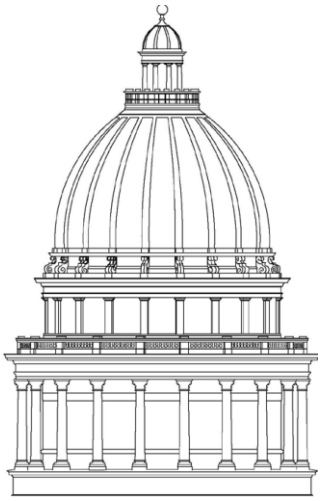
REPORT TO THE

UTAH LEGISLATURE

Number 2018-02



An In-Depth Budget Review of the Utah Department of Health

February 2018

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah

STATE OF UTAH

Office of the Legislative Auditor General

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JOHN M. SCHAFF, CIA
AUDITOR GENERAL

February 2018

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **An In-Depth Budget Review of the Utah Department of Health** (Report #2018-02). 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, CIA
Auditor General

JMS/lm

Digest of an In-Depth Budget Review of the Utah Department of Health

The Department of Health (DOH) needs to independently determine how greater cost efficiencies can be achieved with Accountability Care Organizations (ACO). DOH also needs to strengthen some of its budgeting practices to ensure consistency in their financial reporting.

Chapter II DOH Needs to Control Costs for Accountable Care Organizations

Increased ACO Efficiencies Can Aid in Future Cost Reductions. Milliman analyzed savings based on each plan achieving the rates of the lowest cost provider for the modeled year. This analysis showed that between 2014-2016 historical savings of $74.6 million were available or on average $25 million per year. Modeled historical costs may not equal future cost savings exactly, therefore Milliman believes that between $4 to $8 million of annual savings can be realized in the future. These cost reductions are contingent on DOH proactively performing analyses on their contracted ACOs.

DOH Should Proactively Perform Analysis to Ensure Efficiency Amongst ACOs. The goals of the ACOs are to maintain quality of care and improve health outcomes for Medicaid recipients and to control costs. The theory of cost control with ACOs has been to let the ACO's themselves to control costs. It is assumed that because DOH has a capitated contract with the ACOs, it is in the ACO's best interest to keep costs low. While capitated contracts that are risk adjusted have shown promise in maintaining costs, we believe, that over time, if costs are not examined and managed, they can increase, and should be examined in detail to ensure any cost savings opportunities are realized. While DOH has responsibility in this area, we understand the Office of the Inspector General has also been charged with program integrity efforts over Medicaid funds. A companion audit to this one, *A Performance Audit of the Utah Office of the Inspector General of Medicaid Services (2018-03)* discusses the role of the OIG in providing greater oversight.

Chapter III
DOH Can Improve Some Budgeting Practices

Budget Consistency Is Required by Governmental Accounting Standards Board. We are concerned that an external stakeholder, such as our office, was not able to make comparable year-to-year assessments in some categories of DOH's budget. Inconsistent budget data complicated our budget review and limited our ability to analyze and review budget trends. Examples of budget inconsistencies are provided in the next section of this report.

Inconsistent Coding and Budget Structure Complicate Historical Budget Analysis. Our budget review of DOH was complicated by inconsistent coding of expenditures. First, we found budget staff inconsistently coded contractual expenditures in the Baby Watch Early Intervention program. Consequently, expenditures in the program appear erratic from year to year because coding is inconsistent. Second, we found that expenditures relating to the Office of Primary Care and Rural Health are being budgeted in the Medicaid Mandatory Services Line Item, but those same expenditures are managed in Family Health and Preparedness, a separate division with a separate line item.

REPORT TO THE
UTAH LEGISLATURE

Report No. 2018-02

An In-Depth Budget Review of the Utah Department of Health

February 2018

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Chapter I
Introduction

The Department of Health (DOH) needs to independently determine how greater cost efficiencies can be achieved with Accountability Care Organizations (ACO). The Office of the Inspector General (OIG), an independent oversight entity of Medicaid, needs to improve its oversight of the ACOs and make changes to its planning and reporting processes. DOH also needs to strengthen some of its budgeting practices to ensure consistency in its financial reporting.

Federal Dollars Constitute a Substantial Portion of Total Budget

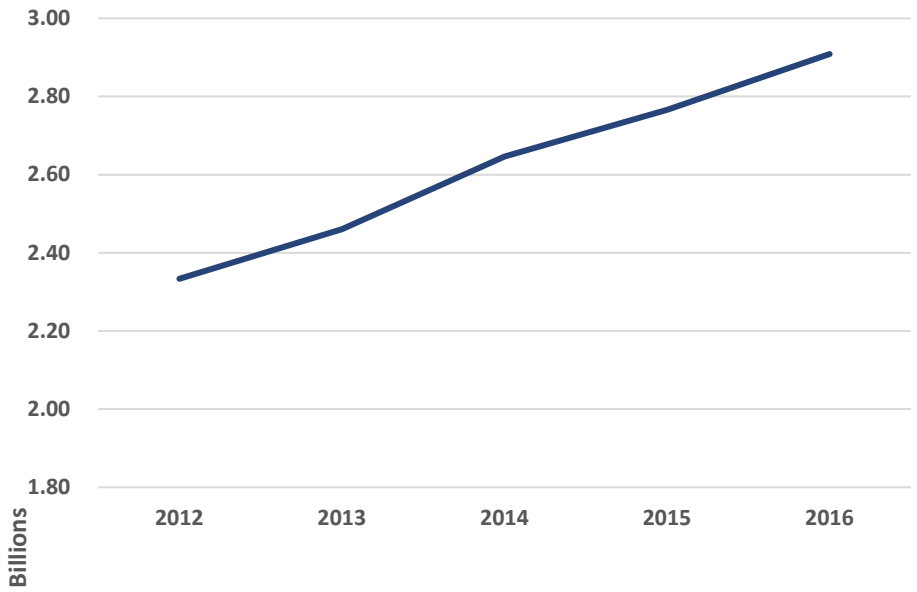
The mission of DOH is "…to protect the public's health by preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles." DOH oversees a budget of approximately $2.9 billion to address its mission. On average, 65 percent, about $1.7 billion, of DOH funding comes from federal funds. Figure 1.1 shows the total budget increase since fiscal year 2012, not including beginning balances.[1]

The total DOH budget was about $2.9 billion in FY 2016.

[1] In fiscal year 2016, the DOH actual budget was $2,908,718,700; however, total financing sources available to spend totaled $2,944,428,600. The actual budget includes nonlapsing and lapsing balances.

DOH's total budget increased by about 25 percent ($575 million) in fiscal years 2012 to 2016.

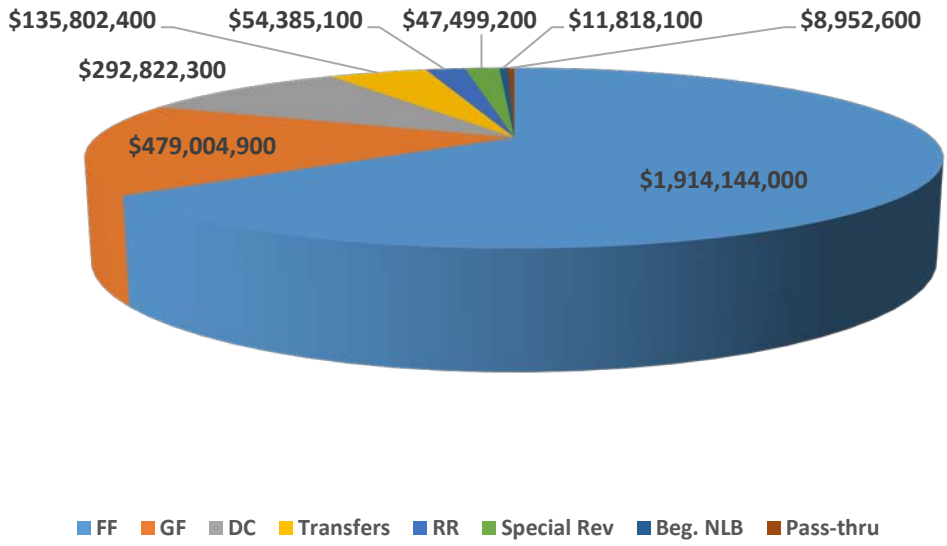
Figure 1.1 DOH Total Funding for Fiscal Years 2012 through 2016 (in Billions). DOH's budget has increased from $2.3 billion to $2.9 billion, a 25 percent increase.



Source: Legislative Fiscal Analyst

Figure 1.1 shows that the DOH budget increased each fiscal year, for a 25 percent increase in 2016 from 2012 of approximately $575 million. This increase is a close mirror of the 25 percent increase in federal funds for the same years, which was about $384.2 million. Figure 1.2 breaks down DOH funding sources.

Figure 1.2 Federal Funding Comprises the Largest Part of DOH's Budget. Approximately 65% of the total budget is comprised of federal funds. Fiscal year 2016 totals are shown.



Source: Legislative Fiscal Analyst
Note: FF – Federal Funds; GF – General Fund; DC = Dedicated Credits; RR = Restricted Revenue; Beg. NLB = Beginning Nonlapsing Balance

65 percent of DOH's $2.9 billion budget consists of federal funds.

Figure 1.2 shows that federal funds are the largest source of financing in the DOH budget at about 65 percent each year, while General Fund and dedicated credits averaged about 16 and 10 percent respectively. Transfers, restricted revenue, special revenue, beginning nonlapsing balances, and pass-through funds make-up the remaining 9 percent. The monies received were mostly expended in the Medicaid program, which we will discuss in the next section.

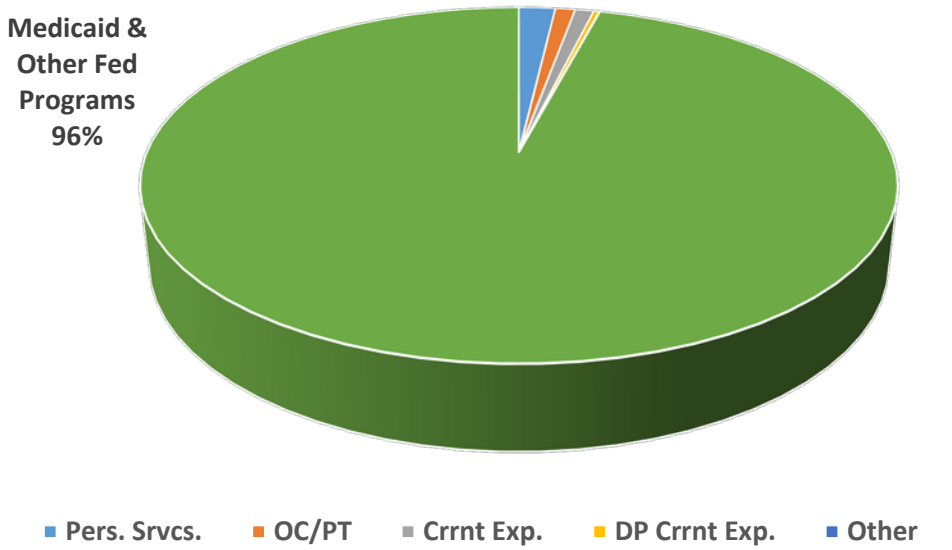
Medicaid Costs Make Up Majority of DOH Expenditures

The majority of funds in the DOH budget are expended on Medicaid-related costs and costs of other large federal programs. A clear majority of the funding DOH receives is passed through to reimburse providers participating in Medicaid and other federal programs, local entities, and private providers by contract payments, to name a few. Figure 1.3 shows the breakdown of funding at DOH.

Most funding DOH receives is passed through to providers in the Medicaid program, local entities, and private providers by contract payments.

Figure 1.3 Medicaid and Other Federal Programs as a Percentage of Total Budget. Medicaid and other federal programs are the largest expenditures for DOH. Fiscal year 2016 totals.

96 percent of expenditures in the DOH budget are for Medicaid and other federal programs.



Source: Datawarehouse
Note: Pers. Srvcs. = Personnel Services; OC/PT = Other Charges/Pass-Through; Other = Travel - In-State and Out-of-State, Capital Expenditures, Data Processing Capital Expenditures, Cost of Goods Sold, and Trust & Agency Disbursements

Of the $2.9 billion budget, $2.8 billion (96 percent) is spent on Medicaid and other federal programs. With most of the budget being pass-through funds, we will discuss the cost of administering DOH's programs in the next section.

Administrative Budget Comprises a Fraction of DOH's Budget

DOH administrative costs in fiscal year 2016 were about $184 million of a total $2.9 billion budget.

Non-Administrative expenditures in Medicaid and other federal programs eclipse DOH's administrative budget. DOH's administrative budget consists generally of the costs to perform DOH activities. DOH's administrative budget is only 6 percent of its total budget, or $184 million in fiscal year 2016. It was a very time-consuming task to get this information from DOH because of the complexity of the budget. As a result, our budget review was limited. Figure 1.4 shows the administrative budget when non-administrative expenditures are subtracted from the total budget.

Figure 1.4 Non-Administrative Expenditures in Federal Programs Overshadow DOH Operations (Millions). Administrative expenses make up a small portion (about 6 percent) of DOH's budget.

	2012	2013	2014	2015	2016
Total Budget	**$2,333.54**	**$2,460.00**	**$2,671.00**	**$2,766.00**	**$2,909.00**
			Non-Admin. Expenditures		
Medicaid	$(2,098.62)	$(2,215.60)	$(2,395.40)	$(2,485.90)	$(2,617.73)
WIC	(55.01)	(53.90)	(51.32)	(50.95)	(50.05)
Vaccine Commodities	-	-	(24.27)	(27.15)	(25.51)
Baby Watch	(17.24)	(15.47)	(17.01)	(17.24)	(18.25)
Other	(10.48)	(11.74)	(12.40)	(12.01)	(13.55)
Admin. Budget	**$152.19**	**$163.29**	**$170.60**	**$172.75**	**$183.91**

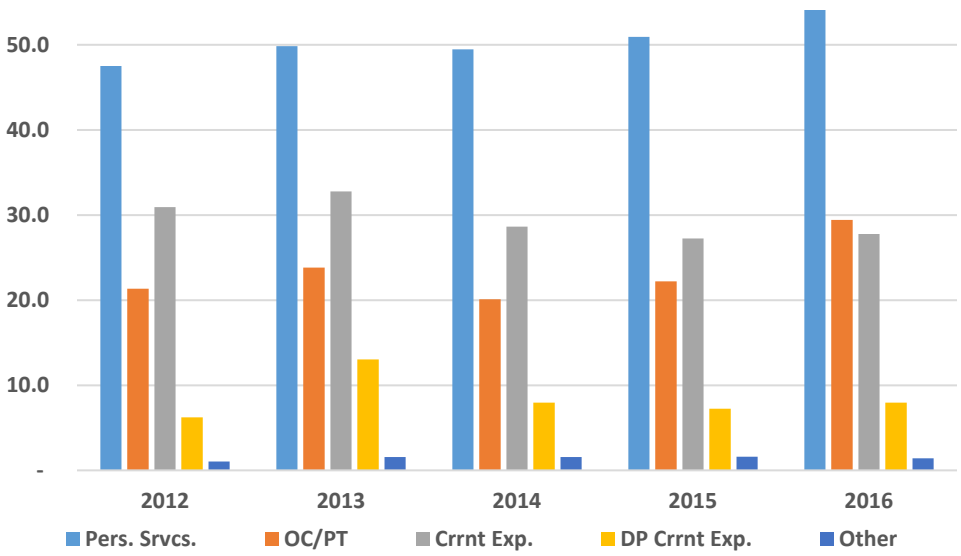
Source: Utah Department of Health

DOH's administrative budget is only 6 percent of its total budget.

In Figure 1.4, DOH's average total budget over the five years were about $2.6 billion. Program costs average about $2.5 billion each year. When program (pass-through) expenditures are subtracted, the total budget shrinks by 94 percent. We also see that the administrative budget has increased approximately $32 million, a 21 percent increase since 2012. These administrative costs are generally associated with managing Medicaid and other federal programs.

Personnel services are the largest expense in the administrative budget. Figure 1.5 shows a breakdown of costs in the administrative budget over five fiscal years.

Figure 1.5 DOH Has Significant Administrative Costs. DOH spent about $54 million in personnel costs in fiscal year 2016.



Source: Utah Department of Health

Personnel services costs account for 45 percent of the DOH administrative budget.

Looking at administrative funds at DOH, personnel costs at DOH have increased 14 percent since 2012 and they now account for 45 percent of administrative funds at DOH. Other charges and current expense expenditures follow at 24 and 23 percent, respectively.

Audit Scope and Objectives

This audit was initiated as part of the in-depth budget review process required by ***Utah Code*** *36-12-15.1.* This is the third audit to be released relating to the in-depth review of the Department of Health. The first audit released, *A Performance Audit of the Beaver Valley Hospital's Medicaid Upper Payment Limit Program* (2017-10) was released in October 2017. The second audit, *A Performance Audit of the Division of Family Health and Preparedness* (2017-13) was released in November 2017. A fourth audit, *A Performance Audit of the Utah Office of the Inspector General of Medicaid Services* (2018-03), is a companion report to this one, and details how the OIG can improve its oversight over Medicaid funds.

The scope of this audit was to review the following objectives:

- ACO historical cost efficiency
- DOH budget coding and management practices

Chapter II
DOH Needs to Control Costs for Accountable Care Organizations

We engaged actuaries at Milliman to determine the relative historical efficiencies of each individual Accountable Care Organization (ACO) contracted by the Department of Health (DOH). From these historical savings we calculated the optimal savings possible if each ACO could achieve the risk-adjusted rates of the current lowest cost provider in each year. Milliman modeled that $74.6 million could have been saved from 2014-2016 if each plan had achieved the most efficient price, or on average $25 million per year. It is important to note that the historical savings analysis does not directly translate to future savings potential, therefore of the $25 million in historical savings, Milliman believes that $4 to $8 million of annual savings can be realized in the future. $8 million of annual savings is 0.8 percent of the total ACO budget. DOH, in conjunction with the Office of the Inspector General (OIG), should use this analysis as one method to devise future cost-savings policies.

Milliman modeled $74.6 million savings over three years, $25 million annually, had ACO plans achieved efficient pricing.

Milliman also conducted the analysis from a different perspective to determine the predicted relative historical cost differences between plans if an ACO served the entire Medicaid ACO population. While federal rules require that at least two plans must be offered, this analysis was useful to determine the relative efficiency of plans managing all patient utilization mixes (from healthy recipients to very sick recipients). This alternative perspective on the analysis confirmed the findings that substantial future cost reduction opportunities exist in the ACO program. Again, future cost savings will not necessarily mirror the historical savings from Milliman's modeling, which can be found in Appendix A.

It is important to note that the proposed cost reductions calculated in these analyses would not necessarily be realized through budget reductions, but by proactive evaluation strategies at DOH's Medicaid Office to decrease future medical costs incurred by the ACOs. We found that there has not been sufficient independent comparative analysis of efficiencies at the ACOs since coming online in fiscal year 2014. However, the Office of the Legislative Fiscal Analyst (LFA) performed an analysis on the effect of ACOs since coming on line,

which showed that ACOs have been a more efficient model than what was previously used in the state. This report accepts the ACO model and provides several recommendations to ensure costs stay low and future cost saving opportunities are realized.

Increased ACO Efficiencies Can Aid in Future Cost Reductions

To determine efficiencies in ACOs, Milliman conducted two analyses. First, Milliman analyzed savings based on each plan achieving the rates of the lowest cost plan for the modeled year. This analysis showed that between 2014-2016 historical savings of $74.6 million could have been achieved or on average $25 million per year. As previously discussed, modeled historical costs do not imply similar future cost savings. Based on the modeling provided, Milliman believes that $4 to $8 million of annual savings can be realized in the future.

According to the Milliman modeling, $4 to $8 million of annual future savings are possible.

Second, Milliman conducted a relative efficiency review of the ACOs that confirmed the results of the first analysis. The second analysis reviewed potential inefficiencies if the entire Medicaid managed care population is shifted to one ACO. All cost efficiencies in this report are based solely upon ACOs' medical costs and exclude pharmacy costs.

These cost reductions are contingent on DOH proactively performing analyses on their contracted ACOs, discussed later in this chapter, as well as the ACOs agreement to a strategy of managing costs on a risk adjusted, unit cost adjusted approach. Also, in a companion audit to this, *A Performance Audit of the Utah Office of the Inspector General of Medicaid Services (2018-03),* we discuss how the Office of the Inspector General (OIG) can provide greater oversight to the ACOs.

Millions in Potential Cost Efficiencies Found in ACO Analysis

According to Milliman's analysis, each year, some ACOs could be more cost efficient relative to the performance of other ACOs. After a risk adjustment to evenly compare each ACO, Milliman identified the most efficient historical unit cost unit price performer over the ACOs' historical experience. Potential savings was estimated by shifting each

individual ACO population to the most efficient cost. Figure 2.2 breaks down how many member months each plan had in 2016.

Figure 2.1 Most Members Were in One of Two ACOs in 2016. Select Health and Molina account for 73 percent of all member months.

Plan	Member Months
Total	**2,822,417**
Select Health	1,143,584
Molina	929,776
HealthyU	542,951
Health Choice	206,106

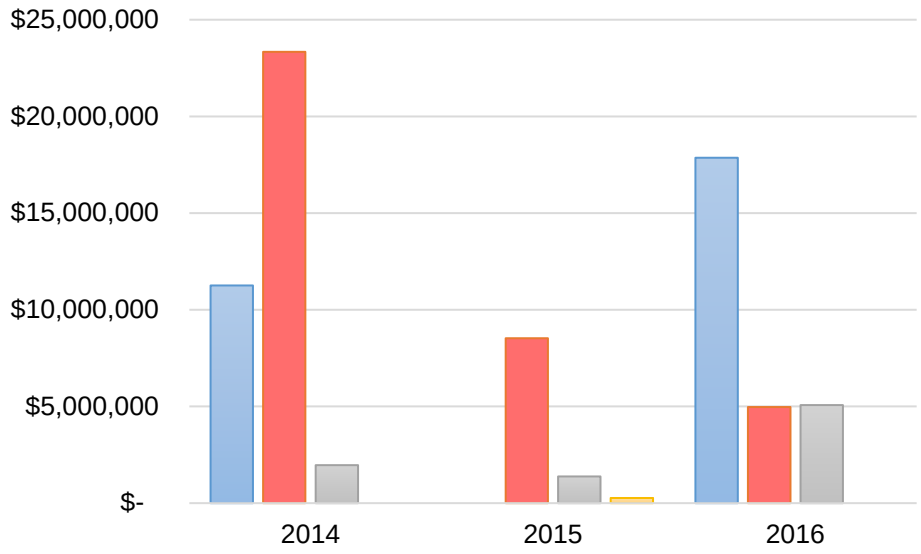
Source Milliman, see Appendix A

Approximately 73% of members are in these ACOs: Select Health and Molina.

Figure 2.1 shows that most of the members are in Select Health and Molina, while HealthyU and Health Choice have only about a quarter of the total member months.

Figure 2.2 demonstrates the total historical reductions of $74.6 million over the last three years, or on average $25 million annually. A zero-potential savings next to a plan denotes that plan as the most efficient for that calendar year.

Figure 2.2 $75 Million Total Potential Cost Reductions Are Possible If Most Efficient Cost Could Be Achieved. Cost efficiencies could have saved about $74.6 million during this period.



	2014	2015	2016	Average	Total
Select Health	$11,257,501	$0	$17,861,925	$9,706,475	**$29,119,426**
HealthyU	23,333,130	8,521,094	4,977,548	12,277,257	**36,831,772**
Health Choice	1,965,288	1,380,920	5,071,944	2,806,051	**8,418,152**
Molina	0	266,980	0	88,993	**266,980**
Total	**$36,555,919**	**$10,168,994**	**$27,911,417**	**$24,878,777**	**$74,636,330**

Source: Milliman, see Appendix A

Molina was modeled to be the most cost-efficient plan in 2014 and 2016. Select Health was the most efficient ACO in 2015.

As shown in Figure 2.2's modeled results, Molina would have been the most efficient plan in 2014 and 2016. Select Health would have been the most efficient plan in 2015. It should be noted that the risk adjustment conducted by Milliman is sensitive and not perfectly aligned with costs, meaning minor calculation adjustments can adjust efficiency rates. However, we believe that DOH, and the OIG, should utilize a method like this to understand how to best reduce costs going forward, but not necessarily as an absolute measure on savings.

Alternative Perspective Confirms Millions in Potential Cost Reductions

To help ensure the potential cost reductions shown in Figure 2.2 are possible, Milliman ran the analysis using a different perspective of comparison to help validate potential cost reductions. Milliman worked under the assumption that all Medicaid recipients were

hypothetically modeled to be managed under one[2] ACO plan to determine whether that plan would be less expensive or costlier than the actual aggregate costs. Figure 2.3 shows the results of this second perspective on the analysis. Plans below the line (in red) show cost savings or a cost reduction. Plans above the line (in black) reflect a cost increase. This analysis confirms the above analysis that Molina and Select Health are the two more efficient plans.

Figure 2.3 ACOs Cost and Savings If Populations Were Shifted to the Most Cost-Efficient ACO. Molina has been the most cost-efficient ACO according to the analysis. Savings are shown in (red), costs in black.

All	2014	2015	2016
Health Choice	$55,305,112	$20,097,587	$49,105,590
HealthyU	61,520,144	26,423,500	(4,337,508)
Molina	(36,112,208)	(7,334,817)	(27,482,224)
Select Health	$(7,839,865)	$(9,613,198)	$18,975,839

Source: Milliman, see Appendix A

Health Choice has been modeled consistently as the least cost efficient amongst the ACOs.

We have found that HealthyU's inefficiency, shown in Figure 2.3, may be related to a high average risk score, meaning they have a less healthy population in relation to the other ACOs. There are limitations to the accuracy of risk modeling that need to be considered when interpreting these results. However, HealthyU improves each year, which seems to demonstrate that their cost management strategies are working. The next section provides some ways that DOH can help improve efficiency for the ACOs.

Further review of Figure 2.3 shows that this alternative perspective still identifies Molina as the most cost-efficient ACO in 2014 and 2016. However, DOH is concerned that this efficiency could be because Molina typically has the healthiest population. Milliman's risk adjustment tried to account for this fact, but sensitivities exist in the

[2] According to Federal Rules there must be at least two plans offered.

data. Regardless, the analysis provides a target and shows that efficiencies could be achieved.

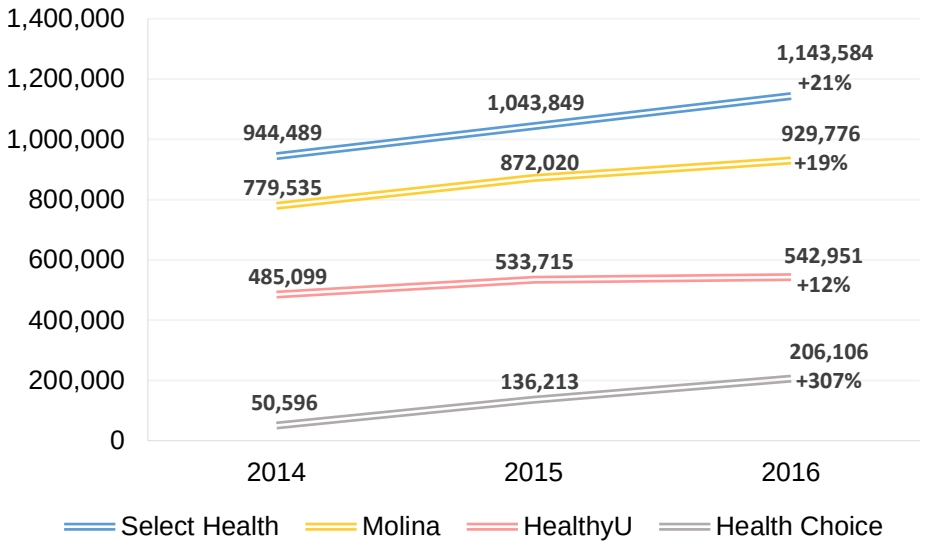
Select Health, which has the largest member population was relatively efficient in 2014 and the most efficient in 2015, increasing dramatically in 2016. The 2016 performance model calculated nearly $19 million in costs if they managed the entire population. We recommend that DOH seek to understand how to encourage more efficient costs in all the plans in the future and maintain historical cost efficiencies once they are achieved.

ACO's Are Growing, Further Increasing the Need for Cost-Savings Measures by DOH

Member months are the number of individuals participating in a particular plan each month. A member month multiplies the number of individuals enrolled in a plan by the number of months in the plan, Figure 2.4 shows the member months for each plan. A plan with a higher percentage of new enrollment can often have higher costs initially, but once that ramp up has occurred greater efficiencies are possible.

Health Choice has increased member months by over 300-percent.

Figure 2.4 Member Months Have Increased Since 2014. All plans have experienced enrollment increases, with Health Choice increasing its population by over four times.



Source:Milliman, See Appendix A

Since 2014, total membership has increased by 25 percent, which would certainly lead to an increase in total costs. Select Health had the

largest membership, with approximately 41-percent of total membership in 2016. However, in the next section, we show that costs have been increasing and there are additional monitoring activities that can be implemented to better understand the nature of these increases. DOH has responsibility to assure that these populations are being managed efficiently. We discussed the findings of Milliman's report with DOH to provide recommendations that will obtain cost savings. These recommendations are provided later in this chapter.

Legislative Fiscal Analyst Forecasted Decreasing ACO Cost Curve

The Office of the Legislative Fiscal Analyst performed a forecasting analysis on the cost impact of ACOs into the future. They found that the cost curve was increasing but at a slower rate when compared with cost increases prior to the implementation of the ACOs. In other words, if the ACOs had not been contracted and DOH continued to provide coverage in the manner it used to, those costs would be increasing faster than the ACO cost; thus ACOs appear to be more cost efficient than the traditional fee-for-service model previously employed. This report accepts the ACO model, but shows that even greater efficiency is possible through a comparison of the plan specific results. We believe that DOH, and the Office of the Inspector General, should perform additional analysis to ensure ACOs are performing at the most efficient level possible.

Legislative Fiscal Analyst forecasted that ACOs should be more efficient than prior models.

Unit Costs Are Increasing

Costs to provide services have increased since 2014, which is to be expected with inflation. The question we would like DOH to review is whether the costs increases are commensurate or are there opportunities for savings like the ones in Milliman's report. Figure 2.5 shows how the Paid Per Member Per Month (PMPM) costs have increased on average for most of the ACOs.

Figure 2.5 All Plans Paid Per Member Per Month (PMPM) Cost. The PMPM cost are the average claim costs, however the costs shown here only measure medical costs.

Plan costs have increased by about 8-percent since 2014.

Year	Paid PMPM
2016	$192.07
2015	$182.13
2014	$177.71

Source: Milliman, See Appendix A

As Figure 2.5 shows PMPM has increased by about $14 PMPM, an 8-percent increase, which appears to be modest. However, the analysis by Milliman shows efficiency issues that can and should be addressed.

DOH Should Proactively Perform Analysis to Ensure Efficiency Amongst ACOs

In the future, DOH should regularly conduct efficiency analysis on the ACOs beyond the annual rate setting process. The goals of the ACOs are to maintain quality of care and improve health outcomes for Medicaid recipients and to control costs. Past practice has been to let the ACOs themselves control costs. DOH has assumed that because DOH has a capitated contract with the ACOs, it is in the ACOs' best interest to keep costs low. Risk-adjusted capitated contracts have shown promise in maintaining costs, we believe, that over time, if costs are not examined and managed, they will increase, and should be examined in detail to ensure any cost savings opportunities are realized.

DOH Should Regularly Benchmark Plans To Determine Most Cost-Efficient Plans

DOH should conduct analyses similar to the one in this report, (See Appendix A) and regularly benchmark their plans for efficiency. According to ***Utah Code*** 26-18-405, DOH shall:

DOH needs to identify best practices and measures and reward providers for delivering services at the lowest cost.

> (c) …identify the evidence-based practices and measures, risk adjustment methodologies…funding sources…to reward providers for delivering the most appropriate services at the lowest cost.…

As mentioned previously, DOH needs to start performing analyses similar to the one shown in Appendix A, which would give DOH the

opportunity to ask questions about cost efficiency. The OIG should also conduct such independent analysis, which we discuss further in our ***Performance Audit of the Utah Office of the Inspector General of Medicaid Services (2018-03)***. Using this information, DOH could then set goals for ACOs to achieve reasonable levels of efficiency over time that can be actuarially certified. These goals should be developed in partnership with the ACOs. This approach will also give DOH a method to see what cost areas may need to be examined to diagnose ways to increase efficiency. Over time, such an analysis will help to recognize year over year fluctuation versus ineffectiveness and show how the ACO deals with those fluctuations.

Medicaid Recipients Could Be Placed in Cost Efficient Plans Rather than Assigned Randomly

Currently, recipients who do not choose an ACO plan during the application process are randomly assigned to an ACO. In 2014, DOH randomly assigned over 23,000 members (18 percent of the ACO population) to plans, with approximately $50 million in total annual costs. DOH did not have reliable data for 2015 and 2016. We recommend assigning recipients who don't self-select a plan, to one of the more efficient plans based on a cost-to-quality ratio score. This strategy can help control costs and provide high quality care to recipients.

In 2014, DOH randomly assigned over 23,000 members (18% of the ACO population).

DOH Should Consider a Competitive Bid To Obtain Most Efficient ACO Plans

One option DOH should consider is a competitive procurement through an RFP process. DOH would need to weigh the pros and cons of this approach, but it could help set cost targets at a more efficient level. Even using the second most efficient plan as the benchmark could bring considerable savings. Naturally, there must be health plans willing to contract at established target levels to consider engaging in a competitive recruitment. Additional analysis may also be required to set cost targets. Further, DOH reported that federal regulations require DOH to provide at least two ACO plans, so that requirement would need to be considered in a procurement process.

Using the second most cost-efficient plan to bid out for a less costly ACO could be another means to increase savings.

DOH Needs to Increase Oversight of ACO Program Integrity

DOH needs to provide a stronger control environment over the ACOs. A recent report by the Centers for Medicare and Medicaid Services (CMS) recommended that DOH "should ensure that ACOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud..."

DOH has a responsibility to suspend payments to a provider if an allegation of fraud is found credible.

One issue found in the report is that DOH is responsible to suspend payments if an allegation of fraud is found to be credible. It was found that DOH delegates the responsibility to suspend provider payments to the ACOs, however, this does not remove the responsibility from DOH to ensure that there is an effective process in place that meets full requirements of the regulation. DOH recently strengthened the requirement for ACOs to suspend payments when allegations of fraud occurred. According to the CMS report, which sites Federal Regulation 42 CFR 455.23(a), it states:

> "…that upon the state Medicaid agency determining that an allegation of fraud is credible, the state Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payments only in part."

DOH must not rely solely on the ACOs to deal with fraud allegations or other issues that may increase unmanaged risk to DOH. While DOH has responsibility in this area, we understand the Office of the Inspector General has also been charged with program integrity efforts over Medicaid funds. A companion audit to this one, *A Performance Audit of the Utah Office of the Inspector General of Medicaid Services (2018-03)* discusses the role of the OIG in providing greater oversight.

Recommendations

1. We recommend that the Department of Health, in conjunction with the Office of the Inspector General, in addition to this current analysis in the future perform a similar Milliman type evaluation, as appropriate, and use that to benchmark plans to determine reasonable cost efficiency target for the ACOs.

2. We recommend that the Department of Health use the results of the efficiency evaluations to improve efficiency and maintain historical cost efficiencies once they have been achieved.

3. We recommend that the Department of Health use the results of the efficiency evaluations to determine how to best distribute the recipients who do not have a predetermined ACO to join.

4. We recommend that the Department of Health set efficiency targets that lead to a more cost-effective program that is achievable and sustainable. The Department of Health should evaluate whether a competitive procurement will help them achieve that goal.

5. We recommend that the Department of Health provide greater cost oversight of ACOs.

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Chapter III
DOH Can Improve Some Budgeting Practices

The Department of Health (DOH) has a large and complex budget. We found some areas where DOH can improve its budgeting practices, which will make it easier to review and analyze its budget. Some DOH programs have not been consistently coding expenditures. Inconsistent coding of expenditures in federal programs allows inconsistencies in budget data and creates difficulties to conduct comparative analyses. We found that spending in the Baby Watch Early Intervention program is not necessarily changing, but the way it is being coded, presented, and reported has changed year to year. Unbalanced budget structure in the Office of Primary Care and Rural Health misrepresents DOH activities. We recommend that DOH improve some budget controls and reporting to foster a healthier review of its budgets.

Some DOH programs have not been consistently coding expenditures. Inconsistencies in budget data makes it difficult to conduct comparative analyses.

Budget Consistency Is Required by Governmental Accounting Standards Board

We are concerned that an external stakeholder, such as our office, was not able to make comparable year-to-year assessments in some categories of DOH's budget. Inconsistent budget data complicated our budget review and limited our ability to analyze and review budget trends. Examples of budget inconsistencies are provided in the next section of this report.

The Governmental Accounting Standards Board (GASB) promotes greater consistency and comparability in financial reporting, and establishes rules "…that require state and local governments to report clear, consistent, and transparent financial information to their constituents". GASB also states that "… to be effective, information in financial reports must have… basic characteristics [of] understandability, reliability, relevance, timeliness, consistency, and comparability."

GASB states that to be effective, information in financial reports must have basic characteristics of understandability.

As the budget is a form of financial report, GASB explains consistency further: …financial reports should be consistent over time; that is, there is a presumption that once an accounting principle or

reporting method is adopted, it will be used for all similar transactions and events.

Similar to financial statements, after an agency budget has been adopted and the money spent, the activities carried out and their resulting accounting transactions become a financial record of who the agency is and what it does. For external stakeholders, these financial records are a primary source for analyzing agency activities and spending.

Inconsistent Coding and Budget Structure Complicate Historical Budget Analysis

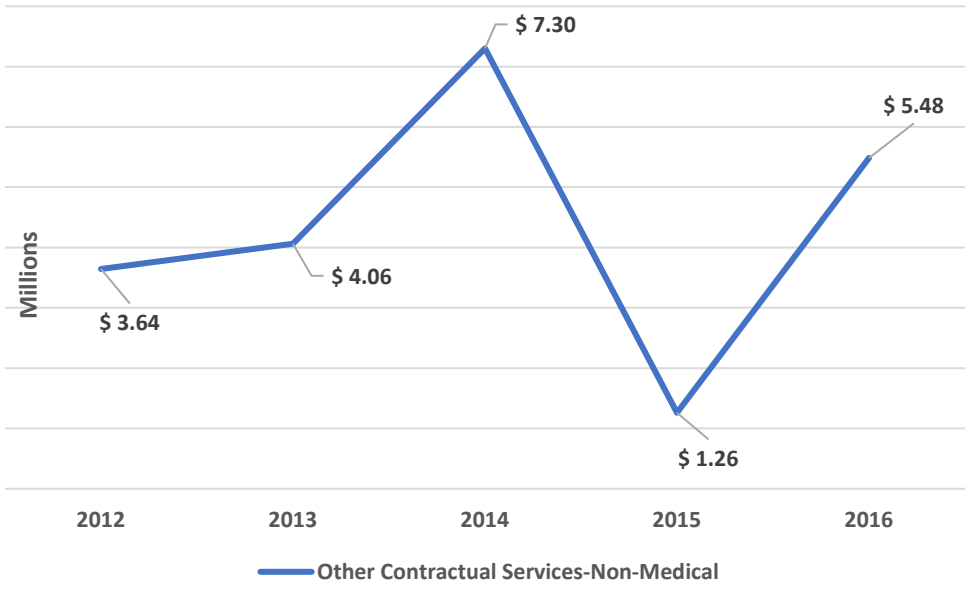
Our budget review of DOH was complicated by inconsistent coding of expenditures. First, we found budget staff inconsistently coded contractual expenditures in the Baby Watch Early Intervention program. Consequently, expenditures in the program appear erratic from year to year because coding is inconsistent. Second, we found that expenditures relating to the Office of Primary Care and Rural Health are being budgeted in the Medicaid Mandatory Services (MMS) line item, but those same expenditures are managed in Family Health and Preparedness (FHP), a separate division with a separate line item.

Inconsistent Coding Obscured the Budget

Inconsistent Coding in the Baby Watch Early Intervention program obscured DOH budget.

The Baby Watch Early Intervention program is managed within FHP and its expenditures are located in the FHP line item. Payments to contract providers in the Baby Watch program have been inconsistently coded in recent years, causing data ambiguities and complicating external oversight. These issues obscure the FHP budget when it is rolled up to the line item level. Figure 3.1 demonstrates how inconsistent coding of contract payments to Baby Watch providers affects budget data.

Figure 3.1. Baby Watch Early Intervention Coding Practices Are Inconsistent (Shown in Millions). This figure shows annual totals for "Other Contractual Services – Non-Medical." Because coding has been inconsistent, DOH's budget data paints a confusing expenditure history.



Source: Datawarehouse

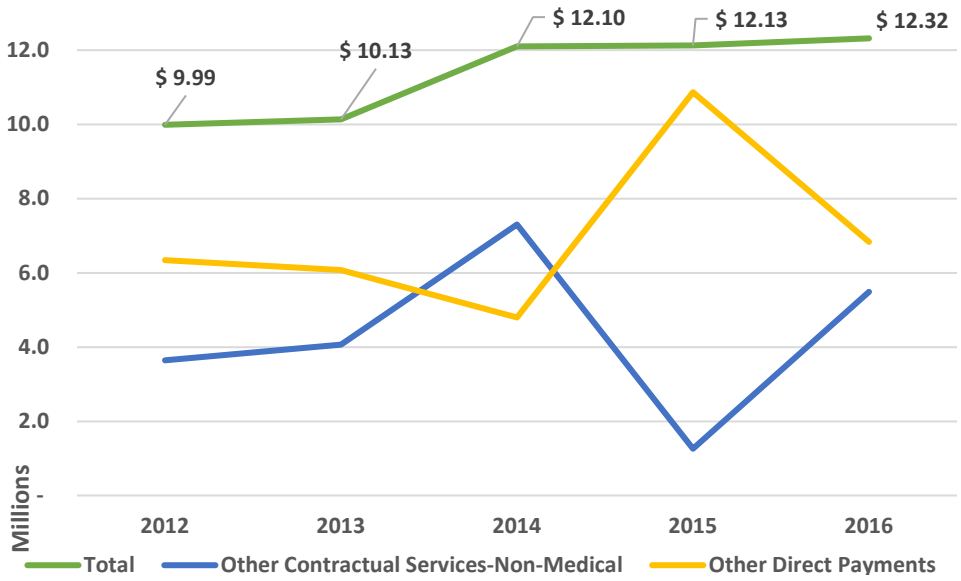
Expenditures in the Baby Watch Early Intervention program appear erratic from year to year because coding of contract payments to providers has been inconsistent

In Figure 3.1, expenditures fluctuate from year to year with significant increases and decreases. These wide swings do not fit a normal spending pattern. Over the course of the audit, we learned that DOH has coded contract payments to providers in the Baby Watch Early Intervention program inconsistently. Specifically, two different codes, Other Contractual Services – Non-Medical and Other Direct Payments, were used for the same expenditures.

DOH has used two different categories of expenditure interchangeably to code contract payments to providers.

We were informed that these two areas of expenditure were used interchangeably over the years to code contract payments to providers. In order to have a consistent picture of these expenditures, both needed to be placed together. Figure 3.2 graphs both expenditure areas and shows their total when added together.

Figure 3.2. Contract Payments to Baby Watch Providers Were Coded Interchangeably to Two Expenditure Areas (Shown in Millions).



Source: Datawarehouse

We were not able to determine what portion of the blue or yellow lines in Figure 4.2 consisted of contract payments to providers from year to year.

Graphing Other Contractual Services – Non-Medical and Other Direct Payments together (blue and yellow lines) shows large increases and decreases that are correlated. The green line shows what would be occurring, if the codes were consistently applied. We were not able to determine what portion of these two expenditure areas consisted of contract payments to providers from year to year. A consistent definition for each expenditure should be developed and applied, which will be discussed later in this section. DOH should review contract payments to providers and code them consistently from year to year in the appropriate expenditure area.

DOH should do more to ensure consistent training of its employees and implement internal controls to ensure consistency of coding expenditures.

DOH management explained that this specific instance of inconsistent coding started when a new employee in DOH's Office of Fiscal Operations began approving Baby Watch Early Intervention expenditures in 2015. The new employee had concerns with the way provider payments were being accounted for and changed the object code to what the employee deemed to be a more appropriate code.

DOH management indicated that its coding depends on who is sitting in the seat at the time and how they were trained, and that swings like those in the Baby Watch program will always happen when someone new, with different ways of looking at things is thrown into the mix. DOH should do more to ensure consistent training of its

employees and implement internal controls to check and monitor for consistency.

Inconsistent coding also skews high-level budget detail shown to the Legislature. Figure 3.3 shows that because coding has not been consistent, two high-level object categories appear to have significant annual expenditure fluctuations.

Inconsistent coding of expenditures skews high-level budget detail provided to the Legislature.

Figure 3.3 Inconsistent Coding Paints an Inaccurate Spending Picture. This figure shows that expenditures appear to fluctuate year to year, but the changes resulted from inconsistent expenditure coding.

Object Category	2013	2014	2015
Current Expense	$14.2	$18.1	$11.5
Other Charges/Pass-Through	$76.4	$70.6	$77.3

Source: Datawarehouse

In Figure 3.3, fiscal year 2014 shows a $3.9 million increase in Current Expense from fiscal year 2013and a $6.6 million decrease in fiscal year 2015. The opposite effect is seen in Other Charges/Pass-Through.

The lack of consistency from year to year in coding payments to providers is concerning. Not only is the interchangeable coding of contract provider payments undiscernible to someone outside of DOH, but DOH program managers with working knowledge of the program are unable to supply correct data for contract payments to providers without painstaking efforts. We recommend that DOH management review its coding practices for contract payments, not only in the Baby Watch program, but in all programs and provide direction in these areas with policies and procedures that will enable consistency and understandability in its budget and financial data. To this end, and in conjunction with this recommendation, we also suggest that DOH consider coding its contract payments to providers in the Other Charges/Pass-Through category of expenditure rather than the Current Expense category.[3]

We recommend that DOH management provide direction through policies and procedures to enable consistency and understandability in budget and financial data.

[3] The Office of the Legislative Fiscal Analyst made a similar recommendation to the Department of Human Services (DHS) in its 2010 in-depth budget review titled *Human Services In-Depth Budget Review*, Pgs. 47-48 and 49-50. DHS had a similar

Office of Primary Care and Rural Health Lacks Clarity in DOH Budget

Health Clinics are managed in the Office of Primary Care and Rural Health, FHP division, but budgeted for in Medicaid, creating inconsistency and confusion in the DOH budget.

The Health Clinics and the Family Dental Plan (Health Clinics) in the Office of Primary Care and Rural Health are located in and managed by the Family and Health Preparedness (FHP) division. However, DOH has been managing the Health Clinics budget in the Medicaid Mandatory Services (MMS) line item. FHP and Medicaid are two separate divisions at DOH. It is confusing and inconsistent to have costs of one division being managed and shown in a separate division. This practice also results in overstating expenditures in the Medicaid budget and understating those costs in FHP. Further, since Medicaid's budget is over $2 billion, the Health Clinics' budget is not visible in Medicaid's budget. Figure 3.4 breaks down the Health Clinics' expenditures to show the magnitude of the miscoding and overstatement in Medicaid.

Figure 3.4 Health Clinics Budget Is Reported Incorrectly. More than $5 million on average has been overstated in the Medicaid budget.

	2012	2013	2014	2015	2016
Health Clinics Total Expenditures (should be reported in FHP)	$5.6	$5.1	$5.7	$5.7	$6.0

Source: Datawarehouse

$5.6 million on average has been miscoded in the Medicaid budget, which should be reported in the FHP division.

The Health Clinics have been miscoding an average of $5.6 million that should have been coded in FHP. DOH management explained that this off-balance budgeting/management issue began in 2005, resulting from an internal reorganization from new leadership. It appears the budget did not get adequate attention from management to stay up-to-date with the internal restructuring and this issue has persisted for 13 years. Consequently, revenues, expenditures, and FTEs have been overstated in the Medicaid department and understated in FHP for 13 years.

issue of inconsistent coding with contract payments to providers for services in its Division of Juvenile Justices Services.

Recommendations

1. We recommend that Department of Health management improve budgeting activities by creating clear policies and procedures for coding provider payments and all other expenditures where alternate interpretations of spending activities can create inconsistencies in its coding.

2. We recommend that the Department of Health management implement budget practices and procedures that will ensure its budget is reflective of actual expenditures and operations.

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Appendix A
Milliman Utah Accountable Care Organization Efficiency Analysis

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Utah Accountable Care Organization Efficiency Analysis

December 15, 2017

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EXECUTIVE SUMMARY

We are pleased to present the Utah Office of the Legislative Auditor General (OLAG) with the results of our relative efficiency review of the Medicaid Accountable Care Organization (ACO) program run by the Utah Department of Health (DOH). To complete this analysis, we relied on data provided by the DOH and the participating ACOs. We understand that OLAG will use the results presented in this letter to better understand the relative efficiency of the individual Medicaid ACO vendors and to possibly use these results as part of an audit of the program. It may not be appropriate for other purposes and any reliance on these results should include a complete copy of this report. It is important that the reader of this report understand that these results are modeled values based upon historical experience of the individual DOH ACO vendors and future results will vary.

Our relative efficiency review of the ACO program compares estimated unit cost adjusted and risk adjusted experience for the last three calendar years for each plan participating within the program. The relative efficiency of an individual ACO plan is presented as the measurement against the collective experience of all DOH ACO plans. We did not conduct an efficiency analysis compared to any external benchmarks.

Tables 1 and 2 present the relative efficiency results by plan, and include the following columns:

- **Unit Cost Impact PMPM** - represents the modeled costs / (savings) under two comparison scenarios. Table 1 summarizes the impact in a scenario where all DOH ACO members shift to each of the listed plan's specific unit cost reimbursement levels. Table 2 summarizes the impact in a scenario where each of the individual ACO plan's members shift to the benchmark plan unit cost reimbursement levels. The benchmark plan is the DOH ACO with the lowest overall risk adjusted PMPM cost.
    - The Unit Cost Impact PMPM reflects each plan's estimated overall percent of Medicare, relative to either the program average (Table 1), or the benchmark plan average (Table 2), percent of Medicare. For example, the Health Choice percent of Medicare was significantly higher than the all DOH ACO plan average, which is reflected in the high Unit Cost Impact PMPM of $33.27 (Table 1).
    - The percent of Medicare represents our best estimate of what Medicare would have paid for those claims that are covered under the Medicare fee schedule relative to what the plans actually paid.
    - For example, the Molina 2016 Unit Cost Impact PMPM in Table 1 is -$3.16. This means that if all DOH ACO members switched to the Molina unit cost reimbursement levels, then the theoretical modeled savings to DOH would be $3.16 PMPM in 2016, or approximately $8.9 million ($3.16 PMPM x 2,822,417 total 2016 DOH ACO member months).
- **Utilization/Mix Impact PMPM** - represents the modeled costs / (savings) under the same comparison scenarios. Table 1 summarizes the impact in a scenario where all DOH ACO members shift to each of the listed plan's-specific level of utilization and mix of services. Table 2 summarizes the impact in a scenario where the individual plan DOH ACO members are shifted to the benchmark plan level of utilization and mix of services.
    - The Utilization/Mix Impact PMPM is intended to reflect the difference in cost explained by each plan's utilization management programs and coordinated care delivery systems, relative to either the program average (Table 1), or the benchmark plan average (Table 2), after accounting for unit cost and risk differences.
    - This value is based on the risk-adjusted Relative Value Units (RVUs) for each plan, compared to the average across all plans. RVUs are commonly used within payment schedules to define relative cost between services.
    - For example, the Molina 2016 Util/Mix Impact PMPM in Table 1 is -$6.58. Therefore, if all DOH ACO members switched to the Molina utilization levels, then the theoretically modeled savings to DOH would be $6.58 PMPM in 2016, or approximately $18.6 million ($6.58 PMPM x 2,822,417 total 2016 DOH ACO member months).

Our modeled cost / (savings) scenarios rely on our Medicare repricing analysis of the claim experience for each ACO plan that is summarized by each category of service. As these values reflect the average unit cost contracting levels of each ACO plan's network, due to proprietary considerations, the estimated percent of Medicare values are not included in this report.

All scenario results are modeled values based on the historical experience for the time period analyzed (1/1/2014 to 12/31/2016) and may not be representative of future outcomes. These modeled values are also based on the assumption that the experience of each ACO plan reflects the capabilities and capacity of a network to handle all DOH ACO members shifting into a single plan, without impact on the results reflected within the historical experience. It is unlikely that any of the individual ACOs would be able to maintain their risk adjusted utilization and unit cost position if the entire enrollment shifted to a single ACO.

The ACOs experience reflects the management of their own enrolled populations. We use the average across all ACO experience together to set one benchmark of performance and select the plan with the lowest overall risk adjusted cost as the second benchmark. The Total Impact PMPM represents the modeled individual ACO performance relative to the first benchmark. The Plan Specific Cost Impact PMPM represents the modeled individual ACO performance relative to the second benchmark. Totaling the Plan Specific Cost Impact PMPM over all plans represents the savings to shift the DOH ACO members for all plans into the lowest cost benchmark plan.

This analysis is limited to medical costs, and does not include any cost related to the pharmacy prescription drug benefit due to our inability to reprice pharmacy claims to a consistent basis of reimbursement. A follow-up analysis may be warranted to estimate the relative efficiency of the pharmacy services for each Medicaid ACO vendor. The medical component of the ACO program covers physical health only and does not include long term services and support, custodial care nursing facility or behavioral health benefits. All adjustments and exclusions are included in the "Methodology" section of this report.

Table 1: All Enrollment switching to each Individual Plan

		Experience Summary		Cost Impact				
		(1)	(2)	(3)	(4)	(5) = (3) + (4)	(6) = (5) x (All ACO MM)	(7) = (5) / (All ACO Paid PMPM)
Year	Plan	Member Months	Paid PMPM	Unit Cost Impact PMPM	Util/Mix Impact PMPM	Total Impact PMPM	Total Cost Impact	%Impact
2016	**All**	**2,822,417**	**$192.07**					
2016	Health Choice	206,106	193.53	$33.27	($15.88)	$17.40	$49,105,590	9.1%
2016	HealthyU	542,951	226.83	(9.34)	7.81	(1.54)	(4,337,508)	-0.8%
2016	Molina	929,776	168.41	(3.16)	(6.58)	(9.74)	(27,482,224)	-5.1%
2016	Select Health	1,143,584	194.54	2.65	4.07	6.72	18,975,839	3.5%
2015	**All**	**2,585,842**	**$182.13**					
2015	Health Choice	136,213	175.94	$28.86	($21.09)	$7.77	$20,097,587	4.3%
2015	HealthyU	533,715	229.37	4.50	5.72	10.22	26,423,500	5.6%
2015	Molina	872,020	164.42	0.58	(3.42)	(2.84)	(7,334,817)	-1.6%
2015	Select Health	1,043,894	173.59	(6.48)	2.76	(3.72)	(9,613,198)	-2.0%
2014	**All**	**2,259,719**	**$177.71**					
2014	Health Choice	50,596	197.19	$49.75	($25.28)	$24.47	$55,305,112	13.8%
2014	HealthyU	485,099	231.52	20.39	6.84	27.22	61,520,144	15.3%
2014	Molina	779,535	146.53	(2.36)	(13.62)	(15.98)	(36,112,208)	-9.0%
2014	Select Health	944,489	174.77	(12.23)	8.76	(3.47)	(7,839,865)	-2.0%

The efficiency calculations shown in Table 1 reflect the impact of shifting all ACO enrollees to the unit cost and utilization/mix levels of the indicated ACO. Based on our model, Molina was the most efficient ACO in 2014 and 2016, while Select Health was the most efficient ACO in 2015.

Exhibit 1 provides additional detail supporting the overall results shown in Table 1.

While reviewing these results, it is important to consider the limitation of the risk model we use to risk adjust the paid costs for each health plan. The modeling relies on the concurrent risk scores from the Chronic Illness and Disability Payment System, based upon the national coefficients. Risk scores may not perfectly adjust for the true underlying morbidity. This report does not address any errors that may be introduced to the analysis through the risk score model.

The size of enrollment for each plan is an important consideration in the year-over-year comparison of results. For the populations included in this analysis, the overall paid cost trends are 5 percent for 2016 and 2 percent for 2015. Because the individual plan efficiency measures are relative to the overall average for each individual year, the comparisons of results are relative within each calendar year.

As the plan with the largest enrollment, Select Health has a substantial influence on the average of all plans. Select Health ranges between 2.0 percent savings to 3.5 percent cost relative to the overall benchmark over the three-year period. If the entire population were managed by Select Health, the modeled savings estimate would be approximately $9.6 million in 2015 and the modeled costs would be approximately $19.0 million in 2016 under Scenario 1. Molina also has high enrollment and is the only plan to generate modeled savings estimates for all three years, which is primarily driven by efficient utilization management and possibly optimizing risk score coding. If the entire population were managed by Molina, the modeled savings would be approximately $7.3 million in 2015 and $27.5 million in 2016.

Conversely, Health Choice and Healthy U both generate modeled costs for all three years. Health Choice generates modeled costs due to higher unit cost levels. HealthyU has steadily improved their overall efficiency by improving their unit cost levels. One important consideration to these results is that HealthyU has the highest average risk scores across all three years. Any errors in the risk score modeling would have a notable impact on the results of this analysis. Although HealthyU had higher unit costs, they did present net savings when compared to average experience.

Table 2 provides further detail by showing the impact of shifting each individual ACO population to the unit cost and utilization/mix levels of the most efficient ACO within each year. Exhibit 2 provides additional detail of the results shown in Table 2.

The All Plans impact from Table 2 is equal to the Total Cost Impact from Table 1 for the plan that is designated as the benchmark. In 2016, over half of the Molina savings are generated by managing the large Select Health membership. It is important to consider that the modeled costs are not representative of future results. The next section of this report includes a more detailed discussion of our observations.

Table 2: Individual Plan Enrollment switching to Benchmark Plan

		Experience Summary		Cost Impact				
		(1)	(2)	(3)	(4)	(5) = (3) + (4)	(6) = (5) x (1)	(7) = (5) / (2)
Year	Plan *(Benchmark)*	Member Months	Paid PMPM	Unit Cost Impact PMPM	Util/Mix Impact PMPM	Total Impact PMPM	Plan Specific Cost Impact	%Impact
2016	**All Plans**	**2,822,417**	**$192.07**	**($3.16)**	**($6.58)**	**($9.74)**	**($27,482,224)**	**-5.1%**
2016	***Molina***	929,776	168.41	-	-	-	-	-
2016	Select Health	1,143,584	194.54	(5.80)	(9.82)	(15.62)	(17,861,925)	-8.0%
2016	HealthyU	542,951	226.83	7.68	(16.85)	(9.17)	(4,977,548)	-4.0%
2016	Health Choice	206,106	193.53	(31.29)	6.68	(24.61)	(5,071,944)	-12.7%
2015	**All Plans**	**2,585,842**	**$182.13**	**($6.48)**	**$2.76**	**($3.72)**	**($9,613,198)**	**-2.0%**
2015	***Select Health***	1,043,894	173.59	-	-	-	-	-
2015	Molina	872,020	164.42	(6.36)	6.05	(0.31)	(266,980)	-0.2%
2015	HealthyU	533,715	229.37	(13.50)	(2.47)	(15.97)	(8,521,094)	-7.0%
2015	Health Choice	136,213	175.94	(29.47)	19.34	(10.14)	(1,380,920)	-5.8%
2014	**All Plans**	**2,259,719**	**$177.71**	**($2.36)**	**($13.62)**	**($15.98)**	**($36,112,208)**	**-9.0%**
2014	***Molina***	779,535	146.53	-	-	-	-	-
2014	Select Health	944,489	174.77	10.43	(22.35)	(11.92)	(11,257,501)	-6.8%
2014	HealthyU	485,099	231.52	(26.58)	(21.52)	(48.10)	(23,333,130)	-20.8%
2014	Health Choice	50,596	197.19	(45.17)	6.33	(38.84)	(1,965,288)	-19.7%

RESULTS

The following summary identifies additional observations from the results of the efficiency analysis. We recommend reviewing Exhibits 1 and 2 concurrently while reading this section.

- **Health Choice:** The Health Choice plan consistently generated modeled overall cost inefficiencies between CY2014 and CY2016. This plan also has the smallest enrollment of all plans, so it may be more difficult for Health Choice to negotiate reimbursement rates as low as the other ACO plans. If all DOH ACO members shifted to the Health Choice plan, and the utilization and cost profile remain unchanged from the historical experience, then the modeled annual DOH costs would have increased by approximately 13.8%, 4.3% and 9.1% respectively for calendar years 2014 through 2016.
    - As shown in Exhibit 1, the significant reason for the Health Choice plan's relative inefficiency is related to high unit cost experience, as reflected in their high modeled Unit Cost Impact PMPM. This is also the newest ACO and higher reimbursement levels may be the result of initial network development in order to provide sufficient access for enrollees.
    - The Health Choice plan appears to generate modeled cost savings through efficient utilization and mix of services. However, their modeled savings due to utilization and mix are not enough to overcome their unit cost inefficiencies relative to the overall plan average.

- Health Choice has the highest increase in membership since CY2014 (approximately 400% increase).

- **HealthyU:** The HealthyU plan shows significant improvement between CY2014 and CY2016. The potential total cost impact of shifting all DOH ACO enrollees to HealthyU improves the overall modeled impact of a 15.3% increase in CY2014 total costs, to a modeled savings of 0.4% for CY2016 total costs.
    - The high overall utilization patterns for HealthyU appear to be the primary source of modeled cost inefficiency relative to the overall plan average. HealthyU has the highest risk score in each of the years, and the modeled cost inefficiency could be influenced by estimation error in the risk adjustment model.
- **Molina:** The Molina plan has managed their ACO population efficiently between CY2014 and CY2016 relative to the overall plan average. If all DOH ACO members shifted to the Molina plan, the modeled savings estimates for DOH would be approximately 9.0%, 1.6% and 5.1% of total costs.
    - Molina cost in 2014 and 2016 is modeled to be more efficient that the overall plan average. As shown in Exhibit 2, the largest total savings would be generated by the Select Health members shifting to the Molina plan in 2016, and from Healthy U members shifting to the Molina plan in 2014.
- **Select Health:** The Select Health plan has been consistent with the overall benchmark between CY2014 and CY2016 (ranged between approximately 3.5% overall costs and 2.0% in overall savings).
    - Select Health is modeled to have more efficient cost than other health plans in 2015. As shown in Exhibit 2, the largest total savings for that year would be generated from Healthy U members shifting to the Select Health plan in 2015.

METHODOLOGY

The purpose of this section is to provide an overview of the methodology used to model and analyze the historical ACO claims data, estimate Medicare repriced amounts, calculate concurrent risk scores and conduct an efficiency analysis of the ACO individual organizations.

Data and Exclusions

Several sources of information were relied upon to complete the efficiency analysis. Information was provided by both the DOH and the health plans including:

- ACO encounter data
- Detailed eligibility files by rate cell

The DOH provides Medicaid eligibility and encounter data to us on a regular basis, as a part of the ongoing management of the ACO program by the DOH. Our understanding is that the DOH initially reviews, edits, and processes the health plan submitted claim and encounter data files into the state data warehouse. The state data warehouse is used to generate the claim files that are shared with us, and then we further process these data files for this analysis.

We process these DOH claim and eligibility files through Milliman's *Health Cost Guidelines (HCG) Grouper* software, in order to:

1. Perform data validation to review the data quality and check the data for reasonableness. We did not perform a complete audit of the data provided; to the extent that the data we received is inaccurate or incomplete, this analysis may also be inaccurate.
2. Assign each claim to a category of service consistent with the categories published in the Milliman *HCG's*. In particular, each claim is assigned a high-level category of "Inpatient Facility", "Outpatient Facility", or "Professional/Other"

Processed claims files and summaries are shared with the DOH with each ACO for feedback and validation. The DOH and Milliman have joint meetings and discussions with the ACOs to confirm that all summary totals reasonably align with the initially submitted raw data, individual financial reporting, and with all parties' expectations for total benefit costs. These processed and validated eligibility and claims costs form the starting point for this analysis.

Claims from the period of 1/1/2015-12/31/2016 reflect runout through 6/30/2017, while claims from the period of 1/1/2014-12/31/2014 reflect runout through 10/31/2016. Incurred but not reported (IBNR) completion factors are calculated separately for each of these two periods and applied during the construction of the cost models.

All ACO costs are modeled based on paid claims, excluding coordination of benefits or third-party liability (COB/TPL) and enrollee cost sharing.

The following claims are excluded from this analysis:

- Claims from the following Medicare rate cells:
    - Rate Cell E – Aged (65 years and older)
    - Rate Cell M – Aged (65 years and older)
- Skilled Nursing Facility (SNF), newborn delivery and Pharmacy claims
- Claims with an unknown ACO program or an unknown rate cell
- Claims incurred outside the study period (1/1/2014 through 12/31/2016)
- Claims without records on the eligibility file

Please refer to the ACO Databook delivered to DOH on June 30, 2017 for complete documentation regarding the methodology and assumptions used to process and summarize the DOH ACO claims and enrollment information.

Medicare Repricing and RVU Assignment

Milliman's GlobalRVUs™ are a relative value system that covers the entire range of healthcare services: facility (inpatient and ambulatory) and professional. RVUs are commonly used with payment schedules to define relative cost between services, similar to Medicare's Resource Based Relative Value System (RBRVS). Once RVUs are assigned, the data is repriced to Medicare allowable amounts using the Milliman Medicare Repricer. Having the Medicare allowed costs as a benchmark permits analyzing costs relative to the Medicare fee schedule.

If an RVU assignment is unavailable for a particular type of claims, then the tool imputes an RVU value based on average provider and area-level information within the incurred year.

A portion of the ACO data could not be repriced to Medicare, either due to DOH-specific coding or other limitations. In these cases, we relied on the RVU's assigned to the claim lines and average Medicare allowed conversion factors, by plan, year and service category.

Multiple assumptions are necessary to reprice the ACO data at estimated Medicare payment levels. Those assumptions and limitations of the repricer are described below:

Inpatient Facility

- The inpatient Medicare Repricer is based on the data and information published by CMS as of the beginning of the fiscal year being priced (e.g., as of 10/1/2015 for FY2016). CMS may update these values throughout the fiscal year. In general, our repriced amounts do not reflect these updates.
- Medicare typically uses facility-specific base rates when determining inpatient Medicare allowed amounts. If no provider information was available in the claims data, the Salt Lake City, UT area-specific base rates were used instead. These base rates do not include adjustments for Disproportionate Share (DSH), Uncompensated Care, and Indirect Medical Education (IME) which are also specific to each facility.
- The inpatient Medicare Repricer does not include new technology add-on payments.

- No adjustment is made for providers that participate in Medicare's Bundled Payments for Care Improvement (BPCI) initiative.
- The inpatient Medicare Repricer does not include Section 1109 payments. Section 1109 makes available $400 million in funds from the Medicare Trust Fund for CMS to allocate to hospitals located in counties with age, sex, and race adjusted per capita costs in the lowest quartile nationwide. Medicare pays these outside of PPS as annual one-time payments.
- Inpatient claims are repriced based on their diagnosis-related grouping (DRG). DRGs are assigned during the repricing process in the CMS grouper.

Ambulatory Facility

- The ambulatory Medicare Repricer is based on the data and information published by CMS as of the beginning of the calendar year being priced to (e.g., as of 1/1/2016 for CY2016).
- The ambulatory Medicare Repricer prices claims using Medicare's Hospital Outpatient Prospective Payment System (OPPS) fee schedule for hospital claims and the Ambulatory Surgical Center (ASC) payment for ASCs.

Professional/Non-Facility

- Medicare makes significant changes to payment rates annually. Interim payment changes are also made throughout the year, though these mid-year updates usually have a small impact on Medicare allowable levels. The Physician Repricer represents our understanding of Medicare payment rules in effect as of the date of release. The repricer is updated annually to reflect annual changes to Medicare's payment rules and rates (e.g., as of 1/1/2016 for CY2016).
- We assume Private Duty Nursing and Home Health claims had the standard physician conversion factors (e.g. $35.87 in CY2016). The total repriced allowed amount is then calculated as the total RVUs multiplied by this conversion factor.
- The Physician Repricer does not reduce payments to reflect Sequestration.
- Ambulance claim payments are based on 'urban', 'rural', or 'super rural' area status of the location of pickup, but the Medicare Repricer uses the ambulance provider's county in pricing since the pickup location is not always available in the claims data.
- The Physician Repricer does not include physician incentive payment adjustments made under Medicare.

Risk Scores

In order to assess the morbidity of each individual ACO population, we calculate the concurrent risk scores using the Chronic Illness Disability and Payment System (CDPS), v6.2.2. These medical risk scores are used to assess the efficiencies of the individual ACO populations, relative to the statewide average.

Members are defined as credible if they met the following criteria:

- Enrolled for at least six months in each calendar year (CY) data period; and
- Did not have dual eligibility for both Medicaid and Medicare

The concurrent risk scores are calculated from the credible member experience. We use the national coefficients with prescription drug and mental health costs carved out in the CDPS risk score calculation, with the exception of an adjustment to the HIV/AIDS coefficient that was modified to represent Utah-specific cost coefficients. For non-credible members, the concurrent risk scores are based on the average concurrent risk scores by plan, rate cell and calendar year.

The CDPS risk score model classifies recipients by age category (adult/child) and by disability status (disabled/non-disabled). The CDPS risk scores for each age category and disability status are not necessarily centered on the same risk score level, so risk score relativities were developed to create a composite measure of relative risk among the DOH ACO plans.

The development of the risk score relativities are summarized in Exhibit 3.

LIMITATIONS AND STATEMENT OF QUALIFICATION

The attached efficiency analysis results are intended for the use by OLAG in support of its annual program audit. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this presentation to third parties. Similarly, third parties are instructed that they are to place no reliance upon this analysis prepared for OLAG by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. The terms of Milliman's contract with DOH signed on March 21, 2017 apply to this analysis and its use. Other parties receiving this report must rely upon their own experts in drawing conclusions about the data underlying the cost model. It is the responsibility of any insurance carrier to establish required revenue levels appropriate for their risk, management, and contractual obligations for the prospective population.

Results presented here represent best estimates of future experience. Actual experience will vary from our estimates for many reasons, potentially including differences in population health status, unit cost levels, delivery systems, random variation, or other factors. It is important that actual experience be monitored and adjustments made, as appropriate.

This analysis has relied extensively on data provided by DOH and the current ACOs participating in Medicaid. The data included claims and encounters for medical benefits. Milliman has reviewed this data for reasonableness, but has not performed an independent audit. Adjustments may be necessary if the data is inaccurate or incomplete.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries and meet the qualification standards for performing this analysis.

Exhibit 1
Office of the Legislative Auditor General
Department of Health Audit Request
Summary of Modeled Cost / (Savings)
Scenario: All Enrollment switching to each Individual Plan

		Demographics			Paid Claims		Cost Impact				
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Year	Plan	Member Months	Risk Score	Risk Relativity	Paid PMPM	Risk-Adj. PMPM	Unit Cost Impact PMPM	Util/Mix Impact PMPM	Total Impact PMPM	Total Cost Impact	% Impact
2016	**All**	**2,822,417**	**1.075**	**1.000**	**$192.07**	**$192.07**					
2016	Health Choice	206,106	1.011	0.924	193.53	209.49	$33.27	(15.88)	$17.40	$49,105,590	9.1%
2016	HealthyU	542,951	1.224	1.165	226.83	194.76	(9.34)	7.81	(1.54)	(4,337,508)	-0.8%
2016	Molina	929,776	0.993	0.929	168.41	181.35	(3.16)	(6.58)	(9.74)	(27,482,224)	-5.1%
2016	Select Health	1,143,584	1.081	0.987	194.54	197.04	2.65	4.07	6.72	18,975,839	3.5%
2015	**All**	**2,585,842**	**1.068**	**1.000**	**$182.13**	**$182.13**					
2015	Health Choice	136,213	0.963	0.898	175.94	195.89	$28.86	(21.09)	$7.77	$20,097,587	4.3%
2015	HealthyU	533,715	1.203	1.147	229.37	199.89	4.50	5.72	10.22	26,423,500	5.6%
2015	Molina	872,020	0.995	0.930	164.42	176.75	0.58	(3.42)	(2.84)	(7,334,817)	-1.6%
2015	Select Health	1,043,894	1.074	0.989	173.59	175.54	(6.48)	2.76	(3.72)	(9,613,198)	-2.0%
2014	**All**	**2,259,719**	**1.052**	**1.000**	**$177.71**	**$177.71**					
2014	Health Choice	50,596	1.022	0.946	197.19	208.48	$49.75	(25.28)	$24.47	$55,305,112	13.8%
2014	HealthyU	485,099	1.157	1.118	231.52	207.14	20.39	6.84	27.22	61,520,144	15.3%
2014	Molina	779,535	0.969	0.917	146.53	159.80	(2.36)	(13.62)	(15.98)	(36,112,208)	-9.0%
2014	Select Health	944,489	1.069	1.003	174.77	174.33	(12.23)	8.76	(3.47)	(7,839,865)	-2.0%

Notes:
(1) This analysis excludes Medicare members (Rate cells E & M) and those with an "Unknown" ACO provider or rate cell assignment.
(2) The medical-only concurrent risk scores were developed using the Chronic Illness Disability and Payment System (CDPS)
(3) See Exhibit 3 for development of the risk relativities
(4) Paid claim amounts exclude DCR costs, SNF claims, pharmacy claims, claims outside the study period and claims without records on the eligibility file.
(5) = (4) / (3)
(6) The unit cost efficiency indicator is based on the relativity between the plan-specific percent of Medicare and the average year-specific percent of Medicare.
(7) The utilization/mix efficiency indicator is based on the relative risk-adjusted Relative Value Units (RVUs) for each plan, compared to the average across all plans.
(8) = (6) + (7)
(9) = (8) x (All ACO Membership)
(10) = (8) / (All ACO Paid PMPM)

Exhibit 2
Office of the Legislative Auditor General
Department of Health Audit Request
Summary of Modeled Cost / (Savings)
Scenario: Individual Plan Enrollment switching to Benchmark Plan

			Demographics			Paid Claims		Cost Impact				
			(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Year	Benchmark	Plan	Member Months	Risk Score	Risk Relativity	Paid PMPM	Risk-Adj. PMPM	Unit Cost Impact PMPM	Util/Mix Impact PMPM	Total Impact PMPM	Total Cost Impact	% Impact
2016	**Molina**	**All Plans**	**2,822,417**	**1.075**	**1.000**	**$192.07**	**$192.07**	**($3.16)**	**($6.58)**	**($9.74)**	**($27,482,224)**	**-5.1%**
2016	Molina	Molina	929,776	0.993	0.929	168.41	181.35	-	-	-	-	-
2016	Molina	Select Health	1,143,584	1.081	0.987	194.54	197.04	(5.80)	(9.82)	(15.62)	(17,861,925)	-8.0%
2016	Molina	HealthyU	542,951	1.224	1.165	226.83	194.76	7.68	(16.85)	(9.17)	(4,977,548)	-4.0%
2016	Molina	Health Choice	206,106	1.011	0.924	193.53	209.49	(31.29)	6.68	(24.61)	(5,071,944)	-12.7%
2015	**Select Health**	**All Plans**	**2,585,842**	**1.068**	**1.000**	**$182.13**	**$182.13**	**($6.48)**	**$2.76**	**($3.72)**	**($9,613,198)**	**-2.0%**
2015	Select Health	Select Health	1,043,894	1.074	0.989	173.59	175.54	-	-	-	-	-
2015	Select Health	Molina	872,020	0.995	0.930	164.42	176.75	(6.36)	6.05	(0.31)	(266,980)	-0.2%
2015	Select Health	HealthyU	533,715	1.203	1.147	229.37	199.89	(13.50)	(2.47)	(15.97)	(8,521,094)	-7.0%
2015	Select Health	Health Choice	136,213	0.963	0.898	175.94	195.89	(29.47)	19.34	(10.14)	(1,380,920)	-5.8%
2014	**Molina**	**All Plans**	**2,259,719**	**1.052**	**1.000**	**$177.71**	**$177.71**	**($2.36)**	**($13.62)**	**($15.98)**	**($36,112,208)**	**-9.0%**
2014	Molina	Molina	779,535	0.969	0.917	146.53	159.80	-	-	-	-	-
2014	Molina	Select Health	944,489	1.069	1.003	174.77	174.33	10.43	(22.35)	(11.92)	(11,257,501)	-6.8%
2014	Molina	HealthyU	485,099	1.157	1.118	231.52	207.14	(26.58)	(21.52)	(48.10)	(23,333,130)	-20.8%
2014	Molina	Health Choice	50,596	1.022	0.946	197.19	208.48	(45.17)	6.33	(38.84)	(1,965,288)	-19.7%

Notes:
(1) This analysis excludes Medicare members (Rate cells E & M) and those with an "Unknown" ACO provider or rate cell assignment.
(2) The medical-only concurrent risk scores were developed using the Chronic Illness Disability and Payment System (CDPS)
(3) See Exhibit 3 for development of the risk relativities
(4) Paid claim amounts exclude DCR costs, SNF claims, pharmacy claims, claims outside the study period and claims without records on the eligibility file.
(5) = (4) / (3)
(6) The unit cost efficiency indicator is based on the relativity between the plan-specific percent of Medicare and the average year-specific percent of Medicare.
(7) The utilization/mix efficiency indicator is based on the relative risk-adjusted Relative Value Units (RVUs) for each plan, compared to the average across all plans.
(8) = (6) + (7)
(9) = (8) x (1)
(10) = (8) / (4)

Exhibit 3
Office of the Legislative Auditor General
Medicaid Audit Request
Risk Relativity Development

Year	Population	1: Member Months					2: Risk Scores				
		Health Choice	HealthyU	Molina	Select Health	Total	Health Choice	HealthyU	Molina	Select Health	Total
2014	Total	50,596	485,099	779,535	944,489	2,259,719	1.022	1.157	0.969	1.069	1.052
2015	Total	136,213	533,715	872,020	1,043,894	2,585,842	0.963	1.203	0.995	1.074	1.068
2016	Total	206,106	542,951	929,776	1,143,584	2,822,417	1.011	1.224	0.993	1.081	1.075
2014	Able Bodied Adults	10,164	67,959	117,065	137,948	333,136	1.145	1.476	1.322	1.362	1.364
2015	Able Bodied Adults	23,681	67,345	118,023	145,435	354,484	1.240	1.514	1.430	1.398	1.420
2016	Able Bodied Adults	33,950	66,509	122,726	164,482	387,667	1.290	1.594	1.431	1.385	1.427
2014	Able Bodied Children	34,662	326,003	573,518	662,981	1,597,164	0.954	0.975	0.878	0.965	0.935
2015	Able Bodied Children	96,937	363,527	646,353	738,365	1,845,182	0.856	1.023	0.891	0.967	0.946
2016	Able Bodied Children	148,155	370,759	686,293	807,281	2,012,488	0.923	1.034	0.885	0.981	0.954
2014	Disabled Adults/Children	5,770	91,137	88,952	143,560	329,419	1.212	1.571	1.091	1.269	1.304
2015	Disabled Adults/Children	15,595	102,843	107,644	160,094	386,176	1.207	1.637	1.145	1.272	1.331
2016	Disabled Adults/Children	24,001	105,683	120,757	171,821	422,262	1.161	1.657	1.162	1.261	1.326

Year	Population	3: Risk-Adjusted Paid PMPM					4: Risk Scores Relativity				
		Health Choice	HealthyU	Molina	Select Health	Total	Health Choice	HealthyU	Molina	Select Health	Total
2014	Total	$208.48	$207.14	$159.80	$174.33	$177.71	0.946	1.118	0.917	1.003	1.000
2015	Total	$195.89	$199.89	$176.75	$175.54	$182.13	0.898	1.147	0.930	0.989	1.000
2016	Total	$209.49	$194.76	$181.35	$197.04	$192.07	0.924	1.165	0.929	0.987	1.000
2014	Able Bodied Adults	$250.53	$264.06	$268.91	$242.08	$256.28	0.839	1.082	0.969	0.998	1.000
2015	Able Bodied Adults	$276.21	$288.50	$287.73	$264.41	$277.80	0.873	1.066	1.007	0.984	1.000
2016	Able Bodied Adults	$304.79	$316.90	$307.74	$301.28	$306.60	0.904	1.117	1.003	0.971	1.000
2014	Able Bodied Children	$127.41	$124.28	$100.21	$102.99	$107.12	1.020	1.043	0.938	1.031	1.000
2015	Able Bodied Children	$116.44	$104.22	$110.27	$100.43	$105.25	0.906	1.082	0.942	1.023	1.000
2016	Able Bodied Children	$131.20	$100.53	$114.21	$115.23	$113.11	0.968	1.084	0.928	1.028	1.000
2014	Disabled Adults/Children	$621.43	$461.11	$400.45	$438.71	$440.51	0.930	1.205	0.837	0.974	1.000
2015	Disabled Adults/Children	$567.83	$480.06	$454.22	$441.21	$461.70	0.907	1.230	0.860	0.955	1.000
2016	Disabled Adults/Children	$557.96	$448.45	$434.46	$481.62	$463.23	0.875	1.249	0.876	0.951	1.000

(1) The population is divided into broad categories as follows:
Able Bodied Children: Rate Cells A, C, K and L
Able Bodied Adults: Rate Cells B, D, P, Q and R
Disabled Children/Adults: Rate Cells F, G, H, I, and N
(2) The medical-only concurrent risk scores were developed using the Chronic Illness Disability and Payment System (CDPS).
(3) The paid PMPM for each ACO, year and population combination is normalized using the corresponding risk score from Box 2.
(4) The risk score relativity for each population, plan and year combination is calculated as the risk score from Box 2 normalized across all ACOs. The all-population risk relativity is the average of each population's relativity weighted by the member months and risk-adjusted PMPMs, shown in Boxes 1 and 3.

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Agency Response

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State of Utah

GARY R HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health
Executive Director's Office

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

Marc E. Babitz, M.D.
Deputy Director

Nate Checketts
Deputy Director
Director, Medicaid and Health Financing

February 21, 2018

Mr. John M. Schaff, CIA
Auditor General
State of Utah – Office of the Legislative Auditor General
W315 Utah State Capitol Complex
Salt Lake City, UT 84114-5315

RE: Report No. 2018-02

Dear Mr. Schaff:

Thank you for the opportunity to respond to the audit entitled, "An In-depth Budget Review of the Utah Department of Health." We appreciate the effort and professionalism of both you and your staff in this review.

We concur with the recommendations in this report. We will use the recommendations to further maximize the benefit of the Accountable Care Organization (ACO) model for Utah's Medicaid program and to improve coding and consistency in our budget. Our responses describe the actions we plan to take in response to the recommendations in the report. The Department is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need to be improved.

Sincerely,

Joseph K. Miner, MD

Joseph K. Miner, M.D.

Cc: Nate Checketts, Deputy Director, DOH
Marc Babitz, M.D., Deputy Director, DOH
Shari Watkins, Director, OFO, DOH

Chapter II, Recommendation 1

We recommend that the Department of Health, in conjunction with the Office of Inspector General, in addition to this current analysis in the future perform a similar Milliman type evaluation, as appropriate, and use that to benchmark plans to determine reasonable cost efficiency target for the ACOs.

UDOH Response: We concur with the recommendation. The Department will work with Milliman to conduct a similar analysis beginning with the contract period of January 1-December 31, 2019. The Department will use the results of the analysis obtained by OLAG to establish benchmarks as one indicator of the financial performance of the ACOs.

Contact: Julie Ewing, Director, Bureau of Managed Health Care, 801-538-9125
Implementation Date: December 1, 2018

Chapter II, Recommendation 2

We recommend that the Department of Health use the results of the efficiency evaluations to improve efficiency and maintain historical costs efficiencies once they are achieved.

UDOH Response: We concur with the recommendation. As discussed in the response to Recommendation 1, the Department will use the results of the analysis to establish benchmarks as one indicator of financial performance. Also, the Department will work with Milliman to determine the best way to incorporate identified efficiencies in the rate setting process.

Contact: Julie Ewing, Director, Bureau of Managed Health Care, 801-538-9125
Implementation Date: December 1, 2018

Chapter II, Recommendation 3

We recommend that the Department of Health use the results of the efficiency evaluations to determine how to best distribute the recipients who do not have a predetermined ACO to join.

UDOH Response: We concur with this recommendation. The Department will develop a plan to use the results of the efficiency evaluation in conjunction with information on ACO quality performance measures to develop a new plan for enrolling Medicaid members that are not assigned to a selected or predetermined plan. The plan will be implemented for the 2019 open enrollment.

Contact: Julie Ewing, Director, Bureau of Managed Health Care, 801-538-9125
Implementation Date: May 15, 2019

Chapter II, Recommendation 4

We recommend that the Department of Health set attainable efficiency targets that lead to a more cost-effective program that is achievable and sustainable. The Department of Health should evaluate if a competitive procurement will help them advance their goal.

UDOH Response: We concur with the recommendation. The Department will explore establishing efficiency and performance targets that would become part of the ACOs contractual responsibility to the Department. The Department will evaluate and make a recommendation as to whether or not a competitive procurement for ACOs would be beneficial. The Department will share that evaluation with the Governor's Office and if approved, with Legislative leadership with a request for further direction.

Contact: Julie Ewing, Director, Bureau of Managed Health Care, 801-538-9125
Implementation Date: January 1, 2019

Chapter II, Recommendation 5

We recommend that the Department of Health provide greater costs oversight of the ACOs

UDOH Response: We concur with the recommendation. Through the cost efficiency analysis addressed above as well as new provisions in federal regulation regarding Medicaid managed care contracts, the Department will provide greater oversight of the ACOs' costs.

Contact: Julie Ewing, Director, Bureau of Managed Health Care, 801-538-9125
Implementation Date: January 1, 2019

Chapter III, Recommendation 1

We recommend that Department of Health management improve budgeting activities by creating clear policies and procedures for coding provider payments and all other expenditures where alternate interpretations of spending activities can create inconsistencies in its coding.

UDOH Response: We concur with this recommendation. The Department will review its Chart of Accounts and provide guidance and training to Departmental financial staff to ensure transactions are consistently reported across the Department.

Contact: Shari Watkins, Financial and Operations Director, Utah Department of Health, 801-538-6601.

Chapter III, Recommendation 2

We recommend that the Department of Health management implement budget practices and procedures that will ensure its budget is reflective of actual expenditures and operations.

UDOH Response: We concur with this recommendation. The Department will evaluate the oversight, financial and accountability reporting of the Health Clinics and Family Dental Plan (Health Clinics). The Department will develop a plan to address the Legislative Auditor General's concerns with the Health Clinics' expenditure reporting by September 2018.

Contact: Shari Watkins, Financial and Operations Director, Utah Department of Health, 801-538-6601.