



MEDICAID SURVEY RESULTS

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: RUSSELL FRANSEN

ISSUE BRIEF

SUMMARY

Primarily during the spring and summer of 2010, 47 comments from four State agencies and 945 comments from sixty-two members of the public were obtained regarding suggestions for Utah Medicaid.

STATE AGENCY SURVEY (PAGES 11 TO 17)

The four state departments that responded (Health, Human Services, Workforce Services, and the Medicaid Fraud Control Unit within the Utah Office of the Attorney General) provided a total of 47 suggestions or comments to improve Medicaid. All agencies except the Medicaid Fraud Control Unit provided their suggestions in June 2010. The Medicaid Fraud Control Unit received an invitation to provide ideas in November 2010 and responded January 2011. The suggestions and comments are summarized in three categories in the discussion below:

Suggested Changes Within the State's Control – 23 Changes That Could Start Immediately

1. "Authorize the use of TEFRA liens" (page 11)
2. "Coordination of oversight" (page 11)
3. "Expand the number served in Home and Community Based Waivers" (page 11)
4. "Limit certain expensive services in DSPD Home and Community Based Waivers" (page 11)
5. "Replace the current [Medicaid Management Information System]" (page 11)
6. "Both [Health] and [Workforce Services] have demonstrated consistent willingness to better coordinate policies and implementation, yet there is unquestionably room to improve." (page 12)
7. "standardize reporting requirements" (page 12)
8. "strengthening some existing service model components" (page 12)
9. "The causes of fraud from FY2006 through FY2010 remained relatively similar and unchanged." (page 12)
10. "improve identification of fraud" (page 12)
11. "increased effort at identifying third-party liability" (page 12)
12. "The use of traditional payment methodologies does not provide the appropriate incentives for providers to keep down costs." (page 12)
13. "increased capacity for detecting improper claims" (page 12)
14. "Determine the cost-benefit analysis of each administrative procedure against the potential program cost savings." (page 13)
15. "independent Office of Inspector General" (page 13)
16. "utilize updated technology to review claims and detect patterns of abuse and fraud" (page 13)
17. "more responsive to known abuses in the pharmaceutical industry" (page 13)
18. "increasing oversight on claims for payment" (page 13)
19. "increased awareness by Medicaid recipients about fraud and waste" (page 13)

20. "I believe we need to evaluate all Medicaid provider contracts and agreements" (page 13)
21. "Medicaid recipients need to be held more accountable and be better informed" (page 14)
22. "Drug costs and long term care are two of the most costly aspects of the program and should be a serious area of focus." (page 14)
23. "I believe that up coding throughout the industry is a real problem." (page 14)

Suggested Changes Within the State's Control – 11 Items for Future Consideration

1. "It is imperative that the department [of Workforce Services] be provided the opportunity to mitigate these changes [from federal health care reform]." (page 14)
2. "the way Utah assesses Medicaid program performance." (page 15)
3. "exploring the implementation of [Workforce Service's] existing customer homepage" (page 15)
4. "Utah Medicaid's preferred drug list (PDL) is working well." (page 15)
5. "Emergency Room (ER) diversion program... is showing success and will continue beyond the life of the grant." (page 15)
6. "developing additional disease management/care coordination models" (page 15)
7. "Utah Medicaid program integrity efforts have been hampered by outdated systems and technologies." (page 15)
8. "Program integrity should not be outsourced to contingency fee contractors." (page 15)
9. "evaluate and change how Utah reimburses pharmacies for medications" (page 15)
10. "Medicaid does a tremendous job at providing access to care" (page 16)
11. "Program integrity also needs to be empowered" (page 16)

Suggested Changes Outside the State's Control – 13 Suggestions for the Federal Medicaid Program

1. "Federal [Centers for Medicare & Medicaid Services] Medicaid policy is error-prone, due to its complexity." (page 16)
2. "Guidance from federal partners, like [Centers for Medicare & Medicaid Services], can be vague. Too much flexibility allows variation in interpretation." (page 16)
3. "1115 waiver submissions and amendments should be subject to a standard timeline for approval." (page 16)
4. "1915(b) and 1915(c) waivers should have a uniform renewal period of three years." (page 16)
5. "States should be granted the flexibility of running a combined 1915(b)(c) waiver." (page 16)
6. "The federal look back period of five years on the divesting of assets prior to qualifying for Medicaid should also take into account the amount of assets transferred." (page 16)
7. "The institutional bias for long-term care services should be eliminated." (page 16)
8. "Federal limits on client cost sharing should have some inflationary escalator." (page 16)
9. "[Centers for Medicare & Medicaid Services] should develop a core [Medicaid Management Information System] technology and make it available to states." (page 16)
10. "The Disproportionate Share Hospital (DSH) payments should be equalized across states based on a per capita formula." (page 16)

11. "The provision of a Medicaid Health Opportunity Account (HOA) could provide a better model to meet the needs of healthy Medicaid clients." (page 16)
12. "The area that is most likely to be abused is clients' use of Medicaid services when they have the means in their family to pay for the services themselves." (page 17)
13. "Individuals, including family members who defraud vulnerable adults including aging parents is a growing problem." (page 17)

PUBLIC SURVEY (PAGES 18 TO 94)

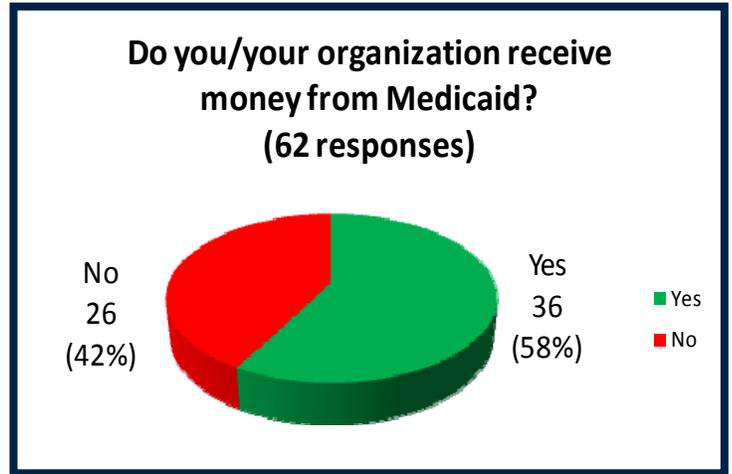
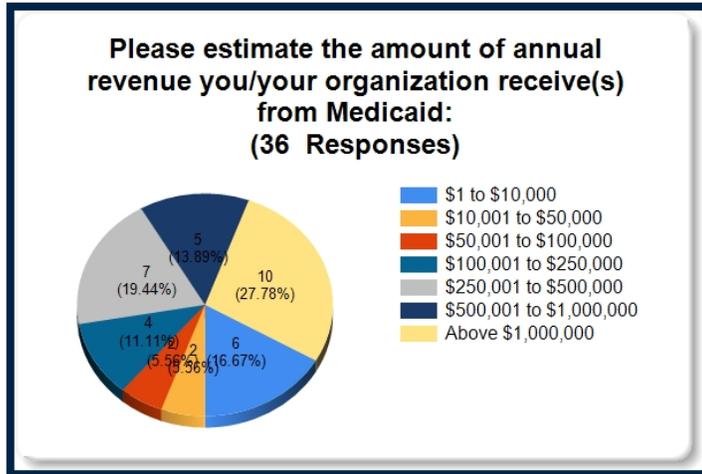
Sixty-two members of the public made 945 comments and/or suggestions regarding Utah’s Medicaid program in response to ten survey questions. The table below details the 945 comments by general topic areas by grouping responses to each of the ten questions into general themes. None of these comments were altered significantly in any way.

General Themes	Comments	%	Subcategories starting on the following pages
Specific Suggestions for System Improvement	140	15%	18,38,47,52,60,68,71,84
Fraud, Waste, and Abuse Issues*	126	13%	28,30,70,79(question 9 - all),88
Specific Services	89	9%	22,26,27,28,29,29,33,34,35,35,35,41,45,45,46,63,65,86
Medicaid Administration	77	8%	32,35,44,56,64,66,68,69,70,70,72,74,74,92
Eligibility Process	69	7%	19,26,34,40,50,59,69,73,89
Reimbursements	45	5%	20,30,35,42,49,56,64,90,92
Increase Co-Pays to Clients/Change Incentives for Clients	39	4%	24,31,53,61,86
Prior Authorization Problems & Suggestions	34	4%	22,42,62,72
Pharmacy/Drug Issues	32	3%	23,34,43,73,87
Increase Case Management/Managed Care	28	3%	51,53,91
Change the Eligibility Criteria	27	3%	26,28,29,30,35,54,65
Compliments	24	3%	30,47,85
No Comment/Do Not Know	24	3%	36,56,69,71,91
Dental Coverage	23	2%	25,25,35,43,48
Medical Homes	23	2%	27,44,49,55,66,92
Home and Community-Based Services	16	2%	27,37,43,55
Utilize Technology	15	2%	30,49,57,65,74
Improve Client Education	13	1%	23,44
Prevention	13	1%	27,36,45,50,57
Miscellaneous Comments	88	9%	31,37,45,46,46,48,48,50,57,67,70,74,89,90,91,92,92
Total	945	100%	
*Includes all of the 111 responses to question 9 in the survey: "In your opinion which area of the Medicaid program is most abused?"			

Who Responded to the Public Survey?

Sixty-two individuals or groups responded to the public survey. Of those 58% or 36 receive money from Medicaid for services provided. This survey was done without additional funding or extensive resources and so

those individuals who had the opportunity to respond to the survey were contacts in possession of the analyst, contact information for association groups found online, or contacts suggested by State agencies or providers.



Editor’s Notes

- No recommendations were deleted or altered
- The majority of changes by the editor to original responses were for spelling changes and spelling out acronyms
- The only words deleted were phrases like “my recommendation is...” or “I think...”
- Some recommendations contained several recommendations and were broken up so as to be summarizable. To clarify some of these separated recommendations phrases were copied and put in [].
- All changes by the editor except for first letter capitalization are indicated by []
- The same concept had to be mentioned at least twice in order to be put have a category created
- Names of individuals mentioned in comments were removed as indicated by [name removed]

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Suggestions from State Agencies to Improve Utah Medicaid

Suggested Changes Within the State's Control – 23 Changes That Could Start Immediately

1. **“Authorize the use of TEFRA liens...Liens against the real property of persons receiving inpatient care under Medicaid are authorized by TEFRA. This would reduce the cost of Medicaid to taxpayers. State legislation would be required.”** (Human Services) **“Medicaid should be allowed to recover from the estates of people who used extended long-term care services.”** (Health)
2. **“At all levels, assessments are excessive.** The federal government has its own set of required audit tools. In addition to those, DOH exercises its own edits and ad hoc, targeted reports. Lastly, DWS has its own internal quality control for performance assessment and case reviews. Redundant assessments do not add value and detract from real work. Reducing those exercises would alleviate administrative burden. One solution may be a **consolidated approach to reporting** Medicaid expenses between the three state agencies involved. As mentioned earlier, such an integrated system could prove very valuable in the expected substantial administrative burden, precipitated by federal healthcare reform, of differentiating between those recipients “currently” enrolled in Medicaid and those “newly enrolled” in Medicaid when determining eligibility for medical programs.” (Workforce Services) **“The coordination of oversight could be improved by restructuring the financial reporting of Medicaid expenditures across participating agency line items. Currently the expenditures can show up twice (once in the originating agency and once in the Department of Health when the federal funds are drawn).”** (Health)
3. **“Expand the number served in Home and Community Based Waivers...Home and Community Based Waivers for the elderly and disabled save money over more costly institutional care and provide greater independence and freedom of choice for Medicaid Clients. When funds are available, consideration should be given to serving more people in Home and Community Based Waivers...Nursing Home care, which is an entitlement for Medicaid clients, is an appropriate model to meet the needs of Medicaid clients. In some cases, the availability of Home and Community Based services can allow Medicaid clients to leave a nursing home or avoid placement in a nursing home altogether.”** (Human Services) **“The provision of a range of institutional and home and community based services (HCBS) in the long-term care setting provides for the needs of many Medicaid clients. However, the waiting lists for HCBS services demonstrate that the needs of many clients are not currently being met by this service model.”** **“The provision of Home and Community Based Services (HCBS) in lieu of institutional services, such as those provided in skilled nursing facilities (SNF) and intermediate care facilities for the mentally retarded (ICF/MR) is a success. Utah currently offers six different waiver options for these services to the elderly and to those with cognitive or physical disabilities. In general, the cost of providing care to individuals in an HCBS program is less than the cost of care in an institution.”** (Health)
4. **“Limit certain expensive services in DSPD Home and Community Based Waivers...The Division of Services for People with Disabilities is examining limiting certain expensive services currently available under the Home and Community Based Waiver to meet budget reduction targets and to make limited dollars go further to serve more people in the future.”** (Human Services)
5. **“Replace the current MMIS (Medicaid Management Information System)...A new MMIS could help coordination by providing timely and accurate data needed to administer the program.”** (Human Services) **“An upgraded Utah MMIS could offer quicker adoption of payment changes, better reporting and more transparency to providers.”** **“Replacement of the current MMIS system will improve the administrative capacity of the Medicaid program and provide more transparency to providers.”** (Health)

6. “**Coordination between and within state agencies** can be challenging. Both DOH and DWS have demonstrated consistent willingness to better coordinate policies and implementation, yet there is unquestionably room to improve. One solution might be automation and enhanced technological solutions. While DWS strives to align benefits to simplify the process for the customer, it can be complicated, depending on the case. In all medical programs, DWS determines eligibility, DOH owns the policy and DHS has responsibility for establishing third party liability (e.g., child support, medical coverage). Many states have similar models. For foster care children, DHS has its own arm of eligibility, unrelated to DWS eligibility operations. One challenge is that DHS has not converted to imaging. Another challenge is foster care children may temporarily be with a relative (DWS responsibility) and then in a foster home (DHS responsibility), so the case may be repeatedly transferred between agencies. Prior to recent combined DOH/DWS efforts to improve communication, at times information was not disseminated within DOH’s entire structure, resulting in delay and confusion when DWS or other partners engage. There will be significant benefit if DOH bureaus coordinate and communicate, as well as simplify policy.” (Workforce Services)
7. “The **semi-annual reviews** required by many DWS programs is also working well, but annual medical reviews then become diluted. Optimally, Medicaid would follow the same change reporting parameters as other DWS-administered programs and standardize reporting requirements.” (Workforce Services)
8. “Rather than advancing a different service model, DWS suggests **strengthening some existing service model components** in accordance with our two-year goals, including:
 - Secure better online access for customers
 - Enhance existing customer homepage
 - Enhance telephone options (application and review)
 - Enhance online features and services so system and customer can do more
 - Educate customers and community partners regarding online services
 - Strengthen outreach with community organizations, including hospitals and schools
 - Streamline and simplify policy
 - Coordinate and communicate policy with state and federal partners” (Workforce Services)
9. “The **causes of fraud** from FY2006 through FY2010 remained relatively similar and unchanged. Roughly, 50% of fraud cases occurred because the customer did not report an additional household member. Thirty-five percent of fraud cases occurred because the customer did not report income or additional income. Five percent of fraud cases occurred because the customer did not report assets or additional assets. Ten percent of fraud cases occurred because of miscellaneous reasons, such as not residing within the state, resident of a public institution, identity verification, etc.” (Workforce Services)
10. “To **improve identification of fraud**, DWS could consider enhanced publication of our toll free fraud hotline, issuing more frequent press releases on our criminal prosecutions and providing greater up-front education to the customer concerning potential fraud consequences and penalties.” (Workforce Services)
11. “An **increased effort at identifying third-party liability** for Medicaid enrollees. This should be better facilitated by the adoption of the eREP system.” (Health)
12. “The use of traditional payment methodologies does not provide the **appropriate incentives** for providers to keep down costs. Utah Medicaid will continue to work with other commercial insurers to develop payment reform models that bring the promise of controlling costs.” (Health)
13. “An **increased capacity for detecting improper claims** would be a significant improvement. A prescreening payment tool and a fraud and abuse detection tool should be procured by the Medicaid program.” (Health)

14. “The administrative burden imposed on Utah Medicaid by CMS or by Utah Medicaid on its providers is correlated to program costs. The greater the administrative burden, the higher the cost avoidance or the costs savings. For example, the management of the preferred drug list requires prescribing practitioners to document a need for a client to have a non-preferred drug. This is inherently burdensome to the practitioner, yet it is part of the process that results in savings to the State. CMS, on the other hand, forces Utah Medicaid to provide a tremendous amount of administrative justification for various waivers and contracts in the hope that this will reduce expenditures. So the best way to limit the administrative burden is to **determine the cost-benefit analysis of each administrative procedure against the potential program cost savings.**” (Health)
15. “I support removing Medicaid’s oversight or ‘program integrity’ functions to an **independent Office of Inspector General**. It has been my experience, which has been supported now by two legislative audits of Medicaid, that the single state agency (DOH) which is responsible for providing patient access to services as well as to catering to the pressures of providers for reimbursement should be removed from the difficult role of enforcing compliance issues and seeking recovery due to fraud or waste. Medicaid is unique from private health care insurance programs. The program integrity function requires independence to enforce legislative policies and rules in a manner removed from the political and other pressures which exist within the DOH. I believe that the culture at DOH has been to overlook or excuse violations of policy in order to accomplish its primary goal of patient access.” (Medicaid Fraud Control Unit)
16. “Program integrity needs to **utilize updated technology to review claims and detect patterns of abuse and fraud** in the system. Prompt investigation and resolution of often complex fraud schemes can best be achieved with updated Fraud and Abuse Detection Systems (FADS). Fraud cases are time consuming and difficult to investigate. It would be beneficial to utilize technology to increase referrals and speed the process of detection and financial recovery.” (Medicaid Fraud Control Unit)
17. “I believe Medicaid needs to be **more responsive to known abuses in the pharmaceutical industry** by being more proactive in addressing issues such as off label promotion of drugs, abuse of prescription drugs, etc. We also need to use a bonafide preferred drug list to negotiate or obtain lower prices for medications that are purchased in high volumes for Utah residents. Utah has been successful in litigation of known abuses, but the cost of settling these issues has become the cost of doing business in the pharmaceutical industry. We need to protect ourselves from this waste rather than try and recoup a percentage of our losses through expensive litigation.” (Medicaid Fraud Control Unit)
18. “I support **increasing oversight on claims for payment** and eliminating as much fraud and waste on the front end of the transaction rather than the current ‘pay and chase’ mentality. (where only a small number of claims are reviewed for accuracy and propriety.)” (Medicaid Fraud Control Unit)
19. “I also encourage **increased awareness by Medicaid recipients about fraud and waste** and sending out explanations of benefits and other surveys to allow recipients to be more involved in alerting Medicaid to fraud or waste. Even if a small number of recipients respond and report fraud, the recovery I believe will be greater than the administrative cost of sending EOBs to recipients.” (Medicaid Fraud Control Unit)
20. “I believe we need to evaluate all Medicaid provider contracts and agreements to **assure that the contracts are well written and specify the obligations of the provider to the Medicaid program**. For

instance, the MFCU has recommended that contracts for durable medical equipment relating to oxygen supplies be revised to eliminate confusion and otherwise provide more guidance on what is required of the service provider. Contracts which contain inconsistencies, fail to close important loopholes or that fail to specify provider obligations are detrimental to enforcing compliance. Contracts should be reviewed on a regular basis and reviewed by attorneys experience in procurement law. Many of these contracts deal with multimillion dollar transactions but are poorly written or [were] drafted years ago and left unaltered in subsequent contract cycles.” (Medicaid Fraud Control Unit)

21. “I have insufficient knowledge in this area to comment about different service models. However, I do believe that **Medicaid recipients need to be held more accountable and be better informed** of what services they have received via explanations of benefits so that they can assist the program in eliminating fraud and waste. Moreover, recipients who abuse Medicaid by being deceptive in the eligibility process need to be investigated and if necessary, prosecuted. I do not believe we as a State have prosecuted Medicaid recipient fraud as we should. The MFCU is prohibited from prosecuting or investigating recipient fraud under OIG grant rules and by federal law. The only exception is where the recipient acts in concert with a provider to commit fraud against Medicaid. We need increased enforcement in this area. Recipient fraud investigation would reduce money spent on ineligible recipients who are currently obtaining services.” (Medicaid Fraud Control Unit)
22. “**Drug costs and long term care** are two of the most costly aspects of the program and **should be a serious area of focus**. This involves complex decision making and strong political will to address the strong lobby efforts of the drug industry. Medicaid is one of the largest purchasers of drug products and should be able to leverage this into considerable savings by negotiating with drug manufacturers for lower prices.. I support the preferred drug list concept and expanding that list to address the expensive drugs such as the mental health drugs which are a significant cost to Medicaid.” (Medicaid Fraud Control Unit)
23. “Based on a recent legislative audit in which serious up coding was discovered amongst two clinics that were managed by DOH, **I believe that up coding throughout the industry is a real problem**. I do not attribute all up coding to fraud, but the MFCU has discovered several areas where up coding or using certain codes in appropriately has resulted in substantial overpayments. Even small clinics have been discovered to have inappropriately coded certain procedures costing tens of thousands of dollars in waste. I believe that a culture exists among the provider industry that Medicaid’s low reimbursement justifies this practice. This is a issue that needs to be addressed with increased audits, recovery and training.” (Medicaid Fraud Control Unit)

Suggested Changes Within the State’s Control – 11 Items for Future Consideration

1. “**Federal health care reform** will significantly impact DWS operations and the administration of other supportive programs. It is imperative that the department be provided the opportunity to mitigate these changes. Potential costs can be contained by leveraging the use of technology and the pursuit of grants or enhanced funding opportunities in absorbing workload increases and managing the complexity of medical policy. It is important to note there has been very little guidance or direction about available funding for system support and/or technology needs. Online reviews, touch points for customers under consideration, and other technology solutions may help DWS administer its Medicaid responsibilities. With reform efforts, DWS anticipates complicated policy differentiating between “currently” and

“newly” enrolled recipients. Without technical support and assistance, DWS will be disadvantaged in its role.” (Workforce Services)

2. “An additional consideration may be **the way Utah assesses Medicaid program performance**. Comparing data obtained before DWS acquired BES from DOH to current DWS BES performance will not yield reliable analysis for several reasons, including the complexity of the two systems, enrollment increases, excessive exceptions, and delayed state revenue responses to changing caseloads. While some assert a multi-program DWS focus compromises accuracy, DWS leadership contends that more time is requisite for accurate performance assessments in the midst of ESD consolidation, historic caseload increases and e-REP implementation.” (Workforce Services)
3. “DWS is presently exploring the **implementation of its existing customer homepage**—a personalized access portal whereby clients can access their case and facilitate case maintenance and compliance. Such a solution offers a lot of promise for most mainstream customers, but aged and disabled customers may still require more intense case management and assistance.” (Workforce Services)
4. “Utah Medicaid’s **preferred drug list (PDL)** is working well. It currently saves the State over \$4.5 million in general fund annual. The Pharmacy and Therapeutics (P&T) Committee meets monthly to consider new drug classes to be added to the list.” (Health)
5. “The **Emergency Room (ER) diversion program** was started as a grant to test the hypothesis that contacting enrollees who used the ER inappropriately after the first visit and helping them find a primary care provider would reduce ER visits. The program is showing success and will continue beyond the life of the grant.” (Health)
6. “Utah Medicaid has a successful **disease management program** for the care of hemophiliacs. Utah Medicaid is now developing additional disease management/care coordination models.” (Health)
7. “Utah Medicaid **program integrity efforts** have been **hampered by outdated systems and technologies**. New contract services and systems technologies should provide better outcomes than have been seen in the recent past.” (Health)
8. “**Program integrity should not be outsourced to contingency fee contractors** at the expense of trained internal auditors and investigators who are directly accountable to State government. Contingency fee contractors may be part of an overall solution to combat fraud and abuse, but Medicaid enforcement is more often than not, a secondary consideration to a private contractor who evaluates cases based on the return of investment to the contractor’s profit margin. Quite often stopping or preventing abuse is as important as obtaining recovery. Program integrity needs to have adequately trained personnel and fraud fighting technology to be successful. Enhancing and improving our program integrity unit, not replacing them with outsourced private contractors, is in the best interests of the State and the taxpayers.” (Medicaid Fraud Control Unit)
9. “I support efforts to **evaluate and change how Utah reimburses pharmacies for medications** which is a major cost driver in Medicaid. I oppose continued use of the Average Wholesale Pricing methodology that has been the subject of ongoing litigation with drug manufacturers over falsely inflated prices. In fact, a common defense raised by drug manufacturers to various lawsuits in this country is that the States have known for years that reported average wholesale prices (upon which Medicaid bases reimbursement) are not true prices. Moreover in spite of this knowledge Medicaid nonetheless continues paying for drugs using the same reimbursement methodology. Although Medicaid discounts AWP by a certain percentage, evidence is clear that this discount is a shot in the dark approach to trying to pay the correct price. Pharmacies will undoubtedly protest reduced reimbursement for their products, but the “shot in the dark” method of reimbursement is wasting millions of dollars in the Medicaid program.” (Medicaid Fraud Control Unit)

10. "I believe that **Medicaid does a tremendous job at providing access to care** and instructing both recipients and providers with respect to the programs benefits and services." (Medicaid Fraud Control Unit)
11. "I do not feel that they are doing well with the compliance side of Medicaid...It is important to note that the program integrity staff at Medicaid do an excellent job with limited resources. There simply has not been the proper focus or resources devoted to this aspect of the program. **Program integrity also needs to be empowered** to enforce the rules without pressure or direction to overlook violations." (Medicaid Fraud Control Unit)

Suggested Changes Outside the State's Control – 13 Suggestions for the Federal Medicaid Program

1. "**Federal CMS Medicaid policy is error-prone**, due to its complexity. For example, long-term care and waiver programs are very involved, as are determinations involving self-employment; there is significant documentation and verification around expenses, income, self-employment ledgers, etc. Cases could also include detail about assets, spousal deeming and review of trusts." (Workforce Services)
2. "Guidance from federal partners, like CMS, can be vague. **Too much flexibility allows variation in interpretation**—both among state agencies and across states—and can create error and result in inconsistency across regional offices. Communication between medical programs and the coordination of policy has improved, but still poses notable challenges. One challenge is the sharing of information in relation to data agreements with third parties, since across the nation there are differences between states. While DWS and DOH attempt to align eligibility and services between programs like CHIP and Medicaid, there are instances when that is problematic, or even impossible. Furthermore, nuances promulgated by federal agencies are difficult to navigate. For example, although both DWS and DOH agree an interview is the best way to obtain information from a customer to accurately determine their eligibility, CMS doesn't "require" an "interview.'" (Workforce Services)
3. "1115 waiver submissions and amendments should be subject to a **standard timeline for approval** by CMS and have an appeals process like other Medicaid waivers." (Health)
4. "1915(b) and 1915(c) waivers should have a **uniform renewal period of three years**, rather than the (b) waivers be renewed for two years and the (c) waivers being extended for three years." (Health)
5. "States should be granted the **flexibility of running a combined 1915(b)(c) waiver** without having to operate the combined waiver parts as two separate waivers." (Health)
6. "The federal look back period of five years on the divesting of assets prior to qualifying for Medicaid should also take into account the **amount of assets transferred**." (Health)
7. "The **institutional bias for long-term care services** should be eliminated." (Health)
8. "**Federal limits on client cost sharing** should have some inflationary escalator to at least keep pace with medical inflationary costs." (Health)
9. "**CMS should develop a core MMIS [Medicaid Management Information System] technology** and make it available to states. States would then need to customize their individual systems to meet their needs. This could save the federal and state government millions of dollars by not having each state procure its own MMIS." (Health)
10. "The Disproportionate Share Hospital (**DSH**) **payments should be equalized** across states based on a per capita formula." (Health)
11. "The provision of a **Medicaid Health Opportunity Account (HOA)** could provide a better model to meet the needs of healthy Medicaid clients. These individuals would become better users of the health care

system because they would need to shop for services based on price and quality. This would allow them to have their needs met while on Medicaid, but also prepare them for dealing with the health care system after leaving the Medicaid program. This would require a change in federal law.” (Health)

12. “While all areas of the Medicaid program may be subject to abuse, the area that is most likely to be abused is clients’ use of Medicaid services when they have the **means in their family to pay for the services themselves**. This can take on many different forms and in many cases may be legal under the Medicaid rules: parents allowing a child to enroll on Medicaid for a baby delivery when the parents could pay for it, elderly clients divesting assets to children so Medicaid will pay for their long-term care services, and the inability of the State to recover on an estate after both spouses have passed and all dependent children are living outside the home.” (Health)
13. “Individuals, including family members who **defraud vulnerable adults including aging parents is a growing problem**. Formerly the MFCU prosecuted these offenses. However OIG has disallowed this practice under grant rules. Increased prosecution of theft from vulnerable adults, particularly financial exploitation which renders the vulnerable adult without resources to care for themselves or pay for their long term care needs is a serious issue that needs to be addressed. The MFCU receives complaints on a weekly basis about this problem. By intentionally and fraudulently reducing aging parents, neighbors, relatives to poverty, Medicaid ends up with the obligation to pay for the long term care needs of these individuals when other assets are available to defray those costs.” (Medicaid Fraud Control Unit)

Sources for Agency Survey:

- State agency responses to an April 6, 2010 letter from the Speaker of the House and the President of the Senate requesting ideas to improve Utah Medicaid. The letter asked the following six questions:
 1. In your professional opinion, what areas of Medicaid could be improved?
 2. What are we doing now that is working well and should be expanded? What are we doing now that is not working well?
 3. How effectively are our current service models serving the needs of Medicaid clients? What service models would better serve the needs of Medicaid clients?
 4. What improvements should be made to better deliver and/or administer Medicaid services in the state?
 5. How could the coordination of oversight responsibilities be improved? How could we limit the administrative burden required?
 6. In your opinion which area of the Medicaid program is most abused?

1. WHAT AREAS OF MEDICAID COULD BE IMPROVED?

(59 Responders)

Specific Suggestions for System Improvement (28 Comments)

1. With electronic claims for dental services payment time is much improved.
2. Smoking cessation programs should be eliminated and the tax on cigarettes increased proportionally. Higher taxes are far more effective than anti-smoking campaigns. Also, tax full sugar soda and other harmful foods and invest in diabetes prevention and anti-obesity campaigns.
3. Do not fight against the federal government! Rather, work to maximize federal funds.
4. Give the Health Dept. and Human Services more authority to do what is best for Utah's economy and its citizens.
5. If the patient has a TPL, they should use that instead of the Medicaid card to keep costs down for taxpayers and NOT have the State "pay and chase" for payment from TPL's after Medicaid has paid providers either. This would keep costs down also.
6. Responding to requests for policy changes.
7. Use of Advanced Practice Clinicians such as nurse practitioners or physician assistants. Current regulations discourages independence of such providers employed by hospitals. These highly skilled practitioners could function as "hospitalists" in rural and even urban environments to enhance the quality of patient care and are less expensive than physicians.
8. Provide re-imburements to mid-level providers for procedures, ie skintag removal, excision of benign skin lesions etc. Now these are considered MD only procedures. We are trained to provide these services but cannot be paid to provide them. Mandate that all licensed medical professionals take Medicaid patients. Why should one sector, the most altruistic, accept the burden of caring for [Medicaid], who reimburses at [such] a low amount?
9. Make the PASARR process electronic.
10. Medicaid could improve by converting to a competitive reimbursement system. Using the managed care [health maintenance organization] causes dollars to go toward management of the [health maintenance organization] that could toward actual Medicaid services.
11. FMAP extension.
12. Some of the issues that are currently face to face expensive visits can be handled over the phone. This may save money in expensive office visits and keep patients out of busy waiting rooms and having to take time off work. We should have formularies for Medicaid patients in the same way some of the insurance companies have formularies to cut costs.
13. [Improved interpersonal skills of] the pre-hearing and hearing team.
14. Clear expectations for providers with respect to documentation needs and who qualifies for Medicaid service (Home Health). Currently we hear that the lower cost alternative is where the patient will be best served. Home Health agencies don't have costing information readily available to make the decision.

15. Increasing strategy around quality improvement processes could be strengthened. Aligning with Medicare quality strategies may be [beneficial] to overall community.
16. Focus on strengthening outcome oriented services (rather than evidenced based services). Providers are very creative and innovative when it comes to their service delivery and when it comes to tailoring the services to their unique geographic area. Increased focus on the “how” leads to increased administrative burden without necessarily obtaining better results.
17. Medicaid needs to mail out membership (paper) cards monthly at a monthly cost, we heard, about \$400,000. Now [Utah Health Information Network] has developed a standard health plan member ID card. Can Medicaid use it for eligibility and not do paper-mailing? This card can have real time information, verification, Medical Home information. It can be linked to annual payment, episode care, etc.
18. One problem is Healthy U does not serve many clinics in Utah County. Either Medicaid needs to be consolidated to one provider or give select access to children living in Utah County.
19. Get the incentives right. At present Medicaid has taken the uninspired, politically correct approach that ignores incentives to human behavior.
20. Many Medicaid patients need some incentive for taking responsibility for their lives and health, not just an open card for any health care need that may arise.
21. The provision that only one service can be rendered and be compensated is a disservice to the patients. As an allergist doing skin testing, I either do not bill for services given or ask that the patient return for another visit.
22. Make sure that it is a program for the masses and insure minimum benefits for all who participate.
23. Drop the [Medicaid] program.
24. Medicaid should be a single payer. Transferring patients because they presented to the wrong facility and having to transfer them to the appropriate facility is a waste of resources.
25. Another area that is important is the care of chronically ill children and children with special health care needs. These budgets continue to be cut in this causes more hardship for families who are already stressed and their providers.
26. Interactive process of contracting.
27. Decrease silos of funding.
28. Qualification criteria for medically fragile children.

Specific Problems/Suggestions for Medicaid Eligibility (17 Comments)

1. Complete medical formulas for at risk clients. Currently clients have to get some from [Women, Infants, and Children] monthly and get some from Medicaid. That is a hardship on those who already have fragile children and many appointments and responsibilities.
2. Since the program eligibility has been moved to Workforce Services the workers are not as [familiar] with the program and it is difficult to access services if you are not [familiar] with a computer. Much better at Dept. of Health.

3. Communication between caseworkers and clients. Caseworkers need to help better understand clients' needs and be very patient with clients. Some clients struggle with literacy and are not bilingual. Caseworkers need training on rural areas and customer services. Caseworkers & [Department of Workforce Services] employees are not pleasant to work with. The interview telephone lines have wait times that exceed 45 [minutes]. When you finally get someone on the line, they hang up on you.
4. I feel that some of your staff have way too many caseloads and errors are being made that were not previously.
5. Quality of eligibility workers needs to be improved. Job performance, follow-up, customer service, [timeliness]. [Separation] of 10A & eligibility. They do not communicate with one another.
6. Currently the Financial Eligibility process is slow and cumbersome. It is very costly to the [nursing home] facilities. We should move the financial eligibility piece back to the Department of Health where they have more trained workers to handle the load.
7. Expand eligibility to two-years for Medicaid babies to ensure proper development (adherence to immunization schedule and well-child checks) and improved health outcomes, thus reducing potential complications/conditions that will be more expensive in the long-term continuum.
8. Simplifying the enrollment and renewal process.
9. Streamline enrollment and retention processes. Examples: 12 month continuous eligibility, express lane eligibility and paperless income verification, ex parte renewal.
10. Eligibility – administrative simplification (ex parte review, 12 [month] continuous coverage, express lane eligibility).
11. Simplify application and review forms.
12. Eliminate asset test.
13. Expedite determination of eligibility.
14. Determine eligibility locally.
15. Eligibility verification.
16. Communication on the different Medicaid programs. Workers need to be better educated on the different Medicaid options/programs. They need to be able to answer questions and direct people in the community on what program would work best for them. There are a lot of families who have communicated with Medicaid workers regarding regular income based Medicaid and not informed of the other Medicaid options after not qualifying (i.e. Disability Medicaid and spend-down program).
17. Changes are affecting the elderly on the reservation people. Some don't have phone or access to the internet and some don't even know how to use turn the computer on or how to dial the phone.

Raise Reimbursements (13 Comments)

1. Reimbursement levels for all dental procedures need to be raised. Procedures that are covered need to be expanded to cover what is considered standard of care. (ex. posterior white fillings on some posterior teeth, Cast crowns instead of Stainless [steel] crowns).

2. Give them more money!!!!
3. As a physical therapy clinic we lose money every time we see a Medicaid patient. The reimbursement of \$20.88 a session is very low. That doesn't even cover the billing and rent - let alone the cost of the therapist. It is very hard for us to see [Medicaid] patients.
4. I have not participated in Medicaid for 15 years now. Initially, reimbursements were sufficient to provide the service, now they lag substantially behind average fees for our State.
5. Ease of reimbursement to providers.
6. At the present time most physicians are fortunate to collect 50 cents on the dollar for seeing Medicaid patients instead of private pay/insured patients. Frankly, the reimbursement does not cover the cost of keeping the office open and staffed to cover the paperwork and supplies needed to serve these patients. The result is that many physicians simply refuse to see Medicaid patients. Increasing the level of reimbursement even to the level of Medicare reimbursement would be a great step forward that would improve access and quality of care provided to Medicaid recipients. The only way physicians in private practice are now able to care for Medicaid patients is by supplementing the cost by revenues generated by private pay and private insurance-covered patients. When the pool of Medicaid patients reaches a certain point, no physician will be able to afford to provide any care.
7. More reimbursement. Anesthesia literally makes pennies on the dollar. My plumber and electrician both charge me more than Medicaid reimbursement for anesthesia services.
8. Obviously reimbursement levels to providers in general can be improved but of particular importance is reimbursement to primary care: FP, IM, pediatrics and [obstetrics]; if it were possible to create tiered reimbursement for [primary care providers] for certain CPT (Current Procedural Terminology) codes – particularly those codes used by [primary care providers] 80 percent of the time or more along with the basic E/M codes and preventive codes this may improve access for patients and help to create a [primary care medical home] environment; also creating an incentive system which reimburses providers more for certain measures such as access and certain quality measures, which may also create improved access.
9. The reimbursement rates are terrible and an insult to providers. Society expects medical providers to provide services at a cost that is not covered by the reimbursements.
10. Physician reimbursement: in total amount reimbursed .
11. We need better reimbursement. There could be a very big cost savings in [neonatal intensive care unit] expenses if we could provide better [obstetrics] care. Because of such low reimbursement there is no incentive to take on this group of patients. When we do, we get no support from other providers. I cannot tell you how many times a week I need the help of another provider and cannot get anyone to see my patients. The worst is the [University] of Utah Department of Neurology. I cannot get them to see any of my patients!
12. The most obvious is that the reimbursement needs to at least cover the expenses of care. This applies to Medicare as well, but I will stick to the subject. Specifically, emergency visits are covered at a fraction of the rate that a regular office visit is covered. I realize this is to discourage non-emergency use of [emergency department], but providers do not have control over where the patient shows up for care and to penalize a [primary care provider] who has come in to care for a patient in the middle of the night seemed unreasonable.
13. Raising [dental] reimbursement rates to a reasonable level.

Prior Authorization Problems & Suggestions (11 Comments)

1. Prior Authorizations are too cumbersome and take too long now. It used to be we could get info to you and would get [authorization] in a reasonable time now it takes weeks sometimes. Paperwork being lost is another problem sometimes we send paperwork 2 or 3 times. We do use your new system.
2. Prior approval process for Home Health and Hospice.
3. Preauthorization process for surgery is horrible!
4. Timeliness of pre-authorization process.
5. Consistency in the pre-[authorization] process.
6. Improved interpersonal skills of the pre-authorization team.
7. If the federal [regulations] are followed, OASIS Data sets are completed, we are asked to duplicate the information on the OASIS data sets for the pre-auth process.
8. [Utah Health Information Network]/[Clinical Health Information Exchange] can be used by Medicaid to obtain in-completed information for pre-authorization.
9. Remove administrative waste. Half of the time spent by Medicaid employees is trying to figure out how NOT to pay the physician for services rendered. Many claims are erroneously denied, almost randomly, and have to be resubmitted, sometimes several times before they're paid. This game playing is an administrative waste for Medicaid and an added expense for physicians who have to hire additional billing people to push paper back and forth. Promptly paying legitimate claims instead of indulging in fictitious excuses for denials would save Medicaid & physicians a great deal of expense.
10. Physician reimbursement: decrease the complete hassle of chasing down payments.
11. Confusion of 3 or 4 plans for a [doctor] to do pre-authorizations. We have to remember which process to use for each one and it is confusing. Phone tree is maddening for a doctor to call and they are closed a lot, pharmacy pre-authorization people are an exception and reply quickly.

Add/Expand Specific Services (10 Comments)

1. My community, Brighton Gardens of Salt Lake offers skilled nursing care as well as assisted living. Although we do not participate with Medicaid for skilled nursing care, we do have residents that exhaust their life savings for care related services. Once they exhaust their resources but still needing assisted they have to leave Brighton Gardens Assisted Living to go to a Medicaid contracted facility for 90 days to qualify for New Choice Waiver/Flexcare. The approximate cost savings between skilled nursing care ([approximately] \$155/day) and assisted living care (\$69/day) is \$85/day. Taking into consideration just one resident at \$86/day x a minimum of 90 days results in a \$7740 savings if you could allow them to stay in assisted living to qualify.
2. Chiropractic benefits.
3. Provide preventive care for all children.
4. Greatly expand "money follows the person" programs.
5. [Greatly expand] preventive services in Medicaid waivers.

6. Amend existing waivers to provide more low-cost, low-intensity supports for families.
7. I also feel that single people need more coverage. Our bad debt and charity usually involve single adults with no insurance and who have been laid off work in this economy.
8. More [assistance] to families who have children with [tracheotomies] and [ventilators]. Private Duty Nursing. We are seeing more and more children get cut off services that could benefit [from] services.
9. Payment for circumcision should be reinstated.
10. The New Choice Waiver/Flex Care program should be expanded. There is significant savings and quality of life is enhanced in being in a less restrictive setting.

Improve Pharmacy Coverage/System (10 Comments)

1. Continue work on a preferred pharmacy list to help save money.
2. Prescription benefit coverage. Why is Medicaid paying for patient requested name brand Oxycontin? THAT is ridiculous! Trim down prescription coverage - require generics over name brand. Cover one or two medications in each therapeutic category.
3. An updated computer system that would allow for faster [pharmacy] price updates. As it is currently established, my cost for an item can go up and it takes 3 to 4 weeks for Medicaid to pay the new higher price for the item. While we wait, we are actually losing money on each prescription we sell for that particular product. No other insurance program is that slow in updating prices.
4. Become consistent in establishing preferred formulary drugs, and then sticking to that formulary. As it is currently established, it seems more like Baskin Robbins and the flavor of the month club. We never know when the formulary will change or revert back to the previous coverage. It makes it impossible to stock adequate inventory when we never know which items are preferred and then they are deleted or revised a short while later.
5. [Prescriptions] – implement a formulary or expand the [Preferred Drug List] to lower costs.
6. Make the formulary generic only and no exceptions, this allowing all Medicaid participants the same benefit. The pharmacy benefit should cover 99 percent plus of all patient needs.
7. Only allow medications for the [Federal Drug Administration]-allowed medication.
8. Need Medicaid [pharmacy] formulary.
9. I have sent patients to specialists who come back to me on expensive “designer” drugs when the generics they were on before were doing more than an adequate job. When the patient is told this is a very expensive medicine the response is always the same “I have Medicaid, I don’t have to pay for it.” This policy of no oversight of expensive medications seems odd as there are over-the-counter cheap meds that require prior authorization.
10. Case management of people who overuse services/closer monitoring of prescription drug use.

Improve Client Education (10 Comments)

1. Patients should have some responsibility for seeking healthcare services, which requires education. Some effort at education on how and when to utilize medical services would be helpful. A hotline where Medicaid patients could

talk to a nurse, physician or other healthcare provider to discuss their situation prior to seeking direct medical advice might minimize over-utilization.

2. Caseworkers could identify consumers of resources and give us options for their follow up care to keep them out of our offices and [emergency rooms].
3. Make enrollment understandable to the average client, make it easier.
4. Medicaid patients need to be educated on what their benefits are and what is covered. Most seem to be oblivious of any restrictions and get angry if they can't have everything they want.
5. Utilizing caseworkers to educate clients about [dental] prevention, dental office etiquette, and to act as liaisons with the providers.
6. Incentivizing [dental] education and [dental] prevention efforts to clients.
7. Giving clients clear, concise instruction on how Medicaid works. They acceptance and denial letters are VERY confusing. In one letter you can be accepted and denied in the same paragraph. Better communication with Medicare's computers when a client uses a "spend down" to get on Medicaid. Currently you send premiums to Medicare/Social Security for 3 months then you request it returned because client has not paid monthly spend down. This puts a hardship on the client to have 3 months of Medicare premiums withdrawn from their account at one time. Most clients will claim they were never told this would happen.
8. As far as eye care is concerned: helping patients know what benefits they have. Many patients I see that have Medicaid are not aware that often times an eye examination is a covered service. Most are not aware of "material benefits"....frames and glasses allowance.
9. Patient education could also be improved.
10. More education!

Increase Client Co-Pays (7 Comments)

1. There needs to be greater cost sharing by the participants. Even [though] Medicaid is provided to lower income households, the co-pays etc do not increase as the cost of providing care has increased.
2. I think there is a lot of overuse in the system. I am a Medicaid provider and find that since there is no personal responsibility for any minor co-pay that patients can be seen whenever and for whatever they feel is necessary.
3. Having recipients, those on Medicaid pay into the system even if it is minimal - ability to pay. Look at anybody on Medicaid they can sacrifice like the [rest] of the tax payers and go without a few [luxuries] and pay into the system.
4. Co-pays have done miracles to reduce excess utilization; something that puts a fiscal note on the patient is ideal. Those using the [emergency department] for non-[emergency department] stuff should have to pay a share. I have no idea if this is allowed or not because the feds are increasingly tying everyone's hands with gorilla glue, but this would help.
5. Medicaid recipients currently (to my understanding) have no financial responsibility and, hence, little or no personal appreciation for the services they receive. They need to have a real sliding-scale co-pay system or be required to provide some form of community service or some other way to pay back to the community for the

benefits that they get from tax payers. If you do not do this Medicaid recipients will eventually develop an attitude of “entitlement” that is destructive to their sense of ability to provide for themselves and make their own way in life, and the tax payers, who see this sense of entitlement, get quite resentful and eventually unwilling to “spread the wealth around” as President Obama likes to say.

6. Patient responsibility. Instituting consistent co-pays that do not place economic burden but encourage prudent choices in accessing medical services.
7. Co-pays for [emergency room] – Currently in my understanding it is actually cheaper for patients to go to the [emergency room] for their sinus infection than pay their \$3 co-pay at the office. There seems to be nothing to discourage inappropriate use of the [emergency room]. Everyone who does NOT have Medicaid (self-pay or standard insurance) has to think twice before saying “this is worth going to the [emergency room],” which helps control costs and improves access for true emergencies. I do not know why Medicaid can’t be similar. I understand no upfront co-pay but having them pay a small portion of the bill, or even a flat rate (like \$30-\$50), would discourage frivolous use of [emergency room] and thus cut costs. Change the Strict financial cutoffs – I have actually heard people say, “I cannot get a second job/my spouse cannot go to work or we will no longer qualify for Medicaid and we cannot afford private insurance.” There seems to be a gap between where Medicaid ends and where private insurance becomes a realistic option. Medicaid seems to actually DISCOURAGE improving one’s financial situation. I would propose a tiered system similar to a sliding scale that allows and perhaps even encourages people to improve their situation without fear of losing coverage. As they begin to earn more they become more responsible for portions of their care (the co-pay increases or they begin to pay medication co-pays or a portion of the bill) up to the point where their income improves sufficiently for private care.

Suggested Changes to Dental Benefits (7 Comments)

1. Have a cap on Dental.
2. Require children, at least, to see dentist every 6 [months] for cleaning [appointment].
3. Apply frequency limitations to dental procedures.
4. Pay for porcelain crowns on posterior teeth if necessary.
5. Incentivizing [dental] education and [dental] prevention efforts to providers.
6. Simplifying [dental] claims processing.
7. Simplifying the [dental] provider handbook and updates.

Provide Adult Dental Care (4 Comments)

1. [Fund] Dental Care.
2. Providing more preventive services such as adult dental care.
3. The loss of adult dental services alone has brought many of dental safety net clinics to capacity in patient volume and costly procedures. The costly procedures are due to the fact that adult patients delay dental care until they are in pain. The availability of preventive and early treatment of dental caries would save Medicaid millions of dollars on less expensive treatment programs. Utah should be a leader in the nation in recognizing that oral health is a part of overall health and make sure it is an integrated part of our Medicaid program.

4. [Need] dental benefits.

Provide Family Planning Services (4 Comments)

1. More family planning...I know it is hard with the religious overtones in the state, but unplanned pregnancies are REALLY expensive. We should be doing a better job of educating Medicaid recipients about family planning options and paying for birth control.
2. Prevent pregnancies by funding birth control measures. Tubal ligation should be a benefit. This would reduce the number of future enrollees, and also help the disadvantaged. The cost of these are relatively low, and would have a long term benefit to the Medicaid program.
3. Implement a Family Planning Medicaid State Option to help reduce unintended pregnancies and improved maternal and child health outcomes. The Legislative Fiscal Analysts office estimated the state savings to be over \$800K annually by providing family planning services to families with household incomes of less than 133% of federal poverty level.
4. Make sterilization procedure more accessible. Currently women must wait a lengthy 6 weeks, I believe, after delivery of their baby in order for their tubal ligation to be covered by Medicaid. Medically the easiest time to perform this is right after delivery or before the C-section is sutured close. Many women are not following up with their desire to get their tubes tied and unwanted pregnancies are occurring. This further burdens the patient's financial future and a vicious cycle recurs. Also, epidurals need to be reimbursed more or they will not be able to be provided.

Reduce Time Waiting on the Phone to Talk to Medicaid Eligibility (4 Comments)

1. When families call Central Region Eligibility Service Center to talk to an eligibility work, sometimes the wait time can take more than 30 minutes. On occasion, the call gets disconnected. Please reduce the wait time.
2. The way the phone interview process is set up. Clients have to wait on the line for a long time (45 minutes to 1 hr) to long to be on hold. On the reservation some people don't even have phone and some don't even know how to use phone (elderly).
3. Customer Service phone time.
4. The waiting time when calling in on the customer service line.

Change the Eligibility Criteria (4 Comments)

1. Change the eligibility criteria for short term nursing home admission. Currently patients can qualify for a hospital stay on Medicaid but not qualify for a nursing home stay. That can cause a person to stay longer in the hospital than necessary due to the fact that they are not yet ready to go home but cannot be sent to the nursing home for a fraction of the hospital cost because they do not qualify. If we could change the criteria for a short term nursing stay it could get the patient out of the hospital sooner and save Medicaid money.
2. Expanding the program to include a greater proportion of the population is a great error in my opinion.
3. Those on Medicaid somehow find a way to drive nicer cars and wear nicer clothes than the providers they are seeing.

4. We need to broaden [obstetrics] coverage for “entry” level families, even if they have to pay to “buy” Medicaid for the pregnant mother and new baby. If they don’t qualify under today’s standards, then they have the option to buy Medicaid coverage that is rated according to their income.

Implement Medical Home Model (4 Comments)

1. Timely access to a primary care provider through the implementation of a patient-centered medical home model.
2. Ensure the implementation and adherence to case-managed chronic disease care utilizing the Institute for Healthcare Improvement models.
3. A medical home would aid Medicaid patients in getting appropriate health care/in appropriate health care settings (would help prevent overuse of emergency departments).
4. Providing every enrollee with chronic illness a medical home to manage their issues.

Focus More on Prevention and Wellness (4 Comments)

1. Be it federal or state health care reform, there is a much discussion on prevention and wellness as being a cornerstone of reform. The Medicaid program does have a focus on prevention and wellness for children with the Early, Periodic, Screening, Diagnosis and Treatment program, as it is called in federal regulations. This program is known as Child Health Evaluation Check in Utah.
2. We do not have a prevention and wellness emphasis for adults on Medicaid. Utah should examine where prevention and wellness programs and screenings will make sense for Utah Medicaid beneficiaries.
3. Persons accepting Medicaid should be required to participate in some kind of preventative medicine.
4. Allowing preventive measures.

Community-Based Long Term Care (3 Comments)

1. Work harder to eliminate the institutional bias for long term care.
2. Focus more on community-attendant based long term care, as this is cheaper than nursing home care.
3. With the baby boomers reaching age 65 and older, the demand for services will increase significantly over the next several years. It will be much more cost effective to serve as many people in the community as possible rather than in nursing homes.

Mental Health (3 Comments)

1. Mental Health.
2. Limit the treatment sessions in Mental Health to a meaningful number over the first year, say no more than 9 sessions over the year.
3. We have found in Intermountain Healthcare that integrating mental health services into our primary care practices has improved outcomes, increased satisfaction, and cut [emergency room] costs significantly. I’d suggest that [University of Utah] and Intermountain (and other large groups – Granger Clinic, Wasatch Pediatrics et al.) work with Medicaid so that the mental health providers located in their primary care clinics can provide services along with locally contracted providers such as [Valley Mental Health]. This is one way to decrease [emergency room] expense.

Fraud, Waste, and Abuse Issues (3 Comments)

1. Hopefully with the \$3.3 Million FY 2011 state appropriation for the fraud, waste and abuse, the [Department of Health] is purchasing a new detection system. This added system will give Healthcare Financing improved tools to detect and mitigate patterns of fraud, waste and abuse in Utah. Under Federal Health reform, there are additional resources available to states (up to \$10 Million per year) for each year between 2011 and 2020 to improve states' efforts to improve its detection of fraud, waste, and abuse. Utah should pay attention to these additional federal resources as our program's efforts to detect fraud, waste and abuse are better understood.
2. I do have some insight after comparing the patients I treated in the military for 15 years compared to the Medicaid patients I have treated in Utah over the subsequent 15 years. There ought to be a reporting system. Medicaid has spent a lot of time and money looking into physicians making coding errors. I believe there is a much BIGGER AND COSTLY ABUSE, which is the FRAUD AND ABUSE COMMITTED BY MEDICAID PATIENTS.
3. Make use of emergency services available limited to "true" emergencies by putting the client through a mini "means" test that could be waived by [emergency room] administrators and professionals — the "means" inquiry could be limited to those clients known to the [emergency room] system as chronic abusers or those who simply do not make use of their limited medical visits — the decision could be left to the client to forego the [emergency room] visit if he/she could be seen on a regular visit under "urgent" conditions formally requested (required?) by [emergency room] personnel to the "regular" clinic or individual treatment resource.

Make Sure Only Truly Needy and Eligible Receiving Medicaid (3 Comments)

1. Making sure recipients are truly in need before giving benefits.
2. One way to improve is to check to find out if those obtaining Medicaid services have a Social Security Card and have paid taxes previously.
3. If you are a citizen of the [U.S.] you deserve these benefits, and the ones that are not a [U.S.] citizen need to go back to their countries and tax their [government]. Maybe, also for that are illegally obtaining benefits, the [U.S.] should send a bill to that country.

Nursing Homes/Nursing Care (3 Comments)

1. We need to reduce the number of Nursing Home beds in Utah. Currently we experience an occupancy rate of about 65%. It is much more expensive to deliver care at 65% occupancy than it is at 85 or 90% occupancy. Nursing Homes will still play an important role in the continuum of services [for the aging baby boomers]. It will also be important to have a healthy nursing home profession because there are many residents who can be served at less cost in the nursing home than a hospital or even for some it is less expensive in the nursing home than the community. The best way to keep nursing homes financially sound so they deliver the highest quality of care possible at the lowest cost possible is to maximize the occupancy in the nursing homes and that can be achieved by coming up with a program to reduce the number of beds. It has been done various ways in many other states.
2. Currently nursing homes have to fill out a Form 10A to get a patient approved for Medicaid. This is a cumbersome process as well as redundant due to the fact that we send in all of the same information on the MDS. If we could eliminate the Form 10A and replace it by using the MDS data, it would save the nursing homes time and money as well as save the Department of Health employees time. In the case that we do not eliminate the Form 10A process we recommend making it electronic, saving staff time and Department of Health staff time.

3. Currently the Department of Health contracts for Oxygen services for Nursing Home Residents. It would be much cheaper if the nursing homes contract for that service themselves and then bill Medicaid. Nursing facilities can contract for oxygen for less money that the State does.

Change Requirements for Medicaid Clients (3 Comments)

1. [Medicaid clients] also should have to pass a drug test each month to [receive] their benefits. If they don't pass the drug test they don't get benefits. We have a patient that comes into our office every few months because he abuses drugs and has [an] [abscess], we have to treat this patient with very expensive antibiotics. This patient continues to use drugs and does not care because he does not have to pay for any of his medical care. It is my believe that just as when you are unemployed and collecting unemployment check you have to be ready, able and willing to work. Why don't those on Medicaid have to be [actively] trying to better themselves.
2. Have those that use Medicaid, to have them do work within the Medicaid system, maybe 20 hours a month. If kids are on it, than have the parents work for those benefits. Example: volunteer at schools, community clean up, [administration] work, it can be anything.
3. Making [preventative] dental visits [mandatory], at least once per year, or LOSE THEIR [BENEFITS]! This can't help but improve people's care and it will eventually cut costs. [By] seeing Medicaid [recipients] [once] a year (every 6 months would be better) dentists & staff will then able to [access] needs & instruct basic dental care. This will probably cost more to begin with but it will enable more people to seek care as only the ones who want to keep their coverage will be seen. With [preventative] care a must, the restoration part will be taken care of, if patients know that there are problems they are pretty good to get the work completed. Those who [lose] their coverage open areas for others who qualify. I never again want to receive a phone call from a mother saying that her 5 year old son has no teeth because they have all rotted off and is in pain. When I asked how long they had had Medicaid coverage she said, "Oh, we have had Medicaid for years". She had never taken him to the dentist because she "had never thought about it"! Everything is expensive, however, prevention can be just that, a [preventative] way of making care less expensive by catching the problems every year and while they are small instead of a last ditch effort to save teeth that need root canals, crowns, or worse expensive extractions and dentures on children.

Provide Vision Services (2 Comments)

1. Fund vision.
2. I would strongly urge that services such as vision be a part of a critical and primary care package for Medicaid beneficiaries.

Provide Hearing/Speech Services (2 Comments)

1. Funding for cognitive and swallowing services (speech-language pathology) and audiology services (hearing and balance) have been cut with no date for restoration of funds. Survivors of moderate to severe traumatic brain injury often turn to Medicaid for funding after insurance and other sources run out. This population is only served in the [physical therapy] and [occupational therapy] realm, which only treats part of the problem. Without treatment for cognitive, hearing/balance, speech, or swallowing deficits, these patients stay on tube feedings longer, require more supervised care, and have difficulty functioning independently.
2. I would strongly urge that services such as speech/hearing be a part of a critical and primary care package for Medicaid beneficiaries.

Health Information Technology (2 Comments)

1. Better use [health information technology] and [health information exchange] can improve Medicaid administrative efficiency. Utah Medicaid was instrumental in developing [Utah Health Information Network's] administrative data exchange. Utah Digital Health Commission suggests that Medicaid uses [health information technology] more broadly.
2. Seems like a lot of duplications of services and products; centralize [electronic medical records] to easily access.

Limit Amount of Time Someone Can Receive Medicaid (2 Comments)

1. It seems to me that the Medicaid program encourages people to stay on State [assistance] rather than being a stepping stone to a better life. There are families that are on Medicaid from one generation to another. I think there should be a limit on the amount of time a [person] can [receive] Medicaid assistance in their life time.
2. I understand that all should be insured, especially children and elderly. However, I believe that there is a misuse of Medicaid benefits by some that feel it's [necessary] to stay on it for the rest of their lives, which is one of the biggest causes of this system malfunction. This money comes from hard working tax payers that pay their taxes, and are legally here in this nation.

Reduce Inappropriate Emergency Room Use (2 Comments)

1. Reduce inappropriate emergency room use by allowing hospitals to triage and refer patients to their [primary care provider] for follow up - Expanding on Medicaid's Restriction program, which allows health plans and [fee-for-service] to redirect frequent emergency room users to their [primary care provider] for care, Utah should implement a program that would allow [emergency room's] to triage and refer non-emergent issues to a patient's [primary care provider] or urgent care center. New Mexico began using this program in May 2010. Emergency rooms are reimbursed a triage fee for non-emergent issues and refer the patient to their [primary care provider] or an urgent care center for follow up. The patient signs a form stating they have been presented with both options of care. If they accept financial responsibility, they may receive treatment in the emergency room. Utah Medicaid saves, on average, \$1,080 per visit for every [primary care provider] visit in lieu of a non-emergent trip to the [emergency room] (Stewart, Salt Lake Tribune, 6/16/10). Allowing hospitals to refer patients with non-emergent issues to their [primary care provider] or an urgent care center will also decrease [emergency room] waiting times and ensure [emergency room's] have the resources available to better care for the truly emergent.
2. Decrease the cost to Medicaid for existing patients: Part of receiving Medicaid should include educating families to use primary care doctors (medical homes) for preventive care (for the obvious benefit of increased health) AND for urgent care concerns as much as possible (versus going to emergency departments for earaches). Case workers could help decrease overuse by targeting and teaching families who use [emergency department] care inappropriately (since we can't add the disincentive of a small co-pay for an [emergency department] visit versus a FREE urgent care visit to a [primary care provider]—darn it!)

Pay Providers Based on Performance (2 Comments)

1. Provider payment that moves away from fee-for-service which incents volume over quality and efficiency.
2. The State could consider piloting alternative reimbursement models, compensating groups for outcomes and not just fee-for-service.

Compliments (2 Comments)

1. Medicaid does a good job where I am at [rural health clinic].

2. One of the best things done was small co-pay for Medicaid.

Primary Care Network Comments (2 Comments)

1. [Primary Care Network] needs to cover primary care procedures.
2. Primary Care Network makes no sense. The program pays for a cold but not appendicitis, pays for the diagnosis of a kidney stone but will not pay for its treatment because it pays for primary care treatment but not for specialty care. It is illogical, unfair and indefensible.

Rewards for Clients (2 Comments)

1. Reward the client who uses resources appropriately with extra regular [mental health] sessions for the next fiscal year — say 2 extra sessions.
2. Find a creative but humane way to reward patients for going to non emergency room urgent care (like Instacare and Kids care) instead of the [emergency room] for care that does not require [emergency room] care.

2. WHAT ARE WE DOING NOW THAT IS WORKING WELL AND SHOULD BE EXPANDED? (52 Responders)

Specific Administrative Effort (19 Comments)

1. Prior authorizations required for expensive medications.
2. We have been working on making it easier to apply, these efforts should continue.
3. Contracting with [private] sector administrators to lower the [per member per month] cost.
4. Looking into fraud and ways to save money. Being fiscally responsible is always important in making sure the right people get the funding needed.
5. Direct Deposit.
6. One of the good things we are currently doing in Medicaid that is holding costs down is the gate keeping feature in the New Choices Waiver program. Currently it requires a person be in a nursing home for 90 days prior to qualifying for the New Choices waiver and being able to return to the community for services that Medicaid will pay for. Many people want to get rid of the 90 day requirement. Eliminating the 90 day requirement will open the flood gates and cause the woodwork effect and overload the Medicaid system to the point where that state cannot afford the program anymore. The 90 requirement keeps that program in check and validates the legitimacy of qualifying for the services.
7. The Medicaid client restriction plan should be expanded to slow doctor shopping.
8. There are currently some providers, mostly ambulatory surgery centers, that are performing services at a lower cost than hospitals. These costs should be reimbursed at the same rate, regardless of the type of facility. True competition is fostered when government refrains from imposing cost differentials.
9. Providing coverage to 140,000 eligibles.
10. Funding positions of medical home providers.
11. The desire to improve relationships with the providers.
12. Always tricky to balance available funds with needs. No easy solutions.
13. Willingness to participate in multi-payer dialogue and exchange of ideas for demonstration projects is very important to the state healthcare reform.
14. Encouraging patients who use the [emergency department] for primary care to develop a relationship with a provider is an excellent use of limited community resources.
15. Risk based contracts with private providers- we should look at expanding this to all or most providers/networks.
16. With State Health Reform, Utah is piloting areas of payment reform with Medicaid and other private providers. Utah should be following closely the development of the [Centers for Medicare & Medicaid Services] Innovations Center, which is designed to test, evaluate, and expand in Medicare, Medicaid and [Children's Health Insurance Plan] different payment structures and methodologies to improve patient centered care, improve quality, and slow the growth of health care costs. In addition, there are multiple demonstrations and payment initiatives targeted specifically to Medicaid, including higher payment rates for primary care; enhanced FMAP for health

homes for chronically ill Medicaid beneficiaries; state demonstration programs for bundled payments for episodes of care that include hospitalizations. Utah could be a leader in expanding these models to our Medicaid and [Children’s Health Insurance Plan] programs. Some of the more promising areas for demonstrations are Patient-Centered Medical Homes, Bundled payments for Episodes of Care (effective 1/1/12-12/31/16), and Global Payments for safety net hospitals (FFY 2010-2012) , and pediatric medical providers organized as Accountable Care Organizations (effective 1/1/2012- 12/31/2016).

17. What is the role of public payment in Utah Health Insurance Exchange? The Utah Digital Health Service Commission suggests that the Exchange should include Medicaid, maybe PEHP as well. This should include both private and public sector. Why do you protect public sector here? Comingling of public and private sector will reduce risks.
18. You are up to date on electronic fund deposit remittance advices etc This helps a lot Your customer service unit are helpful and we are happy that we can fix some things with a phone call.
19. With the exception of Molina Medicaid, it is relatively easy to get patients in for specialty consultation and advanced imaging.

Specific Service (10 Comments)

1. [Counseling].
2. If you haven't visited this program you should, the best thing that is happening to save Medicaid dollars, [Supplemental Security Income] & [Social Security Disability Insurance] and get people back to work, Utah Work Incentives Program or have them present at a hearing <http://www.usor.utah.gov/specialized-services/employer-resource-center/utah-benefits-planning-assistance-and-outreach-program-bpao-work-incentive-planning-and-assistance-program-wipa>.
3. School programs.
4. We have made efforts to insure that more people have some basic health care, this should also continue.
5. [Primary Care Network] coverage should be expanded for those with chronic condition that is not considered disabling, such as diabetes, to prevent emergency visits for maintenance care.
6. Expand Mandatory Managed Care Into Rural Counties - Managed care has been proven to be a successful means for managing costs and providing better care. Utah’s historical use of managed care for Medicaid enrollees, including [aged, blind, disabled] and [Supplemental Security Income] eligible populations, has helped us maximize our Medicaid dollars. Converting the Molina contract back to a risk based contract was also the right step in order to optimize potential savings. A 2009 study by The Lewin Group “noted that the [fee-for-service] setting model makes coordination of care and cost-containment difficult, while health plans create savings opportunities without reducing eligibility and benefits (AHIP Press Release, Lewin Group Finds, 5/20/09).” One state found their “health plan enrollees [were] much more likely to receive many critical preventive services than beneficiaries enrolled in [fee-for-service] Medicaid. For example, 71 percent of women enrolled in Medicaid health plans were screened for cervical cancer within the past three years compared to 39 percent in [fee-for-service] (The Lewin Group, Medicaid Managed Care Cost Savings, March 2009).” To achieve additional savings and increase quality of care for Utahns statewide, mandatory managed care should be expanded statewide. As a statewide [Children’s Health Insurance Plan] health plan, Molina has demonstrated network capacity and would be committed to ensuring access to all rural Medicaid members. Proposed Change: Use a State plan option to require Medicaid enrollees in

rural areas to enroll in a single managed care organization. In Utah, this would expand managed care into 19 counties that are currently [fee-for-service] or voluntary managed care. Create a preferred plan option in the remaining 6 non-mandatory managed care counties; defaulting members directly to Molina, with an option to opt out to [fee-for-service]. Michigan is using this model and has shown lower [per member per month] costs in the managed care program than in [fee-for-service] (The Lewin Group, Medicaid Managed Care Cost Savings, March 2009). In addition to the savings that would be achieved from moving [fee-for-service] members into managed care, the State would also eliminate the need for Local Health Department's to conduct Medicaid orientations since this is already a contract requirement of the managed care plan.

7. Access for uninsured mothers.
8. Working well is coverage.
9. Helps many who would otherwise go without.
10. The system does cover treatment.

Children Services (7 Comments)

1. Providing preventive care for some children.
2. Children's health care.
3. Medicaid covers most services for children.
4. We intervene with appropriate early supports for children with special healthcare needs, because we see clearly that timely support decreases future costs and expense.
5. Providing preventive care to children is working well and should be expanded.
6. Programs for children with special needs is vital.
7. Paying for the care of children.

Customer Service (6 Comments)

1. Our ability to talk to someone on the phone when we have question seems to be reasonable.
2. The Constituent Affairs office, specifically [name removed], is an incredible asset. She always goes out of her way to serve the client. Apply on line is great too. Very convenient.
3. Your customer service people do a good job. The fact that we can correct some claims through your workers is a great asset.
4. Checking information for Medicaid people is a good program.
5. Having workers in the facilities is a great program for us.
6. You have a most helpful support staff when we call with billing questions.

Pharmacy Efforts (5 Comments)

1. Not paying for high price drugs, forcing doctors to make a cost effective decision.

2. [Preferred Drug List] –expand classes and/or implement a formulary.
3. Placing quantity limits on abused medications is working to slow down abuse.
4. The Medicaid client restriction plan should be expanded to slow pharmacy shopping.
5. The use of the Preferred Drug List with prior authorization. The drug classes should be further expanded.

Fast Reimbursement (4 Comments)

1. Quick payment of claims.
2. Fast payment and processing for the most part.
3. I have been fairly impressed with turn around on payment of claims.
4. Reimbursement time for the provider is very good.

Disabled Services (4 Comments)

1. Handicapped provisions.
2. Services such as family preservation, respite and supported employment should be made available to individuals when they are determined eligible for [Division of Services for People with Disabilities] services. These services help deter the need for more costly/intense services.
3. [Paying for the care of] mentally retarded.
4. [Paying for the care of] handicapped.

Pregnancy Services (4 Comments)

1. Good coverage for pregnancy.
2. The areas which Medicaid has good control, such as the care for infants and pregnant/nursing woman is great and wouldn't it be great to [individualize] every person's coverage as well.
3. We are proactive in helping pregnant women and unborn children.
4. Care of pregnancy care.

Mental Health Services (4 Comments)

1. The mental health system we have set up is one of the best in the country - FUND IT MORE, especially for children!
2. Serving serious mental illness.
3. Mental health courts to serve Medicaid mentally ill offenders.
4. Utah’s Behavioral Healthcare System is well coordinated and works well together. One of our strengths is that we have one system throughout the state and that our state association is strong and works with [Utah Association of Counties].

Eligibility (4 Comments)

1. [Department of Workforce Services] Eligibility Services Division – greater access to case-workers, implementation of eREP and other IT improvements.
2. Love the 800 line to review application with [Department of Workforce Services] Eligibility Specialist. I have found them to be extremely knowledgeable and patient with clients.
3. Access Now for telephone eligibility information.
4. [Being] able to call and get eligibility.

Dental Coverage (4 Comments)

1. Pediatricians and family practice providers need to get educated on dental health care and fluoride applications for the patients and this should be reimbursed to the providers. This may help with dental problems down the road.
2. Dental coverage for kids and pregnant women.
3. Dental coverage for pregnant adults.
4. Dental coverage that we currently have for children and pregnant women is a nice benefit. A strong case can be made for expansion by reinstating basic coverage for the aged, blind and disabled adult populations as well. These are some of our most vulnerable citizens and they currently have no dental benefit. Most do without routine and sometimes emergent dental care due to lack of resources. Evidence has established that there exist oral/systemic links to heart disease, diabetes, and other medical conditions. These medical conditions may have dental disease as a contributing factor or as the direct cause. Currently these conditions are being treated medically when they become serious, and at a very high cost. Basic dental services could lessen the severity of some conditions and prevent some others altogether at a fraction of the cost being paid out for medical treatment.

Not Sure/Nothing (3 Comments)

1. Not sure.
2. Nothing really.
3. I really can't think of anything.

Preventative Care (3 Comments)

1. Preventive health programs are the best value for the dollar. Avoiding dependence on the state is a far better investment than rescuing people who have no other option. Build the fence at the top of the cliff and stop building more [ambulances] at the bottom!
2. Working well – preventative care.
3. [The] efforts to make well child care and preventative care more readily available and accessible have worked quite well.

Keeping Medicaid Locally Controlled (3 Comments)

1. Utah Medicaid remains local, managed here in Utah by Utahns, and not contracted to an outside party. This allows for more direct interaction with, and participation by, Medicaid as efforts are made to implement [health information technology] innovations and health reform.

2. Utah Medicaid remains local, managed here in Utah by Utahns, and not contracted to an outside party. This allows for more direct interaction with, and participation by, Medicaid as efforts are made to implement [health information technology] innovations and health reform.
3. It is good to keep Medicaid local and not contracted to a distant, commercial firm.

Home and Community-Based Services (2 Comments)

1. Home and community based long-term care services (waivers) are the best investment Utah can make. They are cheaper and far more effective than institution based care. Expand waivers for aging and disability services.
2. Home and Community based services for people with disabilities should be expanded. These services are generally less expensive than services provided in institutional settings.

Pro-Bono Services (2 Comments)

1. The Volunteer Care Clinic that is staffed completely by physicians and nurses and other health care workers who are simply donating their time provides care in our community for those who truly cannot afford medical care.
2. Community Connect oversees low income/non-insured patients and has made agreements with local physicians to see these patients to provide specialty care (i.e., 1 or 2 patients per month) for no cost to the patient. Such efforts are reaching out to the truly needy in our community and making sure no one is left entirely with no recourse when there is a legitimate medical need. Such ventures should be supported by grants for supplies. Such volunteerism by physicians should be rewarded. Instead of paying the unsustainable low current “Medicaid” rate for qualifying patients, why not admit that physicians are volunteering their services and reward them by offering a tax credit equivalent to the lost revenue from seeing the patient and providing services?

3. WHAT ARE WE DOING NOW THAT IS NOT WORKING WELL?

(53 Responders)

Specific Suggestions for System Improvement (40 Comments)

1. Not giving it enough funding!!!
2. Efforts to restrict eligibility, to reduce it to 75% of poverty should be scrapped.
3. Utah is failing to look at the cost drivers and planning accordingly...older people, long-term care, people with disabilities, poverty...these are the major drivers of health care expense and Medicaid cost. We should be planning NOW to better deal with these cost drivers by enhancing a family's ability to care for people AT HOME. It is so much cheaper and more effective than institutional care! Yet we cut funding for these waiver services before cuts to institutions. It is non-sensical, and it offends conservative principles.
4. Paper work flow.
5. Programs are very limited. There is no program for students or single individuals with no dependents. These areas need to be considered greatly.
6. Complicated phone system.
7. Print on the Medicaid card itself what the patient needs to pay for their co-pay.
8. Currently, we would like to be able to see all clients who would like to get mental help, but we are not able to see clients that have Medicaid as their primary insurance because we are not contracted with Wasatch Mental Health. There have been several people who have said that they are not happy with Wasatch and would like to come see us, but cannot afford to be "cash" clients. We are able to see clients if they have Medicaid as secondary to a different primary insurance.
9. Trying to get policies in writing.
10. Medicaid has chosen too many services to deliver any one of them well. Utah should take a hard look at the [thousands] of reimbursements and select the ones that are life sustaining for reimbursement first, and next reimburse as funds [allow] quality of life services.
11. [People staying on Medicaid the rest of their lives] is something that needs to be addressed. Otherwise, eventually there won't be money/benefits left for those that do get laid off from their jobs. What will we do then[?]
12. The pre-hearing process: One physician in [particular]; [name removed] is typically not prepared for the pre-hearings. He asks for additional information each time we meet for the pre-hearing. The end result is that we average 2-3 pre-hearings before a decision is made on whether or not the requests are approved. He asks for records for which we don't have access (a year's worth of records as well as records from outside sources) to make the determination. He is antagonistic in his communication style. He comes across as if we, as the providers are committing fraud when we request visits. The reality of the situation is that Medicaid is one of the lowest paying insurances in the state.
13. I have always wondered of the money appropriated to dentistry, what part goes to administrative costs and what goes to providers?

14. Utilizing telemedicine and technology in general for reimbursement. Helping people help themselves or having Medicaid [recipients] pay into the system.
15. Medicaid eligible college students being served at the expense of other needy. (A college student may be poor but they can think, reason, and will eventually be employable. Serious and persistent illnesses preclude many from the workforce.)
16. Availability of data for community improvement efforts is not readily available.
17. State law that requires outpatient hospital payment be based on a fee schedule. This is a step in the right direction way from fee-for-service but still [incentivizes] volume not quality and efficiency.
18. The Digital Health Commission encourages Medicaid to consider more uses of the Telehealth, which are best practices that could reduce costs. Utah Medicaid reimburses few telehealth services. We may want to ask [Centers for Medicare & Medicaid Services'] permission to change telehealth reimbursement policies.
19. One way to reduce Medicaid spending is to lower the income level for participation in the program. With fewer people qualifying for Medicaid, expenses should be down.
20. Medicaid must have a co-pay for acute sick visits!!! They must have a higher Urgent Care & [emergency room] co-pay!! [Emergency rooms] are abused by Medicaid patients. This is a huge loser for the tax payer.
21. Your biggest challenge is that many relatively expensive things are relatively ineffective (e.g., spine fusion for [low back pain] is an obvious one; endless utilization of [physical therapy], [Doctor of Chiropractic] for [low back pain] is another). If one wants to both increase quality and reduce costs, then it is likely best to put limits on numbers of visits etc. and rely in the highest quality guidelines available (e.g., [American Academy of Orthopaedic Surgeons], [American College of Occupational and Environmental Medicine], [U.S. Preventive Services Task Force]).
22. Many patients who have significant medical problems receive high quality, cost-effective medical care; however, the suspicion is that many overutilize the system and gain little benefit, other than attention. A visit to the [emergency department] in the middle of the night for a problem that could have been managed at an Instacare or doctor's office earlier in the day is certainly a burden to the system.
23. Medicaid recipients should have a restructured benefit system that incentivizes them to get a job and work if at all possible. The current system of suddenly cutting all benefits at a certain level of income promotes and encourages long-term unemployment or underemployment and poverty and ultimate dependence on government institutions. Set up a system that encourages a person to get out of the system.
24. Difficulty knowing which of the several sub-species of Medicaid we can and are participating in — patients move in from out of town or travel to be seen and we cannot participate in their particular plan.
25. Referrals are difficult.
26. Multiple physicians without a referral needed.
27. Multiple times we seem to run into the fact that Molina is not accepted by many providers.
28. May be too liberal (in treatment) for poorly defined reasons.

29. Consistently too lax in determination of “medically necessary” care; in the [mental health] field, clients may be being seen for social problems not definable as “medically necessary” but rather definable as a result of poor motivation or just what they’ve gotten accustomed to being seen for — the chronically returning, non-progressing client who has socially and vocationally “never made it” socially and vocationally in our society — the client who has ceased long ago to seek any form of gainful employment.
30. Determination of each clinical evaluation of each client as to appropriateness for continuation in treatment should be required to demonstrate the medically necessary next objective by requiring the [quality improvement] evaluator to meet certain simple criteria that indicate the medical necessity for continuation — or the sessions should be slowed over a reasonable number of sessions, then terminated.
31. The Initial Evaluation should be required to determine not only how the processes of treatment should start, BUT ALSO THAT TREATMENT SHOULD NOT START, if that is the clinically valid conclusion; a clinical appeal could require a second Initial Evaluation, to help the client applicant understand the first evaluative conclusion, or to show the client how he/she is requesting help with social dysfunction, not medical impairment.
32. Expanding the program is the worst possible scenario.
33. Not generally available to adult males – many need it.
34. Benefits tend to come and go with Utah budget cycles. We need more consistency.
35. I do not see that the Healthy Connections requirements are limiting costs. It appears to just be an added burden of paperwork that does little to create a more efficient system.
36. Make them responsible for their coverage: a percent co-pay for the higher end things may make them think about utilizing so much.
37. Something that helps access a chronic pain [doctor] easily for assistance in evaluation.
38. “The baby your baby” program is in jeopardy. This has been an excellent program and it is foolhardy to dismantle it.
39. Limiting Medicaid clients to Valley Mental Health is contrary to all of the recent medical home literature. We currently are piloting the integration of psychologists and psychiatrists into our clinics and it is disappointing to have to send Medicaid clients away from our clinic, the people they know, our care manager, and mental health clinicians into a new and complicated system for this care.
40. Allowing a continuum of care is very good and needed.

Eligibility Process (10 Comments)

1. The telephone system does not work well with our non-English speaking clients. Caseworkers from SLC, Utah do not know the circumstances of many rural clients because they've never stepped off the pavement in the metro area!
2. The length of time it takes for an application to be approved or denied is not working well.
3. Most clients I deal with are not emotionally or physically able to understand what is needed of them and how to provide it to the Medicaid offices. One case, I had a client who was sent to four different [Department of Workforce Services] offices, only to be turned away each time for not being at the right office or having the wrong

information. Had one employee taken the time to LISTEN and guide him, he would not have come storming into my office frustrated and angry. He rides the bus and this cost him a lot of money to run around town and get to the right office. I eventually was able to help him, but it took me 3 days and several phone calls to straighten out his case. I'm not sure what is the best solution to fix this. Many clients complain that they leave the [Department of Workforce Services] office without a true understanding of how the process works or what they need to do.

4. Calling in for interview, people don't have [a] phone in [their] home, on the reservation it [is usually] a phone and they call in for interview and put on hold for 45 [minutes] to 1 [hour]; Elderly don't know how to use phone. Apply on line: reservation people don't have access to internet.
5. The financial eligibility program in not working [well] in Workforce Services.
6. Eligibility – Too much bureaucratic “red-tape” and administrative oversight causes unnecessary “churning” of eligible clients leading to unnecessary and costly administrative expense.
7. Applications are sometimes closed or denied because when families fax required verification to the Centralized Image Center, the documentation gets lost.
8. Providing reasonable avenues and processes for enrollment and renewal. The current process provides a disincentive for patients to enroll and stay enrolled, thereby worsening their health and causing higher costs to the state when they get really sick.
9. The on-line application, although available, is complicated and time-consuming.
10. Utah should simplify the Medicaid eligibility process with the removal of the asset test for parents, children, and pregnant women under existing guidelines and consider ‘continuous eligibility’ for a 12 month period, similar to [Children’s Health Insurance Program].

Specific Services (8 Comments)

1. Education.
2. Job skills.
3. Smoking cessation...huge expense, dubious results.
4. Disagree that clients are denied if their condition is expected to improve, what about the care they need to return to full strength? I believe there should be a short term benefit for those with a condition that will exist for more than a month, but less than the requirement for disability.
5. Not paying for circumcision.
6. Not paying for non face to face encounters.
7. Medicaid should pay for EM-25 codes. This allows physicians to be paid for the work they are doing otherwise providers defer addressing all issues to separate visits. Medicaid needs to pay for materials AND services!! Many providers severely restrict Medicaid patient load because Medicaid does not pay for the actual cost of materials and time. Why should a business donate materials and time? It is like asking a paving company to construct a State road for free.
8. [Emergency room] usage as a convenience.

Prior Authorization/Obtaining Authorization (7 Comments)

1. Review process for fragile clients sometimes takes weeks, not days.
2. Communicating with the provider office when we are trying to get a patient authorized for surgery. We have now told our patients to switch to Molina because the process is unworkable.
3. Can never get paid for our sterilizations. I fax the consent in at least 10 times before it is processed. [Ridiculous]!
4. For some time [authorizations] were going smooth and for the past 3 months we have had major issues. We have not [received] some [authorizations] we submitted for 2 months ago. [It] is also very difficult to have communication with the authorization department.
5. Prior [Authorizations].
6. Prior authorization system is difficult to navigate.
7. Preauthorization for common procedures like cholecystectomy and common medications like proton pump inhibitors is a waste of my office staff's and your administrative time.

Reimbursement Levels (6 Comments)

1. Looking to provider reimbursement cuts would hamper Medicaid participation and limit the quality of care patients would receive. If only certain groups take Medicaid, then it is harder for patients and their families to get timely and easy to schedule appointments. It also overwhelms the providers and makes more of a wait to get in.
2. Reimbursement levels.
3. Reimbursement. I understand the state is paying for these services but as a provider we lose money and that is not fair to us.
4. Poor reimbursement to providers for sick visits.
5. Low reimbursement rates to providers. The best way to provide dental treatment to Medicaid recipients is through private dental providers. A large network of providers is already in place. If each provider was able to provide some Medicaid treatment then patients seeking treatment could quickly and easily be seen, and they would have a "dental home" to oversee their dental care. Unfortunately, Medicaid dental reimbursement in Utah is approximately 30-35% of usual fees, while typical dental offices operate at 50-80% overhead. The low reimbursements simply do not cover the cost of providing treatment, and dental offices must subsidize the treatment of Medicaid patients. Consequently, most cannot afford to treat Medicaid patients. Those who do cannot provide very much care because of the need to subsidize treatment. Even pediatric dentists who see the bulk of private care patients are dropping off as providers or are offering less service.
6. Differential reimbursement. Currently those [dental] providers seeing more than 100 Medicaid patients a year, or those providing care in rural locations, receive an enhanced reimbursement. Even though the enhanced reimbursement generally does not cover the cost of providing service, the offices that are willing to treat some Medicaid clients but cannot afford to treat the higher number to qualify for the enhanced reimbursement, are essentially further penalized for trying to treat Medicaid clients. The ideal solution would be for every office to treat some Medicaid; providing the enhanced reimbursement to every office willing to treat Medicaid clients would be an easy gesture by the State to encourage this.

Dental Services (5 Comments)

1. Discontinuing adult dental is increasing the cost to Medicaid for emergency room visits.
2. We need to recognize that dental [is a] basic core [need], not optional services. [It] should be moved to the base budget and guaranteed funding every year. Too many are seriously harmed when these services are not funded.
3. Providing dental providers with enough incentive to participate.
4. No dental coverage for disabled adults.
5. Needs to allow dental care.

Pharmacy Problems (5 Comments)

1. Covering name brand medications that have a generic equivalent.
2. Prescription price updates are unacceptably slow.
3. Closing the pharmacy help desk phone lines down on Thursday mornings and all day on Friday limits our ability to help Medicaid clients. This jeopardizes their health when we cannot get problems resolved for several days at a time.
4. Medicaid also needs to get proactive to force physicians to use tamper resistant prescription paper by penalizing them directly and not making pharmacists the police force. We repeatedly request tamper proof prescriptions from physicians only to have them belittle our staff and treat us rudely when we request properly written prescriptions. We are not your police, we are pharmacists, it is not our job to force physicians to comply with federal/state requirements.
5. The medicine list must be revised for children. Aldara should NOT be covered by Medicaid unless a DERMATOLOGIST has tried everything else. Aldara is \$600 a box!

Institutional Bias for Nursing Home Care vs. Home Based Services (4 Comments)

1. We still have an institutional bias where people who need support have an entitlement for nursing home care, which is more expensive, but not for home based attendant care, which is less expensive. We need to eliminate our institutional bias.
2. For years disability and senior advocates have asked the state and federal governments to create a paradigm shift and end the bias favoring institutional care. Many advocates for years have argued that home and community based care is less expensive than institutional care and that quality of life is better in a home and community based environment but for years the federal rules and regulations have continued to extend the bias favoring institutional care.
3. Under the new federal health care reform, [Centers for Medicare & Medicaid Services] will provide to Medicaid state agencies new incentives (enhanced match rates) for states to increase non-institutionally based long term care services (October 1, 2011 through September 30, 2015). Long term care is one of the highest costs in Utah's Medicaid Program, we should look at all options to make long term care more affordable with community based care.

4. Federal health care reform also establishes the Community First Choice Option to provide community based attendant support services to detain people with disabilities. Utah should take advantage of this for our members of our disabled community.

Medical Homes (4 Comments)

1. We are not actively trying to prevent emergency room visits and I think if all patients were required to have a medical home and contact them prior to a visit to the [emergency room] could cut costs. Often times things are not an emergency and offices may have after hour clinics. Triage is very important either in the Medical home or through the emergency room itself.
2. Medical homes is an area that the Utah [Children's Health Insurance Program] and Medicaid programs have some established programs for children with special needs, and a new [Children's Health Insurance Program] special grant pilot for children with special needs in Utah and Idaho that will begin in FY 2011. Utah should want to take advantage of new state plan option (available in 2011) under the new federal reform to permit Medicaid enrollees with a least two chronic conditions (with one being a serious or persistent mental health condition) to designate a provider as a health home. States taking up this option are provided with a 90% FMAP for two years for home health related services including case management, care coordination, and health promotion. For those with multiple chronic conditions, it may give our state another way to improve our quality of care and cost containment.
3. No required [primary care provider] (pediatrician, family practice or general internal medicine physicians) to review outside care and to control referrals and multiple medications. [Obstetricians] could be [primary care provider] only for pregnancy care.
4. Of all specialties, I am impressed by the lack of communication by mental health care providers to primary care providers. We typically only receive a letter stating that our patient was seen. How is that helpful?

Billing Problems/Suggestions (3 Comments)

1. Secondary claims process has to be dropped to paper so that you can write on the HCFA what the primary insurance paid then if the primary paid zero you have to attached the EOB. For any J code that is billed Medicaid requires that we drop the claim to paper so that we can write in the NDC# This is not required by any other insurance company including Medicare.
2. Stop giving recipients retro coverage back further than one year. Providers cannot bill any insurance after 1 year. Especially Pharmacies cannot back-bill any provider more than 30 days because their system is electronic and "real-time" (no paper billing) and the [pharmacy benefit managers] will not allow pharmacies to bill claims past 30 days. Caseworkers are telling recipients pharmacies can back bill Medicaid regardless of date of service. Also, if a 3rd party is billed pharmacies cannot reverse the 3rd party and bill Medicaid. The claims are too old to reverse. (What happen to "Medicaid is payer of last resort?")
3. We have always had problems billing Medicaid as a secondary insurance carrier. It seems even with the codes in the [explanation] area we still receive payments as though Medicaid is the primary which is very costly to Medicaid it is costly to us to correct the problem is very frustrating as well as time consuming.

Client Education (3 Comments)

1. Insulating the participants from the increasing costs of healthcare. Not providing incentives for healthy behavior.

2. Communicating with clients exactly the how, what, where and when. When clients call me they are confused and frustrated by the system. They feel they are not being educated properly on how the Medicaid System works and if they are initially denied benefits, what to do to appeal.
3. Most [patients] do not know [their co-pay] and when the office [personnel] ask them to pay their co-pay they dispute it.

Vision (3 Comments)

1. We need to recognize that vision and physical therapy are basic core needs, not optional services. They should be moved to the base budget and guaranteed funding every year. Too many are seriously harmed when these services are not funded.
2. [Reimbursement]: CPT [current procedural terminology] code 920x4 is a "comprehensive eye examination" CPT [current procedural terminology] code 92015 is a "refraction" (which is better one or two?) These are TWO [separate] and very distinct procedures. Eye doctors only get paid for a 920x4. Which is great, I am fortunate to get paid for this service. But I can perform a comprehensive eye exam without even checking someone's prescription (refraction)....most people call a refraction "an eye exam" when in all actuality it is about 10% of a real eye exam. Please consider reimbursing doctors for this valuable procedure in addition to a 920x4.
3. Needs to allow vision care.

Prevention (2 Comments)

1. Decrease cost by decreasing the time families need Medicaid AND preventing future need: access to tobacco-cessation, birth control and drug abuse and mental health treatment for parents (and children where needed) would save a lot of money by preventing illness, addiction, abuse, neglect, school dropouts, etc., in children and their parents — and could really help to keep people off Medicaid and get them back into gainful employment faster, with private insurance options, again saving the State money.
2. Money used in PREVENTION goes a lot further than — and saves us —the money needed for TREATMENT. (Which is why I fear the few millions we cut from the [Health and Human Services'] budget will really cost us 10-fold or more!)

Division of Services for People with Disabilities (2 Comments)

1. We seem, however, to have trouble applying the same logic [we apply to children with special healthcare needs] to the needs of adults with disabilities, requiring them to wait a long time and to experience extreme difficulties in their life before we provide help. For people with [traumatic brain injury], often a small prompt investment can preserve employment and families, and prevent long term extensive costs. Our reluctance to be proactive and preventive in responding to [traumatic brain injury] is an expensive error.
2. The [Division of Services for People with Disabilities] waiting list is not working well. Because the Legislature has determined that only the most critical should be served first, others on the waiting list languish, experiencing declining health and loosing skills. Families break apart under the stress of caring for their family member with disabilities.

Mental Health Issues (2 Comments)

1. The responsibility for some services (especially children and youth services) is [split] between the Community Mental Health Centers and the State. This leads to a potential parallel system that duplicates some services.

Similarly, the burden of documentation and compliance appear significantly different for private sector providers and [Community Mental Health Centers]. This challenges reasonable cost comparisons.

2. We need to improve access to mental health care for schizophrenia/bipolar/resistant depression and resistant anxiety. This is a hugely neglected population, that quite frankly, primary care doctors try to treat, but we often do not have timely access.

Medically Fragile Children (2 Comments)

1. Need waivers that would allow parents who have medically fragile children besides Travis Calson Waiver to allow parents to work at a higher wage, pay into the Utah system and pay taxes to help our economy but be able to pay the [incredible] medical bills needed by Medicaid, maybe a fee structure that these parents could pay into. So they don't have to have a job that is underpaid and they are not paying taxes so their child can be on Medicaid services to get needed medical care.
2. Medicaid Waivers would work well for individuals if the criteria for receiving these services were looked at more closely and/or changed. There are many families with medically fragile disabled children that do not qualify for these services due to the current qualification criteria. These children require 24/7 care, are in and out of hospitals, require multiple supplies, therapy services, nutritional needs, and durable medical equipment to maintain life and daily cares but do not qualify due to the fact that their IQs are equal to peers of their own age. Many families in this situation are overwhelmed and in financial hardship trying to maintain the daily costs to care for their children, whereas some individuals who qualify under the current qualifications do not have the extreme medical costs required to maintain life. Many of these families with medically fragile children run into problems associated with making just above the income level for regular State Medicaid, but do not make enough money to cover the required costs to care for their children.

Primary Care Network Issues (2 Comments)

1. [Primary Care Network] is a waste of time. We need a program that helps people when they really need it-eg Appendicitis, Gallbladder [surgeries] etc. We eat most of those. The [Primary Care Network] people still think that everything is covered even although education has been good in that field. I believe they expect write offs because they have [Primary Care Network].
2. [Primary Care Network] patients still think they have coverage even although you have had good education We feel like they think we owe them a write off. We do write off many things eg inpatient and cat scans but we are a small facility and it does put us in a crunch.

Miscellaneous Comments (2 Comments)

1. Most everything.
2. I am happy to hear that physical therapy is now being covered.

4. HOW EFFECTIVELY ARE OUR CURRENT SERVICE MODELS SERVING THE NEEDS OF MEDICAID CLIENTS?

(46 Responders)

Specific Concerns (13 Comments)

1. Not too well, given that we have waiting lists for Medicaid funded services that extent over decades, while nursing homes are immediately available, at higher costs.
2. Our rules of serving those with the most severe disabilities first means that a very few eat up all funding--we need a more equitable way to distribute funding so we can prevent problems from becoming critical needs.
3. From a pharmacy standpoint, too effectively. I often see patients come in and demand a name brand prescription just to have Medicaid approve it.
4. Models are outdated.
5. Better if there was more funding!
6. They would be far more effective if legislators would stop funding institutions over institutional care. More focus on community supports.
7. It seems as though recipients can manipulate the system very well and not get caught. A lot of abusers out there.
8. Prior approval is not allowing providers to attend to patients needs. Providers are dropping the service in home health.
9. [Medicaid] [takes] care of those who refuse to take care of themselves and turn away those that truly need the help for a short period of time while they get back on their feet. The current system encourages patients to not get a job and be responsible members of [society].
10. Time delays are frustrating for both clients and the facility. Low satisfaction.
11. [Primary Care Network] is the only one we have problems with.
12. Access at this time seems limited.
13. Service models that revolve around fee-for-service often do not meet specific needs of clients due to incentives that run counter to provider and patient best interest, particularly in long term care arena.

Good/Fairly Well/Fine (11 Comments)

1. Fairly well.
2. Mostly helpful and good.
3. Fair.
4. They work pretty well. I have heard clients say that they have trouble going online to apply for your [programs].
5. Fine.
6. For the most part I think service is good.

7. Fine.
8. For the most part I think things work well for the current clients.
9. Medicaid services are excellent to a point.
10. They are fine. The process is just cumbersome.
11. At times good, at times slow. I'm not sure of the roller coaster ride.

General Comments (8 Comments)

1. 50%
2. I think adding the 800 number to initially qualify candidates is working great.
3. You would have to ask the Medicaid clients that question.
4. I don't know the term "service models".
5. Medicaid seems to do well for babies and pregnant/nursing mothers, with prenatal care, immunizations as well as [the Women, Infants and Children Program]. Specifically designed to help healthy moms have healthy children. This kind of attention to detail is exactly the kind of continued aid we need to be giving.
6. [Community Health Centers] and affiliated providers are very effective and provide excellent service to clients.
7. Not sure what this means.
8. Too many people are receiving Medicaid benefits. I frequently see Medicaid clients driving very nice/expensive cars and getting free Medicaid services. More thorough investigations should be done to determine client eligibility and benefit levels.

Not Very Well (6 Comments)

1. Not very.
2. I don't believe they are very effective at all.
3. Not very well.
4. Current models are not effective.
5. Not very well.
6. Not well.

Dental Problems (3 Comments)

1. As a dentist, I notice a few areas that need improvement to meet the needs of patients. Giving a stainless steel crown to anyone and calling it a permanent crown is substandard care. Crowns should be covered to prevent future expenses related to the care given that is required by Medicaid. Root canals on some teeth are paid for by Medicaid, yet they do not pay for the crown afterwards. Again, it forces substandard care that becomes a temporary fix.

2. Family Dental Plan turns away dental emergencies almost every day, and those private practitioners who currently provide treatment are overwhelmed by the demand. Efforts need to be made to expand capacity. We suggest that more dental offices be enabled to afford to see at least some Medicaid, thereby increasing the provider base.
3. There is an entire segment of the Medicaid client base that currently has no dental benefit. Being left to fend for themselves, they often seek service for dental pain in the hospital emergency room, where they receive antibiotics and pain medication at great expense to the Medicaid medical budget but seldom receive definitive treatment. Safety net clinics, such as Donated Dental and the Community Health Clinics are currently overrun with these patients and are usually unable to see most of them because of limited capacity and resources.

Reimbursement Rates (3 Comments)

1. Medicaid clients are forced into using [a health maintenance organization] for [services] and not allowed to select the [lowest] cost provider. This would be solved if all services were comparably reimbursement regardless of provider.
2. We should make a sound commitment to all our providers in Medicaid with reasonable reimbursement rates. Utah responds to budget pressures with provider cuts, but it is poor program planning and a blunt instrument for the providers willing to serve these populations.
3. Higher reimbursement rates have dramatically shown to increase provider panels and access to care.

Medical Homes (3 Comments)

1. Access to primary and preventive care continues to be an issue judging by the use of the emergency room for primary care sensitive or ambulatory care sensitive conditions. Increasing access to a primary care “medical home”, in which coordination of care across the health care continuum would reduce inappropriate emergency room use and unnecessary or avoidable hospitalizations for primary care sensitive conditions.
2. To see if there are cost saving in new payment models, we should aggressively pursue and pilot many of the demonstration projects that were mentioned earlier. We need to assess our success with the current “Medical home pilots in [Children’s Health Insurance Program] and Medicaid” and consider some other projects, such as the State plan option for individuals with two or more chronic conditions to designate a provider as a health home under [the Patient Protection and Affordable Health Care Act].
3. Medical Home is a best practice model. We need to improve doctor and Medicaid patient relationship.

Telemedicine (3 Comments)

1. “Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care.” – <http://www.cms.gov/Telemedicine> Utah Medicaid currently makes very little use of telehealth as a means to deliver cost-effective services to clients.
2. “Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care.” – <http://www.cms.gov/Telemedicine> Utah Medicaid currently makes very little use of telehealth as a means to deliver cost-effective services to clients.
3. Telemedicine is a cost-effective alternative to the more traditional face-to-face way of providing medical care. Utah Medicaid currently makes very little use of telehealth as a means to deliver cost-effective services to clients.

Specific Problems/Suggestions for Medicaid Eligibility (2 Comments)

1. Workforce Service screens everyone by using a computer system. However, if you are low income or have a disability yourself, you do not own a computer. You can go to Workforce Services and use their computers but if you don't own a computer you are usually not computer [savvy], may be at a low reading level (thus without a job) and have difficulty making it through the first level of screening. If you have a child with significant health needs it may be difficult. The [Department of Workforce Services] Case Workers are generalists and not very [familiar] with the ins and outs of Medicaid and the difference between someone who has a disability, a medically fragile or needy child, a single mother or an out of work father all requiring different items. Because screeners and first line workers or customer service workers are not paid much they tend to leave this position quickly and do not treat the clients very well or have much knowledge. Please treat the clients with respect.
2. When clients get on the program services it good, it [is] the process to get on the programs.

Prevention/Intervention (2 Comments)

1. In 2007, according to [Department of Health] Indicator Based Information System data, Medicaid was billed \$10.2 M in “treat and release” and \$17.1M in “treat and admit” ambulatory sensitive conditions. [Ambulatory sensitive conditions] are defined as conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.
2. The priority needs to be preventive to continue to have coverage.

Survivors of Traumatic Events (2 Comments)

1. Not effectively for areas of rehabilitation for survivors of traumatic events such as stroke and traumatic brain injury. These funds are some of the first cut and only restored in times of plenty. Despite budget cuts, these services are still necessary for promoting recovery in return to daily living and employment. If these services can help patients get back to independent living, they have the potential of becoming part of the tax base system once again.
2. The current models of case management for people with [traumatic brain injury] are not as effective as they could be. People with [traumatic brain injury] have needs along a continuum of immediate medical stabilization, then skills recovery, and, too often, long term support. The Medicaid program in Utah skips the middle, and people have longer and more severe deficits as a result.

5. WHAT SERVICE MODELS WOULD BETTER SERVE THE NEEDS OF MEDICAID CLIENTS?

(42 Responders)

Individualization of/Improve Case Management (17 Comments)

1. I still feel because of their medical background the Dept. of Health was a better start for the client to access first time.
2. One person to coordinate services and approval for each patient, who understands the background and specific needs of each client.
3. Restrict more clients to one pharmacy, one doctor to stop "shopping" and abuse.
4. Better [accommodate] the clients by showing them they are trying their hardest to get them on some type of Medicaid.
5. One that treated the clients with respect.
6. Access is the key to better care.
7. Greater access to people who can answer questions.
8. More timely responses.
9. Unfortunately, more hand holding and patience to ensure that client understands what they are being told.
10. That the caseworkers be honest with the clients don't tell them they are covered when they are not.
11. The new computerization of claims and prior approval that I think is just starting.
12. Having some screening process to assess the true needs of patients prior to their seeking direct medical care would likely be helpful in reducing overutilization, but implementation is problematic.
13. Families have a hard time knowing whom to contact for questions. Individual case managers need to be brought back and be educated on the different models/programs. This helps families communicate with one person to ask questions, someone who is well informed on their particular situations and the families feel more comfortable asking questions. It also eliminates families calling different people getting different answers each time.
14. Models utilizing caseworkers to work directly with Medicaid clients to see that they receive the proper oral health education and preventive services, as well as serving as intermediaries between the patient family and the service provider have worked well. Washington State's ABCD program works well in rural areas to address the dental needs of children on Medicaid and their families. It is a model that we should continue to look at as we explore ways to improve our own Medicaid delivery systems.
15. Education and prevention are the most effective means of treating dental disease by eliminating its occurrence. Encouraging and reimbursing prevention and education would be a great long-term investment of Medicaid dollars. However, since there is so much dental disease existent in the population to address before the benefits of prevention and education can be realized, basic dental treatment needs to be provided today and in the near future. An emphasis on education and prevention will lower restorative and emergency needs in the future, and

will directly impact the number of expensive visits to the ER by this population. This would reduce a significant drain on the Medicaid resources.

16. Medicaid allows targeted case management for [traumatic brain injury] as a state plan service. Utah has not opted to provide this service. The case management that is available in Utah Medicaid is an integral part of a service model, as in [the Division of Services for People with Disabilities] support coordination or mental health case management. Those case managers tend only to know their own system and function as gatekeepers for that agency's budget rather than facilitating appropriate use of all Medicaid services [available]. As a result, people who have limited ability to make effective choices and who need and use a spectrum of services do not get appropriate, coordinated supports. We feel that many poor health care utilization decisions could be prevented if [traumatic brain injury] survivors with Medicaid had access to a knowledgeable [traumatic brain injury] case manager. This kind of case management could be particularly helpful for those [traumatic brain injury] survivors who also experience mental illness and substance abuse. These three diagnoses frequently occur together, and the systems of support for each diagnosis which are available with Medicaid funding in Utah are separate. Few people get effective help because no one can advocate for them across all the systems.
17. Utah's state plan also does not provide inpatient post/acute rehabilitation services. Many people whose medical costs at the time of the [traumatic brain injury] accident exceed their immediate financial resources do not get the services that could help them return to gainful employment and independence. We promote increased long term disability in Utah by not providing this timely, short term assistance.

Specific Suggestions for System Improvement (11 Comments)

1. State must partner with physicians and hospitals to create models that focus on improving quality outcomes. Savings will follow. New models should not necessarily provide more care, even [though] that might be the case at times, but the improvement of the lives of children with critical long term health care needs.
2. Eliminate the "most acute need" system for coming off the disabilities waiting list, make it a lottery or better yet, amend the waiver to provide preventive services to all who are eligible. Using "most acute need" creates bad incentives...families have to collapse before any help is given, and then services are horribly expensive.
3. For patients with diabetes physical exercise should be added as a component of management and to enhance patient function. Recommend adding 2 hours per year of physical activity education for persons with diabetes in addition to the diabetes education that is already part of the program.
4. Recommend allowing certified physical therapists be allowed to function as diabetes educators.
5. A service model that provides a selection of quality care providers at an efficient cost would aid the Medicaid population.
6. More self directed/family directed care...with appropriate parameters.
7. Need to continue to strengthen our collaboration and integration with physical health care services.
8. Favor a focus on outcome based services rather [than] evidence based services.
9. [Primary Care Network] is a joke. It doesn't pay for primary care procedures that are necessary. So, I can see a patient with regular Medicaid and remove or treat a skin cancer, but if they have [Primary Care Network] they have to pay for it. If you are going to tout [Primary Care Network] as a primary care solution, it needs to cover commonly performed primary care procedures. (This doesn't touch on the wide variety of problems [primary care

providers] can't manage, but again that is not the point of [Primary Care Network]. It should cover primary care procedures though.)

10. Social growth and development groups should be supported under a special new group "treatment" program, limited in scope but required for any client who is terminated, or willing to terminate, regular visits to save the remainder of his/her annual visit limitations for [medically] necessary care; it is estimate that this approach would eliminate the need for inappropriate individual treatment.
11. There have only been a couple of times when I really needed something done and there was some red tape but I was able to see the reason why certain policies were in place.

Change Incentives for Clients (9 Comments)

1. Accountability.
2. If Medicaid imposed a sliding scale of Medicaid co-pays, there would be more cautious use and more careful selection of providers.
3. Limitations on some level is the only thing to get them to understand that this can no longer be a free ride.
4. Patients should be penalized for using the [emergency room] for outpatient services
5. Having the patient bear some financial responsibility for seeking medical advice might encourage them to utilize a hotline where they could obtain sound advice concerning their circumstances, at least in many instances.
6. [A] [Health Savings Account]/ [Medical Savings Account] model probably has the best chance of both giving freedom to the patient and physician while also providing some financial responsibility for the patient.
7. Patients bear little or no financial responsibility for seeking medical advice; the system encourages overutilization.
8. Medicaid [emergency room] visits must require a larger co-pay from ALL Medicaid recipients.
9. Incentivize patients for seeing a single provider outside of the [emergency room] setting. Like complete coverage of prescribed medications if they came from their primary care provider vs. a co-pay if they come from an [emergency room] or from more than one provider.

Increase Managed Care (8 Comments)

1. Closer monitoring of patient that are abusing Medicaid.
2. Carve-in Pharmacy and Behavioral Health with Managed Care The idea of implementing the medical home model and integrating pharmacy and behavioral health into managed care are closely related. If more time is needed before moving to this model of care, the State should carve-in pharmacy and behavioral health into managed care. To maximize the value of a managed care model, a health plan must be able to see across a member's continuum of care – not only their medical needs, but their prescription medications and mental health needs as well. For example, a Center for Health Care Strategies study found that "the frequency of psychiatric illness increases from 29 percent to 49 percent when pharmacy data is combined with diagnostic data (CHCS, The Faces of Medicaid III, Oct 2009)." This shows the critical link timely access to pharmacy data has in properly identifying and caring for members with chronic health needs. The close coordination and oversight provided by managed care leads to more seamless, quality care for the member and significant potential savings to the Medicaid program.

3. Pharmacy Benefit With relation to the pharmacy benefit, a comparison of drug costs under FFS vs. Medicaid managed care found that “[per member per month] prescription drug costs were 10 to 15 percent lower in a capitated Medicaid managed care than in the [fee-for-service] setting, although the [managed care organization] initially started at a 15 percent price disadvantage largely due to Medicaid drug rebates rules (The Lewin Group, Medicaid Managed Care Cost Savings, March 2009).” A claims pricing analysis of Utah’s estimated Medicaid costs compared to what they would be if managed by Molina’s showed an estimated savings of more than \$750,000 for brand name prescriptions and over \$100,000 for generic. The potential savings are even greater now that Medicaid managed care plans are eligible to receive the drug rebates once only available to States.
4. Behavioral Health “The behavioral healthcare system has historically been a separate care system, although for many of the individuals served in the public sector, it has also been their principal source of care.” However, providing individuals with behavioral health needs with coordinated, bi-directional care has huge benefits. “The IMPACT model [a form of bi-directional behavioral health care provided in a primary care setting], has been found to double the effectiveness of care for depression, improve physical functioning and pain state for participants and lower long term healthcare costs.” (National Council for Community Behavioral Healthcare, Behavioral Health/ Primary Care Integration & the Person-Centered Healthcare Home, April 2009).” The strain on State resources can be alleviated by tapping into the existing managed care structure rather than maintaining dual programs. By partnering with managed care, the State can move resources to quality oversight vs. maintaining an operation staff.
5. Is it possible and does it make sense to make all of managed care contracts for Wasatch Front counties (Salt Lake, Weber, Utah and Davis counties) risk based contracts?
6. In our fee-for-service counties (rural) does it make sense to see if the new Accountable Care Organizations may be a better model for improving quality of care and lowering the costs of health care.
7. Creating a gatekeeper model which assigns a patient to a [primary care provider] who is incentivized to actually manage the patient, create access with the patient and provide referrals; if this occurred then patients may use [the emergency room] less and also get hospitalized less; also if members had to pay more for medications prescribed by certain providers – particularly [emergency room] providers – perhaps they would use this avenue less.
8. I also suspect that a model of care such as accountable healthcare organizations is in our future even with Medicaid in light of the budgetary realities.

Change Rules/Eligibility for Clients (7 Comments)

1. Limit on how long a client can be on Medicaid.
2. Client must be able to pass a drug test before [receiving] Medicaid card each month.
3. Something to help those people who need help for a short period but do not qualify for Medicaid because they own a car, and have a job.
4. We need something to help the single adults most of our charity is for people who are single with no insurance they struggle when they have an emergency eg appendicitis they have no [insurance] and no money what about a [program] like [Utah Medical Assistance Program] for these people?

5. When the system is 'giving people fish instead of teaching them how to catch fish' we are not even treading water! These are people who are children, [invalids], disabled or just letting us care for them. There are plenty of people out of work who could be trained and lots of empty schools or buildings that could be used to teach others skills to help themselves, if only it is how to clean [their] homes and [their] bodies. Let us do something - anything to help them make [their] lives better, give them pride in themselves and make our burdens lighter. The problem comes in making many of them want to learn and change.
6. [My Medicaid patients] will do whatever it takes to get a note from the [doctor] that says they are unable to work. Most of them do not respond to treatment like other patients in that they take months longer to recover and as soon as I can convince them that there is nothing wrong with one body part, they come in complaining about another. In the absence of hard physical findings to account for the complaints of pain, we are obligated to order very expensive tests in order to rule out obscure, severe conditions as well as to have evidence that the patient does NOT have a diagnosis that should preclude their ability to work or recover.
7. The biggest problem is patients having to renew their Medicaid month by month. Quarterly or semiannually makes way more sense. People who have Medicaid are poor. They do not have it together, in general. Asking them to renew their Medicaid every month makes them ineligible for care half of the time.

Home and Community Based Waivers (7 Comments)

1. More focus on home and community based services, based on the Community Choice Act and Money Follows the Person. We especially need a Money Follows the Person model, where people can take their nursing home funding with them to the community, for [Intermediate Care Facilities for the Mentally Retarded].
2. More home and community based services.
3. Change the waivers to require more low-cost, low-intensity services.
4. Greater focus on community based care vs. expensive institutional care for long-term care cases.
5. Utah needs both a comprehensive Home and Community Based Services Waiver and a limited services waiver that offers such services as respite, day programs (including supported employment), and family support.
6. Increase exploration of the use of Community and Home Waiver; provide incentives to serve more clients in home community.
7. Greater access to mental/behavioral health services from less costly, yet high quality community based programs/organizations.

Medical Home (6 Comments)

1. Patient Centered Medical Home for non-traditional adults and children.
2. Implement Medical Home Model – or as a first step, require [primary care provider] assignments (even in [fee-for-service]) Molina firmly believes that a medical home model, or as a first step, requiring Medicaid members to select a [primary care provider] increases the quality of care a member receives and allows payers to shift reimbursement from episodic to value based care. Medicaid members, who traditionally have lower rates of health literacy, higher rates of poor health, and fewer resources than the general population, are not served well by the [fee-for-service] system that relies on a patient's ability to self-refer. The existing infrastructure within managed care plans would allow states to pilot various levels of the medical home model more quickly and with greater beneficiary care and cost protections than developing an independent service model. Already Molina has

partnered with a behavioral health provider in Washington to bring to life the concept of a Person-Centered Healthcare Home. Launched earlier this year, Molina Medical at Compass Health is a revolutionary new treatment center focused on integrating primary care and behavioral health services. The care management team provides primary care, including assessing risks for chronic health conditions, facilitating consultations for mental health and chemical dependency services, and focusing on a holistic approach to providing care.

3. More emphasis on the patient centered medical home.
4. Health promotion and prevention through primary care physicians.
5. All should be in a medical home, where they can be followed closely to assure preventive care and continuity. With the patient always returning to the same caregiver, disease prevention is improved, chronic diseases are better managed and serious complications can often be precluded due to overall improved health of the patients in a medical home.
6. Medicaid would benefit from a medical home model.

More Helps for Clients (5 Comments)

1. Building clients self-esteem, introducing them to employment options & workshops, which is what [the Department of] Workforce Services does now except for customer service.
2. Other need encourage clients to access other services if needed i.e. low reading level - The Literacy Action Center, Adult Basic Education, getting their GED.
3. Helped the clients to move to other models where they can become as independent as possible. I.E. waivers where the parents can pay in but work at a decent living wage.
4. Need Native American interviewer in Salt Lake City, Utah (Phone).
5. Expand the concept of a "Fountain House Club" type program to encourage socio-therapeutic guidance for all Medicaid clients — offering help with location of residency, financial problem solving to extend Medicaid coverage \$\$\$, and to keep the confused client from diversion — or inappropriate allocation — of State funds, practical issues such as grocery shopping could also be addressed.

No Comment/Do Not Know (5 Comments)

1. I do not know [what] you mean by service model.
2. Unknown.
3. No comment.
4. Not sure what this means.
5. The question presupposes that the term "service model" has meaning to those to whom the question is being asked. I have no idea what the term means.

Increase Funding/Provider Reimbursement (4 Comments)

1. More funding.

2. An improvement in reimbursement rates and resolution of access issues can allow for better pediatric dental services.
3. Make sure that the percentage of Medicaid patients does not increase without increasing payment to health care providers.
4. Let's be clear. Medicaid service models DO NOT PROVIDE ANY CARE. That care is exclusively provided by providers and hospitals and, for the most part, providers care for the uninsured and indigent because they need care and not as a revenue source. Medicaid reimbursement barely covers doctors' and hospitals' high overhead costs.

Telehealth (3 Comments)

1. Expand the use of telemedicine, including the use of remote patient monitoring, to address access, quality, and cost issues. Access – telemedicine provides specialty consultations in the face of shortages and maldistribution of coverage in rural and urban areas, and timely coverage for emergencies such as telestroke. Quality – telemedicine delivers the right care at the right time at the right place; supports appropriate triage of patients in emergencies; improves chronic care management. Cost – telemedicine reduces unnecessary (and more costly) ambulance and air transports; reduces patient travel costs; reduces duplication of diagnostic tests; reduces ER visits & hospital readmissions.
2. Expand the use of telemedicine, including the use of remote patient monitoring, to address access, quality, and cost issues. Access – telemedicine provides specialty consultations in the face of shortages and maldistribution of coverage in rural and urban areas, and timely coverage for emergencies such as telestroke. Quality – telemedicine delivers the right care at the right time at the right place; supports appropriate triage of patients in emergencies; improves chronic care management. Cost – telemedicine reduces unnecessary (and more costly) ambulance and air transports; reduces patient travel costs; reduces duplication of diagnostic tests; reduces ER visits & hospital readmissions.
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Well Child Visits (2 Comments)

1. In many ways, especially the well child arena, these patients are better served than some who are on private health plans. For example, well child visits and immunizations are fully covered.
2. One possible pilot project could be group well child visits which work well in some practices (I have not tried this in my own practice, because of concerns about how to properly bill the service).

Miscellaneous Comments (9 Comments)

1. Expand the Medicaid programs like other states.
2. Allowing all mental health providers the opportunity to meet the needs of Medicaid clients.
3. The new health reform law has [resources] [available] for demonstration projects that Utah should explore.

4. The Digital Health Commission would like to invite a Medicaid representative to attend the Commission's meetings to better support Medicaid on eHealth initiatives.
5. [My Medicaid patients] will do whatever it takes to prolong the use of narcotics, such as Lortab.
6. Set up a public information system where taxpayers get to see the plight of those who, for whatever reason, cannot afford necessary healthcare, so Medicaid beneficiaries get to discover that their next door neighbor is paying their medical bills, and that their physician is basically seeing them for free (minimal or no take-home pay after paying office/operations overhead). There is nothing that irritates me more as a tax payer than when I hear some Medicaid recipient say that the "government is paying" for their healthcare. Make the system more transparent so that the average Joe on the street can understand where the money comes from and where it goes. I am happy to pay taxes that are used to care for Medicaid clients as long as I sense some appreciation for my "contribution" and some reasonable restrictions on how the money is used (for life-saving and health-promoting interventions and not for frivolous or expensive elective interventions).
7. Certain patients are disadvantaged because of the inability to provide allergen immunotherapy. Interestingly Wyoming Medicaid provides for this service.
8. Making them pay a co-pay has improved patients abusing the system.
9. If the changes with eREP have been completed, it may end up meeting this need.

6. WHAT IMPROVEMENTS SHOULD BE MADE TO BETTER DELIVER AND/OR ADMINISTER MEDICAID SERVICES IN THE STATE?

(46 Responders)

Improve Eligibility Determination System for Medicaid (15 Comments)

1. Empower every [Department of Workforce Services] employee to help the client through the process. Stop saying "that's not my job".
2. Call in "shorter wait" for interview.
3. Less paperwork and some patients who come in here give up on applying for Medicaid as they think the worker is not as helpful as they should be and they don't have access to a computer I don't know if they are being straight or not I know a lot do not complete their application.
4. [Require] your eligibility workers to perform, Issue warnings. Get rid of the dead wood. Reward performance & results, not seniority. Develop a culture of zero [tolerance] for unwillingness to perform.
5. [Conduct] "[mystery] shopper" applications to judge performance.
6. Reduce unnecessary administrative costs by implementing an aggressive, streamlined approach to the renewal process utilizing: 1) Ex-parte telephone and web renewals (requires access to "express lane" eligibility data such as taxes, food stamps, etc. and aggressive follow-up telephone calls); 2) Targeted administrative renewals for cases identified as being low risk of ineligibility (issue automated letter that allows an enrollee to call in only if there have been changes in the household or if current information on file is incorrect).
7. Simplification of application and renewal processes will allow for better service and delivery to clients.
8. We find that many people with [traumatic brain injury] do not understand and follow through with application and documentation requirements. We also worry about those who cannot maintain employment or places of residence long enough to complete the application process and get basic help. Resource facilitation, as provided by the [Traumatic Brain Injury] Fund, can be an invaluable support and can minimize wasted efforts by eligibility workers. The [traumatic brain injury] fund is in statute and can receive further legislative appropriations, which would allow us to help many people with [traumatic brain injury] maximize their private resources, and also to help reduce the administrative cost when public resources become necessary.
9. Allow providers online access to electronic verification of benefits and or approval of referrals.
10. Suspend Medicaid eligibility for incarcerated individuals rather than terminate - There are profound concerns regarding the complications and inefficiencies that appear systemic relative to unnecessary redundancies in the Medicaid bureaucracy. An actual case example is a seriously mentally ill Medicaid eligible individual who is incarcerated for a period of two months and, as a result, loses Medicaid. Upon release from jail, subsequent to his acceptance into a mental health court program, he reapplies for Medicaid. Three months later he receives a denial letter but is informed, after contact with the [Department of Workforce Services] case worker (in a distant area of the State), that due to the installation of new software, the letter was sent in error. Two months pass without any word of determination. Upon re-contact with the case worker, we are informed that the individual was denied for failure to submit a particular form. Contact is made with the local [Department of Workforce Services] office which verifies that the form was in fact submitted, but determines that the form was misfiled by the area office. Contact is again made with the out-of-area case worker who is informed of the misfile by the area office. The case

worker concludes that since the determination has already been made, the individual may have to start over and reapply, which could take another ninety days to determine eligibility. This individual, who is on life-sustaining medication treatment, is now being denied medication supplies by the local pharmacy due to inability to pay, as other medication funding sources utilized over the past five months while waiting for Medicaid reinstatement have been exhausted. The absurdity of the above scenario is inexplicable and likely not an isolated case. The inherent difficulty that occurs in any system that tries to distantly manage eligibility determination through hardcopy, as well as electronic means, is unquestionably problematic. Besides the mere problems of logistics and the convolutions weaved throughout the system as a whole, other concerns regarding Medicaid maintenance and reinstatement of justice-involved individuals is equally problematic. Currently, nearly every jurisdiction in the State either has implemented or is in the planning stages of implementing a mental health court designed as an interception strategy applicable to the mentally ill offender. The system of therapeutic jurisprudence is designed to divert individuals from points of incarceration to appropriate community settings. However, as in the case above, many seriously and persistently mentally ill individuals being diverted from jail will simply be at risk for reentry into mental health institutions without prompt Medicaid reinstatement. It seems past time for Utah to seriously consider adopting law, policy, and procedure, as currently in practice in many other states, for suspending Medicaid eligibility for incarcerated individuals as opposed to Medicaid termination.

11. To implement the standard health insurance ID card can prevent fraud or abuse. To better prevent fraud and abuse of Medicaid services, the State needs a Master Person Index. The Medicaid ID card needs to have photos and photos can be saved in the [Master Person Index].
12. Additional staff resources, which I know is not feasible.
13. Get rid of the red tape! Dealing with Medicaid is not a good thing!
14. Proof of citizenship. Look at medical need of individuals vs. other qualifications.
15. Drug test patients. Why waste resources on patients who are self-medicating despite our best efforts to help them?

Specific Suggestions for System Improvement (14 Comments)

1. Fraud checks implemented that are clear to providers.
2. Change the way people come off the waiting lists.
3. Shouldn't be open to everyone.
4. Mandate that all medical professional accept [Medicaid].
5. Send this [questionnaire] to your employees.
6. Medicaid should eliminate the [health maintenance organization] system and use a [competitive] bidding process for services.
7. Funding of new Medicaid [Management Information System] to replace antiquated "cobalt" system.
8. Full protection on hospital savings currently Utah hospitals are required to accept the Medicaid fee schedule if they have not entered into a contract with a payer. To achieve full protection on hospital savings, the State can follow the model used in Texas, where non-contracted hospitals are required to accept 95% of the fee schedule.

Reimbursing less than the established fee schedule encourages facilities to contract with health plans and provides additional long term payment protection to the Medicaid program as a whole.

9. Quality based auto-assignment for [Children’s Health Insurance Program] and Medicaid Although managing rising costs quickly becomes the focus in any health care discussion, savings cannot be achieved at the sacrifice of quality. Further, as the need for services rises, so too is the risk of payers or providers to cut corners. To reinforce the State’s goal to provide high quality service and promote healthier outcomes Medicaid and [Children’s Health Insurance Program] should base their default auto assignment ratios on quality measures. This model is used by several other states and is one way to reward those health plans that demonstrate their commitment to providing quality care. Molina’s mission is to provide quality health services to financially vulnerable families and individuals covered by government programs. In 2010, the Utah Molina program has again maintained its “excellent” accreditation status from the National Committee for Quality Assurance, a non-profit organization dedicated to improving health care quality. [National Committee for Quality Assurance] evaluates a health plan’s quality through the use of quality standards and performance measures. “Accredited health plans...face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas in order to earn [National Committee for Quality Assurance]’s seal of approval” and only the top performers receive an excellent rating (www.NCQA.org). The established and widely accepted standards used by [National Committee for Quality Assurance], including Healthcare Effectiveness Data and Information Set rates, provide states with a valuable resource to draw from when developing their own quality based default auto assignment measures. And in so doing, reinforcing the message that quality matters.
10. Additional providers to serve the needs of [Community Health Center] clients.
11. Align payment systems away from the traditional fee-for-service which can promote inappropriate use and align with payer models that encourage consumer responsibility.
12. What if the State purchased health insurance policies for those requiring Medicaid, or gave patients a voucher to buy their own health insurance? The State would be relieved of all the administrative work that goes with current Medicaid processing of claims, etc. Most in the private sector find purchasing health insurance a worthwhile expense in terms of return on investment and having coverage for expensive care if one should need it. I can’t see why it should not also be advantageous for governments to purchase health insurance for those who qualify for social services. The premium voucher could pay for all, or a portion of the health insurance bill on a sliding scale, based on income, need and/or other criteria to be developed. The State legislature should also pass laws permitting the sale of healthcare insurance across state lines. Private, independent insurance agents could sell any policy; people would select the insurance & coverage they want at the price they want in a highly competitive marketplace.
13. Do whole-picture cost analysis on treatments for chronic conditions like diabetes, hypertension, and mental illnesses and incentivize healthcare providers to start with the most cost-effective (from a long-term perspective) treatment available at the time.
14. Centralize [electronic medical records] that all physicians have access to decrease duplication of services and procedures.

Increase Co-Pays to Clients/Change Incentives for Clients (12 Comments)

1. [Expand] rewards for being [responsible].

2. You should consider higher prescription co-payments and have a co-payment on every prescription and not on just 5 per month with a \$15.00 monthly total. Maybe this could be income based. There are too many abusers of the system.
3. Medicaid should establish a co-pay system for Medicaid clients based on income level and/or ability to pay.
4. Personal responsibility in a small co-pay format would help.
5. Having patients bear some financial responsibility for the medical care they seek and receive.
6. Urgent care centers a much lower co pay to keep people away from the [emergency rooms].
7. Make the Medicaid participant or guardian responsible for using the system correctly.
8. All care should cost the patient something. Otherwise the services are too cheap and will be overutilized. It's simply supply and demand.
9. More incentive for private practices to extend hours so there is an alternative to [emergency room] medicine. We have extended hours, but the reimbursement really does not encourage it.
10. Higher co-pay on pain medications. They always seem to find a way to pay for them if they are drug seeking or selling them.
11. All Medicaid patients should be required to pay something in return for their benefits even if it is community service there should be some type of return for the benefits once the person is over a certain age.
12. Don't renew Medicaid if patient are noncompliant with treatment. If they don't show up for appointments or take their prescribed medications they are just wasting resources anyway.

Improve Prior Approval System (10 Comments)

1. Explanations as to why visits have been denied, rather than just an arbitrary denial.
2. Prior approval system is killing the service.
3. Eligibility should be clear to the provider, to know which procedures are covered and which are not, and which require prior authorization. It would be easy to create, use, and update a small chart outlining the benefits. It could at the front desk for the business manager to appoint patients for procedures and bill for reimbursement. The current system is biased toward those who provide a large number of Medicaid services where they have the system essentially memorized. An office that only occasionally treats Medicaid often does not have a clear picture of benefits. It is demoralizing to try to assist a client in need, only to spend time completing paperwork and then have the claim denied because it was not preauthorized, or was a non-covered benefit by virtue of the material used.
4. Have a [portal] to submit [authorization] [requests] online, also be able to view status and print off [authorizations]. I would like to see us eliminate faxes and use scanned items and emails more.
5. Allow us to take care of our patients in a more timely fashion instead of sitting them in a waiting situation why we try and get them authorized for services.

6. Streamline the authorization process: eliminate RN admission for [physical therapy] treatments. Clarify documentation expectations.
7. Set a yearly limit for [physical therapy?] visits....[similar] to what [the] commercial insurances do.
8. The judgment of a trained professional should be accepted. Many times, simply due to a regulatory requirement, a Medicaid patient will not receive needed care due to a bureaucratic requirement. For example, an MRI will not be covered for a Medicaid patient unless certain time requirements and treatment interventions have accomplished. Needed surgery will not be done unless physical therapy has been tried. Many times I have seen patients (as an orthopaedic surgeon) whom I know have a torn meniscus and have not recovered despite conservative care measures. I will schedule surgery only to find the surgery is not allowed by Medicaid because the patient did not do specific physical therapy. We then do the therapy, adding hundreds of dollars to the patient's bill, only then to proceed with the surgery that was indicated in the first place. There are other times when an MRI truly would help determine whether surgery is necessary or not, but because the MRI is not covered we do the surgery anyway. With the MRI we may have been able to avoid the surgery in the first place. I do admit MRIs are expensive and in general over utilized. But when an orthopaedic surgeon requests one it has been my experience it truly is needed and would help provide better quality care. Possibly MRIs should not be allowed when ordered by primary care providers who do not have the expertise to determine if a decision for surgery could be made without it. But the judgment of a competent consultant should be valued and supported.
9. The process of approval and denial of medical services could be more transparent. Physicians often provide services that are denied after the fact, because they were not aware of the lack of coverage. The decisions sometimes seem a bit idiosyncratic about what to cover and not to cover. For example, most insurances will cover an extended discharge from the hospital 99239 (discharge greater than 30 minutes), but Medicaid will not. I only found this out because of denials, rather than a proactive approach of Medicaid letting us know what common procedures and codes are not covered ahead of time. They could do more often what they did with the decision about no longer covering circumcisions. They let all the providers know ahead of time that that service would no longer be covered.
10. Administration of Medicaid claims needs to be smooth and as trouble free as possible. When providers are already working at a financial loss, it adds insult to injury to make obtaining reimbursement a chore.

Add/Expand Specific Services (8 Comments)

1. Expand Chiropractic.
2. More up-front preventive services.
3. Adult Dental needs to be [reinstated]. It has been proven time and time again that when dental is taken away, patients then go to the emergency room for tooth trouble, which then results in them being given pain medication, which then results in them returning to the [emergency room] over and over for a problem that could be solved with a \$60 tooth extraction. Instead, we spend thousands of dollars on [emergency room] visits and still no solution has been made to the original problem. It costs the taxpayers more to take adult dental away from Medicaid patients. Cost is only one of the issues. Oral health is related to the rest of the body. Heart disease, Diabetes, premature birth, low birth weights, etc. call all be worsened by the existence of mouth and tooth problems. The demand for Community Health Centers increases to a point that they demand more funding and subsidies while revenue and patient flow for the private dentist decreases. Studies have shown that when dental

coverage is taken away, most Medicaid patients will no longer get dental treatment and increase the likelihood for major problems.

4. Give more dental coverage to adult patients in need.
5. [Emphasize] early/preventive services.
6. Allow family-directed/self-directed care.
7. Prioritize reimbursement for preventive care.
8. Emphasize family support rather than institutions or group homes.

Better Communication (6 Comments)

1. Advertising. When [programs] become available let providers and clients know a little more ahead of time.
2. Make sure all outside companies (Molina) have all the current updated info.
3. Participate in health fairs in the community to provide information on how to apply for Medicaid.
4. Explain pharmacy benefits of covered/uncovered to patients, so they can expect to pay for some things and understand which ones.
5. The Medicaid provider manual, with its constant updates, is extremely confusing for a private practitioner.
6. The pertinent information [in the Medicaid provider manual] for dentistry should be separated out and distilled onto one page easy reference, and all update should be modifications of that one page. Simpler is always better.

Increase Funding/Provider Reimbursement (5 Comments)

1. More funding.
2. Improve reimbursement to pediatricians and family physicians.
3. Improve provider reimbursement. It is joke. What mechanic would fix your car if you said you would pay them 50 percent of what they regularly charge? One of my partners is worried he will get let go for only seeing Medicaid patients because we need to see almost twice as many to earn the same amount of money for our clinic.
4. The current State Medicaid reimbursements to physicians are not fair. I am a family physician, and our office currently accepts new Medicaid patients. I used my own actual over head for last year (about \$18,000 per month) and the reimbursement I would have received for the actual number of patients that I see per month (about 400). I calculated what my total annual income would be if I saw only patients covered by private insurance (~\$242,000 per year), and if I saw only Medicare (~\$145,000 per year), and if I saw only Utah state Medicaid (~\$13,600 per year). So if I had to choose between seeing only Medicaid patients and working at Arby's, I would be better off working at Arby's because at least there I would likely get some benefits. Basically, right now, Utah asks me to see Medicaid patients essentially for free. They pay me enough to cover my overhead of rent and staff costs, but not enough to pay any to me for my work. When people ask me if I do any charity care for free, I say "Yes, I accept Medicaid patients."
5. Medicaid needs to find a way to make it beneficial for [medical doctors], either in the form of better payment or tax deduction.

Limit Services/Procedures Covered (5 Comments)

1. Medicaid should adjust the number of services and eliminate some that are not life sustaining.
2. There needs to be a realistic look at what is covered and what is not. Everyone would like everything but that is not affordable nor is it doable. Take food stamps for instance!!! A person can buy ice cream, candy all the cakes and donuts as well as soda pop they want but they can't buy tooth paste, floss, laundry detergent, [deodorant], or any cleaning supplies. Why? This is expensive thinking in the healthcare field. Obesity is becoming a killer and the soda pop is eating their teeth. The [inability] to be clean and care for themselves as well as their home is stopping their ability to even have a desire to better themselves or their lives. Something has to be done to give the people who need Medicaid & food stamps [discipline] as well as education to better their lives. We have turned them loose in a "candy store" of [benefits] with no direction or responsibilities. If we are going to continue to pay for [their] babies then we need to take some responsibility to help them get out of the system instead of increasing the numbers requiring welfare. They are sucking the government dry and eating up the monies set aside for Social Security which belong to people who have worked hard all their lives! This has become our fault and being more attentive to the things that are covered with more [practical] attention to details has to make a [difference] over the long term.
3. A very large number of Medicaid patients spend more money on cigarettes than an insurance policy would cost. Furthermore, studies have shown that at least 50 percent of our health care dollars go to treating tobacco and alcohol related illnesses!
4. Rationing care makes sense. In Oregon the treatments of various diagnoses are prioritized with acute chest pain near the top and stress incontinence near the bottom and neonatal care of babies born at 24 weeks or earlier at the bottom of the list. On a given year the top 413 diagnoses are covered based on expected resources. Next year the cutoff is lower or higher based again on resources and needs.
5. Suboxone – I use it, but very expensive. I would limit Medicaid patients to a one time month course, after that they would have to pay for it on their own.

Expand Medicaid to More Individuals (4 Comments)

1. Looking at waivers. Co-pays and buy in to Medicaid for services that cannot be accessed through the insurance system. Currently insurance will not pay for autism or much outpatient mental health services. Many clients need to access the Community mental health centers which they cannot access because they do not qualify for Medicaid but their health insurance will not pay. How about once again a payment plan where they could buy into Medicaid?
2. Expand Medicaid programs to suit everyone including single people with no dependents.
3. Consider implementing a sliding fee schedule for waiver services.
4. Making sure that the MOST needy are getting the services.

Use Telemedicine (4 Comments)

1. Allow Medicaid-eligible patients to receive care via telemedicine from Medicaid-eligible providers for Medicaid-eligible services by either 1) reimbursing at the same rate as an in-person visit, or 2) including telemedicine in payment reform initiatives.

2. Allow Medicaid-eligible patients to receive care via telemedicine from Medicaid-eligible providers for Medicaid-eligible services by either 1) reimbursing at the same rate as an in-person visit, or 2) including telemedicine in payment reform initiatives. Support the use of the medical home concept, particularly for chronic disease patients, by incorporating remote patient monitoring. An Iowa Medicaid pilot using this technology for congestive heart failure patients showed a 24% reduction in inpatient admissions by participating members, a 22% reduction in total inpatient bed days, and \$3 million in Medicaid savings. Of participating patients who began the study without a “regular provider”, more than 36% had a medical home by the end of the study.
<http://www.cms.gov/medicaidchipqualprac/mcppdl/itemdetail.asp?itemid=CMS1227587>
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Oversight Process (4 Comments)

1. The administrative burden and numerous audits that at times duplicate oversight efforts are taking away from service delivery. A streamlined oversight process that avoid any duplication would be a benefit.
2. Streamline the oversight and monitoring process.
3. Selectively expand administrative oversight of clinical conclusions using clinical consultants as part of an administrative/clinical QI program; representation from every State-supported facility and clinic should include senior clinicians and senior administrators to make the decisions truly relevant to optimal clinical care; this administrative/clinical representation would meet as often as necessary to address accomplishment of targeted interim goals that would attempt to focus on (1) the true achievement of optimal care; then, and only then, (2) improvement of administrative lassitude, inappropriateness, and arbitrary \$\$ dispersal.
4. Ongoing, active peer review of records of patients who may be over-utilizing medical services should be conducted, to assess the appropriateness of care, and to confirm the need for the frequency/type of utilization.

More Use of Medical Homes (3 Comments)

1. Support the use of the medical home concept, particularly for chronic disease patients, by incorporating remote patient monitoring. An Iowa Medicaid pilot using this technology for congestive heart failure patients showed a 24% reduction in inpatient admissions by participating members, a 22% reduction in total inpatient bed days, and \$3 million in Medicaid savings. Of participating patients who began the study without a “regular provider”, more than 36% had a medical home by the end of the study.
<http://www.cms.gov/medicaidchipqualprac/mcppdl/itemdetail.asp?itemid=CMS1227587>
2. More emphasis on the patient centered medical home.

3. The primary care physician assignment doesn't seem to be working. Most patients go to whomever they want, when they want, with no recourse to them. Make them go to a gatekeeper and really get a referral. The restricted Medicaid patients seem to be better educated on what they can and can't do and seem to follow the rules better.

Miscellaneous Comments (3 Comments)

1. Electronic claims should be easily handled.
2. Access is always the key.
3. Not sure.

7. HOW COULD THE COORDINATION OF OVERSIGHT RESPONSIBILITIES BE IMPROVED? (38 Responders)

Better Coordination Among/From Agencies Administering Medicaid (10 Comments)

1. It sounds like there are two entities that monitor assisted living Medicaid services. They are the New Choice Waiver program through [Salt Lake] County Aging Services and then Flex Care. These two agencies should be combined into one program which should reduce some overhead costs which would equate to additional savings for Medicaid.
2. Human Services often administers Medicaid funded services. Combining several of their [oversight] and monitoring functions would be helpful and cost effective.
3. Sometimes we call and get different rules from different workers. Departments maybe could get together better to make sure on the same page.
4. Creation of single division/bureaucracy to oversee all aspects of Medicaid separate/independent of the Department of Health.
5. Perhaps centralization of the oversight and/or better coordination at the Medicaid State level and State level of audit functions could reduce the administrative burden.
6. Each agency which provides services with Medicaid funding has its own oversight process. So, for example, if someone with [traumatic brain injury] is on the [Division of Services for People with Disabilities] waiver, has mental health and substance abuse issues, and is a parent whose children's needs are being addressed by [Division of Child and Family Services], and has of course a Medicaid case worker, then this single person accounts for 5 case managers, five supervisors, and five to eight contract or quality assurance monitors. And typically, none of these people collaborate in their oversight responsibilities. Centralizing oversight could create substantial savings.
7. Eliminate the "silo" effect. Many times it appears that one area doesn't know what the other area is doing.
8. Make sure there is no duplication of efforts between agencies.
9. Coordination of Medicaid administrators in the Health Department and the Fraud Investigation unit is paramount. A good discussion between a Medicaid administrator and a provider can clear up misunderstandings better than an all-out investigation by the Fraud unit. Such communication problems in the past have resulted in well-meaning, ethical providers needlessly being investigated for small misunderstandings. The fallout from such investigations has caused a loss of good providers and widespread negative publicity for the Medicaid dental program. Significant abuses of the Medicaid system should be investigated, but the Medicaid administrator should assess the situation carefully first to see if the problem can be handled one-on-one.
10. Allow State Medicaid audits to be sufficient. I see no need for the State to spend funds for External Quality Review Organizations.

Specific Suggestions for System Improvement (9 Comments)

1. Get the legislature to butt out and stop cutting funding.
2. Quality of care measurements.

3. Hire the appropriate number of staff to handle the process more effectively.
4. Online resources.
5. Allow health plans to coordinate subrogation rather than referring to [the Office of Recovery Services]- In line with ways to better coordinate oversight responsibilities, health plans should be allowed to coordinate subrogation issues directly rather than having to refer to [the Office of Recovery Services]. Health plans already have systems in place to identify other potential payers and collect overpayments as well as a relationship with the member. The Medicaid contract requirement for health plans to use [the Office of Recovery Services] creates unnecessary duplication of services and hinders the collection process.
6. Provide a patient centered medical home.
7. Making information available [about money given to State administration vs providers] would help.
8. Health information technology, including telemedicine, is more auditable and may, therefore, be less conducive to fraud than traditional medical practice.
9. What about a reward for made appointments and a penalty for missed appointments.

Better Communication (5 Comments)

1. One manager for specific services, i.e., one manager to approve rehabilitation services ([physical therapy], [occupational therapy], speech, audiology) in order for the manager understand the necessity of services and appropriateness of recommendations.
2. When denials are incorrectly given because the priors are 6 or more weeks behind then oversight is increased and our costs of doing business greatly increases.
3. Better communication.
4. Make it easier to find a phone [number] for the department you need to talk to about [explanation of benefits] issues.
5. Clarify the information written in the manuals re: qualifying for services; homebound vs. least cost alternative, etc. Share this information with discharge planners, physicians etc.

Don't Know/No Comment (5 Comments)

1. No opinion.
2. Not really familiar.
3. I do not understand this question.
4. No comment
5. I don't know.

Eligibility Determination Improvements (4 Comments)

1. In the Blanding area have the eligibility do face to face interview with their clients, it was much easier for Native American (Navajo) to do it that way [especially] the elderly.

2. Eligibility streamlined to coordinate with other public programs such as [Women, Infants, and Children], Free/Reduced Lunch, etc.
3. I think many of the workers have too big of a caseload and have seen a downward swing on accuracy.
4. Many of your [departments] do not get the correct [information] from your workers in the field e.g. - family cost share on long term care [patients] and we have to make adjustments after we make Medicaid aware.

Expand Feedback (4 Comments)

1. Survey of patient satisfaction.
2. Please mail surveys to the clients to get a better answer.
3. Listen to employees on the front line. They know what needs to be fixed.
4. The department does an adequate job of overseeing the program and is open to suggestions on how to improve it.

Increased Efforts to Reduce Abuse/Restrict Clients (3 Comments)

1. Monitor patients to prevent abuse.
2. Restrict more clients
3. Eliminate the many benefits to illegal aliens.

Have the Department of Health Administer/Coordinate All of Medicaid (2 Comments)

1. Coordinate through [Department] of Health.
2. The Utah Health Department should perform all administrative services.

Miscellaneous Comments (4 Comments)

1. It can't...unless the state is willing to accept more risk of fraud or health and safety being diminished.
2. It could be improved in a lot of ways.
3. Not as bad as Medicare.
4. [Government] programs can be extremely expensive from the administrative standpoint.

8. HOW COULD WE LIMIT THE ADMINISTRATIVE BURDEN REQUIRED? (40 Responders)

Specific Suggestions for System Improvement (10 Comments)

1. Combining the New Choice Wavier and Flex Care programs.
2. Get the legislature to butt out and stop cutting funding.
3. Eliminate the [health maintenance organization] duplication of services, and allow the Health Department to coordinate and reimburse all Medicaid services.
4. Work for your [benefits] option. That would maybe take away some of the administrative burden. At the same time it will train some clients to be better prepared for the workforce.
5. Run like an insurance company.
6. Allow providers online access to electronic verification of benefits and or approval of referrals.
7. With payment arrangements with the right incentives Medicaid can spend less time medically managing. This happens because providers ([doctors] and hospitals) have the incentive to find ways of spending more effectively THEMSELVES [without] having to be forced to. In the end, the tax payer gets better use of their taxes that support Medicaid.
8. Medicaid & Medicare fraud should be stopped. I mean real fraud, where the Mob is submitting claims for dead people with a fake home health company. Physicians billing and coding should not be criminalized; with the new law, the prosecution does not even have to show intent, only that the physician used the “wrong” code, according to their stooges’ testimony. A difference of opinion between the physician and Medicaid, as to the correct interpretation of the use of a particular code (especially when the physician is right), should not be cause to take action against the physician, especially criminal action. The criminalization of medicine is a crime!
9. You must increase reimbursement to primary care providers, no ifs, ands, or buts. If the [primary care providers] felt that they were reimbursed for more than part of their overhead for the office visit then there would be more buy-in for taking care of this unique patient population.
10. Require that “all practices” accept some Medicaid or donate a certain amount pro bono to be licensed in the State. There could be business tax incentives to encourage this.

Don't Know/No Answer (8 Comments)

1. Can't give specific answer. I am not knowledgeable enough on this issue.
2. No opinion.
3. Not sure.
4. N/A
5. I cannot answer this question.
6. Not sure of what the administrative burden is.
7. We lack sufficient understanding about the [administrative] processes to comment.

8. Ask a health care management specialist. As a provider I just don't know.

Streamline Processes (8 Comments)

1. Each level of bureaucracy adds to the burden of paper work and price for the service provided. Local boards should be given power to authorize needed care in a timely fashion.
2. Eliminate redundant oversight.
3. Streamline the process and don't tie the hands of providers and taxpayers.
4. Layers of bureaucracy should be streamlined or eliminated.
5. Think lean about administrative requirements, clearly separating research endeavors from state rules and regulations.
6. Can decrease the burden by using a common set of monitoring key factors. Currently, each audit and oversight mechanism asks for a different set of reports.
7. It has always been interesting that in most very large institutions such as the government, school districts, hospitals and the corporate world [are] all top heavy. Too many at the top being paid most of the money! If fewer people could do more of the work more of the money could be better spent on the programs that need it. When [salaries] are printed as public information, one can't help but feel as though no one needs to make that much money! We [aren't] even going to discuss what athletes make!!!
8. The Utah Department of Health estimates that under Federal Health Care Reform an additional 110,000 "new" people are likely eligible. In addition, it is estimated that there are 50,000-60,000 children currently eligible but not enrolled in [Children's Health Insurance Program] and Medicaid. Utah should streamline their application process by removing the asset test in our current program. Many of our newly eligible Medicaid consumers in 2014 will have many medical needs that will have been unmet for many years. Utah should work closely with state agencies involved with Medicaid, hospitals, physicians (in particular primary care providers), dental providers, and other health professionals to prepare for this increase demand and consumption of medical services.

Improvements to Pre-Authorization/Hearing Process (6 Comments)

1. Reduce prior authorization to only those areas where there is significant cost impact.
2. [Pre-authorization] [program] needs to be worked over. It takes too long! Home Health in particular.
3. Not enough [pre-authorization] staff.
4. Limit the excessive documentation required for pre-hearings and hearings. The authorization process requires significant documentation that is found in the [Outcome and Assessment Information Set] documentation set. No one in [pre-authorization] wants to review the [Outcome and Assessment Information Set] set for information. The impression is that the information must be "spoon fed" to the [pre-authorization] people for review.
5. Standardize what is required [for hearings]. Create a form if [Outcome and Assessment Information Set] data sets are not used.
6. I'm not sure how to reduce the burden without taking away the requirement for preauthorization of certain services.

Improve Medicaid Eligibility Determination Policy (5 Comments)

1. More outreach workers on the reservation.
2. Implementation of “administrative simplification” in enrollment and eligibility processes. The Louisiana [Children’s Health Insurance Program] program experienced a \$19M annually in administrative savings by implementing a paperless renewal process (ex parte telephone and web renewals, and targeted administrative renewals) while maintaining a payment error rate measure Medicaid eligibility rate of 1.56% (one of the lowest in the country).
3. Partner with health plans to help clients complete their renewal paperwork - At a time when States and other stakeholders are looking for ways to manage costs, it may seem reasonable to not worry if qualified beneficiaries become ineligible for a month or two because they fail to complete their renewal paperwork. However, this has been proven to be a costly mistake. The costs of churning (the avoidable disenrollment and then subsequent reenrollment of a beneficiary) are significant. A study by The California Endowment found “when Washington State shifted children’s certification periods from 12 to 6 months, administrative costs rose by \$5 million.” In California, the cost for processing a beneficiary into their Medicaid program is just under \$200; in New York the cost is over \$280. (The California Endowment, How Much Does Churning in Medi-Cal Cost?, April 2005) With thousands of members renewing each month, these unnecessary costs can add up quickly. To avoid these costs, without increasing the workload of the eligible staff, the State should allow health plans to help their existing members complete the renewal paperwork. Beneficiaries would still be required to sign and certify their information is correct, but health plans could assist by calling and reminding members that their renewal form is due, answer questions regarding the process, and even help walk the member through the renewal form. The level of assistance provided would be determined by the state. Along with avoiding the costs and staff time to process a new application once a member has been terminated for more than 30 days, Molina’s retention programs in other states have benefited their respective programs by:
 - Prompting the member to take action and not wait until the last minute, which helps the eligibility staff avoid the large influx of paperwork to be processed at the end of the month;
 - Using health plan staff to make phone calls and send member reminders rather than eligibility staff resources; and
 - Eliminating errors and subsequent eligibility reprocessing time, if the health plan is allowed to assist or answer questions about the form. Keeping members enrolled in Medicaid and [Children’s Health Insurance Program] may sound counterintuitive, but reprocessing applications from an avoidable disenrollment only adds to caseloads unnecessarily.
4. Simplify the enrollment and renewal process.
5. Streamline enrollment and retention processes.

Pharmacy/Drug Issues (5 Comments)

1. Don’t cover over the counter medications at all. The rest of us have to buy them at the store.
2. Have physicians supervise oversight. I’ll give you an example of Molina practice – teenager with migraine headaches. I write for Topamax. They write back that there is no [Food and Drug Administration] medication for Topamax for migraine headaches. Funny because there is **no** medication with [Food and Drug Administration] approval for migraine prophylaxis in kids. I fax [back] 3 study abstracts supporting the use of Topamax for kids with migraines. Molina faxes back a denial. Then I talk to a pharmacy technician who says “What the hell, we’ll approve it.” I don’t mind following an algorithm or pathway if there is one. But, when there isn’t, denying available options is not helpful.
3. Consistent formulary. Getting approvals for certain drugs [is] a pain. List them or don’t cover them.

4. Well over 90 percent of the afterhours phone calls I get from patients looking for narcotics come from Medicaid patients. This is particularly disturbing because Medicaid is less than 10 percent of my entire patient base. Similarly, the largest percentage of patients I turn into the [Drug Enforcement Administration] (for obtaining narcotics from multiple doctors and then lying about it) are Medicaid patients.
5. Use the [pharmacy benefit management] system to monitor possible abuse and track problem client.

Reduce/Less Paperwork (4 Comments)

1. Less paperwork
2. For hospitals and physicians - minimize paperwork to get things approved.
3. Less paperwork. When we do send in paperwork don't lose it. That seems to happen quite a bit on the Long Term Care side.
4. Administrative burden is the sum of paperwork and chasing down Medicaid payments.

Utilize Technology (3 Comments)

1. Utilize technology to better serve clients (communicate with clients via text messaging, email, etc).
2. Computers are much less expensive than people. We could expand the role of technology in identifying patterns and situations that may warrant further investigation and continue efforts to automate billing and payment processes.
3. Online resources.

Better Communication (2 Comments)

1. Simple, effective and regular communication with providers as outlined previously would go a long way in limiting administrative burden. Online communication on the State website could also be a means of decreasing telephone calls to answer questions. It would require someone to monitor and respond to posting on a daily basis, but could be much more efficient than trying to deal with those same issues on the telephone.
2. The social workers who explain the benefits to the patients really do not seem to understand the benefits themselves. You need someone who has worked in an office to explain these benefits, so patients know from the start what coverage really means.

Miscellaneous Comments (8 Comments)

1. It is already limited to the point that it is very difficult to access services that previously were [accessible] that you could not locate anywhere else. [Department] of Health, Children's Special Health Care Needs Travis Carlson Waiver Community Mental Health Services - I get calls at least every other day from parents desperate to access their services because their young adult or child has mental health needs. The individual needs outpatient services and is seriously mentally ill. The family has maxed out their limited insurance services. They are willing to pay, nothing is out there! Parents who have children with autism, private insurance does not cover them, parents are desperate! I've already talked about the frustration of accessing Medicaid services through Workforce Services. I have talked to clients who have given up, who want to work. I have helped some individuals with disabilities access their services, it is difficult. I am sure it was to help cut funding and administrative burden.
2. It can't...unless the state is willing to accept more risk of fraud or health and safety being diminished. The deep cuts of the past two years have shaved off about all that can be shaved.

3. Do it right the first time.
4. Ask all your clients. It starts with customer service!
5. Doing well.
6. Keep things simple.
7. Help those in need not everyone that wants another taxpayer to carry the burden.
8. The detailed knowledge required to answer this question should rest within administrative personnel of the program. However, history has shown us that some governmental agencies are established with structures that require significantly more personnel than would be found in any similar private sector situation; many of our governmental agencies are extremely inefficient and overstaffed.

9. IN YOUR OPINION WHICH AREA OF THE MEDICAID PROGRAM IS MOST ABUSED? (44 Responders)

Specific Services/Programs/Users Types (20 Comments)

1. Pediatric services? Millions given to help rehabilitation of children, yet denial for young adults who are part of employment base.
2. Smoking cessation. It is absurd to spend lots of \$\$ on questionable programs when tax increases are FAR more effective.
3. Medical
4. Over utilization of high-cost, and often times, unnecessary medical procedures driven by specialty care providers and uneducated/uninformed enrollees.
5. Appears that physical healthcare in the Medicaid realm had less stringent oversight than behavioral healthcare. (Of course, that's easy for me to say, as I am in behavioral healthcare and are much more familiar with the oversight processes in that area).
6. Urgent care.
7. [Primary Care Network].
8. Elective diseases (especially chronic pain disorders without significant benefit with current therapy, i.e. irritable bowel disease, migraines, interstitial cystitis, chronic pelvic pain disorders).
9. Disorders that result from irresponsible behavior ([motor vehicle accidents] without seatbelts, tobacco and alcohol related disorders, obesity related disorders, etc.).
10. Chronic pain issues around MRI.
11. The controllable aspect that is most abused are the frequent users related to problems fully evaluated, like chronic pain, revolving pain issues, and issues related to lifestyle choices, obesity, smoking. I think caseworkers could work wonders and be much cheaper than me and my office trying to manage this.
12. Those that are allowed access. I see many young healthy male patients in the [emergency department] that are on Medicaid, they could be gainfully employed and making some contribution to society.
13. The "floating" Medicaid population, that has no "responsibility" or knowledge of their health care coverage.
14. A limited number of people that have chronic abdominal pain or chronic pain for other reasons who use the [emergency department] for their primary care and narcotic prescriptions. These people require expensive work-ups.
15. The most abused Medicaid program is unwed fathers who are not held financially responsible for their children. More must be done to collect from them.
16. As a spring board for disability claims.
17. Patients who don't understand how to obtain cost effective outpatient care and go to much more expensive facilities for care.

18. Patients who disregard medical advice.
19. Smokers.
20. Adults on the program who should be working, but don't so they don't lose Medicaid benefits, etc.

Emergency room (19 Comments)

1. [Emergency room].
2. Patients overuse the services for simple problems in [emergency rooms], just to meet their work schedule.
3. Overuse of [emergency room] services.
4. Families go emergency rooms instead of an urgent care center for medical needs.
5. Emergency room services are most misused, for reasons relating to the deficits in judgment frequently seen in [traumatic brain injury] survivors. It may be very difficult for a person with [traumatic brain injury] who is experiencing pain and fear to rationally decide whether an accident or illness is an emergency or can wait until regular office hours. Additionally, the doctor's office usually requires a small copayment, and the [emergency room] does not, so the person may feel that the [emergency room] is the more affordable option and present there with a sore throat or similar complaint. Also, because people with [traumatic brain injury] are extremely vulnerable to exploitation, they may be taken to the [emergency room] with a pain complaint by a "helpful friend" who wants access to prescription pain meds. In our experience, those who do not have someone reliable to help them process options may frequently overuse the [emergency room] setting. Targeted case management could be very helpful with this issue.
6. [Emergency] room usage by Medicaid patients. They don't have to pay or worry about insurance [therefore] they abuse the system driving up the cost for all of us.
7. Emergency department. Medicaid recipients have been shown in national studies to be the greatest users of the [emergency room]. This is probably due to the fact that they cannot be rejected and payment must be accepted. If the above measures I have discussed were utilized, maybe more physicians would be willing to see these patients in their private offices and provide the care in a more appropriate venue than the [emergency room].
8. [Emergency room] visits.
9. Emergency department services.
10. Use of the [emergency room] by patients – need to create cost disincentives for patients.
11. [Emergency room] use.
12. Use of the emergency department by clients.
13. [Emergency room].
14. [Emergency room] visits for simple, non-urgent problems.
15. Indiscriminate use of the hospital emergency rooms for routine illnesses or even the common cold or influenza.

16. Clients utilizing the emergency room because they are unsure or unaware of service or provider options. Limited provider access also leads to over usage of the emergency room.
17. Make sure they have incentives to go to URGENT CARE instead of the [emergency room] would help. (For many Medicaid patients, it is silly to go to urgent care when they can receive a higher level of care for the same price in the [emergency room].)
18. The most abused area of Medicaid is the utilization of the emergency department. This is partly to do with the way Medicaid patients are treated in many offices, as well as a lack of providers in specialty areas.
19. It is obvious to most in the healthcare field that the hospital emergency room is utilized too frequently by many, including Medicaid clients, as their source of primary care. It is an inefficient way to provide primary care and is very costly. Any effort on the part of Medicaid to create a "medical home" and a "dental home" for these people by directing them away from the [emergency room] could improve the quality of provided care and decrease the cost of providing that care.

Pharmacy Drugs (14 Comments)

1. Prescriptions.
2. Pharmacy.
3. [Prescriptions].
4. Those clients that are addicted to pain medication.
5. Pharmacy program.
6. Drug seekers. We have more people from Medicaid come in with toothaches and back pain than any other clients.
7. Narcotic seekers We have more Medicaid people seek drugs for toothaches etc than anyone else we do realize that their dentation is poor and sometimes pain occurs up your dental [program] maybe this would help We also have many with backache etc.
8. Prescription abuse.
9. Pharmacy.
10. Narcotics.
11. Expensive long-acting narcotic.
12. Pain medications are not a right.
13. Drug abusers.
14. Now that adults are not covered except for pregnant/nursing woman and those with [Primary Care Network] it has limited much of the abuse by adults. In the dental field we see most of the abuse with the "drug seekers". Those who have a huge draining abscess or gross decay which they do not want treated only pain medication and they always have a specific drug in mind. They also want to make sure that they will still have a legitimate problem for the next dentist they see so they always refuse treatment. Then if you don't tell the pharmacist that your

patient can only pick up the pain meds if they also purchase the antibiotics they will only get the pain meds. This process costs Medicaid \$68.00 in our office but they have to be seen because there is an actual problem.

Require a Higher Co-Pay/More Client Responsibility (8 Comments)

1. If there was a co-pay system, abuse would decrease.
2. Hold abusers more accountable – either through limiting eligibility or require higher co-pays for those who abuse the program - As health care costs rise, so does the risk for misuse. The Medicaid program and health plans have tools and sanctions available to them when a doctor and other provider abuses the program, but there are few courses of action when it comes to a beneficiary abusing the program. Fraud can be prosecuted, but program waste and abuse are difficult to manage. Currently in Utah, depending on the type of abuse, a member can be placed on the restriction program (if their actions meet the program requirements) or be removed from the health plan (which only transfers the cost to [fee-for-service]). The inability to hold members accountable who continually abuse the program becomes especially frustrating when their patterns of care seem to indicate they have learned how to game the system. Federal statute makes it complicated, if not impossible, to remove a member from Medicaid when they are abusing the program. And realistically, the cost of a member removed from the program would most likely just shift to uncompensated care in the [emergency room]. However, now is the time to open up a dialogue on this issue. Are new solutions available that would allow the State to charge higher co-pays to members who abuse the program? Or would streamlined reporting and coordination among all stakeholders (Medicaid Fraud Control Unit, Health Plans, Department of Workforce Services, Department of Insurance, and others) provide the necessary leverage to prosecute abusers? These are only two of many questions worth considering. With limited funds, growing costs, and individuals with real needs – those who abuse the program need to be held accountable.
3. If there is no co-pay there is no reason that the patients should wait until the next morning to be seen or wait until a simple cold resolves.
4. I am most bothered by patients using Medicaid with no consideration for cost of emergency services. A patient with private insurance and a co-pay is judicious about their use of medical services and very cautious about higher co-pays for emergency services. Medicaid patients (or more fairly some of them) will come to the [emergency room] to avoid waiting in clinic with trivial problems that don't require emergency services but that are very expensive.
5. I spend a lot of time in urgent care and in the emergency room. As an antidote it seems like the patients with Medicaid want every test done at any expense. On the contrary those with insurance or self-pay who are responsible for some or most of the bill want the absolute minimum done. There seems to be a disconnect when there is absolutely no financial responsibility.
6. Patients do bring their children in a more minor illnesses because they can and there is no disincentive to do so, than patients with private insurance. Unfortunately, a co-pay may also deter parents from bringing very sick children to their providers in a timely way. Perhaps a study should be done of [Children's Health Insurance Program] patients who do pay a small co-pay to see if very ill children have fallen through the cracks because of that requirement.
7. I would suggest introducing a small co-pay for all care, \$2 for office visits and urgent care visits, and \$10 for [emergency department] visits. These could be waived by offices and [emergency department]s (and covered by

the state) for hardship and appropriate decision making, but not covered if the client shows up at the [emergency department] with ear pain.

8. In my experience, a large abuse has been those with Medicaid using emergency room services for colds, strains, and simple other non emergency services. We do not want to limit their access, but they need some incentive to use resources like those who have insurance (who use emergency room services more appropriately because of concerns for their high deductibles and co-pays). I work at a Community Health Center (who sees 80% uninsured, including no Medicaid) and find that even the poorest of poor can afford our co-pay of \$25 a visit, why shouldn't those with the benefits of Medicaid need to do the same? Run an analysis of those with Medicaid and the codes on [emergency room] visits and see if most of the services rendered match those with insurance. You could also run an analysis and see if in general they overuse services at regular clinics. I would assume this would be a major savings that would allow expansion of the Medicaid program and allow others access to health care that they do not have now.

No Answer/No Opinion (6 Comments)

1. No opinion.
2. [Unsure] to be honest.
3. NA
4. No opinion.
5. Not sure.
6. We are not in a position to reasonably comment on abuse within the Medicaid program.

Frivolous/Unneeded Doctor Visits (5 Comments)

1. Frivolous sick visits.
2. Doctor.
3. Visits.
4. Unnecessary office visits.
5. When patients can be seen for any little problem that could have been handled over the phone. Physicians are paid so poorly that they feel they have to bring them in.

People With Money/Resources Still Getting Medicaid (5 Comments)

1. We see people walking into the office with designer clothes, nice cars, boob jobs, cell phones, fake nails, etc and they can't pay their \$3 copay. There should be tighter regulations on who should qualify
2. [Insurance] when clients say they do not have another insurance and they do.
3. Review the patients' resources on a more regular basis. If you can afford a boat and ATVs the state should not be paying for your health care.
4. Qualifying...many people are abusing the system in order to meet regular State Medicaid qualifications leaving those who really need services to maintain life, without anything.

5. You should involve the physician's office in alerting you to these patients [people walking into the office with designer clothes, nice cars, boob jobs, cell phones, fake nails, etc and they can't pay their \$3 copay].

Optimizing Medical Care (5 Comments)

1. Medical offices either not doing specific tests [because] of price or doing too many when not needed.
2. Patient care should be coordinated by a primary care physician, or primary care "team". Misuse and overuse of specialty care could be controlled and avoided.
3. One solution for critically ill children in families that cannot afford the co-pay is to have a screening nurse on call who can provide an authorization code if she feels that the patient should be seen that night and the patient would not have to pay the co-pay.
4. Many programmatic decisions are based only or primarily on capturing \$\$ – "saving" \$\$s – omitting the issue of medically optimal care as the reason for d/c'ing or changing expenditures. I suspect that limited or inadequately trained clinicians are used for input to "rubber stamp" administrative decisions with the only or primary objective to conserve available program \$\$s. This results in inappropriate protraction of clinical sessions, subversion and diversion of \$\$ expenditures into medically unnecessary care, and ultimately diversion of precious \$\$s away from essential patient care. It encourages inappropriate client-hood and restricts appropriate treatment of essentially medically necessary care.
5. Matching the services provided with the needs/profile of the clients.

Limit Client Access to Medicaid (3 Comments)

1. It is my understanding that Medicaid people get additional [money] for the more children they have, there should be a cap and once they reach that cap they are required to have a hysterectomy and vasectomy.
2. Restricting ALL patients to a couple of different primary care providers so they have a backup option, but are still restricted to a small number of doctors.
3. Medicaid should be only for a defined time and people should not be able to be Medicaid recipients for more than a certain amount of time.

Illegal Aliens/Undocumented Immigrants (3 Comments)

1. Illegal immigrants using the program.
2. Undocumented patients having children in the U.S. are [automatically] covered when they have the baby, plus their offspring are automatically citizens and [eligible] for [Medicaid]. This is unfair.
3. Benefits to illegals.

Fraud, Waste, and Abuse (3 Comments)

1. To what extent efforts to identify "fraud, waste, and abuse" are processes that make cost cutting more feasible. The danger is that we change oversight and documentation requirements due to a restricted number of outliers.
2. Millions of dollars in tax payers money could be saved if there were a system to report and prosecute PATIENTS WHO ABUSE THE MEDICAID SYSTEM. This includes the PARENTS of CHILDREN ON MEDICAID.
3. It is frustrating to see so much waste in the Medicaid system.

Do Not Feel There is a Lot of Abuse (3 Comments)

1. I am proud that Utah requires single mothers to become employed after two years of technology training so that they can get a decent paying job and pay for their own education if they want to go further. I work with the Medicaid population often in the area of [disabilities] and over the years honestly have not heard of abuse.
2. Are we assuming that there are significant abuses?
3. I don't think it is generally abused by patients.

Mileage Reimbursement (2 Comments)

1. The mileage reimbursement is most abused because clients come into the physician's office from 2 to 3 times a week for minor things. It seems like some of clients rely on mileage reimbursements to make a living.
2. [Mileage] reimbursement.

Dental Coverage (2 Comments)

1. I know a lot do have bad teeth but most of the time we write off their services as no coverage. Fix your dental coverage.
2. The abuse we see with our patients who are children is neglect. As in the story I told you earlier about the 5 year old whose teeth had rotted off, we see lots of kids of all ages who have never seen a dentist and the expense for repairs are enormous! Or there are the ones who let their little children have a bottle all of the time, including to go to sleep with - some having soda pop in them, usually because whoever is caring for them either doesn't know or doesn't care what it does to their teeth.

Medicaid Contracting (2 Comments)

1. Medicaid managed care – Move all managed care organizations into risk-based contracting such as the current contract with Molina. Non risk-based contracted Medicaid managed care organizations have no incentive to control utilization or limit expensive, and often times unnecessary, specialty care services under their current fee-for-service contracts.
2. It is important to review all Medicaid contracts to determine that all services contracted for are actually being delivered.

Elderly (2 Comments)

1. It is mentally abusive to mandate moving a vulnerable senior out of the home they have known for years in order to qualify for the Medicaid Assisted Living programs funding.
2. Sometimes it is the elderly and [impaired] who suffer the most abuse due to lack of monies available to treat them.

Provider Reimbursement (2 Comments)

1. Non face-to-face encounters should be reimbursed.
2. Our own legislative audit suggests that provider reimbursement was the largest area of concern.

Miscellaneous Comments (7 Comments)

1. The Legislature abuses by not having Christian values and beliefs when they want to cut funding/services.

2. The Utah State Legislature has done a good job.
3. The ones that are supervised by stupid people.
4. The [emergency room] has slowed down with your patients so I do think the word is getting out to use the doctors' offices.
5. There should be comprehensive Medicaid client education on the costs.
6. It would seem obvious that the people who administer this program would have access to the required detailed information enabling them to answer this question most accurately and effectively.
7. Which one is not should be the question.

10. ANY OTHER IDEAS/SUGGESTIONS? (28 Responders)

Specific Suggestions for System Improvement (15 Comments)

1. Trust me, if you can make my suggestions happen [Combining the New Choice Wavier and Flex Care programs] you will save close to 200K annually.
2. I have an idea for saving lots of money; provide used items to some clients in certain circumstances. Right now when someone breaks their leg they get a NEW pair of crutches paid for by Medicaid. After limited use the crutches end up being thrown out or given to a thrift store. The same goes for walking cast/boots, neck braces, walkers, sometimes even wheelchairs. I work for a non-profit and we get these items donated to our thrift store all the time. Twice the wheelchairs were still in their original boxes - never used! The canes and crutches we get are often barely used and cost the taxpayers a lot of money. I am sure there are more items that we don't know about. It is even worse with Medicare - bedside toilets, glucometers, shower seats and more.
3. Make the directors of the pharmacy program available to pharmacists by a direct phone line so that we can resolve problems that cannot be resolved by their staff. Leaving a message on the answering machine and waiting 2-3 days for a call back is not acceptable.
4. Task force with representatives from the industry to discuss program improvements. The task force should include decision makers and policy makers from both arenas.
5. The Medicaid contract currently requires the local mental health provider to subcontract with the local Federally Qualified Health Center even though we have capacity and are not in an underserved area. Other subcontracts are discretionary. We are forced to address a need that doesn't exist. All subcontracts should be discretionary based on real needs.
6. There are quality incentives too based on reducing readmissions and in hospital complications that drive quality up and cost down.
7. A few years ago, the U.N. was in need of money, and Ted Turner made a large pledge. When I register my car, I am asked if I would like to make a small donation towards the transplant program. Could there be a tax-deductible, charitable contribution to raise money for these programs?
8. To save money should just have one Medicaid plan, not Molina, Healthy U, etc. Each plan must require separate administrative costs which could all be consolidated into one. It also costs more for the practice to have to call several numbers to verify benefits.
9. Put the check register on the internet so the public can peruse exactly where the money is going (as to consultants).
10. My recommendation is to shift all the kids to [Children's Health Insurance Program] and make the adults qualify for Medicare.
11. Farm out the entire Medicaid program to a private insurance company that is willing to work five days a week and give their employees incentives to get their clients taken care of NOW! Get rid of the [Department of Health] Medicaid bureaucracy, and the 800-plus employees that swell the cost of the overhead and add nothing to the care of patients.

12. We need to stress prevention of obesity, malnutrition that is often present even in the thin population, the importance of exercise in preventing and create programs that address these issues and motivate the patients. Perhaps those of us who are interested could be paid to give public lectures, and Medicaid patients could be rewarded in some immediate small financial way for coming (like a coupon for fruits and vegetables).
13. We still have a lot of improvement in seeing an increase in breastfeeding rates. Again, breastfeeding has been shown to decrease diseases and even improve IQ of the infants. Perhaps we can work together more closely with the [Women, Infants, and Children] program to provide incentives for patients who breastfeed.
14. We need to develop better guidelines to avoid unnecessary repeat studies – I see patients who have had 4 MRIs ordered by 4 different doctors over 4 years – tremendous waste of the medical dollar. We need better access to ALL medical records – HIPAA has made it more difficult to get records and unnecessary repetitive testing results from that. We need smart cards to solve this problem. I do not know enough about Medicaid administration to make useful comments. I do know that some of the Medicaid patients are frequent utilizers and run up excessive costs – but I do not know the fix for that, unless some type of case manager would supervise patients with monthly or yearly medical bills above a particular threshold. Care has to be pared back, and this will not be easy or popular.
15. Some items that are covered appear to be unnecessary, such as non prescription items (I have many Medicaid families [request] large prescriptions for Tylenol and Ibuprofen), humidifiers, etc.

Compliments (11 Comments)

1. Medicaid is a great [program] on the whole. I feel that they do business just as well or better than most insurance companies.
2. On the whole Medicaid is one of the best run [programs].
3. We do not feel like there is too much abuse of your [program].
4. [Medicaid] does help people when they really need it except the singles.
5. Medicaid is a good, efficient system when you compare it to all other insures in the market. Some are better and some are certainly worse.
6. The vaccine for children [is working well].
7. The automated number to call for verification is working well.
8. Until everyone is covered, let us continue to expand Medicaid to fill the void left by private insurance and Medicare.
9. The system otherwise [besides low reimbursement] works pretty well. I can get most things my patients need and it is far better than having them uninsured on a limited insurance like the Primary care Network.
10. We don't want to end up like California, a fiscal nightmare. We have to make [responsible] decisions that might upset some, but when it comes down to it, if there's no money left to support these programs, than what. Thank you.
11. I appreciate this opportunity to offer input and suggestions on how Utah's Medicaid program can be strengthened and improved, while managing the budget.

Increase Client Co-Pays/Client Incentives (9 Comments)

1. One work-around for those who absolutely cannot afford the co-pay would be a RN on call. She can screen patients. If she feels a patient should be seen in the [emergency room], she would give them a preauthorization code. This would allow them to not pay to be seen.
2. Make the problem clients/abusers pay a "deductible" each month before the Medicaid card is effective for the month. This deductible can help with the taxpayer burden and curb abuse. (Like a monthly spend down?)
3. Have people work for what they [receive].
4. One way that would have an IMMEDIATE effect is to require a \$10 co-pay. This is for all procedures and office visits. At least in my office this would stop a family with four kids all coming in with a cold. There is no reason why people who receive health care services should not be asked to contribute at least a little bit. It is insane to allow this idea that healthcare is free to be perpetuated.
5. I would recommend that Medicaid have a tiered co-pay structure. Those who use emergency room services should need to make a \$25 co-pay, and those that use Instacares \$10 and those that use a regular clinic \$5.
6. Institute significant co-payments.
7. Co-pays are absolutely vital to cost control in Medicaid in Utah.
8. A co-pay for acute sick visits, a higher co-pay for urgent care visits and a higher co-pay for [emergency room] visits.
9. Very small co-pay for office visits (\$3-5) and a little bigger co-pay for [emergency room] visits (\$20) could save the program tons of money on wasted visits and save a little on cost per visit.

Increase/Provide Specific Services (8 Comments)

1. Replace the "Triple" test with the "Quad" test for Down Syndrome - It has come to our attention that Utah Medicaid only covers the "Triple" prenatal screening test for Down Syndrome and neural tube defects. As compared to the "Quad" test, the Triple test is below the national standard-of-care and is considered a poorer screening test. As an example, for [Down Syndrome], the "Triple" test (AFP, hCG and E) has a detection rate of 69%, while the "Quad" test (AFP, hCG, E and In-A) has a detection rate of 81% during the second trimester. When first and second trimester testing are combined with nuchal translucency, the detection rate increases to 88-95%. Reliance on the Triple test increases the risk of false positive results that lead to the unnecessary risk and expense of amniocentesis. The American College of Obstetrics and Gynecology and the American College of Medical Genetics both recommend that all women, regardless of age, be offered fetal chromosomal abnormality screening or confirmation. The State of California now provides three options to patients, based upon when a patient enters into prenatal care, the availability of testing and the particular screening desires of the patient. The "Quad" test, rather than the "Triple" test, is now offered to patients "late to enter" prenatal care. All other states contacted, including Pennsylvania, New York and Virginia, confirm that they have replaced the "Triple" test with the "Quad" test for their Medicaid patients. When expectant mothers in Utah now present for the "Quad" test, as ordered by their physicians, they are asked to read and sign a self-pay waiver (an Advance Beneficiary Notice). We believe that health care delivery to expectant Utah mothers can be improved and **request that Utah Medicaid revise this policy and replace the "Triple" test with the "Quad" test, as current standard of practice.** Based upon 2010 Medicare reimbursement rates, the cost of adding the Inhibin-A to the "Triple" test (the "Quad") is \$22.32. This relatively inexpensive "upstream" cost can significantly reduce the morbidity and cost downstream of unnecessary false positive Triple test results.

2. Many studies have been done that show chiropractic care can be more cost effective than traditional medical [procedures].
3. Circumcisions are inexpensive to do and save money in the long run when these patients are sent to the urologists after 2 months of age and then have a surgical charge.
4. Please be aware that people with [traumatic brain injury] don't disappear if funding for their needs does. They are in jails, on streets, and frequently are victimized by others in unsafe settings. Many do not have families or caregivers. Cost shifting, not savings, results from ineffective and inadequate support.
5. One specific item for improvement: the covering of physical therapy for chronic musculoskeletal injuries would decrease long-term need for pain medications such as narcotics, which would save money for the program. If the patient receives physical therapy, there is less need for chronic follow-up, continuous medication management, the payment of Medicaid for medications, significant morbidity, and the possibility of narcotic abuse or even death there from.
6. Medicaid with chronic conditions such as diabetes should get reminders of annual [Hemoglobin] A1c, foot care, eye exam to make them aware of these preventive services. This may help patients from delaying needed care.
7. Well visits, annual eye visits, annual dental visits, vaccine visits, and chronic follow-up sick visits [should] be free (i.e. asthma follow-up).
8. Restore Medicaid dental benefits for adults for exam, x-rays and extractions only. This will save Medicaid medical for the cost of emergency room visits for serious infection. The next least expensive thing would be to allow oral surgeons and dentists to extract teeth in the emergency room with a medical code for reimbursement. The upside is fewer serious infections. The down side would be more toothless people who would less employable.

Pharmacy Coverage and Reimbursement (7 Comments)

1. I serve on the [Pharmacy and Therapeutics] committee that was enacted by the Legislature a few years ago. The recommendations of the committee and the resultant medication contracts that the State has been able to sign have saved Utah hundreds of thousands of dollars, and those savings will continue to add up as time goes on.
2. Medicaid has not acted on any of the [Pharmacy and Therapeutics] committee's recommendations now for 5 or 6 months. It is not clear to me which employee or administrator is exactly responsible for this. The main employee (Duane Parke) responsible to work with the committee resigned last month, and said that one of his frustrations was that his superiors simply wouldn't take action on the committee's recommendations, costing the State a lot of extra money.
3. It has become clear that the [maximum allowable cost] list that the state uses to reimburse pharmacies for all medication in the absence of a specific contract has not been kept up for some time. This means that if the price of a medication falls over several months as a generic becomes available, that the State continues to pay the high price of the past, not realizing that it is overpaying. Michael Hales who is the division director assures me that the new person that is being hired to replace Duane Parke will have some time to spend on this, but it should never have been allowed to get this way in the first place. Michael Hales says their staff is so short they just haven't had time to pay attention to this, but that makes no financial sense for the state when they are paying out hundreds of thousands of dollars every month in medication costs to not have someone paying close attention that they aren't overpaying.

4. Under current state law, the Pharmacy and Therapeutics committee is prohibited from even considering any psychoactive medications. This was put in the Legislation under lobbying pressure from the pharmaceutical industry, but doesn't make any sense. All private insurers in the State such as Blue Cross and Altius or [Deseret Mutual Benefit Administrators] consider all medications when they put together their preferred drug list. Just because the [Pharmacy and Therapeutics] committee considers a medication class, doesn't mean that a single preferred agent will be chosen. There are some classes, for example anti seizure medications, where the likely outcome of [Pharmacy and Therapeutics] consideration would be to say that it would be dangerous to restrict coverage so all medications must still be covered, however in other classes, there are expensive new medications that are minimal reformulations of generic medications where money could be saved with no detriment to patient care if a preferred drug list encouraged physicians to use the identically effective but much less costly medications first. Senator Christensen plans to bring a bill to this effect up again this year, and I hope that House and Senate leadership and the [Utah Medical Association] will support him.
5. Medicaid offers a surprisingly generous pharmaceutical formulary. It seems to be much easier to [get] the [medications] you want for Medicaid patients compared to private insurances.
6. As much as I hate to say it and despise filling out prior authorization forms, it seems like there could be some more promotion of generic [medications] in the program. I think (again, I will regret making the suggestion) that any use of a brand name medication for the public insurance product should be by prior authorization only if there are generics available. I know this is tough but pharmaceutical costs are huge. If this is done, primary care [doctors] really need to have folks in their teams who can jump through the hoops. [Doctors] should direct it but the process should be something that an assistant can do. If it is too tough on [doctors], no one will participate.
7. You should also mandate generic medication [prescriptions] first whenever available.

Emergency room usage (7 Comments)

1. There should be accountability by the patients to avoid [emergency room] visits for non-urgent issues and other expensive waste. The physicians could be asked if the visit was a necessary Emergency visit, and if not, action should be taken to remove abusive patients from the program. Medicaid patients should have to consider the financial consequences of obtaining medical care just like the rest of us even if they aren't the ones paying for it.
2. If you talk to the Medicaid people, the thing that's killing them financially is emergency room visits by Medicaid participants who don't have a regular provider, can't get in to see their Medicaid provider, or don't want to go anywhere else.
3. A model that would best address this [emergency room usage] problem is one that requires every patient to have a [primary care provider] who acts as a gatekeeper to a patient's medical care. It would require that every patient be assigned someone willing to see them, even on short notice. It would require that no patient go to the [emergency room] unless referred by the gatekeeper. Converting to this model would probably cut Medicaid costs in half, given how expensive it is to provide care through the [emergency room]. Establishing and enforcing the gatekeeper model would be a major undertaking, but would save tens of millions of dollars each year.
4. Keeping the patients out of the [emergency room] is crucial. Strong case management and getting patients a medical home is key ... again tough to do at times with the current limited reimbursement and fee-for-service payment system.
5. I have been practicing for 27 years in Utah in family practice. For the first six years I practiced in Richfield and was involved with office family medicine as well as [emergency room] medicine. During the days when I was in the

office and was on-call for the [emergency room], it was irritating to note the number of Medicaid patients that would show up in the [emergency room] for a sore throat or other minor problems that I could have seen that day in my office. They had no incentive to show up in my office because it was all the same to them, for they had no negative financial disincentive to do so. Over the many years I have noted my Medicaid patients showing up in our local [emergency rooms] for minor illnesses. I do not see my “private pay” patients showing up in [emergency rooms] hardly ever. I do not see my “privately insured” patients in the [emergency room] except for major issues. I used to call the Medicaid card the “golden ticket.”

6. Medicaid [Primary Care Network] has a list of diagnoses that they will cover in the [emergency room]. Good idea! It should be so for all Medicaid.
7. I see many people abusing Medicaid privileges by using [emergency rooms] as [their] convenient place to get care that is not necessarily urgent, using up precious resources.

Physician Issues with Medicaid (6 Comments)

1. Medicaid needs to work with the physician/hospital community rather than dictate to the community.
2. It would help to have pharmacists more involved in the committee and decision making processes for [coverage] and formularies.
3. In return many providers say they take Medicaid, however they severely restrict the availability in their schedule for Medicaid patients. For example only one slot per day may be available for patients with Medicaid. This results in a delay in treatment. I know [a] surgeon who will only operate when forced to. For example acute cholecystitis presents to the [emergency department] they admit the patient give antibiotics and pain meds but do not operate despite it being the patients 4th episode in the hospital.
4. Consider having a preferred provider network. Most physicians will not volunteer for this but you don't want most physicians. You want physicians who volunteer for this, and likely those who volunteer will treat Medicaid patients equally as those with BC/BS. Those physicians after a time could possibly get slightly higher reimbursement as part of preferred provider status. Unfortunately, if you tell physicians that they will get more reimbursement for preferred status everyone will sign up and defeat the purpose. The preferred could also be narrowed to include [pediatricians], [obstetrics]/[gynecology], family [medicine], general surgery as this is where 90% of the need is. Preferred provider for specialist may narrow down a small group already.
5. Many physicians quit billing Medicaid a long time ago because what they pay isn't work the cost and trouble of the billing. I am one of these physicians. Probably the last time I sent them a bill was in 1989. This makes it difficult for physicians here and elsewhere to render a meaningful critique of such billing or of Medicaid generally. It is a total loss from the standpoint of getting paid at all. A physician who likes Medicaid or thinks of it as benign is probably on a salary such that he or she is shielded from the bare facts of what the agency consists of.
6. Utah physicians in primary care should attempt to find an equitable way to share the “burden” of the care of Medicaid patients. As an “employed” physician of Intermountain Medical Group I appreciate that [work relative value unit] credit attributed to me is the same no matter what insurance a patient is on. As a result there does not seem to be a disinclination to accept new Medicaid patients.

Specific Problems/Suggestions for Medicaid Eligibility (6 Comments)

1. Train eligibility workers to be more [courteous] to their clients.

2. Have caseworkers expand their horizon. Learn about the needs of every individual in the geographical area of the State of Utah. Not everyone has the [accommodations] of different types of services/programs available within city limits. Not every town has a transit service. Our clients with no vehicle have to hitchhike, some with health problems.
3. The biggest frustration my patients have is communication with their Medicaid representative. The interface agents with the patients are seemingly not at all interested in the clientele and their welfare, but in how to deny the service to the patient.
4. I hear frequently of duplication in paperwork, or the office being closed on Friday when the patient can finally get there. I hear of unnecessary letters coming out to the patient because the office is closed on Friday and then the Monday is a holiday so the computer sends out a letter canceling a patient's Medicaid.
5. I am frustrated with the government worker mentality of doing as little as is possible and having no quota or goal to meet. My patients are frustrated that when the office is open their representative is frequently unavailable because they are in a meeting.
6. Medicaid helps a number of families who badly need help, but it appears that the rules for coverage are difficult to interpret, and getting coverage can be very cumbersome.

Reimbursements (6 Comments)

1. The weakest part of Medicaid is the low reimbursement which limits access to specialists. It will likely always be so.
2. Make all reimbursements to beneficiary by means of a dual-payee check. (i.e. no assignment).
3. The major drawback from many providers I speak to is primarily reimbursement.
4. Legislature - FUND THE PROGRAMS MORE! You have no idea of the ramifications of cutting these programs - you do essentially create your own death panels if you do... Think of children at the Davis rehab hospital who need services like life support/respirators to live.. if Medicaid was gone.. what other choice to most families have but to pull the plug?
5. I see the Medicaid patients because they are my neighbors and friends in church and the small community in which I live, not because of any benefit I get from the payment - which I really doubt meets the cost of the overhead.
6. The reimbursement rate is of course problematic, and discourages physicians from wanting to take on Medicaid patients, especially complicated ones. I know this is an allocation of resources issue, and I don't know the solution, but it is a problem.

Quality Care/Cost Containment (5 Comments)

1. The most effective way to address the growing costs in health care service ... Medicaid included, is to focus our attention on quality improvement and waste reduction.
2. We practice medicine in a system that does not adequately reward quality. Medicaid is no exception to this. There is a perverse incentive to provide more services, more tests, and more treatments. We get paid for doing more things ... not for doing the right things. We are not compensated for our outcomes ... only for our processes.

3. I was recently employed by Intermountain Healthcare as medical director of imaging services. We are actively formulating a plan to escalate our commitment to quality and cost containment in imaging. This means that we will take many of the things we have learned from our clinical programs and apply them to imaging as well. We have some pilot data and pilot processes in place. For example, under some estimates, up to 30 percent of imaging procedures are non-contributory to patient well-being. As a practicing radiologist, I believe this number. At Intermountain we are committed to developing processes that allow us to document with data those subsets of examinations that are non-contributory and we will put in place care plans that make high quality, low-waste care a habit.
4. We should invest in data registries, global care plan development, and commitment to measuring and reporting outcomes. Establishment of accepted standardized care plans with tort protection for compliant practices would also be a powerful tool to improve quality and contain cost.
5. Investigation of payment strategies that reward providers for outcome rather than process would have the beneficial byproduct of improving processes.

Legislative Efforts (3 Comments)

1. The Legislature’s recent efforts to reform the Medicaid outpatient hospital reimbursement method will help to stabilize the rising costs.
2. The collaborative nature with which the Legislature acted demonstrated your commitment to doing the right thing to protect Medicaid’s long term stability and strengthening the program as a whole.
3. Listen to the experts at the state agencies...I love that Legislators care about Medicaid, but they don't spend enough time listening to the experts who could properly advise them. Instead, they spend too much time listening to lobbyists who are blatantly self-interested.

No Answer (3 Comments)

1. Nothing specific.
2. NA
3. You can see that I don’t have many answers, and that is part of the difficulty in fixing the problem.

Invest in Case Managers/Health Educators (3 Comments)

1. Investment in case managers, social workers, health educators, and nursing is key for this population. Dollars spent here will help keep these patients healthier and away from high cost services. Medicaid patients should have contact from a member of a health care team at least once a month and if the patient doesn’t initiate that the team should. Some patients need to be contacted weekly. This will improve health and lower cost in the long run.
2. There needs to be innovative use of health educators, nurses and pharmacists in this arena. This is where the concept of a Medical Home comes in and some sort of flat, per-patient fee given to a primary care provider or organization with some fee-for-service component financial bonuses to meet certain health goals. a provider or organization should have a certain population it is responsible for with the sicker folks spread out among different providers so no one gets overwhelmed with a real sick population. This may require putting some restraints on Medicaid patients on who they can have as a [primary care provider].

3. I would strongly suggest that the State initiate a program to educate Medicaid recipients about lifestyles in general and nutrition in particular. According to very good data, this is where the most money can be saved. Sadly, doctors, insurance companies and politicians have not had the motivation to tackle this issue.

Use Medical Homes for Medicaid Clients (3 Comments)

1. What works poorly – not managing the patients’ choices of care. I believe we should get patients assigned to medical homes that would then be responsible for managing the care. For instance, the patients would call for after hours care and be triaged appropriately to reduce [emergency room] visits and costs – the [emergency rooms] do not want to see primary care type visits and if health care organizations are given responsibility (and reimbursed by capitation, thus incentivizing them to reduce [emergency room] costs), we could save money AND, most importantly, redirect care to more appropriate venues.
2. When Medicaid patients can identify a specific “medical home” or primary care provider that this reduces unnecessary visits to Urgent Care and emergency facilities. Anything that can be done to assist/require Medicaid recipients to identify a consistent medical home would assist here.
3. As a pediatrician I have no experience with Medicaid patients in Nursing homes, only with pediatric patients. With many newborns being covered by Medicaid I would suggest an effort be made to identify a follow-up medical home for newborns prior to delivery instead of random assignment to a physician (family practice or pediatrician) in the hospital nursery. The [obsterics]-[gynecologist]/[certified nurse midwife] community could play a significant role here.

Payment System Reform (2 Comments)

1. There is going to need to be some sort of return to capitated payments or a new bundled payment system rather than fee-for-service. I know this has been done before and has not been dropped. It’s difficult because these patients can be very high users of services.
2. There needs to be delivery system payment reform but it’s tough to say what that would be. This is definitely an area where the state can get innovative and try some things that would help drive payment reform in all insurance venues. Permit unrestricted private contracting with Medicaid beneficiaries if no reimbursement is requested.

Reduce Administration (2 Comments)

1. Cut, cut, cut administrative burdens.
2. Limit Admin Burden

Use Federal Health Care Reform to Innovate (2 Comments)

1. The new Health Care Reform bill offers many grant opportunities, demonstration projects and incentives in payment and delivery system reform. Utah Medicaid staff should work closely with policymakers to determine which pilots and demonstrations make sense for Utah and aggressively pursue those opportunities.
2. This passage of the recent federal health reform is a perfect opportunity to [innovate].

Miscellaneous Comments (20 Comments)

1. Keep doing things like this!
2. Medicaid's intention needs to be to improve the lives of their members.

3. There are many out there who deserve to be helped who are not. Hospitals bear that burden even more now with the rate of unemployment. I know there are limited funds.
4. Medicaid used to be a dream to work with. Now in the last year it has become our biggest nightmare! We are going to use Molina as much as possible until Medicaid has fixed these problems.
5. Despite program complexities and rising costs, there are several areas where Medicaid can be improved. Molina's expertise in covering this population will allow us to serve as a resource to you in meeting these challenges. I look forward to the continued collaboration. I would be happy to provide additional information on the ideas submitted or meet with you in person to discuss these and other opportunities to further strengthen Utah's Medicaid program.
6. In a perfect world [everything] would work perfectly! I have given this a lot of thought and we are all between a rock and a hard place. The entire system of welfare needs to be redone but it will take brave people with thick skin to stop where we are and change everything. These people can learn to take care of themselves, their families, learn a trade and to help themselves! It can be done - please just start over!
7. Focus on the process. Streamline and increase efficiency while reducing the burden on the taxpayer.
8. It is hard to not stereotype the population and see people with nicer cell phones than mine, covered in expensive tattoos, finding money for drugs and alcohol, but not the money to take care of themselves. The public needs to learn to take care of themselves and be wise with what they have, and not expect the government to take care of it.
9. [The second major drawback] many providers may not publicly say this but they believe that many of these lower socioeconomic patients are more liability or "sue happy." I personally don't believe this but I do not have any data to support either position.
10. What works well – covering people not otherwise covered.
11. There is an administrative burden to this type of operation but it is patient education and triage which health care organizations should do well.
12. All this can be figured out but it will require innovation like we have never seen before.
13. Renovation and reinvention of the Medicaid system is a very interesting area of health reform to me. Glad to help the [Utah Medical Association] or State on this at any time. Medicaid reform has received too little attention in the recent debate. It is an area where the states can lead the way and really utilize and rejuvenate federalism in governance of the entire nation.
14. I'm a pediatrician in Provo, Utah. I see about 50 percent Medicaid or cash patients in my practice.
15. Any resource that is free will be abused or hyper-consumed. Only when people have to think about opportunity costs do they self-ration health care.
16. I find that as a physician who accepts Select Access and State Medicaid but is NOT permitted to accept Molina and/or Healthy U. I do have patients who will attempt to access care from our group who are on the "other" programs.

17. There are no simple fixes and no simple answers. The problems with Medicaid are not dissimilar to those for Medicare and private insurance – escalating costs. The fix revolves around the explosion of technology and the desire of our population to have the “latest and greatest” with no one wanting to pay the bills. We expect Ford Escort costs for our medical care, but we want Cadillac care. This cannot happen in medicine any more than we can walk on to a car lot, pay for an Escort and drive off in a Cadillac. We all need a reality check. Heart-lung transplants, liver transplants, bone marrow transplants for unproven indications are examples of procedures that should be reconsidered. And also the large number of [Patent Foramen Ovale] closures that are being done at a cost of \$10-20,000 each when the [Food and Drug Administration] will not approve the procedure but third party payers continue to cover it – with 25% of the general population having a [Patent Foramen Ovale]! We need to provide basic preventative, diagnostic and therapeutic care – prenatal care, heart attack and stroke prevention, cancer screening, treatment of diabetes, etc. We need to make difficult and unpopular decisions about care that is in the luxury (as opposed to basic) category. Basic care should be available to all – luxury care to those who choose to put [their] money into medical care – just as luxury cars (and gourmet food and wine) go to those who are able and willing to foot the bill. Food is a necessity – caviar is not.
18. I do not think malpractice issues are the main contributors to cost.
19. I think [the main contributors to cost] is demand and expectations of our high tech, luxury oriented society.
20. Erratic approval of requested procedures and preferred [medicine] lists is also frustrating.

Article Submission (Submitted From the Public Survey)

“Illinois Combines Two Programs to Improve Quality, Save Costs,” James Arvantes, American Academy of Family Physicians, 7/21/2010, available at <http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100721illinoismedicaid.html>

APPENDIX A - LETTER SENT TO AGENCIES REQUESTING INPUT



<http://le.utah.gov>

Utah State Legislature

Senate • Utah State Capitol Complex • 320 State Capitol
PO Box 145115 • Salt Lake City, Utah 84114-5115
(801) 538-1035 • fax (801) 538-1414

House of Representatives • Utah State Capitol Complex • 350 State Capitol
PO Box 145030 • Salt Lake City, Utah 84114-5030
(801) 538-1029 • fax (801) 538-1908

April 6, 2010

Our State Agency Partners in Medicaid,

With the Medicaid budget growing from 9.5% of Utah's General Fund in FY 1999 to 16.5% in FY 2009 and total spending over \$1.8 billion in FY 2009 (with no slowing on the horizon), it is our desire to ensure professional, prudent stewardship over the use of all funds. It is important for us to ensure that the money in this program goes toward providing high quality service for real identified needs in a fiscally efficient manner.

We would like your help as we take the pulse of our Medicaid program to determine areas where we can improve. We welcome your suggestions and feedback including proposed changes to current state or federal law. Your ideas and responses are important to us. Please take a moment and share your ideas by responding to the following questions:

1. In your professional opinion, what areas of Medicaid could be improved?
2. What are we doing now that is working well and should be expanded? What are we doing now that is not working well?
3. How effectively are our current service models serving the needs of Medicaid clients? What service models would better serve the needs of Medicaid clients?
4. What improvements should be made to better deliver and/or administer Medicaid services in the state?
5. How could the coordination of oversight responsibilities be improved? How could we limit the administrative burden required?
6. In your opinion which area of the Medicaid program is most abused?

Please provide your responses by May 31, 2010 to Russell Frandsen with the Office of the Legislative Fiscal Analyst who can be reached at 801-538-1034 and rfrandsen@utah.gov.

Thank you for your service to the great citizens of the State of Utah.

Sincerely,

David Clark
Speaker of the House of Representatives

Michael Waddoups
President of the Senate

APPENDIX B – SCREEN SHOTS OF ONLINE MEDICAID SURVEY FOR THE PUBLIC

Ideas to Improve Utah Medicaid



With the Medicaid budget growing from \$0.8 billion in 1999 to \$1.8 billion in 2009 (with no slowing on the horizon), it is our desire to ensure professional, prudent stewardship over the use of all funds. The Medicaid program is large and has many participants, therefore, coordination can be lost and some regulations may be unnecessarily cumbersome. It is important for us to ensure that the money in this program goes toward providing high quality service for real identified needs in an efficient manner.

We are interested in any and all ideas for improving Medicaid in the State of Utah. Please do not limit yourself to what is currently allowed by federal or state law as changes can be proposed to both. In your professional opinion, what areas of Medicaid could be improved? As you consider your responses, please keep in mind the following points:

- Since state funds are being used, some level of oversight is likely necessary
- Money does not exist to fund every need for everyone
- We want to reward and encourage positive health outcomes for clients

David Clark
Speaker of the House
of Representatives

Michael Waddoups
President of the Senate

If you experience technical problems please email legisweb@utah.gov.

Ideas to Improve Utah Medicaid



Utah State Legislature

Please answer as many of the ten survey questions as you would like. You may return to previous questions if you wish to modify your comments prior to completing the entire survey.

Please be aware that information submitted in this survey may become public under Utah public record laws. If you would like to report fraud in Medicaid, please visit <http://health.utah.gov/bpi/main/fraud.php>.

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Ideas to Improve Utah Medicaid



1. What areas of Medicaid could be improved?

2. What are we doing now that is working well and should be expanded?

3. What are we doing now that is **not** working well?

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Ideas to Improve Utah Medicaid



4. How effectively are our current service models serving the needs of Medicaid clients?

5. What service models would better serve the needs of Medicaid clients?

6. What improvements should be made to better deliver and/or administer Medicaid services in the state?

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7. How could the coordination of oversight responsibilities be improved?

8. How could we limit the administrative burden required?

9. In your opinion which area of the Medicaid program is most abused?

10. Any other ideas/suggestions?

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Ideas to Improve Utah Medicaid



An asterisk "*" indicates a required field. You may be contacted by Utah Legislative staff if there are additional questions regarding your suggestions.

*Name

Organization

Title

*Email Address

*Phone Number (please include your area code)

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Ideas to Improve Utah Medicaid



An asterisk "*" indicates a required field. You may be contacted by Utah Legislative staff if there are additional questions regarding your suggestions.

*Name

An answer is required.

Organization

Title

*Email Address

An answer is required.

*Phone Number (please include your area code)

An answer is required.

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*From what perspective are you sharing your suggestions?

- Physician/Osteopathic services
- Therapy services
- Dentist services
- Pharmacy
- Nursing Home/ICFMR
- Home and community based service provider
- Mental health/substance abuse provider
- Hospital
- Surgical center
- Government
- Advocate
- Committee member
- Medicaid client
- Other, Please explain

*How many years experience do you have working with Medicaid?

*Do you/your organization receive money from Medicaid?

- Yes
- No

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Ideas to Improve Utah Medicaid



*Please estimate the amount of annual revenue you/your organization receive(s) from Medicaid:

- \$1 to \$10,000
- \$10,001 to \$50,000
- \$50,001 to \$100,000
- \$100,001 to \$250,000
- \$250,001 to \$500,000
- \$500,001 to \$1,000,000
- Above \$1,000,000

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Ideas to Improve Utah Medicaid



Thank you for your help in identifying areas where the state can improve Medicaid. Together we can make a difference.

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Finish