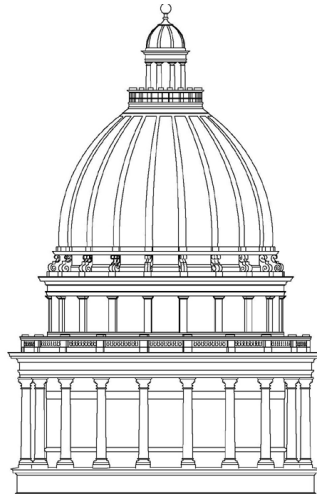


REPORT TO THE
UTAH LEGISLATURE

Number 2009-12



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

August 2009

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah



STATE OF UTAH

Office of the Legislative Auditor General

315 HOUSE BUILDING • PO BOX 145315 • SALT LAKE CITY, UT 84114-5315
(801) 538-1033 • FAX (801) 538-1063

Audit Subcommittee of the Legislative Management Committee

President Michael G. Waddoups, Co-Chair • Speaker David Clark, Co-Chair
Senator Patricia W. Jones • Representative David Litvack

JOHN M. SCHAFF, CIA
AUDITOR GENERAL

August 18, 2009

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program** (Report #2009-12). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

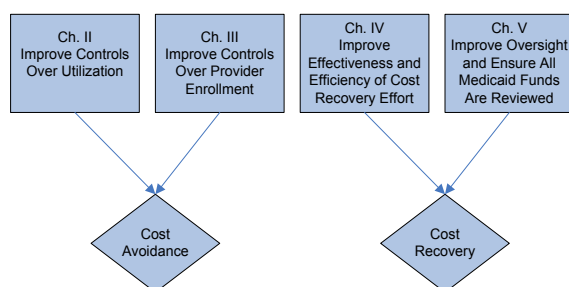
Sincerely,

John M. Schaff, CIA
Auditor General

JMS/km

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

The Division of Health Care Financing (HCF or Medicaid program), located within the Department of Health (DOH), administers the Medicaid program for the State of Utah. This report focuses on the Bureau of Program Integrity (BPI or program integrity) located within HCF. We believe there is significant room for improvement in BPI's operations, which over time can result in savings of over \$20 million in federal and state dollars for the state Medicaid program. Savings through an improved program integrity effort is achieved through (1) cost avoidance and (2) cost recovery. The following figure illustrates a cost savings model for Utah's Medicaid program integrity function. Steps in the model relate to individual chapters in the report, with the exception of Chapter VI's identification of the need for greater independence of some DOH oversight functions, particularly in the cost recovery area.



Placing a definitive dollar amount of potential savings is difficult, but this audit outlines two areas of potential cost savings:

- **Prior Authorization (Cost Avoidance):** Figure 2.8, on report page 27, shows that just for physician services alone, a 1 percent change in the approval rate for the prior authorization process (approval of certain medical procedures before they are provided) can save about \$700,000 (\$210,000 in state dollars). If all ancillary costs are included, and the approval rate decreases by more than 1 percent, potential savings significantly increases.
- **Improved Recovery Effort (Cost Recovery):** Figure 4.1, on report page 44, illustrates that by increasing fraud, waste, and abuse recovery efforts to 3 percent, \$20.2 million (\$5.8 million in state dollars) can be saved over time. We believe 3 percent is a realistic target. The extent to which BPI can achieve this savings depends on several areas discussed in this report that require greater efficiency and improved management control.

Insufficient Management Control Has Led to Unnecessary Medical Costs

Chapter II: Prior Authorization Is Not Adequately Controlling

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

Controlling Provider Enrollment Helps Control Fraud and Waste

Chapter III: More Controls Needed with Provider Enrollment.

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

Improvements in Recovery Efforts Can Help Save Medicaid Dollars

Chapter IV: Inefficiency and Ineffectiveness Is Hampering Cost

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

BPI Should Increase Utilization Reviews

Chapter V: Majority of Medicaid Dollars Receiving No Oversight by

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

Independence of Oversight Functions Is Not Sufficient

Chapter VI: Greater Independence Needed for DOH Oversight

Functions. Three Medicaid oversight functions within the Department of Health (DOH) have not been well utilized and are not adequately independent. This lack of program independence prevents BPI, DOH internal auditors, and Medicaid auditors from satisfactorily conducting effective oversight of the Medicaid program. We recommend that these oversight bureaus be given greater independence by reporting either to the agency head of DOH or an independent board.

REPORT TO THE UTAH LEGISLATURE

Report No. 2009-12

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

August 2009

Audit Performed By:

Audit Manager	Tim Osterstock
Audit Supervisor	Kade Minchey
Audit Staff	Benjamin Buys Broc Christensen David Pulsipher

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Chapter I

Introduction

The Division of Health Care Financing (HCF or Medicaid program), located within the Department of Health (DOH), administers the Medicaid program for the State of Utah. For fiscal year 2010, the Medicaid program is budgeted at about \$1.7 billion in federal and state funds—about \$1.6 billion for programs and about \$120 million for administrative costs.

This report focuses on the Bureau of Program Integrity (BPI or program integrity) located within HCF. BPI is responsible for protecting valuable Medicaid dollars from fraud, waste, and abuse through both cost avoidance and cost recovery mechanisms. Some other organizations may also recover Medicaid dollars, but these efforts have not been coordinated, and BPI is largely unaware of their efforts. We believe there is significant room for improvement in BPI's operations, which can result in significant savings over time for the Medicaid program. Placing a definitive dollar amount on potential savings is difficult, but this audit outlines two areas of potential cost savings:

- **Prior Authorization (Cost Avoidance):** Figure 2.8, on report page 27, shows that just for physician services alone, a 1 percent change in the approval rate for the prior authorization process (approval of certain medical procedures before they are provided) can save about \$700,000 (\$210,000 in state dollars). If all ancillary costs are included, and the approval rate decreases by more than 1 percent, potential savings exponentially increases.
- **Improved Recovery Effort (Cost Recovery):** Figure 4.1, on report page 44, illustrates that by increasing fraud, waste, and abuse recovery efforts to 3 percent, \$20.2 million (\$5.8 million in state funds) can be saved over time. We believe 3 percent is a realistic target. The extent to which BPI can achieve this savings depends on several areas discussed in this report that require greater efficiency and improved management control.

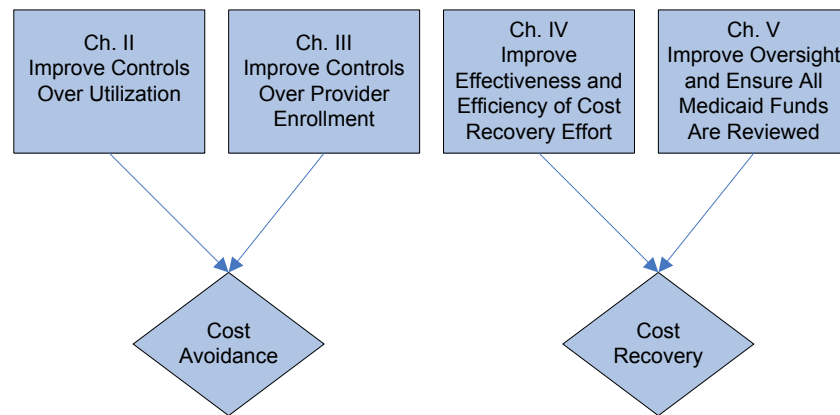
The Bureau of Program Integrity (BPI) is responsible for protecting Medicaid dollars from fraud, waste, and abuse.

BPI can significantly improve its operations and consequently save substantial Medicaid funds.

Cost savings through an increased fraud, waste, and abuse effort is achieved through (1) cost avoidance and (2) cost recovery. The following figure illustrates the cost savings model for Utah's Medicaid program integrity function. Steps in the model relate to individual chapters in the report, with the exception of Chapter VI's identification of the need for greater independence of some DOH oversight functions, particularly in the cost recovery area.

Figure 1.1 Cost Savings Model. Fraud, waste, and abuse cost savings can be realized through cost avoidance (Chapters II and III) and cost recovery (Chapters IV and V). Independence (Ch. VI) is also a key component in doing these activities effectively that is needed particularly with cost recovery.

The cost savings model described in this report entails cost avoidance (Chapters II and III) and cost recovery (Chapters IV and V). Chapter VI discusses several oversight functions that need greater independence.



Cost avoidance deals with ways the Medicaid program can prevent paying out improper payments. Cost recovery focuses on the recovery of improper payments after they have been paid out. A brief synopsis of each of the chapters follows.

- **Chapter II: Prior Authorization Is Not Adequately Controlling Utilization.** Medicaid's prior authorization policies are unclear and neglected by prior authorization nurses, which has led to unnecessary medical costs and has delivered inconsistent care to Medicaid recipients.
- **Chapter III: More Controls Needed with Provider Eligibility.** The provider enrollment process allows billings from a small percentage of providers that should have been excluded from the program. Excluding these providers can bolster cost avoidance efforts.

- **Chapter IV: Inefficiency and Ineffectiveness Are Hampering Cost Recovery Efforts.** Inefficiencies, data concerns, and ineffective utilization of staff resources have limited BPI's ability to recover inappropriate payments. Thus, greatly reducing potential recoveries.
- **Chapter V: Majority of Medicaid Dollars Receiving No Oversight by BPI.** BPI is only systematically reviewing 5 percent of Medicaid dollars for fraud, waste, and abuse, thus greatly reducing potential recoveries.
- **Chapter VI: Greater Independence Needed for DOH Oversight Functions.** Lack of program independence prevents BPI, DOH internal auditors, and Medicaid auditors from satisfactorily conducting effective oversight of the Medicaid program.

This audit of BPI is a high-level review of BPI's business and management practices. Audit work seldom directly reviewed specific claim-level detail; however, based on limited work in claim detail, we believe risk is present in some areas of claim payments. The remainder of this chapter provides some background on the Medicaid program, the BPI function, and the scope and objectives of the audit.

Medicaid Program Primarily Serves Low-Income and Disabled Individuals

Medicaid was established in 1965 as a joint federal-state entitlement program to provide medical services for individuals and families with limited assets and income. In March 2009, recipients qualifying for Utah's Medicaid program climbed to the highest point in history, reaching 184,341. For fiscal year 2010, about \$1.7 billion in federal and state funds (\$520 million in state funds) is budgeted for the Medicaid program. The Medicaid program is a federal/state partnership. States have some discretion and autonomy in administering the Medicaid program and developing policies and rules for the program; consequently, no two states' Medicaid programs are alike.

This audit reviews BPI's business and management practices. Claim-level audit work was limited.

Medicaid is a federal-state partnership that provides medical services for individuals and families with limited assets and income.

Traditional Medicaid provides services for low-income children, and disabled or blind adults. Non-traditional Medicaid includes more adults, but has higher co-payments and fewer benefits.

Medicaid Serves Low-Income and Disabled

Medicaid provides medical services for individuals and families with limited assets who also do not exceed an income standard. The federal government pays the majority of Medicaid costs. In Utah, for fiscal year 2009, the Federal Medical Assistance Percentage (FMAP) was 70.71 percent of program cost, and the state's portion was 29.29 percent. However, due to the federal stimulus plan recently passed, federal participation has increased to 77.83 percent and will continue at that level until the end of calendar year 2010. Administrative costs to run the program are split 50 percent state to 50 percent federal.

Income standards are determined by family size and the specific Medicaid program, and range between approximately 42 percent and 135 percent of the Federal Poverty Level. States have the options to include more eligibility groups than those mandated federally. Utah does allow a spend-down for individuals whose income is above this standard. Spend-down allows those whose income is greater than the income limit to pay excess income to the state or pay part of their medical bills. Groups of low-income individuals who can qualify for Utah's Medicaid include the following:

- Aged (persons 65 and older)
- Blind or disabled
- A parent or caretaker relative caring for a dependent child
- A child under age 19
- A pregnant woman
- A woman with breast or cervical cancer
- A person with tuberculosis
- Certain eligible refugees

The two most common types of Medicaid are traditional and non-traditional (family). Traditional Medicaid provides services for children and individuals with low income who are also disabled, blind, or over the age of 65. On July 1, 2002, Utah started a non-traditional Medicaid program for other low-income adults with dependent children. This program has higher co-payments and fewer benefits than traditional Medicaid.

Medicaid Budget Is 18 Percent of State Budget

For fiscal year 2010, the Medicaid budget represented 18 percent of the state's budget and 90 percent of the DOH's budget. Since 2003, Medicaid expenditures have been over \$1 billion. The authorized budget for fiscal year 2010 places Medicaid expenditures at about \$1.6 billion for program costs and \$119 million for administration.

Figure 1.2 Medicaid Expenditures—A 6-Year History. Total Medicaid expenditures increased about 12 percent from FY 2006 to projected FY 2009.

	FY 06	FY 07	FY 08	FY 09 ²	FY 10 ²
¹ Program Expenditures	\$1,518	\$1,486	\$1,624	\$1,666	\$1,603
Admin Expenditures	75,905,085	107,492,661	117,295,387	121,831,901	118,516,700
¹ Total Expenditures	\$1,594	\$1,594	\$1,741	\$1,788	\$1,722

Source: Legislative Fiscal Analyst (LFA)

1. in millions of dollars

2. projected spending

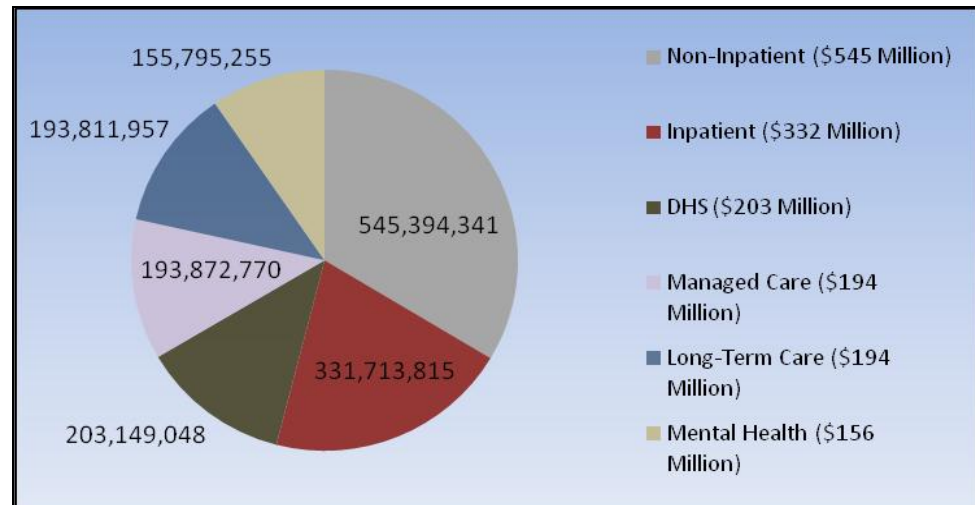
Note: Numbers may not represent all federal disallowances. See LFA [Issue Brief](#), February 2009 for a list of disallowances.

Medicaid expenditures are broken out into several different areas, as shown in Figure 1.3. Inpatient care and non-inpatient care (which includes pharmacy claims, outpatient claims, dentist claims, etc.) account for just over 50 percent of claims. Health Maintenance Organizations or (HMOs) refer to Medicaid-managed care companies that are run by organizations outside of the DOH, such as Molina Healthcare and University of Utah Health Plans (Healthy U).

The Medicaid program, or the Division of Health Care Financing (HCF), accounted for 18 percent of the state's budget and 90 percent of the Department of Health's (DOH) budget in FY 2009.

Total Medicaid expenditures are projected to be about \$1.7 billion for FY 2010.

Figure 1.3 Breakdown of Medicaid Expenditures FY 2008. Inpatient and non-inpatient (outpatient, pharmacy, dental, etc.) combined to account for more than half of the \$1.6 billion in Medicaid program expenditures (not including about \$100 million in administrative dollars).



Medicaid Program Is a Federal and State Partnership

Unlike Medicare, which is solely a federally funded and administered program, Medicaid is administered by the states. The federal government participates in the Medicaid program by partially funding the program and through oversight by the Centers for Medicare & Medicaid Services (CMS).

Since states have some discretion and autonomy in administering the Medicaid program and developing policies and rules for the program, no two states' Medicaid programs are alike. However, there are certain federally mandated standards common to all states' Medicaid programs. For example, in order to receive federal matching funds, each state must provide a certain core set of services and cover specific groups of individuals.

Beyond these requirements, states have flexibility in covering other services and eligibility groups. Even for required services, states have some discretion in setting limits on the amount of any given service available to its beneficiaries. States also have a certain amount of freedom in setting reimbursement rates paid to most of the providers of Medicaid-covered services.

States have some discretion and autonomy in administering the Medicaid program. This creates uniqueness in each state's program.

Even though Medicaid programs are different, there are some commonalities among programs where comparisons can be made.

Improved Cost Avoidance and Cost Recovery Efforts Can Save Medicaid Dollars

This report discusses the prevention, detection, and collection of fraud, waste, and abuse in the Medicaid provider community. Medicaid recipient fraud, waste, and abuse is a function handled at the Department of Workforce services (DWS) and is not discussed in this report.

Provider Fraud, Waste, and Abuse Occurs in Several Ways

Fraud, waste, and abuse can be perpetrated in several different ways. Overt fraudulent activity is typically less likely than abusive or wasteful billing. The following figure provides definitions of fraud, waste and abuse.

Figure 1.4 Definitions of Fraud and Abuse. The *Utah Administrative Rules* and the GAO provide definitions for fraud and abuse.

Utah Administrative Code R-414-22-2

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in reimbursement for services that are either not medically necessary or that fail to meet professionally recognized standards for health care.

Fraud means intentional deception or misrepresentation made by a person that results in some unauthorized Medicaid benefit to himself or some other person. It includes any act that constitutes fraud under applicable state law.

Government Accountability Office

Waste involves a transgression that is less than fraud and abuse. Further, most waste does not involve a violation of law, but rather relates primarily to mismanagement, inappropriate actions, or inadequate oversight.

The following are examples of Medicaid and general health insurance fraud, waste, and abuse as explained by the National Health Care Anti-Fraud Association (NHCAA):

- Billing for services never rendered, either by using genuine patient information, sometimes obtained through identity theft, to fabricate claims or by padding claims with charges for procedures or services that did not take place.

This report focuses on fraud, waste, and abuse in the provider community. The report does not detail recipient fraud and abuse, which is a function handled at the Department of Workforce Services (DWS).

Overt fraudulent activity is typically less likely than abusive or wasteful billings.

The National Health Care Anti-Fraud Association (NHCAA) reports that fraudulent, wasteful, and abusive payments take on several different forms.

- Billing for more expensive services or procedures than were actually provided or performed, commonly known as “upcoding”—i.e., falsely billing for a higher-priced treatment than was actually provided.
- Performing medically unnecessary services solely for the purpose of generating insurance payments.
- Misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining insurance payments. This is widely seen in cosmetic surgery schemes, in which non-covered cosmetic procedures such as “nose jobs” are billed to patients’ insurers as deviated-septum repairs.
- Falsifying a patient’s diagnosis to justify tests, surgeries, or other procedures that are not medically necessary.
- Unbundling, or billing each step of a procedure as if it were a separate procedure.
- Billing a patient more than the co-pay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed-care contract.
- Waiving patient co-pays or deductibles and overbilling the insurance carrier or benefit plan.

Structure of Fraud and Abuse Efforts in Utah

In Utah, as with most states, two agencies share responsibility for protecting the integrity of the state Medicaid program: the Medicaid agency and the Medicaid Fraud Control Unit (MFCU), located in the Attorney General’s Office. Utah’s Medicaid program has established BPI as the state’s primary watchdog for fraud, waste, and abuse in the Medicaid program. Some other organizations make Medicaid recoveries, but we found little coordination and communication between these other organizations and BPI. BPI’s role should be more central and coordinated to ensure a proper accounting of Medicaid dollars. The mission of BPI is to

(1) Monitor the reliability of providers and clients to ensure fiscal integrity and compliance with State and Federal Rules and Regulations, and (2) develop, implement and enforce measures to identify, prevent and reduce fraud, waste and abuse in the Medicaid System.

BPI is the state’s primary watchdog for fraud, waste, and abuse in the Medicaid program. Some other organizations are involved with recovering Medicaid funds, but little coordination and communication occurs between them and BPI.

Department of Workforce Services (DWS) Handles Recipient Fraud/Abuse. DWS determines Medicaid eligibility. Medicaid recipients do not receive Medicaid payments; thus, recipient abuse takes other forms, the most common involving physician or drug shopping. When this happens, the individual can be locked into a single provider by HCF or be required to repay inappropriate Medicaid expenditures. This report focuses strictly on provider fraud, waste, and abuse.

MFCU, Located Within the Attorney General's Office, Prosecutes Medicaid Fraud. MFCU is charged with some investigatory responsibilities and all prosecution of health care providers who defraud the Medicaid program. BPI sends referrals to MFCU when they detect fraud that may warrant prosecution. MFCU also reviews complaints of abuse or neglect of nursing home residents. MFCU is funded 75 percent federally and 25 percent with matching state funds.

The Medicaid Fraud Control Unit (MFCU) is located within the Attorney General's Office. BPI sends referrals to MFCU that may warrant prosecution.

Audit Scope and Objectives

We were asked to audit the Division of Health Care Financing, also known as Utah's Medicaid program, to determine if the program is operating effectively and efficiently. The scope of the audit was to review the following objectives:

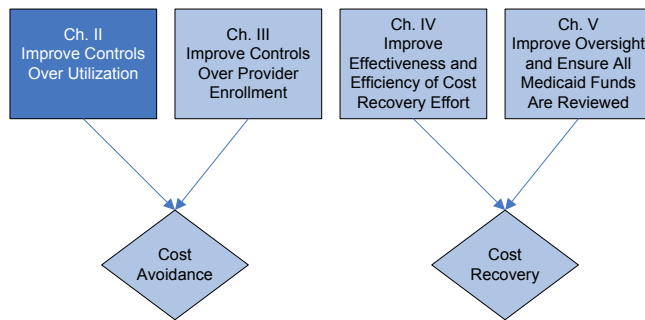
- Determine if the Medicaid program is effectively avoiding costs through the prior authorization process.
- Determine if the Medicaid program is effectively recovering inappropriate payments involving fraud, waste, and abuse.
- Determine if the oversight functions at DOH are effectively reviewing the operations within the Medicaid program.

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Chapter II

Prior Authorization Is Not Adequately Controlling Utilization

Approval of certain Medicaid expenditures before service is provided, called prior authorization, can be an effective method to prevent overutilization in Medicaid and, thereby, avoid unnecessary expenditures. However, the Bureau of Program Integrity (BPI or program integrity) located within the Division of Health Care Financing (Medicaid program or HCF), is not adequately utilizing this tool. Accordingly, the section of the cost savings model discussed in this chapter is cost avoidance through implementing a more controlled, robust prior authorization process; as the darker shaded box below denotes.



To improve cost avoidance savings through the prior authorization process the following concerns should be corrected.

- **Unclear/non-existent policies.** Prior authorization nurses unilaterally approved 106 requests for non-covered services due in part to insufficient policy.
- **Neglect of policies.** We found prior authorization nurses ignored HCF policy and inappropriately approved 127 sleep studies in calendar year 2008.
- **Poor management control.** Prior authorization nurses have not consistently followed statute, administrative rule, division policy, and established criteria.

These three concerns have resulted in HCF underutilizing prior authorization as a cost control, which has led to the expenditure of unnecessary costs. Due to data and time limitations, we were not able to specifically quantify the level of unnecessary costs, but we believe it

Prior authorization, or approving a medical expenditure before service is rendered, can be an effective utilization and cost control method. However, HCF is not adequately utilizing this tool.

To improve the prior authorization process, HCF management should clarify some policies, enforce other policies, and ensure consistent application of statutes, administrative rules, and policies.

is likely to total in the millions. Further, our review was limited to a few medical procedures requiring prior authorization. There are other areas that we suspect to be problematic that we were not able to review. Accordingly, the scope of the problem is likely understated in this review.

Unclear/Non-Existent Policies Have Led to Unnecessary Medical Costs

HCF has not clearly established criteria and policies for some medical procedures. This has led to prior authorization requests being inconsistently approved and to the deterrence of cost control.

The Medicaid program has not clearly established criteria and policies for some medical procedures that require prior authorization. Additionally, the Medicaid program does not have clear policies dictating when a prior authorization request can be approved unilaterally by a nurse or when it is required to be reviewed by a utilization review committee.

The lack of clear, consistent criteria and policy has led to prior authorization requests being inconsistently approved and to the deterrence of cost control. Specifically, a review of surgeries and sleep studies showed that prior authorization nurses approved 106 non-covered procedures in calendar year 2008 without obtaining appropriate authorization. These procedures include breast augmentation, circumcision, breast reduction, and rhinoplasty surgeries. Some of these procedures may not have fulfilled the statutory requirements for Medicaid reimbursement.

A Clear Process Has Not Been Established For the Prior Authorization Function

HCF has not developed clear prior authorization policies for some medical procedures. Where this occurs, the nurses should take the case to a utilization review committee. However, this is not always happening, which has likely led to some unnecessary medical expenses.

HCF requires prior authorization for certain medical procedure codes in an attempt to control inappropriate utilization. Some medical procedures do not have a clear policy for directing the nurses in their decisions to approve or deny prior authorization requests. In these cases, the nurses should take the case to a utilization review (UR for adults or child health evaluation and care (CHEC) for recipients under the age of 21). However, a clear policy has not been developed stipulating the use of a utilization review committee. Consequently, nurses have unilaterally approved prior authorization requests, which may have led to unnecessary medical expenses.

Upon receipt of the information from the provider, the prior authorization nurse must determine (1) if the service is covered, and (2) if the requested service meets the definition and criteria established by BPI concerning medical necessity or appropriateness. *Utah Administrative Code 414-1-2(18)(a)* states that a procedure is medically necessary if

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

If HCF does not have criteria for a specific procedure, the prior authorization nurses are instructed to use the InterQual database. InterQual is a universally used database that contains criteria for medical procedures. However, HCF does not agree with all InterQual criteria, which has led to some confusion.

If the request does not meet the criteria or does not contain sufficient information, statute requires the prior authorization nurse to deny the request. *Utah Code 26-18-2.3(1)(b)* states that the Medicaid program shall “deny any claim for provider services that fails to meet criteria established by the division concerning medical necessity or appropriateness.”

HCF generally does not reimburse non-covered procedures; however, division policy allows for exceptions in certain circumstances, including the following:

- The patient is under 21 years old.
- Reconstructive procedures following disfigurement are caused by trauma or surgery is medically necessary.
- Reconstructive procedures to correct serious functional impairments are needed.
- Performing the procedure is more cost-effective for the Medicaid program than other alternatives.

Confusion exists due to the lack of clear policy in some areas.

Ambiguous policy has led nurses to approve prior authorization requests that may not have been approved if the request would have been presented to a utilization review committee.

The utilization review committee consists of seven medical doctors, seven nurses, and one medical device specialist.

If a request is not covered by Medicaid, the prior authorization nurse may present the case before the appropriate utilization review committee. HCF policy states:

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

The wording of this policy allows prior authorization nurses to make decisions on requests for procedures that are not covered by Medicaid and do not have criteria on which the nurse can base the decision. This ambiguous policy has led nurses to approve prior authorization requests that may not have been approved if the requests would have been presented to the appropriate review committee.

The *Code of Federal Regulations* requires the formation of a utilization review committee to assist in the prior authorization process. This committee must consist of at least two physicians who are assisted by other professional personnel.

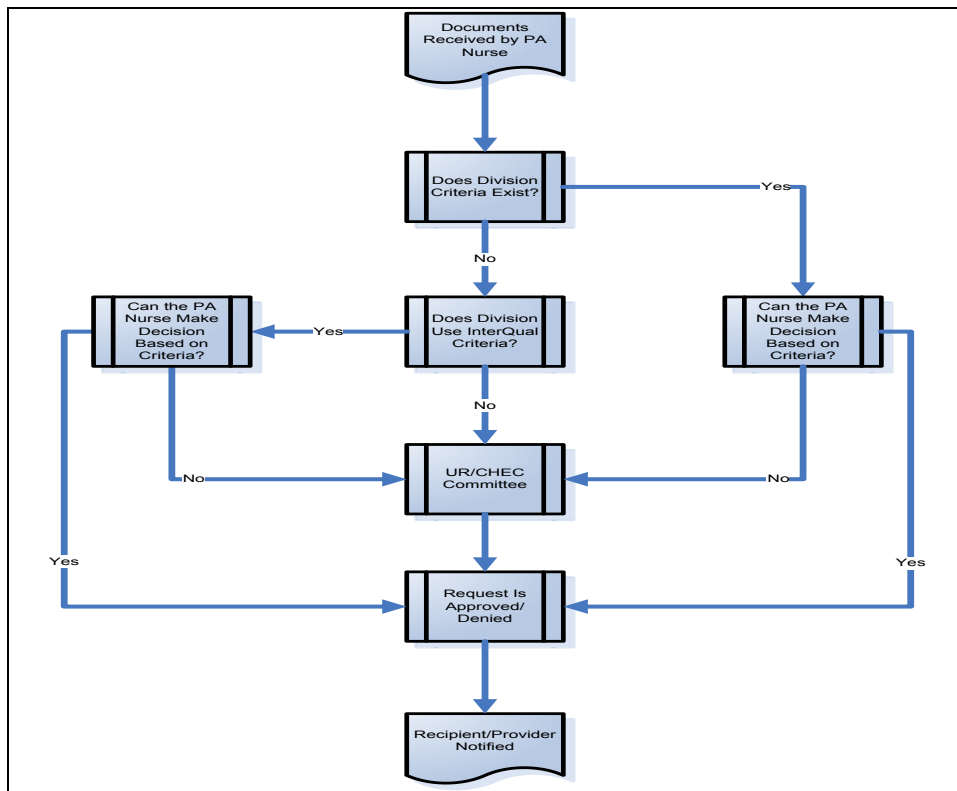
According to policy, a prior authorization nurse may take a request to the appropriate utilization review committee if the request is either (1) for a non-covered benefit, or (2) the nurse reviewer prefers to discuss the case with a professional group. The utilization review committees each meet twice per month. During calendar year 2008, the UR and CHEC committees reviewed 165 prior authorization requests. It appears the committees have the capability to review a greater number of requests.

The Utah UR committee consists of seven medical doctors (including two psychiatrists), seven nurses, and one medical device specialist. The CHEC committee includes eight medical doctors (including two psychiatrists), five nurses, one dentist, one physical therapist, and one medical device specialist. One of the nurses and the physical therapist are non-voting members of the CHEC committee.

HCF Does Not Have a Clear Policy for When a Request Should Be Taken to the Appropriate UR Committee. BPI has not developed a clear process for the prior authorization function. As such, medical procedures may have been approved, even though a

potentially more conservative and less-expensive alternative may have been available. Figure 2.1 displays how the prior authorization process should be functioning. BPI should utilize this flow chart to improve their processes.

Figure 2.1 Prior Authorization Flow Chart. This flow chart shows how prior authorization requests should be reviewed, according to statute, administrative rule, and internal policy.



The prior authorization program is not properly utilizing the process shown in the flow chart.

BPI should implement a clear process for the prior authorization process and train its nurses to follow the process. This will help nurses understand when to approve requests and when to request feedback from the appropriate utilization review committee.

Electronic Criteria Differ from Provider Manuals and Lead to Greater Confusion. The Medicaid program has made an effort to facilitate the prior authorization process by placing criteria in an electronic format. The electronic format provides a checklist that allows the prior authorization nurses to easily determine if a recipient has fulfilled the requirements to be approved for the prior authorization request.

HCF has placed some criteria in an electronic format to facilitate the prior authorization process. However, the electronic manual does not contain criteria for all procedures, and is not always consistent with HCF's provider manual.

A draft policy allows the utilization review committees to circumvent statute, when warranted by medical judgment. HCF should not create policies that contradict laws established by the Legislature.

Nurses approved procedures that appear inconsistent with established criteria and seemed based on personal judgment.

However, the electronic manual does not have criteria for either circumcision or sleep study procedures reviewed in this report. Additionally, one prior authorization nurse said that she does not use the electronic manual because it is inconsistent with the providers' manual. HCF should update its own electronic criteria to match the criteria listed in the providers' manual. Additionally, HCF should establish criteria for commonly requested procedures where HCF practice does not agree with InterQual criteria.

Contradictory Policies Also Make Prior Authorization Difficult. HCF draft policy allows the utilization review committees to circumvent statute, if medical judgment leads committee members to believe an exception must be made. While this policy is still in draft form, it appears that it is the practice of prior authorization nurses. As previously mentioned, statute states that the prior authorization nurses are required to deny any request that fails to meet medical necessity or appropriateness. The HCF draft policy, however, states:

There are certain circumstances under which medical judgment points to a possible exception to policy or criteria even though it has been previously noted that it is a violation of the law to approve service that does not meet criteria.

While certain circumstances may require exceptions, this policy allows the utilization review committees to supersede statute. This policy can lead to confusion among the prior authorization nurses. HCF should not create policies that contradict laws established by the Legislature.

Absence of Policy Has Led to Potentially Unnecessary Medical Costs

In calendar year 2008, prior authorization nurses unilaterally approved requests for 106 non-covered surgeries and 127 sleep studies for which BPI does not have established criteria. An additional 17 requests for non-covered benefits without criteria were approved by an appropriate UR committee. Some of these decisions appear to be inconsistent with established criteria and seem to be based on personal judgment. Figure 2.2 shows the prior authorization requests for non-covered procedures in calendar year 2008.

Figure 2.2 Prior Authorization Nurses Approved 106 Requests for Non-Covered Benefits Without Utilization Review Committee Approval in CY 2008. Only 31 of 165 requests for non-covered benefits that do not have criteria were reviewed by the appropriate UR committee.

	Approved	Requests	Percent Approved
Non-Covered Procedures Without Criteria	123	165	74.5
Non-Covered Procedure, No Criteria, & Presented to UR	17	31	54.8
Non-Covered Procedure, No Criteria, & Not Presented to UR	106	134	79.1

Figure 2.2 shows that 106 non-covered procedures that did not have established division criteria were approved in calendar year 2008 without the review of the appropriate utilization review committee. Only 54.8 percent of these requests that were presented to the appropriate utilization review committee were approved, compared to 79.1 percent of requests that were approved when prior authorization nurses made the decision on their own. The nurses making these decisions based only on their own judgment may have led to unnecessary medical costs.

The most frequently approved non-covered procedure that does not have established policy and criteria was circumcision. During calendar year 2008, prior authorization nurses approved 65 circumcisions without consulting with the appropriate utilization review committee. A circumcision costs the Medicaid program up to \$3,000. Figure 2.3 shows the other approved, non-covered procedures that do not have established HCF criteria and were not presented to the appropriate utilization review committee.

Non-covered procedures presented to a utilization review committee were approved 54.8 percent of the time, compared to a 79.1 percent approval rate when nurses unilaterally approved requests. It appears nurses making unilateral decisions has led to unnecessary medical costs.

Circumcision was the most frequently approved non-covered procedure without established criteria and policy.

Figure 2.3 Prior Authorization Nurses Unilaterally Approved 106 Non-covered Procedures That Do Not Have Criteria. Non-covered procedures should be reviewed by the appropriate UR committee.

Procedure	Number Approved
Circumcision	65
Bi-frontal or mid-face reconstruction	15
Reconstruction of nipple & areola	4
Reduction mammoplasty	3
Graft of ear or nose	3
Rhinoplasty	3
Osteotomy	2
Mastopexy	2
Radiotherapy	2
Radiation treatment	2
Otoplasty	1
Mammoplasty augmentation	1
Repair of nasal vestibular stenosis	1
Ventricular implant assist device	1
Tissue culture	1
Total	106

It would be difficult to determine if these requests would have been approved had they been presented to the appropriate utilization review committee. However, it is concerning that these costly procedures were approved without established criteria on which to base the decisions.

A Prior Authorization Nurse Approved a Questionable Breast Reconstruction Procedure. At least one request for a non-covered procedure that was approved by the prior authorization nurse but was not presented to the UR committee does not appear to be medically necessary, based on precedent set by the UR committee. The Medicaid recipient had previously undergone a simple mastectomy of the left breast to treat non-invasive breast carcinoma. The prior authorization nurse approved the reconstruction and augmentation of both breasts, though no cancer was removed from the right breast, without presenting the request to the UR committee.

A similar request was presented to the UR committee shortly thereafter by a different prior authorization nurse. The committee denied the request for reconstruction of the non-affected breast by a vote of 6 to 3, with one nurse abstaining. Due to the similarity of these two requests, it appears that the request that was not presented

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

to the UR committee would have been denied if the prior authorization nurse would have presented the request to the committee for review.

In addition to leading to potentially inconsistent decisions by prior authorization nurses, unclear/non-existent policies inhibit providers from knowing what steps to take to determine if Medicaid will reimburse them for certain non-covered procedures. All non-covered procedures for which HCF criteria does not exist should be reviewed by the appropriate UR committee.

Some Procedures May Have Been Unnecessarily Denied

Unclear policy can also delay or deny Medicaid recipients from receiving necessary medical care. As previously mentioned, BPI policy allows prior authorization nurses to seek the advice of utilization review committees. Prior authorization nurses have made important medical decisions without properly using this resource. Management should be more involved to ensure complex management cases are reviewed by a utilization review committee.

For example, a prior authorization nurse denied a request for a knee arthroscopy because the recipient had not received the adequate treatment required by criteria. The delay in services likely cost the Medicaid program unnecessary medical expenses because the case was not presented to the UR committee for an exception. The request for a knee arthroscopy was delayed for four months, until after the recipient had fulfilled conservative treatment, despite an MRI that showed a torn meniscus.

The prior authorization nurse appears to have followed protocol by denying the initial request until the patient had completed eight weeks of conservative physical therapy treatment. However, the prior authorization nurse should have presented the request to the UR committee after an MRI showed a meniscal tear and the physical therapist and physician stated that therapy would not correct the problem. Figure 2.4 shows the timeline for the patient in question.

Unclear policy can delay or deny medical care when it is legitimately needed.

A nurse denied a knee arthroscopy because criteria required treatment first. However, the nurse should have presented the case to a utilization review committee after an MRI showed treatment would not correct the problem.

Figure 2.4 Questionable Prior Authorization Denial. A Medicaid recipient was denied a knee arthroscopy despite an MRI showing a torn meniscus and the physical therapist claiming therapy would not help her. HCF criteria require eight weeks of conservative treatment prior to a knee arthroscopy.

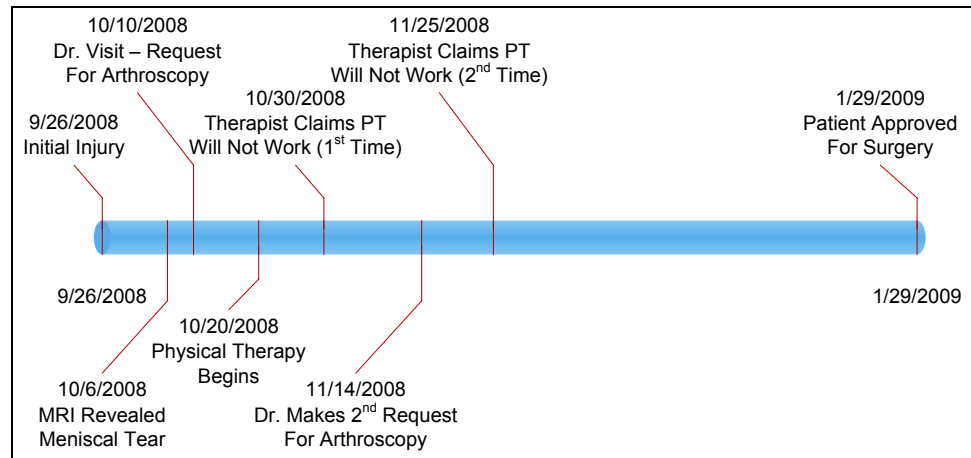


Figure 2.4 shows that this Medicaid recipient was denied a necessary surgery to repair her knee, despite the physician and physical therapist claiming that conservative treatment would not repair a torn meniscus. This appears to be a circumstance in which the prior authorization nurse should have taken the second request to the appropriate UR committee to expedite the approval of a knee arthroscopy.

Disregarding Policy Has Led to Unnecessary Medical Costs

In other instances, HCF has developed policies and criteria, but the prior authorization nurses have simply ignored them.

In some instances, sufficient policies and criteria have been established by the Medicaid program, but the prior authorization nurses have simply ignored the policies. Prior authorization nurses ignored policy and unilaterally approved 127 sleep studies during calendar year 2008. Due to time and resource constraints, we only reviewed surgeries and sleep studies, but we believe there are likely other areas in which disregarded policy and lack of management oversight have led to unnecessary medical costs.

Policy Requires Certain Sleep Studies Receive UR Oversight

Medicaid policy requires that all requests for procedure code 95811, the most complex and costly sleep study, be reviewed by the appropriate utilization review committee. However, as Figure 2.5 shows, this did not occur during calendar year 2008.

Figure 2.5 Prior Authorization Nurses Approved 127 Sleep Studies Without Proper Approval in CY 2008. Policy requires that all approvals for this procedure code be discussed by the appropriate UR committee. The three cases that went to UR were denied.

Nurse	Total Requests	Approved Requests	Requests Presented to UR (all denied)
Nurse F	88	55	0
Nurse G	59	24	2
Nurse O	<u>63</u>	<u>48</u>	<u>1</u>
Total	210	127	3

Figure 2.5 shows that prior authorization nurses only presented three requests for procedure code 95811 to the appropriate utilization review committee in calendar year 2008, even though BPI criteria require committee oversight. All three cases that were presented to the appropriate UR committee were denied. None of the 127 approved requests were approved by the appropriate utilization review committee.

The Medicaid program provider manual for physician services and anesthesiology states that procedure code 95811 is “for polysomnography, or sleep staging with four or more parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist.” The manual also states that “prior authorization is required through [the utilization review] Committee” for this procedure code.

The prior authorization manager claims that policy management told the prior authorization nurses to use their own judgment regarding requests for this procedure. However, this new direction

Policy requires that all complex sleep studies be reviewed by a utilization review committee. However, this policy is not being followed, which has led to unnecessary medical expenses.

Only 3 out of 210 requests were presented to the utilization review committee.

It appears mismanagement of surgeries and sleep studies has likely created unnecessary costs to the Medicaid program.

Medicaid management has not sufficiently controlled the prior authorization process. More can be done to ensure consistency among the nurses.

was not changed in the provider manual, nor was it documented. We are concerned that informal policy changes may lead to confusion and inconsistency among the prior authorization nurses. We recommend that BPI adequately document all policy changes.

Ignoring Policy Can Result in Unnecessary Medical Expenditures

The action of the prior authorization nurses to ignore policy and the inaction by management to allow this practice may have led to unnecessary medical expenditures. We did not have time to review all medical procedures involving prior authorization; however, it appears that mismanagement of surgeries and sleep studies has likely created unnecessary costs to the Medicaid program.

The sleep study previously discussed costs the Medicaid program around \$1,200 per study, including all costs that appear to be related to the procedure. We believe this is further evidence that the Medicaid program is missing out on an important cost-control area. Thus, better management oversight is needed to ensure the prior authorization tool is actually controlling costs and utilization.

Insufficient Management Control Has Led to Unnecessary Medical Costs

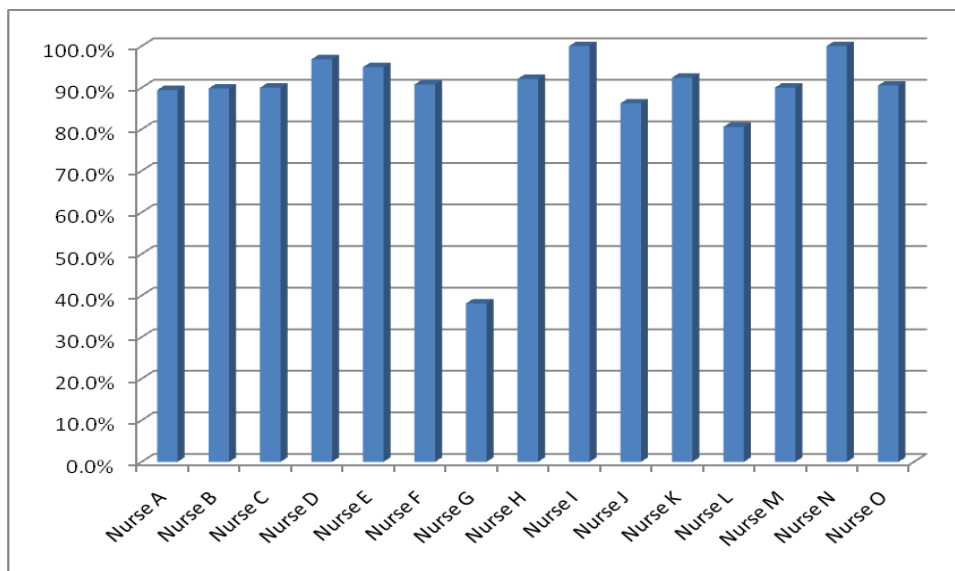
Significant discrepancies exist in the approval rates of prior authorization nurses. Inconsistency among prior authorization nurses can lead to unnecessary medical costs and confusion among recipients and providers. Due to the unique nature of each state's Medicaid program, it is difficult to apply an industry benchmark for the rate of requests each nurse should approve. Nevertheless, management could do a better job to ensure greater consistency among the nurses.

Approval Percentages Vary By Prior Authorization Nurse

It appears that nurses are not consistently following the criteria for approving prior authorization requests. This lack of consistency can lead to some recipients receiving expensive procedures even though less-costly alternatives may be available. Conversely, other recipients may be denied necessary services altogether. Prior authorization nurses, on average, approved 88 percent of all prior authorization

requests in calendar year 2008. However, individual nurses' authorization rates vary considerably. One nurse approved 38 percent of all requests while two nurses each approved 100 percent of their reviews. Figure 2.6 shows the prior authorization approval rates by nurse for calendar year 2008.

Figure 2.6 Approval Rates for Prior Authorization Nurses Vary from 38 Percent to 100 Percent. The average approval rate is 88 percent, with a 15 percent standard deviation.



Greater than expected inconsistency exists among nurses' approval rates.

Figure 2.6 shows that approval rates vary among nurses. The standard deviation of the approval percent is almost 15 percent, which indicates a large spread of data. Nurse G causes the high standard deviation by only approving 38 percent of the assigned requests. If Nurse G were removed from the list, the approval percentage of the remaining 14 nurses would be 89 percent with a 5 percent standard deviation. Each nurse is assigned a specific area of expertise, such as surgery, pharmacy, or dental. It should be expected that each area of expertise would have a different approval percentage; however, we are concerned about the variability among nurses who share the same area of expertise.

Inconsistency in nurses' approval rates is a reflection of poor oversight by management.

Inconsistency Exists Among Individual Nurses' Prior Authorization Approvals

Nurses are not consistently approving similar medical procedures. We believe this is a reflection of poor oversight by management. While the prior authorization approval rate by area of expertise should be expected to vary, the approval rate among nurses who review the same prior authorization requests should be similar.

An example of this can be found in surgeries and sleep studies. Nurse F and Nurse O reviewed prior authorization requests for surgeries and sleep studies until October 2008. At the beginning of October 2008, Nurse G assumed the responsibilities of Nurses F and O. Figure 2.7 shows the difference in how these three nurses reviewed the same areas of responsibility.

Figure 2.7 Prior Authorization Nurse Approvals Vary Drastically for the Same Procedure Areas. Nurse F and Nurse O approved more than twice the number of prior authorization requests for the same procedures than Nurse G approved in FY 2008.

Nurse	Approval Percent	Average Monthly Approvals	Average Monthly Requests
Nurse O	92.2%	165	179
Nurse F	91.4	159	174
Nurse G	48.4	74	153
Average	86.7%	150	173

Figure 2.7 shows that Nurse G approved less than half of the monthly prior authorization requests for surgeries and sleep studies while Nurses F and O approved 92 percent of requests. We believe the approval percentage for Nurse G is consistent with her approval percentage in other areas in which she has worked.

Consistent monitoring by the prior authorization manager is needed to help ensure nurses are only approving appropriate requests.

The prior authorization manager believes that Nurse G has a lower approval percentage because this nurse is much more thorough than the other nurses with evaluating prior authorization requests. The manager claims that Nurse G bases all decisions on the documentation submitted, while the other two nurses may give providers the benefit of the doubt. If this is the case, Nurse F and Nurse O approved procedures for which less-costly alternatives may have been performed. Possible additional reasons for the discrepancy include unclear policy

and inadequate training and supervision. Without regular monitoring by the prior authorization manager, it is difficult to determine if Nurses F and O are too lenient or if Nurse G is too strict. In the future, consistent monitoring by management should occur.

Increased Training and Monitoring Could Mitigate Unnecessary Medical Costs

Management over the prior authorization program should increase their oversight, particularly in the areas of training and monitoring. The prior authorization nurses do not receive regular training on how to review prior authorization requests. Additionally, prior authorization nurses are not regularly monitored to determine if they are following statute, administrative rule, HCF policy, and BPI criteria. Regular training and monitoring could prevent unnecessary medical costs and help increase consistency among prior authorization nurses.

Prior authorization nurses have been telecommuting since 1999. The nurses meet together twice per month as part of the utilization review committees, however they rarely receive training. The prior authorization manager should regularly meet with the prior authorization staff to train them how to perform their job functions.

The prior authorization manager recently had some concerns that some of the nurses were approving prior authorization requests without thoroughly reviewing the requests against established BPI criteria. To correct this concern, the manager, along with the BPI director, reassigned some of the nurses to different areas within the prior authorization section. However, there is no evidence that the prior authorization manager attempted corrective action with these nurses. In fact, both nurses in question received favorable remarks from the manager on their most recent annual performance appraisals. Regular training and monitoring may have helped to correct these issues before problems arose.

Prior Authorization Tool Should Be Better Utilized to Control Cost

Prior authorization is an effective method to prevent overutilization of Medicaid and control the expenditure of millions of

Nurses should be given more training and monitoring by management.

Management recently had concerns with some of the nurses and reassigned them to different areas. However, no evidence exists to suggest that corrective action was taken to change their behavior.

Management should set a target approval range, and track adherence.

dollars. However, as shown, the Medicaid program is not effectively utilizing this method. The Medicaid program has not established a target approval rate or range. Thus, we believe the lack of a target approval range is exposing millions of Medicaid dollars to the risk of being spent unwisely.

Further, BPI is underestimating the financial impact of its prior authorization efforts by only monitoring physician-related costs. Cost data collected by BPI shows that by reducing the prior authorization approval rate by 3 percent, \$2.2 million could be saved. However, we believe that if BPI data were to include ancillary costs, reported savings would be much higher.

Prior Authorization Tool Can Be Better Used to Save Program Dollars

Improved prior authorization practices discussed in this chapter can be used to save valuable program dollars. HCF management should focus more on this tool to ensure its full potential is being realized. Where other private insurance providers can utilize co-pays to contain costs, Medicaid is limited by federally mandated limits on the co-pay amount it can require Medicaid recipients to pay.

At a minimum, HCF management should set a target prior-authorization approval range and monitor the nurses to ensure they are consistent with policy. This benchmark range would have prevented unnecessary medical expenses in the past.

BPI Underestimates the Impact of Prior Authorization

Savings from current prior authorization efforts are understated. Thus, savings from prior authorization activities are many times greater than BPI reports. Savings are understated because BPI has not been including ancillary costs in their estimate of savings. Rather, only the physician fee is tracked and reported. In calendar year 2008, BPI claimed that prior authorization saved the Medicaid program \$8.8 million by denying procedures that were either medically unnecessary or procedures for which a less-costly alternative could yield similar results. BPI claims that all of the procedures for which a prior authorization request was made totaled \$73.5 million in calendar year

BPI is underestimating savings from prior authorization. Consequently, BPI is underselling the potential cost savings possible by improving the prior authorization process.

2008. Of these requests, the prior authorization unit denied 12 percent, saving the Medicaid program \$8.8 million.

However, including ancillary costs, the actual total cost of the prior authorization requests was much higher and, consequently, so were savings. Ancillary costs include fees such as hospital/facility fees, anesthesia, and equipment fees. In total, the cost is likely many times that of the physician fee alone. For example, BPI identifies the cost of a circumcision at \$143.72; however, including all ancillary costs, circumcisions commonly cost over 10 times that amount and has been as high as \$3,000. Figure 2.8 shows Medicaid's cost fluctuation range as prior authorization approval rates change.

Figure 2.8 Prior Authorization Cost Savings Would Have Changed \$735,000 per 1 Percent Change in Approval Rate in CY 2008. The requested cost and cost savings do not include ancillary costs. Including these costs would significantly increase potential savings.

Prior Authorization Approval Rate	Estimated Cost Savings	Difference from Actual CY 2008 Cost Savings
75%	\$18,300,000	\$9,500,000
77	16,900,000	8,100,000
79	15,400,000	6,600,000
81	14,000,000	5,200,000
83	12,500,000	3,700,000
85	11,000,000	2,200,000
87	9,500,000	700,000
88%	8,800,000	\$0*
89	8,100,000	(700,000)
91	6,600,000	(2,200,000)
93	5,100,000	(3,700,000)
95	3,700,000	(5,100,000)
97	2,200,000	(6,600,000)
99	700,000	(8,100,000)
100%	0	(\$8,800,000)

**Actual approval rate and reported cost savings for CY 2008*

Figure 2.8 shows that for each one percent the prior authorization approval rate deviates, the Medicaid program is impacted by \$700,000, not including ancillary costs.

Since the financial impact on the Medicaid program is so high and the importance of the prior authorization control is vital, it is crucial

An example of how BPI is underestimating potential savings is evident in BPI's calculation of a the cost of a circumcision. BPI reports the cost at \$143.72, which only includes physician fees. However, the true cost is many times higher with all ancillary costs included.

Even with cost savings understated, a change of three percent in the approval rate could save \$2.2 million annually in federal and state dollars.

that the prior authorization nurses only approve requests that fulfill the criteria for Medicaid reimbursement. As previously mentioned, BPI does not have clear policy for reviewing prior authorization requests, and prior authorization nurses have not always followed the established criteria.

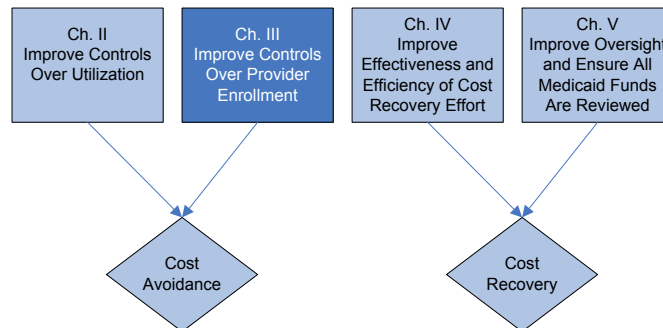
Recommendations

1. We recommend that BPI establish clear guidelines for when a prior authorization request should be reviewed by the appropriate utilization review committee.
2. We recommend that BPI management ensure prior authorization nurses receive regular training on how to review prior authorization requests.
3. We recommend that BPI management ensure prior authorization nurses present the following to the appropriate UR committee:
 - a. Non-covered procedures that do not have established criteria
 - b. Requests for procedures that may require an exception to policy
4. We recommend that the HCF establish criteria for the following circumstances:
 - a. Procedures for which HCF does not agree with InterQual criteria
 - b. Common prior authorization requests, such as circumcision
5. We recommend that more management oversight be given to the prior authorization process. The prior authorization manager should regularly monitor prior authorization nurses to ensure adherence to statute, administrative rule, HCF policy, and established criteria when evaluating a prior authorization request.
6. We recommend that the HCF adequately document all changes to policy.

Chapter III

More Controls Needed With Provider Enrollment

Cost avoidance, or the ability to prevent fraud, waste, and abuse from occurring, can produce substantial savings. Along with a robust prior authorization process, identifying Medicaid providers that exhibit “red flags” for committing fraud, waste, and abuse and either excluding them from the Medicaid program or flagging them for closer observation is an important cost avoidance practice. We found several areas where Utah’s Medicaid program can improve in this area and, consequently, better protect both Medicaid recipients and Medicaid dollars from unscrupulous providers. The section of the cost savings model discussed in this chapter is cost avoidance through improved controls over provider enrollment, as the darker shaded box below denotes.



Exclusion of questionable providers from the Medicaid program is allowed and appropriate but not adequately enforced. The Provider Enrollment Function (provider enrollment) within the Division of Health Care Financing (HCF or Medicaid program) has enrolled a number (about 1 percent) of providers with concerning sanctions, including: histories of fraud, unnecessary procedures, and unethical behavior. Provider enrollment is located within the Bureau of Operations at HCF, but the Bureau of Program Integrity (BPI) should still conduct oversight of providers with a history of disciplines.

To improve its processes, provider enrollment should correct the following. First, provider enrollment does not have policies in place, as other states do, to fully review enrolled providers to ensure higher

Flagging Medicaid providers that are higher risks for fraud, waste, and abuse can be a valuable cost avoidance mechanism.

Most Medicaid providers are honest and provide a valuable service to the community. We found about 1 percent of Medicaid providers have some concerning sanctions.

risk providers are tracked or removed. Provider enrollment should develop policies and procedures to ensure providers with a history of concerning sanctions are more closely screened and in some cases excluded. Second, existing providers with concerning sanctions should be more carefully reviewed and tracked to help protect Medicaid clients from being abused and avoid possible fraudulent, wasteful, or abusive billings.

Provider Enrollment Controls for New Applicants Should Be Strengthened

Utah's current Medicaid policies might not be sufficient to preclude or identify providers that are at higher risk for committing fraud, waste, or abuse. Medicaid may not be aware of current providers with either past disciplinary actions on their occupational license or with histories of fraud, unnecessary procedures, and unethical behavior. Medicaid's Provider Enrollment Unit should review their provider policies to ensure the policies are consistent with best practices from federal and state laws/rules, other states' Medicaid programs, and private insurance companies.

Provider Enrollment Is Not Denying Any Providers

Current policies and procedures for enrolling providers are not adequate. The current process allows any provider with an active license from Utah's Division of Occupational and Professional Licensing (DOPL) that was not excluded from the Office of Inspector General (OIG) or Centers for Medicare and Medicaid Services Medicare Exclusion Database (MED) to be enrolled as a Medicaid provider. While these checks are good, they are not sufficient, in that the current process has allowed several providers with concerning sanctions to be enrolled.

According to provider enrollment, if DOPL has a disciplinary action against a provider, provider enrollment will investigate the reasons for the action and make an exclusion determination. However, we could not verify that this was occurring because records are not kept by provider enrollment. Additionally, we found that no

HCF's current policies governing provider enrollment can improve. Currently, HCF may not be aware of some providers with concerning disciplines or histories of fraud, patient abuse, etc.

Several providers with concerning sanctions have been enrolled as Medicaid providers.

new provider applications had been denied for the last 3 years due to disciplinary actions.

Provider enrollment complies with OIG, MED, and DOPL databases if a provider is ineligible to serve as a Medicaid provider, but does not make independent decisions to exclude providers. Provider enrollment should develop its own standards to ensure that provider selection is in the best interest of Utah's Medicaid program and Medicaid recipients.

Also concerning is that provider enrollment does not investigate any past disciplinary measures. Thus, if an applying provider's only discipline through DOPL occurred in the past and had been cleared off of their license, provider enrollment would not be aware of this discipline. Providers are frequently placed on probation or given a restricted license for a number of years. However, once this probation ends, the record of discipline is removed. In such a case, provider enrollment would not investigate the discipline. By failing to do this, they are not aware of these individuals who may be at a higher risk for fraud, waste, or abuse. Further, to ensure compliance with the Social Security Act, Provider enrollment should investigate past disciplines and crimes regardless of the current status of the provider's license.

The Social Security Act addressed provider exclusions in section 1902(p), which reads, "A state may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128." Section 1128 lists specific circumstances under which providers shall or may be excluded. Individuals who are convicted of the following offenses shall be excluded from federal health care programs:

- Program-related crimes
- Crimes related to patient abuse
- Felonies related to health care fraud
- Felonies related to controlled substances

Additionally, providers *may* be excluded for offenses such as the following:

HCF does not investigate past disciplinary measures. Accordingly, they are not aware of individuals whose past action makes them a current risk for fraud, waste, or abuse.

The Social Security Act lists specific circumstances where providers shall or may be excluded. Some current Medicaid providers appear to fall into some of those exclusionary categories.

- Convictions related to fraud
- Misdemeanor convictions related to controlled substances
- Claims for excessive charges or unnecessary services
- Failure to disclose required information

As discussed below, some current Medicaid providers appear to fall into some of the above categories.

Other state Medicaid programs and some insurance companies have stronger policies and practices than Utah's Medicaid program.

Other State Medicaid Programs/Insurance Companies Have Stricter Acceptance Policies. We found that other states and insurance companies have instituted stronger requirements for providers than Utah has instituted. Based on 10 responses from a survey sent to all other state Medicaid programs, the majority (60 percent) review applicants' disciplinary cases on an individual basis.

Washington's Medicaid program has a committee who votes on whether high-risk providers will be enrolled and issues provisional billing numbers for moderate-risk providers. Vermont's Medicaid program reviews providers with disciplines for a period of time depending on their discipline.

In Utah, the University of Utah's "Healthy U" program requires written statements regarding past disciplines before a determination is made. Healthy U, along with Utah Public Employees Health Plan (PEHP) and Arizona's Medicaid program all consider provider need before an applicant is accepted. If an applicant is located in an area with many similar providers, the provider may not be accepted. Also, another insurance company told us they have a zero tolerance policy for providers with patient sexual abuse and fraudulent billings.

Utah's PEHP told us that it does not enroll any provider with a current discipline on their license.

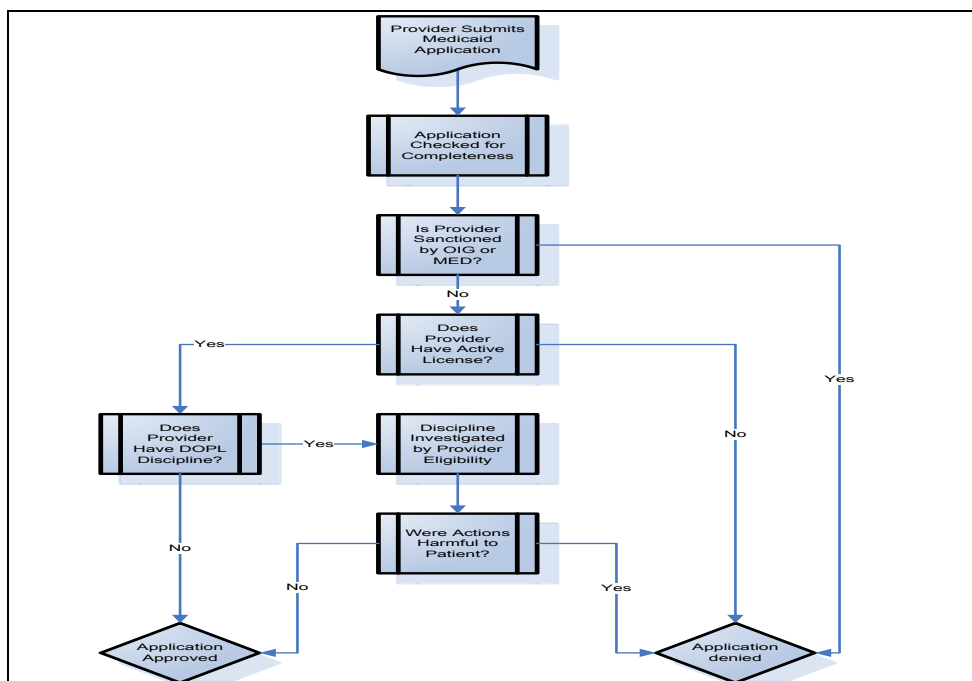
We also discussed provider disciplines with PEHP. Provider enrollment told us that they will not accept any provider that has a current discipline on their license. This means that any provider on probation is automatically rejected, or if they are already contracted with PEHP, terminated. They require DOPL to restore all privileges before a provider is accepted if they have past disciplines. Even then, most of these providers will be denied unless it is an area where providers are needed.

Providers with very concerning fraud or abuse disciplines should not be accepted in any location, but by employing stricter acceptance

standards for areas with sufficient access to care, Medicaid can avoid some of the high-risk providers without severely limiting Medicaid recipients' provider choices.

Current state policies might not be sufficient to preclude or identify providers from Medicaid that are at higher risk for committing fraud, waste, or abuse. As previously discussed, provider enrollment may not be aware of providers with past disciplinary actions on their license, so providers with histories of fraud, unnecessary procedures, and unethical behavior are currently enrolled as Medicaid providers. Figure 3.1 shows the provider application process as described by provider enrollment. However, it is not being followed. We found that some providers have been accepted with disciplines resulting from actions harmful to patients.

Figure 3.1 Utah's Medicaid Provider Enrollment Process. According to provider enrollment, providers are not accepted if they had disciplines from harmful actions. However, we did not see this process being followed.



HCF is not following the established process.

We found that any provider with an active license that applied to Medicaid from 2006-2008 was accepted, even if they had disciplinary

Any provider with an active license was enrolled from 2006-2008, even if they had disciplinary actions on their record.

Along with improving policies over provider enrollment, HCF also needs to improve its policies and practices with sanctioning current providers.

HCF management is concerned about access problems if too many providers are excluded. However, access concerns should not trump concerning disciplines that can compromise safe care to Medicaid recipients and increase the likelihood of inappropriate billings.

actions on their license. Provider enrollment only denied two applications in 2006 and three in 2007; they were denied not because of disciplinary action but because they were provider types that Medicaid does not enroll.

Policies Governing Existing Medicaid Providers Need Improvement

Along with improving policies over the enrollment of new providers, the Medicaid program also needs to improve policies and procedures with disciplining/sanctioning current providers. The Social Security Act allows states to exclude providers from Medicaid that have fraud, patient abuse, and controlled substance convictions. We found, some Utah providers have been disciplined for fraud, patient abuse, or controlled substance issues, yet continue to be Medicaid providers. Of particular concern are current Medicaid providers with patient abuse histories who have restricted licenses that limits their practice. Currently, Medicaid is not monitoring these providers to ensure they are following the restrictions on their licenses, yet they allow them to continue providing care to Medicaid recipients.

Medicaid management expressed a concern that excluding too many providers could cause access problems for Medicaid recipients, specifically in rural areas. However, they agree that this does not mean that any applicant should be accepted regardless of past problems. Providing quality/safe care to Medicaid recipients and avoiding fraudulent providers should be a high priority. Clearly, individuals with concerning disciplines should be sanctioned, regardless of location.

HCF Should Make Improvements To Provider Enrollment Policy

The authority of HCF to sanction (deny or remove) providers is given in *Administrative Rule 414-22-3*, which lists 23 reasons for which a provider may be either terminated or suspended from the Medicaid program. Additionally, their policy states:

In order to effectively and efficiently operate the Medicaid program, the Department [DOH] may implement administrative sanctions against providers: Whose practices fail to comply with

established Medicaid policy regarding billing for services or provision of services, or whose continued participation in the Medicaid program is determined by the Department to be not in the best interest of the program.

Not only has provider enrollment not denied any providers because of disciplines on their licenses, only 20 providers were sanctioned by HCF in the past five years, and half of those were sanctioned because their license to practice was revoked, lost, or surrendered. The others were removed because of OIG sanctions or restrictions that provider enrollment could not track. Of the 20, 7 had a history of DOPL disciplines prior to their sanction.

Punishments handed down by DOPL that resulted in providers being sanctioned by Medicaid were given for a variety of reasons. Providers were accused of, or admitted to, sexual battery, abuse, or inappropriate actions, falsifying certifications, and use of controlled substance abuse. These providers are clearly at higher risk of fraud or doing harm to patients. While most providers are acceptable, clearer standards of when not to accept providers should be adopted by the Medicaid program.

BPI Should Monitor Providers Deemed At Risk for Fraud, Waste, and Abuse

A BPI official told us that they may monitor a questionable provider on a quarterly basis based on information they receive from provider enrollment. We question if this level is sufficient. Once BPI is aware of providers with concerns, they need to monitor them closely to ensure that billings are appropriate and claims are supported by proper documentation. BPI should make an extra effort to sample claims from these providers to ensure fraud, waste, and abuse are not occurring.

Further, in order to ensure that BPI is aware of providers with disciplinary actions on their license, HCF should consider moving provider enrollment under BPI. This is done in other states and would allow BPI to control provider enrollment as well as make it easier to track provider discipline.

Though management agrees some providers should be sanctioned there is little evidence of this occurring.

BPI should more closely monitor providers with known disciplines.

HCF is aware of some providers with concerning disciplines but has chosen to take no action.

Some concerning disciplines by Medicaid providers include sexual misconduct with patients, filing false claims, and prescribing controlled substances for non-medical purposes.

Some Current Medicaid Providers Have Concerning Sanctions Against Them

There are 127 current Medicaid providers with active licenses that have some type of discipline on the DOPL database.

Provider enrollment is aware of these providers. However, if the discipline ended before the provider's application was made to Medicaid, provider enrollment has no record of the discipline. This is due to provider enrollment not investigating past disciplines. The following is a list of some of the disciplines for current Medicaid providers. Provider enrollment was aware of some of these examples, but chose to take no action.

- Sexual conduct with a patient under the influence of nitrous oxide
- Multiple instances of filing false insurance claims
- Lack of proper documentation for claims
- Conviction of communications fraud
- Actions contrary to ethical standards or conduct that "might constitute a danger to the health, welfare or safety of the patient or public"
- Unwarranted dental procedures
- Multiple instances of using controlled substances illegally
- Multiple instances of prescribing controlled substances for non-medical purposes or overprescribing controlled substances

A review of these claims showed provider enrollment did have documentation of most of these actions and made determinations that either allowed continued provider status or allowed enrollment as a Medicaid provider. Utah's Medicaid program should develop clear policies of when to exclude providers to ensure it is in compliance with federal law, and that it is adequately protecting Medicaid recipients and funds from fraud, waste, and abuse.

As discussed previously, some of these convictions may call for mandatory or possible exclusions of Medicaid under Section 1128 of the Social Security Act, and adopted by the Utah State Plan under the act. We were not able to positively determine if some of these providers should be excluded under the Social Security Act. By reviewing the providers above in regard to the Social Security Act, provider enrollment can ensure that the highest-risk providers are avoided.

We also found that some providers with restrictions on their license are currently enrolled as Medicaid providers. These restrictions are not tracked by provider enrollment or BPI. A supervisor in provider enrollment told us that, often, providers are denied or removed if they have a restricted license that only allows contact with select patient categories and situations when they cannot easily verify if the restriction is being followed. We found six instances where providers were sanctioned or removed due to restrictions on their license.

However, we found that this practice is not consistently followed. For example, one provider had been convicted of attempted sexual exploitation of a minor and given an indefinite restriction to provide services only to patients over 18. Prior to the charges and conviction, this provider was terminated from the program and later reinstated, four years before the probation was lifted. Additionally, the restriction on this provider to only provide services to individuals over 18 remains in place. Since, by their own admission, neither BPI nor provider enrollment is monitoring this restriction, we question the decision to allow this provider to continue to be enrolled. More consistent standards and policies regarding restricted providers are needed.

Legislature Should Consider Granting Medicaid Access To Controlled Substance Database

There are currently no controls in place to monitor and prevent fraudulent prescription billings. As required by *Utah Code* 58-37-7.5, DOPL maintains a database of all pharmacy distribution of controlled substances. According to the code, the manager of the database shall make information in the database available to law enforcement personnel for the purposes of investigating Medicaid fraud. The Legislature should evaluate the merits of extending access to BPI to detect Medicaid fraud.

We compared this database to Medicaid's records of paid claims for controlled substances. Although the basis of our comparison was limited by the data, we identified four instances from one pharmacy where Medicaid paid for prescribed substances that were not listed in the DOPL database.

In some instances providers that have restrictions against certain classes of people (e.g. minors) are still being enrolled, but HCF is not ensuring the restriction is enforced.

BPI is not adequately utilizing the controlled substance database to detect provider fraud.

This could be a case where the pharmacy failed to report the prescriptions, or it could be a fraudulent activity. Since BPI doesn't have access to the database they are unable to institute controls to find such instances. Furthermore, a pattern of failing to report this information to DOPL is grounds for the following penalties under *Utah Code*:

- Refuse to issue a license to the individual.
- Refuse to renew the individual's license.
- Revoke, suspend, restrict, or place on probation the license.
- Issue a public or private reprimand to the individual.
- Issue a cease and desist order.
- Impose a civil penalty of not more than \$1,000 for each dispensed prescription regarding which the required information is not submitted.

If access is given, BPI should compare Medicaid data to the DOPL database on a regular basis. This would allow BPI to (1) check the appropriateness of dosage and frequency of prescriptions, (2) ensure claims paid were actually dispensed, and (3) identify providers whose documentation regarding claims may be inadequate based on failure to submit information to DOPL.

Controlling Provider Enrollment Helps Control Fraud and Waste

A stronger policy to restrict providers with past instances of wrongdoing could help in controlling fraud, waste, and abuse. Removing those providers that have a history of fraud seems to be in the best interest of the Medicaid program. As discussed previously, 7 of 20 providers sanctioned by provider enrollment had previous disciplines on their license.

Additionally, BPI should be flagging and carefully monitoring providers with a history of unwarranted procedures or lack of proper documentation. Both of these are serious problems in Medicaid, and efforts to recoup fraud, waste, and abuse would be much more productive with a targeted search of at-risk providers.

BPI should routinely use the controlled substance database to check for inappropriate billings.

Stronger policies on restricting providers with past instances of wrongdoing can help control fraud, waste, and abuse.

Stricter Eligibility Standards Are Not Likely To Affect Provider Access

Maintaining a sufficient number of providers to allow equal access to Medicaid recipients is a concern to the Medicaid program. Stricter eligibility standards are not likely to have a strong effect on Medicaid provider enrollment. There are currently over 12,500 unique Medicaid providers, and the number with license-related disciplines is only 127, or 1 percent. While the rate of disciplined providers is small, it is still concerning due to the fact that a small percent of Medicaid providers commit fraud, waste, and abuse.

United States Code 42-1396a-30(A) requires states' plans to provide access to care "at least to the extent that such care and services are available to the general population in the geographic area." As shown in Figure 3.2, the number of Medicaid providers was increased over the last three years.

Figure 3.2 Information on Medicaid Providers. It appears that Medicaid provider enrollment has kept pace with Medicaid enrollment.

	CY 2006	CY 2007	CY 2008
New Enrolled Providers	2,725	2,596	3,232
Closed Providers	2,779	4,020	1,927
Average Change Per Week	-1	-27	25
Avg Medicaid Enrollment	172,140	160,006	166,221

Overall provider enrollment has kept pace with Medicaid enrollment, though some specific provider types may have not increased as substantially.

We asked the director of BPI if it would be a concern if 127 providers were lost. He told us that access to certain types of care is a concern in rural areas, so location and service type are an issue. However, bad providers should not be allowed to see Medicaid recipients. We agree that providers should not be maintained just to increase access to care if they are fraudulent or detrimental to patients.

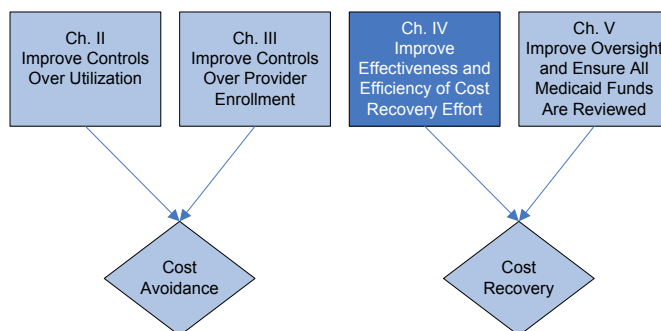
Recommendations

1. We recommend that HCF determine the feasibility of putting provider enrollment in the Bureau of Program Integrity.
2. We recommend that provider enrollment develop its own standards and policies for enrolling new providers to ensure they are properly precluding fraudulent and other high-risk providers.
3. We recommend that provider enrollment consider provider need when considering providers with disciplines, for providers not automatically precluded by policy.
4. We recommend that the Legislature consider the merits of extending access of the controlled substance database to BPI. If access is granted, BPI should develop and institute controls to ensure providers are billing Medicaid correctly and that prescriptions are appropriate in regards to frequency and dosage.

Chapter IV

Inefficiency and Ineffectiveness Is Hampering Cost Recovery Efforts

The newly created Bureau of Program Integrity (BPI or program integrity) within the Division of Health Care Financing (HCF or Utah's Medicaid program) does not have an effective fraud, waste, and abuse recovery system. Basic and necessary management information is not being collected; this concern, along with others in Chapter V, results in the Medicaid program not recovering valuable program dollars lost to fraud, waste, or abuse. We estimate that an improved recovery program could result in additional \$20.2 million (\$5.8 million state dollars) annually. The section of the cost savings model discussed in this chapter pertains to cost recovery through improving effectiveness and efficiency of the cost recovery effort, as the darker shaded box below denotes.



BPI was created in January 2008 and is housed within HCF. The new bureau director has been making headway in organizing BPI. However, we found that the cost recovery process is currently not working. Specifically, there are four key areas where the cost recovery effort is being hampered and correction is needed. These areas are:

- Ineffective fraud, waste, and abuse analytical tool
- Unreliable data relating to recovery amounts and types
- Inefficient utilization of staff time and resources
- Limited use of performance measures and business metrics

Improvements in these areas are not costly but can result in substantial benefits. Better information, better resource allocation, and a redirection toward performance-based goals when used in

BPI is not effectively and efficiently recovering inappropriate payments.

We estimate that an improved recovery effort by BPI could return about \$20 million in additional recoveries.

BPI's cost recovery effort is hampered due to an ineffective analytical tool, unreliable data, inefficient utilization of staff, and limited application of performance measures.

BPI should demonstrate it is using staff efficiently and effectively before consideration is given for more staff.

conjunction with a functional fraud, waste, and abuse analytical tool, will improve Utah's Medicaid program integrity system. Until BPI can demonstrate it is using staff efficiently and effectively based on accepted performance standards and that it is providing a strong rate of return, additional staff are not likely to be effectively utilized. However, once it is clear that staff utilization is improved, the state may benefit from more staff because there are many areas and functions that are not currently being evaluated.

Improvements in Recovery Efforts Can Net Millions in Savings for the Medicaid Program

The federal government projects that by 2030, spending for Medicare, Medicaid, and Social Security alone will be almost 60 percent of the federal budget. The Deficit Reduction Act (DRA) of 2005 sought to save nearly \$40 billion from these government programs in five years. A key component of cost reduction in the 2005 DRA was to reduce the predominance of fraud, waste, and abuse in the Medicaid program. We believe that much more can be done in Utah's Medicaid program to both avoid and recover fraud, waste, and abuse.

A small minority of health care providers submit inappropriate payments or payments involving fraud, waste, and abuse. However, the actions of this minority add up to many millions of dollars.

Fraud, waste, and abuse is committed by a small minority of health care providers. Sadly, the actions of this minority can add up to millions in wrongful and inappropriate billings. Fraud, waste, and abuse is a significant concern in Medicaid programs throughout the country, including Utah's program. Representatives in private insurance companies that have operations in other states report that Utah's health insurance fraud rates are not abnormally low. An individual familiar with insurance fraud enforcement in Utah told us that his perception was that Utah has similar fraud rates as other states.

The GAO reported in 2006 that Medicaid is especially at risk for fraud, waste, and abuse.

The GAO estimated several years ago that health insurance claims related to fraud were about 10 percent. More recently, in 2006, GAO reported that Medicaid is especially at risk to waste, or extravagant and unnecessary expenditures. The GAO report stated the following:

A nationwide rate of improper payments for Medicaid has not been estimated, but even a rate **as low as 3 percent** would have resulted in a loss of about \$5 billion in federal funds in fiscal year 2004. (emphasis added)

The National Health Care Anti-Fraud Association (NHCAA) estimated that, nationally, at least 3 percent of total health care costs are lost to fraud each year, or about \$70 billion. The NHCAA's most recent report on fraud in health care stated the following:

NHCAA estimates *conservatively* that 3% of all health care spending—or \$68 billion—is lost to health care fraud. . . . Other estimates by government and law enforcement agencies place the loss due to health care fraud as high as 10 percent of our nation's annual health care expenditure.

While 3 percent is a small percent of total billings, for fiscal year 2008 in Utah, that 3 percent translated to \$47 million in Medicaid program dollars (\$13.5 million in state dollars) potentially lost. The Medicaid program recovered approximately 1.50 to 1.72 percent of total program cost in fiscal year 2008, or \$23.7 million to \$27.1 million. However, most of those recoveries are third party liability recoveries (TPL), or the collection of payment from other insurance companies that should have paid the claim first, but did not. Accordingly, the Medicaid program is currently recovering the easiest form of wasteful recoveries to identify. As Chapter V shows, very little is done to recover fraud, waste, and abuse from the majority of claims.

If the Medicaid program obtained recoveries approaching NHCAA's conservative three percent estimate of fraud and abuse, an additional \$20.2 million (\$5.8 million in state funds) additional could be saved. Figure 4.1 shows that increasing fraud, waste and abuse collections above the current 1.72 percent can net a substantial savings.

The National Health Care Anti-Fraud Association conservatively estimates that 3 percent of all health care spending is lost to health care fraud.

The majority of recoveries are coming from other insurance companies that should have paid a claim, but instead Medicaid paid the claim (known as TPL). BPI is only recovering a fraction of a percent.

If BPI increased its recoveries to a conservative 3 percent, an additional \$20.2 million annually could be recovered.

Figure 4.1. Possible Additional Recoveries. Increasing recoveries can save valuable program dollars. The extent to which recoveries can be increased depends on several factors many of which this audit report covers. Dollar amounts shown in the table are the additional dollars that could be recovered, factoring in what was already recovered.

Increased Recovery	Increased Savings Federal and State	Increased Savings State Only
.03% to 1.75%	\$ 498,000	\$ 143,000
.28% to 2.00%	4,443,000	1,278,000
.53% to 2.25%	8,388,000	2,413,000
.78% to 2.50%	12,333,000	3,548,000
1.03% to 2.75%	16,277,000	4,683,000
1.28% to 3.00%	20,222,000	5,818,000
1.53% to 3.25%	24,167,000	6,953,000
1.78% to 3.50%	28,112,000	8,088,000
2.03% to 3.75%	32,056,000	9,223,000
2.28% to 4.00%	36,001,000	10,358,000
2.53% to 4.25%	39,946,000	11,492,000
2.78% to 4.50%	43,891,000	12,627,000
3.03% to 4.75%	47,835,000	13,762,000
3.28% to 5.00%	51,780,000	14,897,000

**To be as precise as possible, this chart uses annual program expenditures of \$1.57 billion due to a federal disallowance of \$46 million. However, to be consistent with appropriation reports, the other figures in this report show Medicaid program costs of \$1.6 billion.*

As the figure shows, about \$20 million in additional program dollars could be saved by increasing recovery efforts to 3 percent from the current 1.72 percent. At 5 percent, an additional \$52 million could be recovered. The extent to which this recovery rate is possible depends on several factors, which are discussed in this chapter and the next chapter.

Ineffective Analytical Tool Is Hindering Cost Recovery Efforts

BPI does not have a functioning analytical tool to assist in detecting inappropriate payments. This is one reason why BPI's recoveries are lower than nationally recognized levels.

BPI does not have a working analytical tool to look for fraud, waste, and abuse systemwide, as such BPI is not recovering inappropriate payments at nationally recognized levels. Currently, BPI utilizes a software system programmed in 1980, with the last update occurring in 1987. This system, known as the Surveillance and Utilization Review System (SURS), is ineffective. A primary reason for the system ineffectiveness is the lack of updates over the last 20

years. For example, since 1987, multiple changes have been made to the Medicaid Management Information System (MMIS), the system that pays medical claims, but these updates have not been programmed into the SURS system. Specifically, we found:

- SURS only reviews 38 percent of all provider types (e.g., physician, podiatrist, dentist, etc.), which means 62 percent of provider categories get no electronic utilization review.
- SURS reports that are being conducted are not complete. We found that one SURS report missed 78 percent of inpatient records.

BPI received quotes on a new system with an estimated annual state cost of \$127,000 (based on a 50/50 federal-to-state match). A functional analytical tool, at a relatively minor cost, would likely help return inappropriate payments that have cost the state much more than the price of the tool.

SURS System Only Programmed to Review 38 Percent of Categories of Service

Categories of service, or provider types (e.g., hospital, nursing home, physician, etc.), are the base sorting criteria for Medicaid's SURS reports. In a May 2007 report, program integrity stated that the SURS system was only extracting data from 27 of the 71 (38 percent) categories of service programmed into the MMIS system. Sixty-two percent (44 categories) of service categories are getting no utilization review from the SURS system. Therefore, they receive minimal oversight.

Currently, BPI has no process in place that can fully review utilization of Medicaid providers. Consequently, a great majority of Medicaid providers are not being reviewed for fraud, waste, and abuse by BPI. If other entities are conducting reviews, it is not being coordinated through BPI. The following 6 categories are among the 44 that are currently not being reviewed by the SURS system (dollars amounts shown below are for fiscal year 2008):

- Inpatient hospital, mental youth center: \$16 million
- Rural health clinic services: \$1.1 million
- Well child care services: \$10.6 million
- Osteopathic services: \$4.5 million

BPI's ineffective analytical tool known as SURS, is only reviewing 38 percent of all provider types.

Since the SURS tool is ineffective and BPI has few other processes in place to review providers, a great majority of Medicaid providers have little risk of being detected if they submit an inappropriate claim.

BPI is not conducting consistent risk analysis or random sampling of providers. Consequently, most providers are never reviewed for inappropriate payments.

- Aging waiver services: \$3.9 million
- Managed-care billings: \$194 million

With 62 percent of provider types not being reviewed, it is clear that the SURS system is not adequate to detect and help recover fraud, waste, and abuse. This has led to lower-than-expected recovery amounts, resulting in millions of potential recoveries left unrecovered.

Insufficient SURS System Impedes BPI from Completing Federal Mandates

Because of the issues BPI has had with the SURS program, its ability to identify aberrant billing processes is limited. As well, with non-inpatient providers, BPI is not conducting consistent risk analysis and random sampling. Instead, BPI has limited its utilization reviews to non-inpatient providers that were found to have problems in the past; BPI has also conducted minimal reviews of some of the highest-paid providers. These reviews have essentially become follow-up reviews that have produced little results. Consequently, most non-inpatient providers are never reviewed for inappropriate billing (this is discussed more in Chapter V).

BPI reports that they get most of their data needs from the state's data warehouse, not their own systems. While the data warehouse can provide useful information to BPI, "it was neither intended nor designed as a 'fraud, waste, or abuse detection' system or a post payment review tool." These data limitations have impeded BPI from collecting valuable information.

For example, in calendar year 2008, the SURS system provided program integrity 9,029 inpatient claims to review. We checked the accuracy of this report with the data warehouse and found the system was missing about 78 percent of inpatient records, or about 31,600 claims. We asked BPI staff about the discrepancy. They did not know if this problem was due to specific hard coding (looking for specific category of service types) in the non-updated SURS system, or if it was due to another malfunction in the system.

Program integrity's May 2007 report concludes that due to weaknesses in the SURS system, program integrity is not complying with all Federal mandates as required by CFR 456. Federal regulations found in 42 CFR 456 state:

The Medicaid agency must implement a statewide surveillance and utilization control program [that] safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of those services; provides for the control of the utilization of all services provided under the plan . . . and provides for the control of the utilization of inpatient services.

Program integrity further concludes that failures in the SURS system have handicapped the program integrity unit. Program integrity wrote in its May 2007 report:

Our current review process is inconsistent, cumbersome, time consuming, and often incomplete. Effective detection of fraud, abuse, and waste is very difficult to identify without the use of appropriate and effective fraud detection software tools. Utah Department of Health - Health Care Financing has failed to stay current or take advantage of the continual improvements to claims management and fraud detection tools over the years and had not heeded warnings on the impending Federal Requirements of the Deficit Reduction Act of 2005 and the newly formed Medicaid Program Integrity Group within CMS [Centers for Medicare and Medicaid Services]. These failures have handicapped the effectiveness of the unit.

We concur with the above statement. With the shortcomings of the analytical tool, program integrity falls short of adequate fraud, waste, and abuse detection and collection.

A Functioning Fraud, Waste, and Abuse Analytical Tool Is Needed

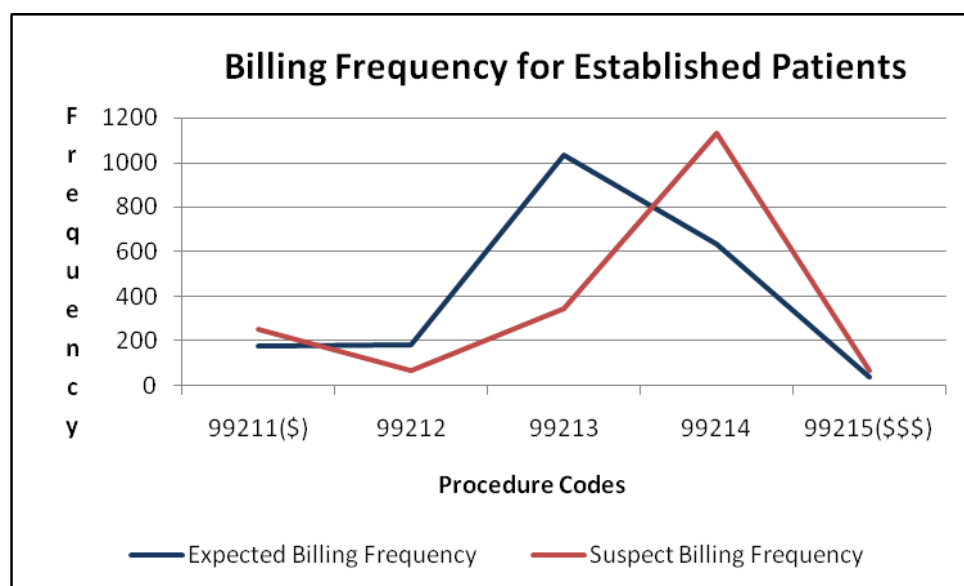
To become compliant with federal regulations, and to effectively detect and collect inappropriate payments, BPI needs a functioning analytical tool. A key feature of a working analytical tool is its ability to look for abnormal billing practices. One way this is accomplished is to compare a provider's billing practice against normal billing practices to look for variations. Figure 4.3 shows examples of a normal billing claims cycle and a suspected inappropriate billing claims cycle.

BPI is aware of the deficiencies that an ineffective analytical tool causes. They reported in 2007 that their current review process was "inconsistent, cumbersome, time consuming, and often incomplete."

BPI needs a functioning analytical tool to effectively detect and collect inappropriate payments.

An effective analytical tool can detect potential up-coding claims, or claims from a provider that frequently bill more expensive procedures than what is normally expected.

Figure 4.3 Expected and Suspect Frequencies of Claims. This shows the expected frequency and a suspect frequency of established patient claims.



This is an example of a suspected inappropriate billing cycle that BPI conducted manually from a referral they received. If BPI had a functioning analytical tool the system could review the entire universe of claims for this and other abnormal billing practices.

An analytical tool similar to that used in other states and other insurance organizations would provide information to BPI on claims that need further investigation. Such tools have been used effectively by others and they would allow BPI to drill down to the diagnosis level, which may provide information on why the claim was unusual without having to make phone calls or request records.

An Effective Analytical Tool Could Also Help Detect Payment Errors. A complete and functioning analytical tool would help eliminate errors, such as inaccurate billings, duplicate billings, coding errors, misclassification errors, etc.

Healthy U (a managed-care entity), recently purchased a fraud and abuse analytical tool. Their estimates show that this tool will save them approximately \$720,000 per year. Healthy U said that by using this software they were able to pay for the system with just one claim.

An effective analytical tool could also help detect payment errors.

They have received a cost estimate for a new fraud and abuse analytical tool of \$200,000 in initial set-up costs and ongoing costs of about \$255,000 (based on a five-year average). With a 50/50 percent match from the federal government, this tool would cost the state about \$127,000 a year. Program integrity recognized their need for better evaluative tools and attempted to upgrade the SURS system in 1999 when upgrades were being made to the MMIS system. However, it appears Medicaid management refused the upgrade request due to budget constraints. BPI should either correct the problems in the SURS system or obtain a new analytical tool.

Cost of a new analytical tool is estimated to be around \$127,000 in state funds annually.

Unreliable Recovery Data Is Hampering Cost Recovery Efforts

BPI does not have reliable data. BPI's system for tracking recovery information is also ineffective and produces inaccurate information. For example, we requested total recovery amounts, line-by-line detail of recovery amounts, and recovery amounts detailed by program area and found significant data problems. Each iteration of retrieved data, although based on similar requests, contained different numbers, missing data, and incomplete information. Our audit work was limited due to these data inaccuracies. BPI staff acknowledged that most times they pull data they get conflicting data.

BPI has unreliable recovery data, another likely reason why BPI's recoveries are lower than nationally recognized levels.

Multiple Data Problems Exist

We found three specific problems with the database. First, some mandatory fields are blank. The database has no safeguards in place to ensure mandatory fields are entered. For example, we found 60 cases that had no significant information entered other than a case number. No case type or assigned staff was listed. Hundreds of other cases were missing information such as important dates, review issue, or case status. After we notified staff of some of this missing data, we were told they forgot to put the information in the database, even though it had been completed six months earlier. BPI should correct this data problem.

Three specific problems exist with BPI's recovery data: (1) mandatory fields are blank, (2) the database is not designed to pull relevant data, (3) several input errors exist.

Second, the database is not designed to pull all relevant data. Data is held in various locations, but queries have not been designed to adequately bring all relevant data together. For example, data could

As evidence of data problems, HCF has conflicting information on the amount and type of recoveries made.

not be pulled and sorted by year. To obtain calendar and fiscal year data, BPI staff must pull information from several areas and manually compare. Further, BPI could not pull data by functional program area. For example, BPI was unable to pull how much was recovered by category of service, such as dentistry, chiropractic, pharmacy, etc. BPI should design a system that allows them to pull and sort relevant data.

Lastly, several input errors exist in the database. BPI staff are worried about system outputs because some data are incorrectly recorded. For example, several cases we reviewed indicated payment recoveries, but further audit work could not verify that the recoveries were actually made. BPI is currently working on a new database system that will hopefully address these concerns.

Cost Recovery Information Not Fully Understood

Reported recoveries are inconsistent from one report to another. This inconsistency is because program integrity does not completely understand what percent of claims it is recovering. This lack of knowledge is due to BPI not fully tracking all relevant information and not correcting data inaccuracies that exist in the information they do have.

BPI data shows that in fiscal year 2008 the Medicaid program recovered \$23.7 million, or 1.50 percent of total Medicaid program expenditures. However, a report provided to the federal government (CMS 64 report) showed total recoveries of \$27.1 million, or 1.72 percent of program expenditures. Figure 4.5 shows some of the discrepancies between BPI's data and data reported to the federal government.

Figure 4.5 Discrepancies in Recovery Data. We found there was a wide discrepancy between recovery data we received from BPI and the data that is reported to the federal government. Information is based on data for FY 2008.

BPI Report	Report to Federal Government
1.5 percent recovered	1.72 percent recovered
\$2.6 million fraud/abuse recoveries ¹	\$4.5 million fraud/abuse recoveries
\$18.4 million recovered from TPL	\$16.7 million recovered from TPL
\$23.7 million in total recoveries	\$27.1 million in total recoveries

1. *Fraud and abuse recoveries shown here include MFCU recoveries. Accordingly, this number is higher than BPI-only recoveries reported elsewhere in this report.*

Most of the recovered dollars did not fall into the fraudulent category. In fact, (according to BPI information) about 78 percent, or \$18.4 million, was wasteful billing that was later recovered, not by BPI, but by the Office of Recovery Services (ORS). ORS recovers third-party liability (TPL) claims, or Medicaid-paid claims that should have been paid by another insurance company. (Having private insurance does not preclude individuals from being on Medicaid.)

Payment Accuracy Rate Not Known

Several employees in the Medicaid program claimed the program's payment error rate is around 1 percent. However, the Medicaid program has not completed a study to know what its error rate is. A recent federal audit found that the rate was close to 4.5 percent. The federal audit, called the Payment Error Rate Measurement (PERM), however, did not sample a sufficient number of claims to determine the degree of payment accuracies. The PERM audit only sampled 504 cases from a universe of 9.2 million claims, or a fraction of 1 percent of total claims. This low sampling amount is not statistically significant.

From the 504 claims sampled, PERM estimated an overall error rate of 4.49 percent. The PERM audit samples three different areas: eligibility, data processing, and medical necessity. The latter two are completed through consultants, with the eligibility section being

BPI information is not consistent with data reported to the federal government.

A recent federal audit found a payment error rate of 4.5 percent, though the study was not statistically significant.

completed by staff within the DOH. Figure 4.6 shows the results of the PERM audit.

Figure 4.6 PERM Error Final Report. Sampled claims from the federal PERM audit. In the case of Utah, the claims were taken from a universe of more than 9 million claims filed. Total reported errors were 4.49%.

	Eligibility	Data Processing	Medical
Sample number	504	520	272*
# of errors	5	14	23
Percentage	1.0%	2.7%	8.5%

**The 272 cases must come from the 520 cases sampled for data processing.*

A statement from CMS strongly advised states not to compare error rates among states, since each state program and its policies vary. CMS says that the PERM study will be used to measure each state's progress in reducing improper payments over time, not compared to other states. The error rates are calculated every third year of the federal PERM audit cycle.

BPI Can Improve Its Utilization Of Staff Time and Resources

Program integrity has a poor process for maximizing staff resources because they have not developed employee assignment protocols or a cost allocation system. In some instances, staff may spend several hours or days and only recover a few dollars. Management appears unaware of potential returns that staff can accomplish. This is evident by reviewing BPI's recoveries and reviewing estimates of where staff spend their time.

BPI Not Aware of Employees' Return on Investment

BPI does not track performance-based information on employee return on investment. Where BPI has the potential to return a significant amount of dollars back with its investment in staff, we believe it is important for BPI to track this information. To provide an estimate of return on investment, we obtained staff salary

BPI is not maximizing staff resources, another likely reason why BPI's recoveries are lower than nationally recognized levels.

BPI is not adequately tracking employees' performance and is not aware of employees' return on investment.

information and asked BPI to estimate the percent of time they spend on various activities. We then estimated the percent of staff salary and benefits that were allocated to certain recovery efforts; we did not include any fixed expense, such as administrative overhead. We were surprised by our findings. In one area of review, BPI was achieving a negative return on investment, but in another, more organized area, BPI was receiving a five-to-one return. BPI was unaware of these discrepancies in the return on staff investment. Figure 4.7 provides the results of this study for two primary BPI activities (BPI reports six different activities they are engaged in).

Figure 4.7 Rates of Return for Two Primary BPI Activities. According to information provided by BPI, rates of return vary drastically between two recovery types. In one case, BPI is achieving a negative return on investment.

	Follow-Up Reviews (Formally Known as MFRs)	Inpatient Hospital (Not Including 30-Day Re-Admit)
Salary/Benefits	\$63,730	\$112,367
Recoveries	16,346	588,632
Recovery/Expenditure	.26	5.24
Net or Benefit Cost	(\$47,384)	\$476,265

This figure clearly shows that follow-up reviews are an inefficient use of staff resources. We question why BPI continues to conduct annual follow-up reviews of the same providers when there is no requirement to do so. It is clearly inefficient to do redundant reviews without an idea of return on investment.

Looking at the dollar amount of some of BPI's recoveries, we found 145 recoveries that were \$100 or less. Twenty-eight percent of these recoveries were under \$20, and several were under \$5. Consequently, many of these claims cost significantly more in staff resources than what the recovery collected.

As part of a recommendation made to the Utah State Tax Commission by a legislative audit in 2006, the tax commission has implemented a staff cost allocation and assignment system that monitors staff time and calculates the return on investment. The tax

In one activity BPI is getting a negative return on investment, but in another area BPI is getting a substantial return on investment. However, BPI was unaware of this information and continued to invest staff resources in the unproductive area.

We also found that BPI staff were spending some time collecting minor recoveries. Thus, the staff cost to make the recovery was more than the actual recovery.

commission reports value in knowing and understanding the return on investment for individual staff members. Developing a staff cost allocation and assignment system will allow BPI to effectively and efficiently allocate staff time and resources.

**Program Integrity Efforts
Can Pay for Itself**

To determine the return on investment for program integrity activities, we asked several states, including Utah, for expenditure information related specifically to program integrity staff. Several other states provided us this information in a timely manner. It took over six months for Utah’s Medicaid program to provide this information, and then we received it only, accidentally, as part of a different data request. Our initial and repeated requests for this specific data were never granted. Figure 4.8 shows that every state that responded to our survey obtains a return on its program integrity investments. Utah’s Medicaid program is not tracking this information.

Figure 4.8 Program Integrity Return vs. Expenditure. This figure shows that for every dollar spent on program integrity, a higher return is received. Utah Medicaid does not track this information.

State	Savings per \$1 Dollar Spent	State	Savings per \$1 Dollar Spent
Maine	\$12.85	Maryland	\$ 5.25
Illinois	6.55	California	2.50
Connecticut	\$6.50	Utah	1.74
		Louisiana	\$1.54

** Data validation was limited to information supplied. Utah data reflects only estimated program integrity recoveries.*

We believe BPI needs to clearly demonstrate it is using staff efficiently and effectively based on accepted performance standards. BPI also needs to show that it is providing a strong rate of return. Once it is clear that staff utilization is improved, the state may benefit from more staff because there are many areas and functions that are not currently being evaluated.

It was difficult for HCF to produce information that allowed us to compare its return on investment to those of other states.

Overall, Utah’s BPI is recovering more than its cost, but Utah’s cost recovery is lower than other states.

Better Performance Measures And Reporting Needed

Improved performance measures and a clear reporting structure would allow BPI to better utilize their resources and discover how to efficiently adjust their efforts for the best results. The lack of specific performance goals and reporting requirements may contribute to the program's low recovery levels as compared to national standards. Without such performance measures, it is difficult for BPI to determine their program's efficiency or effectiveness. There are several performance metrics used throughout the industry that would help BPI determine their program effectiveness.

Clear Performance Measures Should Be Established

In speaking with other health care organizations, we found several commonplace metrics that programs use to determine efficiency and effectiveness. The first, and most basic, measurement is a ratio of the number of open cases in process to the total number of cases closed. BPI would benefit from such a metric that identifies their efficiency in both case closures and time frames for completion.

A second performance measure that would be helpful, and is used by at least one other health care system, refers to the number of investigations that lead to prosecution as well as the number of ongoing investigations. Neither of these statistics is currently tracked by BPI. BPI could use this information to determine if additional training is needed or if more resources should be put toward detecting improper billings. A third area of performance metrics focuses at the investigator level. It would be helpful and beneficial if BPI knew the number of cases per investigator and the amount of money recovered per investigator to help them to allocate resources appropriately.

BPI should establish specific performance measures that identify, among other things, an established number of reviews in functional areas, and their bureau's goals for cost avoidance and cost recovery. BPI should then track these goals and implement changes to processes and policies based on the achievement of these goals.

BPI is not effectively utilizing performance goals to track and monitor performance. This is another likely reason why BPI's recoveries are lower than nationally recognized levels.

We found other health care organizations have several metrics to track efficiency and effectiveness. BPI has not been utilizing these metrics.

BPI should report annually to the Legislature and Governor on cost avoidance, cost recovery and performance goals.

Reporting Requirements Should Be Developed

A reporting requirement should be instituted that requires BPI to report to both the Legislature and Governor on cost avoidance, cost recovery, and performance goals. Other states that have a formal report on Medicaid fraud and abuse include in their reports useful information not only on cost avoidance and cost recovery efforts, but also on the status of the Medicaid program, highlights in service, and methodological practices employed.

Recommendations

1. We recommend that BPI either fix the current SURS system or purchase a working analytical tool that can systematically review claims for fraud, waste, and abuse.
2. We recommend that BPI begin tracking the exact percentage of total program expenditures recovered.
3. We recommend that BPI design a system that allows them to better track, pull, and sort recovery data.
4. We recommend that BPI develop a staff cost allocation and assignment system that can effectively and efficiently allocate staff time and resources.
5. We recommend that BPI track its employees' return on investment.
6. We recommend that BPI develop specific performance measures and develop rating metrics, and then track adherence to these goals.
7. We recommend that BPI report annually to the Legislature and Governor on their cost avoidance and cost recovery efforts.

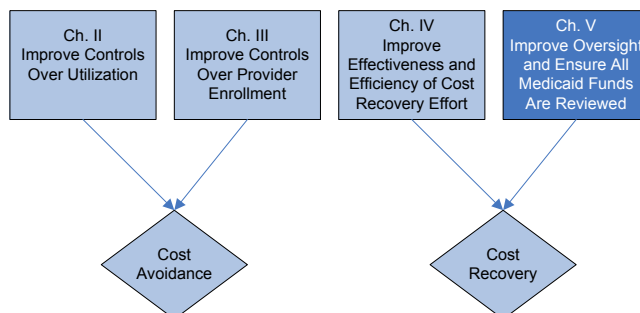
Chapter V

Majority of Medicaid Dollars Receiving No Oversight by BPI

About 95 percent of Medicaid funds, or \$1.5 billion, receives little to no systematic, consistent oversight by the Bureau of Program Integrity (BPI or program integrity) within the division of Health Care Financing (HCF or Medicaid program). This is evidenced by the fact that BPI has a limited sampling methodology for inpatient claims, virtually no sampling methodology for non-inpatient claims, and no oversight over all other contracted Medicaid services (i.e., mental health, long-term care, human services, and managed care).

This lack of oversight by BPI has placed valuable program dollars at risk and has undermined the recovery effort. Due to these oversight weaknesses, a substantial amount of fraud, waste, and abuse is going uncollected. Hence, we believe the National Health Care Anti-Fraud Association's (NHCAA) conservative estimate of 3 percent for the occurrence of fraud, waste, and abuse in health care billings is a realistic target collection rate for Utah (discussed in Chapter IV). Achieving the 3 percent target would save about \$20.2 million additional Medicaid funds annually.

The section of the cost savings model discussed in this chapter pertains to cost recovery through improving oversight and ensuring all Medicaid funds are reviewed, as the darker shaded box below denotes.



To help ensure that all Medicaid dollars are being properly reviewed, BPI should, at least, address three specific objectives.

95 percent of Medicaid expenditures receive little to no oversight by BPI.

The lack of oversight by BPI has placed Medicaid dollars at risk; this is another likely reason why BPI's recoveries are lower than nationally recognized levels.

Most recoveries have come from other entities; BPI's recoveries only represent a fraction of 1 percent of total program expenditures.

- Bolster recovery efforts with inpatient care. Currently, 78 percent of inpatient care expenditures are not being reviewed.
- Conduct random sampling for non-inpatient care. Currently, BPI is only reviewing non-inpatient care providers on a referral basis and selecting a few of the highest paid providers. This means that over 90 percent of non-inpatient care providers are receiving no systematic review.
- Conduct oversight/coordination of efforts over all other contracted Medicaid services currently receiving no oversight by BPI. Other contracted Medicaid services account for about \$747 million, or about 50 percent of the Medicaid budget.

As shown in Chapter IV, Utah's Medicaid recovery system has been an uncoordinated effort that is ineffective and inefficient. Most recovered funds are a result of third-party liability recoveries, which are done outside of BPI by the Office of Recovery Services (ORS). Medicaid spends over \$1.6 billion in Utah each year in program costs, yet BPI only recovers a fraction of 1 percent of total program expenditures. (As shown in Chapter IV, factoring in recoveries by third parties, the recovery rate was about 1.72 percent.) Figure 5.1 illustrates recovery by program area.

Figure 5.1 Expenditures and Recoveries by Program Area FY 2008.

The amount recovered by BPI is shown in the first two rows and totals about \$1.5 million. The last two rows were recoveries made by other entities and total about \$22.2 million. We believe that much more can be recovered in each of the below program areas.

Program Area	Expenditures by Program Area	Reported Recovery Amount ¹	Summary of Recovery Effort Concerns
Inpatient	\$331,713,815	\$1,421,000	BPI recovered \$589,000 with inpatient reviews using limited sampling. BPI also recovered \$832,000 in the 30-day re-admit reviews.
Non-Inpatient	545,394,341	70,000	BPI used limited review methodology to recover this low dollar amount.
Other Contracted Medicaid Services ²	746,629,030	1,809,000	No evidence of BPI oversight exists in this area. 94% of recoveries were made by Healthy U managed care plan.
	Misc Recoveries ³	20,376,000	Recoveries were not made by BPI. Data was not sufficient to break out these recoveries. 90% of these recoveries are third-party liability (TPL) made by ORS.
Total	\$1.6 Billion	\$23.7 Million	

1. Recoveries listed are amounts we obtained directly from program integrity. Further, as discussed in Chapter IV, many data problems exist. Accordingly, we could not precisely categorize all recovery amounts. Some numbers reflect general estimates
2. These other contracted Medicaid services include managed care, long-term care, mental health, and human services. BPI did not have data on these recoveries, as they should. We obtained this information from other entities and are relying on their reporting of the information. Some discrepancies may exist, and some information may be partial.
3. These recoveries were conducted by ORS, MFCU, and Medicaid auditors. However, again, the sophistication of the data did not allow us to break these recoveries out by program area; thus, they are listed separately in aggregate.

The majority (78 percent) of the \$23.7 million recovered came not from program integrity, but from the Office of Recovery Services (ORS), third party liability (TPL) collections. BPI has a contract with ORS to conduct these recoveries. TPL recoveries reflect refunds ORS sought from private insurance companies (private insurance does not preclude Medicaid eligibility). A lack of documentation exists, but likely these recoveries occurred predominately in the inpatient and outpatient health areas. Comparing Utah's recovery rate to rates of other states is difficult due to differences in reporting, but it does

Limited recovery efforts are in place for many of Medicaid programs. The inpatient program area is currently receiving the most oversight by BPI.

The majority of recoveries shown in Figure 5.1 are for third-party liability, collected by the Office of Recovery Services.

appear that some states recover more than the NHCAA's 3 percent fraud, waste, and abuse estimate.

BPI Should Increase Inpatient Utilization Reviews

BPI has a process in place to review some inpatient claims, but due to SURS problems (see Chapter IV), the process is limited. This is also likely contributing to BPI recovering less than nationally recognized levels.

According to BPI's records, they are only systematically reviewing about 5 percent of Medicaid dollars. The majority of BPI's recoveries come from two activities within inpatient care: (1) inpatient utilization reviews, or hospital utilization reviews (HUR), and (2) 30-day re-admits. The 30-day re-admit process is a technical billing method that does not require sampling and is not discussed in detail in this report. However, we are encouraged that this system appears to be working well.

The primary handicap to the inpatient utilization reviews is the ineffective Surveillance and Utilization Review System (SURS), discussed in Chapter IV. Specifically, the SURS system is only capturing about 22 percent of all inpatient expenditures, or about \$74 million of the \$332 million spent for inpatient care.

Recoveries Could Be Increased by Increasing Inpatient Utilization Reviews

Increasing inpatient utilization reviews could significantly help increase recoveries lost to fraud or abuse. BPI's system for monitoring inpatient claims is through the HUR process. Program integrity utilizes the HURs to provide a random check of inpatient claims. According to BPI's records, approximately 40,600 inpatient claims were submitted for payment in fiscal year 2008. However, because the SURS report is not coded correctly, it is not sampling from the entire universe of claims. Thus, many inpatient claims have no chance of ever being selected.

For fiscal year 2008, only 494 (1.2 percent) of the 40,600 inpatient claims were reviewed. However, at the time of our review, 76 of the cases were still open, leaving 418 completed cases. Increasing the percentage of inpatient claims reviewed would increase recoveries of fraud and abuse and help avoid future inappropriate

BPI only reviewed about 1.2 percent of inpatient claims in fiscal year 2008.

billings due to the sentinel effect of knowing that the claims are receiving greater scrutiny.

Increasing Inpatient Reviews Can Help Save Medicaid Dollars

Fiscal year 2008's case review resulted in the inpatient review process (or HUR) recovering about \$579,000 for claims that were not medically necessary, fraudulent, or simply lacking proper documentation. The \$579,000 recovery amount is based on the date service was given and differs slightly from the recovered amount, which is based on the date recovery was made. The 30-day re-admit process recovered \$832,000.

BPI works with the hospitals to ensure proper documentation is provided, but hospitals often fail to provide the necessary documentation within the 30 days allowed by Utah and other states. There is an appeal process if providers feel program integrity wrongly recovered funds. The most common reason that HURs generate payment recoveries is that hospitals fail to send medical records. Not sending in medical records could be evidence of either a non-contested review or the hospital simply forgetting to comply with the request.

Of the 418 claims that were inspected in 2008, 46 (11 percent) were recovered through the HUR process. Of these, 37 were recovered because medical records were not received or were received late, and 9 were recovered because the claim did not meet Medicaid requirements.

The 9 claims that were deemed medically unnecessary represent 2.2 percent of the 418 inspected claims and account for \$63,028.77 of inpatient recoveries. Extrapolating this 2.2 percent to all inpatient claims translates into 875 claims that potentially could have been deemed medically unnecessary. When the 2008 recovery average of \$7,003.20 per medical necessity claim is applied, \$6.1 million of additional recoveries may be possible from testing all inpatient claims. If all claims were reviewed and BPI continued to recover on 11 percent of claims, BPI would recover \$31.3 million.

We were surprised to see the extent of claims where money was recovered because no claim was sent in. We asked some surrounding states what time limits they have in place for sending in records once

If BPI was able to test all inpatient claims and the higher recovery rate stayed true, BPI could have recovered about \$31.4 million in fiscal year 2008.

requested and found that Utah had the longest standard. However, hospitals often do not send in records within 30 days. We were able to find a number of instances where BPI requested several different patients' medical records from a hospital at the same time, and the hospital sent in some, but not all, of the records. In these instances, it appears that the hospitals are not contesting the claims review, since sending in some other records seems to indicate their awareness of the records request. Some of the claims that were recovered because records were not sent could be legitimate claims that should have been paid. However, many of these may have not knowingly been contested by the hospital.

The extent to which the current HUR collection rate can be applied to all collections depends on several variables. One such variable is the level of effort on Medicaid's part. A high level of effort may prompt hospitals to be more precise in the billings and more diligent in sending in medical records, which could reduce the amount of recoveries but would still help save millions through cost avoidance.

BPI Should Consistently Review Non-Inpatient Medical Care Claims

Currently, BPI does not have an organized, systematic review process in place to adequately review the utilization of Medicaid funds in non-inpatient categories of service, such as physician services, outpatient, pharmacy, dental, etc. However, it is a requirement of the federal government to have such a system in place.

Federal Government Requires Utilization Reviews

Prior to the Balanced Budget Act in 1997, states were required to conduct a certain number of System Performance Reviews (SPRs). These utilization reviews were designed to detect fraud, waste, and abuse in the Medicaid system. The 1997 Balanced Budget Act eliminated this requirement but requires the states to "have in operation mechanized claims processing and information retrieval systems" that is "adequate to provide efficient, economical, and effective administration" of the State Plan.

BPI has no systematic process in place to review non-inpatient claims. This is another likely reason BPI's recoveries are lower than nationally recognized levels.

The 1997 Balanced Budget Act requires states to have a mechanized claims processing and information retrieval system.

Further, according to the *Guidance and Best Practices Relating to the States' Surveillance and Utilization Review Functions* prepared by the Health Care Financing Administration, "When Congress eliminated the SPRs, it did not diminish the importance of the Surveillance and Utilization Review (SUR) function. It intended to provide the States with greater flexibility in performing the SUR function."

BPI has not followed this guidance due to SURS' inability to access all program expenditures. This deficiency has limited BPI's ability to identify aberrant billing processes. Currently, BPI limits its non-inpatient reviews to the following:

- Reviews of providers that had past concerns
- Referrals
- A limited review of some of the highest-paid providers

This process ignores the vast majority of providers; consequently, most non-inpatient providers have virtually no risk of being reviewed. To correct this large gap in reviews, BPI should:

- Conduct a random sampling of claims.
- Conduct more financial audits of providers.
- Obtain a functioning computer analytical tool.

It is difficult to quantify how much more BPI could recover by implementing these steps. However, we believe this non-inpatient area is a critical part of BPI achieving NHCAA's conservative 3 percent recovery amount, which would translate into about \$20.2 million annually in savings.

BPI Should Establish a System For Randomly Sampling of Claims

Since BPI is not employing random sampling of claims or regular checks on providers, as other states do, it is possible that a provider could be committing fraud, waste, or abuse with great frequency and not risk detection by the current system. Unless BPI receives a referral from an outside source, they have essentially no way of detecting fraud, waste, and abuse in the majority of the non-inpatient provider population.

BPI does not have an adequate system in place that reviews non-inpatient claims.

Due to BPI's lack of random sampling in non-inpatient claims, a majority of non-inpatient providers are never reviewed.

In the event that a follow-up review is conducted, the process currently used by BPI involves sampling a very low percentage of the selected provider's claims. The selected claims are checked by BPI to ensure that billing was done appropriately and that documentation exists to show appropriateness of claims. However, according to the program integrity director, serious problems exist with the review of data. Reviews are only done on billing issues that had problems in the past. The entire claim is not reviewed, just the area that had past problems.

BPI Should Consider the Use of Statistical Sampling When Reviewing Providers. Using statistical sampling or extrapolation in provider utilization reviews can increase the amount of recoveries made for inappropriate billings. Extrapolation should be used when BPI can clearly demonstrate a pattern of inappropriate billing.

A sample conducted by BPI shows that with the use of extrapolation, the effective number of audited claims could increase over 2,000 percent and, with that increase, claim recoveries would also increase. The use of statistics in auditing is a common practice utilized by auditors and accepted by both the Government Accountability Office (GAO) and the American Institute of Certified Public Accountants (AICPA). Further, several other state Medicaid programs use extrapolation or statistical sampling in their provider audits. From 12 states that responded to our survey, 7 reported using extrapolation in their review of providers.

The GAO has published audit sampling guidelines in both the Yellow Book, its auditing standards, and in their report titled "CMS Methodology Adequate to Estimate National Error Rate." Further, the AICPA *Statements on Auditing Standards* (SAS), Number 39 provide guidelines to auditors when using statistics to extrapolate audit findings.

Figure 5.3 provides the results of a sample of six cases conducted by program integrity. The sample shows that by using extrapolation in these cases, BPI could have increased recoveries by almost \$47,000.

The use of statistics in auditing is a common practice.

The GAO and the AICPA have guidance on the use of statistical sampling in auditing.

Figure 5.3 Use of Statistical Sampling. Cases and data provided to us by BPI show nearly a 2,400 percent increase in recoveries using extrapolation.

Case Number	Sample Size	Amount Recovered	Amount Recovered Extrapolation	Percent Increase Using
Case 1	25	\$ 89	\$ 2,417	2,600%
Case 2	30	1,280	39,921	3,020
Case 3	89	29	150	420
Case 4	16	83	758	820
Case 5	18	260	666	160
Case 6	25	\$ 210	\$ 4,781	2,180%
			Average Increase	1,530%

At least 7 out of 12 states that responded to our survey use extrapolation in their audit findings. The following examples show two other states that use extrapolation:

- Texas Medicaid reports a 2,016 percent increase using extrapolation, or \$367,106 collected by using extrapolation and \$17,351 by not using extrapolation.
- Oklahoma reported that without using extrapolation they would have recovered \$37,056 in 18 months. Using extrapolation, the Medicaid agency recovered \$523,713 a 1,313 percent increase.

We found that at least one private insurance company uses extrapolation in conducting audits of their providers.

BPI Should Conduct More Financial Audits of Providers

Increased financial audits could further ensure correct payments as well as provide a disincentive to providers who commit fraud, waste, and abuse. BPI has expressed a desire to look at medical goods providers to ensure they have real physical addresses and inventory, nursing homes that have withheld information regarding ownership and control of facilities, and mental health reviews to ensure services

Other state Medicaid programs report using extrapolation in their auditing.

BPI should increase the frequency of financial related audits of providers.

The only financial audit of a provider conducted by BPI in the last several years found potential fraud.

Other contracted Medicaid services totaling \$747 million are receiving little oversight from BPI. This is another likely reason why BPI's recoveries are lower than nationally recognized levels.

rendered were appropriate. BPI claims that these areas have known problems, but they do not have the staff to investigate.

The only Medicaid “financial audit” from the last several years that we could identify found possible fraud. In this case, a BPI employee noticed an abnormally large number of payments to a particular provider. The provider was billing for units of particular health care equipment beyond the provider’s physical ability to store the equipment. Further inquiries showed that billing amounts did not equal what drivers reported delivering. After preliminary inquiries, the case was handed over to the Medicaid Fraud Control Unit (MCFU) for further investigation, where the case is currently still being researched.

Other Contracted Medicaid Services Need Better Coordination

Other contracted Medicaid services have made some minor fraud, waste, and abuse recoveries. These services include managed care, human services (DHS), mental health, and long-term care and accounted for nearly 50 percent of all Medicaid expenditures, or about \$747 million in fiscal year 2008. However, less than 1 percent of this amount has been recovered for fraud, waste, and abuse.

In total, \$1.8 million of the \$747 million was recovered, 94 percent of which came from one managed-care entity. That entity accounted for about \$81 million of the \$747 million in other contracted Medicaid services. Of the remaining \$666 million, we could only find documentation for about \$43,000 (.006 percent) in recoveries. With such a small amount of recoveries being made, we believe the lack of oversight by BPI is partially to blame. BPI did not have any data on recoveries, nor have they been supervising recovery efforts in these other areas. Little is known about what, if any, recovery efforts are occurring in these areas. Increasing recovery efforts in these untapped areas makes the potential of recovering 3 percent of program expenditures, or an additional \$20.2 million annually, more likely.

BPI Not Conducting Oversight With Managed Care

It appears that the managed-care plans have returned some recoveries to the state, which have been primarily TPL recoveries. However, BPI was not aware of the recoveries. The managed-care plans had apparently been reporting some information to another bureau in Medicaid, but poor coordination between bureaus apparently resulted in BPI not obtaining the information on the recoveries. It was reported to us that the managed care plans have cost avoidance measures in place. These measures have not yet been audited. The information in this section details cost recovery amounts as reported by the managed care plans.

Managed Care Has a Disincentive to Report Fraud and Abuse. The current contract structure between the state and managed care entities creates a disincentive for these entities to attempt recoveries for fraud, waste, and abuse. The contract stipulates that when fraud or abuse is found that the claim amount, along with the 8 percent administrative fee charged by the health care group, is returned to Medicaid. Therefore, any claim that is recovered as a result of fraud, waste, or abuse is lost administrative revenue for the managed-care entity. These entities have to incur costs to find fraud, waste, and abuse, yet they would receive less income for doing so. Consequently, oversight by BPI is needed.

Recovery Amounts Reported to Us by the Two Managed-Care Plans Vary Drastically. Currently, there are two managed-care plans that receive an administrative fee of 8 percent for overseeing care of Medicaid recipients: University of Utah Health Plans (Healthy U) and Molina Health Care (Molina). The administrative percent was changed to 8 percent from 9 percent in January 2009.

Healthy U received about \$81 million in Medicaid funds and reported \$1.76 million in fraud, waste, and abuse recoveries. This equates to a 2.2 percent recovery rate. On the other hand, Molina received about \$108 million in Medicaid funds and only reported recoveries of \$3,473. This equates to a .003 percent recovery rate. Further, Molina reported to us that they “did not have any record of receiving refunds [to the state] due to fraud or abuse.” It should be noted that Healthy U utilizes an analytical tool for detecting fraud, waste, and abuse; Molina does not.

BPI should conduct more oversight over the managed care plans’ recovery efforts.

Recovery amounts vary significantly between the two managed care plans.

Greater coordination and oversight needed between BPI and DHS.

BPI Conducting No Oversight Of Human Services Medicaid Spending

The Department of Human Services (DHS) received \$203 million in Medicaid funds for fiscal year 2008, which represents 13 percent of all Medicaid program dollars. However, BPI has not conducted any fraud, waste, and abuse recovery efforts at DHS, nor do they have a coordination/oversight system over these dollars. The Medicaid auditors at HCF have conducted audits at DHS, but their efforts are not coordinated with BPI.

DHS has their own audit group, called the Bureau of Internal Review and Audit (BIRA), which performed over 50 audits and 13 reviews last year. However, only seven of the reviews involved Medicaid funds. BIRA reports recoveries totaling approximately \$20,000, none of which was reported to BPI for tracking purposes. Accordingly, more oversight by BPI is needed.

BPI Not Conducting Oversight With Mental Health

Mental health centers not actively reporting recovery information to BPI.

The various private organizations providing mental health treatment also provide some review of their programs, but these reviews are outside the purview of BPI. Mental health operates on a capitated (per-client) basis. We spoke to two of the largest mental health providers, and they claim to do frequent audits. However, any recoveries made are not reported to BPI, and they go back to the private health care businesses themselves. We believe that these recoveries should be reported because they need to be accounted for when determining the annual capitated amount paid to private mental health facilities. One fraud case was recently turned over to BPI, but the error was determined to be unintentional and has since been corrected.

BPI Not Conducting Oversight With Long-Term Care

BPI should be more involved in reviewing long-term care expenditures.

Long-term care is broken into two different sections. One division of long-term care focuses on nursing homes, and the other deals with community programs for the developmentally disabled. We were able to identify \$19,000 in recoveries from the community program section.

The supervisor of the section of long-term care over nursing homes indicated they do not have a role in fraud, waste, and abuse because it is BPI's responsibility. BPI had no information from any of the bureaus within HCF on nursing home fraud, waste, and abuse. BPI staff said that they were told the financial bureau was conducting those reviews. That may be true, but there is no record that BPI was receiving information on these reviews. We believe this indicates poor coordination among HCF bureaus.

Recommendations

1. We recommend that BPI develop a systematic methodology that allows them to review all Medicaid dollars in inpatient and non-inpatient program areas for fraud, waste, and abuse.
2. We recommend that BPI provide adequate oversight and ensure Medicaid dollars are being reviewed for fraud, waste, and abuse in all other contracted Medicaid services.
3. We recommend that BPI consider using statistical sampling or extrapolation in their audits of providers.
4. We recommend that BPI conduct more financial audits of providers.

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Chapter VI

Greater Independence Needed For DOH Oversight Functions

Medicaid’s oversight functions within the Department of Health (DOH) have not been well utilized. Three entities, the Bureau of Program Integrity (BPI), DOH internal auditors, and Medicaid auditors all lack the level of independence necessary to appropriately address their missions and functions. For BPI, the function that particularly needs independence is the cost recovery function, also known as post-payment review. The cost savings model is not shown in this chapter because oversight independence is not a specific step or process that needs to be taken to improve savings; rather, it ensures the steps are completed fully and correctly.

In one case, BPI’s mission to “prevent and reduce fraud, waste, and abuse in the Medicaid system” was questioned when an established appeals process was not followed, and a recovery was ordered even though there is no record that BPI ever reviewed the medical records to test for medical necessity before the money was returned. We also found that DOH internal auditors do not have the statutorily required level of independence and rarely audit the Medicaid program, even though Medicaid comprises about 90 percent of DOH’s budget and 18 percent of the state’s budget. Lastly, Medicaid auditors within the Medicaid program’s finance bureau also do not conduct internal reviews of the Medicaid program.

In each case, the bureaus conducting the oversight functions have been inappropriately placed in a position of reporting directly to the management of the reviewed entity. Oversight independence is impaired because management can fall into a protective mode that fails to make needed improvements.

Program Integrity Independence Has Been Limited

BPI’s cost recovery or post-payment review function does not have sufficient independence from Medicaid operational leadership. Our concern is that the recovery process established in policy and administrative rule can be circumvented by the Medicaid director.

Medicaid’s oversight functions have not been well utilized and need greater independence.

DOH oversight functions are placed in a position of reporting directly to management of the reviewed entity.

The Medicaid director has too much control over BPI's functions.

A recovery was returned even though no documentation exists that the provider's claim was selected to be tested for medical necessity.

Further, the current reporting relationship of program integrity to the Medicaid director does not allow reviewer independence and is not allowed in some other states, where program integrity reports to either a board or a higher-level officer.

Medicaid Director Ordered the Return of \$370,000 Though Recovery Process Had Not Been Completed

In our limited review of inpatient recovery claims for the last several years, we found one instance a few years ago where a provider discontinued the established appeals process and, instead, took the case directly to the Medicaid director. The Medicaid director sided with the provider and ordered the recovery of a \$370,000 claim. Our concern is that there is no evidence that BPI determined the medical necessity of the claim before the funds were returned. In fact, no records could be found during the course of the audit, and there was no indication in BPI's files during the audit to suggest the records were ever reviewed.

A new copy of the records was sent in by the provider, at the request of the Medicaid director, after our audit work was completed. BPI reviewed the documents and found the claim medically necessary, though this knowledge was not available to the Medicaid director at the time the funds were returned. The Medicaid director indicated to us that he believes one-time exceptions are appropriate to maintain relationships with providers. However, providers should still be required to submit to the inpatient utilization review process that reviews records for medical necessity.

Determination of Medical Necessity Should Be First Priority.

The inpatient utilization process requires that claims be sampled from hospitals. For the provider in question, BPI requested medical records in order to determine the medical necessity of the claim. *Utah Administrative Rule R414-1-14-4* requires hospitals to comply with the information request within 30 days, or "if there is no response within the 30 day period, the agency will close the record and will evaluate the payment based on the records available."

The provider did not comply with medical records request within 30 days leaving BPI with no information to evaluate medical necessity. Accordingly, they notified the provider after 43 days that they would

recover \$3700,000 paid for the claim. About two months later BPI recovered payment.

The provider originally followed procedure and filed a request for hearing. The provider filed this request 30 days late. Nevertheless, HCF accepted the request even though medical necessity had still not been determined. Two months after filing the request for a hearing, the provider dropped its request. In dismissing the case the Administrative Law Judge (ALJ) wrote:

It is my understanding that you [the provider] no longer wish to pursue a formal hearing for the above-referenced case. Accordingly, I am dismissing your hearing request.

Five months after the hearing was dismissed, the provider contacted the Medicaid director and asked that the recovery be paid back due to extenuating circumstances (staff turnover and document transition), that “may have contributed to the records not being sent timely.”

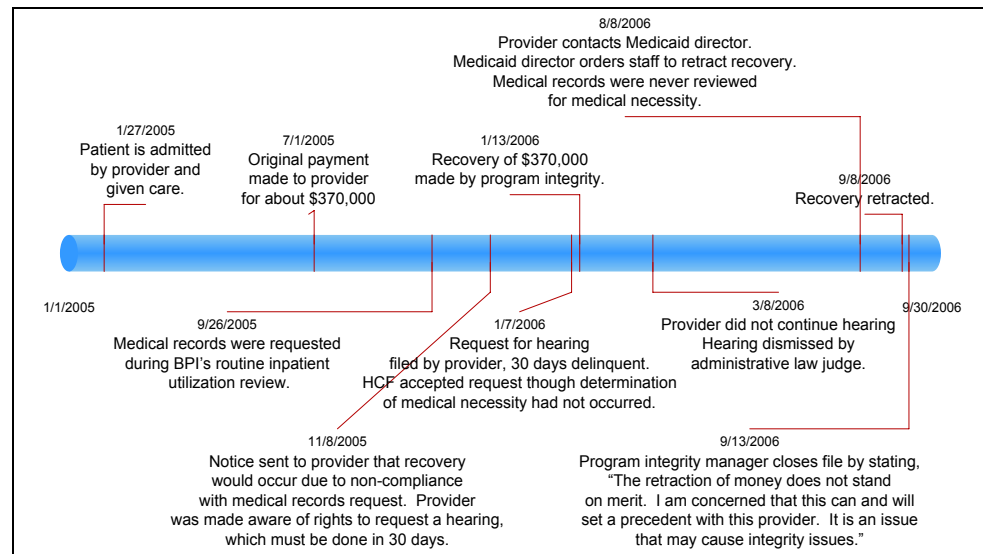
The Medicaid director asserts that the records were sent in a few days delinquent, and Medicaid should not keep \$370,000 based on such a minor delinquency. Nevertheless, whether or not the records were sent on time, the case documentation clearly shows that BPI made no determination of medical necessity before the funds were returned to the provider. BPI only reviewed the medical records after our audit fieldwork was completed, which was about two and half years after the funds had been returned.

This Case Shows that the Medicaid Director Can Control The Recovery Process. Our concern is that the recovery process established in policy and administrative rule may be dictated by the Medicaid director. Regardless of the specific details of this case, it shows that the Medicaid director oversees the program integrity function. We believe a function such as program integrity should have greater independence. Figure 6.1 shows key events that occurred during this process.

The Medicaid director asserts records were sent in a few days delinquent, and Medicaid should not keep a recovery based on this minor infraction. Nevertheless, the provider should have still been required to submit to the medical necessity test.

Though many different events occurred for this one case, we could find no evidence of the medical records being reviewed for medical necessity before the funds were returned.

Figure 6.1 Timeline. Ten months elapsed between BPI requesting medical records and the provider acknowledging the request. The Medicaid director never required a review of medical records, and the provider retained \$370,000 in Medicaid funds.



The appeal process that should have been followed requires the provider to follow through with the hearing process established in administrative rule and BPI policy, as shown by Figure 6.2.

Figure 6.2 Administrative Rule and BPI Policy. BPI policy and *Utah Administrative Rules* both state that an appeal should go through the hearing process.

The process established in rule dictates that reimbursement for services must be verified by adequate records.

Utah Administrative Rule 414-1-14

The Medicaid agency may request records that support provider claims for payment under programs funded through the agency. . . . If there is no response within the 30 day period, the agency will close the record and will evaluate the payment based on the records available. . . . Medicaid will make a written request for a refund of the payment. Unless appealed, the refund must be made to Medicaid within 30 days of written notification. An appeal of this determination must be filed within 30 days of written notification as specified in R410-14-6. Reimbursement for services provided through the Medicaid program must be verified by adequate records.

Program Integrity Manual

The denial letter must not invite the submittal of new information. Once the decision for denial has been made, and the letter sent, the hearing process must proceed. Any further communication on the case from the recipient or the provider must be addressed through the hearing process or through the Health Program Manager responsible for the hearings.

We concur with the statement made by the program integrity director concerning the Medicaid director's decision to return the funds without following the established process:

The retraction of money does not stand on merit. I am concerned that this can and will set a precedent with this provider. It is an issue that may cause integrity issues.

A more independent program integrity function would have followed the appropriate process and allowed the outcome to be decided by the appeals process. By administrative rules, at the end of a formal hearing, the Medicaid director, as assigned by the DOH director, can overturn any decision. See *Utah Administrative Rule 410-14-16*. However, in this case, the provider allowed the formal hearing process to lapse, and the case was dismissed with no decision being rendered. Providers should be sure to appeal the decision within the time frame of the appeals process and see the hearing process through.

We compared the 30-day time limit for providers to submit medical records with time limits in other states and found that 30 days appears reasonable. Further, the BPI director said in the past they tried giving extensions and allowing soft enforcement of the time limits; still, in many instances, BPI had no additional success in obtaining medical records.

Medicaid participates in an electronic-records-review system that providers can utilize instead of manually sending in records. Many hospitals have opted out of this electronic retrieval system. Using electronic records would lessen the likelihood that the lack of records was the reason for a recovery. Also, it appears in some cases that providers do not send in records when they understand a claim will not be held up as medically necessary. For example, we found some instances where a provider responded to several medical requests but did not respond to others within the same time frame.

BPI Independence Not Sufficient to Question Claims Paid for an Undocumented Resident

Another example of BPI not having sufficient independence to accomplish its mission occurred with payments made to an undocumented resident who has received about \$2.3 million in services since July 2000. The BPI director questioned this individual's

Medicaid participates in an electronic-records-review system that providers can utilize to ensure records are received; however, some providers have opted out of this system.

Another example of the BPI's director lack of independence occurred when he attempted to question payment to an undocumented resident. It appears the BPI director's concerns were dismissed.

A memo or some form of formal communication should have been given to the BPI director explaining why his concerns were being dismissed.

eligibility on at least two different occasions. The first attempt was in a memo to the Attorney General's Office. What appears to be the latest attempt to question the eligibility of this person came in a memo dated June 14, 2007 from the BPI director stating the following:

As of June 14, 2007 all claims processed for [individual] have been suspended. No claims will autopay without suspension for claim review. . . . According to the Federal Guideline for Emergency Only, [individual] does not meet criteria at this time. All after his initial accident has resulted in long term care.

The federal guidelines referred to by the BPI director can be found in the *Code of Federal Regulations* (42 CFR 440.255).

According to the above federal regulation, undocumented residents qualify for emergency-only care. We spoke with Medicaid management regarding the eligibility of this individual, and we understand it is a difficult eligibility question. However, it is troubling that the latest concerns of the BPI director were dismissed with relatively no discussion or action. The BPI director clearly felt that this individual did not qualify for Medicaid. Currently, this individual continues to receive care paid by Medicaid, which totals about \$25,000 a month or \$300,000 a year.

In this case, at a minimum, a memo from management to BPI stating the difficulties to eligibility determination and the reasons why this individual continues to obtain Medicaid funding should be expected. Guidelines explaining the circumstances when Medicaid will deviate from the rule would help BPI deal with similar situations that may arise.

Program Integrity Should Be Independent of Medicaid Director

We believe that the program integrity function needs independence from the Medicaid director, as is done in 15 other states. Program integrity was made a bureau in January 2008. Shortly before this date, a memo from the Medicaid director to the deputy director of DOH stated the following:

The formation of the Bureau of Program Integrity within the Division of Healthcare Financing will focus Utah's effort to ensure

a fair and balanced approach to answer the growing concerns within CMS about Utah's commitment to Medicaid integrity.

This was a good first step taken by the Medicaid director; however, because the director did not relinquish control to the agency head or an independent board, BPI's independence was hindered.

Other States Have Independent Program Integrity Offices.

We found 15 other states with program integrity bureaus that do not report to the Medicaid director. For example, in Illinois, the Medicaid inspector general is appointed by the governor and confirmed by the senate and reports to an executive inspector general. In Tennessee, an independent provider fraud task force controls fraud, waste, and abuse recoveries.

We recommend that the program integrity director no longer report within the Medicaid organization. Accepted audit practice shows that the program integrity director should report to either the executive director of DOH or an independent oversight group.

DOH Internal Auditors Do Not Have Statutorily Required Independence

DOH does not allow its internal auditors the required statutory independence. The DOH internal auditors are not conducting consistent internal audits of the Medicaid program. The Medicaid program (Division of Health Care Financing or HCF) comprises about 90 percent of the DOH's budget and 18 percent of the state's budget, yet it receives little internal audit oversight. Over the last 10 years, only 3 reports out of 251 (less than 1 percent) completed by the DOH internal auditors dealt with Medicaid. This lack of internal review exposes the state to considerable risk, in that over \$1.7 billion (\$500 million state dollars) of the state's annual budget is not being internally reviewed for efficient and effective use.

Some other states have independent program integrity offices.

DOH internal auditors do not have statutorily required independence. Internal auditors have only conducted 3 audits in the last 10 years of the Medicaid program.

Internal Auditors Do Not Have Statutorily Required Independence

The DOH's organizational structure violates the statute for internal auditor independence. DOH's current structure has the director of internal audit reporting to the finance director, who reports to a deputy director of the department. According to *Utah Code*, the audit director is required to report to the agency head. Figure 6.3 outlines requirements of the *Utah Code*.

Figure 6.3 Utah Internal Audit Act. *Utah Code* requires that the internal audit director report to the agency head, which is not occurring at DOH. Also, internal audits should be conducted in accordance with professional auditing standards.

Utah Code requires that the internal audit director report to the agency head; however, this is not occurring at DOH.

Utah Code 63I-5-302

The agency internal audit director reports to the agency head and to the audit committee, if one has been established, and has freedom of access to the agency head to ensure that the director is responsive to the agency head's specific requests, directions, and needs.

Utah Code 63I-5-401

Audits are conducted in accordance with professional auditing standards such as those published by the Institute of Internal Auditors. . . .

Utah Code also requires that internal audits be conducted in accordance with professional auditing standards. Professional auditing standards also require that the audit director be independent from impairment; this is generally interpreted to mean that the audit director reports to an independent audit committee. Figure 6.4 provides examples of auditing standards related to independence.

Figure 6.4 Professional Auditing Standards. Professional auditing standards maintain that true independence is achieved when the auditing director reports to an independent body. This is not occurring at DOH.

Institute of Internal Audit Standards

IIA [standards]. . . require that the Chief Audit Executive (CAE) report to a level within the organization that allows the internal audit activity to fulfill its responsibilities. The Institute believes strongly that to achieve necessary independence, the CAE should report functionally to the audit committee or its equivalent. For administrative purposes, in most circumstances, the CAE should report directly to the chief executive officer of the organization. . . . Appropriate reporting lines are critical to achieve the independence, objectivity, and organizational stature for an internal audit function necessary to effectively fulfill its obligations.

Comptroller General of the United States

A government internal audit function can be presumed to be free from organizational impairments to independence if the head of the audit organization. . . (1) is accountable to the head or deputy head of the government entity. . . (2) reports the audit results both to the head or deputy head of the government entity. . . (3) is located organizationally outside the staff or line-management function. . . (4) has access to those charged with governance, and (5) is sufficiently removed from political pressures.

We recommend that DOH comply with *Utah Code* and restructure the reporting relationship so that the director of internal audit reports to an independent board or the agency head of DOH.

Internal Auditors Not Auditing Medicaid Program

With Medicaid being such a large portion of both the DOH's budget and the state's budget, it is reasonable to assume that the DOH internal auditors would be spending a significant amount of time auditing and overseeing the processes of Medicaid. However, in the last 10 years, only 3 out of 251 completed reports dealt with Medicaid. This small number of Medicaid audits may be partially due to the makeup of the DOH audit committee. A controlling number of Medicaid managers make up the audit committee. We were told that the audit committee was set up primarily to discuss audits on Medicaid by the federal government, thus making it understandable to have a controlling representation of Medicaid managers. However, it does not appear this committee is bringing independence to the internal audit function.

Professional auditing standards recommend that the audit director report to the agency head or an independent board.

The Medicaid program represents about 90 percent of DOH's budget, yet DOH auditors only conducted 3 audits of the Medicaid program in the last 10 years.

DOH has an audit committee, but it consists of employees that are not independent.

The committee seems to be somewhat disorganized and unclear of its function. At least one member of the committee was not aware that he was a member. The internal auditors seem to believe that the Medicaid auditors conduct internal audits of the Medicaid program, so they do not see their involvement as needed. As discussed later in this section, the Medicaid auditors perform outside cost settlements of Medicaid providers. We could not find any internal audits conducted by the Medicaid auditors.

The state is exposed to considerable risk. Approximately \$1.7 billion (\$500 million in state funds) of the state's annual budget is not being internally reviewed.

Medicaid Auditors Not Independent

The Medicaid program also has auditors. These auditors do not conduct internal reviews of the Medicaid program and also do not have sufficient independence.

Along with the DOH internal auditors, the Medicaid program itself has auditors. However, these auditors do not internally review the Medicaid program. They perform financial analyses of the Medicaid program and conduct routine cost settlements with various providers. Even if these auditors were assigned to internally review the Medicaid program, their low organizational status would not allow them to conduct independent reviews.

Medicaid Auditors Conduct Mostly Routine Reviews of Providers

DOH internal auditors believed the Medicaid auditors were conducting internal reviews of the program, yet this has not occurred.

The DOH internal auditors believe Medicaid auditors are performing some internal audit functions in the Medicaid program. In fact, Medicaid auditors primarily conduct routine cost settlements, rate increase reviews, and other financial-analyst-type responsibilities. Consequently, this confusion of responsibilities means there is no internal audit review conducted of Medicaid processes and systems.

We reviewed all audits conducted in 2007 and found that about 86 percent of the auditor's work was on cost-settlement-related audits. The remaining 14 percent of the time, the auditors conducted miscellaneous assignments relating to other state agencies or Medicaid providers. We could find no reviews by the Medicaid auditors of any

of the Medicaid program's bureaus, finances, internal policies, state plan initiatives, etc.

Medicaid Auditors Do Not Have Organizational Independence

The current organizational placement of the Medicaid auditors does not allow them to be independent from the Medicaid operation. The Medicaid audit manager reports to the Medicaid finance director, who reports to an assistant Medicaid director. This low organizational placement does not provide satisfactory independence and hinders any attempt by the Medicaid auditors to internally audit the Medicaid program.

Medicaid auditors should achieve more organizational independence by becoming part of the DOH internal audit office or a part of BPI. A representative from Centers for Medicare and Medicaid Services (CMS) believe that the Medicaid auditors will still need to illustrate that their time is spent on Medicaid-related issues to continue to receive the federal participation rate. DOH management may need to redesign their systems to ensure the correct reporting of the Medicaid auditors' time, so the higher match will continue to apply.

The Medicaid auditors should report to either the director of program integrity or the internal audit director, or a combination of both.

Recommendations

1. We recommend that the post-payment review function and all other associated areas within BPI report to either the agency head or an independent board.
2. We recommend that DOH comply with *Utah Code* and restructure the reporting relationship of the internal auditors so that the director of internal audit reports either to the agency head of DOH or an independent board.
3. We recommend that the Medicaid auditors report to either the director of program integrity, the director of internal audit, or a combination of both so they can achieve more organizational independence.

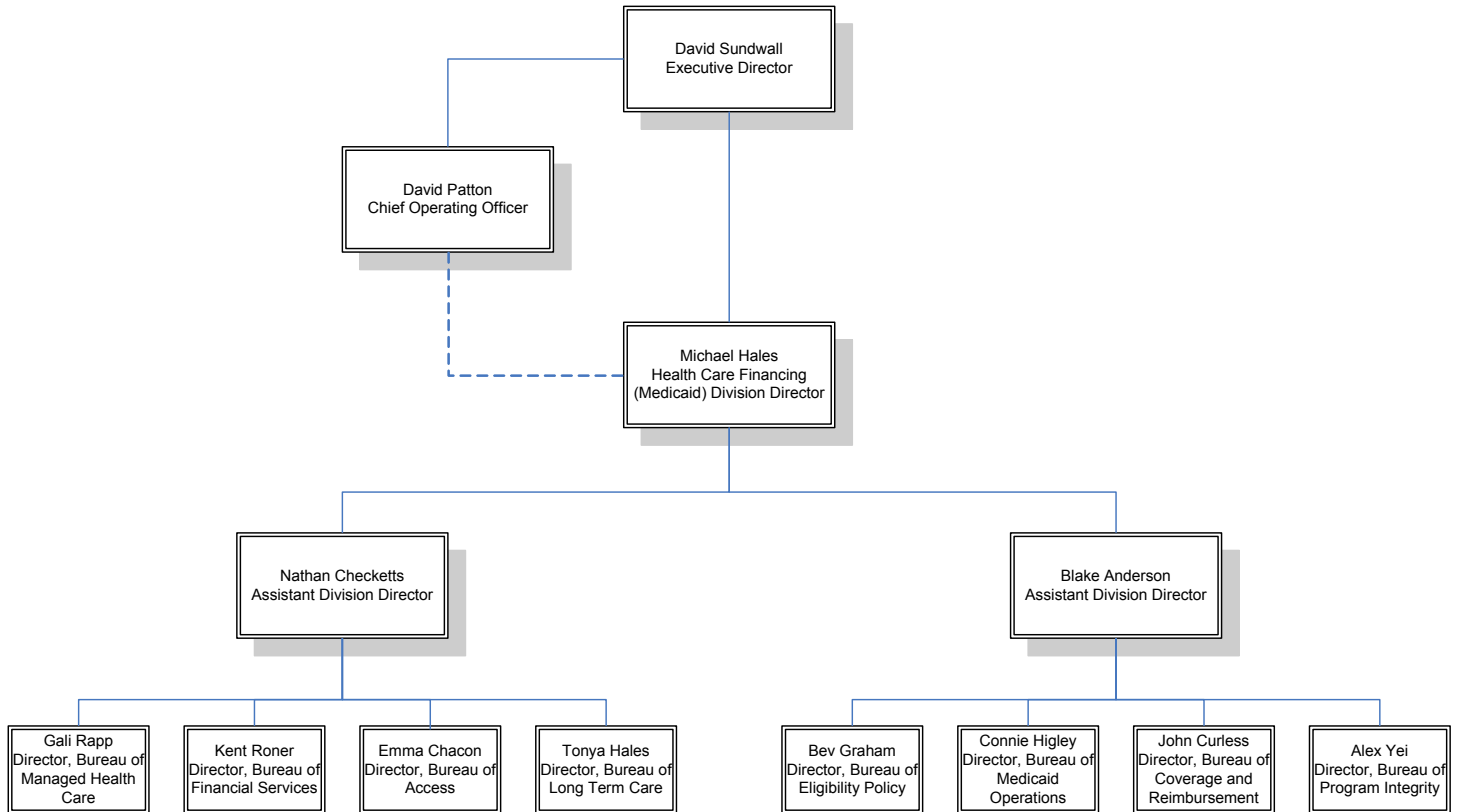
4. We recommend that the DOH executive director immediately direct the internal auditors to conduct performance audits of the Medicaid program and ensure that regular, consistent internal performance audits are conducted of Utah's Medicaid program.

Appendix

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Appendix A

Utah Medicaid Program Organization Chart. This organization chart shows the line of authority over the Medicaid program from the executive director of the Department of Health down to the Medicaid bureau level.



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Agency Response

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State of Utah

JON M. HUNTSMAN, JR.
Governor

GARY R. HERBERT
Lieutenant Governor

Utah Department of Health Executive Director's Office

David N. Sundwall, M.D.
Executive Director

A. Richard Melton, Dr. P.H.
Deputy Director

W. David Patton, Ph.D.
Deputy Director

Health Care Financing

Michael T. Hales
Division Director

August 11, 2009

Mr. John M. Schaff, CIA
Legislative Auditor General
W315 State Capitol Complex
Salt Lake City, UT 84114

Dear Mr. Schaff:

Thank you for the opportunity to review and to respond to your legislative audit titled "A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program" (Report No. 2009-12) dated August 5, 2009.

We in the Department of Health ("Department") appreciate the work performed by you and your staff in the review of the Medicaid program. Your objective analysis and recommendations have been insightful and helpful as we continue to look for ways to improve our operation of the Medicaid program.

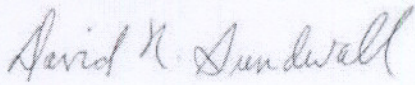
We accept all of the recommendations of the audit and have begun the work required to implement them. Some of these changes already have been implemented. Others will require additional planning, work and, in some cases, funding.

The timing of the report is very beneficial to the Department. Over the past several months, we have been working on reorganizing the Department to achieve organizational efficiencies, reduce costs and better serve the needs of the citizens of Utah. Several of your recommendations addressed the most appropriate location for several work units. As we work toward finalizing our restructuring, we will add these recommendations to our other planned changes. We believe the result will be a stronger, more efficient Department of Health.

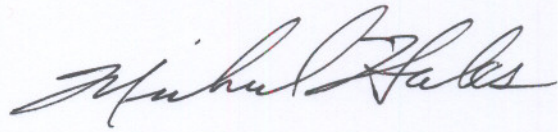
Most of the recommendations in the audit related to the workings of the Bureau of Program Integrity ("Bureau"), within the Division of Health Care Financing. The Bureau was created by the Department in the early part of 2008 to show an increased commitment to eliminating waste, fraud and abuse in the Medicaid program. Your recommendations have identified many areas for improvement in the Bureau as it looks to mature as an organizational unit.

Again, we thank you for your time and efforts in performing this program review and the resulting findings.

Sincerely,



David N. Sundwall, M.D.
Utah Department of Health
Executive Director



Michael Hales
Medicaid Director