OFFICE OF RECOVERY SERVICES, BUREAU OF MEDICAL COLLECTIONS

Response to 2016 Legislative Intent Language

August 2016

Preface

During the 2016 Utah Legislature General Session, the Social Services Appropriations Committee passed intent language seeking information about the Office of Recovery Services' Bureau of Medical Collections (BMC). This document is in response to the following intent language:

> *The Legislature intends the Department of Human Services (DHS), in conjunction with its Office of Recovery Services (ORS), provide to the Office of the Legislative Fiscal Analyst no later than August 15, 2016:*
>
> 1) *A report including a five year history (FY 2012 through FY 2016) of medical collections by its various sub-categories/types of recoveries and data to show the changes in workload. The report should specifically address changes with Accountable Care Organizations (ACOs).*
> 2) *A detailed explanation of additional ORS medical collection duties provided for the Department of Health required by either federal law or by DOH contract and an indication of the effect, if eliminated, on additional direct or indirect collections for DOH as well as which functions are now performed by ACOs that were previously performed by DHS; and*
> 3) *An estimate of how the ORS budget might be reduced to match actual collections to date and future projections.*

Statement from the Division of Medicaid and Health Financing, Department of Health

Requirements related to the identification and collection or cost avoidance of third party liability can be found at the Centers for Medicare or Medicaid website at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/tpl-cob-page.html .

The Department of Health has contracted with the Office of Recovery Services since the early 1980s to perform these functions on behalf of the Department. ORSIS, although primarily a child support services information system was also purposely programmed to support these functions. Over the past 34 years DOH has relied on ORS/BMC to be the experts in this area of regulation and law and to perform these functions on behalf of DOH. Collections made by ORS are used as dedicated credits in the Medicaid program budget. Cost avoidance activities performed by ORS saves taxpayers tens of millions of dollars in what would otherwise be Medicaid expenditures. Although the implementation of the ACO model has served to reduce the rate of increase in Medicaid expenditure, there are still millions of dollars in fee for service claims. Approximately 12% of all Medicaid recipients have other insurance coverage. Identification and collection or cost avoidance of TPL is critical to controlling Medicaid expenditure. The Division urges decision makers to act cautiously before reducing staff who are responsible for these functions.

Overview

The Office of Recovery Services' Bureau of Medical Collections (BMC) performs a number of functions required pursuant to federal regulations and state statutes on behalf of the Department of Health (DOH). These functions serve to avoid costs to the Medicaid program before they occur or to collect reimbursement for the Medicaid program after expenses have been paid.

Functions traditionally performed by BMC include:

- Verification of private insurance coverage for Medicaid recipients;
- Collection on health claims paid by Medicaid when other private options were available;
- Adjudication and collection of inappropriately filed provider claims;
- Recovery from estates (probate); and,
- Investigation and collection in personal injury cases involving Medicaid recipients (tort).

In 2013, Utah implemented an Accountable Care Organization (ACO) model, contracting with managed care entities to provide services to Medicaid members rather than Medicaid directly paying for the medical services on a fee for service basis (FFS). It was estimated that approximately 70% of Utah's Medicaid recipients would be covered by ACOs with the initial roll-out to the most populated counties on the Wasatch Front. On July 1, 2015, mandatory enrollment in an ACO was expanded to 9 additional counties. ACO enrollment is optional in the 16 remaining counties of the state. Currently 85% of all Medicaid members are enrolled in an ACO to receive their health care. Although the majority are enrolled in ACOs, a number of services are "carved out" of the ACO contract and continue to be paid directly by the State. With the shift of a large percentage of customers from traditional Fee for Service Medicaid to enrollment in ACOs, some have questioned the effect of ACOs on BMC collections and workload, even questioning the need for BMC to continue providing services at historical levels.

The only change in BMC duties as a result of ACOs is in health claim collections. By contract, ACOs are now responsible for health claim collections (Coordination of Benefits) against other private entities for their enrollees. BMC remains responsible for health claim collections for Medicaid members not enrolled in an ACO and for specific services "carved-out" of the ACO contracts, such as psychotropic pharmaceuticals. BMC continues to provide all of its other services statewide on behalf of the Medicaid program regardless of whether the member is enrolled in an ACO.

Within the health claim function, BMC expected a decrease in health claim collections and a decreased number of claims being referred to BMC for collection due to the implementation of ACOs; however, neither decrease has manifested at the rate expected given that the majority of the Medicaid recipients in the state are now covered by ACO services. BMC has continued to fully utilize the staffing levels and related budget maintained historically despite the shift to ACOs.

This report will provide information about the variety of functions performed by BMC on behalf of Medicaid, historical and trending collections in each function, and statistics related to the staffing and workload involved with each function. The information shows that workload for most functions performed on behalf of Medicaid are increasing. The discussion will include suggestions of BMC programs where additional staff could help BMC work certain programs more thoroughly.

This report will present a proposal for determining appropriate staffing adjustments related to the health claim program's anticipated workload decrease due to the implementation of ACOs at the point a decrease is experienced. However, due to workload increases in other functions performed for Medicaid, **ORS is recommending that any appropriate staff reductions from the health claim program be reassigned to the tort and estate recovery programs which are currently understaffed.**

ORS/BMC Five-Year Historical Overview

Collection Totals, Overview

ORS Bureau of Medical Collections Totals by Collection Type					
Collection Type	**2012**	**2013**	**2014**	**2015**	**2016**
Tort	$3,175,682.77	$2,731,329.76	$3,047,143.84	$3,845,587.48	$3,420,893.42
Health Claim	$11,799,663.74	$14,155,163.15	$9,952,581.64	$10,745,075.13	$8,844,538.10
Estate Recovery	$2,313,382.40	$2,869,100.69	$3,898,336.65	$3,885,488.76	$4,600,477.91
Medicaid Provider Credit Balance	$2,303.02	$3,435.11	$100.20	$12,842.36	$23,292.25
Subtotal: Collection Work by ORS	**$17,291,031.93**	**$19,759,028.71**	**$16,898,162.33**	**$18,488,993.73**	**$16,889,201.68**
*Medicaid Reimbursement Provider Overpayment	$1,816,411.38	$778,873.38	$761,760.86	$4,983,591.43	$3,907,935.87
*Medicaid Assistance Only Spenddown	$6,469,212.85	$9,556,417.49	$7,741,411.97	$9,229,424.30	$9,403,411.23
*Nursing Home	$510,334.71	$624,707.26	$441,397.78	$494,828.08	$308,729.05
*Primary Care Network Premium (MEDL)	$302,114.68	$500,000.00	$331,666.57	$200.00	$0.00
Total	**$26,389,105.55**	**$31,219,026.84**	**$26,174,399.51**	**$33,197,037.54**	**$30,509,277.83**

*Some debts are collected by agencies such as the Department of Health and the Department of Workforce Services or paid without pro-active collection measures by any agency, but the money is processed through the ORS computer system for tracking purposes only. Other than payment posting, no activities are performed by ORS/BMC staff for these functions.

Cost Avoidance

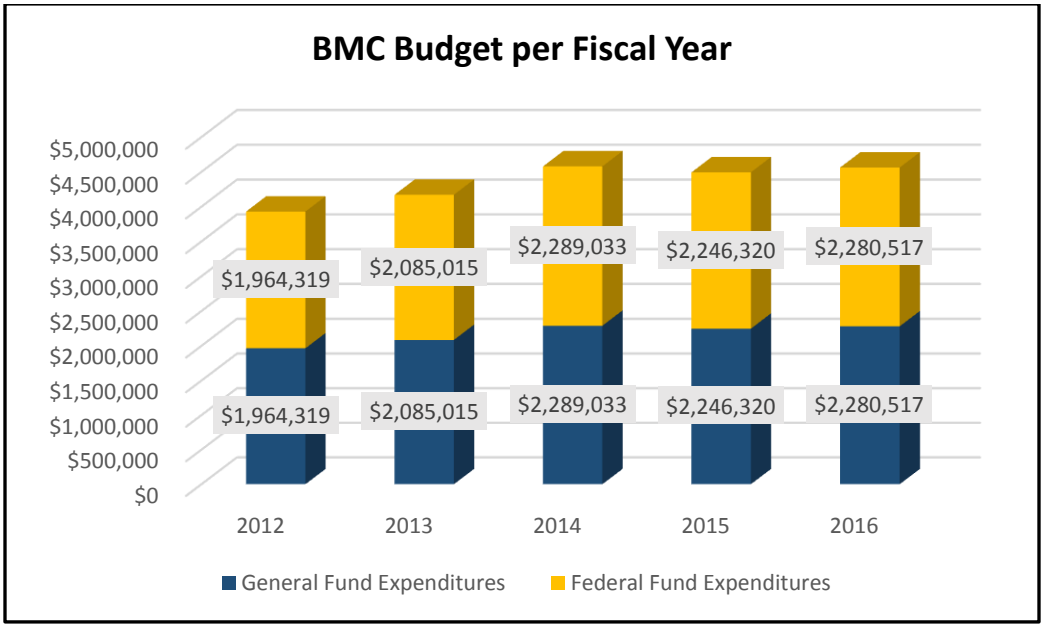
Pursuant to 42 CFR 433.139, Medicaid is generally the payer of last resort. If the Medicaid claim is for a pregnant woman or a child the claim may be paid and the state (ORS/BMC) must pursue reimbursement from the insurer. All other claims are denied back to the provider with instructions to bill the insurer first.

"Cost avoidance" is the amount collected from a third party insurer by the provider that the provider reports on their claim to Medicaid. BMC is responsible for locating and verifying private insurance coverage for all Medicaid members. This activity allows Medicaid to avoid these costs up-front, rather than trying to recover the funds from insurance companies after- the-fact. Five-year cost-avoidance history is provided below. BMC's efforts are most relevant to the non-crossover cost avoidance totals (highlighted).

Medicaid Cost Avoidance					
	2012	**2013**	**2014**	**2015**	**2016**
Crossover (Medicare) Cost Avoidance Amounts	$723,337,680	$753,133,772	$699,528,517	$618,225,042	$538,029,609
Non-Crossover Cost Avoidance Amounts	**$241,043,149**	**$223,294,741**	**$169,711,445**	**$183,026,260**	**$168,987,307**
Total Cost Avoidance Amounts	$964,380,829	$976,428,513	$869,239,962	$801,251,301	$706,016,916

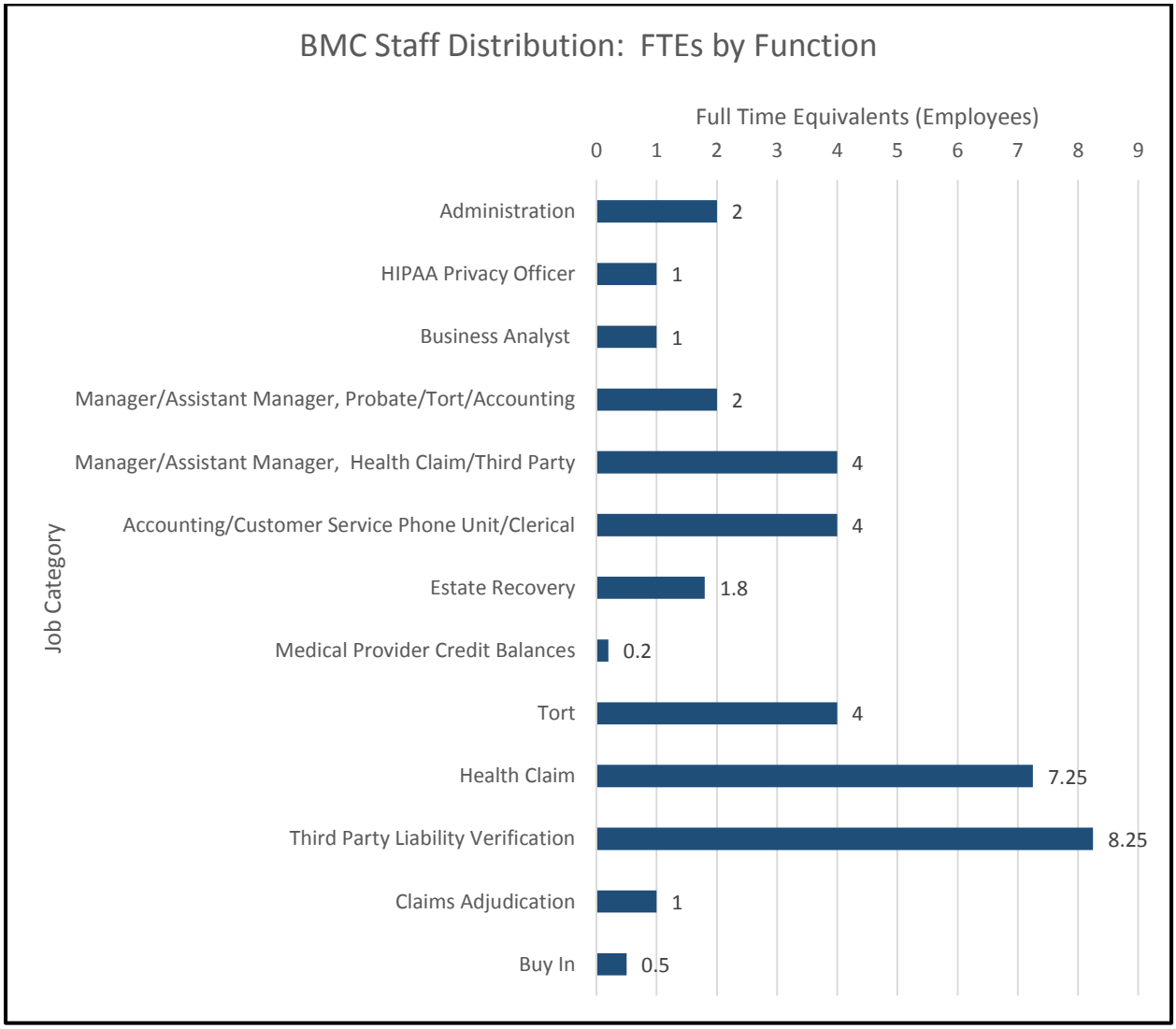
Budget

The BMC budget is funded 50% by General Fund and 50% by Medicaid Administrative Federal Matching Funds. Expenditures are primarily for personnel and technology. As long as BMC performs any services for DOH, the technology will be required, so any budget cuts must be applied to personnel.



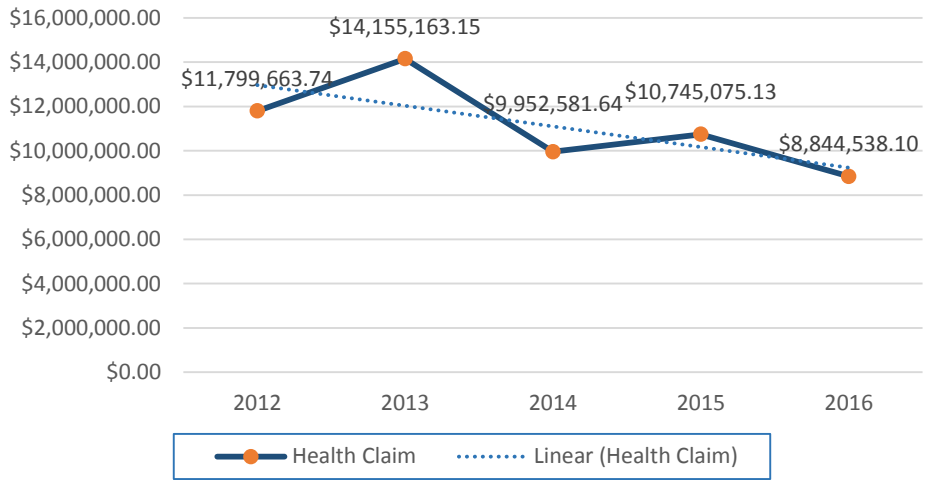
Staffing

The Bureau of Medical Collections currently has 37 "Full Time Equivalent" employees (FTEs) on staff. The positions are assigned among BMC's primary functions as listed in the chart below. Many employees, particularly in health claim and third party liability verification, split their time among multiple functions. This chart is based on the number of FTEs per function if each position only performed one function.



Focus on Individual Programs

Health Claims



FTEs

7.25

17 employees spend up to 50% of work time on this function

Statutes

42 CFR 433.139
UCA Chapter 26 Title 19

ACO Impact

Yes

Program Description:

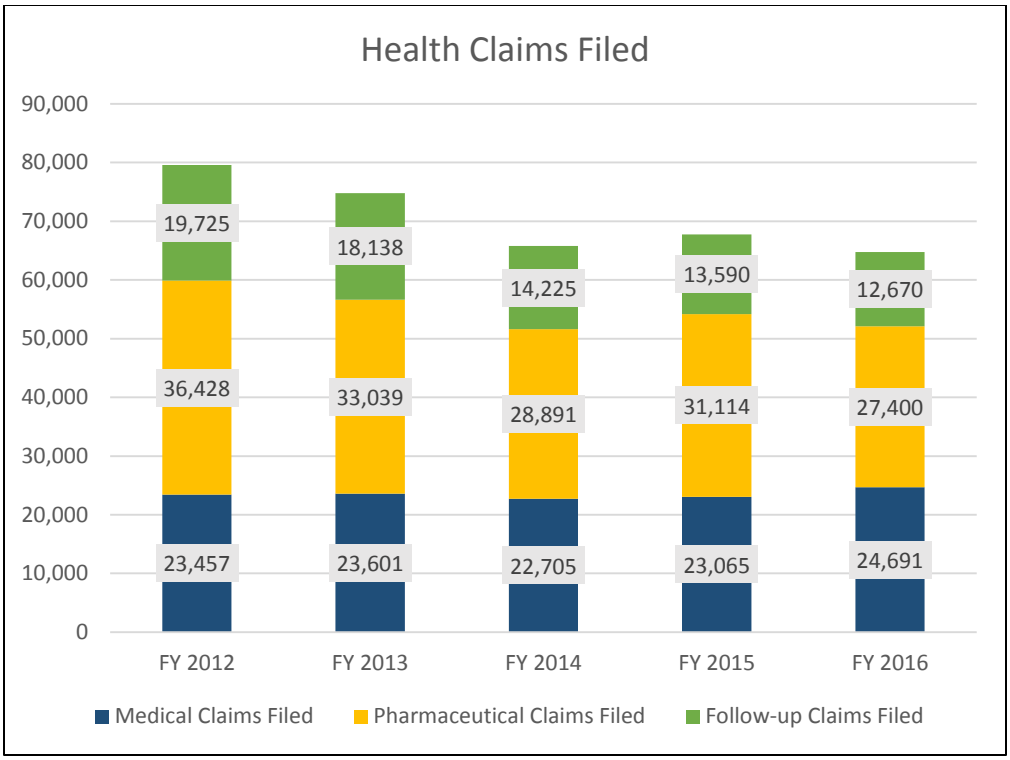
The health claim program files insurance claims with private insurance companies to recover funds paid by Medicaid. Workers file insurance claims, then monitor and follow-up with insurance companies when payments are not received. In addition , staff works with the Attorney General's Office to pursue collections from uncooperative third parties.

ACO Impact:

With the implementation of ACOs, the ACOs are responsible for coordination of benefits for their enrollees. As a result, BMC's responsibilities for filing health claims have reduced. BMC files health claims only on Medicaid fee for service claims.

Workload:

Pursuant to federal regulations, if other insurance coverage exists, all health claims referred to ORS must be worked, regardless of the potential amount to be collected. While it is tempting to measure health claim program workload by the dollars collected, workload is more accurately measured by the number of claims which must be filed and monitored, with particular concern given for those claims which must be manually filed. Currently, all medical claims must be filed manually, and approximately 40% of the pharmaceutical claims are filed manually. Follow-up claims must be filed due to non-payment and generally require manual corrections to the claim or additional information from the providers, so BMC considers the work impact to be equivalent to an initial manual claim, even if the follow-up claim can be submitted electronically.



Although the Medicaid fee for service population has decreased with the implementation of ACOs, the number of claims referred to BMC has not yet diminished proportionally. An expected change to the way that pharmacy claims are handled in Utah will further reduce the number of pharmaceutical claims referred to ORS in the future, but since the majority of pharmaceutical claims are filed electronically, their loss will not have a dramatic effect on the manual work efforts required of BMC workers.

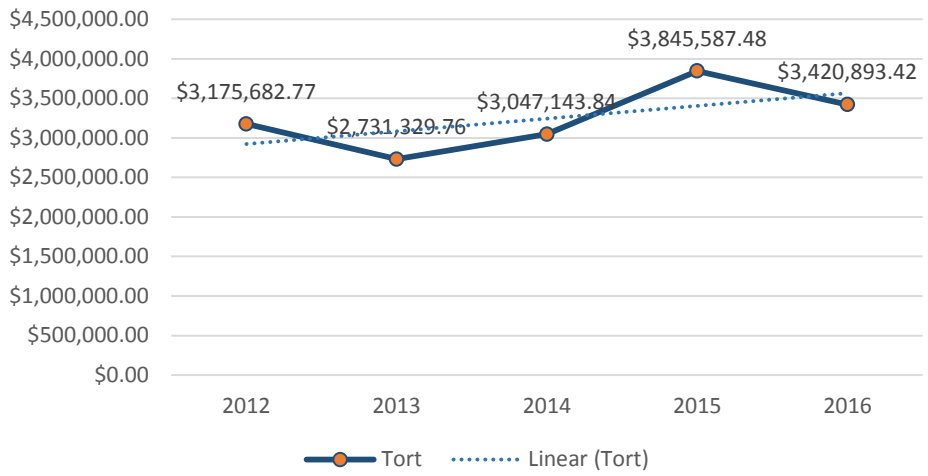
If Eliminated:

This program is a required function for the state's Medicaid program per statute. 42 CFR 433.139 (d)(2) states:

> Except as provided in paragraph (e) of this section, if the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available.

Premature reductions to the BMC staff assigned to this program (prior to a substantial decrease in claims to be filed) will decrease the claims filed and the follow-up performed on unpaid claims to ensure payment.

Tort (Personal Injury)



FTEs

4

4 employees spend 100% of their time on this function

Statutes

42 CFR 433.138
UCA Chapter 26 Title 19

ACO Impact

No

Program Description:

42 CFR 138(g) requires investigation and collection in personal injury cases involving Medicaid recipients. BMC investigates each Medicaid claim with a diagnosis code indicating trauma or injury. If a liable third party is identified, BMC files liens to add the state as a party in personal injury cases, ensuring that a portion of the settlement or judgment is paid to the state to reimburse medical expenses for the injury in question which were paid by Medicaid. BMC also completes the preparation for all tort cases filed by the Attorney General's Office working with ORS. Due to Utah State statute, by contract, ACOs are required to refer all personal injury cases to ORS for investigation and collection.

ACO Impact:

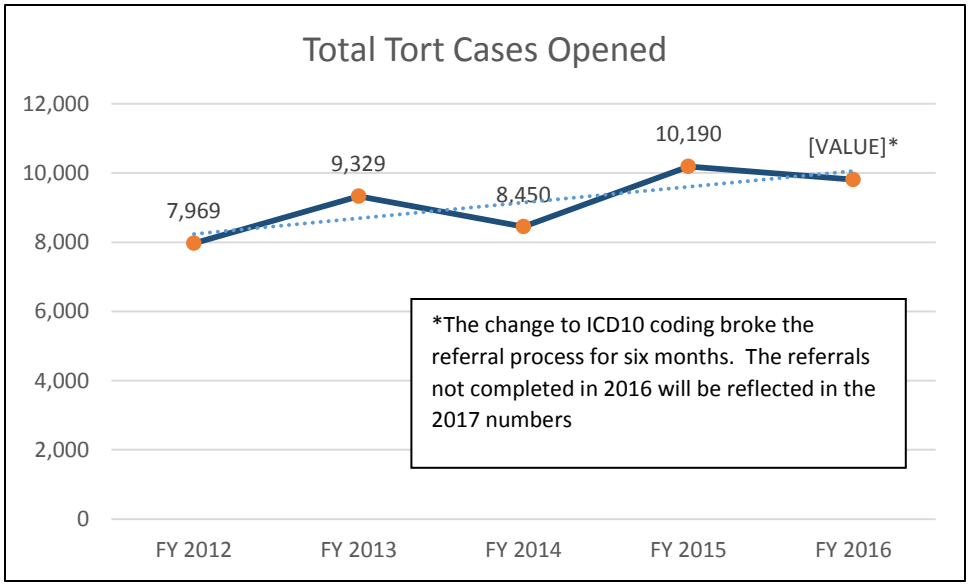
BMC's workload for this program is not affected by the implementation of ACOs. BMC performs tort collections statewide, including related to Medicaid members enrolled in ACOs.

Workload:

The tort program has not received a lot of attention historically due to the primary focus being placed on health claims. With four employees devoted to this program, staff manage to open all new referrals each month, investigate the each Medicaid expenditure to determine if it was related to an accident, and send initial letters seeking information about the accident and requesting medical records. The staff must analyze all responses, review medical records they receive, and file liens to secure the state's right to recover. The staff work with the Attorney General's Office or recipient's counsel when legal action is necessary. BMC staff are involved in extensive mediation and negotiations to determine the appropriate amount of any settlement/payment to reimburse Medicaid.

When asked for their input, staff expressed three concerns regarding their ability to thoroughly work tort cases due to current staffing levels. First, at current staffing levels, workers are not able to follow-up when individuals do not voluntarily respond to the initial inquiry letters with information about the

accident and potential third parties who may be liable for expenses. Second, once a lien is placed, BMC lacks the ability at current staffing levels to actively follow-up on liens, including updating the amount of the lien as more expenses are submitted. Finally, BMC is not receiving tort claim information from the ACOs. Since ACOs cover the majority of the state, receiving those referrals will increase the workload well beyond what the staff can handle. With more staff, more follow-up could be performed to obtain information about potential claims and update existing claims, and BMC would be in a better position to handle the tort cases anticipated to be referred by the ACOs.

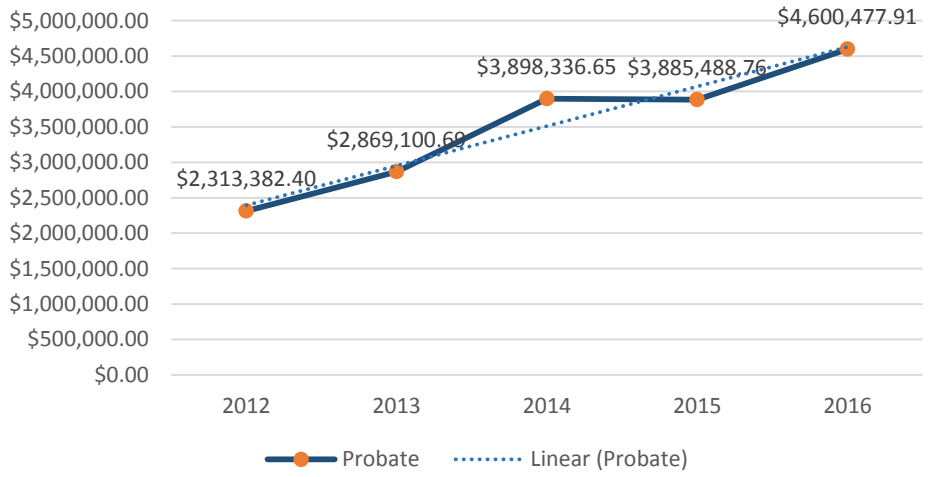


If Eliminated:

Investigation and collection on Medicaid personal injury claims is a required activity pursuant to 42 CFR 433.138.

Any reduction in staffing within the tort program will directly impair the ability of BMC to file the initial liens for all of the tort referrals currently being received and render it impossible to keep up with tort referrals anticipated to be received from the ACOs. Any reduction in staffing will also further affect BMC's already limited ability to follow-up when information is not voluntarily provided to assess the existence of liable third parties and to monitor and negotiate on liens which have already been filed by BMC. Any reduction in staff will reduce collections on behalf of Medicaid which are considered dedicated credits in the Medicaid budget. Finally, if BMC is no longer able to perform this function on behalf of Medicaid, state law will need to be amended (U.C.A. 26-19-3.5.). This section specifically directs Medicaid recipients and their legal counsel to work with ORS on tort referrals and collections.

Estate Recovery (Probate)



FTEs

1.8

2 employees spend 90% of their time on this function

Statutes

42 USC 1396p; 42 CFR 433.36; UCA 26-19-13.5

ACO Impact

No

Program Description:

Cases are referred for estate recovery (probate) whenever a Medicaid eligible individual over the age of 55 passes away and Medicaid has paid for any expenses since they turned 55. BMC staff investigate the existence of any estates, trusts, or other assets of the decedent and file liens against the estate to recover the expenses paid by Medicaid.

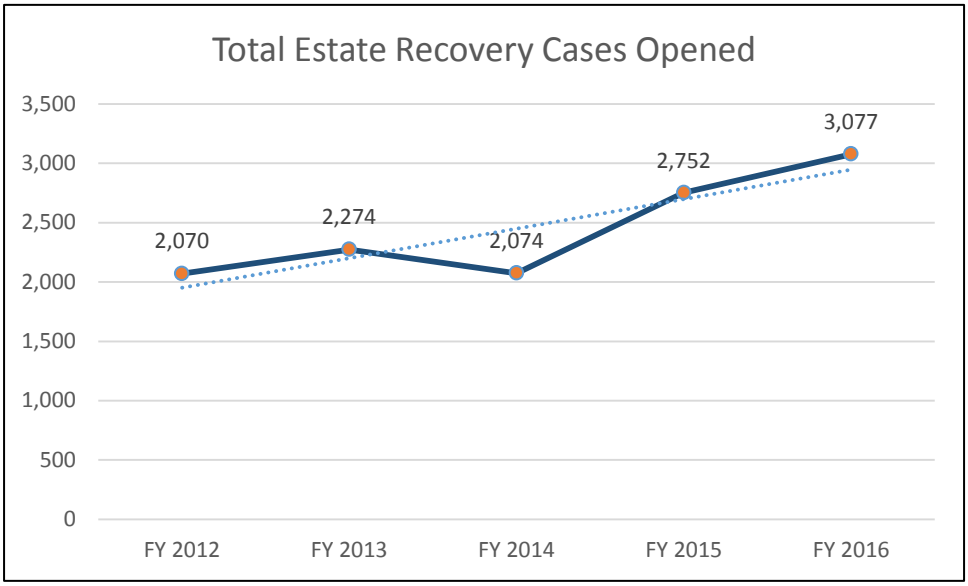
ACO Effect:

BMC's workload for this program is not affected by ACOs. BMC is responsible for all estate recovery collections statewide, even for those Medicaid members enrolled in ACOs.

Workload:

For estate recovery staff, workload is best measured by the number of referrals opened.

With less than 2 FTEs dedicated to the estate recovery function (a second worker was added for the first time in 2013), the staff are managing each month to keep up with the initial tasks required for new referrals (such as



investigating assets, locating relatives and filing the initial liens), but follow-up work is limited to those cases where someone responds to the lien. There is not enough staff to perform any follow-up on other filed liens where no one contacts BMC.

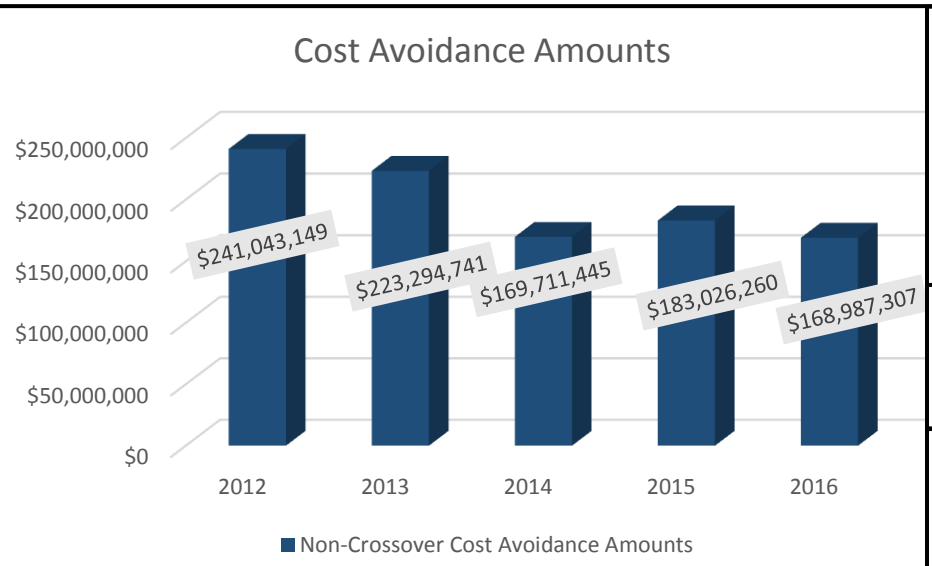
Because many liens cannot be settled immediately due to claims of heirs with rights to the assets or property, many liens filed now will not result in money being collected until several years from now. When staff were interviewed for this response, they stated that the inability at current staffing levels to follow-up on liens is the primary problem that prevents additional collections in this program. Without follow-up, liens are often ignored and property is disbursed inappropriately. Without follow-up, BMC is unable to ensure that the relatives with claim to the property remain living. If more staff were available, more follow-up could be done on the liens that have been filed.

If Eliminated:

Recovery of the expenses paid by Medicaid which are pursued by the estate recovery program is a required function of a state Medicaid program. 42 USC 1396p(b)(1) directs that "the State shall seek adjustment or recovery of any medical assistance correctly paid…" "(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance…".

Any reduction in staffing within the estate recovery program will directly impair the ability of BMC to file the initial liens for all of the estate recovery referrals which are received each month and will further affect BMC's already limited ability to follow-up on liens which have been filed. This will reduce collections on behalf of Medicaid which are dedicated credits in the Medicaid budget.

Third Party Liability Verification



FTEs

8.25

17 employees spend up to 50% of work time on this function

Statutes

42 CFR 433.138
UCA Chapter 26 Title 19

ACO Impact

No

Program Description:

Staff receive private insurance policy leads from the Bureau of Child Support Services within ORS, from Department of Workforce Services eligibility workers, and from electronic matches with a number of Utah-based insurance companies. When information is received regarding possible insurance coverage for a Medicaid member, staff contact the insurance companies to verify coverage and gather information needed to file future claims. The data gathered is stored in the Office of Recovery Services Information System (ORSIS). This information is then reported to the Department of Health and is used when processing Medicaid claims. The data is also matched with Medicaid expenditures within the past three years. If insurance was in place for a claim previously paid by Medicaid, the claim is referred back to BMC for health claim collections discussed above. This information is also reported to all Medicaid managed care plans (ACOs, Prepaid Mental Health Plans (PMHP), and Dental Plans) to assure the plans can also properly adjudicate their claims. Finally this information is reported on the Provider Eligibility Look Up Tool so providers have information to bill third party insurance before billing Medicaid.

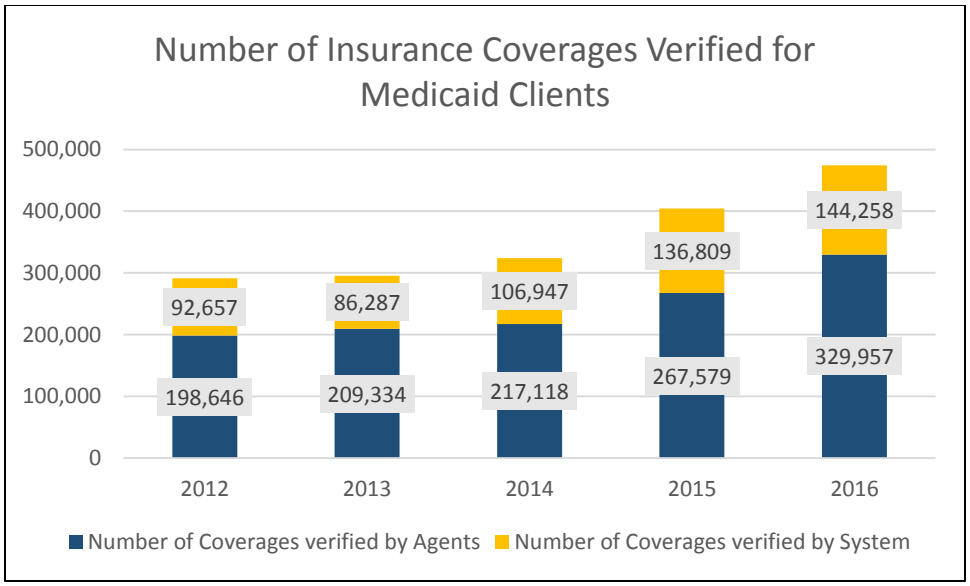
Coverage information provided by BMC is also used by the Department of Workforce Services to determine eligibility for CHIP and PCN.

ACO Impact:

BMC's workload for this function is not impacted by ACOs.

Workload:

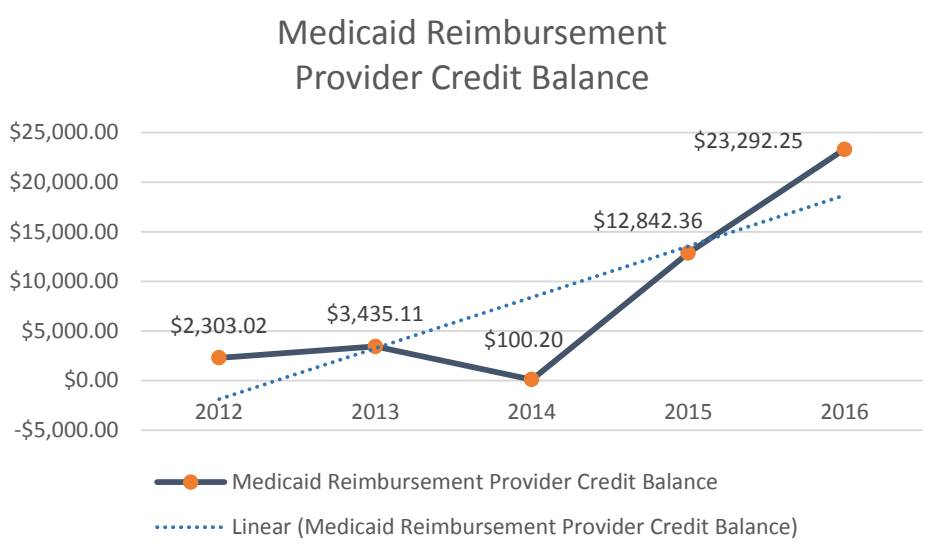
Workload for third party liability verification program is best measured in the number of individual insurance coverages BMC verifies and provides to Department of Health for Medicaid cost-avoidance purposes.



If eliminated:

Verifying third parties which are liable for claims paid by Medicaid is a mandatory function of a state Medicaid program. Pursuant to 42 CFR 433.138 (a), "The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan." The section goes on to describe required efforts to obtain insurance coverage information from clients, employers, or other sources. Any reduction to the workforce in this function will reduce the number of policies/individual coverages which BMC is able to verify. BMC is attempting to increase the ability to match electronically with insurance companies through the use of the All Payer Claims Database (APCD). However, a recent decision by the Supreme Court related to All Payer Claims Databases may reduce the number of ERISA insurance plans that are willing to report enrollment information to the APCD. There are also concerns that these same plans may no longer be willing to voluntarily conduct data matches with BMC on behalf of Medicaid.

Medicaid Reimbursement Provider Credit Balances



FTEs

.2

2 employees spend about 10% of work time on this function

Statutes

42 CFR 433.318

ACO Impact

No

Program Description:

This program attempts to collect from health care providers who were overpaid by Medicaid, but who have not submitted any claims to Medicaid for 12 months. The Department of Health performs the initial collections by offsetting future claims (see Medicaid Reimbursement Provider Overpayment totals in the "Overview" section). However, after one year, DOH refers the uncollected amounts to BMC for final attempts to collect or to settle the debt.

ACO Impact:

These are fee for service overpayments. Implementation of ACOs does not have an impact on this function.

Workload:

This is a program where BMC has not been able to invest much staff time to this program due to other priorities and higher potentials for successful collection in other programs.

If eliminated:

42 CFR 433.318 outlines the efforts that must be taken by a state Medicaid program to determine that money overpaid to a provider who is now out of business or bankrupt does not need to be included when refunding the Federal share. This program does not generally carry a high potential for collection, but certain efforts must be made to demonstrate that the amounts are not collectible. BMC and DOH are aware of the need to weigh efforts expended against any potential gain.

Potential ORS Budget Reductions Based on Workload

The final request stated in the Legislative intent language is for an estimate of how the ORS/BMC budget might be reduced to match actual collections to date and future projections. The following must be considered:

Health claims collections is the only BMC program on behalf of Medicaid that has been impacted by the ACOs. The idea of reducing the BMC budget is based on an assumption that the existence of the ACOs will reduce BMC collections overall. ORS agrees that the existence of the ACOs is likely to reduce BMC collections, but only in the health claim program. No other Medical collection programs are impacted by the ACOs. **ORS proposes that the budget for health claim employees is the only portion of the BMC budget that can be considered for reduction.**

Workload and staffing needs must be based on referrals, not collections. ORS disagrees with the suggestion that collection totals are the appropriate measurement of workload and required FTEs. As demonstrated in each of the program sections above, many referrals are sent for each program; if a referral is received, it must be worked, regardless of the amount of the potential collection. Although this response presents separate FTEs for the health claim program (7.25 FTEs) and the third party liability verification program (8.25 FTEs), the reality is that 15.5 FTEs split their time between these two programs. As a result, any discussion about a reduction to the budget should be based on referrals for both health claim and third party liability, accounting for potential upward and downward fluctuations in the referrals for each program. **ORS proposes that for each 15% net decrease in health claim and third party liability manual referrals worked, one FTE can be reduced from these programs.**

Workload estimates should be weighted for manual vs. electronic work. Any proposal for reduced staff must also consider the difference between manual work and electronic work. Manual work to verify insurance coverage and file insurance claims requires significantly more staff time. **ORS's proposal calculation is based on the manual portion of the workload, since that is the most time consuming.**

Potential Staff Reductions need to be based on multi-year trends. BMC workloads fluctuate from year to year. In 2014, there were fewer health claims and fewer third party liability insurance referrals than would have been expected based on the trends; however, the numbers the following years returned to normal levels. **ORS proposes that three-year averages be used to more accurately reflect trends.**

As long as any health claim and third party liability duties remain with BMC, sufficient staff must remain in those programs. Even though the electronic/automated processing takes less time initially, even electronically filed claims require manual efforts to review unpaid claims and manual adjustments when the payments are received. At this time, our estimates are that even if everything were electronic, BMC requires 10 FTEs to perform the required follow-up and adjustment activities based on payment results; therefore, **ORS's proposal initially limits potential cuts to 5 FTEs.**

Other BMC programs are understaffed and could benefit from additional FTEs. Finally, as discussed in the specific program sections above, the tort and estate recovery programs are both receiving an increasing number of referrals each year, but are currently understaffed to be able to adequately follow up on cases beyond the initial referral activity. **ORS requests that, in lieu of a budget decrease, any FTEs that could potentially be reduced from health claim and third party liability programs by this proposal be reassigned to the tort and estate recovery programs.**

Description of Calculation for Proposal

The following is a narrative description of the proposed calculation of workload and staffing needs. The following pages contain a Microsoft Excel examples showing the last five years of data, the baseline, and hypothetical 2017 results.

Calculate: Percentage Change in Health Claim Manual Workload

	Average Three Most Recent Years Manual Claims Filed
Less:	Baseline: 2014 - 2016 Average Manual Claims Filed
Divided by:	Baseline: 2014 - 2016 Average Manual Claims Filed
Yield:	Percentage Change in Health Claim Manual Workload

Calculate: Percentage Change in Manual Verification of Coverage Workload

	Average Three Most Recent Years Manual Verification of Coverage
Less:	Baseline: 2014-2016 Average Manual Verification of Coverage
Divided by:	Baseline: 2014-2016 Average Manual Verification of Coverage
Yield:	Percentage Change in Manual Verification of Coverage Workload

Calculate: Net Change in Workload from Baselines

	Percentage Change in Health Claim Manual Workload
Add:	Percentage Change in Manual Verification of Coverage Workload
Yield:	Net Change in Workload from Baselines

Calculate: Total Number of FTEs to be Reduced from Health Claim and TPL Verification

	Net Change in Workload from Baselines
Divided by:	15%
Yield:	Total Number of FTEs (whole number) to be reduced from Baseline Staffing Levels in Health Claim and TPL Verification (up to 5)

Calculate: Number of FTEs to Reduce from Health Claim and TPL Verification in Next Fiscal Year

	Total Number of FTEs (whole number) to be reduced from Baseline Staffing Levels in Health Claim and TPL Verification (up to 5)
Less:	Number of FTEs Already Reduced from Baseline, Prior Years
Yield:	Number of FTEs to Reduce from Health Claim and Verification in Next Fiscal Year

Calculate: Potential General Fund Reduction if FTEs not Reassigned to Tort or Estate Recovery

	Number of FTEs to Reduce from Health Claim and Verification in Next Fiscal Year
Multiply by:	Cost per FTE (Wages and Benefits only)
Multiply by:	50% Federal Match
Yield:	Potential Budget Reduction, General Fund Portion Only.

Examples of Calculations for Proposal

Example 1

	2012	2013	2014	2015	2016	2017
Health Claim						
Total Medical Claims Filed	23,457	23,601	22,705	23,065	24,691	10,000
% Medical Filed Manually	100%	100%	100%	100%	100%	80%
Total Medical Claims Filed Manually	23,457	23,601	22,705	23,065	24,691	8,000
Total Pharmacy Claims Filed	36,428	33,039	28,891	31,114	27,400	10,000
% Pharmacy Filed Manually	40%	40%	40%	40%	40%	40%
Total Pharmacy Claims Filed Manually	14,571	13,216	11,556	12,446	10,960	4,000
Total Follow-up Claims filed Manually	19,725	18,138	14,225	13,590	12,670	10,000
Total Manual Claims Filed	57,753	54,955	48,486	49,101	48,321	22,000
Most Recent Three-Year Average (2016= Baseline)					48,636	39,807
% Change in Workload from Baseline					0.00%	-18.15%
Third Party Liability Verification						
Number of Coverages Manually Verified	198,646	209,334	217,118	267,579	329,957	225,000
Most Recent Three-Year Average (2016 = Baseline)					271,551	274,179
% Change in Workload from Baseline					0.00%	0.97%
Net Change in Workload from Baselines						-17.19%
FTE Adjustment						
Number of FTEs to Reduce from Health Claim and TPL Compared to Baseline (Up to 5, 1 FTE per 15% net decrease)						1
FTEs Reduced in Prior Years						0
Number of FTEs to Reduce in Next Fiscal Year						1
Potential Budget Reduction						
Cost per FTE						$66,000
Potential Budget Reduction (General Fund Reduction Only)						$33,000

This **hypothetical** example demonstrates how this proposal would work **if** there were dramatic decreases in both health claim manual claims filed and in third party liability verifications. Using a three-year average compared to the baseline, the net changes are -15.81%, which means one worker can be reduced from the health claim/third party liability FTE group.

Example 2

	2012	2013	2014	2015	2016	2017
Health Claim						
Total Medical Claims Filed	23,457	23,601	22,705	23,065	24,691	15,000
% Medical Filed Manually	100%	100%	100%	100%	100%	100%
Total Medical Claims Filed Manually	23,457	23,601	22,705	23,065	24,691	15,000
Total Pharmacy Claims Filed	36,428	33,039	28,891	31,114	27,400	10,000
% Pharmacy Filed Manually	40%	40%	40%	40%	40%	40%
Total Pharmacy Claims Filed Manually	14,571	13,216	11,556	12,446	10,960	4,000
Total Follow-up Claims filed Manually	19,725	18,138	14,225	13,590	12,670	10,000
Total Manual Claims Filed	57,753	54,955	48,486	49,101	48,321	29,000
Most Recent Three-Year Average (2016= Baseline)					48,636	42,141
% Change in Workload from Baseline					0.00%	-13.36%
Third Party Liability Verification						
Number of Coverages Manually Verified	198,646	209,334	217,118	267,579	329,957	330,000
Most Recent Three-Year Average (2016 = Baseline)					271,551	309,179
% Change in Workload from Baseline					0.00%	13.86%
Net Change in Workload from Baselines						0.50%
FTE Adjustment						
Number of FTEs to Reduce from Health Claim and TPL Compared to Baseline (Up to 5, 1 FTE per 15% net decrease)						0
FTEs Reduced in Prior Years						0
Number of FTEs to Reduce in Next Fiscal Year						0
Potential Budget Reduction						
Cost per FTE						$66,000
Potential Budget Reduction (General Fund Reduction Only)						$0

This **hypothetical** example demonstrates how this proposal would work **if** either health claims or third party liability experienced a dramatic decrease in workload, but the other program experienced an increase in workload. Shown here, a 13.36 decrease in manual health claims filed from the baseline is offset by a 13.86 increase in coverages manually verified, leaving a net change in workload of .50%. No employees would be reduced from the health claim/third party liability workgroup.

Conclusion

The Bureau of Medical Collections (BMC) works a variety of cost-recovery and cost-avoidance programs on behalf of the Department of Health. With a relatively small budget ($2.5 million in general fund matched by equivalent federal funds), BMC has a long history of excellent return on investment for money recovered or cost-avoided versus the money invested in the program.

While the implementation of Accountable Care Organizations in Utah covers the majority of the Medicaid population, the only program at BMC which is potentially impacted by the ACOs is health claims. The health claim program has not yet experienced a decrease in referrals (workload) in proportion to the state's population covered by ACOs, even though the collection totals for this program are beginning to decrease.

ORS has carefully examined the workload in all of its programs in response to this legislative intent language. As requested, we have presented a proposal for gradually reducing the employees in the health claim and third party liability verification programs based on actual and lasting shifts in the workloads for these combined programs rather than based on collection totals. Any potential budget cuts would be limited to personnel costs for reduced FTEs since the technology must remain intact.

ORS has also demonstrated that the workloads in the tort and estate recovery programs are increasing each year, but neither program has received additional staffing to handle the increases. Examination of the workflow in these programs indicates that additional staff would be beneficial for handling increasing caseloads and allowing timelier and more accurate follow-up after the initial work required to open a referral.

ORS requests that, rather than implementing budget cuts for any FTEs potentially reduced from the health claim and third party liability workgroups under this proposal, we be allowed to reassign those workers to the tort and estate recovery programs.