LFA
LEGISLATIVE FISCAL ANALYST

MEDICAID REVIEW

HEALTH AND HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE
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REPORT

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EXECUTIVE SUMMARY

This report addresses the following questions:

1. *What is Medicaid?*
2. *Where is Medicaid in Utah?*
3. *What does State Statute Say Concerning Medicaid?*
4. *How did we get here with Medicaid?*
5. *What are the Known Deficiencies in Utah Medicaid?*
6. *What are Some Ideas from Other States/Organizations?*

This report makes the following recommendations in four general areas:

Policy Changes:

1. Direct the Department of Health via statute to change their reimbursement methodology as soon as possible away from paying a percentage of billed charges for outpatient hospital and ambulatory center services reimbursements. The levels of reimbursement should be set at historical levels similar to what is being paid to other service providers.
2. Remove $5,818,000 ongoing General Fund and $14,404,000 federal funds from Medicaid services in FY 2012 to match potential savings found from improved fraud recoveries discussed in the Legislative Auditor General's "A Performance Audit Of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program." Additionally, appropriate $3,386,800 one-time General Fund in FY 2011 to provide for a phased-in implementation.
3. Change UCA 26-18-4.2 to allow for psychotropic or anti-psychotic drugs to be considered for the Preferred Drug List.
4. The "(Legislative Auditor General) recommend(s) that the Legislature consider the merits of extending access of the controlled substance database to (the Bureau of Program Integrity). If access is granted, (the Bureau of Program Integrity) should develop and institute controls to ensure providers are billing Medicaid correctly and that prescriptions are appropriate in regards to frequency and dosage (2009 Medicaid audit, page 40)."
5. In statute change the fee-for-service payment system to be the same for services regardless of who the provider is. Explore paying the lowest price for a service to all providers. If pricing cannot be fixed, then explore requiring a client to use an ambulatory surgical center for approved services before using a hospital unless prior authorization is approved.
6. Change statute to remove the requirement to have CHIP providers have two hospital networks. Instead, focus requirements on sufficient access and coverage.
7. Allow immunosuppressive drugs, used to prevent organ rejection, to be placed on the Preferred Drug List Program.
8. Require the Department of Health via intent language to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee its plans for a Medicaid Management Information System replacement. The presentation should include the full array of options for which parts of claims processing are performed by State vs contracted workers. Consider funding a portion of this request beginning in FY 2011 in a separate line item.

9. Require the Department of Health via intent language to report to the Executive Appropriations Committee the responses to the request for proposals for the Medicaid Management Information System replacement.
10. Consider providing more access points to clients applying for Medicaid eligibility (allow local health departments and non-profit groups who work with low income individuals to help complete applications for their clients for Medicaid).
11. Consider a statutory change requiring all unused funds that are associated with the Medicaid program in the Department of Workforce Services and the Department of Human Services to be deposited into the Medicaid General Fund Restricted Account at year end.
12. Study the return on investment for resources provided to the Attorney General's Medicaid Fraud Control Unit. Study the feasibility of increased recoveries if the unit is provided with more resources.
13. Require internal Health auditors to do audits at least in proportion to their Medicaid funding, which is currently about one-third.

New Reporting Requirements

1. Change statute to require the Department of Health to report annually to the Health and Human Services Appropriation Subcommittee on how they are meeting their statutory mandates to be more efficient and effective.
2. The "(Legislative Auditor General) recommend(s) that (the Bureau of Program Integrity) report annually to the Legislature and Governor on their cost avoidance and cost recovery efforts (2009 Medicaid audit, page 56)." This could be accomplished via intent language.
3. Change statute to require the Departments of Health, Human Services, and Workforce Services to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee before reapplication of Medicaid waivers. The report should include an analysis of costs and benefits as well as recommendations on whether or not to expand enrollment and/or end the waiver.
4. Require a report annually via intent language from the Department of Health on the implementation of "A Performance Audit Of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program" to be presented to the Health and Human Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.
5. Require a report annually via intent language from the Department of Health on the implementation of "A Performance Audit of Utah Medicaid Managed Care" to be presented to the Health and Human Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.
6. Require a report annually via intent language from the Department of Workforce Services on the implementation of "A Performance Audit of DWS Eligibility Determination Services" to be presented to the Commerce and Workforce Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.
7. Require a report via intent language from the Department of Workforce and the Department of Health on how they have addressed the problems found by the Utah State Auditor. After reviewing the results

of the FY 2009 audit, the Legislature may want to consider requesting the auditors to check the status of this problem more frequently than the current annual basis.

8. Beginning December 1, 2010, require a combined, unified annual report from the Departments of Health, Workforce Services and Human Services to the Executive Appropriations Committee or Health and Human Services Appropriations Subcommittee that shows how all Medicaid appropriations are being spent for administration and services in the prior fiscal year. For December 1, 2011, expand the coordinated reporting requirement to include non-State entities providing services via contracts. This report will help enable coordination of funding and policy decisions.
9. Require the Department of Health to gather reports from local health departments. The reports should include at a minimum: (1) explain why local health departments are not using all of the State match provided and their county match for the Early Periodic Screening, Diagnosis and Treatment Program for Utah Medicaid and (2) where the unmatched grant money has been used.
10. Require a report via intent language from the Departments of Health, Human Services, and Workforce Services on how they will increase public awareness of their fraud reporting systems and encourage the public to report Medicaid fraud.
11. Direct the Department of Health and Public Health Employee's Program (PEHP) via intent language to provide a report to the Legislature on ideas learned by PEHP that could be applied in Medicaid and a time frame for carrying out those proposals.

Areas for Additional Research in Coming Sessions (listed in order of priority for how helpful the information may be):

1. Direct the Department of Health via intent language to report by October 1, 2010 on reimbursement options for pharmaceutical drugs that would give the State more control over inflationary increases and/or move away from a reimbursement based on Average Wholesale Price.
2. Convene a meeting of all provider groups to recommend which level of government and which type of providers should administer which portions of Medicaid. Additionally, make a list of recommended changes to the Medicaid program to present to the federal government.
3. Revisit the role and efficiency of the Office of Recovery Services in the Department of Human Services. Direct the Departments of Health, Human Services, and Workforce Services via intent language to develop a list of options for expansions in the areas of collections (such as requiring insurers to share benefit information for all medical assistance recipients to increase collections and cost avoidance).
4. Review Medicaid statute for clarification in assigned responsibilities, desired policy direction, and agency interactions. Consider raising all the statutes relating to Medicaid from chapter level in statute to a separate title and consolidate all related statute beneath that title.
5. Further study consolidating and/or better coordinating the Medicaid program for the agencies involved (Health, Workforce Services, and Human Services).
6. Explore contracting for direct Medicaid providers for primary care services. Direct the Department of Health to issue a Request for Information for direct contracting for primary care services and report on results to the Health and Human Services Appropriations Subcommittee by February 1, 2011.
7. Explore moving away from fee-for-service payments to pay for quality.
8. Direct the Department of Health to study the feasibility of a three-year pilot project with medical homes within their existing budget. During the third year of the pilot, the Department of Health shall report to the Legislature with recommendations for expansion or termination of the pilot project. Direct the

Department of Health via intent language to study the five recommendations from the Henry J. Kaiser Foundation September 2009 report on Medicare and give options for implementation in the Medicaid program in a report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee by February 1, 2011.

Administrative Budget Structure Changes:

1. Direct the Department of Health via intent language to report incomes sources in Medicaid to the Legislature annually by major income type. Additionally, direct the Department of Health to work with the Division of Finance to identify a tracking method for all revenues to the Medicaid program that will also reflect expenditures in the expenditure reports provided to the Legislature wherever feasible.
2. Direct the Department of Health to work with the Division of Finance to identify a way to clearly track total administrative seed revenues annually beginning with the FY 2011 budget.
3. Add two budget programs in Health Care Financing entitled "DWS Seeded Services" and "Other Seeded Services" detailing the seeded money the Department of Health gives for Medicaid to DWS and other entities.
4. Identify a budgeting method to remove the double counting in Medicaid due to transfers between the Department of Health and other State agencies (situation not unique to Medicaid).
5. Add a budget program in the Medicaid budget entitled "Medicaid Non-service Expenses" and move costs from non-service categories to this budget program.
6. Make mental health inpatient hospital a separate program within the Medicaid Optional Services line item. This may help highlight the difference between optional and mandatory and contrast with the capitated mental health costs that we are paying.
7. Make Crossover Services, Hospice Care Services, and Medical Supplies their own budget program within the Medicaid service line items (Medicaid Mandatory Services and Medicaid Optional Services).
8. Move primary care grants statute UCA 26-18 Part 3 out of the Medicaid chapter of statute.
9. Add another budget program to break out the detail for services through Select Access (not managed care) and the 2 managed care networks.
10. Move the Bureau of Program Integrity through appropriations from part of Medicaid administration (Health Care Financing) to a budget program within the Executive Director's Office line item.

WHAT IS MEDICAID?

Medicaid is a joint federal/state entitlement service that provides health care to selected low-income populations. Overall, Medicaid is an "optional" program, one that a state can elect to offer. However, if a state offers the program, it must abide by strict federal regulations. It also becomes an entitlement program for qualified individuals; that is, anyone who meets specific eligibility criteria is "entitled" to Medicaid services. The federal government establishes and monitors certain requirements concerning funding, and establishes standards for quality and scope of medical services. Requirements include services that must be provided and specific populations that must be served. States may expand their program to cover additional "optional" services and/or "optional" populations. In addition, states have some flexibility in determining certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits, and service delivery. As long as services meet State and federal standards, the federal government will provide a match for all State money spent on Medicaid. The match is known as the Federal Matching Assistance Percentage (FMAP). The entire Medicaid program is based upon an approved contract with the federal government, known as a State Plan. While this plan can be changed and/or amended the federal government must approve all changes. If the State were to provide a service without federal approval, the cost would be 100% paid for by the State rather than the usual 70% federal match.

For more information on Medicaid please see "*Understanding Medicaid; A Policymaker's Introduction*" Available at http://www.le.state.ut.us/lrgc/briefingpapers/understandingmedicaid2005.pdf. Additionally, please see the FY 2010 Compendium of Budget Information at http://le.utah.gov/lfa/reports/cobi2010/COBI2010.htm.

Financial Overview

Medicaid requires a State match for the majority of Medicaid dollars spent. In Utah the State provided 82% or $354,775,200 of all the State match required in FY 2009. The other 18% or $76,433,700 State match provided by other entities is detailed in Table 9. Of the $76 million provided by these other entities, over $25 million originally came from the State.

Medicaid in Utah state government totals $1,719,251,600 in the FY 2010 initial appropriation. This is 15 percent of the total FY 2010 appropriated state budget. A distribution of funds from the Department of Health's perspective is shown below in Figure 1. Additionally, a distribution of expenditures from the Department of Health's perspective is shown below in Figure 2.

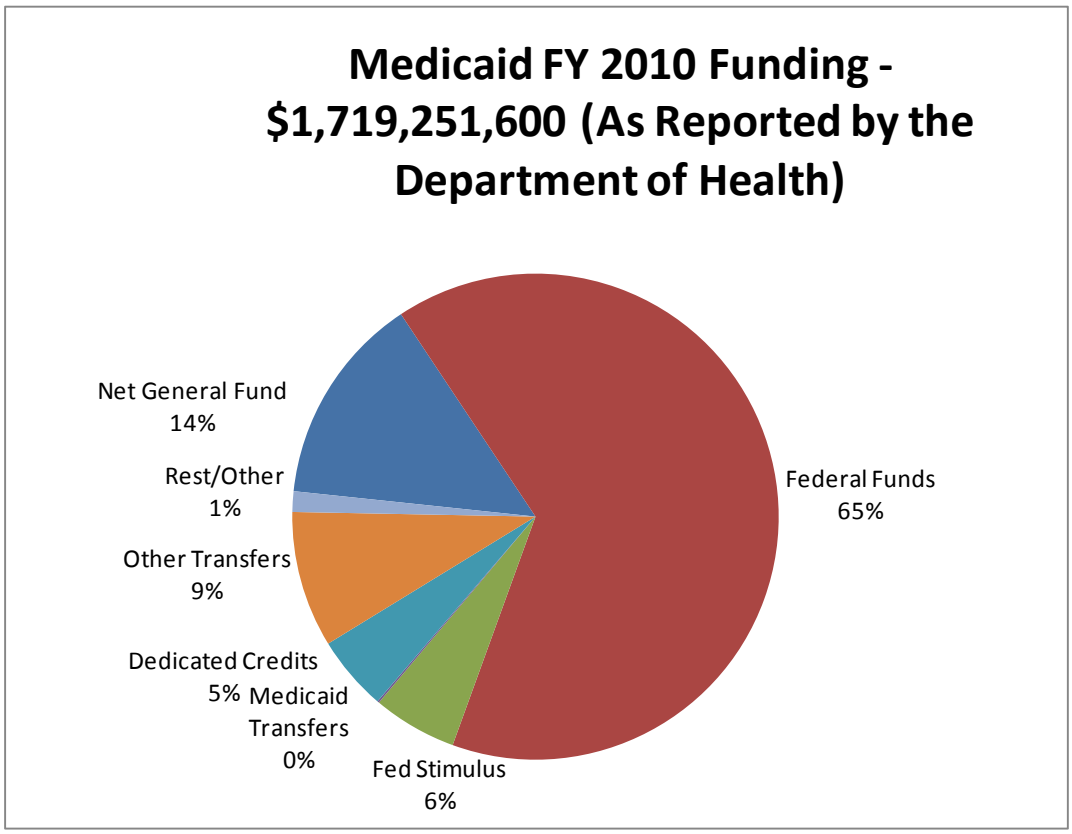

Figure 1

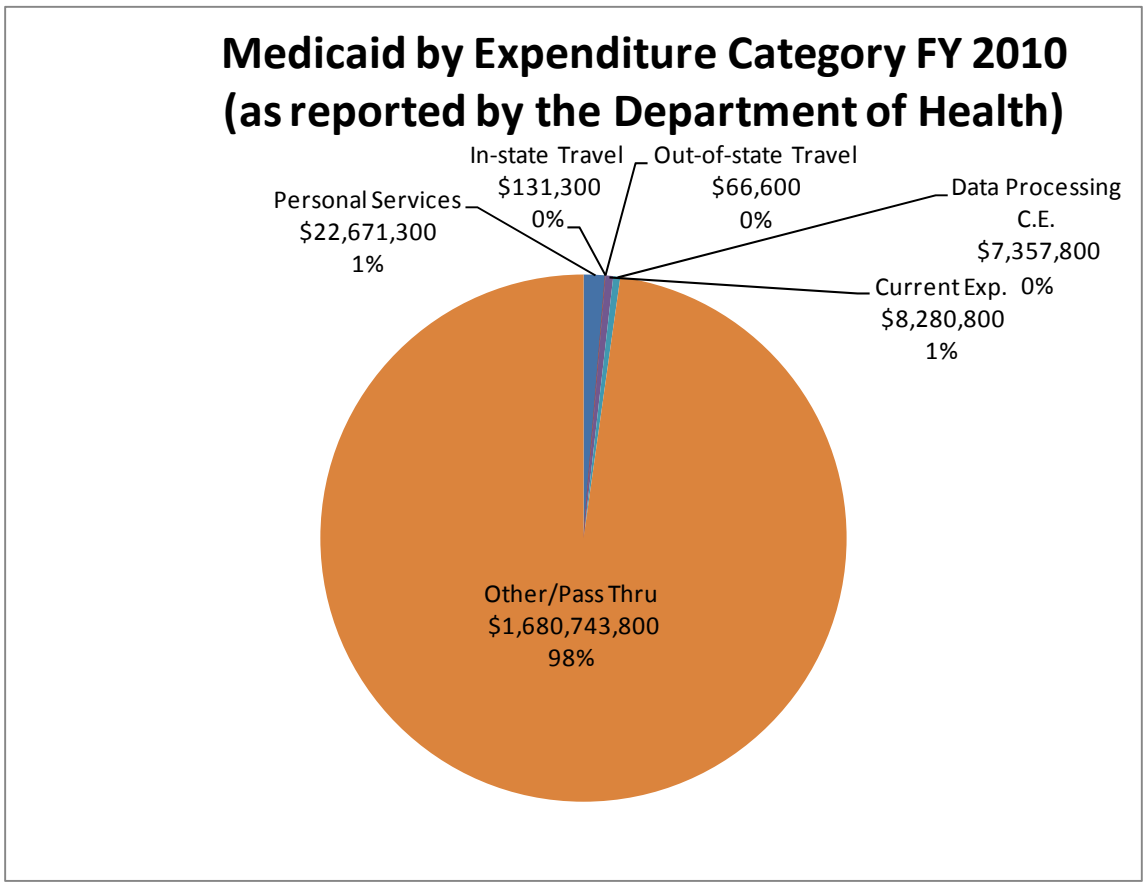

Figure 2

Figure 3 below shows total Medicaid funding from FY 2003 through FY 2009 as compared to client caseloads.

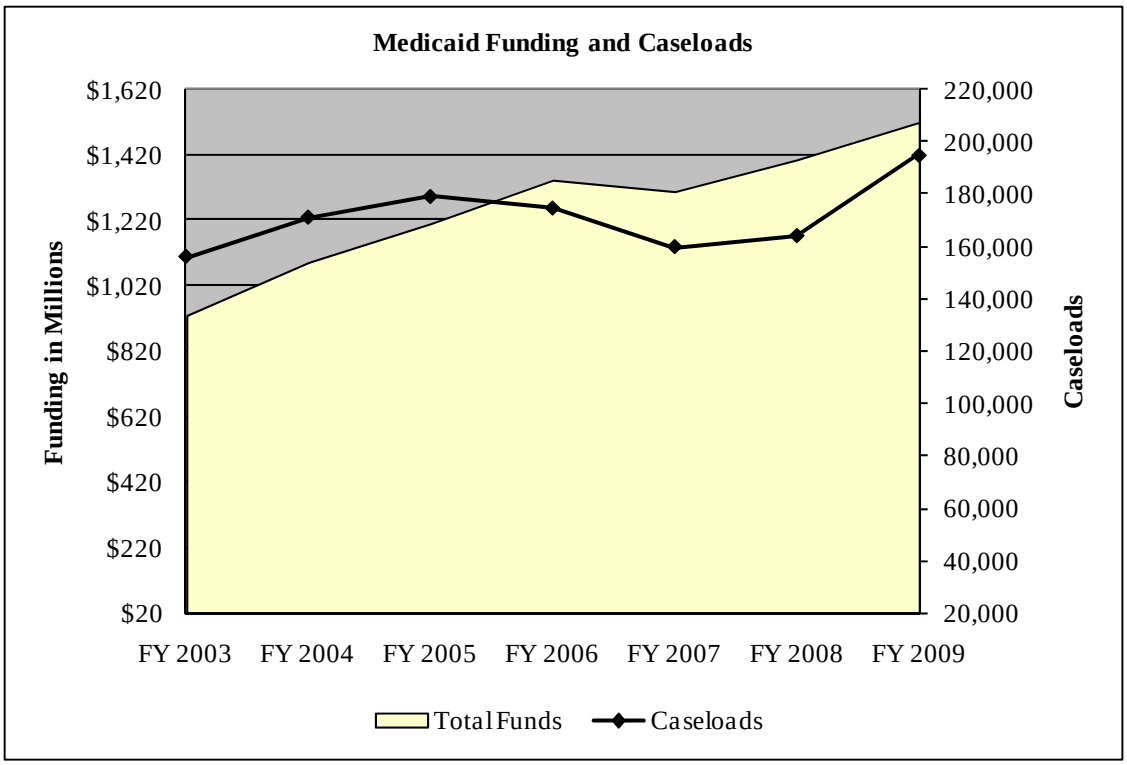

Figure 3

Figure 4 below from page 86 of the Governor's Budget Recommendations for FY 2011 (http://governor.utah.gov/budget/Budget/Budget%20Recommendations/FY2011_RecBk.pdf) sums up the growth of Medicaid from FY 1999 to FY 2011:

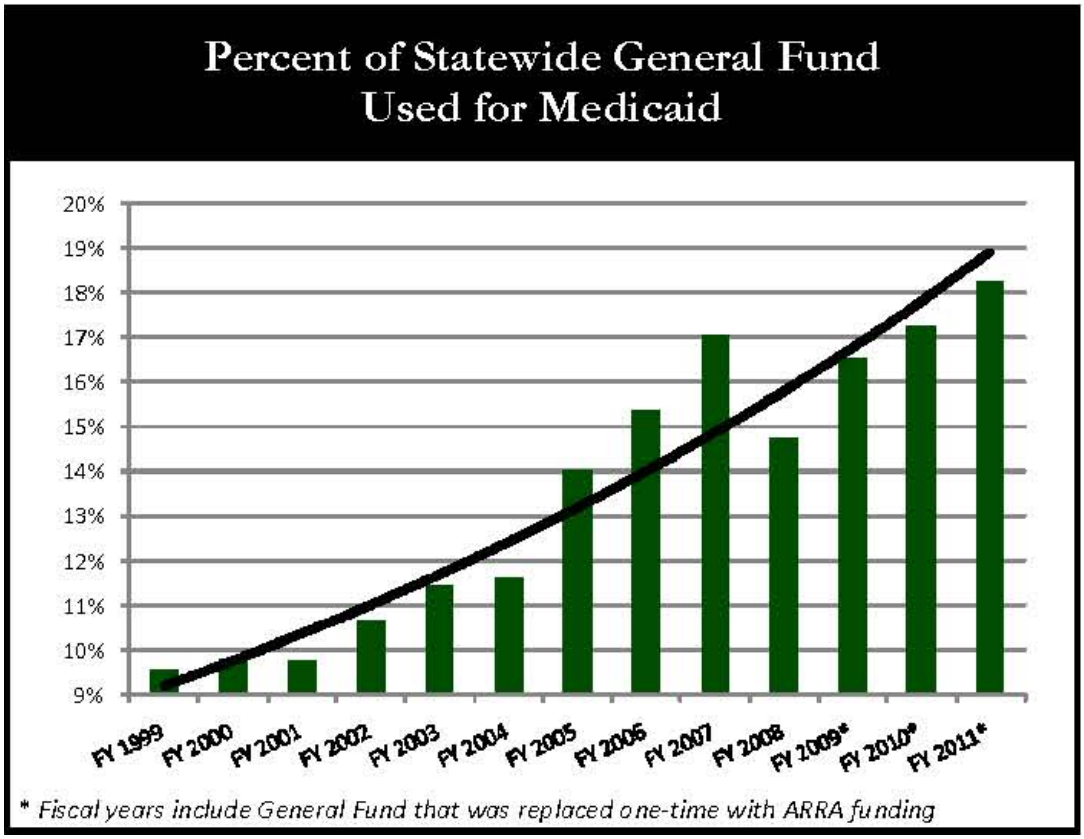

Figure 4

The difficulty in getting a complete picture of what is happening in Medicaid can be seen by looking at Figure 1 and 2 above. This perspective does not reflect the $75 million spent by other State agencies on Medicaid administration as shown in Table 4.

RECOMMENDATION: Beginning December 1, 2010, require a combined, unified annual report from the Departments of Health, Workforce Services and Human Services to the Executive Appropriations Committee or Health and Human Services Appropriations Subcommittee that shows how all Medicaid appropriations are being spent for administration and services in the prior fiscal year. For December 1, 2011, expand the coordinated reporting requirement to include non-State entities providing services via contracts. This report will help enable coordination of funding and policy decisions.

Income Sources

Medicaid also tracks income to the program. In FY 2009, there were 2 main sources of income to the program:

1. Office of Recovery Services – the Department of Human Services is responsible to track money payable to the State or other insurers who should pay some of Medicaid's costs for their clients. This also includes all recoveries from the Attorney General's Medicaid Fraud Control Unit. These sources brought in $29,266,200 in FY 2009, which represents 1.6% of all FY 2009 Medicaid expenditures.

2. Spenddown Money – clients who have too much income to qualify for Medicaid can spend down their income if they have qualifying medical expenses that bring their net income to Medicaid levels. Individuals contributed $1,339,400 to qualify for Medicaid. This amount represents those that chose to give their excess income to the State in order to qualify; other individuals chose to directly pay for their initial medical expenses until they qualified for State help.

These income sources are used to offset expenditures. Currently, the $31 million mentioned above is not clearly identified in the current reporting system to the Legislature. This $31 million represents 2% of all expenditures.

RECOMMENDATION: Direct the Department of Health via intent language to report incomes sources in Medicaid to the Legislature annually by major income type. Additionally, direct the Department of Health to work with the Division of Finance to identify a tracking method for all revenues to the Medicaid program that will also reflect expenditures in the expenditure reports provided to the Legislature wherever feasible.

Mental Health

In April of 1990, under a federal waiver, the Utah State Division of Health Care Financing established its Prepaid Mental Health Plan (PMHP). It initially asked for potential bidders to provide mental health services for Medicaid beneficiaries on a capitated basis. This capitated basis pays providers a per member per month fee to cover all of their clients' service needs. In order to be eligible, a bidder needed to be able to provide the full range of mental health services covered by Medicaid. The state originally entered into contracts with three of the state's eleven community mental health centers representing capitated coverage to nearly 52 percent of the state's Medicaid-eligible population at that time. The PMHP now covers 27 of Utah's 29 counties. Participating community mental health centers provide mental health services to Medicaid beneficiaries in their respective

areas of the state in return for capitated Medicaid payments. The use of a capitated payment system, because it provides for the assignment of responsibility for the financing and delivery of services to individual entities, was seen as having the potential to reduce costs associated with more expensive inpatient hospital services as well as increase the use of less costly community alternatives in the hope of reducing Medicaid costs overall. These costs are currently tracked in a budget program entitled "Capitated Mental Health Services" within the "Medicaid Optional Services" budget line item. The Legislature may find it helpful to track the often more costly (by individual) other mental health option, mental health inpatient hospital, which in FY 2009 cost the Medicaid program a total of $24,831,00.

RECOMMENDATION: Make mental health inpatient hospital a separate program within the Medicaid Optional Services line item. This may help highlight the difference between optional and mandatory and contrast with the capitated mental health costs that Utah currently is paying.

Top 10 Expenditure Categories

The Department of Health reports all Medicaid spending in 72 categories. The top 5 categories represent 44% of all FY 2009 Medicaid services spending with the top 10 categories representing 66%. The two Health Maintenance Organization (HMO) categories provide the full array of services and some of that funding otherwise would appear in the other categories if the HMOs were not providing its service. The top 10 categories and their FY 2009 expenditures are listed in Table 1 below:

Medicaid Category of Services	FY 2009 Expenditures
Inpatient Hospital - General	$234,741,000
Community Supports Waiver	$155,542,200
HMO Molina Health Care	$128,633,200
Pharmacy Services	$126,840,100
Outpatient Hospital Services	$108,703,900
HMO U of U Healthy Utah Health Care	$89,754,800
Mental Health Capitated Services	$88,073,700
Physician Services	$80,359,500
Nursing Facility 2 (ICF-1)	$61,732,000
Nursing Facility 3 (ICF-2)	$61,704,900
Subtotal	**$1,136,085,300**
Percent of Total Services	**66%**
Total Medicaid Services	**$1,723,257,800**

Table 1

Expenditure Categories Over $10 Million

Additionally, there are several other expenditure categories in Medicaid representing over $10 million total funds that are not a part of a smaller budget program. This is detailed in Table 2 below:

Medicaid Category of Services	FY 2009 Expenditures	Current Budget Program	% of Total Expenditures
Inpatient Hospital - General	$234,741,000	Inpatient Hospital	13%
Community Supports Waiver	$155,542,200	Home and Community Based Waiver Services	9%
HMO Molina Health Care	$128,633,200	Contracted Health Plans	7%
Pharmacy Services	$126,840,100	Pharmacy	7%
Outpatient Hospital Services	$108,703,900	Outpatient Hospital	6%
HMO U of U Healthy Utah Health Care	$89,754,800	Contracted Health Plans	5%
Mental Health Capitated Services	$88,073,700	Capitated Mental Health Services	5%
Physician Services	$80,359,500	Physician Services	5%
Nursing Facility 3	$61,732,000	Nursing Home	3%
Nursing Facility 2	$61,704,900	Nursing Home	3%
DHS Enhancement Services	$55,146,300	Human Services	3%
Utah State Developmental Center	$40,515,700	Human Services	2%
Inpatient Disproportionate Share Hospital	$39,754,500	None	2%
Medicare Insurance Buy-In Program	$38,954,000	Buy-in/Buy-out	2%
Dental / Orthodontic Services	$34,283,400	Dental Services	2%
Inpatient Graduate Medical Education	$26,594,900	None	2%
Community Intermediate Care Facilities for the Mentally Retarded	$25,324,300	Intermediate Care Facilities for the Mentally Retarded	1%
Mental Health Inpatient Hospital	$24,841,300	Human Services	1%
Pharmacy Medicare Part D Clawback Buy-In Program	$24,111,100	None	1%
Physician / Dental Enhanced Services	$21,724,700	Physician Services	1%
New Choices Waiver	$19,327,900	Home and Community Based Waiver Services	1%
Crossover Services	$18,950,800	None	1%
School Districts Skills Development	$18,611,900	None	1%
DHS Utah State Hospital	$16,897,100	Human Services	1%
Inpatient Indirect Medical Education	$16,698,200	None	1%
Hospice Care Services	$13,298,000	None	1%
Home Health Services	$13,223,300	Contracted Health Plans	1%
Medical Supplies	$11,674,800	None	1%
Nursing Facility 1	$10,800,900	Nursing Home	1%
Substance Abuse Services	$10,002,600	Home and Community Based Waiver Services	1%
Subtotal	**$1,626,350,300**		**94%**

Table 2

RECOMMENDATION: Make Crossover Services, Hospice Care Services, and Medical Supplies their own budget program within the Medicaid service line items (Medicaid Mandatory Services and Medicaid Optional Services).

Non-service Expenditures Mixed in With Services Funding

The Medicaid services budget has two line items, Medicaid mandatory services and Medicaid optional services. Of the total in these two line items, 7% is not services. These non-services items are listed and discussed below along with their FY 2009 total expenditures:

1. Inpatient Disproportionate Share Hospital ($39,754,500) – these funds are used to pay hospitals that serve a disproportionate share of uninsured patients. The funds are intended to offset some of the hospitals costs in serving these clients.

2. Inpatient Graduate Medical Education ($26,594,900) – these funds help offset some of the costs of residency programs that serve Medicaid clients. The University of Utah received 74% of the available funding in FY 2009.

3. Clawback Payment ($24,111,100) – this item was discussed above and is the federally-required payments to the Medicare program that began in 2006. Medicare began serving the pharmacy needs of Medicare clients that were also eligible for Medicaid in 2006.

4. Inpatient Indirect Medical Education ($16,698,200) – these funds help offset some of the costs of residency programs that serve Medicaid clients. The University of Utah received 100% of the available funding in FY 2009.

5. Inpatient Hospital Graduate Medical Education Non-Seeded Services ($6,319,200) - these funds help offset some of the costs of residency programs that serve Medicaid clients. The University of Utah received 74% of the available funding in FY 2009.

The Legislature may be interested in tracking Medicaid service expenditures vs non-service expenditures. By adding another budget program in the Medicaid program, these non-service costs could be tracked more readily. This type of information may help to show where the changes in the cost of Medicaid are taking place.

RECOMMENDATION: Add a budget program in the Medicaid budget entitled “Medicaid Non-service Expenses” and move costs from non-service categories to this budget program.

Contracted Health Plans

Currently the Medicaid budget has a program called “Contracted Health Plans” under the Medicaid Mandatory Services line item. This budget includes the expenditures for three different plans, each of which are discussed below:

1. Molina - as of September 1, 2009 Molina has a fully risk-based contract. Molina receives a per member per month payment for each Medicaid client in their program and assumes the risk of paying for all of the incurred costs.

2. Select Access - Medicaid processes claims for Select Access members and pays Select Access’ providers based on Medicaid’s fee schedule. Medicaid also pays Select Access a service network fee per member per month.

3. Healthy U - Medicaid pays Healthy U the amount they pay their providers and an administrative fee for each claim. Healthy U processes and pays the claims for their providers.

RECOMMENDATION: Add another budget program to break out the detail for services through Select Access (not managed care) and the 2 managed care networks.

WHERE IS MEDICAID IN UTAH?

All Medicaid money is administered by the Department of Health. As per federal requirements, all funding for Medicaid must flow through the Department of Health and be governed by a memorandum of understanding for all functions performed by other entities whether State, non-profit, for profit, local government, etc. About 83% of the medical services are provided by any willing provider who bills Medicaid directly. The other 17% of medical services are provided through two contracted health plans who handle the billing and case management services of their clients.

For all Medicaid services in State government in FY 2009, the Department of Health directly administered 73% of the total. The second largest player in Medicaid is the Department of Human Services which provides services to its qualifying aged, disabled, and foster care clients and represents 15% of total spending in the State. Other providers, who provide matching money to receive federal funds, make up the other 12% of Medicaid services.

Mandatory vs Optional, Range of Services Covered

Mandatory services in the Medicaid Program are those that the federal government requires to be offered if a state has a Medicaid program. These include: inpatient and outpatient hospital, physician, skilled and intermediate care nursing facilities, medical transportation, home health, nurse midwife, pregnancy-related services, lab and radiology, kidney dialysis, Early Periodic Screening Diagnosis and Treatment, and community and rural health centers. The State is also required to pay Medicare premiums and co-insurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the Federal Poverty Level.

There are currently 53 services included in the entire Medicaid Program. Of these, inpatient hospital, outpatient hospital, intermediate care facilities for the mentally retarded, long-term care, physician, dental, pharmacy, and health maintenance organizations make up approximately 60 percent of all Medicaid expenditures. The line dividing mandatory and optional services is occasionally blurred by the fact that some optional services are mandatory for specific populations or in specific settings. For example, the federal government requires more services be provided to children and pregnant women. Additionally, clients in institutionalized settings must be provided a wider range of services.

Determining Eligibility and Administration

The Department of Workforce Services determines the eligibility for nearly all clients to receive Medicaid services. The Department of Human Services contracts with the Department of Health to perform Medicaid eligibility functions for most children in foster care and for children receiving adoption assistance. The Department of Human Services determines Medicaid eligibility for children in the custody of other states, but residing in Utah. Additionally, the Department of Human Services maintains Medicaid eligibility for children in the custody of Utah, but living in other states where they do not qualify for Medicaid. Counties are the contracted Medicaid providers statewide of substance abuse and mental health services. The University of Utah

receives Medicaid funding for its graduate medical education program of physicians. All of the State's 12 local health departments receive some Medicaid funding as the State's contracted Early Periodic Screening, Diagnosis, and Treatment Program provider for providing outreach to clients regarding their benefits. This is a required program and another provider and/or delivery system would be needed if the local health departments were not used. Twenty-eight out of forty school districts also voluntarily participate in the Medicaid program. Additionally the federal Indian Health Services receives some funding from Utah Medicaid. Table 3 below lists the different provider groups and what percentage of Medicaid service dollars they received during FY 2009:

FY 2009 Utah Medicaid Services	
Provider	**% Total**
Medical Providers	60%
Department of Human Services	15%
2 Contracted Health Plans	13%
County Providers*	7%
University of Utah Medical School*	3%
28 School Districts*	1%
12 Local Health Departments	1%
Indian Health Services (federal)	0.4%
Total	100%
*Provide some matching funds to participate in Medicaid.	

Table 3

The distribution of administrative expenditures in FY 2009 for Medicaid is listed in Table 4 below:

FY 2009 Utah Medicaid - State Administration		
Recipient	**Total Funds**	**% Total**
Department of Workforce Services	$ 58,499,100	48%
Department of Health	$ 46,546,700	38%
Department of Human Services	$ 16,786,100	14%
Total Administration	**$ 121,831,900**	
Administration as % of Total	7%	
Total Medicaid	**$ 1,845,089,700**	

Table 4

In FY 2009, 7% of every dollar in the Medicaid program went to State administration.

As noted in the tables above, there are a variety of different groups providing services to Medicaid clients. In some cases multiple different providers are serving the same Medicaid client. There may be some potential for improving efficiency by gathering the different providers and deciding as a whole which providers should serve which portions of Medicaid.

RECOMMENDATION: Convene a meeting of all provider groups to recommend which level of government and which type of providers should administer which portions of Medicaid. Additionally, make a list of recommended changes to the Medicaid program to present to the federal government.

As mentioned above, currently the vast majority of all Medicaid applications are screened for eligibility by the Department of Workforce Services. The Department has been developing capabilities to accept more and more parts of an application online. By having an online system, this opens the possibility for more organizations to help collect the needed Medicaid application information for clients. For example, Utah's 12 local health departments determine eligibility based on income for the Woman, Infants, and Children (WIC) Program that serves families with children up to age 6 up to 185% of the Federal Poverty Level. Many WIC clients are potential Medicaid clients and interact with local health departments. Local health departments and other organizations serving low-income populations could be allowed to help their clients apply for Medicaid. The federal requirement is that the final eligibility determination be done by a state worker, but all the paper work could be prepared and submitted from these agencies. Additionally, clients would need to sign a waiver to allow these organizations to see and help process their personal eligibility information.

HB 188 "Health System Reform - Insurance Market" from the 2009 General Session required a link to be added to government medical programs to the online health portal for applying for health insurance. This task was assigned to the Departments of Health, Workforce Services, and Insurance.

RECOMMENDATION: Consider providing more access points to clients applying for Medicaid eligibility (allow local health departments and non-profit groups who work with low income individuals to help complete applications for their clients for Medicaid).

Medicaid Overseen in Three Legislative Subcommittees

The Legislature oversees Medicaid in three appropriation subcommittees. Below is a list of each subcommittee and what percentage of the Medicaid budget it oversees:

1. Health and Human Services Appropriations Subcommittee oversees $1,772,471,400 or 96% of all Medicaid funding. Nearly all Medicaid services and administration are funded under the supervision of this subcommittee.

2. Commerce and Workforce Services Appropriations Subcommittee oversees $58,499,100 or 3% of all Medicaid funding. The function overseen is the Medicaid eligibility determination performed by the Department of Workforce Services.

3. Executive Offices and Criminal Justice Appropriations Subcommittee oversees $14,119,200 or 1% of all Medicaid funding. The function overseen is youth in residential care under the supervision of the Division of Juvenile Justice Services.

Because pieces of Medicaid are reviewed in three different legislative appropriation subcommittees, this creates some challenges to coordination of policy direction. The following are some suggestions on how improved coordination could take place as well as a brief pro and con analysis of each option:

1. **Hear all Medicaid-related portions of an agency in one subcommittee**

    a. Pro – this may help to facilitate a more coordinated policy approach across all parts of Medicaid.

b. Con – due to the size of the Medicaid program, this may be difficult for one subcommittee to handle under the current distribution of agencies by subcommittee.

2. **Consolidate all Medicaid functions into one agency**

   a. Pro – by having all of Medicaid in one agency, this may improve program and service coordination.

   b. Con – due to the size of the Medicaid program ($1.8 billion in FY 2009) this may mean that some parts of Medicaid receive less attention and supervision.

3. **Have all agencies and other non-State entities participating in Medicaid compile a unified, comprehensive report**

   a. Pro – by seeing all of the parts of Medicaid in one report, this may help facilitate a more coordinated policy approach across all parts of Medicaid.

   b. Con – this would require staff time to complete and depending on the clarity and level of interest in the report, this may not help guide policy decisions.

Seed Money

The Department of Health allows entities that want to participate in the Medicaid program to provide the needed match or "seed" money to receive federal funds. In the case of counties, they use their appropriations from the State, together with county match to participate in the Medicaid program. The counties use the money to help fulfill their statutory obligations for mental health and substance abuse services. Below are five tables that show who provided seed money to the Department of Health to participate in the Medicaid program in FY 2009 by service provided:

Mental Health - County(s) or Contracted Providers								
Provider Group	Money Seeded for Services	Money Seeded for Admin Fee (est.)	% Admin Charged	Total Seeded	State Pass-thru Provided	20% County Match	Total Match & Pass-thru	Match & Pass-thru Over/(Under) Seeding
BEAR RIVER	$ 1,403,300	$ 65,000	4.6%	$ 1,468,300	$ 1,490,400	$ 298,100	$ 1,788,500	$ 320,200
CENTRAL UTAH	$ 1,006,200	$ 49,600	4.9%	$ 1,055,800	$ 949,900	$ 190,000	$ 1,139,900	$ 84,100
DAVIS COUNTY	$ 2,302,300	$ 92,900	4.0%	$ 2,395,200	$ 2,643,600	$ 528,700	$ 3,172,300	$ 777,100
FOUR CORNERS	$ 819,500	$ 43,700	5.3%	$ 863,200	$ 502,600	$ 100,500	$ 603,100	$ (260,100)
SALT LAKE COUNTY	$ 12,873,500	$ 488,100	3.8%	$ 13,361,600	$ 9,099,000	$ 1,819,800	$ 10,918,800	$ (2,442,800)
SAN JUAN COUNTY	$ 111,600	$ 11,600	10.4%	$ 123,200	$ 182,700	$ 36,500	$ 219,200	$ 96,000
SOUTHWEST	$ 1,778,000	$ 77,600	4.4%	$ 1,855,600	$ 1,991,700	$ 398,300	$ 2,390,000	$ 534,400
NORTHEASTERN/UINTAH BASIN	$ 642,400	$ 37,000	5.8%	$ 679,400	$ 547,900	$ 109,600	$ 657,500	$ (21,900)
WASATCH (UTAH COUNTY)	$ 4,589,400	$ 180,400	3.9%	$ 4,769,800	$ 4,478,000	$ 895,600	$ 5,373,600	$ 603,800
WEBER COUNTY	$ 2,625,400	$ 106,800	4.1%	$ 2,732,200	$ 2,084,600	$ 416,900	$ 2,501,500	$ (230,700)
TOOELE COUNTY	$ 681,400	$ 40,200	5.9%	$ 721,600	$ 514,100	$ 102,800	$ 616,900	$ (104,700)
SUMMIT COUNTY	$ 108,900	$ 12,200	11.2%	$ 121,100	$ 366,000	$ 73,200	$ 439,200	$ 318,100
WASATCH COUNTY	$ 45,000	$ 1,200	2.7%	$ 46,200	$ 246,500	$ 49,300	$ 295,800	$ 249,600
FY 2009 TOTAL	**$ 28,986,900**	**$ 1,206,300**	**4.2%**	**$ 30,193,200**	**$ 25,097,000**	**$ 5,019,300**	**$ 30,116,300**	**$ (76,900)**

Table 5

The State pass-thru provided for mental health services is outlined in UCA 17-43-301, as shown above in Table 5. The Department of Human Services estimates that 57% of individuals served by the counties for mental health

services use Medicaid as a source of payment. This percentage varies by service area from 10% in Summit County to 80% in Central Utah. Five of thirteen mental health providers provided more money to be matched for Medicaid dollars than what was provided to them via State appropriations and their required statutorily-required 20% county pass-thru match. In FY 2008 two mental health providers provided more seed money than the total of their State appropriation and statutorily-required 20% county match (Department of Human Services January 19, 2010 email).

Substance Abuse - County(s) or Contracted Providers								
Provider Group	Money Seeded for Services	Money Seeded for Admin Fee (est.)	% Admin Charged	Total Seeded	State Pass-thru Provided	20% County Match	Total Match & Pass-thru	Match & Pass-thru Over/(Under) Seeding
BEAR RIVER	$ 53,400	$ 2,000	3.7%	$ 55,400	$ 576,800	$ 115,400	$ 692,200	$ 636,800
CENTRAL UTAH	$ 22,100	$ 1,100	5.0%	$ 23,200	$ 301,200	$ 60,200	$ 361,400	$ 338,200
DAVIS COUNTY	$ 79,700	$ 3,200	4.0%	$ 82,900	$ 1,044,100	$ 208,800	$ 1,252,900	$ 1,170,000
FOUR CORNERS	$ 51,000	$ 2,700	5.3%	$ 53,700	$ 203,600	$ 40,700	$ 244,300	$ 190,600
SAN JUAN COUNTY	$ 31,400	$ 3,300	10.5%	$ 34,700	$ 107,700	$ 21,500	$ 129,200	$ 94,500
SOUTHWEST	$ 98,400	$ 4,300	4.4%	$ 102,700	$ 780,100	$ 156,000	$ 936,100	$ 833,400
NORTHEASTERN/UINTAH BASIN	$ 16,400	$ 900	5.5%	$ 17,300	$ 243,700	$ 48,700	$ 292,400	$ 275,100
WEBER COUNTY	$ 128,100	$ 5,200	4.1%	$ 133,300	$ 930,400	$ 186,100	$ 1,116,500	$ 983,200
SALT LAKE COUNTY	$ 1,754,400	$ 61,400	3.5%	$ 1,815,800	$ 4,187,900	$ 837,600	$ 5,025,500	$ 3,209,700
TOOELE COUNTY	$ 13,400	$ 800	6.0%	$ 14,200	$ 278,500	$ 55,700	$ 334,200	$ 320,000
SUMMIT COUNTY	$ 1,600	$ 200	12.5%	$ 1,800	$ 231,800	$ 46,400	$ 278,200	$ 276,400
UTAH COUNTY	$ 491,600	$ 17,300	3.5%	$ 508,900	$ 1,278,300	$ 255,700	$ 1,534,000	$ 1,025,100
WASATCH COUNTY	$ 3,100	$ 100	3.2%	$ 3,200	$ 79,500	$ 15,900	$ 95,400	$ 92,200
FY 2009 TOTAL	**$ 2,744,600**	**$ 102,500**	**3.7%**	**$ 2,847,100**	**$ 10,243,600**	**$ 2,048,700**	**$ 12,292,300**	**$ 9,445,200**

Table 6

The State pass-thru provided for substance abuse services is provided for substance abuse treatment and prevention services, as shown above in Table 6. The Department of Human Services estimates that 12% of individuals served by the counties for substance abuse services use Medicaid as a source of payment. This percentage varies by service area from 1% in Summit County to 25% in Weber County. The low percentage of clients eligible for Medicaid helps explain the low percentage of money that is matched for Medicaid federal dollars by the counties and contracted providers (Department of Human Services January 19, 2010 email).

Early Periodic Screening, Diagnosis and Treatment Program - Local Health Departments								
Provider Group	Money Seeded for Services	Money Seeded for Admin Fee	% Admin Charged	Total Seeded	Pass-thru Provided	20% County Match	Total Match & Pass-thru	Match & Pass-thru Over/(Under) Seeding
BEAR RIVER	$ 51,000	$ 5,300	10.4%	$ 56,300	$ 71,700	$ 14,300	$ 86,000	$ 29,700
CENTRAL UTAH	$ 21,600	$ 2,200	10.2%	$ 23,800	$ 33,500	$ 6,700	$ 40,200	$ 16,400
DAVIS	$ 21,700	$ 2,200	10.1%	$ 23,900	$ 55,400	$ 11,100	$ 66,500	$ 42,600
SALT LAKE VALLEY	$ 267,200	$ 27,500	10.3%	$ 294,700	$ 247,600	$ 49,500	$ 297,100	$ 2,400
SOUTHEAST	$ 12,600	$ 2,400	19.0%	$ 15,000	$ 27,400	$ 5,500	$ 32,900	$ 17,900
SOUTHWEST UTAH	$ 46,200	$ 4,800	10.4%	$ 51,000	$ 42,300	$ 8,500	$ 50,800	$ (200)
SUMMIT	$ 900	$ 100	11.1%	$ 1,000	$ 5,800	$ 1,200	$ 7,000	$ 6,000
TOOELE	$ 21,800	$ 2,200	10.1%	$ 24,000	$ 27,400	$ 5,500	$ 32,900	$ 8,900
TRI COUNTY HEALTH	$ -	$ -	0.0%	$ -	$ 12,400	$ 2,500	$ 14,900	$ 14,900
UTAH	$ 67,600	$ 7,000	10.4%	$ 74,600	$ 117,400	$ 23,500	$ 140,900	$ 66,300
WASATCH	$ 500	$ 100	20.0%	$ 600	$ 5,900	$ 1,200	$ 7,100	$ 6,500
WEBER-MORGAN	$ 23,800	$ 2,500	10.5%	$ 26,300	$ 60,200	$ 12,000	$ 72,200	$ 45,900
FY 2009 TOTAL	**$ 534,900**	**$ 56,300**	**10.5%**	**$ 591,200**	**$ 707,000**	**$ 141,500**	**$ 848,500**	**$ 257,300**

Table 7

As noted in Table 7 above, the $707,000 State pass-thru provided to local health departments to provide the Early Periodic Screening, Diagnosis and Treatment Program for Utah Medicaid exceeds the $591,200 money used by local health departments for the program by $115,800. When you factor in the statutorily-required 20% county match for State funds, the unused match money rises to $257,300.

RECOMMENDATION: Require the Department of Health to gather reports from local health departments. The reports should include at a minimum: (1) explain why local health departments are not using all of the State match provided and their county match for the Early Periodic Screening, Diagnosis and Treatment Program for Utah Medicaid and (2) where the unmatched grant money has been used.

Table 8 below shows the money provided by school district for skills development services.

Skills Development - School Districts			
Service Provided & Provider Group	Money Seeded	Admin Fee	% Admin Charged
NORTH SANPETE	$ 15,300	$ 3,100	20.3%
MILLARD	$ 15,300	$ 2,800	18.3%
BEAVER COUNTY	$ 4,500	$ 700	15.6%
GRAND COUNTY	$ 16,800	$ 2,200	13.1%
KANE COUNTY	$ 11,300	$ 1,400	12.4%
SEVIER	$ 26,800	$ 3,100	11.6%
SAN JUAN	$ 24,400	$ 2,800	11.5%
SOUTHERN UTAH	$ 64,100	$ 7,200	11.2%
WAYNE COUNTY	$ 900	$ 100	11.1%
CARBON COUNTY	$ 56,200	$ 5,900	10.5%
JUAB COUNTY	$ 29,800	$ 3,100	10.4%
CACHE COUNTY	$ 117,600	$ 12,200	10.4%
LOGAN CITY	$ 89,300	$ 9,200	10.3%
TOOELE COUNTY	$ 141,200	$ 14,500	10.3%
UINTAH	$ 57,500	$ 5,900	10.3%
BOX ELDER	$ 148,200	$ 15,200	10.3%
WEBER	$ 124,900	$ 12,600	10.1%
MURRAY	$ 30,800	$ 3,100	10.1%
SOUTH SANPETE	$ 49,700	$ 4,900	9.9%
WASHINGTON	$ 224,700	$ 22,000	9.8%
SALT LAKE	$ 184,000	$ 17,900	9.7%
NEBO	$ 131,700	$ 12,000	9.1%
OGDEN	$ 112,100	$ 7,800	7.0%
DAVIS COUNTY	$ 749,400	$ 51,400	6.9%
JORDAN	$ 667,900	$ 45,200	6.8%
GRANITE	$ 913,000	$ 56,300	6.2%
ALPINE	$ 755,700	$ 46,500	6.2%
PROVO	$ 584,500	$ 32,300	5.5%
FY 2009 TOTAL	**$ 5,347,600**	**$ 401,400**	**7.5%**

Table 8

FY 2009 Providers	Money Seeded for Services	Money Seeded for Admin Fee (est.)	% Admin Charged
Mental Health	$ 28,986,900	$ 1,206,300	4%
Substance Abuse	$ 2,744,600	$ 102,500	4%
School Districts	$ 5,347,600	$ 401,400	8%
Local Health Departments	$ 534,900	$ 56,300	11%
University of Utah	$ 36,066,000	$ 987,200	3%
Total	**$ 73,680,000**	**$ 2,753,700**	**4%**
% Admin. Added Via Fee		**56%**	
General Fund for Admin.		**$ 4,900,400**	

Table 9

Similar to most other providers who provide match money, some of the FY 2009 $36,066,000 University's match money came directly from State funds. In FY 2009, $2,079,800 of the University's seeded money came from appropriations from the State's Cigarette Tax Restricted Account as per UCA 59-14-204.

The total seed money to provide services received in FY 2009 from non-State entities was $73,680,000, and is summarized in Table 9 above. In addition the Health Department charged administrative fees of $2,753,700, which represents a charge of 3.7%. This same percentage was 4.0% in FY 2008 ($2,438,000 administrative fee charged for $60,868,800 in seed money). This represents an increase of $315,700. Medicaid administration had their ongoing State funding reduced by $288,000 for FY 2009 (this figure excludes fund transfers).

As shown above, there is a wide range of administrative charges by provider ranging from 2.6% to 20.2%. This administrative fee began during the last fiscal down turn of 2000 to 2002. The Department of Health explains how they assess their administrative fee with the following three scenarios based on total funds matched:

1. 3% of amounts less than $500,000
2. $15,000 and 2% of amounts above $500,000 up to $1,000,000
3. $25,000 and 1% of amounts above $1,000,000

This administrative fee revenue is not clearly distinguishable in the current budget reporting through Finance. Because this administrative fee is used for administrative expenses, the Legislature may be interested in tracking the increases and decreases from this revenue source. In FY 2009, the $2,753,700 gave the Department of Health an extra 56% in available State match for administrative expenses.

RECOMMENDATION: Direct the Department of Health to work with the Division of Finance to identify a way to clearly track total administrative seed revenues annually beginning with the FY 2011 budget.

The money that is received by other agencies besides the Health Department is not always readily visible in the Medicaid budget. For example, within Health Care Financing, the Medicaid administration within the Department of Health, $46,546,700 or 38% of all administrative dollars out of $121,831,900 spent in FY 2009 was given to other agencies, other levels of government for Medicaid, or other non-State entities. The Legislature may be interested in a break out the information of how much money is seeded by other State agency and other organizations where they provide or are appropriated the matching funds in order to

participate in the Medicaid program. One of largest recipients is the Department of Workforce Services for their eligibility determination services.

RECOMMENDATION: Add two budget programs in Health Care Financing entitled "DWS Seeded Services" and "Other Seeded Services" detailing the seeded money the Department of Health gives for Medicaid to DWS and other entities.

Double Counting

The seed money that is transferred between State agencies, as mentioned above, gets double counted on the State books. For example, in Table 10 below for the Department of Health, all of the transfers listed in the "FY 2009 actuals" column to other State agencies, which totaled $121,310,900 (mostly for Medicaid), are counted both in the Department of Health and the receiving agency. This double-counting adds approximately 3% to the FY 2009 actuals statewide.

Health

Sources of Finance	FY 2009 Actual	FY 2010 Appropriated	Changes	FY 2010 Revised	Changes	FY 2011* Base Budget
General Fund	353,377,000	324,624,200	0	324,624,200	0	324,624,200
General Fund, One-time	(46,639,600)	(50,053,900)	0	(50,053,900)	50,053,900	0
Federal Funds	1,352,662,700	1,265,510,800	168,825,800	1,434,336,600	(57,366,800)	1,376,969,800
American Recovery and Reinvestment Act	74,154,500	105,875,100	0	105,875,100	(105,875,100)	0
Dedicated Credits Revenue	120,212,100	119,785,500	6,086,700	125,872,200	1,405,600	127,277,800
GFR - Cat & Dog Spay & Neuter	66,200	80,000	0	80,000	0	80,000
GFR - Cigarette Tax Rest	3,131,700	3,131,700	0	3,131,700	0	3,131,700
GFR - Children's Organ Transplant Trust	100,000	100,000	0	100,000	0	100,000
GFR - Medicaid Restricted	8,790,900	4,613,500	0	4,613,500	(4,613,500)	0
GFR - Nursing Care Facilities Account	15,716,200	18,240,300	0	18,240,300	0	18,240,300
GFR - State Lab Drug Testing Account	418,000	418,800	0	418,800	0	418,800
GFR - Tobacco Settlement	16,768,000	20,373,600	0	20,373,600	0	20,373,600
TFR - Dept. of Public Safety Rest. Acct.	0	100,000	0	100,000	0	100,000
Organ Donation Contribution Fund	113,000	113,000	0	113,000	0	113,000
Transfers	1,290,800	56,133,700	(53,755,000)	2,378,700	(1,474,200)	904,500
Transfers - Environmental Quality	6,500	200	(200)	0	0	0
Transfers - Governor's Office Administratio	185,900	0	208,900	208,900	(208,900)	0
Transfers - Human Services	70,268,730	57,741,500	2,101,870	59,843,370	7,369,630	67,213,000
Transfers - Intergovernmental	70,309,970	(273,300)	25,693,630	25,420,330	1,834,670	27,255,000
Transfers - Medicaid	0	2,010,800	(2,010,800)	0	0	0
Transfers - Other Agencies	2,400	7,233,600	(7,233,600)	0	0	0
Transfers - Public Safety	545,900	380,200	112,600	492,800	(137,800)	355,000
Transfers - Within Agency	16,049,000	42,333,500	(28,261,400)	14,072,100	1,963,100	16,035,200
Transfers - Workforce Services	28,325,700	2,883,800	24,317,300	27,201,100	139,500	27,340,600
Transfers - Youth Corrections	5,926,800	0	3,398,000	3,398,000	154,900	3,552,900
Rural Health Care Facilities Fund	277,500	0	0	0	0	0
Pass-through	2,611,100	0	(260,400)	(260,400)	287,500	27,100
Beginning Nonlapsing	6,892,600	2,578,700	9,014,400	11,593,100	(9,893,200)	1,699,900
Closing Nonlapsing	(11,593,100)	(1,568,900)	(131,000)	(1,699,900)	537,400	(1,162,500)
Lapsing Balance	(1,546,300)	0	0	0	0	0
Total	**$2,088,424,200**	**$1,982,366,400**	**$148,106,800**	**$2,130,473,200**	**($115,823,300)**	**$2,014,649,900**
Line Items						
Executive Director's Operations	27,171,200	25,902,200	5,720,200	31,622,400	(5,840,100)	25,782,300
Health Systems Improvement	15,727,100	15,375,300	126,500	15,501,800	(343,400)	15,158,400
Workforce Financial Assistance	560,000	0	422,800	422,800	(122,800)	300,000
Epidemiology and Laboratory Services	23,055,900	21,102,400	1,736,600	22,839,000	3,832,600	26,671,600
Community and Family Health Services	111,099,000	121,975,700	(743,600)	121,232,100	(6,485,800)	114,746,300
Health Care Financing	114,719,500	115,664,200	(1,519,400)	114,144,800	1,427,300	115,572,100
Medicaid Mandatory Services	898,735,200	810,761,100	103,822,100	914,583,200	(91,970,300)	822,612,900
Medicaid Optional Services	824,560,100	792,826,300	29,726,800	822,553,100	(6,392,100)	816,161,000
Local Health Departments	2,497,000	2,309,700	0	2,309,700	(187,300)	2,122,400
Children's Health Insurance Program	70,299,200	76,449,500	8,814,800	85,264,300	(9,741,400)	75,522,900
Total	**$2,088,424,200**	**$1,982,366,400**	**$148,106,800**	**$2,130,473,200**	**($115,823,300)**	**$2,014,649,900**
Categories of Expenditure						
Personal Services	74,126,100	73,812,200	(70,600)	73,741,600	(513,900)	73,227,700
In-state Travel	688,600	878,400	(163,600)	714,800	27,100	741,900
Out-of-state Travel	528,500	662,200	(146,600)	515,600	3,100	518,700
Current Expense	52,036,200	43,492,200	12,285,800	55,778,000	(1,418,700)	54,359,300
DP Current Expense	14,211,500	13,624,000	1,419,500	15,043,500	(455,900)	14,587,600
DP Capital Outlay	106,500	0	8,200	8,200	0	8,200
Capital Outlay	614,900	80,700	697,300	778,000	(678,000)	100,000
Other Charges/Pass Thru	1,946,111,900	1,849,816,700	134,076,800	1,983,893,500	(112,787,000)	1,871,106,500
Total	**$2,088,424,200**	**$1,982,366,400**	**$148,106,800**	**$2,130,473,200**	**($115,823,300)**	**$2,014,649,900**
Other Data						
Budgeted FTE	978.4	1004.0	22.7	1026.7	(11.5)	1015.2
Vehicles	64.0	67.0	(3.0)	64.0	0.0	64.0

*Does not include amounts in excess of subcommittee's state fund allocation that may be recommended by the Fiscal Analyst.

Table 10

RECOMMENDATION: Identify a budgeting method to remove the double counting in Medicaid due to transfers between the Department of Health and other State agencies (situation not unique to Medicaid).

WHAT DOES STATE STATUTE SAY CONCERNING MEDICAID?

"The Legislature has given the…Utah Department of Health broad leeway to define and administer the program. Although a few program specifics are spelled out in statute, these are the exception. The volume of Medicaid administrative rules outnumbers state statutes twelve to one. Administrative rules address both optional and mandatory features of Medicaid (*Understanding Medicaid; A Policymaker's Introduction*" Office of Legislative Research and General Counsel, December 2005, http://www.le.state.ut.us/lrgc/briefingpapers/understandingmedicaid2005.pdf)." Since 2003 the Legislature has required reporting from the Department of Health on all changes to the Medicaid State Plan.

Below is a list of all significant parts of statute, shown in *italics*, that provide direction for the administration of the Medicaid program in Utah. Additionally, for most statutory references there is a brief discussion of what is happening in relation to the direction provided in statute.

26-18-2.3 Division responsibilities -- Emphasis -- Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall:

(a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;

"About 95 percent, or $1.5 billion of Medicaid funds receive little to no systematic, consistent oversight by the Bureau of Program Integrity (BPI). This is evidenced by the fact that BPI has a limited sampling methodology for inpatient claims and virtually no sampling methodology for non-inpatient claims, and conducts no oversight over all other contracted Medicaid services (i.e. mental health, long-term care, other human services, and managed care). This lack of oversight has placed valuable program dollars at risk and has undermined the recovery effort. We recommend that BPI develop a business plan that ensures all Medicaid funds are being effectively reviewed (2009 Medicaid audit page ii)."

(b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and

"Approval of certain Medicaid expenditures before service is provided, called prior authorization, can be one of the most effective methods to prevent overutilization in Medicaid and, thereby, avoid unnecessary expenditures. However, (the Bureau of Program Integrity) is not adequately utilizing this tool. Medicaid's prior authorization policies are unclear and have been neglected by prior authorization nurses, thus leading to unnecessary medical costs and inconsistent care for Medicaid recipients. To correct these problems, we recommend increased management oversight and clearer policies and procedures. (2009 Medicaid audit page ii)"

(c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

"The Division of Health Care Financing (HCF or Utah Medicaid) has provided little oversight over costs and utilization of the health plans. Utah Medicaid has chosen to primarily focus on fulfilling federal requirements on quality of care and enrollment data. While quality of care is important, oversight over cost and utilization should also be higher priorities for HCF, especially considering the cost-plus reimbursement structure that has been in place the last seven years that encouraged overutilization…Utah Medicaid has not established a clear cost

reduction strategy. Our contracted actuary, Milliman, did not conduct a detailed analysis in this area, but believes from related experiences that significant cost savings can be achieved through improved health plan contracts, utilization management efforts, and a review of provider reimbursement levels (2010 Medicaid audit, page 39)."

(2) The division shall implement and utilize cost-containment methods, where possible, which may include, but are not limited to:

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

"Inefficiencies, data concerns, and ineffective utilization of staff resources have limited BPI's (Bureau of Program Integrity) ability to recover inappropriate payments. These concerns, along with others in Chapter V, are resulting in the loss of Medicaid dollars to inappropriate payments. BPI should first demonstrate it is using staff efficiently and effectively before requesting additional staff resources. We recommend BPI correct analytical tool deficiencies, better track recovery data, and measure staff efficiency based on clear performance goals. (2009 Medicaid audit page ii)"

(b) preadmission certification of nonemergency admissions;

"Because of the disparity in reimbursement rates between emergency rooms and primary care visits, it is crucial that nonemergent uses of emergency rooms be reduced. While it is unreasonable to think that all non-emergent visits to the ER could be eliminated, we believe that HCF can reduce a portion of these claims and achieve cost savings (2010 Medicaid audit, page 68)."

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) consistent with Sections 26-18-2.4 and 58-17b-606, a Medicaid drug program;

(g) coordination of benefits; and

(h) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.

"Medicaid's provider enrollment controls are not sufficient and have allowed billings from a small percentage of providers that should have been excluded from the program. Excluding these providers can bolster cost avoidance efforts. To improve controls over the provider enrollment process, we recommend (Health Care Financing) develop and consistently follow clearer policies. (2009 Medicaid audit page ii)"

(3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

"To Realize Future Savings, Medicaid Must Implement Better Oversight. Utah Medicaid was not fully aware of the potential cost reduction opportunities noted in Chapter III and consequently could not capture this savings potential. To accomplish this savings, Medicaid should use claim data to understand the cost of medical services, gather administrative cost data, utilize prior authorization information, and establish appropriate contracts (2010 Medicaid audit, page ii)."

In the various pieces of statute mentioned above, there are several goals given to the Department of Health for how to run the Medicaid program. The Legislature may find it helpful to hear annually how the Department of Health is doing in meeting these statutory mandates.

RECOMMENDATION: Change statute to require the Department of Health to report annually to the Health and Human Services Appropriation Subcommittee on how they are meeting their statutory mandates to be more efficient and effective.

26-18-7 Medical vendor rates.

Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division in cooperation with providers of services for each type of service purchased by the division. As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

In the 2009 General Session, the Legislature passed intent language directing the Department of Health to move away from paying a percentage of billed charges for outpatient hospital services. The Department proposed two different methodologies but has not provided a timeline for implementing any change in methodology (see Appendix E). This kind of analysis should be done automatically by the Department of Health, rather than requiring specific legislative mandates.

26-18-11 Rural hospitals.

(2) For purposes of the Medicaid program and the Utah Medical Assistance Program, the Division of Health Care Financing shall not discriminate among rural hospitals on the basis of size.

26-18-302 Department to award grants and contracts -- Applications.

(1) (a) Within appropriations specified by the Legislature for this purpose, the department may make grants to public and nonprofit entities for the cost of operation of providing primary health care services to medically underserved populations.

This function is carried out by a non-Medicaid portion of the Department of Health and so no further discussion of this item is included in this report. There is no obvious need for this non-Medicaid portion to stay in the Medicaid chapter.

RECOMMENDATION: Move primary care grants statute UCA 26-18 Part 3 out of the Medicaid chapter of statute.

26-20-13 Medicaid fraud enforcement.

(5) Any violation of this chapter which comes to the attention of any state government officer or agency shall be reported to the attorney general or the department. All state government officers and agencies shall cooperate with and assist in any prosecution for violation of this chapter.

The Department of Health has had a fraud reporting system in place for providers or the general public since the 1990's. The Department has a phone line and an email address where the public can report fraud. The phone lines have received about 40-50 calls per week. Currently the phone is limited to voice-mail and callback service. A new fraud phone line should be live by March 2010. The Department of Health includes fraud reporting information in their annual statewide provider training to promote awareness of their fraud reporting hotlines. The current options for reporting fraud to Utah Medicaid can be found at http://health.utah.gov/bpi/main/fraud.php. As of December 15, 2009 it is not clear how a person would get to this page to report fraud from either the Department of Health (http://health.utah.gov/) or Medicaid website (http://health.utah.gov/medicaid/). There are no links mentioning either reporting fraud in Medicaid or the name of the program, Bureau of Program Integrity that handles fraud. In Figures 5 and 6 below these two websites are shown as they were on December 15, 2009:

Utah Department of Health Main Web Site Page 1 of 2

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UTAH DEPARTMENT OF HEALTH

News | A to Z List | Health & Safety | Health Services | Data & Stats | Online Services

FLU.GOV
Know what to do about the flu.
VISIT FLU.GOV
SHARE THIS WIDGET

BE A FLU FIGHTER

the faces of diabetes

Find a Flu Vaccine
Click here to find seasonal and H1N1 influenza vaccine
more ...

Join the Fight!
Find all you need to know about the H1N1 virus
more...

Living With Diabetes?
Share your story and read how others are coping - even thriving - with the disease
more...

Health and Safety Topics
Check Your Health
Disease Facts
FDA Peanut Product Search
HEALTHY LIFESTYLES
Patient Safety
Report a Disease
Safe Kids
Tobacco Prevention
Travel Health & Safety
Utah Health Story Bank
Violence & Injury Prevention
more...

Health Services
Birth Certificates
CLINICS ... more
ER Education
HEALTHY LIFESTYLES
MEDICAID, CHIP ... more
LICENSING & CERTIFICATION
Primary Care & Rural Health
Report a Disease
Utah Health Care Safety Net
more...

Data and Statistics
DATA RESOURCES IN UDOH
Health Care Information
Public Health Data Resource
MyHealthCare Resource
Reports Online
Vital Statistics
more...

Online Services

UTAH Health News

EXTENDED HOURS TO BETTER SERVE YOU:
MONDAY - THURSDAY 7 am to 6 pm
CLOSED FRIDAYS!

Infectious Disease, Mental Health Problems as Diverse as Utah
Reports show racial, ethnic minorities face challenges. More...

Mammography: What's Right for Utah?
Utah Department of Health Calls for Further Discussion. More...

New Utah Health Plan Ratings Available
Member satisfaction higher than national average for most measures. More...

State Health Officials Announce Smoke-free Campus Plan
Great American Smoke Out marks countdown to new 2010 policy. More...

SL County Teen Leads Launch of 'Faces of Diabetes'
Personal blog inspires campaign to share stories of diabetes. More...

Utah Named 2nd Healthiest State in the Nation
State improves three spots from last year's rankings. More...

UDOH Contest Wants Kids' Brains
Students invited to create new anti-tobacco ads. More...

New Campaign Recruits Utahns to be 'Flu Fighters'
The Utah Department of Health, the state's 12 local health departments, and representatives from the private health care sector today unveiled a new campaign aimed at limiting the spread of Pandemic H1N1 influenza. More...

Huge Savings Through Early Detection of Breast Cancer
Catching breast cancer early saves lives and now, new data show it saves money, too. More...

Big Tobacco Puts Deadly Drug in Prettier Packages
They're just cancer-causing tobacco, wolves in sheep's clothing that will entice and hook new, young smokers and keep current smokers addicted. More...

'Thirteen Stories We'd Rather Not Tell'
Families of Teen Crash Victims Share Their Stories of Loss. More...

With Pandemic H1N1 on the Rise, Public Health Stresses Importance of Prevention & Vaccination
New statewide data released today by the Utah Department of Health (UDOH) indicate a substantial increase in the spread of the pandemic H1N1 virus throughout the state. More...

Emergency Room Staff Can Help Detect, Prevent Domestic Violence
New data released today by the Utah Department of Health (UDOH) show that emergency department staff are in an important position to uncover and ultimately stop the cycle of domestic abuse. More...

Influenza Vaccines: Safe and Important During Pregnancy
This flu season, new mothers and mothers-to-be should be among those who are first in line for influenza vaccine. More...

past news ...

The Director's Message

On behalf of almost 1,000 employees of the Utah Department of Health, welcome to our Web site. More...

Director's Links
Pandemic Influenza Preparedness
Immunization Rates
Utah Partnership for Healthy Weight
STDs in Utah
Autism in Utah
ASTHO - Association of State and Territorial Health Officials

Figure 5

http://health.utah.gov/ 12/15/2009

Medicaid Home Page Page 1 of 1

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UTAH DEPARTMENT OF HEALTH

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Utah Medicaid Program

HOME

PROGRAMS

PROVIDERS

CLIENTS

ESPAÑOL

CONTACT US

Medicaid From A - Z
Index of keywords, with links

Medical Assistance
Help with the cost of medical care

- Children's Health Insurance Program (CHIP)
- Primary Care Network (PCN)
- Utah's Premium Partnership for Health Insurance "UPP"
- Baby Your Baby
- Utah Medical Benefits
- Medicaid Education Video
- Find a Health Program Representative

Clients

- How and Where to Apply for Medicaid
- Apply On-Line
- Medicaid Policy
- Medicaid Member Guide
- Forms
- Adult Program Co-Pay Charts
- Leaving Foster Care
- Dental Information

Health Care Providers
Information for Medicaid providers

- Enroll as a Utah Medicaid Provider
- Bulletins
- Manuals
- Forms
- Fee Schedule
- State Plan
- Companion Guides
- Coordination of Benefits (COB) Instructions
- Electronic Data Interchange (EDI) Enrollment
- Pharmacy Program

What's New
Bulletins, press releases, notices, waivers

- December 2009 Interim MIB
- Working 4 Utah
- Medicaid Identification Cards
- Paper Claim Forms, examples

Questions

- Administration for Utah's Medicaid agency
- Department of Health
- Language and Interpretive Services

HIPAA: Health Insurance Portability and Accountability Act
Rules and Regulations, Federal and Utah State

UDOH Home | Contact UDOH | About UDOH | UDOH A-Z Index | UDOH Use Disclaimer | UDOH Privacy Policy | Utah.gov Accessibility Policy

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Can't find it? Try the Search Utah.gov feature below.

Google Search Utah.go GO

Figure 6

http://health.utah.gov/medicaid/ 12/15/2009

The Department of Workforce Services has had a fraud reporting system in place for suspected public assistance fraud (more than just Medicaid) since June 2002. Workforce Services has a phone line and an email address where the public can report fraud. The email addresses have received 1,120 tips since 2002 when they started. The phone lines have received 11,520 tips since they started in 2002. Workforce Services does verbal communication with customers to promote fraud reporting.

The Department of Human Services indicated that it has a "Hotline Phone Numbers" link on its home page that leads to a list of phone numbers that includes fraud reporting phone numbers. The agency is aware of one case that has been reported via the hotline. Providers are required to post a "Provider Code of Conduct" that includes information on how to contact the internal auditor for misuse of public funds. The internal auditors referred 6 Medicaid cases to the Attorney General from FY 2005 to FY 2009 (December 22, 2009 and January 5, 2010 emails from the Department of Human Services).

RECOMMENDATION: Require a report via intent language from the Departments of Health, Human Services, and Workforce Services on how they will increase public awareness of their fraud reporting systems and encourage the public to report Medicaid fraud.

26-18-402 Medicaid Restricted Account.

(1)(i) any general funds appropriated to the department for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and which are not otherwise designated as nonlapsing shall lapse into the Medicaid Restricted Account;

Utah Code requires any General Funds appropriated to the Department of Health for Medicaid that are not spent during the fiscal year to lapse to the Medicaid Restricted Account. If the purpose behind this part of statute is to have all unused Medicaid funds go into this restricted account, this is not currently happening. There are two other State agencies, the Department of Workforce Services and the Department of Human Services, that receive State funds for their parts of Medicaid, but are not currently required to lapse their unused Medicaid funds into the Medicaid Restricted Account.

RECOMMENDATION: Consider a statutory change requiring all unused funds that are associated with the Medicaid program in the Department of Workforce Services and the Department of Human Services to be deposited into the Medicaid General Fund Restricted Account at year end.

UCA 26-40-110(4)(ii) Managed care -- Contracting for services.

(A) the responsive bidder is able to offer the program access to two different provider networks; or
(B) the selection of two different responsive bidders will provide the program with access to two different provider networks.

As part of our federal approval to deliver services in a managed care model, Medicaid is required to offer recipients at least two choices for receiving their medical services. In the Children's Health Insurance Program, this requirement is contained in State statute and is not required by the federal government.

RECOMMENDATION: Change statute to remove the requirement to have CHIP providers have two hospital networks. Instead, focus requirements on sufficient access and coverage.

Penalty Deposits into the Medicaid Restricted Account

The following statutory references included below direct monetary penalties to be deposited into the Medicaid Restricted Account:

- 17B-2a-818.5 Contracting powers of public transit districts -- Health insurance coverage.
- 19-1-206 Contracting powers of department -- Health insurance coverage.
- 63A-5-205 Contracting powers of director -- Retainage -- Health insurance coverage.
- 63C-9-403 Contracting power of executive director -- Health insurance coverage.
- 72-6-107.5 Construction of improvements of highway -- Contracts -- Health insurance coverage.
- 79-2-404 Contracting powers of department -- Health insurance coverage.

These laws became effective in FY 2010. Since July 1, 2009 there have been no penalties deposited into Medicaid Restricted Account.

62A-11-104 Duties of office (Office of Recovery Services (ORS))

(10) to determine whether an individual who has applied for or is receiving cash assistance or Medicaid is cooperating in good faith with the office as required by Section 62A-11-307.2.

The Department of Human Services indicated their compliance with the following statement in a December 3, 2009 email: "If a custodial parent/Obligee receiving Medicaid or TANF benefits fails to comply with any of the minimum duties as defined in 62A-11-307.2 without a good cause determination the responsible ORS case worker generates a non-cooperation letter (N15A) to the Obligee informing them Workforce Services has been notified and instructed to deny or reduce their cash and/or medical assistance. The notification of DWS is concurrent with the N15A being generated to the Obligee. The ORS worker in generating the N15A notice creates a trigger which passes the non-cooperation details in a nightly batch to PACMIS/eRep for the DWS worker to sanction the benefits. From January 1, 2009 – December 3, 2009 ORS agents have generated 4,714 N15A notices to Obligees."

75-7-508 Notice to creditors (Office of Recovery Services)

(3) (a) If the deceased settlor received medical assistance, as defined in Section 26-19-2, at any time after the age of 55, the trustee for an inter vivos revocable trust, upon the death of the settlor, shall mail or deliver written notice to the Director of the Office of Recovery Services, on behalf of the Department of Health, to present any claim under Section 26-19-13.5 within 60 days from the mailing or other delivery of notice, whichever is later, or be forever barred.

The Department of Human Services indicated their compliance with the following statement in a December 3, 2009 email: "ORS has a duty to file claims against the estate within 60 days only when a trustee notifies us that there is an inter vivos revocable trust in place for a recently deceased Medicaid recipient over age 55. To date, ORS has never received notification from a trustee, as such there has been no duty. However, ORS Policy requires that we file the statutory post-death lien—the claim for Medicaid recovery—against qualifying estates within 60 days of knowledge of the Medicaid recipient's death when information is received from any valid source. For example, we have an interface with PACMIS (eligibility information system) which notifies us when a Medicaid recipient over age 55 has died. Additionally, DOH Vital Records and Statistics is another notification source which provides ORS notification of all deaths in the state reported in the month."

Table 11 below shows the recoveries for Medicaid from estates from FY 2005 to FY 2009:

Medicaid Estate Recovery Collections FY 2005 to FY 2009	
FY 2005	$ 2,732,400
FY 2006	$ 3,407,300
FY 2007	$ 3,685,500
FY 2008	$ 2,465,600
FY 2009	$ 2,591,000
Total	**$ 14,881,800**

Table 11

For the last five fiscal years estate recoveries have brought in $14,881,800 total funds. Recoveries over this period have averaged $2,976,360 annually. These income sources are used to offset Medicaid expenditures. The FY 2009 recoveries of $2,591,000 is included in the $29,266,200 total recoveries figure mentioned in the subsection entitled "income sources" above. The Legislature considered SB 50 "Medical Benefits Recovery Amendments" from the 2008 General Session, which may have increased collections from estates. SB 50 passed the Senate but did not receive a vote in the House.

RECOMMENDATION: Revisit the role and efficiency of the Office of Recovery Services in the Department of Human Services. Direct the Departments of Health, Human Services, and Workforce Services via intent language to develop a list of options for expansions in the areas of collections (such as requiring insurers to share benefit information for all medical assistance recipients to increase collections and cost avoidance).

67-5-1 General duties (Attorney General)

(18) investigate and prosecute violations of all applicable state laws relating to fraud in connection with the state Medicaid program and any other medical assistance program administered by the state, including violations of Title 26, Chapter 20, False Claims Act;

(19) investigate and prosecute complaints of abuse, neglect, or exploitation of patients at:

(a) health care facilities that receive payments under the state Medicaid program; and

(b) board and care facilities, as defined in the federal Social Security Act, 42 U.S.C. Sec. 1396b(q)(4)(B), regardless of the source of payment to the board and care facility;

The Utah Medicaid Fraud Control Unit was established in January of 1980 under the Department of Social Services. In 1981 it was transferred to the Department of Public Safety (DPS), Law Enforcement Services. In 1987 it became part of DPS, Criminal Investigative Bureau. In 2000, it was officially transferred to the Office of the Attorney General. The 11-member Unit is composed of two attorneys (including the MFCU Director), six investigators (certified peace officers), one auditor, one paralegal and one administrative assistant. Primary unit responsibilities include enforcement actions against fraudulent Medicaid providers, both criminally and civilly, and criminal prosecution involving abuse or neglect, including financial exploitation, of vulnerable adults in care facilities.

Mission: "To protect the integrity of the Medicaid program and the safety and property of institutionalized citizens of the State of Utah through skilled detection, proactive investigation, prevention, prosecution and financial recovery."

76-8-1205 Public assistance fraud defined (Attorney General)

(2) any person who fraudulently misappropriates any funds exchanged for food stamps, any food stamp, food stamp identification card, certificate of eligibility for medical services, Medicaid identification card, or other

public assistance with which he has been entrusted or that has come into his possession in connection with his duties in administering any state or federally funded public assistance program;

The Attorney General's Office provided the information below in Table 12 to show how many cases they had brought against individuals and companies to enforce UCA 76-8-1205 during FY 2005 through FY 2009:

Utah Attorney General's Office Medicaid Fraud Unit - Criminal Justice & Civil Cases					
Performance Measures	**FFY 2005**	**FFY 2006**	**FFY 2007**	**FFY 2008**	**FFY 2009**
New Investigations	138	134	49	104	115
Patient funds investigations	38	45	22	17	9
Abuse and neglect investigations	55	46	13	63	67
Provider fraud investigations	45	43	14	24	39
Investigations Closed[1]	54	76	24	92	92
Pre-filing diversions	1	2	3	0	2
Number Convicted	7	14	3	9	8
Civil Fraud Cases	5	4	4	5	2
Total Recoveries	**$ 3,627,000**	**$ 460,300**	**$ 3,045,700**	**$ 4,788,400**	**$ 3,307,700**
Cost of Attorney Unit	($823,800)	($1,040,200)	($1,232,300)	($1,333,800)	($1,362,800)
Net Recoveries[2]	**$2,803,200**	**($579,900)**	**$1,813,400**	**$3,454,600**	**$1,944,900**
[1]Investigations may take years to close because of an outstanding warrant or ongoing restitution payments.					
[2]Net recoveries is in Total Funds. We keep about 30% of the recoveries and pay about 10% of the admin costs.					

Table 12

From October 1, 2009 through January 15, 2010 the State has received over $21,000,000 from additional lawsuit settlements with an additional $118,800 won but not received. There may or may not be an opportunity to obtain more recoveries via increased resources provided to this part of the Attorney General's Office. Administrative costs are paid 10% State and 90% federal, while the State gets to keep about 30% of all recoveries.

RECOMMENDATION: Study the return on investment for resources provided to the Attorney General's Medicaid Fraud Control Unit. Study the feasibility of increased recoveries if the unit is provided with more resources.

RECOMMENDATION: Review Medicaid statute for clarification in assigned responsibilities, desired policy direction, and agency interactions. Consider raising all the statutes relating to Medicaid from chapter level in statute to a separate title and consolidate all related statute beneath that title.

HOW DID WE GET HERE WITH MEDICAID?

Medicaid Timeline

Appendix A "Timeline of Major Events for Medicaid in Utah" details the major historical events that have helped shape the current composition of the Medicaid program.

Medicaid Eligibility Consolidation

Since July 2007 the Department of Workforce Services has exclusively handled nearly all the eligibility for Medicaid. Prior to July 2007, the Department of Workforce Services handled about 40% of Medicaid eligibility. This consolidation was projected to eventually generate savings of $3.5 to $4 million annually.

The Office of the Legislative Auditor General looked at this consolidation in its "A Performance Audit of DWS Eligibility Determination Services (http://www.le.state.ut.us/audit/09_19rpt.pdf)." The report found the following: "Medical assistance eligibility determination costs have increased at a disproportionate rate compared to other eligibility programs. Total Medicaid eligibility determination costs increased 114.1 percent, while Medicaid cases increased 14.8 percent since the eligibility determination consolidation in fiscal year 2008

(DWS audit page 2)." The legislative auditors indicated that these increases are largely due to how the Department of Workforce Services allocates eligibility costs amongst the Medicaid and non-Medicaid programs that it administers.

In the October 8, 2009 Executive branch response to Representative Harper's proposal to move the rest of Medicaid in Health to the Department of Workforce Services, potential savings included the reduction of 16 to 32 FTEs for a savings of $1 to $2 million. The Governor's Office of Planning and Budget (GOPB) indicated subsequently that these FTE reductions assumed that various policy staff could be eliminated. GOPB now says that the assumptions behind these savings are incorrect.

RECOMMENDATION: Further study consolidating and/or better coordinating the Medicaid program for the agencies involved (Health, Workforce Services, and Human Services).

Medicaid Interim Committee

The Medicaid Interim Committee met in 2006 and 2007. A summary of those meetings and the products of the committee is found under Appendix C.

State vs Federal Expansions in Medicaid

Figure 7 below shows a summary timeline of the Medicaid program and whether those expansions were a mandatory federal requirement or an optional expansion approved at the State level. There have been five federally-mandated expansions and nine State expansions (including signing up for the Medicaid program). With approval from the federal government the State has the option to further expand or restrict eligibility (after January 1, 2011) in the Medicaid program.

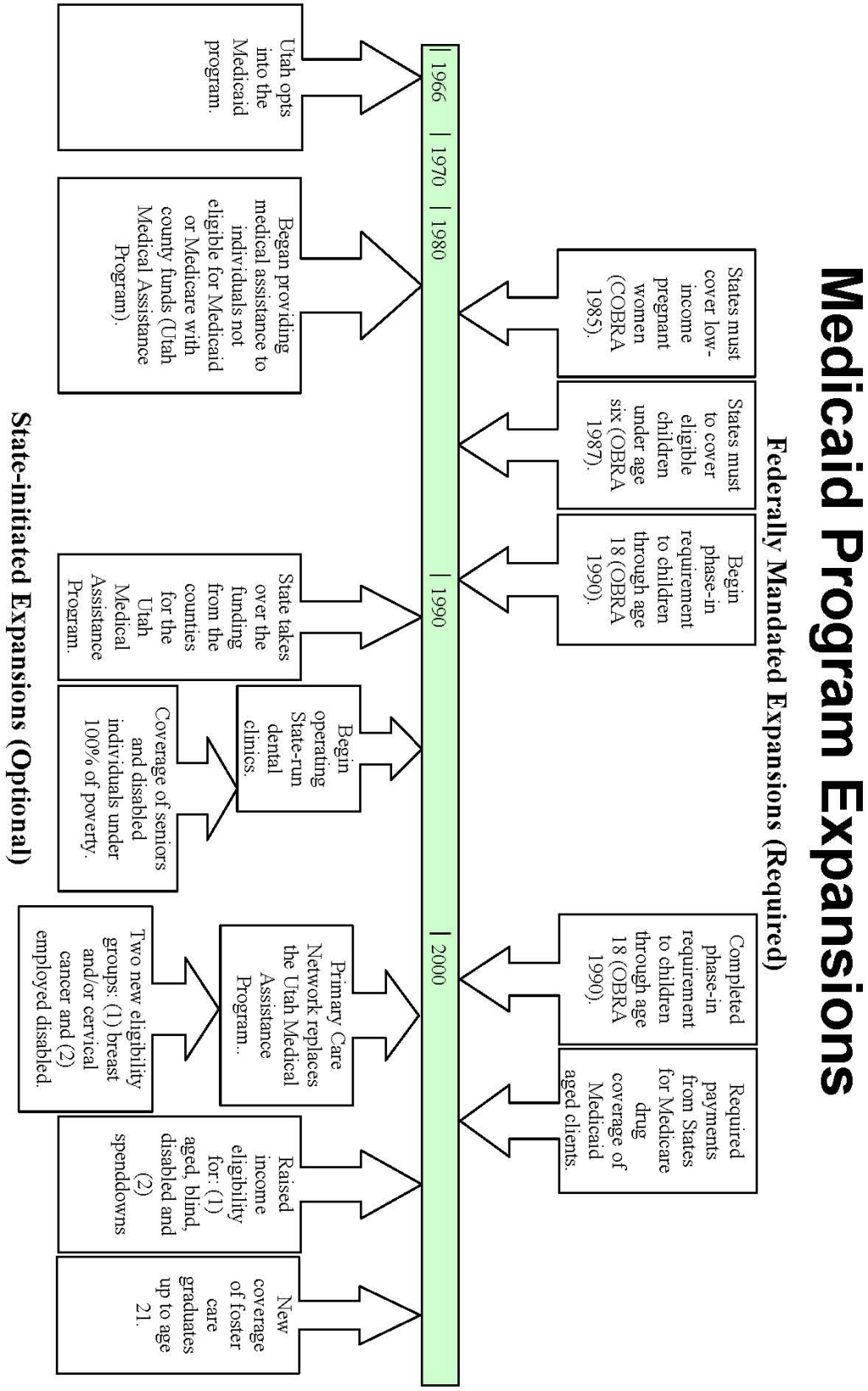
Medicaid Program Expansions
Federally Mandated Expansions (Required)
States must cover low-income pregnant women (COBRA 1985).
States must to cover eligible children under age six (OBRA 1987).
Begin phase-in requirement to children through age 18 (OBRA 1990).
Completed phase-in requirement to children through age 18 (OBRA 1990).
Required payments from States for Medicare drug coverage of Medicaid aged clients.
1966
1970
1980
1990
2000
Raised income eligibility for: (1) aged, blind, disabled and (2) spenddowns
New coverage of foster care graduates up to age 21.
Primary Care Network replaces the Utah Medical Assistance Program..
Two new eligibility groups: (1) breast and/or cervical cancer and (2) employed disabled.
Begin operating State-run dental clinics.
Coverage of seniors and disabled individuals under 100% of poverty.
State takes over the funding from the counties for the Utah Medical Assistance Program.
Began providing medical assistance to individuals not eligible for Medicaid or Medicare with county funds (Utah Medical Assistance Program).
Utah opts into the Medicaid program.
State-initiated Expansions (Optional)

Figure 7

Federal Stimulus Impacts

One of the requirements to receive federal stimulus money through the federal American Recovery and Reinvestment Act of 2009 was that Utah would not make Medicaid eligibility more restrictive until January 1, 2011. During the current economic downturn, this meant that reductions in Medicaid spending could not be achieved through changes in eligibility. Balancing the Medicaid budget primarily came through reductions in rates paid to providers.

Preferred Drug List

The Legislature began a Preferred Drug List in FY 2008 and currently requires a prior authorization in order to use a brand name drug before trying an approved generic drug. Federal regulations prohibit Utah Medicaid from excluding any drug in its program. Another option for increased savings for the Preferred Drug List is to remove drug exclusions from statute. One of these exclusions for psychotropic or anti-psychotic drugs has been part of the program since it began in FY 2008. The Department of Health estimates that these drugs used for mental illness make up about 40% of all Medicaid drug expenditures. Currently estimated savings for FY 2010 from the Preferred Drug List on the 60% of drug expenditures that are not excluded by statute is $(15,112,100) total funds ($4,218,100 General Fund). If mental illness drugs eventually generated similar savings as the current Preferred Drug List, then this would represent annual savings of $(10,074,700) total funds ($2,908,600 General Fund).

RECOMMENDATION: Change UCA 26-18-4.2 to allow for psychotropic or anti-psychotic drugs to be considered for the Preferred Drug List.

In 2008 the Legislature passed HB 258 "Medicaid Drug Utilization Amendments" prohibiting the inclusion of immunosuppressive drugs used to prevent transplanted organ rejection: (1) on a preferred drug list for the State Medicaid Program, (2) in step therapy requirements of the Drug Utilization Board, and (3) in generic substitution requirements of the State Medicaid Program. In FY 2009, the first year of the new law may have added costs up to $225,900 to the Medicaid program, which represents an increase of 23% for spending on immunosuppressive drugs from FY 2008. From FY 2007 to FY 2008 spending on immunosuppressive drugs decreased 5%. As more generic drugs become available, the cost to the State will increase.

The Federal Drug Administration in its article "Greater Access to Generic Drugs" found at http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143545.htm summarizes the following requirements for a generic drug to receive federal approval for patient use:

1. "Generic drugs must have the same active ingredients and the same labeled strength as the brand-name product."
2. "Generic drug manufacturers must show that a generic drug is bioequivalent to the brand-name drug, which means the generic version delivers the same amount of active ingredients into a patient's bloodstream in the same amount of time as the brand-name drug."
3. "Generic drugs must have the same dosage form (for example, tablets, liquids) and must be administered in the same way."

RECOMMENDATION: Allow immunosuppressive drugs, used to prevent organ rejection, to be placed on the Preferred Drug List Program.

WHAT ARE THE KNOWN DEFICIENCIES IN UTAH MEDICAID?

Legislative Auditors "A Performance Audit of Utah Medicaid Managed Care"

"A Performance Audit of Utah Medicaid Managed Care" (2010) from the Office of the Legislative Auditor General provided twenty-seven recommendations for improvement in the Medicaid program. For the full

report, please visit http://www.le.utah.gov/audit/10_01rpt.pdf. Because of the number of recommendations provided and the nature of the changes, the Analyst recommends that the Health and Human Services Appropriations Subcommittee receive an annual report on the progress of the implementation of these recommendations. There is already a follow up done the first year by the legislative auditors and presented to the Legislative Audit Subcommittee. This information may or may not be sufficient to meet the intent of this recommendation in the first year. The twenty-seven recommendations from the report are listed here below:

1. "We recommend that Utah Medicaid appropriately incentivize the health plans to reduce utilization and contain costs.
2. We recommend that Utah Medicaid develop a Request for Proposal to encourage more managed care organizations to enter the state.
3. 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.
4. 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.
5. 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 Utah Medicaid's information to provide policy guidance on this issue.
6. 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.
7. We recommend that Utah Medicaid review methods of accelerating the process of assigning Medicaid recipients to a managed care plan (pages 23 to 24)."
8. "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.
9. 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.
10. We recommend that Utah Medicaid help facilitate the sharing of good health management practices between plans.
11. We recommend that the Legislature direct Utah Medicaid to report to them on cost savings obtained through future contracting with the managed care plans (pages 37 to 38)."
12. "We recommend that Utah Medicaid apply risk-adjusted relative costs to their analysis of health plans to gain potential cost savings.
13. We recommend Utah Medicaid determine an acceptable cost level for the plans and hold the plans to that level.

14. 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.
15. We recommend that Utah Medicaid incorporate prior authorization data in their monitoring of the health plans.
16. 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 (page 53)."
17. "We recommend that the Bureau of Managed Health Care conduct a cost/benefit analysis of collecting similar health quality information, including (Healthcare Effectiveness Data and Information Set) measures, for the Select Access plan.
18. We recommend that the Bureau of Managed Health Care should establish a standard for quality of care appropriate for Utah.
19. 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.
20. 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).
21. 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 (page 63 to 64)."
22. "The Department of Health should frequently review emergent (emergency room) claims to verify the appropriate diagnosis is used to help ensure expected cost savings are realized.
23. Utah Medicaid should monitor results of (emergency room) utilization grants to determine which grants could feasibly transfer to Utah hospitals.
24. 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.
25. The Legislature and Utah Medicaid should consider moving away from a percent of charges to a revenue-code fee schedule.
26. Utah Medicaid should consider using more preventive care and case management through cost-saving programs such as medical homes and disease management.
27. Utah Medicaid should determine potential cost savings that could be realized through (health opportunity accounts), (Health Insurance Premium Payment), and other programs, and implement or expand them if savings are shown. (page 80)."

RECOMMENDATION: Require a report annually via intent language from the Department of Health on the implementation of "A Performance Audit of Utah Medicaid Managed Care" to be presented to the Health and Human Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.

Legislative Auditors "A Performance Audit of DWS Eligibility Determination Services"

"A Performance Audit of DWS Eligibility Determination Services" (2009) from the Office of the Legislative Auditor General provided nineteen recommendations for improvement in the Department of Workforce Services' eligibility determination services. For the full report, please visit http://www.le.state.ut.us/audit/09_19rpt.pdf. Because of the number of recommendations provided and the nature of the changes, the Analyst recommends that the Commerce and Workforce Services Appropriations Subcommittee receive an annual report on the progress of the implementation of these recommendations. There is already a follow up done the first year by the legislative auditors and presented to the Legislative Audit Subcommittee. This information may or may not be sufficient to meet the intent of this recommendation in the first year. The nineteen recommendations from the report are listed here below:

1. "We recommend that DWS exclude all eligibility workers who only determine eligibility for one program from the RMTS pool, including the following workers:
    a. Long-term-care eligibility workers
    b. Outstationed eligibility workers who only administer Medicaid eligibility
    c. Any other eligibility worker who only administers eligibility for one program
2. We recommend that DWS and the Department of Health reassess the amount that DWS could be reimbursed for CHIP eligibility determination costs in order to maximize federal funds.
3. We recommend that DWS exclude all RMTS responses that take longer than one working day for a response.
4. We recommend that DWS regularly train all eligibility workers in the RMTS pool how to respond to inquiries accurately and timely.
5. We recommend that DWS management refrain from encouraging eligibility workers to respond to certain programs if the eligibility workers are unsure what they were doing.
6. We recommend that DWS modify its cost allocation plan for outreach eligibility workers who only determine eligibility for medical assistance programs.
7. We recommend that DWS management encourage eligibility workers to respond as soon as possible after receiving a RMTS inquiry by doing the following:
    a. Requiring all employees to activate GroupWise Notifier
    b. Notifying supervisors if the eligibility worker has not responded within one hour of sending the RMTS inquiry
    c. Including RMTS timeliness on the annual performance appraisals for eligibility workers
    d. Requiring supervisors to explain why certain eligibility workers have a high number of non program responses (DWS audit pages 25-26)"
8. "We recommend that the Legislature review the effect of the medical assistance determination consolidation on the state's share of eligibility costs at the end of each fiscal year until 2012 to determine if Medicaid eligibility determination should remain at DWS.
9. We recommend that the Legislature determine how to use the $16.1 million that was appropriated for the TANF MOE but will not be needed for that purpose.
10. We recommend that DWS report the results of its cost allocation plan quarterly to the Legislature.
11. We recommend that DWS only use current year appropriations to pay for current year expenses instead of relying on the previous year's surplus.

12. We recommend that DWS defer TANF payments as long as possible. (DWS audit page 37)"
13. "We recommend that DWS actively develop partnerships with community organizations that share similar objectives.
14. We recommend that DWS encourage applicants to apply online by doing the following:
    a. Seeking out partnerships with public facilities that have internet access
    b. Encouraging applicants who call to apply for public assistance programs online
    c. Providing community partners with written instructions on how to apply online that they can give to applicants
    d. Training community partners to assist in the application process
15. We recommend that DWS management determine the feasibility of eliminating the following buildings: Emery County, Kanab, Logan, and South Davis.
16. We recommend that DWS management consider the feasibility of downsizing the following buildings: Nephi, Panguitch, and Tooele.
17. We recommend that DWS regularly evaluate the need for all buildings.
18. We recommend that the Department of Health regularly determine which hospitals should be considered disproportionate share.
19. We recommend that the Department of Health determine if all disproportionate-share hospitals should have an outstationed eligibility worker or submit an alternate in the State Plan. (DWS audit pages 48 to 49)"

RECOMMENDATION: Require a report annually via intent language from the Department of Workforce Services on the implementation of "A Performance Audit of DWS Eligibility Determination Services" to be presented to the Commerce and Workforce Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.

Legislative Auditors "A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program"

"A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program" (2009) from the Office of the Legislative Auditor General provided twenty-five recommendations for improvement in the Medicaid program. For the full report , please visit http://www.le.utah.gov/audit/09_12rpt.pdf . Because of the number of recommendations provided and the nature of the changes, the Analyst recommends that the Health and Human Services Appropriations Subcommittee receive an annual report on the progress of the implementation of these recommendations. The legislative auditors perform a follow up on their audits after the first year and can do additional follow up at the direction of the Legislature. This information may or may not be sufficient to meet the intent of this recommendation in the first year. Some of the recommendations from the report are contained in this report with several here below and others in other parts of this report.

RECOMMENDATION: Require a report annually via intent language from the Department of Health on the implementation of "A Performance Audit Of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program" to be presented to the Health and Human Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.

The legislative auditors determined that the Department of Health eventually could improve its fraud recoveries conservatively to 3% from its current 1.5% of total program cost, the State could save $5,818,000 General Fund and $14,404,000 federal funds (2009 Medicaid audit, pages 41 to 44). The Department of Health provided an update on what they are doing in response to obtaining some improved fraud software for the Medicaid program. There are two projects in progress:

1. Prepay editing software - working towards a January release date for a request for proposal (RFP) and pay for it with a cost savings arrangement where the vendor would get paid based on savings generated.

2. Fraud and abuse detection software - Health is working to get federal approval for a 90% federal match rate and to release a RFP the first part of February.

RECOMMENDATION: Remove $5,818,000 ongoing General Fund and $14,404,000 federal funds from Medicaid services in FY 2012 to match potential savings found from improved fraud recoveries discussed in the Legislative Auditor General's "A Performance Audit Of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program." Additionally, appropriate $3,386,800 one-time General Fund in FY 2011 to provide for a phased-in implementation.

The Public Employee's Health Program (PEHP) indicated that as of December 2009, it is currently receiving 2.6% of total claims paid in its recovery efforts. PEHP has just implemented a new fraud, waste, and abuse detection system and is currently hiring staff to ramp up the program.

RECOMMENDATION: Direct the Department of Health and Public Health Employee's Program (PEHP) via intent language to provide a report to the Legislature on ideas learned by PEHP that could be applied in Medicaid and a time frame for carrying out those proposals.

The legislative auditors expressed some concerns about the independence of Medicaid's fraud unit, the Bureau of Program Integrity, because it reports to the Medicaid Director. The auditors noted that in some other states this direct reporting relationship is prohibited in order to maintain independence (2009 Medicaid audit, pages 71 to 77). The Department of Health in a December 15, 2009 email stated: "The Bureau of Program Integrity was dissolved on 11-23-09 and most of the (Program Integrity) work was shifted to the new Office of Internal Audit Services. (The Bureau of Program Integrity) report(s) directly to Dr. David Patton. (The Bureau of Program Integrity is) no longer under the Division of Medicaid and Health Financing and…no longer report(s) to the State Medicaid Director."

RECOMMENDATION: Move the Bureau of Program Integrity through appropriations from part of Medicaid administration (Health Care Financing) to a budget program within the Executive Director's Office line item.

The legislative auditors determined that during the past 10 years Health's internal auditors had completed 3 of their 251 audit reports on Medicaid. These 3 audits represent about 1% of all audits completed (2009 Medicaid audit, pages 77 to 81). The Department of Health has indicated that Medicaid pays for approximately one third of the cost of their internal auditors.

RECOMMENDATION: Require internal Health auditors to do audits at least in proportion to their Medicaid funding, which is currently about one-third.

The recommendations below come straight from the Medicaid audit itself based on the research done by the Legislative auditors:

RECOMMENDATION: The "(Legislative Auditor General) recommend(s) that the Legislature consider the merits of extending access of the controlled substance database to (the Bureau of Program Integrity). If access is granted, (the Bureau of Program Integrity) should develop and institute controls to ensure providers are billing

Medicaid correctly and that prescriptions are appropriate in regards to frequency and dosage (2009 Medicaid audit, page 40)."

RECOMMENDATION: The "(Legislative Auditor General) recommend(s) that (the Bureau of Program Integrity) report annually to the Legislature and Governor on their cost avoidance and cost recovery efforts (2009 Medicaid audit, page 56)." This could be accomplished via intent language.

Utah State Auditor

The Utah State Auditor recommended the following from their annual financial audit for FY 2008 in relation to Medicaid (http://www.sao.state.ut.us/reports/08-33.pdf):

1. "We recommend that the Department of Health work with (Department of Workforce Services) and (Department of Human Services) to ensure that they follow established policies and procedures when determining eligibility for Medicaid Programs, including adequate documentation of all eligibility factors and decisions. We also recommend that the Department of Health work with (Department of Workforce Services) to ensure that Medicaid policies are interpreted properly."

2. "We recommend that the Department of Health work with (Department of Workforce Services) to ensure that Medicaid caseworkers follow policies and procedures pertaining to (Third Party Liability) by reporting all (Third Party Liability) information to (Office of Recovery Services) in a timely manner."

3. "We recommend that the Department exercise greater care and draw the federal funds on the appropriate dates coinciding with the Treasury-State Agreement clearance pattern guidelines." ("Drawing funds after the funds have been available for over a day results in lost interest to the State.")

Table 12 below summarizes the findings of the Utah State Auditor from the three items listed above.

Area Checked	Agency(s) Responsible	Problems	Sample Size	% Problems	Errors in Sample*	Total Paid in Sample	% Errors
Eligibility Determination	Workforce Services & Human Services	16	60	27%	$ 3,800	$ 1,281,700	0.3%
Third Party Liability	Workforce Services	2	60	3%	$ 3,500	N/A	N/A
Federal Draws	Health	2	16	13%	$ 9,000	N/A	N/A
*Only federal part of costs are questioned for the first 2 items, if State funds were added the amount and percentage and amounts of costs questioned would be higher.							

Table 12

Because the sampling by the State auditors was done on a random basis for the first two items, we can assume a version of these results are true for the entire Medicaid program. Applying the size of these problems to Medicaid means the State spent 0.3% or $1,251,100 General Fund more than it should due to eligibility determination errors in FY 2008. In FY 2009 the error rate was 0.6%. The $9,000 in errors for the federal draws represents interest lost by the State due to delays in drawing down federal funds by 5 and 13 days in the Children's Health Insurance Program and Medicaid. The State Auditors indicated that these problems were a year end problem and did not suspect that the problem happened throughout the year. The State Auditor has indicated that they do not feel they have resources to do any additional follow up on the issues raised in this audit (phone conversations with State Auditor December 2009 and January 2010).

RECOMMENDATION: Require a report via intent language from the Department of Workforce and the Department of Health on how they have addressed the problems found by the Utah State Auditor. After reviewing the results of the FY 2009 audit, the Legislature may want to consider requesting the auditors to check the status of this problem more frequently than the current annual basis.

Medicaid Management Information System

The current system used to process and pay medical claims, the Medicaid Management Information System, began in 1983 and is based upon a system that began operations in 1975 in Iowa. The Department of Health has expressed concerns about their ability to maintain the system due to a lack of available programmers' knowledge in the COBALT computer language. Additionally, the agency is concerned about the system's ability to meet federal requirements for 2012 and 2013 that will add details to the information required for medical billing. If the Legislature pursues replacing the Medicaid Management Information System, then the change could provide an opportunity to re-evaluate the information gathering and financial billing part of Medicaid as well as who should be providing these services. The Department of Health has indicated that most significant reimbursement changes would take at least a year of programming.

As part of its FY 2010 Appropriations Request, the Department of Health estimated the total cost to replace the Medicaid Management Information System at $85 million ($11 million General Fund) over a three-year period. The Department indicated that the replacement could be done in pieces by function. This request was not included as part of the Governor's FY 2011 Budget Recommendations. The agency received $2,000,000 total funds in FY 2008 to study a replacement of this system. From FY 2008 through FY 2010 the Department has requested non-lapsing authority for the unspent portions of these funds. The agency is nearing completion of its study and intends to spend all the remaining money by the end of FY 2011.

RECOMMENDATION: Require the Department of Health via intent language to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee its plans for a Request for Proposal for a Medicaid Management Information System replacement. The presentation should include the full array of options for which parts of claims processing are performed by State vs contracted workers. Consider funding a portion of this request beginning in FY 2011 in a separate line item. The intent language would need to be connected to an appropriation for the replacement.

RECOMMENDATION: Require the Department of Health via intent language to report to the Executive Appropriations Committee the responses to the request for proposals for the Medicaid Management Information System replacement. The intent language would need to be connected to an appropriation for the replacement.

Automatic Inflationary Increases

For the majority of providers, Medicaid has direct control over the rates that it pays and sets specific reimbursement amounts or methodologies for specific services. There are some exceptions which affect the State funds needed for Medicaid as discussed below with their total FY 2009 expenditures listed:

Federal Mandates:

- **Medicare Buy-in ($39 million)** – The federal government requires the State to pay Medicare premiums and co-insurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the Federal Poverty Level. Additionally, the State pays for Medicare premiums for qualifying individuals with incomes up to 135 percent of the Federal Poverty Level. Premiums have tended to increase annually. For the year beginning January 1, 2010, premiums increased 15%. Depending on how the client qualifies for Medicare determines the State's obligation to pay for that client's premiums and/or co-insurance. In cases where the State has opted to pay part or all of a client's Medicare expenses, the Department of Health estimates that by doing so the State will save money. The State gets the regular Medicaid match for the premiums and deductibles for Medicare and then the services received by the client are paid with 100% federal funds via the Medicare program.

- **Clawback Payment ($24 million)** – As part of the federal Medicare Modernization Act, effective January 1, 2006, Utah Medicaid no longer provides prescription drugs for Medicaid members who are also eligible for Medicare. Instead, Utah Medicaid is required to make "Clawback" payments to Medicare. This contribution is adjusted annually and has increased every year since the program started.

- **Federally Qualified Health Centers ($5 million)** – For specifically designated medical clinics that qualify as federally qualified health centers, Utah Medicaid must pay these clinics their full cost of providing Medicaid services. This is done through an annual adjustment at the end of each fiscal year and usually results in a payment that is higher than what Medicaid would normally pay. Utah has 10 federally qualified health centers.

State Decision:

- **Prescription Drugs ($127 million)** – The State has opted to reimburse prescription drugs based on the published Average Wholesale Price of a drug minus 15%. The State also uses two other pricing options to determine the lowest reimbursement option, but the Average Wholesale Price methodology is the most commonly used. The State has the option to change its methodology or pay a different percentage. The Average Wholesale Price is generated and published by an independent compendia that serves the pharmaceutical industry. There are no Utah pharmacies that do not accept Medicaid reimbursement for prescription drugs. The Department of Health estimates that prescription costs have increased 3% annually for the last five years. The Department of Health indicates that there are three states that use Wholesale Acquisition Cost as the basis of their reimbursement. The federal Deficit Reduction Act of 2005 initially outlined a plan to reimburse drugs based on the Average Manufacturer's Price. As of December 2009, the federal government had yet to publish rules to implement this change.

- **Outpatient Hospital ($109 million)** – The State has opted to pay a percentage of billed charges for reimbursing outpatient services. As the percentage charged by hospitals tends to increase annually, this results in annual increases in these costs for the State. The State currently pays about 40% of billed charges for outpatient services as well as 98% of billed charged for emergency room services for true emergencies.

- **Ambulatory Surgical Centers ($8 million)** – The State has opted to pay a percentage of billed charges for ambulatory surgical center services. As the percentage charged by ambulatory surgical centers tends to increase annually, this results in annual increases in these costs for the State.

- **Buy-out Insurance ($0.5 million)** – if Utah Medicaid determines it will be less expensive to pay for an individual's private insurance premiums, then to serve them in Medicaid, Medicaid pays for those premiums. The premiums paid for these types of insurances have increased an average of 10% annually during the last five years.

Cumulatively these expenditure categories where the State currently does not have direct control over pricing represented 18% of all FY 2009 expenditures. The federally mandated increases represent 4% of FY 2009 expenditures. The State may have an option to take more control over 14% of expenditures by changing its reimbursement methodology in the areas mentioned above under "State Decision." Any significant change in reimbursement methodology would be subject to federal approval.

In response to legislative intent language passed in the 2009 General Session, the Department of Health provided a report for options to move away from paying a percentage of billed charges for outpatient hospital services in September 2009. The full report is attached as Appendix E. The Department of Health has indicated that they would like legislative direction on which new option to adopt.

In a November 24, 2009 email from the Department of Health, the costs of two different reimbursement options for paying ambulatory surgical centers were analyzed: (1) 85% of Medicare rates and (2) 75% of Medicare rates. The first scenario would have saved the State $78,000 General Fund in FY 2009 and the second option would have saved $257,000. The Department has indicated that the current reimbursement computer system may not be flexible enough to compute rates based on Medicare reimbursement. Additionally, the Department estimates that programming changes required on the current system would take approximately one year.

RECOMMENDATION: Direct the Department of Health via statute to change their reimbursement methodology as soon as possible away from paying a percentage of billed charges for outpatient hospital and ambulatory center services reimbursements. The levels of reimbursement should be set at historical levels similar to what is being paid to other service providers.

"The State of Utah, along with other states have been involved in litigation with pharmaceutical companies for alleged fraud in connection with the reporting of inflated prices via the Average Wholesale Price reporting system. The Attorney General has two pending lawsuits with approximately 60 pharmaceutical companies in the Third District Court. Several significant verdicts and settlements (in other States) have resulted from this litigation (January 25, 2010 email from the Attorney General)."

RECOMMENDATION: Direct the Department of Health via intent language to report by October 1, 2010 on reimbursement options for pharmaceutical drugs that would give the State more control over inflationary increases and/or move away from a reimbursement based on Average Wholesale Price.

WHAT ARE SOME IDEAS FROM OTHER STATES AND ORGANIZATIONS?

Direct Contracting - QuadMed

A case study from the Commonwealth Fund from their September/October 2009 "Quality Matters" newsletter (http://www.commonwealthfund.org/Content/Newsletters/Quality-Matters/2009/September-October-2009/Case-Study.aspx) highlighted the use of direct contracting for primary care services by Quad/Graphics, a Wisconsin-based printing company providing medical services to about 20,000 individuals. Quad/Graphics provides its medical services to employees and others via QuadMed, which began in 1990. QuadMed has on-worksite locations to provide primary, dental, and vision care, as well as occupational and rehabilitative medicine and on-site pharmacy, x-ray, and laboratory services. Employees can use providers outside of the on-site clinics, but have a higher co-pay and deductible. The article notes some of the benefits of this arrangement as longer, unhurried visits with primary care providers and being able to complete needed lab/x-ray work all in 1 location. QuadMed has had an electronic medical record system for over ten years. Contracted medical providers are eligible for incentive bonuses if they perform well on national clinical guidelines and patient satisfaction. The program also has incentive programs for encouraging healthy behaviors and managing chronic diseases.

The following is a quote from the article: "Quad/Graphics spends more on primary care per patient than the average employer, but makes up the difference in lower costs for emergency department visits and hospitalizations. In 2008, for example, Quad/Graphics' outpatient visit rate was 15 percent higher for employees and family members in Wisconsin compared with the Midwest norm (434.2 vs. 377.5 visits per 100 lives), while its inpatient visit rate was more than 9 percent lower (55.7 vs. 61.5 per 1000 lives). The difference in dollars between Quad/Graphics' health care costs and those of other Midwestern employers has widened from $500 per employee (including family members) in 1991 to more than $2,500 lower in 2008 (Exhibit 3)." Exhibit 3 from the article is included here below as Figure 8:

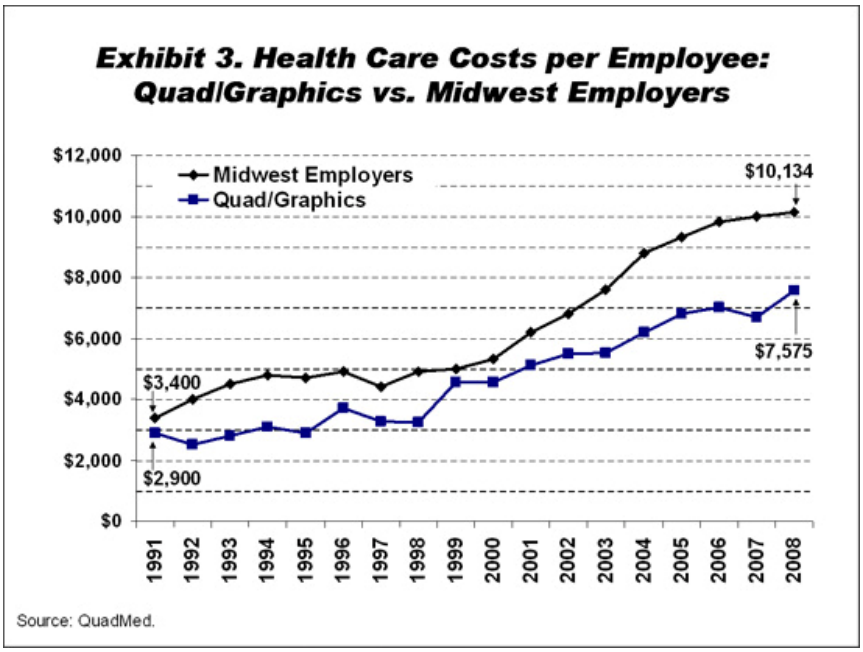

Figure 8

Directly contracting with providers to serve all Medicaid clients, like the example mentioned above, would require a waiver from the federal government. This type of arrangement may be best implemented in the rural setting as many urban Medicaid clients are served via contracted health plans. By directly contracting with providers, this may provide more time for patient care as the provider would no longer need to bill Medicaid for

every service. The primary administrative work would be verifying Medicaid eligibility and ensuring the quality of services delivered.

RECOMMENDATION: Explore contracting for direct Medicaid providers for primary care services. Direct the Department of Health to issue a Request for Information for direct contracting for primary care services and report on results to the Health and Human Services Appropriations Subcommittee by February 1, 2011.

Same Reimbursement for Same Service Across Providers and Incentives for Healthy Behavior - Safeway

A publication from the Commonwealth Fund's "Purchasing High Performance" Newsletter dated November 3, 2009 talked about the efforts of the Safeway company to reduce its costs of medical insurance it provides to about 30,000 individuals (http://www.commonwealthfund.org/Content/Newsletters/Purchasing-High-Performance/2009/November-3-2009/Interview/Safeway-Senior-Vice-President-Ken-Shachmut-Talks-about-Holding-Health-Care-Costs-Steady.aspx). Safeway has held its medical costs constant for 4 years from 2006 through 2009 and project reductions in medical costs in 2010 for the 30,000 employees it has on its programs.

Below is a discussion of the main elements of Safeway's approach as well as a discussion for what has been done in Medicaid or could be done:

1. **Dropped their menu of insurance options and changed to two options: (1) a consumer-driven model or (2) Kaiser –** with special permission Medicaid can restrict the number of options for clients to choose from. This is currently done in the large urban counties (Salt Lake, Weber, Davis and Utah) where clients are required to choose from one of the contracted health plans.

2. **Reimbursement levels for certain procedures set at levels deemed sufficient to get quality service, employee pays the rest (Approximate prices for services at different facilities are provided to the employees) –** this would not be allowed as a charge to the client, but the State could set reimbursement prices based on the lowest acceptable price available and providers could then choose whether or not to provide services at that price.

3. **$1,000 deductible –**Medicaid currently charges the maximum allowable deductible which is in the area of inpatient hospital where clients have a co-payment of $220. A broad deductible for services is not allowed in Medicaid. One way to somewhat mirror a deductible would be to set up Health Savings Accounts where clients would have to pay their medical bills from their accounts. This option is limited to expansion groups within Medicaid or a voluntary option for current Medicaid clients.

4. **Financial penalties for using the emergency room unnecessarily –** Medicaid already charges the maximum penalty allowable which is $6 per non-emergency use of the emergency room.

5. **Aggressive drug formulary to encourage use of generic drugs wherever possible –** the State uses a Preferred Drug list which was mentioned earlier in the report. This requires a prior authorization to be obtained when an approved generic substitute is available to replace a name brand drug.

6. **Financial incentives to take a health risk assessment & to meet goals in 4 areas: smoking, weight, cholesterol, and blood pressure (has 74% employee participation) -** The federal government limits what kinds of incentives can be given to Medicaid clients when federal matching funds are involved. The

approved rewards that could be given would have to be used by the clients on health related items. Medicaid cannot give cash rewards to clients with federal dollars.

7. **Financial incentives employees share in the savings –** see item #6 above.

Medicaid currently has differential pricing for its inpatient hospital services based on where the service was received. Inpatient hospital services for the same service receive a different reimbursement depending on which hospital or ambulatory surgical center provided the service.

RECOMMENDATION: In statute change the fee-for-service payment system to be the same for services regardless of who the provider is. Explore paying the lowest price for a service to all providers. If pricing cannot be fixed, then explore requiring a client to use an ambulatory surgical center for approved services before using a hospital unless prior authorization is approved.

Family Planning

Ashley Barton, Maternal and Child Health Coordinator for the Department of Medical Assistance Services with the State of Virginia, indicated in a November 18, 2009 email that the State of Virginia has seen $5.14 of savings for every dollar spent on family planning from FY 2006 through FY 2009. The State of Virginia provides family planning services to men and women age 19 and older with incomes up to 133% of the Federal Poverty Level. This is the level that Utah Medicaid covers pregnancies in Medicaid and represents the federally-required minimum. According to the Guttmacher Institute's "State Medicaid Family Planning Eligibility Expansions, State Policies in Brief" as of September 1, 2009, 27 States are providing family planning services in their Medicaid program through a federal waiver (http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf). Savings for a State through family planning services are easier to obtain than a simple 1:1 reduction in family planning services vs reduced medical costs because Utah pays 10% of the cost of family planning services and approximately 30% of the cost of medical services. Additionally, as with nearly all federal Medicaid waivers, the proposal must convince the federal government that the cost will be budget neutral (or better) in order to receive permission to provide the services. The savings from family planning services is largely from an estimate of unintended births avoided.

The National Academy for State Health Policy provided some summary information of a study funded by the federal government's Centers for Medicare and Medicaid Services on the impact of family planning services in six states. The study found that all six states (Alabama, Arkansas, California, New Mexico, Oregon, and South Carolina) saw substantial net savings from their family planning services. The annual savings ranged from $1.3 to $6.5 million in New Mexico to $76 million in California (http://www.nashp.org/sites/default/files/shpbriefing_familyplanning.pdf and http://www.nashp.org/sites/default/files/shpbriefing_familyplanningoutcomes.pdf).

Utah currently provides family planning services to the federally-required minimum group of women with children with incomes up to 44% of the Federal Poverty Level. Additionally, Utah covers women in the Primary Care Network with family planning services (income up to 150% of the Federal Poverty Level). Family planning services include everything that is considered a medical method family planning, such as birth control medications, sterilizations, and inserts. Emergency contraception and abortions are not covered services. In paying for pregnancy costs, Utah Medicaid pays a global fee after birth. This means that most of the potential savings from family planning may be delayed at least 9 months from beginning date of services.

The Department estimates that 100% participation amongst new potentially eligible women ages 18 to 50 with incomes up to 133% of the Federal Poverty Level would cost the State $2.6 million General Fund. The Department has not provided a savings estimate from family services for this new population. By providing the

Department with one-time General Fund, offset in future years by an ongoing reduction, this may help the Department start providing family services and cover the potential 9 month delay in achieving savings.

Medicare

A report entitled "Strategies for Reining In Medicare Spending Through Delivery System Reforms: Assessing the Evidence and Opportunities" found at http://www.kff.org/medicare/7984.cfm was prepared for the Henry J. Kaiser Foundation in September 2009. Among other recommendations, this report suggested the following for lowering costs in the Medicare program:

1. "Medical homes" within a physician practice, designed to provide coordinated care for beneficiaries directed by a single physician;
2. Electronic medical records as a means of reducing errors and redundant testing;
3. Bundling hospital and post-acute payments to reduce costs associated with unnecessary hospital readmissions and post-acute care;
4. Accountable health organizations, which are groups of different types of providers with shared financial incentives to provide quality care efficiently; and
5. Comparative effectiveness studies that could be used to guide treatment decisions.

While the Medicaid program has a different service population than Medicare (age 65 and older) and its members are not as consistent year after year like Medicare, these recommendations should be discussed further for possible application in the Medicaid program.

Two of the items above have already been discussed via Legislative Committee meetings and legislation. Those items are included here below as well as a summary of the discussions that have taken place:

1. "Medical homes" within a physician practice, designed to provide coordinated care for beneficiaries directed by a single physician;
    a. Department of Health presented at the October 29, 2008 meeting of the Health and Human Services Appropriations Subcommittee and discussed the following:
        i. Expressed concerns about current low physician reimbursement rates
            1. At that time paid about 75% of Medicare physician reimbursement rates
            2. In the 1990's we used to pay $3 per member per month to primary care providers to be the medical home for Medicaid clients
        ii. Suggested definition for a medical home:
            1. Established relationship with a health care provider
            2. Access to provider via telephone
            3. Access to the provider in the evening or on a weekend
        iii. Suggested starting with diabetic clients and getting those clients into medical homes

2. Bundling hospital and post-acute payments to reduce costs associated with unnecessary hospital readmissions and post-acute care;

    a. Department of Health presented at the October 29, 2008 meeting of the Health and Human Services Appropriations Subcommittee and suggested the following as next steps:

        i. Monitor the results of the 15 Medicare demonstration projects that started January 1, 2009

        ii. Open discussions with existing Medicaid managed care organizations about implementing an episode of care pricing model under a capitated contract

    b. In early 2010 it is anticipated that Medicaid will participate along with 5 other provider groups to for a pilot project with 2 new payment approaches: (1) monthly retainer fee to a physician for each diabetic patient and (2) bundled payments for deliveries (no difference of payment for vaginal vs Caesarean section). This project began from the direction given in HB 165 in the 2009 General Session.

RECOMMENDATION: Explore moving away from fee-for-service payments to pay for quality.

RECOMMENDATION: Direct the Department of Health to study the feasibility of a three-year pilot project with medical homes within their existing budget. During the third year of the pilot, the Department of Health shall report to the Legislature with recommendations for expansion or termination of the pilot project. Direct the Department of Health via intent language to study the five recommendations from the Henry J. Kaiser Foundation September 2009 report on Medicare and give options for implementation in the Medicaid program in a report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee by February 1, 2011.

Medicaid vs Medicare Rates

Medicaid is paying 82% of Medicare rates for medical services and 50% of dental rates in the Children's Health Insurance Program in FY 2010 (Department of Health email on December 23, 2009). Medicare does not pay for most dental services. In comparing inpatient hospital rates paid by Medicaid vs. PEHP, only a minority of PEHP payments match the methodology used for the majority of Medicaid payments. Medicaid on average paid 108% for the 34 of the top 50 rates with the highest total expenditure that could be compared with the rarer, higher cost cases excluded. The range by service for what was paid by Medicaid ranged from 26% for reattaching a limb to 246% of PEHP rates paid for chemotherapy for a client with leukemia. The Department of Health also indicated that because Medicaid uses the reimbursement methodology more, the program will have more higher cost cases than PEHP. Since FY 2009 the Department of Health estimates that inpatient hospital rates have been reduced 15%.

Primary Care Program – Alabama

The State of Alabama has a primary care program for their Medicaid clients which shares savings with providers based on performance, which began in 1997. Participating primary care providers may receive shared savings in one or two areas:

1. **Efficiency** – actual expenditures by clients under provider's supervision vs expected expenditures.

2. **Performance** - by comparing actual performance vs expected performance from peer provider groups, the following three areas of performance become the basis for payment:

    a. Percentage of generic drugs that are dispensed

    b. Average number of unique member visits

    c. Utilization of emergency rooms

Alabama spent about $9 million in monthly case management fees and estimated savings of $9 million in FY 2009. The $9 million in savings is divided equally between the State and providers (November 10, 2009 and January 6, 2010 emails from Alabama's Legislative Fiscal Analyst Office).

Waiver Programs

All waiver programs must be approved specifically by the federal government. The criteria for approval is that the waiver services will not cost more than services provided via the regular Medicaid service delivery and reimbursement system. The waivers allow for new or expanded benefits to be offered to specific groups of individuals in exchange for reducing or maintain overall costs to the program. The State's six Medicaid waivers are summarized below in Table 13.

Waiver Name	Total Spent FY 2009	Clients FY 2009	Average Annual Spending per Client	Annual Spending per Similar Non-waiver Client	Average (Savings)/ Cost Per Client	Started	Renewal Date	Renewal Period	Waiting List?
Community Supports for Individuals with Intellectual Disabilities	$150,935,800	4,476	33,700	$ 75,800	$ (42,100)	FY 1988	7/1/2010	5 years	Yes - 1863
New Choices	$ 17,719,300	800	22,100	$ 45,100	$ (23,000)	FY 2007	4/1/2010	5 years	No
Technology Dependent	$ 9,886,400	132	$ 74,900	$ 168,800	$ (93,900)	FY 1996	7/1/2013	5 years	Yes - 62
Individuals Aged 65 and Older (Aging)	$ 3,907,900	580	6,700	$ 51,800	$ (45,100)	FY 1993	7/1/2010	5 years	Yes - # N/A
Acquired Brain Injury	$ 2,484,900	99	25,100	$ 54,900	$ (29,800)	FY 1996	7/1/2015	5 years	Yes - 74
Individuals with Physical Disabilities	$ 2,018,400	116	17,400	$ 55,500	$ (38,100)	FY 1999	7/1/2011	5 years	Yes - 53
Totals/Averages	**$186,952,700**	**6,203**	**$ 30,000**	**$ 75,300**	**$ (45,300)**				**2,052**

Table 13

Below is a discussion of the five waivers that have capped enrollment:

1. **Community Supports for Individuals with Intellectual Disabilities** – the Department of Health indicates that most of the 1,863 individuals on the waiting list are not currently receiving any Medicaid services. "Medicaid eligibility for individuals on the waiting list is not routinely tracked at the point of intake because Medicaid eligibility occurs on a month-to-month basis which makes the information difficult for DHS to accurately maintain over time. DHS typically gathers Medicaid eligibility information when an individual's potential entrance into the waiver is eminent. For this reason, there is no data available on the number of people on the waiting list receiving Medicaid services (Department of Health January 25, 2010 email)."

2. **Technology Dependent –** the Department of Health indicated that: "This waiver is authorized to serve 'a maximum of 120 recipients at any point in time'. During FY 09, the waiver served a total of 132 recipients at an average per capita cost of $74,897.32...At the end of FY 09, the waiting list for this waiver included 62 individuals, 23 of whom required the level of technology and skilled medical care comparable to FY 09 waiver recipients. Eleven of the 23 were also Medicaid eligible, and their average per capita Medicaid costs in FY 09 were $183,980.51 (Department of Health December 1, 2009 email)."

"The Department of Health indicates there are a variety of reasons reason the other 11 qualifying individuals were not being served (in addition to the point in time "cap") is including: (1) the limited availability of home health agency providers serving pediatric patients; (2) the current capability of the technology dependent individual's family to care for him /her at home (this waiver does not provide 24 hour care and families must be able and willing to care for the child for the majority of the 24 hour day); and (3) - if and when there are a sufficient number of providers available - an increase in the number of recipients served at a point in time will require additional administrative and service funding. The Department of Health will continue to monitor the availability of qualified providers, and if and when access to waiver and state plan services for additional recipients can be assured and additional funding is made available, a request for an amendment will be considered at that time (Department of Health January 25, 2010 email)."

3. **Individuals Aged 65 and Older (Aging)** – the Department of Human Services indicates that the program is capped for enrollment, but they do not maintain information for those individuals denied services and do not maintain a waiting list. "For this reason, there is no data available on the cost of services to those denied Aging Waiver services. However, if Medicaid recipients denied waiver services chose to receive services in nursing facilities, the average annual cost per person is $51,832.00 versus the average annual cost per person in the Aging Waiver -$6,737.76. In order to increase the number of recipients served in the waiver, additional funding would be needed. If additional funding is secured, the Department of Health will amend the waiver as needed to increase the number of unduplicated recipients served. The amendment can be submitted at any time (Department of Health January 25, 2010 email)."

4. **Acquired Brain Injury** – "The Department of Health indicates the Department of Human Services (DHS) maintains the waiting list for this waiver. Medicaid eligibility for individuals on the waiting list is not routinely tracked at the point of intake because Medicaid eligibility occurs on a month-to-month basis which makes the information difficult for DHS to accurately maintain over time. For this reason, there is no data available on the cost of Medicaid services to those who qualify for Medicaid and are waiting for Acquired Brain Injury Waiver services. However, if Medicaid recipients denied waiver services chose to receive services in nursing facilities, the average annual cost per person is $54,902.00 versus the average annual cost per person in the Acquired Brain Injury Waiver - $25,100.42. In order to increase the number of recipients served in the waiver, additional funding would be needed. If additional funding is secured, the Department of Health will amend the waiver as needed to increase the number of unduplicated recipients served. The amendment can be submitted at any time (Department of Health January 25, 2010 email)."

5. **Individuals with Physical Disabilities** – "The Department of Health indicates the Department of Human Services (DHS) maintains the waiting list for this waiver. Medicaid eligibility for individuals on the waiting list is not routinely tracked at the point of intake because Medicaid eligibility occurs on a month-to-month basis which makes the information difficult for DHS to accurately maintain over time. For this reason, there is no data available on the cost of Medicaid services to those who qualify for Medicaid and are waiting for Physical Disabilities Waiver services. However, if Medicaid recipients denied waiver services chose to receive services in nursing facilities, the average annual cost per person is $55,514.00

versus the average annual cost per person in the Physical Disabilities Waiver - $17,399.82. In order to increase the number of recipients served in the waiver, additional funding would be needed. If additional funding is secured, the Department of Health will amend the waiver as needed to increase the number of unduplicated recipients served. The amendment can be submitted at any time (Department of Health January 25, 2010 email)."

RECOMMENDATION: Change statute to require the Departments of Health, Human Services, and Workforce Services to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee before reapplication of Medicaid waivers. The report should include an analysis of costs and benefits as well as recommendations on whether or not to expand enrollment and/or end the waiver.

APPENDIX A - TIMELINE OF MAJOR EVENTS FOR MEDICAID IN UTAH

1963 **Gov. Clyde adds staff to coordinate state programs to prepare for forthcoming Medicaid program.** Governor's staff assists the then independent Health Department with rapidly expanding challenges managing federal programs moving toward Medicaid.

1965 **Congress passes *Social Security Amendments of 1965* creating the Medicaid and Medicare programs.** Medicaid is jointly funded by both federal and state governments with each state's matching rate based upon a formula. **Utah starts its Medicaid program for acute and long-term care in 1966**.

1970's **Utah Starts Using Medicaid Funds for private Institutional Care Facilities for the Mentally Retarded and the Utah State Developmental Center.**

1970's In the late 1970's the program contracted for clinic services for care of State-funded indigent care. In the early 1980's, the **State started running its own health clinics in 1979** for individuals not otherwise eligible for Medicaid (later these clinics changed to serving clients eligible for all State medical public assistance programs including Medicaid)**.**

1977 **Congress establishes the Health Care Financing Administration (HCFA)** to coordinate and administer both Medicare and Medicaid. HCFA is renamed in 2001 as the Centers for Medicare & Medicaid Services (CMS).

1977 **Congress passes *Medicare-Medicaid Anti-Fraud and Abuse Amendments* establishing Medicaid Fraud Control Units**. The Utah Medicaid Fraud Control Unit is established in January of 1980 under the Department of Social Services. In 1981 it is transferred to the Department of Public Safety (DPS), Law Enforcement Services. In 1987 it becomes part of DPS, Criminal Investigative Bureau. In 2000, it is officially transferred to the Office of the Attorney General.

1980 **U.S. Supreme Court Case, *Harris v. McRae*.** Once a State voluntarily chooses to participate in Medicaid, the State must comply with the requirements of Title XIX and applicable regulations. Budget constraints do not allow a State to be out of compliance with Medicaid regulations.

1980 **Congress passes the Boren Amendment** establishing the 'reasonably cost related" test for nursing home rate setting. This was extended to hospitals the following year.

1980 **Legislature passes *County Indigent Funds Act*** providing that counties shall have no duty to care for those persons who have access to certain other means of assistance such as Medicaid or other means reasonably available.

1981 **Congress passes the *Omnibus Reconciliation Act (OBRA) '81*** authorizing home and community based services waivers.

1981 **Congress establishes disproportionate share (DSH) funds in *OBRA '81*.** These funds provided the authority to pay hospitals a higher rate to compensate for the cost of providing care to a disproportionate share of low-income patients.

1982 **Legislature passes HB 135, Medical Assistance Program** (Doane, Rogers), providing for development of a medical assistance program (later known as the Utah Medical Assistance Program or UMAP) for low income individuals not eligible under Medicaid or Medicare. The program allows for participation, by choice, of counties who must then agree to pay the equivalent of ¼ mill of assessed real property valuation in the county for the state to operate UMAP for qualified recipients within that county. UMAP eventually becomes fully state funded.

1982 **Utah receives approval of its first Freedom of Choice Waiver for managed care.** (Utah had enrolled Medicaid recipients into HMOs in the late 1970's under contractual agreements.)

1985 **U.S. Supreme Court Case, *Alexander v. Choate*.** States given a tool to restrict growth in the Medicaid program through reasonable program utilization controls.

1986 **Congress passes the *Sixth Omnibus Budget Reconciliation Act of 1985 (SOBRA)*** requiring states to cover low-income pregnant women.

1987 **Community Supports Waiver Begins,** providing an alternative to institutionalized care for Medicaid clients within the Department of Human Services' Division of Services for People with Disabilities.

1987 **Congress passes the *Omnibus Budget Reconciliation Act (OBRA) of 1987*** requiring states, through their Medicaid programs, to cover eligible children under age six.

1988 **Congress passes the *Medicare Catastrophic Coverage Act of 1988 (MCCA)***, creating nursing home spousal impoverishment provisions and mandated coverage under the Qualified Medicare Beneficiary (QMB) program. The MCCA also added Section 1902(r)(2) to the Social Security Act giving states the authority to adopt "more liberal income and resource methodologies" in their eligibility requirements. Prior to this, state eligibility methodologies could be no more generous than those of the Supplemental Security Income or Aid to Families with Dependent Children.

1990 **Congress passes the *Omnibus Reconciliation Act of 1990 (OBRA '90)***, phasing in the mandated coverage of children through age 18 with family income below 100% of the federal poverty level.

1991 **Utah's public mental health system enters a new capitated arrangement with the state Medicaid program (Department of Health) using a federally approved Medicaid waiver.** The new arrangement allows local county mental health centers to be the sole provider of Medicaid mental health services and to use a capitated fee (i.e. - a per person per month prepaid amount) to develop non-traditional services such as housing and other supports. Local mental health centers are also able to keep any profits earned and use these profits for other purposes such as funding services for non-Medicaid eligible clients. This arrangement lasts until 2003 when the federal *Balanced Budget Act* requires rates be certified and Medicaid funds be used to serve only Medicaid clients. This change creates a large funding gap in the public mental health system because of the loss of federal matching dollars previously providing services to non-Medicaid eligible clients.

1992 **Home and Community-based Waiver Begins,** providing an alternative to institutionalized care for Medicaid clients within the Department of Human Services' Division of Aging and Adult Services.

1993 **Legislature passes HB 204, *Utah Medicaid Hospital Provider Temporary Assessment Act*** (Valentine), imposing an assessment on hospitals to provide temporary funding sources (later repealed in 1998).

1993 **Legislature passes SB 37, *Counties Responsibilities for Poor Persons*** (Peterson), counties are relieved of any responsibility for the Utah Medical Assistance Program population.

1994 **Coverage of poverty level children ages 12 through 17 implemented,** accelerating the federally required phase in of this coverage. This phase in was completed in 2001.

1995 **Coverage of seniors and disabled individuals under 100% of poverty implemented.**

1995 **Home and Community-Based Waiver begins,** providing an alternative to institutional care for Medicaid covered children who are dependent on technology (Travis C. Waiver).

1995 **Home and Community-Based Waiver begins,** providing an alternative to institutional care for Medicaid covered individuals who had a severe brain injury.

1995 **State starts its first dental clinic,** providing services to UMAP patients (and later other low income patients).

1996 **Mandatory enrollment of all non-institutionalized Medicaid recipients on the Wasatch front in risk-based contracting HMOs completed.**

1996 **Legislature passes HB 375, *Department of Workforce* Services** (Protzman), consolidating the Dept. of Employment Security (Job Service), the Office of Family Support (Human Services), the Turning Point Program (Education), the Office of Job Training (Community and Economic Development), and the Office of Child Care (Community and Economic Development) into the new department. Eligibility workers for purely Medicaid cases are allowed to remain in the Department of Health.

1996 **Congress passes the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996,*** creating the Temporary Assistance to Needy Families (TANF) program, severing the direct eligibility tie between family cash assistance and Medicaid.

1996 **All Medical-only Cases are Transferred to the Department of Health**, cases receiving multiple kinds of assistance remain with the Department of Workforce Services.

1997 **Congress passes the *Balanced Budget Act of 1997 (BBA)***, instituting Medicaid managed care beneficiary protections and quality standards. The BBA also repealed the Boren Amendment, relaxing standards on rate setting for hospitals and nursing homes .

1998 **Home and Community-Based Waiver begins,** providing an alternative to institutional care for individuals with a physical disability.

1999 **The U.S. Supreme Court decides *Olmstead v. L.E. ex rel. Zimring,*** holding that the unnecessary institutionalization of the disabled violates the *Americans with Disabilities Act* (ADA) when the state's treatment professionals have determined community placement is appropriate, a less restrictive setting

is not opposed by the individual, the community-based care is a reasonable accommodation, and the placement does not require a state to "fundamentally alter" its services or programs.

2000 **The Long-Term Care Managed Care Demonstration initiated,** providing alternative services to adults residing in nursing homes.

1999-2002 - **Legislature passed intent language for four years consecutively asking for detailed outcome measures for disability and aging services funded through the Departments of Health, Human Services, Workforce Services, and the State Office of Education**

2002 **Primary Care Network replaces the Utah Medical Assistance Program,** the Primary Care Network serves individuals not otherwise eligible for Medicaid with a limited array of primarily preventative medical and dental care services.

2002 **Legislature approves funding for 2 new eligibility groups**, clients with breast and/or cervical cancer with incomes up to 250% of the Federal Poverty Level and employed disabled clients with incomes up to 200% of the Federal Poverty Level can now receive Medicaid services.

2002 **Medicaid contracting Health Maintenance Organizations converted to non-risk contracts.**

2003 **Utah federal court dismisses the M.A.C. and D.C.C., et al. v. SCOTT D. WILLIAMS, Executive Director of the Utah State Department of Health, et al..** This federal class action lawsuit seeks to compel immediate funding of the Division of Services for People with Disabilities waiting list. Utah federal court holds that requested relief is a fundamental alteration of Utah's program and the relief sought is denied and the case dismissed.

2003 **Legislature passes HB 37, *Restructure Spend Down Provisions for Medicaid*** (Lockhart), raises income eligibility level for the aged, blind, and disabled in Medicaid from 75% of the Federal Poverty Level (FPL)to 100%. It also set the "spenddown" threshold for the aged, blind and disabled at 100% of the FPL.

2003 **Congress passes the *Medicare Prescription Drug Improvement and Modernization Act of 2003***, providing pharmacy benefits to Medicare beneficiaries, including those also receiving Medicaid and imposed the "clawback" payments on states.

2004 **Legislature passes SB 128, *Long-term Care Facilities Amendments*** (Blackham), which institutes an assessment on nursing care facilities. This money is then matched with federal funds and returned to the nursing care facilities in the form of a higher reimbursement.

2006 **Legislature passes HB 288, *Health Care Amendments for Foster Children*** (Hogue), expands Medicaid eligibility to include 18 year-old graduates of foster care up to age 21.

2006 **Legislature passes SB 6, *Health and Human Services Sunset and Reporting Amendments* (Christensen),** requires the Department of Health to notify the Executive Appropriations Committee if they amend the state medical plan, initiate new waivers, and they must inform of the current practice, new practice and fiscal impact. In 2008, the Legislation increased the reporting requirements via HB 82, *Notice of Changes to the State Medicaid Plan* (Newbold).

2006 -
2007 **Legislature convenes Medicaid Interim Committee** to review Medicaid as well as other programs in the departments of Health, Human Services, Workforce Services, and the State Office of Rehabilitation.

2006 **Legislature directs the Department of Health to get a waiver for matching federal funds to private donations for providing optional services.** The federal government approves the waiver and the Department receives funding sufficient for dental services in FY 2007 from Intermountain Healthcare.

2007 **Legislature transfers Medicaid eligibility (funding and workers) from the Department of Health to the Department of Workforce Services** to consolidate all Medicaid eligibility staff.

2007 **Legislature passes SB 42, *Preferred Prescription Drug List*** (Christensen), authorizes the Department of Health to develop a preferred drug list. In 2008 the Legislature passed **HB 258, *Medicaid Drug Utilization Amendments*** (Lockhart), prohibits the inclusion of immunosuppressive drugs used to prevent transplanted organ rejection: (1) on a preferred drug list for the State Medicaid Program, (2) in step therapy requirements of the Drug Utilization Board, and (3) in generic substitution requirements of the State Medicaid Program. In 2009 the Legislature passed **SB 87, *Preferred Drug List Revisions*** (Christensen), which allowed the Department to require a physician obtain a prior authorization before deviating from the preferred drug list.

2008 **Legislature makes 2 budget line items, Medicaid Optional Services and Medicaid Mandatory Services, out of 1 old line item, Medical Assistance for Medicaid services delivered through the Department of Health.**

2009 **Congress passes the *American Recovery and Reinvestment Act (ARRA) of 2009*** providing over $240 million in Medicaid funding to Utah with the requirement that eligibility standards for Medicaid not become more restrictive through December 31, 2010 than what was in place July 1, 2008.

2009 **One of two Medicaid HMO reverts to a risk-based contract.** Effective September 1, 2009 the Molina Health Plan accepted a full risk, capitated contract for the clients they serve in Medicaid.

APPENDIX B – HELPFUL RESOURCES AND LINKS TO SOURCES MENTIONED IN THIS REPORT

1. "*Understanding Medicaid; A Policymaker's Introduction*," Office of Legislative Research and General Counsel – this document is from December 2005 but the concepts are all very relevant, just the dollar amounts are larger. http://www.le.state.ut.us/lrgc/briefingpapers/understandingmedicaid2005.pdf

2. *"A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program"* (digest only), Office of the Legislative Auditor General - The full 102 page report can be accessed at http://www.le.utah.gov/audit/09_12rpt.pdf (the agency response and plan of action is Appendix D)

3. *"A Performance Audit of Utah Medicaid Managed Care,"* Office of the Legislative Auditor General - The full report can be accessed at http://www.le.utah.gov/audit/10_01rpt.pdf.

4. *"A Performance Audit of DWS Eligibility Determination Services,"* Office of the Legislative Auditor General http://www.le.state.ut.us/audit/09_19rpt.pdf

5. *"In-depth Budget Review: Department of Workforce Services,"* Legislative Fiscal Analyst, December 15, 2009 presentation to the Executive Appropriations Committee, http://www.le.utah.gov/interim/2009/pdf/00001675.pdf

6. *"Department of Health; Management Letter For the Year Ended June 30, 2008*," Report No. 08-33, Utah State Auditor, http://www.sao.state.ut.us/reports/08-33.pdf

7. Special Health and Human Services Appropriations Subcommittee Meeting at the Request of the Health System Reform Task Force on reform in Medicaid, held on October 29, 2008:

    a. Meeting topics - http://www.le.utah.gov/Interim/2008/html/00001617.htm

    b. Audio of meeting - http://www.le.utah.gov/asp/interim/Minutes.asp?Meeting=7132#Audio

    c. Staff presentation materials:

        i. Medicaid physician providers http://www.le.utah.gov/interim/2008/pdf/00001859.pdf

        ii. Idaho Medicaid Primary Care Management System http://www.le.utah.gov/interim/2008/pdf/00001860.pdf

8. Governor's Budget Recommendations for FY 2011 (http://governor.utah.gov/budget/Budget/Budget%20Recommendations/FY2011_RecBk.pdf)

APPENDIX C – SUMMARY OF MEDICAID INTERIM COMMITTEE

"Medicaid Interim Committee; Summary of Studies, Legislation Recommended, and Other Actions, 2006-2007," Office of Legislative Research and General Counsel – summarizes the two years of work by the Legislative committee assigned to look at Medicaid and come up with recommendations for changes and improvements.

MEDICAID INTERIM COMMITTEE: SUMMARY OF STUDIES, LEGISLATION RECOMMENDED, AND OTHER ACTIONS, 2006 – 2007

Source:
2007 LEGISLATIVE INTERIM REPORT
A report to the 57th Legislature on
recommended legislation and studies
from the 2007 Legislative Interim Committees
(pp. 10, 11, 81-86)

Office of Legislative Research and General Counsel
January 2008

RECOMMENDED LEGISLATION

Medicaid 340B Drug Pricing Programs, H.B. 74 - This bill requires the department to explore the feasibility of expanding the use of 340B drug pricing programs in the state Medicaid program; requires the department to report to the Legislature's Health and Human Services Interim Committee and Health and Human Services Appropriations Subcommittee regarding implementation of the expansion of the 340B drug pricing program; and sunsets the section on July 1, 2013 (page 84).

Medical Benefits Recovery Amendments, S.B. 50 - This bill defines terms; recodifies the Medical Benefits Recovery Act; modifies provisions related to recovery of medical assistance from a recipient's estate or a trust, so that recovery can be made as soon as an exception to recovery, relating to a surviving spouse or child, is no longer in effect; provides for the imposition of a lien, authorized by the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), against the real property of a person who is an inpatient in a care facility, during the life of that person; establishes procedures, requirements, and exemptions, relating to imposing a TEFRA lien; establishes a rebuttable presumption that a person who is an inpatient in a care facility cannot reasonably be expected to be discharged from the care facility and return to the person's home, if the person has been an inpatient in a care facility for a period of at least 180 consecutive days; provides for review and appeal of a decision to impose a TEFRA lien; provides for the dissolution and removal of a TEFRA lien; provides that an agency that the department contracts with to recover funds paid for medical assistance under the Medical Benefits Recovery Act shall be the sole agency that imposes or removes a TEFRA lien; and makes technical changes (page 86).

Notice of Changes to the State Medicaid Plan, H.B. 82 - This bill clarifies the content of the Department of Health's notice to the Legislature when the department makes a change to the state Medicaid plan; and makes technical and clarifying changes (page 85).

MEDICAID INTERIM COMMITTEE

Membership
Sen. Allen M. Christensen, Senate Chair
Rep. Merlynn T. Newbold, House Chair
Sen. Gene Davis
Sen. Lyle W. Hillyard
Sen. Sheldon L. Killpack
Sen. Ross I. Romero
Rep. Stephen D. Clark
Rep. Tim M. Cosgrove
Rep. Bradley G. Last
Rep. David Litvack
Rep. Michael E. Noel
Rep. Paul Ray

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Stan Eckersley, Fiscal Analyst
Russell Frandsen, Fiscal Analyst
William Greer, Fiscal Analyst
Debbie Headden, Fiscal Analyst
Danny Schoenfeld, Fiscal Analyst
Gary Syphus, Fiscal Analyst
Juliette Tennert, Economist
Catherine J. Dupont, Associate General Counsel
Thomas R. Vaughn, Associate General Counsel
Phalin L. Flowers, Legislative Secretary

OVERVIEW

As in many other states where commissions or other groups have been created in recent years to study Medicaid, the Legislature created the Medicaid Interim Committee in 2006 to identify ways to reduce the high rate of spending growth and federal partnership that pays for health care services to many of Utah's expectant mothers, aged, and disabled.

ACCOUNTABILITY

Background
The Deficit Reduction Act of 2005 authorizes state Medicaid programs to create "health opportunity accounts," increase copays, and vary services across populations. These provisions, however, are limited to certain groups of enrollees. Prior to the Deficit Reduction Act, some states adopted similar provisions under waivers.

During the 2006 and 2007 interims, the Committee reviewed actions taken by other states to link individual enrollee behavior to program benefits and costs and recommended that a pilot program for health opportunity accounts be studied and established.

Action
The Committee considered this issue at its January 5, November 20, and December 12, 2007 meetings, but did not recommend draft legislation.

CONSOLIDATION OF MEDICAID ELIGIBILITY SERVICES

Background
In the past, Medicaid eligibility was determined by two state agencies, the Department of Health and the Department of Workforce Services. During the 2006 interim, the Committee considered a proposal to consolidate all eligibility functions under the Department of Workforce Services. The proposal was expected to simplify the eligibility process for potential enrollees, reduce spending on duplicate office space, and perhaps result in some long-term cost avoidance. In January 2007, the Committee recommended that the Commerce and Workforce Services Appropriations Subcommittee and the Health and Human Services Appropriations Subcommittee consider the proposal for the 2007 General Session. Both committees studied the proposal and the Legislature approved the consolidation, transferring funding from the Department of Health to the Department of Workforce Services for 255 full-time equivalent employees, 10 offices, and 10 vehicles.

Action

The Committee considered this issue at its January 2007 meeting, but did not recommend draft legislation.

HEALTH AND HUMAN SERVICES PROGRAMS GENERALLY

Background

Prior to focusing its attention on Medicaid, the Committee reviewed spending trends across all health and human services programs. During the 2006 interim, the Committee conducted a survey of 177 health and human services programs delivered by:

- the Department of Health;
- the Department of Human Services;
- the Department of Workforce Services;
- the State Office of Rehabilitation; and
- the Utah Schools for the Deaf and Blind.

Through the survey, the Committee collected data on eligibility, expenditures, clients served, federal requirements, and the potential impacts of increasing, decreasing, or eliminating state funding. The Committee also received testimony from persons representing consumers, providers, and program administrators of various health and human services programs on how to manage program costs and increase consumer accountability.

Action

The Committee considered this issue during the 2006 interim, not during the 2007 interim, and did not recommend draft legislation in either year.

LIMIT ON OVERALL SPENDING GROWTH

Background

Although Medicaid enrollment has declined somewhat from the levels experienced during the recent economic down turn and annual spending growth has dropped into the single digits, the program is expected to continue its long-term pattern of growing much faster than its revenue sources and other areas of the state budget.

During the 2006 interim, the Committee received reports from staff on the potential growth of future Medicaid budgets and reviewed strategies used by other states to constrain program costs.

In January 2007, the Committee recommended that the Legislature limit the growth in state funding for Medicaid to five percent in FY 2008. State funds appropriated to Medicaid for FY 2008 during the 2007 General Session were approximately three to four percent greater than the amount appropriated for FY 2007.

In January 2007, the Committee also recommended:

- an "acceptable growth" formula be developed and used by the Legislature in future sessions to limit Medicaid growth (among other factors, the formula should recognize the economic impact of the program);
- a precise Medicaid mission statement be developed by either the Medicaid Interim Committee or the Health and Human Services Appropriations Subcommittee and used to prioritize services;
- the Department of Health and the Department of Human Services explore options for reducing Medicaid costs and report their findings to the Health and Human Services Appropriations Subcommittee;
- the Department of Health implement an electronic medical record system for Medicaid and issue a request for proposals to find out whether vendors would be willing to accept payment for developing and implementing the system on a percentage of savings basis; and
- the state consider the offer by Digital Healthcare to conduct a no-cost audit of Medicaid prescription drug purchases to determine the amount of potential cost recovery from third party payers.

During the 2007 General Session, in an attempt to provide services in a more cost effective manner, the Legislature earmarked $174,000 of the amount appropriated to Medicaid in FY 2008 for a capitated adult vision program, pending federal approval.

Action

The Committee considered this issue during the 2006 interim and at its January and October 2007 meetings, but did not recommend draft legislation.

LONG-TERM CARE

Background

Nationally, the aged and persons with a disability make up only 25 percent of Medicaid's enrollment but account for 70 percent of its costs. In Utah, a similar pattern exists. The Committee studied what could be done to reduce the costs associated with these populations, particularly in the area of long-term care services. The Committee received suggestions from many stakeholders, including consumers, providers, and state and local agencies responsible for funding many of these services.

The Committee focused on four areas believed to have potential to reduce long-term care spending: (1) increasing the use of long-term care insurance; (2) increasing the use of home and community based services; (3) reducing nursing home capacity; and (4) prohibiting the future construction of nursing care facilities that derive a majority of their revenue from Medicare patients.

Long-term care insurance is still a relatively new product and not widely used like other forms of insurance. States have used tax incentives to promote the purchase of long-term care insurance. In Utah, taxpayers have been able to deduct their long-term care insurance premiums since 2000. However, that deduction was not carried forward as a credit against the new flat income tax. The Committee discussed whether the new flat tax should include a credit for premiums paid for long-term care insurance.

Nationwide, there has been much discussion about "rebalancing" the long-term care system so that services otherwise provided in nursing homes are provided in home and community based settings where appropriate. The Committee considered a proposal by the Division of Aging and Adult Services to increase placement in home and community based settings. The proposal would create a pilot program that: (1) trains discharge planners in one hospital from each of the major hospital chains about home and community placement options; and (2) sets aside funding so that placement slots are available specifically for those hospitals.

Funding three slots per hospital per month would cost approximately $320,000 in state funds. By contrast, funding the same number of slots in nursing homes would cost approximately $1,300,000 in state funds. The Committee recommended that the proposal be sent to the Health and Human Services Appropriations Subcommittee.

On the whole, Utah nursing homes appear to be operating at excess capacity. Some believe that reducing overall capacity would decrease Medicaid expenditures. Although Utah caps the number of nursing home beds that may be certified for use by Medicaid patients, an exemption permits individual facilities to expand capacity by up to 30 percent each year under certain conditions. The Committee studied the criteria for granting Medicaid certification and the formula used to reimburse nursing homes for long-term care.

During the 2007 General Session, the Legislature imposed a moratorium on the construction of nursing care facilities that derive a majority of their revenue from Medicare patients. The moratorium is scheduled to expire July 1, 2009. The Committee considered whether the moratorium should be extended.

Action

The Committee considered this issue during the 2006 interim and at its July 20, September 7, October 3, November 2, November 20, and December 12, 2007 meetings and recommended that the sunset date for *Utah Code* 26-21-23, which governs the licensing of a new nursing care facility and the licensing of additional beds within an existing nursing care facility, be extended to July 1, 2011.

PHARMACEUTICALS—340B DRUG PURCHASING PROGRAM

Background

Several years ago the Utah Medicaid program arranged for enrollees with hemophilia to purchase their medications through the federal 340B drug program. The 340B drug program allows prescriptions to be purchased at a price sometimes lower than the Medicaid price through federally qualified health centers, disproportionate share hospitals, and other qualified entities. During the 2007 interim the Committee studied whether other Medicaid enrollees could be added to the 340B program. The Committee considered draft legislation, "Medicaid 340B Drug Pricing Programs," which requires the Department of Health to explore the feasibility of expanding use of the 340B program and report to the Legislature.

Action

The Committee considered this issue at its July 20, September 7, November 2, and November 20, 2007 meetings and recommended draft legislation, "Medicaid 340B Drug Pricing Programs."

PHARMACEUTICALS—AVERAGE MANUFACTURER'S PRICE

Background

Federal Medicaid law requires that payment to a pharmacist for a prescription drug sold to a Medicaid enrollee be made in two parts: (1) a reimbursement to cover the pharmacist's cost of acquiring the drug; and (2) a dispensing fee to cover the pharmacist's costs associated with dispensing the drug, i.e., overhead and profit. Historically, reimbursement to Utah pharmacists has been a percentage of the AWP (average wholesale price), subject to several other limits. Recent federal action has provided states with a new measure for either calculating or limiting reimbursements— the AMP (average manufacturer's price). The Department of Health has been considering the impact of adopting AMP as a basis for determining pharmacy reimbursement.

The Committee received testimony from the following on the impact of adopting AMP as a basis for determining pharmacy reimbursement:

- Utah Pharmacists Association,
- National Association of Chain Drug Stores,
- Department of Health,
- Medicaid Fraud Control Unit, and
- Office of the Legislative Fiscal Analyst.

The Committee discussed how to adequately reimburse low volume pharmacies while not overcompensating high volume pharmacies.

Action

The Committee considered this issue at its July 20, September 7, and November 2, 2007 meetings, but did not recommend draft legislation.

PHARMACEUTICALS—GENERAL

Background

Notwithstanding the mandatory use of generic drugs and other strategies implemented by the Department of Health, pharmaceutical spending is the fastest growing component of Utah's Medicaid program. During the 2006 and 2007 interims, the Committee reviewed utilization control and cost containment strategies employed by the Department of Health, other states, and the private sector to reduce the growth in spending on Medicaid pharmaceuticals. These strategies included additional use of the federal 340B drug program, limiting payment for pharmaceuticals to a percentage of average manufacturer's prices, and implementing a preferred drug list.

Action

The Committee considered this issue during the 2006 interim and at its January, July, and September 2007 meetings, but did not recommend draft legislation.

PHARMACEUTICALS—PREFERRED DRUG LIST

Background

During the 2006 interim, the Committee studied whether to institute a Medicaid PDL (preferred drug list) to reduce pharmaceutical cost increases. The Committee concluded that additional study was needed. During the 2007 General Session, the Legislature authorized use of a PDL with the passage of S.B. 42, "Preferred Prescription Drug List."

Following the 2007 General Session, the Committee reviewed the rules proposed by the Department of Health to implement the PDL. The PDL went into effect October 1, 2007, and is expected to reduce the growth of General Fund spending on pharmaceuticals by $1.3 million in FY 2008. Initially, the PDL applied to only statins and proton pump inhibitors. On December 1, 2007 the PDL was expanded to include oral hypoglycemics and diabetic supplies. By the end of FY 2008, the PDL is expected to include several other classes of drugs.

S.B. 42 prohibits the Department of Health from including psychotropic and anti-psychotic drugs on the PDL. The Committee discussed narrowing the exclusion for psychotropic drugs, which may be unduly broad.

S.B. 42 also allows a physician to override the preferred drug list by documenting medical necessity and writing "dispense as written" on the prescription. The Committee studied, but did not recommend, whether to replace the physician override with a provision requiring prior authorization from the Department of Health. Use of prior authorization would likely decrease the use of drugs not on the PDL and thus reduce pharmaceutical spending.

Action

The Committee considered this issue during the 2006 interim and at its January, July, and September 2007 meetings, but did not recommend draft legislation.

OTHER STUDIES

Legislative Oversight

In 2003, the Legislature required the Department of Health to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee whenever the Department implements a change in the Medicaid State Plan, initiates a new Medicaid waiver, submits an amendment to an existing Medicaid waiver, or initiates a rate change requiring public notice under state or federal law. The report must include the proposed change in services or reimbursement; the effect of an increase or decrease in services or benefits on individuals and families; the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and the effect of any proposed increase of benefits or reimbursement on current and future appropriations from the Legislature to the Department. In 2003,the requirement was modified slightly to require the Department to report whenever an amendment to an existing Medicaid waiver is initiated, rather than submitted.

The Committee considered draft legislation, "Notice of Changes to the State Medicaid Plan," that would clarify the Department's reporting requirements by requiring any report to include:

- a description of the Department's current practice or policy that the Department is proposing to change;
- an explanation of why the Department is proposing the change;
- the effect the proposed change may have on federal matching dollars received by the state Medicaid program;
- any costs shifting or cost savings within the Department's budget that may result from the proposed change; and
- identification of the funds that will be used for the proposed change, including any transfer of funds within the Department's budget.

The Committee considered this issue at its December 2007 meeting and recommended draft legislation, "Notice of Changes to the State Medicaid Plan."

Pharmaceutical Litigation
The MFCU (Medicaid Fraud Control Unit) within the Office of the Attorney General reported that it has filed law suits against several pharmaceutical manufacturers to recover reimbursement payments, alleging that the manufacturers used inflated average wholesale prices to market their products.

MFCU also reported that the state has filed suits against Eli Lilly and Merck for failure to warn the public of known risks associated with two drugs, Zyprexa and Vioxx.

The Committee considered this issue at its October 3 and November 20, 2007 meetings, but did not recommend draft legislation.

Reauthorization of the Medicaid Interim Committee
The Committee discussed its accomplishments and whether it should continue its work for an additional year. The Committee considered this issue at it December 2007 meeting and recommended that the Legislative Management Committee reauthorize the Medicaid Interim Committee in 2008.

Recovery of Long-term Care Benefits
Existing law allows the Department of Health to recover the value of Medicaid benefits provided to a recipient 55 years of age or older by imposing a lien on the recipient's estate or trust if the recipient does not have a surviving spouse or does not have a child who is under 21 years of age, blind, or permanently and totally disabled. In practice, the Department is often unable to recover the value of benefits provided because a recipient's heirs liquidate the estate or trust before the Department is able to complete the recovery process. To avoid this problem, many states have authorized use of liens against the real property of a Medicaid recipient who has become permanently institutionalized. The Committee considered draft legislation, "Medical Benefits Recovery Amendments," that would allow the use of these liens, authorized under federal law and called TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) liens, to notify potential heirs of the recovery process and provide notification to the state of any attempt to transfer the property once a Medicaid recipient has become permanently institutionalized for at least 180 days.

The Committee considered this issue at its November 20 and December 12, 2007 meetings and recommended draft legislation, "Medical Benefits Recovery Amendments."

APPENDIX D – DEPARTMENT PLAN OF ACTION TO IMPLEMENT RECOMMENDATIONS FROM LEGISLATIVE AUDITOR GENERAL'S PERFORMANCE AUDIT

Utah Department of Health Plan of Action to Implement Recommendations from Legislative Auditor General's "A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program," sent via email September 15, 2009

UTAH DEPARTMENT OF HEALTH

PLAN OF ACTION

TO IMPLEMENT RECOMMENDATIONS

FROM LEGISLATIVE AUDITOR GENERAL'S PERFORMANCE AUDIT

(NUMBER 2009-12)

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

September 10, 2009

INTRODUCTION

This document is the Utah Department of Health's Plan of Action in response to the Legislative Auditor General's performance audit (Number 2009-12) *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program*. The report was presented to the Legislative Audit Subcommittee on August 18, 2009. A copy of the report can be obtained at the following link: http://www.le.utah.gov/audit/09_12rpt.pdf.

As was stated in the Department's letter of response to the audit report, the Department accepts all of the audit report's recommendations. The Department's remedial actions to implement the recommendations are set forth in detail in this response.

This document is organized by audit report chapters. For each chapter, we begin by addressing that chapter's recommendations and our remedial actions to implement those recommendations. We follow these recommendation responses with audit report comments that are intended to place DOH context and clarification on comments made in the audit report. Since the audit report began making recommendations in Chapter 2, this document starts with Chapter 2 and proceeds through Chapter 6.

Each chapter contains the Department's plans for implementing each of the Legislative Auditor General's recommendations. The plans include target completion dates, responsible manager and specific actions to be taken. Where additional detail may provide helpful context to issues raised in the audit, this information can be found at the end of each chapter under the heading "Audit Report Comments."

EXECUTIVE SUMMARY

Oversight of Prior Authorizations

The audit found that policies were either non-existent, unclear, or inconsistently applied. Thus, medical procedures were either approved or denied inappropriately. A review of the policies is ongoing, and includes the assistant attorney general that advises the Medicaid agency in this area. Additional training of prior authorization staff will be ongoing.

Finally, the Department has assigned a staff physician to monitor and evaluate the decisions of the prior authorization nurses. The monitoring is based on a statistically valid random sample of cases. The physician audits the work of individual staff members across the various categories of service.

Fraud and Abuse Detection (FAD) Tool

Inappropriate payments can be avoided or recovered if made in error. The Department is committed to implement all cost effective strategies to assure that taxpayer funds are effectively managed.

A review by an outside contractor of all claims paid in the last two years is scheduled. This will be done free of charge to demonstrate the value of a possible pre-payment review software package. This review should be complete in early November, 2009. A request for proposal to acquire pre-payment review capability will also be issued.

The Department, with approval and funding from the 2007 Legislature, has been studying Medicaid systems replacement options and strategies for the past two years. One of the recommendations from this study was to build component parts to a new system.

In March 2009, the Department issued a Request for Information (RFI) from potential post-payment FAD contractors. The responses showed initial development and installation costs of a new FAD tool ranging from $600,000 to $1.4 million in total funds. The annual licensing and maintenance costs of these tools ranged from $100,000 to $1 million. The Department is now actively working to prepare a Request for Proposal (RFP) for acquiring an appropriate FAD tool (a component to a SURS system). The Department is also preparing an Advance Planning Document (APD) for CMS to obtain a higher federal participation rate.

Both strategies (pre- and post-payment will be evaluated and implemented in the most cost-effective manner possible.

Tracking of Recoveries and Return on Investment

In May 2009, the Department brought online a new database that can track recovery data and manage staff resources for the post-payment review function. This system has been in design and development since late 2006. The system has the capability to track and report recovery data by staff member and program area.

Periodic updates on the effectiveness of this tool to assure that recovery efforts are focused on those areas where the highest return is made will be provided to Department leadership.

Restructuring of Reporting

The Department will establish an independent Office of Internal Audit. The director of the Office will report to the Executive Director of the Department under the direction of the Chief Operating Officer. In addition to the director, the Office will include departmental internal auditors currently located in the Office of Fiscal Operations, all of the Medicaid auditors currently in the Division of Health Care Financing (DHCF) and the post-payment review function currently operating within the Bureau of Program Integrity in DHCF.

AUDIT REPORT CHAPTER 2

RECOMMENDATIONS AND RESPONSES

1. *We recommend that BPI establish clear guidelines for when a prior authorization request should be reviewed by the appropriate utilization review committee.*

   Response:

   The Department recognizes that the audit found clear examples in which prior authorization decisions did not follow established guidelines. Consistency in decision making is imperative and the Department must have clear guidelines for this to occur. In addition, supervisory staff must assure that the guidelines are being used and are the basis for all decisions.

   After receiving the audit report, the Department asked an Assistant Attorney General to review the policies and procedures governing when a prior authorization request should be reviewed by the appropriate utilization review committee and to make recommendations on how to better clarify them. The review, attached to this document, states that the policies and procedures are sufficiently clear. However, some staff elected not to follow the guidelines.

   To assure that in the future staff use these guidelines in all decisions, the Department has refined a process flow chart that reinforces the appropriate processing of prior approval decisions for non-covered services currently in policy and requests for procedures that may require an exception to policy. The flow chart includes mandatory steps and actions involving both the Utilization Review (UR) Committee and the Child Health Evaluation and Care (CHEC) Committee.

   One critical aspect of the process includes an electronic system control code that identifies when a procedure is non-covered. This code will dictate to the nurse that the procedure must be taken to the UR committee.

   Additionally, the policy will now include a provision for expediting cases requiring immediate attention. This provision formalizes in policy an informal practice previously employed of conducting sub-committee UR reviews to expedite decisions when circumstances require. The sub-committee UR review policy requires that appropriate documentation on the decisions made by the sub-committee be recorded and maintained for review.

   Management will implement regular review of decisions by a physician. Item number three includes more detail on the physician reviews.

Action Date: Implemented August 2009 with ongoing review to assure effectiveness

Responsible Manager: Alex Yei

2. *We recommend that BPI management ensure prior authorization nurses receive regular training on how to review prior authorization requests.*

Response:

Monthly training meetings will be held to train prior authorization nurses. The training meetings will focus on new policies or on policies that are particularly prone to error.

Trainings will also include a peer review by all nurses of the most challenging cases and decisions. Department-established criteria in conjunction with InterQual will be used by the nurses during these peer review sessions to ensure consistency and appropriate application of criteria. There will be at least four peer review sessions per year included in the training meetings.

The Department will maintain records of these training meetings. The documentation will show the topics discussed and a list of attendees. The Department will ensure that those nurses who miss training will receive the information provided in the training.

Action Date: September 2009 to initiate the training meetings

Responsible Manager: Alex Yei

3. *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*

Response:

The response to Recommendation Number 1 describes the efforts of the Department to ensure policy is clear on how to handle these cases. Clarified policy is the first step to improving compliance.

To ensure greater compliance with the policy, the Department has assigned a staff physician to monitor, audit and evaluate the decisions of the prior authorization nurses.

The monitoring is based on a statistically valid random sample of cases. The physician audits the work of individual staff members across the various categories of service. The audits will assure a greater degree of compliance, uniformity and quality. The findings of these audits will be used as topics for the training of prior authorization staff.

Action Date: Implemented August 2009 with ongoing review to assure effectiveness

Responsible Manager: Alex Yei

4. *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*

Response:

The response to Recommendation Number 1 describes the efforts of the Department to ensure policy is clear on how to handle these cases. Clarified policy is the first step to improving compliance.

The InterQual criteria database is a nationally recognized automated system of criteria for medical procedures. It is a standard set of criteria accepted by physicians and hospitals. When the Department determines that InterQual criteria are too broad, it will use Medicaid's Medical Policy Committee to refine and augment the InterQual criteria. The new criteria can be loaded into the InterQual tool and referenced by the prior authorization staff. This process was followed to determine the protocol now in place for circumcisions.

Action Date: Implemented August 2009 with ongoing review to assure effectiveness

Responsible Manager:

- Alex Yei identified areas needing clarification
- Dr Thomas Jones developed criteria updates

5. *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 establish criteria when evaluating a prior authorization request.*

Response:

The responses to Recommendations Number 2 and Number 3 describe the efforts of the Department to ensure regular training of prior authorization staff occurs and that their work is more closely reviewed.

The prior authorization manager will work closely with the staff physician conducting reviews of prior authorization nurses' performance.

Action Date: Implemented August 2009

Responsible Manager: Alex Yei

6. *We recommend that the HCF adequately document all changes to policy.*

Response:

The Department will begin using a feature in the InterQual database that allows for the documentation of policy changes. This will provide a historic context and current policy resource for the prior authorization nurses.

Changes to policy are approved by Medicaid's Medical Committee and/or Medicaid's Policy and Operations Committee depending on the issue. Both committees are required to keep minutes. In addition, the recommendations based on the minutes from the Policy and Operations Committee must be forwarded to the division director for approval.

Further, Medicaid uses the rulemaking process and amendments to the State Plan to document significant modifications to policy.

Action Date: Began Implementation August 2009

Responsible Manager: Alex Yei

AUDIT REPORT COMMENTS

The following section identifies comments made in Chapter 2 of the audit report that we believe need Department clarification.

REPORT COMMENT

"A draft policy allows the utilization review committee to circumvent statute, when warranted by medical judgment. HCF should not create policies that contradict laws established by the Legislature" (Page 16 margin)

CONTEXT

As the audit report notes, this was a **draft** policy. It had not been approved at the bureau level. It had not been sent to the Division's Policy and Operations Committee. It had not been given a legal review and the Division director had not approved it. The policy had never been used, and would not have been approved. The Department has never knowingly approved any action in violation of law.

REPORT COMMENT

"In calendar year 2008, prior authorization nurses unilaterally approved requests for 106 non-covered surgeries and 127 sleep studies for which BPI does not have established criteria." (Page 16)

CONTEXT

Any non-adherence to policy is unacceptable and steps are being aggressively implemented to maximize consistency. It is important to note that the Bureau of Program Integrity performs approximately 40,000 prior authorizations each year.

REPORT COMMENT

"A nurse unilaterally approved the reconstruction and augmentation of a healthy breast without presenting the request to a utilization review committee. Another nurse submitted a similar case to the review committee and the procedure was denied." (Page 18 margin)

CONTEXT

After reading this statement, it seems reasonable to conclude that the prior authorized breast reconstruction was not medically necessary. Yet a review of the medically necessary definition quoted on page 13 of the audit report (Utah Administrative Code 414-1-2(18)(a)) shows a procedure is medically necessary if it

> "is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, *cause physical deformity* or malfunction, or threaten to cause a handicap; and there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly." (Emphasis added)

The Utilization Review Committee is tasked with making that decision on a case-by-case basis given the circumstances of the woman fighting breast cancer. Given the individual nature of human anatomy, the committee approves some of these cases and denies others.

AUDIT REPORT CHAPTER 3

RECOMMENDATIONS AND RESPONSES

1. *We recommend that HCF determine the feasibility of putting provider enrollment in the Bureau of Program Integrity.*

   Response:

   The Department will study the feasibility of moving Provider Enrollment and to look for ways to strengthen the provider enrollment process.

   The Department has conducted an initial review of provider enrollment functions. The Department agrees that the new Post Payment Review Unit (refer to Recommendation 1 in Chapter 6) should conduct oversight of certain providers. The Department believes it would be most appropriate for the unit to monitor providers with a history of discipline related to improper claims. The Department also believes that more information on previous disciplines should be provided to the new unit. In addition, the Department believes that the new unit should review decisions made by Provider Enrollment when previous disciplines have been identified.

   The Department will conduct additional analysis to determine if Provider Enrollment should be moved to the Bureau of Program Integrity or if it should remain in the Bureau of Medicaid Operations.

   Action Dates:

   - October 29, 2009 to determine the appropriate location for Provider Enrollment
   - December 31, 2009 to determine the appropriate relationship between the new Post Payment Review Unit and Provider Enrollment

   Responsible Manager: Blake Anderson

2. *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.*

   Response:

   The Department agrees that adopting additional standards in this area will strengthen the provider enrollment process.

The Department has been excluding providers when Utah's Division of Occupational and Professional Licensing (DOPL) only allows the provider to practice in the presence of a chaperone because the program could not monitor compliance with this DOPL restriction. However, this practice was not part of the Department's written policy for Provider Enrollment. Written policy will be updated to include this practice.

In addition, several other exclusions will be added to policy. Providers with a history of patient abuse or sexual misconduct with clients will be excluded from the program.

Providers with prior felony convictions related to health care fraud or controlled substances have generally been excluded from the program. However, if Provider Enrollment has determined that a certain provider might help guarantee client access to certain services in an area of the state, then the application will be reviewed by a committee consisting of the bureau director that supervises Provider Enrollment, the unit manager over Post Payment Review, and the Department's chief operating officer.

Providers with other types of discipline in their history will be referred to the new Post Payment Review Unit for monitoring. These activities include convictions related to fraud, other convictions related to controlled substances, claims for excessive charges or unnecessary services and failure to disclose required information. The new unit will develop protocol for appropriate monitoring of these providers' billing practices.

Provider Enrollment will also match data from the DOPL licensing database to ensure that the new policies are appropriately applied to existing providers with discipline histories.

In addition, Provider Enrollment will change several of its current practices to improve documentation of its efforts and to obtain more up-to-date information on providers. The audit report noted that Provider Enrollment could not provide records of denials for providers with severe discipline history. Provider Enrollment had been placing these applications that were not going to be approved in a "pending" status along with many other applications that were still waiting other actions. Applications from providers with severe discipline histories were closed after 90 days without enrolling them in the program. However, Provider Enrollment did not officially deny the application. Provider Enrollment will now send an official denial letter to providers with severe discipline histories.

Provider Enrollment has been accepting physical copies of licenses because they indicated that a provider's license was current. However, this process does not allow Provider Enrollment to see the disciplinary history of a provider. Provider Enrollment will now check the DOPL website for every provider before approving an application.

Action Dates:

- October 29, 2009 for Provider Enrollment to revise its written policies and implement the changes described above
- December 31, 2009 for the new Post Payment Review Unit to establish written policy for the claims monitoring of providers with discipline histories.

Assigned Managers:

- Connie Higley for Provider Enrollment activities
- Dr. David Patton for Post Payment Review Unit activities

3. *We recommend that provider enrollment consider provider need when considering providers with disciplines, for providers not automatically precluded by policy.*

Response:

The Department agrees that considering the program's need to enroll certain providers may be a factor for consideration in certain provider enrollment decisions.

Providers with a history of patient abuse or sexual misconduct with clients and providers that can only practice in the presence of a chaperone will be excluded from the program, regardless of the program's need for the provider's services in that area.

Providers with prior felony convictions related to health care fraud or controlled substances will generally be excluded from the program. However, if Provider Enrollment has determined that a certain provider might help guarantee client access to certain services in an area of the state, then the application will be reviewed by a committee consisting of the bureau director that supervises Provider Enrollment, the unit manager over Post Payment Review, and the Department's chief operating officer.

Providers with other types of discipline in their history will be referred to the new Post Payment Review Unit for monitoring. These activities include convictions related to fraud, other convictions related to controlled substances, claims for excessive charges or unnecessary services, and failure to disclose required information. The program's need for the provider's services in an area will not be considered in the monitoring or approval of these providers.

Action Dates:

- October 29, 2009 for Provider Enrollment to revise its written policies and implement the changes described above
- December 31, 2009 for the Department to establish the provider enrollment review committee

Assigned Managers:

- Connie Higley for Provider Enrollment activities
- Dr. David Patton for establishing the committee

4. *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.*

Response:

The Department agrees that extending access to the database will help the program identify client and provider fraudulent activity.

If the Legislature were to provide the Department with additional access to the database, then the program's pharmacy staff would expand its review of client's use of controlled substances to all payers in the state, not just Medicaid data (which is currently available to program staff). This review would help identify some types of potential client abuse of these substances (e.g., a client receives an approved prescription from Medicaid but then also pays for another prescription for the same substance with cash). The Department would accept specific safeguards and assurances required by DOPL for use of client information.

If the Legislature were to provide the program with additional access to the database, the new Post Payment Review Unit would be able to compare program data to the DOPL database on a regular basis to ensure claims paid were actually dispensed and that providers submit program data to DOPL.

Action Date: Upon legislative approval

Responsible Manager: Tim Morley

AUDIT REPORT COMMENTS

The following section identifies comments made in Chapter 3 of the audit report that we believe need Department clarification.

REPORT COMMENT

"*Provider Enrollment is Not Denying Any Providers*" (page 30)

CONTEXT

The audit report noted that Provider Enrollment could not provide records of denials for providers with severe discipline history. Provider Enrollment had been placing these applications that were not going to be approved in a "pending" status along with many other applications that were still waiting other actions. Although Provider Enrollment did not officially deny the applications, the providers with severe discipline histories were not enrolled as Medicaid providers.

REPORT COMMENT

"There are currently no controls in place to monitor and prevent fraudulent prescription billings." (Page 37)

CONTEXT

The program's first line of defense in preventing fraudulent billings is its payment system (MMIS). The system has numerous controls (called edits) in place that determine if a prescription claim will be paid. These edits require that the claim meet established criteria before a payment can be made. These criteria include:

- the pharmacy submitting the claim is an approved program provider (which has been verified to have a valid license)
- the prescribing provider is a valid prescriber (who has been verified to have a valid license)
- the person obtaining the prescription is currently on the program (the person's identity has been verified during the client enrollment process)
- the prescription being dispensed is an approved program drug
- the prescription does not exceed approved program guidelines (e.g., monthly limits, no early refills, and/or other drug specific limits that have been recommended by the program's Drug Utilization Review Board)
- the prescription claims is not a duplicate of another claim

Once a payment has been made, several additional controls exist to monitor for fraudulent billings. The program has a contract with the Drug Regimen Review Center at the University of Utah. The center takes and reviews program prescription data to ensure clients are receiving appropriate drug therapies. When the center identifies inappropriate therapies for a condition, the center contacts the prescriber and provides information to educate the prescriber about appropriate therapies.

If the center identifies potential abuse of a controlled substance, it notifies program staff for further investigation. If the program staff believe abuse is occurring, the issue is referred to the Bureau of Program Integrity for fraud review and/or to the Medicaid client restriction program for client abuse. The restriction program helps prevent doctor or physician "shopping" by limiting the client to one physician and one pharmacy in order to obtain prescription drugs through the program.

AUDIT REPORT CHAPTER 4

RECOMMENDATIONS AND RESPONSES

1. *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.*

   Response:

   Inappropriate payments can be avoided or recovered if made in error. The Department is committed to implement all cost effective strategies to assure that taxpayer funds are effectively managed.

   A review by an outside contractor of all claims paid in the last two years is scheduled. This will be done free of charge to demonstrate the value of a possible pre-payment review software package. This review should be complete in early November, 2009. A request for proposal to acquire pre-payment review capability will also be issued.

   A standard Surveillance and Utilization Review Subsystem (SURS) is made up of several component parts. One of which, is a Fraud and Abuse Detection (FAD) tool. The Department has concluded that updating the current SURS is impractical. The system is nearly 40 years old and hasn't been able to be successfully updated for 20 years. The last attempt to update the system resulted in a crash of the entire claims payment system. Furthermore, the technology is outdated and would not be as effective as a newer FAD tool.

   Therefore the Department has been exploring the replacement of the Medicaid Management Information System (MMIS), which includes the SURS, for several years. The Department has been unsuccessful in its several attempts to obtain appropriations for a full system replacement.

   Consequently, the Department, with approval and funding from the 2007 Legislature, has been studying alternative replacement options and strategies for the past two years. One of the recommendations from this study was to build component parts to a new system. At the conclusion of the study, there will be some funds left over that can be used toward the state match of the new FAD tool. The funding is not sufficient to replace the entire SURS subsystem.

   In March 2009, the Department moved forward and issued a Request for Information (RFI) from potential contractors who could provide a FAD tool to Medicaid. The Department received responses from four potential bidders. The responses showed initial development and installation costs of a new FAD tool ranging from $600,000 to $1.4

million. The annual licensing and maintenance costs of these tools ranged from $100,000 to $1 million. The Department is now actively working to prepare a Request for Proposal (RFP) for acquiring an appropriate FAD tool and an Advance Planning Document (APD) that, if approved by CMS, will bring a higher federal match rate in the development of the new tool.

Action Date: December 31, 2010 to implement a new FAD tool and examine other review options

Responsible Manager: Paula McGuire

2. *We recommend that BPI begin tracking the exact percentage of total program expenditures recovered.*

Response:

Effective May 4, 2009, the Department brought online a new Oracle database that can track recovery data and manage post-payment review staff resources for the Medicaid program. This system, the Unified Program Integrity Case Management System (UPICMS), has been in design and development since late 2006. The system has the capability to track and report recovery data, which can be used to calculate the exact percentage recoveries constitute of total program expenditures.

The Department will have all program expenditure recovery data collected from throughout the Division of Health Care Financing and have it entered into this database so that it will present an accurate picture of all recoveries.

Action Date:

- May 4, 2009 implementation began
- December 31, 2009 for collecting information from throughout the Division

Responsible Manager: Alex Yei

3. *We recommend that BPI design a system that allows them to better track, pull, and sort recovery data.*

Response:

Effective May 4, 2009, the Post-Payment Review Unit brought online a new Oracle database that can track recovery data and manage staff resources for the Medicaid program. This system, the Unified Program Integrity Case Management System

(UPICMS), has been in design and development since late 2006. The system has the capability to track, sort and report recovery data.

Action Date: May 4, 2009 implementation began

Responsible Manager: Alex Yei

4. *We recommend that BPI develop a staff cost allocation and assignment system that can effectively and efficiently allocate staff time and resources.*

Response:

Effective May 4, 2009, the Post-Payment Review Unit brought online a new Oracle database that can track recovery data and manage staff resources for the Medicaid program. This system, the Unified Program Integrity Case Management System (UPICMS), has been in design and development since late 2006. The system provides the bureau director with the capability to effectively and efficiently allocate staff time and resources.

Action Date: May 4, 2009 implementation began

Responsible Manager: Alex Yei

5. *We recommend that BPI track its employees' return on investment.*

Response:

Effective May 4, 2009, the Post-Payment Review Unit brought online a new Oracle database that can track recovery data and manage staff resources for the Medicaid program. This system, the Unified Program Integrity Case Management System (UPICMS), has been in design and development since late 2006. The system has the capability to track return on investment by calculating total recoveries by employee and comparing that to the employee's salary and benefits.

Action Date: May 4, 2009 implementation began

Responsible Manager: Alex Yei

6. *We recommend that BPI develop specific performance measures and develop rating metrics, and then track adherence to these goals.*

Response:

The Department will begin immediately to gather the information needed to develop appropriate performance measures for the program integrity staff.

Once these metrics are developed, they will be loaded into the new UPICMS database for tracking performance.

Action Date: October 29, 2009 to have specific performance standards and measurement in place and to begin tracking performance

Responsible Manager: Alex Yei

7. *We recommend that BPI report annually to the Legislature and Governor on their cost avoidance and cost recovery efforts,*

Response:

The Department will plan to report calendar year 2009 data during the 2010 Legislative General Session and on an ongoing basis thereafter.

Action Date: February 26, 2010 to report to the Governor's Office and the Health and Human Services Appropriations Subcommittee on cost avoidance and cost recovery efforts.

Responsible Manager: Michael Hales

AUDIT REPORT COMMENTS

The following section identifies a comment made in Chapter 4 of the audit report that we believe need Department clarification.

REPORT COMMENT

"We estimate that an improved recovery program could result in [an] additional $20.2 million ($5.8 million state dollars) annually [in program savings]." (Page 41)

CONTEXT

The report calculates the possible $20 million based on a national estimate of waste, fraud and abuse in the health care system and multiplying it by the total Medicaid budget ($1.58 billion). This predicts $47 million in waste, fraud and abuse against the actual recoveries of $27 million.

AUDIT REPORT CHAPTER 5

RECOMMENDATIONS AND RESPONSES

1. *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.*

   Response:

   The Department has assigned the Post Payment Review Unit to develop a systematic methodology to review a sampling of claims from all categories of services delivered in the Medicaid program. The Post Payment Review Unit will ensure that the sampling methodology will draw from all types of program expenditures.

   Once the new Fraud and Abuse Detection (FAD) tool mentioned in the Chapter 4 recommendations is in place, the methodology will be updated to reflect the new capabilities of the tool.

   Action Date: October 29, 2009 to develop the new sampling methodology

   Responsible Manager: Kylene Hilton

2. *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.*

   Response:

   The Department has assigned the Post Payment Review Unit to develop a systematic methodology to review a sampling of claims from all categories of services delivered in the Medicaid program, including contracted Medicaid services.

   Some of this oversight is currently performed by other bureaus within the Division of Health Care Financing or by staff in other departments within state government. The Post Payment Review Unit will become the central repository for payment oversight data on Medicaid expenditures and will coordinate as necessary with other organizational units to gather all available information.

   Action Date: November 30, 2009 to ensure oversight of contracted Medicaid services

   Responsible Manager: Kylene Hilton

3. *We recommend that BPI consider using statistical sampling or extrapolation in their audits of providers.*

Response:

The Department will consider using statistical sampling or extrapolation in the audits of providers. Since this is a policy decision that could have a large financial impact on the provider community, the Department plans to engage the Governor's Office, the Attorney General's Office and appropriate legislative oversight committees in considering the use of this recovery methodology.

Action Date: February 26, 2010 to have presented the matter for policy discussion.

Responsible Manager: Michael Hales

4. *We recommend that BPI conduct more financial audits of providers.*

Response:

The Post Payment Review Unit will evaluate the amount of resources needed to perform all of the post payment review audits across all provider types and determine how much time can be spent on financial audits. Then the staff will need to determine which potential reviews, including financial audits will offer the best potential return on investment, and decide how many additional financial audits can be performed.

Action Date: November 30, 2009 to begin conducting more financial audits.

Responsible Manager: Dr. David Patton

AUDIT REPORT CHAPTER 6

RECOMMENDATIONS AND RESPONSES

The Department of Health will establish an independent Office of Internal Audit and Director of Internal Audit reporting to the Executive Director of the Department of Health under the direction of the Chief Operating Officer of the Department. The Office will include departmental internal auditors currently located in the Executive Director's Office under the direction of the Director of Fiscal Operations, all of the Medicaid auditors currently in the Division of Health Care Financing, the post-payment review function currently operating within the Bureau of Program Integrity and a Director of Internal Audit that will be reclassified from an existing auditor position.

A second general response to these recommendations is to redefine the role and function of the Department of Health Audit Committee. The primary role of the Audit Committee has been to review audits conducted by outside auditors on programs within the Department. Because of this role, membership on the Committee is comprised of representatives from all divisions within the Department to provide subject-matter expertise on the audits in question. Because of the size and complexity of the Medicaid Program, significant representation has come from this division. In addition to the role of external audit review and response, the Audit Committee will now include the Director of Internal Audit and add the responsibility of reviewing internal audit planning and scheduling. The Department will carefully review the composition of the Audit Committee and consider expanding its participation.

1. *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.*

   Response:

   The principle of audit independence is important to the effectiveness of the audit functions of the Bureau of Program Integrity within the Medicaid Program. The Department will remove the post-payment review team, the medical investigations team, the PERM claims review staff, the appeal specialist and the appropriate medical staff from the supervision of the Medicaid Director and place these activities within a new unit of Internal Audit under the direction of the Executive Director of the Department of Health and the Chief Operating Officer.

   Action Date: October 29, 2009 to create the new Office of Internal Audit

   Responsible Manager: Dr. David Patton

2. *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.*

Response:

The internal audit function within the Department of Health currently operates within the Executive Director's Office under the direction of the Director of Fiscal Operations. To more clearly comply with Utah Code and enhance the independence of internal program review, the internal audit function has been restructured to report directly to the Executive Director of the Department of Health and the Chief Operating Officer.

Action Date: October 29, 2009 to create the new Office of Internal Audit

Responsible Manager: Dr. David Patton

3. *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.*

Response:

Internal Medicaid auditors need to have the independence to effectively audit programs, processes, and activities within the Medicaid Program while still maintaining their focus on Medicaid-related issues. Although organizationally moved from the Division of Health Care Financing to EDO, the financial analysis functions of post-payment review, cost settlements, rate review, and other Medicaid-related activities will continue without interruption, but under the independent direction of the Office of Internal Audit.

Action Date: October 29, 2009 to create the new Office of Internal Audit

Responsible Manager: Dr. David Patton

4. *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.*

Response:

The role and mission of the Office of Internal Audit will be to conduct financial and performance audits of all programs within the Department of Health with particular emphasis on the Medicaid Program due to its size in terms of public funds and overall complexity. The Director of Internal Audit will prepare an annual plan for review by the Executive Director for regular internal financial and performance audits of the Medicaid Program and other programs within the Department as well as a system to address emerging issues that demand more immediate audit review.

Action Date: November 30, 2009

Responsible Manager: Dr. David Sundwall

STATE OF UTAH
OFFICE OF THE ATTORNEY GENERAL

MARK L. SHURTLEFF
ATTORNEY GENERAL

RAY HINTZE
Chief Deputy

KIRK TORGENSEN
Chief Deputy

September 2, 2009

Michael Hales
Deputy Director
Utah Department of Health
P.O. Box 141000
288 North 1460 West, 3rd Floor
Salt Lake City, Utah 84114-1000

RE: Legal Review of August 2009 Legislative Audit Conclusion of Unclear Policy on Prior Authorizations.

Dear Mr. Hales:

You asked me to conduct a legal review of a conclusion in the August 2009, Legislative Audit. The Audit conclusion for my review is the assertion that the Division of Health Care Financing does not have a clear process for when a request of Medicaid services should be taken to prior authorization.

The Audit bases its conclusion of an unclear process on the following language:

> If the request is a non-covered benefit or the nurse reviewer prefers to discuss the case with a professional group, the request may be taken to Utilization Review Committee or CHEC Committee [if patient is under 21 years old].

The Audit cites this language as agency policy and found it ambiguous. The Audit then concluded that this unclear policy led to medical service requests being inappropriately approved by reviewing nurses when the nurses should have sent the request to the UR or CHEC committee to make the appropriate decision.

I went through the Provider Manual and did not find this language. I located a draft BPI manual and found the language. This language is only accessible to the few writing the draft manual. The draft BPI manual has the word "Draft" written throughout the document. It is not a Medicaid policy document, but rather a work in progress. Nurse reviewers are not aware of the language and would not rely on it.

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I inquired on how nurse reviewers know when to send a request to the UR or CHEC committee for prior authorizations. The supervising nurses stated that the guidance is found in the 'Control Medicaid Codes'.

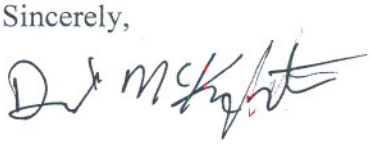
Control Medicaid Codes are numbers or letters attached to each requested case so a nurse reviewer knows how a claim should be handled. If a nurse reviewer has any question on what a particular control code means, the nurse can access an explanation page on the MMIS system or HCF Media Wiki. The explanation pages state that control code '4' concerns non-covered procedures, and then explains that expanded coverage is under CHEC and these cases need to be prior authorized. Control code 'R' has the explanation that the request 'requires prior approval through UR committee".

The Control Medicaid Codes explanation page does not have any language about nurses having discretion to ignore the codes and act on their own. Thus, I do not see this guidance as unclear.

It is my opinion that clear guidance is available for informing nurse reviewers on how they should handle any request that is designated for prior authorization with the UR or CHEC committee. The Control Medicaid Code explanations conform to Medicaid regulation on when only UR and CHEC committees can make prior authorizations.

I hope my legal review and assessment of this particular issue adequately addresses your question raised by the Audit . If you have any further questions or need additional input, feel free to contact me.

Sincerely,



David McKnight
Assistant Attorney General

APPENDIX E – CHANGING MEDICAID OUTPATIENT REIMBURSEMENT

"Report to the Health and Human Services Appropriations Subcommittee; Changing Medicaid Outpatient Reimbursement," Prepared by the Division of Medicaid and Health Financing, September 2009

Report to the Health and Human Services Appropriations Subcommittee

Changing Medicaid Outpatient Reimbursement

Prepared by the Division of Medicaid and Health Financing

September 2009

EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed by the 2009 Legislature:

"The Legislature intends that the Department of Health shall provide a report to the Health and Human Services Appropriations Subcommittee by October 1, 2009 on how to change outpatient hospital reimbursement to a fee-for-service system within the Medicaid program and the estimated savings."

Current Reimbursement Methodology: Percentage of Charges

In Utah Medicaid, most outpatient claims are currently reimbursed as a percentage of charges. This method gives the State no control over the growth in outpatient payments to hospitals. In recent history, the State has not been able to reduce the percentage paid, as the Centers for Medicare and Medicaid Services (CMS) would not approve state plan changes that include percentage of charges.

Two Ways to Implement Fee-For-Service

There are two ways in which Medicaid could change outpatient hospital reimbursement to a fee-for service system:

- Implement a Revenue Code fee schedule, or
- Adopt the CMS Outpatient Prospective Payment System (OPPS)

Both allow more control over reimbursement inflation and both can be used to set reimbursement to a desired level.

Cost Savings

Neither method includes an inherent immediate reduction in reimbursement. Either method can be used to control inflation or to reduce reimbursement. The Revenue Code fee schedule does, however, include two modifications which can logically be used to reduce reimbursement:

- Ranking surgery codes and
- Paying all CPT/HCPCS codes according to the fee schedule.

Recommendation: A Revenue Code Fee Schedule

Of the two methodologies, implementing the Revenue Code fee schedule appears preferable. It has the following advantages:

- Can help control reimbursement inflation
- Can be used to implement reimbursement reduction
- Requires minimal change from the current system
- Is comparatively easy to implement
- Requires minimal maintenance and
- Does not inherently reduce level of care

Introduction

According to the Utah Medicaid State Plan, Medicaid currently pays hospitals a percentage of charges for outpatient claims. Such a reimbursement methodology has no mechanism to limit or control inflation, especially since 2004 when the Centers for Medicare and Medicaid Services (CMS) told the State it would not approve state plan changes that include percentage of charges. More recent discussions with CMS under the current administration have signaled some additional flexibility on this issue.

Terminology

It is useful to explain a few terms at this point, for clarity:

- *APC* means Ambulatory Payment Classification
- *CPT* means "Current Procedural Terminology." CPT codes are determined by the American Medical Association and are primarily used for Physician services.
- *DRG* means Diagnosis Related Group
- *HCPCS* means "Health Care Procedure Coding System." HCPCS codes were developed by CMS and are used for medical supplies, dental procedures, rehabilitative services, drugs etc.
- *NDC* means the National Drug Code as developed by the US Food and Drug Administration (FDA)
- *OPPS* means Outpatient Prospective Payment System as developed by CMS
- *Revenue Code* means the codes developed by the National Uniform Billing Committee. The codes are specific to hospital revenue centers (i.e., the laboratory).

Current Payment Methodology

Before considering potential changes, decision makers should have an understanding of the current outpatient reimbursement methodology.

Currently there are two major sub-divisions of outpatient reimbursement:

- Most claims are reimbursed as a percentage of charges
    - Rural claims are reimbursed at a higher rate than urban claims (93 percent vs. 77 percent or charges)

    - Emergency Room claims for "true" emergencies[1] are reimbursed at the highest rate (98 percent of charges)
    - ER claims that are not for "true" emergencies are reimbursed at a lower rate (65 percent if rural, or 40 percent if urban)
- Other claims are reimbursed according to the CPT/HCPCS fee schedule. These include
    - Laboratory and Radiology claims
    - Physical and Occupational Therapy claims
    - Lithotripsy claims
- In each case, if a lesser amount is billed, Medicaid pays the billed amount.
- Payment for partially completed services, as noted by the appropriate modifier, is paid at 50 percent of the regularly scheduled rate.

Alternative One: A Revenue Code Fee Schedule

Proposed Payment Methodology

One approach to changing outpatient hospital reimbursement to a fee-for-service system within the Medicaid program is to create a Revenue Code fee schedule.

When a hospital submits an outpatient claim, each line of that claim includes a Revenue Code. Some lines also include a CPT/HCPCS code, and some of these also include an NDC.

Reimbursement under this alternative would be as follows:

- Claim lines with a CPT/HCPCS code would be reimbursed using the already existing CPT/HCPCS fee schedule.
    - The surgery ranking system that currently applies in other venues would now also apply to outpatient claims.

      This means that the surgery code with highest reimbursement would be reimbursed at 100 percent of the fee schedule. The surgery code with the next highest reimbursement is paid at 50 percent of the fee schedule and the rest at 25 percent. This only applies to surgery codes.
- Claim lines without a CPT/HCPCS code but with an NDC would be reimbursed using the already existing NDC fee schedule.

[1] Determination of a "true" emergency is based upon the principal diagnosis code.

- Claim lines with neither a CPT/HCPCS code nor an NDC would be reimbursed using the Revenue Code fee schedule.
    - In order to maintain the current relationship between emergency and other claims, claim lines reimbursed using the Revenue Code fee schedule would be multiplied by the following factors:

Urban, not through the ER	1.000	
Rural, not through the ER	1.208	(equal to 93 / 77)
Urban or Rural, through the ER, emergency	1.273	(equal to 98 / 77)
Urban, through the ER, non-emergency	0.519	(equal to 40 / 77)
Rural, through the ER, non-emergency	0.844	(equal to 65 / 77)

Changes Required

In order to move from the current methodology to this alternative, the following would need to be done:

- Develop and implement a Revenue Code fee schedule,
- Amend the State Plan to gain CMS approval for payment via fee schedule,
- Apply the surgery ranking system to outpatient claims,
- Model the impact of the new system on payments
- Coordinate the implementation of the new payment system with hospitals
- Implement the multiplier factors,

Each of these items would take a substantial level of effort and would require changes in both Utah Medicaid and hospital information systems.

The Revenue Code fee schedule could be developed using historical submitted charges per Revenue Code.

If necessary, it is possible to add additional reimbursement for outlier claim amounts, using a threshold multiplier and percentage payment over that multiplier. Claim variability is low enough that there should be very few outliers, though individual outliers can have very high charges. Pharmacy claims have the highest variability, but these would not be reimbursed using the Revenue Code fee schedule.

Alternative Two: Using the CMS OPPs

Proposed Payment Methodology

Another approach to changing outpatient hospital reimbursement to a fee-for-service system within the Medicaid program is to reimburse using the CMS Outpatient Prospective Payment System (OPPS).

This system assigns Ambulatory Payment Classifications (APCs) based on the HCPCS codes submitted for payment. These classifications are similar to Diagnosis Related Grouping (DRG) classifications used for inpatient hospital claims.

- HCPCS codes are assigned into APCs. (An individual outpatient claim may include multiple APCs.)
- Similar to DRGs, each APC has a weight, which is the average relative effort to perform the required procedure(s).
- The weight is multiplied by a base rate, a dollar value that converts the weight to a reimbursement amount.
- Payments for services integral or ancillary to the delivery of a procedure or medical visit can be packaged into the payment for that procedure or visit.
- When multiple significant procedures are performed or when the same service is performed multiple times, a discount may be applied. The full payment amount is paid for the surgical procedure with the highest weight and 50 percent of the payment amount is paid for other surgical procedures during the same visit.
- Procedures terminated prior to anesthesia are reimbursed at 50 percent.
- Codes that should not be billed together for the same patient on the same day would not both be paid.
- Ambulance, diagnostic clinical laboratory, screening mammography, physical therapy, speech therapy and occupational therapy services are paid according to a fee schedule instead.
- The wage portion of the base reimbursement is adjusted according to local wages.
- Outliers are paid at 50 percent of the facility's cost-to-charge ratio adjusted submitted charges over and above the threshold. The 2009 threshold is the higher of 175 percent of the base reimbursement for that APC or the APC plus a fixed threshold of $1,800. For example: If the facility's cost-to-charge ratio was 60 percent, submitted charges were $4,000 and the base OPPS payment was $100, then the facility would receive $100 plus $250.[2]

Changes Required

In order to move from the current methodology to this alternative, Medicaid would need to do the following:

- Obtain a copy of the CMS OPPS grouper and integrate it into claims payment systems
- Change the State Plan to authorize payments based on the CMS OPPS

[2] $250 = ((4000 * 0.6 – 1,900) * 0.5) Threshold of 1,900 = Higher of (100 x 1.75) or (100 + 1,800)

- Develop weights for the APCs in the grouper
- Program reimbursement based on the weights and outlier logic
- Model the impact of the new system on payments
- Coordinate the implementation of the new payment system with hospitals
- Develop and/or maintain payment methodology for services excluded from the grouper
- Update the grouper when CMS does

Advantages and Disadvantages of Each Method

Advantages of a Revenue Code Fee Schedule

- The payment process is very similar to what Medicaid does currently.
- There can be explainable savings from
    - Ranking outpatient surgery codes as Medicaid does in office surgery codes
    - Paying HCPCS codes according to the physician fee schedule
- There should be no added incentive (other than any proposed rate cuts) for providers who continue to see Medicaid patients to reduce the level of care they provide.

Disadvantages of a Revenue Code Fee Schedule

- It does not limit future increases in the number of procedures performed per patient, but such controls could be implemented via utilization edits.

Advantages of the CMS OPPS

- The incentive for providers to maximize costs for a few (but not all) procedures is limited by the grouping of procedures into a single payment per APC.
- Providers have some familiarity with the method because it is used by Medicare.

Disadvantages of the CMS OPPS

- The State would incur costs to purchase and maintain APC grouper software.
- More programming is required to interface with the OPPS with Medicaid claims payment systems, and thus more time required for implementation. (In addition to the required

Grouper interface, the electronic remittance advice detail would need to be revised to report the applicable APC for each HCPCS code.)

- Continued updates would be required to keep current with changes in OPPS groupers and payment methodology. (Medicare updates its APC grouper on a quarterly basis.)

Estimated Savings

No Immediate Savings Inherent in Either Method

While both methods can be used to reduce reimbursement (by reducing reimbursement per item on the fee schedule, or per APC) such a reimbursement reduction is not inherent in either system.

Both proposed methods can be implemented in a budget neutral fashion.

Impact on Inflation

Both methods do, however, have an inherent impact on reimbursement inflation. Higher charges per procedure would no longer translate into higher reimbursement. This would eliminate the need for outpatient hospital reimbursement to be included in the “forced” inflation building block requests that the subcommittee considers each legislative session. Inflationary appropriations would then be at the discretion of the Legislature.

Reimbursement Reduction Can Now Be Specified

Both methods would allow reduction in reimbursement - by reducing reimbursement per item on the fee schedule, or per APC.

This reduction can be to almost any chosen level of reimbursement that still affords client access to services.

Recommendation

If the decision is made to move away from outpatient hospital reimbursement based on a percentage of charges, then Medicaid recommends the implementation of a Revenue Code fee schedule reimbursement methodology.