. Providers are now automatically excluded from being a Medicaid provider for many reasons, including sexual misconduct with a patient as well as current fraud and controlled substance convictions. We found that provider enrollment has denied three applicants under the new policy and removed four existing providers since the policy was put in place.

Provider enrollment controls have been strengthened, resulting in four providers and three applicants being denied.

In addition to the automatic exclusions that were added to policy, provider enrollment has formed a Provider Sanction Committee (PSC) to review providers who are not automatically excluded by policy, but have prior felony convictions involving fraud or controlled substances. The committee has met on three providers, two who were allowed to remain in Utah Medicaid and one who was denied enrollment due to Medicaid fraud.

Utah Medicaid should consider need for a provider when enrolling new providers. No providers have been denied based on provider need.

While the PSC is the mechanism for denying providers not automatically excluded, they have not removed any providers with disciplinary actions who have not automatically been excluded except in the case of one provider who committed fraud against Medicaid. To further guard against fraud, waste, and abuse, the committee should consider removing additional providers with disciplinary actions if they are not needed in the program. Disciplines requiring the Post Payment Review Unit to monitor a provider (see bullet list below) could be a starting point for determining where to adjust policy to consider provider need for non-mandatory exclusion.

Demand for a provider is often determined by the number of similar providers in the area or the amount of billing they perform. A provider with serious sanctions who is not automatically excluded and bills infrequently could be removed with little to no impact on access to care.

Provider enrollment has also implemented a review process for high risk providers who are in the system. The policy states:

> Providers will be monitored by the Post Payment Review Unit for at least six months for actions involving:
>
> - Claims for excessive charges
> - Unnecessary services
> - Failure to disclose required information
> - Misdemeanor conviction involving health care fraud

High risk providers have not been reviewed by Program Integrity.

We found that provider enrollment has been sending the names of these providers to Program Integrity, which is currently working on a process for tracking providers. However, staff has not yet begun tracking these providers. It is crucial that Program Integrity get processes in place to ensure at-risk providers are closely monitored.

Provider Enrollment Should Automate the Disenrollment Process of Providers. In addition to denying high-risk providers, provider enrollment can help ensure program integrity by disenrolling active providers who are no longer submitting claims. We contacted seven states and all seven report that providers are disenrolled if they do not submit any claims for an extended period of time (12, 18, or 24 months). Providers who are disenrolled must reapply if they wish to bill Medicaid; the reapplication process includes another check of disciplinary actions against the provider.

Utah Medicaid disenrolls providers who are inactive for 24 months; however this process is not automatic. Provider enrollment did not have any records of who has been disenrolled due to inactivity; staff reported that they try to run the report once per year. If cost-effective, this process should be automated to ensure it runs regularly, and provider enrollment should track the results of any disenrollment.

Program Integrity Can Now Review Individuals Within The Controlled Substance Database. We recommended in our report that the Legislature consider granting Program Integrity access to the Controlled Substance Database. The Legislature did grant Program Integrity access with H.B. 186 of the 2010 general session, which modified ***Utah Code*** *58-37f-301* to give access to,

> Employees of the Department of Health . . . when the information is requested by the Department of Health in relation to a person whom the Department of Health suspects may be improperly obtaining or providing a controlled substance.

H.B. 186 in the 2010 general session granted access of the Controlled Substance Database to the DOH.

The change to the statute is now allowing Program Integrity the ability to obtain information on individuals it needs additional information on. In the future, our office can work collaboratively with the Division of Occupational and Professional Licensing (DOPL) and DOH to run additional tests to determine if Program Integrity needs access to entire providers or pharmacies.

Tests that could be run with full provider information could include looking to see if Medicaid paid for prescriptions that were not dispensed. In these instances, a prescription may have been written and billed for a beneficiary, but never actually obtained.

Program Integrity would like to use the database to determine if they paid for drugs that were not dispensed.

Also, Program Integrity would be able to use the information to ensure narcotics are being dispensed properly. If Program Integrity could determine where prescribers' recipients are coming from and what is being prescribed, as well as see the recipient's history, they could determine if narcotics were properly being prescribed. If a doctor appears to be prescribing at high frequency, data could be pulled for additional review of possible inappropriate claims.

Additionally, access to providers could help Program Integrity determine if Medicaid recipients are receiving prescriptions from non-Medicaid providers. Program Integrity has found instances where Medicaid beneficiaries pay cash for a doctor's visit to get prescriptions filled. In these instances it can be likely that abuse is occurring and full access to the Controlled Substance Database could alert Program Integrity to this abuse. If the abuse is determined, then the recipient can be placed on a restriction program, limiting them to one physician and one pharmacy that they can use.

Cost Recovery Effort Improvements Are Not Yet Operational

Improvements to the cost recovery effort are starting to be implemented, though some key areas still need to be addressed.

Efforts are underway to improve cost recovery of inappropriately paid Medicaid funds. Currently, Program Integrity is working on improving its tracking of recovery data and its return on investment (ROI). Additionally, Program Integrity is implementing additional performance measures. While these efforts are not yet fully completed, we are encouraged by the progress that has been made.

Cost recovery issues were addressed in the 2009 report in a chapter titled "Inefficiency and Ineffectiveness Is Hampering Cost Recovery Efforts." We addressed Medicaid's lack of an effective fraud, waste, and abuse recovery system. The chapter focused on the lack of necessary management information. The next chapter, "Majority of Medicaid Dollars Receiving No Oversight by BPI" addressed Utah Medicaid's lack of provider information that greatly limited provider oversight abilities.

A critical recommendation (currently in the process of being completed) that is relevant to both chapters is the acquisition of a new analytical tool that can systematically review all claims for fraud, waste,

and abuse. Replacing the current, outdated tool will allow Program Integrity to greatly improve its oversight of all Medicaid funds. The DOH recently released an RFP with the intent of the new tool being fully implemented by September 2011.

Program Integrity Reporting Is Improving

Program Integrity has made some improvements to its performance measures and tracking of data.

When the 2009 report was issued, Medicaid's Program Integrity Bureau did not have the performance measures in place to determine either their cost effectiveness or where to allocate limited resources. The lack of performance measures combined with an outdated, ineffective analytical tool and inaccurate recovery data limited the possible recovery of inappropriately paid funds.

Figure 2.3 lists the recommendations from the report's fourth chapter, recommendation status, and a brief explanation. A more detailed explanation of some of the audit recommendations follows the figure.

Figure 2.3 Status of the 2009 Report's Analytical Tool and Performance Measures Recommendations (Chapter IV). We found that all seven recommendations are still in the process of being implemented.

Recommendation	Status	Explanation
We recommend that BPI either fix the current SURS system or purchase a working analytical tool that can systematically review claims for fraud, waste, and abuse.	In process	DOH issued an RFP for a new system in November 2010.
We recommend that BPI begin tracking the exact percentage of total program expenditures recovered.	In process	New tracking system has been developed, but needs refining.
We recommend that BPI design a system that allows them to better track, pull, and sort recovery data.	In process	System is up and running but full reporting still being built.
We recommend that BPI develop a staff cost allocation and assignment system that can effectively and efficiently allocate staff time and resources.	In process	Individual pieces are in place, but the system is not fully functional.
We recommend that BPI track its employees' return on investment.	In process	Individual pieces are in place, but the ROI is not yet being measured.
We recommend that BPI develop specific performance measures and develop rating metrics, and then track adherence to these goals.	In process	Measures are being designed and refined.
We recommend that BPI report annually to the Legislature and Governor on their cost avoidance and cost recovery efforts.	In process	Report is expected to be submitted during the 2011 Legislative session.

The next few pages discuss in more detail some of the areas that need additional strengthening or further efforts to ensure full implementation of the recommendations. Specifically, the DOH has not yet replaced an outdated analytical tool and Program Integrity is still fine-tuning its performance measures and return on investment calculations.

The SURS tool has not been updated, but an RFP to obtain a new tool was issued with planned implementation in 2011.

SURS Tool Has Not Yet Been Replaced. One of the most effective ways of finding inappropriate payments is through a Surveillance and Utilization Review System (SURS) or Fraud and Abuse Detection System (FADS) tool. These tools can be used to identify both high risk areas and providers with higher billings. While Program Integrity has such a tool, it was purchased in 1980 and has not been updated since 1987. The tool is not current and is ineffective

in identifying fraud, waste, and abuse. The DOH issued an RFP for an updated FAD tool in November 2010 and DOH expects the tool to be operational by September 2011.

Performance Measures Are Being Developed. In order to show the effectiveness of Program Integrity's efforts, we made two recommendations. First, Program Integrity should better track cost recoveries resulting from their efforts and, second, they should implement performance measures for both Program Integrity and individual employees. These additions would enable them to better allocate resources as well as provide goals for recoveries.

Program Integrity reporting has been much improved through a new reporting system, although full functionality is still being developed.

The tracking of recoveries has been much improved with the implementation of a new reporting system. Full reporting capabilities are still being developed and refinements are being made. This tracking system has allowed the newly formed Office of Internal Audit and Program Integrity (OIAPI) to calculate their overall ROI.

We do question some aspects of how OIAPI calculated its ROI. For example, recoveries that are returned to the provider due to appeal are currently being counted in the year they are returned, rather than the year the recovery was originally made. To illustrate, if a $50,000 recovery was made in 2009, but then overturned on appeal and returned in 2010, there was, in effect, no cost recovery so there should be no change reported on the ROI. However, under the current system, the section's 2009 ROI would be overstated by $50,000 and understated by $50,000 in 2010. This concern would also arise if a claim is recovered in one year for improper billing and then paid the next when corrected and resubmitted.

Program Integrity reports positive ROI despite limited staff and systems.

Despite these problems, OIAPI still maintains a positive ROI. Their current ROI was calculated at 106 percent. In other words, for every dollar they spend on program integrity, they recover $2.06. Any positive ROI reflects a positive fiscal impact on the budget.

We believe that with a fully functioning FAD tool, independence to pursue all aspects of the Medicaid program, and continued tracking and adherence to proven performance measures, Program Integrity can substantially increase recoveries. Additional staff resources may also be necessary in the future and would be warranted if Program

Integrity can continue to demonstrate a positive ROI based on sound data.

OIAPI has developed a number of performance measures, which it is currently refining and will track on an ongoing basis. OIAPI should report its ROI and performance goals to the Legislature and Governor on an annual basis.

Staff Cost Allocation and Assignment System Is Being Developed. With the new reporting system that has been implemented, Program Integrity is now able to track the amount of money each employee recovers, the time spent on those cases, and the total time spent in each type of recovery. This gives Program Integrity the pieces that it needs to develop a Staff Cost Allocation and Assignment System as well as track each employee's ROI. However, individual ROI is not yet being recorded and tracked to be used as a basis for workload assignments.

Once these tools are in place, Program Integrity can easily determine which activities are the most effective in recovering money based on the amount of time they take. Resources can then be shifted to more profitable activities, increasing Program Integrity ROI. Individuals can also be tracked to determine how they are performing compared to co-workers so individual best practices can be identified and shared. OIAPI should continue to develop these measures and begin tracking them as soon as possible.

Majority of Medicaid Dollars Continue To Receive No Oversight

Oversight of the majority of Medicaid dollars continues be insufficient.

In 2009, when audit work was being conducted, approximately 95 percent of Medicaid claims payments, or $1.5 billion, received little to no systematic oversight by Program Integrity. While it appears that Program Integrity has clarified its oversight methodology, oversight of the majority of Medicaid payments continues to be insufficient. The primary cause for this lack of review is that the recommended analytical tool has not yet been procured.

Figure 2.4 lists the recommendations from the chapter discussing oversight concerns, the status of the recommendations, and a brief explanation. A more detailed explanation of some of the recommendations follows the figure.

Figure 2.4 Status of 2009 Report's Oversight Recommendations (Chapter V). All four recommendations are in process of being implemented.

Recommendation	Status	Explanation
We recommend that BPI develop a systematic methodology that allows them to review all Medicaid dollars in inpatient and non-inpatient program areas for fraud, waste, and abuse.	In process	Program integrity reports a methodology being developed, but due to persistent system problems, they have not been able to engage this methodology.
We recommend that BPI provide adequate oversight and ensure Medicaid dollars are being reviewed for fraud, waste, and abuse in all other contracted Medicaid services.	In process	Our recommendation to acquire a new system analytical tool is still in process; thus, the majority of Medicaid funds currently have limited oversight.
We recommend that BPI consider using statistical sampling or extrapolation in their audits of providers.	In process	Program integrity is pursuing a change to ***Utah Code*** to begin using extrapolation.
We recommend that BPI conduct more financial audits of providers.	In process	Some of these Audits have occurred, though we believe many more profitable audits can occur with more staff.

As stated, a functioning analytical tool is needed for proper oversight of all Medicaid funds. The DOH is in the process of procuring a new tool. Another recommendation that needs further consideration is that of using statistics in program integrity audits.

The DOH Needs an Administrative Rule Allowing For the Use of Statistics in Program Integrity Audits. Other states' program integrity offices believe that the use of statistically valid extrapolation is a necessary tool both in achieving cost recoveries and in aiding cost avoidance. Some of these states have reported that substantial recoveries cannot occur without the use of extrapolation due to the limits in staff resources.

The DOH should write an administrative rule allowing for extrapolation in audits.

We believe Program Integrity may benefit from the use of competent and proven statistical methodologies in the course of their audits. In addition, some other state program integrity offices have indicated that an administrative rule is the typical venue to approve the use of statistics in program integrity auditing.

Independence for Oversight Functions Has Improved, But Is Still Inadequate

Independence concerns persist for some DOH oversight functions.

The DOH has taken steps to improve the independence of the oversight function for the department; however, independence, particularly for Program Integrity, is still not satisfactory. Three of the four recommendations in the sixth chapter of the 2009 report have been addressed by DOH management but independence concerns persist. Consequently, we designated these recommendations as partially implemented, as the Department's actions to date have not provided the level of independence necessary for Program Integrity.

The final recommendation in this chapter dealt with increasing the number of internal audits of Utah's Medicaid program. This recommendation was codified during the 2010 Legislative General Session. This recommendation has been listed as in process while DOH's internal audit function adjusts to statutory changes and a DOH reorganization.

Figure 2.5 lists the recommendations on oversight independence made in the 2009 report, the status of each recommendation, and a brief explanation. A more detailed explanation of the audit recommendations dealing with independence follows this figure.

Figure 2.5 Status of 2009 Report Recommendations on Oversight Independence (Chapter VI). We found that three of the four recommendations have been partially implemented and one is in process.

Recommendation	Status	Explanation
We recommend that the post-payment review function and all other associated areas within BPI report to either the agency head or an independent board.	Partially implemented	Technically completed, but Program Integrity is still not organizationally independent from Medicaid.
We recommend that DOH comply with ***Utah Code*** and restructure the reporting relationship of the internal auditors so that the director of internal audit reports either to the agency head of DOH or an independent board.	Partially implemented	Technically completed, but internal audit is still not organizationally independent from Medicaid.
We recommend that the Medicaid auditors report to either the director of program integrity, the director of internal audit, or a combination of both so they can achieve more organizational independence.	Partially implemented	Technically completed, but Medicaid auditors are still not organizationally independent from Medicaid.
We recommend that the DOH executive director immediately direct the internal auditors to conduct performance audits of the Medicaid program and ensure that regular, consistent internal performance audits are conducted of Utah's Medicaid program.	In process	H.B. 459 and H.B. 397 from the 2010 general session addressed this issue, but more time is needed to measure implementation.

Independence Concerns Continue

The success of both Program Integrity and internal audit functions is dependent on organizational independence from Medicaid operations. Most surveyed states have recognized this need for a separation between oversight and operations. It is a mainstay in the development of evaluative functions. For state Medicaid organizations, a popular method of maintaining evaluative independence is the use of an independent Office of Inspector General (OIG). An Office of Inspector General, in these states, conducts program integrity work and some agency audit oversight. It appears that states with this structure can be very successful with recovering monies lost to fraud, waste, and abuse.

Several states have found success with an independent Inspector General overseeing Medicaid funds.

A separate report by our office, scheduled for released in late 2010, discusses our concerns with oversight independence of Internal Audit

and Program Integrity in more detail. Many of our concerns with the Office of Internal Audit and Program Integrity or OIAPI (to which Program Integrity and internal audit report) independence stems from the Utah Medicaid Director's continued involvement in OIAPI functions. Specifically the director is:

- A member of the audit committee. The department reported to us at the end of the audit that they are now calling the audit committee a management committee. We still believe actions taken by the committee are compromising to independence.
- A member of the committee hiring the OIAPI director.
- A member of the DOH committee approving all new staff. While the executive director reportedly maintains final decision making power, it appears other members of the committee have asserted influence.
- The direct reporting officer of the hearing officer responsible for upholding or overturning program integrity cases.

In conclusion, our review of Report 2009-12 recommendations has identified areas where additional clarification may be needed in provider enrollment, access to the controlled substance database, and Program Integrity's use of statistical extrapolation.

Recommendations

1. We recommend that the Utah Medicaid program determine the cost-benefit of automating the disenrollment of inactive providers after 24 months, and track results of any disenrollment.

2. We recommend that the Department of Health Implement an administrative rule allowing Program Integrity to use statistics in their cost recovery efforts.

Chapter III
Follow-up of Report 2010-01: A Performance Audit of Utah Medicaid Managed Care

The Utah Medicaid program has made progress addressing many of the recommendations made in Report 2010-01: *A Performance Audit of Utah Medicaid Managed Care*. We are encouraged by Utah Medicaid's effort to implement these needed changes. A number of the recommendations are still in process and need further work to be implemented. Below is a summary of the status of each our recommendations.

Most report recommendations are still in the process of being implemented. However, we are encouraged by the progress being made.

- Implemented = 5
- In process = 20
- Partially implemented = 1
- On hold = 1

Some of the more critical recommendations that are not yet fully implemented include:

- Development of cost and utilization goals. These goals are an essential component for ensuring that full cost-saving potential is realized. Utah Medicaid has implemented only one such goal.

- Benchmarking of quality standards. Utah Medicaid has started this process, but as of yet, it is incomplete. Once completed, better case tracking can occur.

- Monitoring of emergency room claims. In order to ensure that cost savings from correcting errors in programming are realized, Program Integrity should monitor ER claims on a routine basis.

Utah Medicaid had less than a year of implementation time when we conducted our audit follow-up activities. Over time, as complete implementation is achieved for each recommendation, better overall control of the state's managed care providers should result. With

Complete implementation of our recommendations should result in better controls and cost savings in Utah Medicaid managed care.

improved controls, the state should have lower costs and better service provision.

Managed Care Cost Reductions Have Been Achieved, But More Are Possible

Prior to our 2010 report on managed care, the state's managed care program relied primarily on its contracted managed care organizations to control provider charges and recipient utilization. Insufficient oversight led to higher than necessary costs for managed care's nearly 70,000 recipients. Additionally, 110,000 Utah Medicaid recipients were on a fee-for-service program; the state needed to develop strategies to ensure that the lowest cost was being achieved.

The report's second chapter, "Past Managed Care Structure Lacked Sufficient Cost Control Incentives," addressed the state's use of cost-plus contracts and the need for improved cost control measures in managed care. The third chapter, "Cost Reduction Opportunities Possible in Managed Care," identified cost savings made possible by working with managed care contractors to improve their practices.

Some Progress Has Been Made in Improving Cost Controls for Managed Care

Utah Medicaid has made some progress in the introduction of cost control incentives for managed care, but more still needs to be done.

Utah Medicaid is working toward improving its managed care operations. Most notably, Utah Medicaid has improved its procedures in assigning fee-for-service recipients to managed care programs. Progress has been slow in implementing a number of the other recommendations and one is on hold, awaiting the completion of a legislatively required assessment.

Figure 3.1 lists the cost control recommendations made in the managed care report, the status of the recommendations, and a brief explanation of each. A more detailed explanation of some of the audit recommendations follows the figure.

Figure 3.1 The 2010 Report's Status of Managed Care Cost Controls Recommendations (Chapter II). Four of the seven recommendations are in the process of being implemented. The other recommendations status consists of: partially implemented, implemented, and one recommendation on hold.

Recommendation	Status	Explanation
We recommend that Utah Medicaid appropriately incentivize the health plans to reduce utilization and contain costs.	In process	Specific goals have not been developed; Utah Medicaid has targeted certain populations for savings.
We recommend that Utah Medicaid develop a Request for Proposal (RFP) to encourage more managed care organizations to enter the state.	On hold	S.B. 273 from the 2010 general session added an assessment to hospital stays on non-managed care hospital visits. DOH will revisit this process after S.B. 273 sunsets in June 2013.
We recommend that Utah Medicaid review ways to achieve more cost control in its Select Access plan. This could be achieved by turning the population over to a managed care plan, or through other proven, cost-effective methods.	In process	Utah Medicaid has continued an emergency room diversion grant and is currently exploring other cost-saving opportunities such as diabetes and asthma control.
We recommend the Legislature provide policy guidance to Utah Medicaid on appropriate cost control reimbursement methods and require Medicaid to submit progress reports to them on this issue.	In process	The Legislature directed our office to follow-up and report on the progress of this recommendation.
We recommend that Utah Medicaid review the viability and potential benefits of expanding managed care into more areas of the state. The Legislature should use this information to provide policy guidance on this issue.	In process	Medicaid conducted limited analysis in this area; the Legislature may want to consider the results.
We recommend that Utah Medicaid seek a waiver from Federal Medicaid to develop a method of auto-assigning members to the lowest-cost managed care plan after a recipient's open enrollment period has expired.	Partially implemented	DOH contacted Federal Medicaid about this recommendation and was told it was "unlikely and unprecedented." DOH did not pursue it further.
We recommend that Utah Medicaid review methods of accelerating the process of assigning Medicaid recipients to a managed care plan.	Implemented	Utah Medicaid implemented several new procedures that are helping to speed up the process.

Four of the seven recommendations are still in process.

Most of the chapter's recommendations have been classified as in process as some work has been done in addressing concerns. Much of this work has been in the form of limited analyses and tests. In these cases, it is too early to see what steps Utah Medicaid will take in the longer term.

One recommendation, that of seeking a federal waiver to allow auto-assigning of recipients to lower-cost managed care, has been listed as partially implemented because Utah Medicaid made contact with Federal Medicaid administrators, although the federal-level reaction was discouraging. We believe that this recommendation continues to have validity and should not be dismissed at this time.

It appears that the partial implementation of some of the recommendations has resulted in cost reductions.

It appears Utah Medicaid has been able to achieve some cost control in its one capitated managed care plan. Utah Medicaid negotiated a final rate in fiscal year 2011 that was 11 percent of the actuarial certified rate compared to 45 percent of the certified rate in fiscal year 2010. Because overall costs for health care increased in fiscal year 2011, this rate reduction does not demonstrate a one-for-one cost savings. Also due to changes in actuarial assumption, the lower rate may not always signal cost control; however, it appears in this instance cost savings was achieved. It is encouraging to see Utah Medicaid applying principles from our January 2010 report to obtain cost savings.

To achieve full cost reductions, Utah Medicaid needs to achieve savings in all of its managed care plans. Toward this end, Utah Medicaid should work toward full implementation of the prior report's recommendations, which include:

To achieve full cost-savings potential, Utah Medicaid must work toward full implementation of the recommendations.

- Developing specific goals that illustrate how costs and utilization are being controlled and managed.
- Implementing additional proven cost-savings programs, such as diabetes and asthma programs, into its Select Access managed care plan.
- Continually reviewing other states initiatives that effectively lower cost through implementing managed care programs in rural areas.

The Legislature should continue to provide policy guidance in this area and ask Utah Medicaid to provide them with information that tracks progress in achieving the above recommendations.

Managed Care Cost Reduction Opportunities Are Still Available

The actuarial study conducted and discussed as part of Report 2010-01's third chapter showed the risk-adjusted relative costs of the three managed care plans in use. In doing so, the study illustrated how Utah Medicaid can achieve lower rates throughout its managed care program. Utah Medicaid has asked the actuaries to continue providing this type of information. Now Utah Medicaid must be diligent in ensuring that it is obtaining competent care at the lowest available cost.

Utah Medicaid has continued the risk-adjusted relative cost analysis that we reported in our original report.

Figure 3.2 lists the recommendations made in this chapter and the status of each with a brief explanation.

Figure 3.2 2010 Report's Status of Recommendations Related to Cost Reduction Opportunities (Chapter III). The four recommendations in this chapter are still in the process of being implemented.

Recommendation	Status	Explanation
We recommend that, in the future, Utah Medicaid better compare Utah managed care plans through risk-adjusted analyses. Utah Medicaid should also benchmark Utah's plans to other well-managed plans.	In process	Actuary was working on this report while the follow-up occurred.
We recommend that Utah Medicaid develop appropriate performance goals, including cost and utilization goals, that can determine if the managed care plans are contributing adequate value to the Utah Medicaid program. Utah Medicaid should then hold the plans accountable to these goals.	In process	One informal goal was developed, but Utah Medicaid has not completed the full intent of this recommendation.
We recommend that Utah Medicaid help facilitate the sharing of good health management practices between plans.	In process	Meetings have been established and it appears that they have started to share some information.
We recommend that the Legislature direct Utah Medicaid to report to them on cost savings obtained through future contracting with the managed care plans.	In process	The Legislature directed our office to follow-up and report back to them on the progress of this recommendation.

Utah Medicaid must be diligent in developing meaningful cost and utilization goals.

Our greatest concern with implementation rests with the recommendation to develop cost and utilization goals useful in determining managed care plan value. In many cases, managed care plans are not incentivized to lower costs. It is important for Medicaid to identify these situations and enforce fiscal responsibility through goal setting.

Along with the continued effort to ensure that cost reductions are achieved in managed care, Utah Medicaid must also engage in strong oversight of the managed care plans.

Managed Care Oversight Must Be an On-going Effort

It appears that Utah Medicaid has made some improvement in its oversight of the managed care programs, though more work needs to be done. All oversight-related recommendations in the forth chapter are classified as in process of being implemented and two of the five recommendations in the fifth chapter are still in process.

Oversight Improvements Have Begun, But Are Not Yet Fully Implemented

Utah Medicaid can still do more to hold the managed care plans accountable to lowest available cost.

Utah Medicaid can still do more to hold its three managed care plans accountable for achieving the lowest available cost. Utah Medicaid is still in the process of implementing all five recommendations from our prior report's fourth chapter on oversight. Full and continued implementation of these recommendations will help bolster oversight of the managed care plans and, in return, help ensure the lowest cost to the state. Illustrating that this is possible, Utah Medicaid set an informal goal for one procedure, cesarean sections, and instructed the actuaries to set the rates to the lowest available cost. Utah Medicaid should add more of these goals to the rate-setting process.

Figure 3.3 lists the recommendations made in this chapter and the status of each with a brief explanation.

Figure 3.3 Status of Recommendations on Managed Care Oversight (Chapter IV). The five recommendations in this chapter are in-process.

Recommendation	Status	Explanation
We recommend that Utah Medicaid apply risk-adjusted relative costs to their analysis of health plans to gain potential cost savings.	In process	Actuary was working on this report during the follow-up.
We recommend Utah Mediciad determine an acceptable cost-level for the plans and hold the plans to that level.	In process	Utah Medicaid has set cost levels for one procedure– cesarean sections. More can still be done in other areas to lower costs.
We recommend Utah Medicaid determine the actual amount and rate of administering the Select Access plan, managing claims, overseeing the health plans, and other cost centers so that it can be used in further analysis.	In process	Utah Medicaid is in the process of completing this study.
We recommend that Utah Medicaid incorporate prior authorization data in their monitoring of the health plans.	In process	Utah Medicaid has collected some of this data, but still needs to incorporate the data in monitoring.
We recommend that the Legislature direct Utah Medicaid to report to them on cost-savings obtained through improved managed care contracting, and follow-up to ensure that the fullest, appropriate, cost-savings potential is realized.	In process	The Legislature directed our office to follow up and report back to them on the progress of this recommendation.

Utah Medicaid has begun implementation of the recommendations, but, in each case, more still needs to be done. For example, in the case of setting cost levels for the plans, Utah Medicaid has established a measure with cesarean sections, but needs to expand cost controls to other areas.

Utah Medicaid has implemented one informal cost and utilization goal. More should be implemented in the future.

Cesarean Section Cost-Utilization Goal Is A Good Start; More Goals Are Needed To Realize Full Cost Savings. We reported in our first audit the need for specific cost and utilization goals. Utah Medicaid did implement one informal goal for cesarean sections, but more can be done. The following quote from the former Arizona Medicaid director that shows the need for specific cost and utilization goals.

> Sometimes health plans aren't incentivized to look for lowest cost. We have to give them that discipline to look for the lowest cost place to provide the service. If they have no risk,

they are just going to pass it on to the state. They don't care. The only reason why our plans care is because we look at their data and say, "you can save money here and if you don't, we are going to take it out of your rates anyway." So we give the plans ample opportunity to address the issue and then monitor to see if they are addressing the issue appropriately.

We are encouraged that Utah Medicaid instructed its actuaries to set a rate for cesarean sections that is based on the lowest available rate in Utah Medicaid managed care. Utah Medicaid also reports factoring the reduction of emergency-room visits in the rate it set for its one capitated-cost plan. Utah Medicaid should be persistent in this area and add more cost-control goals in the future.

Some Quality of Care Oversight Improvements Have Been Made

Utah Medicaid has made progress in standardizing its quality-of-care oversight.

The prior report's fifth chapter indicated that Utah Medicaid's quality of care oversight was good, but some improvements were still needed. Our follow-up work shows that Utah Medicaid has made needed improvements in some areas and is working on implementing other improvements. One area where Utah Medicaid is still in the process of implementing improvements is a standard for the quality of care.

Figure 3.4 lists the recommendations made in this chapter and the status of each with a brief explanation.

Figure 3.4 Utah Medicaid Quality of Care Recommendations' Status (Chapter V). Three of the five recommendations made in this chapter have been implemented, two recommendations are in process.

Recommendation	Status	Explanation
We recommend that the Bureau of Managed Health Care conduct a cost/benefit analysis of collecting similar health quality information, including HEDIS measures, for the Select Access plan.	Implemented	Cost/benefit analysis was conducted by Utah Medicaid and they are considering it.
We recommend that the Bureau of Managed Health Care should establish a standard for quality of care appropriate for Utah.	In process	Utah Medicaid has held two meetings and continues to work on this recommendation.
We recommend that the Bureau of Managed Health Care require the *Annual External Quality Review Report for Prepaid Inpatient Health Plans* to include a full summary of all results of the corrective action plans.	Implemented	Utah Medicaid has put the summary in place for the next released report.
We recommend that the Bureau of Managed Health Care independently validate, through sampling, some of the information contained within the quality improvement reports (plan description, work plan, and work plan evaluation).	In process	Utah Medicaid has begun this oversight work but has not yet completed it.
We recommend, for comparison purposes, that the Bureau of Managed Health Care ensure that the managed care plans adhere to their required format for quality improvement reporting.	Implemented	Formatting has been standardized.

We hope that establishing standards for quality of care will guide the state's future expectation of quality of care. Until these goals are established, it is difficult to benchmark the quality of care being provided.

Utah Medicaid should continue to establish standards for quality of care that will allow valid and meaningful comparisons.

Medicaid Must Continue to Implement Cost-Saving Options

In addition to the cost savings that were identified through health plans cost reductions, the previous report's sixth chapter identifies that Utah Medicaid could be more proactive in developing cost-saving programs proven to be cost effective in other states. Incorporating

these programs and ensuring that claims are paid accurately and according to policy can result in significant annual savings.

Figure 3.6 lists the recommendations made in this chapter and the status of each with a brief explanation.

Figure 3.6 Status of Recommendations on DOH Cost Savings (Chapter IV). One of the six recommendations listed in this chapter has been implemented. The five remaining recommendations have been classified as in process.

Recommendation	Status	Explanation
The Department of Health should frequently review emergent ER claims to verify the appropriate diagnosis is used to help ensure expected cost savings are realized.	In process	New policy being written to include ER claim review as part of Hospital Utilization Review (HUR) process.
Utah Medicaid should monitor results of ER utilization grants to determine which grants could feasibly transfer to Utah hospitals.	In process	Awaiting status of other states' programs.
Utah Medicaid should ensure that surgical center rates are being paid correctly and should consider adding to the list of defined reimbursement procedures as a way of controlling costs.	Implemented	Ambulatory Surgical Centers were changed to fixed reimbursement for FY11. A sample of claims showed no payment errors.
The Legislature and Utah Medicaid should consider moving away from a percent of charges to a revenue-code fee schedule.	In process	Many procedures have already been moved to fixed-fee schedules. Switch to Medicare payment methodology underway.
Utah Medicaid should consider using more preventive care and case management through cost-saving programs such as medical homes and disease management.	In process	DOH was awarded a five year grant to develop medical homes.
Utah Medicaid should determine potential cost savings that could be realized through HOAs, HIPP, and other programs, and implement or expand them if savings are shown.	In process	DOH looked into savings from increasing HIPP program in Utah.

Five of the six recommendations are in the process of being implemented.

With the exception of one implemented recommendation, all of these recommendations are in-process. The next few pages discuss the status of some of the above recommendations in more detail.

Emergency Room Claims Require Monitoring

Our report on managed care identified that emergency room (ER) claims were being paid incorrectly. ER claims are paid higher reimbursement rates when the primary diagnosis is an emergency. The payment system had been incorrectly paying the higher rate for claims that had either a primary *or secondary* emergent diagnosis. Payment based on what should be a disallowed emergent secondary diagnosis caused significant overpayments.

In early January 2009, DOH identified the issue of paying for a secondary diagnosis of an ER claim and reported that the problem had been corrected beginning September 1, 2009. However, changing the payment system to look only at the primary diagnosis when determining emergent status did not eliminate incorrect payments of ER claims. Claims continued to be paid incorrectly due to programming limitations in the old system. These limitations have allowed non-emergent claims without any emergent diagnoses to be paid at emergent rates.

While the reported ER payment issue has been corrected, other system problems have caused additional ER overpayments.

DOH internal auditors estimated that this error affected about one-third of claims and caused about $102,000 in overpayments per month. According to the Bureau of Operations, this system problem was corrected on October 1, 2010.

In order to ensure that cost savings from correcting the error reported in our January 2010 report are realized, we recommended that ER claims be reviewed for correct coding. Review is necessary because it is easy for providers to switch primary and secondary diagnoses, which could substantially increase their reimbursement. Program Integrity is currently revising its Hospital Utilization Reviews (HUR) to include ER claims in a monthly sample of medical reviews. Once this revision is complete, Program Integrity can review claims on a regular basis to ensure correct billing is occurring.

DOH Has Begun to Implement Cost-Saving Measures

Utah Medicaid has implemented a medical home and has increased use of HIPP programs as a way of decreasing costs.

After our report was issued in January 2010, the Department of Health has implemented a number of cost-saving measures. They have been awarded a grant to establish a medical home, been granted a release on their ER grant, and expanded the HIPP program.

Medical Home Is Being Established. The Department of Health is implementing other Utah Medicaid cost-saving measures. We are encouraged with the awarding of a federal grant that enables Utah to establish a medical home for children with special health care needs. Medical homes focus on physicians who have ongoing relationships with enrollees along with coordinated care between providers. The five-year grant began in March 2010, with the first year being a planning year. DOH also reports actively pursuing disease management programs in addition to the hemophilia program already running. They report saving over $2 million from that program. We encourage DOH to seek other such cost-saving measures.

Twenty states were awarded federal emergency room grants; results are expected to be available in early 2011.

Emergency Room Grant Has Been Extended. In order to reduce costly misuse of the emergency room, Utah Medicaid was awarded a grant which was used to contact recipients who had non-emergent emergency room visits to educate them about the proper use of the emergency room. Additionally, 19 other states were awarded grants to fund other emergency room programs. All twenty states have been granted a one-year no-cost extension. When that year is complete (early in 2011), Centers for Medicare & Medicaid Services (CMS) will put a report together which describes the other programs as well as their results. Utah Medicaid reports it will determine at that time which programs should be extended to Utah to further increase cost savings.

HIPP Is Being Expanded. Another cost-saving measure identified in our first report was the expanded use of Health Insurance Premium Payment Programs (HIPP). HIPP (or buyout) programs pay for premiums, deductibles, and co-insurance under enrollees' employer-based health plans. This can lead to cost savings if these payments are less than the amount of claims the recipient would have. DOH has estimated significant savings achievable by training DWS employees about the program and targeting clients with end-of-life

diagnoses. DWS employees underwent training on buyout in September and October of 2010.

In addition to training, Utah's electronic Resource and Eligibility Product (eREP), which recipients can use to apply for services, sends referrals to Medicaid on any application that has other insurance information or has indicated a "major medical need." These are the recipients who may be eligible for cost-savings through enrollment in a buyout program. This has resulted in a large number of auto-referrals, and Medicaid is planning on DWS helping to refer applicants as well. Because these new measures are just starting and the participation in buyout programs is dependent on a number of factors, there are currently fewer recipients (158 as of October 2010) than when we issued our original report. This number is expected to increase as referrals are refined.

eREP is atuo-referring recipients who may be good HIPP recipients.

Fixed-Fee Schedules Being Implemented

In the 2010 Legislative Session, HB2 directed Medicaid to move to a fixed-fee schedule. It reads:

> The Legislature intends that the Department of Health establish a Medicaid outpatient fee schedule for each of the following types of facilities: rural hospitals, urban hospitals, and ambulatory surgical centers. The first twenty-five percent of the new fee schedule should be implemented no later than July 1, 2010. Fifty percent should be implemented no later than October 1, 2010. Seventy-five percent should be implemented no later than January 1, 2011. The project should be completed by July 1, 2011.

Utah Medicaid is working towards a fixed fee schedule for outpatient claims.

DOH did successfully implement the first 25 percent on July 1. In a letter dated September 6, 2010, cosigned by Senate President Michael Waddoups and Speaker of the House David Clark instructed Medicaid to shift reimbursement schedules for all possible outpatient services to existing Medicare payment rates. DOH has begun work on this task with expected implementation by July 1, 2011. According to a DOH internal audit, the fixed-fee payments for ambulatory surgical centers were paying correctly before the change to a complete fixed-fee schedule was made. Our limited review of the payments made under the new system also showed that claims appear to be paying correctly.

Fixed fee payments appear to be paying correctly.

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Agency Response

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December 7, 2010

Mr. John M. Schaff, CIA
Legislative Auditor General
315 House Building
Salt Lake City, UT 84114-5315

Dear Mr. Schaff:

Thank you for the opportunity to review and respond to your legislative audit entitled "A Follow Up of Utah Medicaid's Implementation of Audit Recommendations" (Report No. 2010-14).

We appreciate the effort and professionalism of you and your staff in the review of our implementation of your past audit recommendations. We accept your additional recommendations and are anxious to ensure organizational improvement and more efficient use of state resources. We hope our efforts to improve demonstrate how committed we are to making effective, efficient, and compliant use of taxpayer dollars.

The legislative auditors have reported the results of their follow-up on the two audits in separate chapters and our response follows this same format. Although the follow-up report highlights the department's success in implementing certain audit recommendations, we acknowledge that many changes are still in process and that continued focus on these efforts will be necessary in order to implement the original audit recommendations. We are fully committed to implementing all audit recommendations.

Chapter II

The Division of Medicaid and Health Financing

The audit recommended several organizational changes in order to improve the independence of division functions. As a result of these changes, the division only supervises two areas that were the subject of the original audit report – prior authorization and provider enrollment. The division appreciates the legislative auditors' acknowledgment of the division's efforts to address the concerns raised in the audit related to these two areas. Of the nine recommendations applicable to the division, five are implemented and 4 are in process.

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The division achieved these successes in the face of several difficult challenges. First, the majority of these changes occurred during a time period when all executive agencies were operating under a statewide budget reduction ordered by Governor Herbert. During that time, agencies had to cut their total personnel budgets by 3.0% for the year. In order to achieve these savings, the division offered an early retirement incentive in December 2009 and then often did not fill the resulting vacancies, implemented a furlough day in January 2010, and did not fill many other positions when they became vacant. Despite this additional strain on its budget, the division directed its scarce resources towards prior authorization. Although most other vacancies in the division were not able to be filled during this period, the division authorized the filling of vacant prior authorization nurse positions. We believe this effort helped to contribute to the success of this unit in implementing the audit recommendations.

In addition, as pointed out in the original Fraud, Waste, and Abuse Controls audit, the prior authorization unit needed significant improvement. The original audit stated that the unit had "poor management control" and that "prior authorization nurses have simply ignored [Medicaid] policies." In order to improve controls in this area, the division temporarily reassigned a bureau director to oversee the reconstruction of this unit. Later, the division decided to permanently reassign this unit to an existing bureau with a stronger emphasis on management controls. As part of that process, the division has reclassified several existing positions to create a training position and two leads. We now believe that an effective management structure over this unit has been established.

One audit recommendation from the follow-up review applies to the division:

1. *We recommend that Utah's Medicaid program determine the cost-benefit analysis of automating the disenrollment of inactive providers after 24 months, and track results of any disenrollment.* [page18 of the report]

   We concur with this recommendation. It might be helpful to have this process automated if it would save staff time and ensure that the disenrollment of inactive providers happens on a regular basis. We will review our current practices for disenrollment of inactive providers, determine if automation would be appropriate, and determine where this request for automation would fit within other programming priorities (e.g., shifting outpatient reimbursement schedules to existing Medicare payment rates, meeting ICD10 and 5010 deadlines, etc.).

<u>The Office of Internal Audit and Program Integrity</u>

The office also appreciates the legislative auditors' acknowledgment of the office's efforts to address the concerns raised in the audit related to these two areas. We concur with the assessment that all of the recommendations in Chapter II of the Fraud, Waste and Abuse Controls report are already implemented or in the process of full implementation with the exception of four of those recommendations. We also agree with your assessment that the four recommendations listed as "partially implemented" are "technically

completed," but are labeled as "partially implemented" in the report due to new information resulting in new or expanded recommendations in your Medicaid Provider Cost Control report.

One recommendation from Chapter II in the report shown as "partially implemented" was a recommendation to the Legislature to give Program Integrity access to the Division of Occupational and Professional Licensing's (DOPL) Controlled Substance Database – which the Legislature did. However, the access given was interpreted by DOPL as being at the recipient level - not at the provider level; therefore, the report stated the implementation status was only "partially implemented." Access at the provider level would help Program Integrity investigate situations such as pharmacies filling subscriptions for unusually high amounts of pain killers and narcotics. We concur with the auditors increased access to the database would improve our fraud, waste and abuse controls.

The other three recommendations from Chapter II in the report shown as "partially implemented," even though the report acknowledged the recommendations were "technically completed," were to make the Medicaid auditors, internal auditors, and program integrity unit more independent. Those 3 recommendations were only considered "partially recommended" because an Office of Inspector General, if created, would make them even more independent. The Department is not opposed, in principle, to an Office of Inspector General but would like to have more time to see if the recent changes in the organizational structure and independence of the new Office of Internal Audit and Program Integrity are sufficient.

The second recommendation from the follow-up review applies to the office:

2. *We recommend that the Department of Health implement an administrative rule allowing Program Integrity to use statistics in their cost recovery efforts.* [page18 of the report]

   We concur with this recommendation. We have already done research of applicable professional standards and the rules and statutes of other states and have written a proposed statute and an administrative rule. We are currently consulting with the Governor's Office of Planning and Budget and seeking a sponsor for the bill. Using statistical sampling and extrapolation in our recovery efforts will be great deterrent to help prevent fraud, waste and abuse.

Chapter III

We were also happy to see that the auditors have been encouraged by the progress being made in this area. As discussed in our response to Chapter II, the Department has struggled with limited resources made worse by budget cuts during this time period; and progress in addressing the managed care audit recommendations has required a major commitment from division management.

Events since the release of the managed care audit demonstrate the constantly shifting landscape of Medicaid managed care in Utah:

- Healthy U moved from a prepaid inpatient health plan to a prepaid ambulatory health plan. This change moved tens of millions of dollars of inpatient claims to Medicaid's fee for service program and required accompanying changes in programming, reporting, etc.
- The State enacted a hospital provider assessment and established a Medicaid inpatient hospital access payment from the division to hospitals. This change dramatically shifted the dynamics of Medicaid hospital reimbursement and had a significant impact on several recommendations from the audit.
- Federal health care reform encouraged states to consider creating accountable care organizations. These organizations have the potential to implement several of the audit recommendations by tying reimbursement and quality measures closer together.

The Department is committed to applying the principles highlighted in these two legislative audits.

Thank you again for your time and efforts in performing these follow-up reviews.

Sincerely,

David N. Sundwall

David N. Sundwall, M.D.
Executive Director