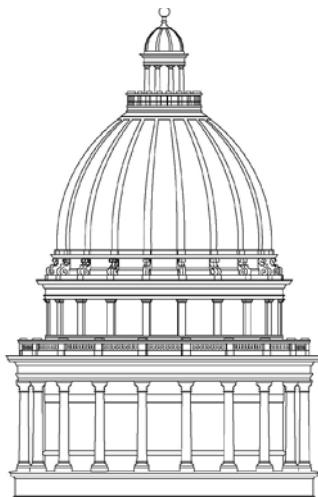


REPORT TO THE
UTAH LEGISLATURE

Number 2012-07



**A Performance Audit of
Medicaid Eligibility**

June 2012

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 Rebecca D. Lockhart, Co-Chair
Senator Ross I. Romero • Representative David Litvack

JOHN M. SCHAFF, CIA
AUDITOR GENERAL

June, 2012

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of Medicaid Eligibility** (Report #2012-07). 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,

A handwritten signature in black ink that reads "John M. Schaff".

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of A Performance Audit of Medicaid Eligibility

The Department of Workforce Services (DWS) is responsible for determining recipient eligibility for Medicaid as well as for other public assistance programs, such as food stamps. The department's Eligibility Services Division (ESD) is charged with the task of identifying and maintaining recipient eligibility information.

Previous audits of Medicaid functions within the Department of Health (DOH) found a number of oversight problems. As a result, this audit of Medicaid eligibility was requested. This audit found that, overall, Medicaid eligibility appears well managed and that the improvements needed are not as extensive when compared to the other audits of Medicaid.

Medicaid Case Review Shows Few Procedural Errors.

We reviewed 245 eligibility cases and found that 13 (5.3 percent) of the Medicaid cases contained errors. One of the 13 cases affected five recipients' eligibility because the family's income had been incorrectly overstated. One other sampled case may have inappropriately allowed two recipients to receive benefits. Of the remaining 11 case errors, five errors were income calculation errors and six errors were citizenship and identity documentation errors. These errors did not affect the recipients' eligibility.

Issuance of Recipients IDs Needs Stronger Procedural

Controls. Problems occur when recipients are assigned multiple unique identification numbers, called PIDs. Multiple PIDs might result in duplicate benefits. In addition, some pertinent information about a recipient may not be available when making decisions about program eligibility. Having a single PID for every recipient allows data systems within DWS and the Department of Human Services to relay and use accurate information while minimizing the cost of errors and duplicate benefit awards. The annual cost to correct existing errors is estimated to be \$150,000.

In addressing this situation, the Department of Technology Services (DTS) identified some possible instances in the eligibility determination system, eREP, and other state systems where public

Chapter I: Introduction

Chapter II: Most Medicaid Recipients' Case Information Is Accurate

Chapter III: ESD Has Reduced Its Error Rate, But More Can Be Done

assistance recipients have been issued multiple PIDs. Working with this data set, we estimate that 2,300 of the 2,669 identified recipients (86 percent) had multiple PIDs. Inconsistent recipient information is the primary cause of these multiple PIDs. DWS and DTS plan to eliminate most new multiple PIDs through a new application process that allows systems to match new information with existing PIDs.

Further ESD Action Is Needed to Address Agency Error

Overpayments. According to the Centers for Medicare and Medicaid Services (CMS), eligibility errors for fiscal year 2010 are lower than the national average, but the error rate has increased since CMS audit of fiscal year 2007 data. For fiscal year 2011, medical benefits to ineligible recipients resulted in nearly \$1 million in overpayments. Since policy prohibits recovery on agency errors in medical programs, the ESD has proactively implemented several initiatives to avoid these overpayments.

In October 2011, the ESD began reviewing some eligibility determinations prior to benefit issuance to serve as a quality control. In addition, several initiatives were introduced to improve initial determination accuracy, which produced an error-rate reduction from 7 percent to 4 percent. These positive improvements could be further enhanced in two ways. First, initiatives could be better coordinated and tracked to provide feedback on individual impact. Second, policies regarding overpayment calculations should be revised to ensure efficient use of staff resources.

Chapter IV: Eligibility Card Process Needs to Be Updated

Distributing a Monthly Card Is Costly. Utah is the only state in its region that provides a monthly, eligibility identification paper card to its Medicaid recipients. For about the last ten years, the five other states in the region have provided a one-time eligibility identification card to their recipients. We contacted some other states outside of Utah's region; they also have relied on a one-time eligibility identification card for several years. If Utah updated its process to provide recipients with a one-time card rather than a monthly paper card, the state could save card distribution costs of \$1.27 to \$1.39 million per year. Utah has been slow to implement a one-time Medicaid identification card. The primary reason given for this slow implementation is that DOH has been focusing on its partnership with the state's insurance community. An insurance workgroup has been focusing on developing standardized health benefit plan cards in accordance with *Utah Code 31A-22-636*.

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UTAH LEGISLATURE

Report No. 2012-07

A Performance Audit of

Medicaid Eligibility

June 2012

Audit Performed By:

Audit Manager	Tim Osterstock
Audit Supervisor	Wayne Kidd
Audit Staff	Tim Bereece Scott Stephens, DWS Auditor

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Chapter I

Introduction

The Department of Workforce Services (DWS) is responsible for determining eligibility for Medicaid as well as other public assistance programs, such as food stamps. The Department's Eligibility Services Division (ESD) is charged with the task of identifying and maintaining client eligibility information.

Medicaid is a healthcare program funded by the federal and state governments that provides medical services for individuals and families with limited assets and income. Nationally, Medicaid is overseen by the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. States must meet mandatory federal requirements, but states have some discretion and autonomy in administering the Medicaid program. Consequently, no two states' Medicaid programs are exactly alike.

The Legislative Auditor's Office has completed five audits reviewing different segments of Utah's Medicaid program within the past three years. All of those audits focused on areas that are under the Department of Health's (DOH's) oversight. Given the problems found in those five audits, the Social Services Appropriations Subcommittee co-chairs requested this audit of Medicaid eligibility, which is under DWS oversight.

DWS Manages the Medicaid Eligibility Process

In Utah, DWS manages the eligibility process for Medicaid, and the Department of Health (DOH) manages the delivery of Medicaid services. Prior to fiscal year 2008, eligibility determinations for medical assistance programs were determined by either DWS or the Department of Health. This changed in July 2007, when 253 eligibility workers were transferred from DOH to DWS in a plan to consolidate workflow.

The medical program provides governmental assistance to more people in Utah than other public assistance programs offered through DWS. DWS has organized the ESD into a single centralized

**States must meet
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program.**

**DWS manages the
eligibility process for
Medicaid and DOH
manages the delivery
of Medicaid services.**

ESD has 700 eligibility determinations employees.

organization rather than offering services on a regional basis. ESD has 700 employees that make eligibility determinations. Additional staff, such as case reviewers, investigators, benefit accuracy analysts, and adjudicators, review determinations and raise the number of DWS employees involved in the eligibility determination process to 857. The department has made several changes within ESD, such as an online application process, call centers, online case information called myCase, and launched a new eligibility determination system called eREP.

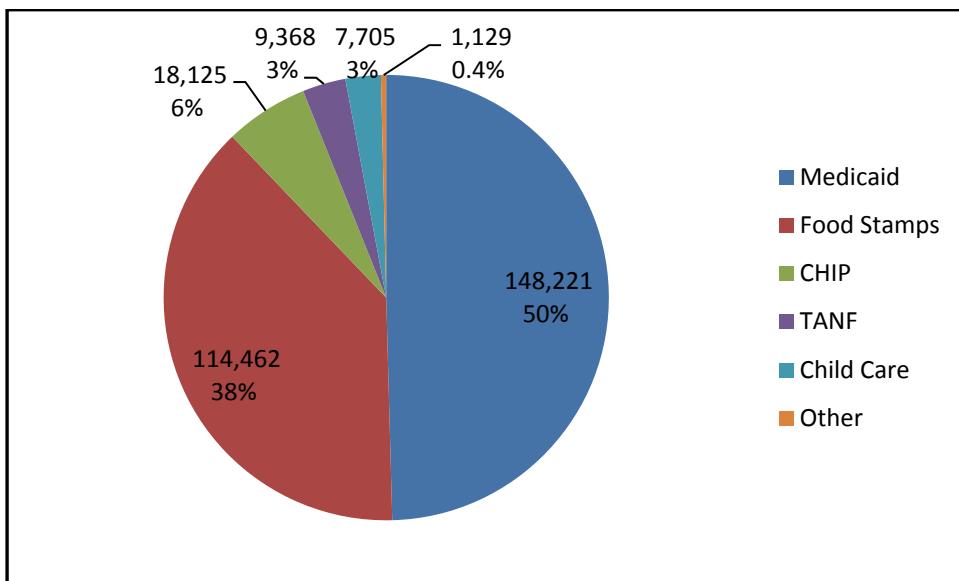
Medicaid Is the Most Utilized Public Assistance Program at DWS

At the end of 2011, 187,296 households were receiving public assistance through DWS.

At the end of 2011, 187,296 households were receiving public assistance through DWS. It is important to note that a household can consist of multiple recipients, with each recipient eligible for one or more programs. For example, within a household, one recipient can be eligible for a Medicaid program, the food stamp program, and the child care program. A household can also have more than one Medicaid program open; for example, a household can have a child on a children's medical plan and a mother on a pregnant women's medical plan. Thus, there is not a direct correlation between the number of households or individual recipients using public assistance and the number of programs that are open.

More people utilize Medicaid programs than other types of public assistance at DWS. Figure 1.1 shows the number of cases by the type of government assistance program.

Figure 1.1 Utilization of Public Assistance Programs. The count of open cases by program type was taken in December 2011.



Source: Workforce Research and Analysis Division (DWS)

For the public assistance programs offered through DWS, Medicaid has the highest utilization at 50 percent. Food stamps follow with 38 percent and all other public assistance programs account for the remaining 12 percent of utilization.

Medicaid is the highest utilized public assistance program offered through DWS.

DWS Has Consolidated the Eligibility Services Division

The ESD, within DWS, has the responsibility of determining if people qualify for medical assistance, financial assistance, food stamps, and/or child care. In June 2009, the ESD brought together eligibility functions that were previously administered by five separate regions into a single standardized organization. The division's former process had multiple levels of oversight and different approaches to service delivery in each region.

In June 2009, the ESD brought together eligibility functions that were previously administered by five separate regions into a single organization.

These services have now been merged together with standard processes and one management structure. According to DWS, the purposes of consolidating the division were to improve its processes by implementing innovations in work design, managing more efficiently, and increasing the quality of services delivered to recipients.

DWS established an online application process, so people throughout the state can apply electronically without leaving their homes.

The department has established call centers and online case access to better serve its customers.

Eligibility Services Has Increased Its Use Of Technology to Better Access Clients

DWS has established an online application process, so people throughout the state can apply electronically from anywhere and complete the application process without leaving their homes. In addition, the department has online assistance in local employment centers for people to utilize. Also, DWS has partnered with several community partners, such as the Odyssey House, to place computers at their locations to allow people to apply for services online. People can also choose to visit an employment center to apply for Medicaid and other assistance programs.

DWS Customers Have Dual Access to Their Case

Information. The department has established call centers throughout the state. Their customers can contact a call center with a toll-free number to complete an interview, check on their case status, and ask questions without having to leave home. DWS customers can also access their case information online through a program called myCase, which allows DWS customers to view case status and benefit information in real time. They can also receive notices, make payments, and access and print forms.

DWS Has Implemented a New, Comprehensive, Integrated Computer System for Eligibility Determinations. The Electronic Resource and Eligibility Product (eREP) provides basic eligibility-related functionality, expanded to include specific requirements for the departments of Workforce Services, Health, and Human Services. The eREP project integrates eligibility functions for state and federal programs. It replaced Utah's 20-year-old Public Assistance Case Management Information system (PACMIS). eREP was implemented statewide in 2010. For Medicaid, as well as for other assistance programs, eREP captures evidence and case history, determines eligibility through rules, and enables workers to calculate benefits and conduct case reviews.

Medicaid Eligibility Appears Well Managed

In March 2009, the co-chairs of the Health and Human Services Appropriations Subcommittee (now called the Social Services Appropriations Subcommittee) requested an audit focusing on the contractual relationship between the Health Department and Medicaid providers. *A Performance Audit of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program* was released in August of 2009 (Report 2009-12). The audit found that significant improvement in the Bureau of Program Integrity (BPI) operations could generate savings of over \$20 million in federal and state Medicaid funds. BPI needed to improve efficiencies and implement better management controls over operations.

This initial audit of Utah Medicaid led to a series of audits of different aspects of the program that found inadequate oversight and controls. Those audits were the following:

- *A Performance Audit of Utah Medicaid Managed Care* released in January 2010 (Report 2010-01).
- *A Follow-up of Utah Medicaid's Implementation of Audit Recommendations* released in December 2010 (Report 2010-14).
- *A Performance Audit of Utah Medicaid Provider Cost Control* released in December 2010 (Report 2010-16).
- *An In-Depth Follow-Up of Utah Medicaid's Implementation of Audit Recommendations* released in January 2012 (Report 2012-03).

These audits found that more effort was needed to control costs, institute management controls over processes, and improve independence of the oversight functions in the DOH. Given the number of problems found in Medicaid areas where DOH has oversight, the chairs of the Social Services Appropriations Subcommittee requested this audit of Medicaid eligibility, for which DWS has oversight. However, this audit found that, overall, Medicaid eligibility is well managed and that the improvements needed are not as extensive when compared to the other audits of Medicaid.

The initial audit of Utah Medicaid led to a series of audits that found inadequate oversight and controls.

This audit found that, overall, Medicaid eligibility has been well managed.

Audit Scope and Objectives

This audit was requested by the co-chairs of the Social Services Appropriations Subcommittee to review DWS's efforts to control Medicaid recipient fraud. We examined the following within the ESD:

- The accuracy rate of workers' eligibility determinations
- The possibility that duplicate recipient data exists within eREP
- The agency's overpayment error amounts and the causes of the errors
- The cost/benefits of utilizing Medicaid ID cards

To complete this audit, we reviewed a statistically valid sample of active Medicaid cases at the 95 percent confidence level to calculate the accuracy rate of eligibility determinations, and compared the accuracy rate with other internal and external accuracy rates. We shadowed eligibility workers, case reviewers, investigators, benefit accuracy analysts, and adjudication specialists to develop an understanding of the controls and processes within ESD. We compared DWS processes with processes of other states within the same region. In addition, we analyzed recipient identification numbers and data showing the division's determination accuracy trends over time.

Chapter II

Most Medicaid Recipients' Case Information Is Accurate

The Department of Workforce Services (DWS) is making an effort to ensure that applicants meet eligibility requirements to receive Medicaid benefits. A review of 245 Medicaid cases found most recipients were accurately assessed for eligibility. We found that 13, or 5.3 percent, of the sampled cases contained procedural errors. Procedural errors in two cases affected eligibility determination.

5.3 percent of the sampled Medicaid cases contained procedural errors.

Of greater concern, about 2,300 recipients of public assistance programs (including Medicaid) in DWS's eligibility determination system have been issued multiple unique identification numbers, called PIDs. Multiple PIDs could allow recipients to obtain benefits to which they are not entitled. Further, pertinent information might not be included in the record used for eligibility determinations. DWS and the Department of Technology Services (DTS) believe that a new application process will reduce multiple PIDs from being created.

Medicaid Case Review Shows Few Procedural Errors

We reviewed 245 eligibility cases and found that 13 (5.3 percent) of the Medicaid cases contained errors. Only one of the 13 cases affected five recipients' eligibility because the family's income had been incorrectly overstated. One other sampled case may have inappropriately allowed two recipients to receive benefits. Of the remaining 11 case errors, five errors were income calculation errors and six errors were citizenship and identity documentation errors. These errors did not affect the recipients' eligibility.

Only one of 245 sampled cases incorrectly withheld Medicaid benefits, while a second case may have incorrectly allowed benefits.

Other audits' error rates are similar to the rate found in this review. DWS's case review of medical programs had an error rate of 5.1 percent on December 2011. Medicaid cases are also audited for eligibility accuracy by the federal Payment Error Rate Measurement (PERM) program. Their last eligibility review completed in 2010 found an eligibility error rate of 7 percent in reviewed cases.

Most Medicaid Recipients Appear Eligible for Benefits

A statistically valid sample of 245 Medicaid cases found 13 cases or 5.3 percent with procedural errors. Only 2 of the 13 errors might have affected recipients' eligibility. We reviewed three significant eligibility elements for each recipient associated with the sampled cases to determine whether:

- The social security number was verified as a valid number
- The citizenship and identity documents were properly verified
- The income was properly documented and correctly calculated

Eligibility was withheld when a family's income was overstated because a parent's self-employment income had not been calculated correctly.

Eligibility may have been inappropriately allowed when self-employment income was not included in the income calculation; as a result, income was understated.

CMS has stated it is concerned with the number of recipients who have been incorrectly denied Medicaid benefits by Utah.

The errors affecting eligibility were income calculation errors. In one case, a family of five recipients should have been eligible to receive benefits, but benefits had been terminated during a case review. That family's income had been overstated and exceeded Medicaid's income limit because a parent's self-employment income had not been calculated correctly.

In the second case, unreported self-employment income may have erroneously resulted in eligibility for two recipients. Since a parent's self-employment income was not included in the income calculation, income was understated. If the self-employment income had been more than \$1,401 per month, then the parent's income would have exceeded the Medicaid income limit. As a result, two recipients would not have been eligible for benefits.

The Centers for Medicare and Medicaid Services (CMS), the federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program, has stated that it is concerned with the number of recipients who have been incorrectly denied benefits in Utah. Denial of services during the 2010 PERM review was regarded as a more serious error than an ineligible recipient receiving benefits. Utah's case error rate for inappropriate denial of Medicaid benefits was 16 percent. This error was rate was 9 percent higher than cases where recipients received benefits but were not eligible.

Most Procedural Errors Did Not Affect Eligibility

The review found that procedural errors in the remaining 11 cases did not affect recipients' eligibility for Medicaid benefits. The procedural errors can be grouped by the three eligibility elements reviewed for each case: (1) income calculation, (2) citizenship and identity documentation, and (3) social security numbers. The review did not find any errors regarding social security numbers in the sample, but problems with social security numbers will be discussed later in this chapter.

Five of the cases contained income calculation errors. These calculation errors were made by eligibility caseworkers, not recipients. The income errors are described below:

- The net amount instead of the gross amount on three paychecks was used to calculate income.
- A recipient's wages and hours for four payment periods were not included in the income calculation.
- "Overhead" expenses were included as revenue to calculate a recipient's gross income.
- An incorrect hourly rate was used to calculate the gross income for a recipient.
- A recipient's wages and tips were separated and, for one payment period, the tips amount was incorrectly counted both as tips and wages.

Five of the cases contained income calculation errors that did not affect recipients' eligibility.

The procedural errors in six cases were citizenship and identity documentation errors. These errors were also made by eligibility caseworkers as described below:

- A recipient's identity document was filed in the wrong Medicaid case.
- A qualified exemption for citizenship verification was not stated.
- Citizenship verification was not correctly documented in eREP for three cases.
- Identity verification was incorrectly documented.

Six of the cases contained citizenship and identity documentation errors that did not affect recipients' eligibility.

These procedural errors did not affect the recipients' eligibility for Medicaid benefits.

Other Eligibility Audit Results Are Similar

DWS's Performance Review Team (PRT) audits Medicaid and other public assistance programs to determine eligibility accuracy, providing eligibility caseworkers with feedback to help improve accuracy on their cases. The PRT provides an internal error rate by program. Medicaid cases are also audited for eligibility accuracy by the federal PERM program. Both of these audits' error rates are similar to the rate we found in this review.

The Internal Error Rate Is Similar to the Rate Found in This Review. The Eligibility Services Division (ESD) has PRTs that review all programs within a case to make sure that applicants for public assistance programs are truly eligible for benefits. In October 2011, ESD implemented a new procedure to review cases. Rather than reviewing programs after benefits have been issued, programs are now reviewed before benefits are issued. The goal is to correct errors before benefit adjudication and prevent overpayments. The PRT error rate at the end of the 2011, which includes eligibility and procedural errors, was 5.1 percent for the medical programs, similar to our sample rate of 5.3 percent.

The PRT's eligibility error rate includes errors that affect eligibility and errors that do not affect eligibility, such as a documentation error. It is important to note that the PRT medical program error rate includes the Primary Care Network (PCN) and the Children's Health Insurance Program (CHIP). These smaller medical programs were not included in the scope of this Medicaid eligibility review. The PRT review of medical cases usually reviews an entire case or element(s) of a case. However, based on the results of the reviews or feedback from managers, reviewers can focus on problem areas. For example, if a team or an eligibility worker is making mistakes calculating income, a reviewer can focus reviews on income assessment to help improve performance.

Utah's PERM Rate Is Higher than the DWS's Internal Review. The federal PERM program, administered by CMS through federal contractors, measures improper benefits in Medicaid and CHIP. Individual state error rates are measured for each program, and then combined to form a national error rate that is reported to Congress. One component of the PERM program is reviewing the accuracy of Medicaid eligibility.

The department's calculated error rate at the end of 2011 was 5.1 percent, which is similar to our review of 5.3 percent.

PERM reviews each state once every three years. Utah's last evaluation was completed in 2010. That review found that Utah's Medicaid eligibility error rate was 7 percent in cases reviewed. Our sample error rate was lower at 5.3 percent, but we only reviewed three elements: social security number verification, citizenship, and income. PERM, unlike our audit, reviews all elements of eligibility qualification, so it is not surprising that the PERM error rate is higher than the rate found by this audit.

The PERM review, last completed in 2010, found the eligibility error rate was 7 percent.

Procedure to Issue Recipient IDs Needs Stronger Controls

Problems occur when recipients are assigned multiple unique identification numbers, called PIDs. Multiple PIDs might result in duplicate benefits. In addition, some pertinent information about a recipient may not be available when making decisions about program eligibility. Having a single PID for every recipient allows data systems within DWS and the Department of Human Services to relay and use accurate information while minimizing the cost of errors and duplicate benefit awards. DTS is spending about \$150,000 annually to correct existing errors.

Having a single unique identifier for every recipient allows data systems with DWS and DHS to relay and use accurate information.

In addressing this situation, DTS identified some possible instances in eREP and other state systems where public assistance recipients have been issued multiple PIDs. Working with this data set, we estimate that 2,300 of the 2,669 identified recipients (86 percent) had multiple PIDs. Inconsistent recipient information is the primary cause of these multiple PIDs.

DTS has identified some possible instances in eREP and other state systems where public assistance recipients have been issued multiple PIDs.

The DTS report was designed to identify exact duplicates of recipient information. However, we discussed a scenario with DTS staff where multiple PIDs could be assigned, but would not appear as a match on the DTS report. This scenario involves recipients whose first names can be spelled differently, such as Tim and Timothy or William and Bill. Those different first names would not be identified as duplicates by the DTS report. Therefore, the actual number of multiple-PID recipients would likely be higher than our estimate of 2,300 multiple PIDs. DWS and DTS plan to reduce the creation of future duplicate PIDs. Their plan is to reduce duplicate PIDs by 99

percent for those identified or created through online application automation.

DTS Matches PIDs with Identical Recipient Information

To identify potential instances where multiple PIDs exist, the DTS created a report that matches PIDs that share some of the same client information. Specifically, these matches use the unique combination of a recipient's first name, last name, birth date, and gender. When matches are identified, they are included in the report to be reviewed in greater detail by DTS's employees.

Multiple systems within DWS and DHS rely on the same PID to identify recipients.

Multiple systems within DWS and the Department of Human Services rely on the same PID to identify recipients. Figure 2.1 shows how many matches were identified in each system on November 14, 2011.

Figure 2.1 Multiple-PID Matches Exist in Other Systems, as Well as in eREP. This list shows six systems that rely on a PID to identify recipients.

	Matches
Workforce Services' Systems	4,538
eREP	2,669
PACMIS	1,819
UWORKS	50
Human Services' Systems	7,649
USSDS	4,822
ORSIS	2,200
SAFE	627
Both Departments' Systems	12,187

Source: Customer Directory Exact Match Duplicates Report on November 14, 2011.

At DWS, recipients with multiple PIDs are most prevalent in the eREP system.

At DWS, recipients with multiple PIDs are most prevalent in the eREP system. The duplicate ID problem is more extensive in the Department of Human Services. As discussed earlier, these matches identify potential instances where multiple PIDs were assigned. Consequently, we reviewed some of these matches in greater depth to provide a better estimate of the actual number of DWS recipients with multiple PIDs.

Most Matches Identify Recipients with Multiple PIDs

Based on our case reviews, we estimate that 86 percent of the 2,669 eREP matches identified in the DTS report resulted in about 2,300 recipients with multiple PIDs. In the DTS report, we observed the following instances where matches were not a problem.

- **Ten Percent of the Matches Were Unborn Children from Different Households.** DWS practice is to give unborn children the temporary first name of “Unborn”. Consequently, when two households with the same last name are expecting a child with the same estimated due date and gender, a match will be identified. We found that 273 (10 percent) of the 2,669 matches involved unborn children.
- **Two Percent Were Different People with the Same Identifying Information.** Reviewing 267 matches of the 2,669 in the DTS report found six matches (2.2 percent) that involved different recipients. We verified that the recipients were different by comparing household addresses and other recipients in the household.
- **Two Percent of the Multiple PIDs in eREP Were Created by DTS to Correct Systemic Errors.** To correct multiple PIDs in other systems, DTS employees sometimes are required to assign a second PID to a recipient so it can be a known duplicate in eREP. We found that the most recent PID for 38 of the 2365 matches (304 records of the 2,669 were omitted because a generic worker code was used during the same time frame when the 304 records were created) had been created by a DTS employee. These corrections account for 2 percent of the matches.

About 14 percent of the eREP identified multiple PIDs reported by DTS were not matches.

Multiple PID Corrections Increase Costs

As shown in Figure 2.1, DTS identified about 12,000 matches in its multiple PID report. Given the current resource allocation to correct these records, it would take about 3.5 years to clean up the existing list if no additional multiple PIDs were created.

Given the current resource allocation, it would take 3.5 years to clean up the existing list of multiple PIDs.

According to DTS, the main benefit of reducing duplicate PIDs is to avoid a health problem if recipients obtain duplicate medications.

Premium overpayment amounts are relatively low for those recipients who received duplicate medical coverage.

DTS has assigned a team of four staff who work part-time correcting multiple PIDs. One member of the team stated that they have been working on this issue for six years and the problem has not reduced with the rollout of eREP. Based on how staff spends their time, annual costs to correct multiple PIDs are \$150,000. The cost to correct existing errors over the 3.5 year period is estimated to be \$525,000. According to DTS, the main benefit of reducing duplicate PIDs is to avoid a health problem if recipients obtain duplicate medications. A recipient with multiple PIDs could potentially obtain the same or similar medications from two different providers.

Reducing duplicate PIDs also ensures duplicate benefits are not issued to the same person. The financial impact of duplicate benefits is limited because claim costs are usually excluded from overpayment amounts, and premium amounts are relatively low for Medicaid recipients. Reviewing a sample of matches from the DTS report found that 4 of the 267 matches involved a recipient who received duplicate medical coverage. Total overpayments for these cases ranged from \$18 to \$1,125 for redundant premiums, for a total of \$1,256. In the case generating a \$1,125 overpayment, the recipient received CHIP coverage for eight months while already covered by a Medicaid program. Because duplicate costs are low, the primary benefit of fixing multiple PIDs is avoiding a health problem if recipients obtain duplicate medications.

Inconsistent SSNs and Middle Names Cause Multiple PIDs

DWS recipients sometimes provide inconsistent identification information, which eligibility workers must screen.

When DWS recipients provide inconsistent identification information, eligibility workers must screen information for existing PIDs by identifying the inconsistent data. Specific recipient information gathered by eligibility workers includes:

- First, middle, and last name
- Date of birth
- Gender
- Social security number

We observed differences in the way information was reported in the four cases of clients receiving duplicate medical benefits with their multiple PIDs. Figure 2.2 shows how one recipient's information was recorded in eREP for the two assigned PIDs. The other three cases

also showed inconsistent information. The differences shown below caused the eligibility worker to assign a second PID and award duplicate medical coverage.

Figure 2.2 Inconsistent Information Submitted by a Multiple-PID Recipient. The following similarities and differences were observed in personal information for **one** recipient with duplicate medical coverage.

	PID A	PID B
First Name		Same
Middle Name	Blank	Initial
Last Name		Same
Birth Date		Same
Social Security Number	Verified	Blank

As Figure 2.2 shows, the recipient's middle name and social security number were contributing factors that would make identifying the recipient more difficult. We observed many inconsistencies with social security numbers and middle names submitted by recipients who were assigned multiple PIDs.

Social security numbers and middle names submitted by recipients are often inconsistent.

Social Security Numbers Are Often Left Blank for Additional PIDs. Our 10 percent sample of 267 cases found that 251 matches did not have a social security number (SSN) for at least one of the two PIDs assigned to a recipient. When the SSN field is left blank, eligibility workers have a more difficult time matching the recipient to existing information in eREP. While SSNs are not verified at this point in the process, SSN verification will take place before benefits are issued. In the remaining 16 matches, where both PIDs had social security numbers, 12 matches had the following problems:

- 11 matches contained at least one invalid SSN
- 1 match involved a recipient with two valid SSNs

Twelve data matches had problems with social security numbers, which illustrates that tighter controls are needed when PIDs are issued.

The remaining four cases had two PIDs issued on the same social security number, but no benefits were issued. DWS staff has verified that both SSNs were valid for the last recipient, and no benefits have been issued so far. While no loss in excess benefits has occurred, this scenario does illustrate that tighter controls are needed when PIDs are issued. Specifically, reliance on a single piece of information as a control is not sufficient.

Our review found 54 percent of recipients spelled their middle names differently on their applications.

Middle Name Information Is Often Inconsistent. Our review of the 2,669 matches found that 1,440 or 54 percent of recipients spelled their middle names differently on their applications. Recipients either provided a middle name, middle initial, or omitted a middle name. Since SSNs are often missing in instances of multiple PIDs, additional information, such as a middle name, becomes important when establishing identity. DTS and DWS staff told us that if recipients do not provide a correct SSN and/or spell their names inconsistently, then the potential for the creation of a duplicate PID is increased.

DWS Is Adding a Control

In May 2012, DWS and DTS implemented a new application process in myCase. myCase is a program that permits recipients to view case status and benefit information online. One goal of implementing the new process is to reduce the creation of multiple PIDs by 99 percent. The new myCase application will automatically attempt to match the recipient by using the following information:

- Case number
- First and last name
- Social security number
- Zip code
- Date of birth

DWS and DTS plan to implement a new application process to reduce the creation of multiple PIDs.

If the system cannot match the recipient to an existing profile, then DWS staff will also verify that no existing profiles match and issue a new PID when appropriate. Prior to this new process, DWS systems had not been matching client data. Instead, the process relied solely on the caseworker to manually screen information in eREP.

While the new myCase application process appears promising, the project was developed without a formal planning document that includes project outcomes. Instead, DWS and DTS staff work collaboratively as the project develops to define what the application will and will not do. We recommend that DWS report to the Legislature regarding the project outcomes of reducing the number of multiple PIDs. Reporting the outcomes may also provide solutions to address the multiple PID problem identified in other systems that use the PID for recipient identification.

Recommendation

1. We recommend that DWS regularly report to the Legislature on the progress of achieving its goal to reduce multiple PIDs.

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Chapter III

ESD Has Reduced Its Error Rate, But More Can Be Done

According to the Centers for Medicare and Medicaid Services (CMS), eligibility errors by the Eligibility Services Division (ESD) are higher than the prior audit completed in fiscal year 2007, but lower than the national average. For fiscal year 2011, medical benefits to ineligible recipients resulted in nearly \$1 million in overpayments. Since policy prohibits recovery on agency errors in medical programs, the ESD has proactively implemented several initiatives to avoid these overpayments.

In October 2011, the ESD began reviewing some eligibility determinations prior to benefit issuance to serve as a quality control. In addition, several initiatives were introduced to improve determination accuracy, which produced an error-rate reduction from 7 percent to 4 percent. These positive improvements could be further enhanced in two ways. First, initiatives could be better coordinated and tracked to provide feedback on individual impact. Second, policies regarding overpayment calculations should be revised to ensure efficient use of staff resources.

DWS is implementing initiatives aimed at eliminating medical benefits to ineligible recipients.

This chapter details the high error rates that required the Department of Workforce Services (DWS) to more aggressively insert quality controls. In addition, we examined the initiatives used to prevent overpayments and reduce the error rate. Finally, the chapter reports on a number of additional changes that can further enhance the processes already implemented by the department.

Increasing Error Rates Necessitate ESD Initiatives to Reduce Costs

Despite being lower than the national average of 6.1 percent, Utah's payment error rates calculated by CMS have increased from .9 percent for fiscal year 2007 to 4.5 percent for fiscal year 2010. The claims and premiums paid to ineligible recipients as a result of agency error accounted for nearly \$1 million for fiscal year 2011. Utah's policy prohibiting recovery on inappropriate medical benefits

According to CMS, the ESD's error rate is 4.5 percent, which is lower than the national average of 6.1 percent.

caused by agency error is shared by most states in Utah's CMS region. Consequently, medical benefit determinations must be accurate before benefits are paid to reduce benefit overpayments.

Eligibility Error Rates Have Increased

CMS has developed the Payment Error Rate Measurement (PERM) program to measure improper Medicaid benefit payments in the 50 states and Washington D.C. The program evaluates 17 states per year over a three-year period. The ESD was reviewed in fiscal year 2010, and the CMS review estimated a 4.5 percent error rate. The error rate has increased since fiscal year 2007, when the error rate was 0.9 percent.

Since fiscal year 2007, multiple factors may have contributed to the increase, such as increases in the number of Medicaid recipients and the consolidation of eligibility determination to the DWS.

Consequently, the ESD has room for improvement as it tries to attain pre-consolidation accuracy levels. However, the ESD has still been successful in achieving a payment error rate that is better than the national average of 6.1 percent for fiscal year 2010.

According to the CMS, "it is important to note the error rate is not a 'fraud rate' but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements." These errors result in inappropriate premiums and claims being paid as well as additional staff work to correct and process these errors.

Agency Errors Contribute to Medical Overpayment Costs

In fiscal year 2011, the ESD processed 1,093 medical overpayments, which accounted for \$2,743,266 of inappropriate benefits issued to recipients. The ESD classifies overpayments based on whether the agency or recipient caused the error. In cases where the recipient was at fault, overpayments are further classified on whether or not sufficient evidence was obtained to suggest the error was intentional.

All overpayments are reported to the Office of Recovery Services Information System (ORSIS). According to data in ORSIS, agency errors tend to account for the largest proportion of the overpayments

Agency errors account for one-third of the \$2.7 million in medical benefits inappropriately paid to ineligible recipients.

(44 percent) but less in terms of costs (34 percent), as shown in Figure 3.1.

Figure 3.1 Agency Errors Represent a Sizeable Portion of Medical Overpayments and Costs. This figure shows how agency errors compare with those caused by medical benefit recipients.

Type of Error	Count	Percent	Amount	Percent
Agency Error	483	44%	\$ 937,963	34%
Inadvertent Household Error	434	40	814,674	30
Suspected Intentional Program Violation	176	16	990,629	36
Total	1,093		\$ 2,743,266	

Source: DWS Summary of ORSIS Data

As Figure 3.1 shows, benefit issued because of an agency error are approaching \$1 million and represent one-third of all medical overpayment costs. Through the first half of fiscal year 2012 (to December 31, 2011), the division incurred \$520,845 in agency error overpayments.

No Recovery on Agency Errors Requires Emphasis on Initial Accuracy

One of the challenges with agency error overpayments in medical programs is that the agency cannot recoup losses from the recipient. According to the Department of Health's (DOH) Medicaid eligibility policy 825-2.2(1), "the agency does not attempt to recover overpayments and understatements of liability caused by agency error." This medical benefits policy differs from the policies of other programs administered by DWS, which do allow for recovery from benefit recipients.

Utah's policy is consistent with four of the five states in its CMS region (Montana, North Dakota, South Dakota, and Wyoming). Colorado is the only exception. Unlike Utah, counties in Colorado are delegated the responsibility to administer Medicaid benefits. Colorado statute requires counties to calculate and collect on medical agency errors; however, many counties do not comply with the statute. Since Utah handles Medicaid eligibility at the state level, its policy is consistent with policies in other states with similar structure.

Utah policy prohibiting the recovery of medical overpayments caused by agency error is similar to actions taken by other states.

Internal auditors at DWS have raised concerns with the cost of collection for overpayments in all benefit programs where they determine eligibility. Considering that Utah's policy is consistent with other states' policies and that collections of overpayments are not pursued, the ESD has focused its efforts on preventing benefit payments to ineligible recipients.

ESD Initiatives Prevent Overpayments and Reduce the Error Rate

To reduce the fiscal impact of overpayments, ESD began conducting case reviews prior to benefit issuance, which allows errors to be corrected before resulting in an overpayment. Since not all eligibility determinations can be reviewed, ESD implemented additional initiatives for eligibility workers that focused on generating determinations that are more accurate. While division-wide reductions in error rate were observed, we also observed substantial improvements for teams that participated in specific initiatives in addition to other division-wide improvements that were taking place.

Errors that are not corrected before benefits are issued result in overpayments.

A clear distinction must be made between error rates and overpayments. When an eligibility worker's incorrect determination impacts a recipient's benefits, an error results, regardless of whether the error was fixed before benefits were issued to the recipient. If the error is corrected before benefits are issued, then no overpayment results but is still tracked as an error by ESD. If the error was not reviewed and corrected, then inappropriate benefits are paid and an overpayment results. Overpayments are the fiscal impact of errors that were not corrected before benefits were issued.

Pre-Benefit Reviews Correct Errors and Prevent Overpayments

Beginning October 17, 2011, the ESD changed its case review process division-wide. Rather than conducting case reviews after benefits are issued to recipients, reviews are conducted prior to benefit issuance. ESD's change is important, because the DOH's Medicaid eligibility policy 825-2.2(1) says, "The agency does not attempt to recover overpayments and understatements of liability caused by agency error." Since policy prohibits any recovery, it is critical that

errors be prevented or corrected before benefits are issued to ineligible recipients.

The ESD has changed its case review process to occur prior to benefits being issued as a quality control that prevents overpayments. In addition, the division has also further enhanced the process to check a larger proportion of cases, which should reduce the amount of overpayments caused by agency errors.

The ESD's review process is now done prior to benefit issuance, so some errors can now be corrected before payments are made.

- **Earlier Reviews Should Reduce Agency Error**

Overpayments. For January 2012, case reviewers were able to review 19 percent of determinations where benefits were awarded. We anticipate that a similar reduction in overpayments should result by correcting the errors identified. For fiscal year 2011, medical overpayments caused by agency error cost \$937,963. Therefore, the ESD's decision to conduct earlier reviews should avoid about \$180,000 in agency-error overpayments. Because of year-to-year variation and the one-year delay that typically exists between when inappropriate benefits are issued and the corresponding overpayment calculated, actual savings from the change could not be verified.

- **More Cases Are Being Reviewed.** From November 2011 to March 2012, the reviews of medical benefit issuance increased 86 percent from 3,402 to 6,316. Since January, ESD managers have established minimum case review requirements per eligibility worker. Four of the seven case reviewers we talked with said they felt the requirements still provided adequate time to perform thorough reviews. The other three stated that the requirement provides a challenge, so consequently they made individual improvements to review cases more efficiently.

ESD's changes have made the case review process more effective and efficient. Prior reviews that occurred after benefits were issued primarily served as a training tool to help eligibility workers understand their mistakes. Now these reviews are enhanced by their timing, which allows incorrect benefits to be corrected.

Multiple Initiatives Focus on Reducing Error Rate

Since all cases cannot be reviewed, ESD implemented other initiatives to reduce error rates.

Since all benefit determinations are not reviewed by case reviewers, eligibility worker accuracy remains vital. Case reviews provide the division with a measurement of the error rate occurring in these determinations. Figure 3.2 shows the error rates for all medical programs over a three-month period beginning October 17, 2011. Medicaid benefits could not be isolated from other medical programs, such as CHIP, because the case review process was not designed to capture which medical program was being reviewed.

Figure 3.2 In Three Months, Error Rates Were Significantly Reduced.
The performance review team began pre-benefit reviews on October 17, 2011. Since then, error rates reported by the team fell quickly.



Source: DWS Weekly Accuracy Report for Medical Programs

Over the first three weeks of Figure 3.2, the error rate was 7.1 percent and decreased by 3.3 percent to 3.8 percent for the last three weeks. The ESD has implemented specific initiatives to help eligibility workers reduce their error rates. The following three changes were identified during the period shown in Figure 3.2.

- **Supplemental Support Is Provided to Poorly Performing Teams.** Supplemental support consists of additional training and increased case reviewer feedback. A total of 9 of the 40 eligibility teams participated in the targeted support initiative. Six teams were selected for supplemental support based on their lower accuracy rates, and three other teams were selected because of the complex cases they evaluate. Team supervisors as

Teams that focus on complex cases or have high error rates received supplemental support and training.

well as case reviewers report that the supplemental support has assisted their teams in reducing their error rates.

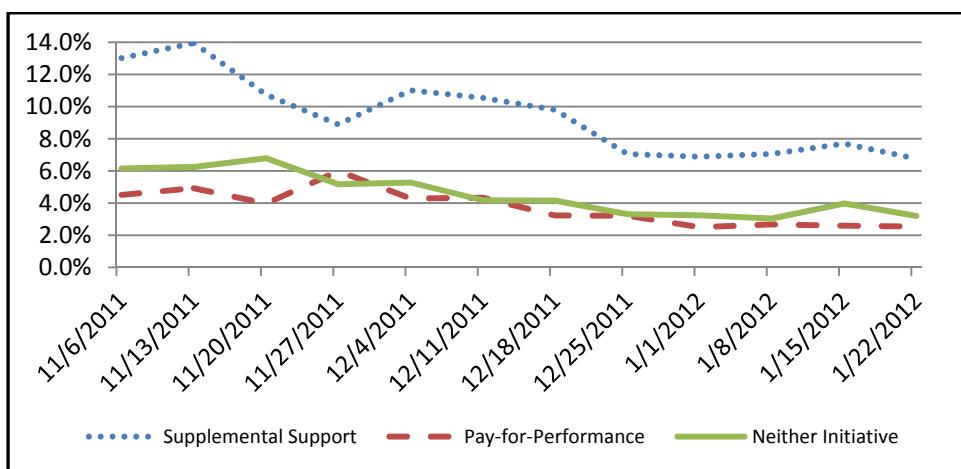
- **Pay-for-Performance Encourages Additional Determinations with High Accuracy.** DWS has implemented a new program that rewards employees with additional pay (\$10 per determination) for every determination over the average volume. Employees must retain 95 percent accuracy on determinations where benefits were approved and 100 percent when benefits were denied. If accuracy standards are not achieved, then the worker is not eligible for the incentive pay that month. While reducing the error rate is not the primary motivation with this program, it does require a relatively high level of accuracy.
- **Error Definitions Have Been Clarified to Provide Better Feedback.** Starting in December 2011 and retroactively for November 2011, missing or unverified information may no longer be cited as an error. Instead, the case reviewers could issue a Case Action Needed (CAN), which clarifies the kind of discrepancy a case reviewer identified during a review. For November 2011, case reviewers retroactively classified 106 errors as CANs. Distinguishing an error from a CAN helps eligibility workers understand the nature of improvements reviewers recommended.

Figure 3.3 compares the error rate reductions experienced for two worker initiatives, supplemental support and pay-for-performance, as well as a control group. The control group participated in neither initiative but their error rate reductions reflect the overall impact generated by CANs and other division-wide changes.

The Pay-for-Performance program encourages quick determinations with a high level of accuracy.

Determinations that lacked some verification were reclassified from an error to a “Case Action Needed (CAN).”

Figure 3.3 Error Rate Trends Are Different for Employees Depending on Their Involvement with ESD Initiatives. This figure uses a 21-day moving average to show the impact of worker initiatives on error rates.



Sources: DWS Weekly Accuracy Report for Medical Programs & DWS Lists Showing Employee Involvement in Initiatives.

DWS's attention to error rates has had a positive system-wide impact.

Figure 3.3 shows that error rates for all three groups decreased by different amounts. The blue dotted line represents poorly performing teams that received supplemental support. Initially, the group's error rate was 13 percent, but after three months, their error rate was 7 percent. The red dashed line represents employees on pay-for-performance. As expected, their error rate is lower, given their incentive to achieve. Finally, the green solid line represents employees who did not participate in supplemental support or pay for performance. Their error rate reductions indicate that attention to error rates have had a system-wide impact.

Six of the seven case reviewers we talked with said improvements by the teams they review have been fairly consistent. However, the other case reviewer was assigned to teams that participated in supplemental support. For those teams, dramatic improvement was noted. For example, one team she reviews improved from 74 to 94 percent and credited supplemental support as the catalyst for the significant change. Based on the error rates and discussions with case reviewers, we conclude that ESD initiatives focused on improving eligibility worker accuracy are having a positive effect on error rates.

Additional Changes Can Further Enhance Process Improvements

While ESD has implemented multiple initiatives to reduce its error rate, other concurrent initiatives made evaluating the effectiveness of a specific initiative difficult. We also found that ESD is incurring considerable costs to calculate agency error overpayments, even though these overpayments are ineligible for recovery. This practice seems like an inefficient use of staff resources, since the ESD appears to have other options to identify agency error causes and estimate the cost of these overpayments. However, if calculations are deemed necessary, then the time used for these overpayment calculations should be made consistent with similar calculations in other benefit programs.

Isolating Each Initiative's Impact Would Enhance Positive Changes

Since October 2011, the ESD has been implementing multiple changes to its case review process. While the cumulative impact of these changes has been positive, we think these changes could also benefit from the ability to isolate the benefits from a specific change.

As we discussed improving error rates with ESD directors, they said they do not know the impact of each individual change. Rather, they look at the net result of the combination of changes. However, the ability to determine the individual impact of a specific program is important when considering its return on investment.

As discussed earlier, the Pay-for-Performance program invests in its employees by providing additional compensation for high quality work. While the program focuses on increasing the number of determinations per employee, understanding the initiative's impact on improving accuracy is uncertain. Employees who did not participate in the initiative also experienced error rate decreases. Therefore, we are uncertain how much of the error rate decrease should be attributed to the Pay-for-Performance program, and how much should be attributed to system-wide improvements.

We acknowledge that ESD's changes have had a positive impact on error rate and overpayment reduction. However, evaluating whether

Multiple changes make isolating individual initiative impact difficult.

Better tracking of initiative impact would help DWS prioritize its more effective initiatives.

Policy requires DWS staff to calculate overpayments even though no recovery takes place.

adequate reductions have taken place to justify the staff investment is a question that remains unanswered. Therefore, we recommend that DWS develop a methodology that tracks initiatives and their impacts. This information will be beneficial to the ESD as it prioritizes its initiatives and evaluates initiative effectiveness.

Utah's Calculation Policy Is Inefficient and Inconsistent with Other States

As directed by the DOH's Medicaid eligibility policy 825-2.2(1): "The agency does not attempt to recover overpayments and understatements of liability caused by agency error." Despite barring the collection of these overpayments, Medicaid policy 825-4 still requires employees to "refer all overpayments and understatements of liability for an investigation or an overpayment calculation."

There are significant ESD costs involved in calculating and processing the costs of medical agency-error overpayments shown in Figure 3.1. The ESD processed almost three times as many agency errors (483) than suspected intentional program violations (176). Therefore, staff costs are a considerable portion of the total costs associated with agency errors. To estimate these costs, we allocated the total compensation for employees who process overpayments to all overpayments.

Figure 3.4 Calculating Agency-Error Medical Overpayments Costs about \$130,000 Annually. Compensation costs include benefit accuracy analysts, who calculate the overpayment amounts, and adjudication specialists, who record and verify overpayment amounts.

	FY 2011	FY 2010
Employee Compensation *	\$ 1,142,000	\$ 1,094,000
Number of Overpayments **	4,119	3,509
Cost per Overpayment	\$ 277	\$ 312
Number of Medical Agency Errors **	483	479
Cost of Medical Agency Errors	\$ 133,791	\$ 149,448

* Source: State of Utah Data Warehouse

** Source: DWS Staff Report from ORSIS

As shown in Figure 3.4, the cost to calculate agency error overpayments for medical programs amounted to about \$130,000 for fiscal year 2011. For the same year, the overpayments team calculated \$940,000 in medical agency-error overpayments. Therefore, the staff

costs to calculate and process overpayments increased the total cost by 14 percent to about \$1,070,000.

The four states in Utah's CMS region that do not collect medical overpayments caused by agency error also do not calculate these costs. Staff from Montana said their state made the decision six to eight years ago not to assess and collect on errors because the costs were much higher than the return. While Utah has adopted a similar policy stance on collections, Utah's stance on calculation is inconsistent. According to CMS, Medicaid program administration should be efficient and effective. Understanding what causes overpayments can be a training tool, but other methods of determining error rate, such as DWS's internal case reviews, are capable of providing necessary training feedback more efficiently.

Internal auditors at DWS have recommended that the department develop a methodology to estimate the cost savings of the reduction and cessation of benefits from their investigation process. We think a similar methodology for the case review process could estimate the amount of inappropriate medical benefits and replace existing overpayment calculations. Consequently, we recommend that DOH reconsider its policy requiring DWS to calculate medical overpayments caused by agency errors, and allow DWS to make overpayment estimates from its case review process.

If Calculations Are Necessary, Time Periods Should Be Consistent

Medicaid eligibility policy 825-4 states: "There are no limits on the time between the occurrence of the overpayment or understatement of liability and the date of the referral." In contrast, other programs where agency error overpayments can be collected are limited to "twelve months prior to becoming aware of agency error overpayments," as specified in policy 815-1(5) of DWS's Eligibility Policy Manual for the Financial, Food Stamps, and Child Care Programs. Requiring more work to calculate an overpayment not eligible for recovery seems illogical.

In Figure 3.5, the Office of Recovery Services Information System (ORSIS) data shows the percent of medical agency error overpayment periods that exceeded one year.

**States that do not
recover agency error
overpayments do not
calculate the cost of
agency errors.**

**Case reviews already
provide feedback and
could estimate
overpayments, which
makes the need for
these calculations
questionable.**

**Despite prohibiting
recovery, medical
overpayment time
periods are longer than
other benefit programs
that allow recovery on
agency errors.**

Figure 3.5 Fourteen Percent of Medical Agency-Error Overpayment Periods Exceed One Year in Duration. The majority of overpayments for more than one year do not exceed five years.

	FY 2009	FY 2010	FY 2011	Average
Less Than a Year	416	429	443	1,288
Greater Than a Year	71	83	55	209
Total	487	512	498	1,497
Percent Longer Than a Year	15%	16%	11%	14%

Source: The Office of Recovery Services Information System

As Figure 3.5 shows, 14 percent of agency error overpayment periods have exceeded one year for the past three fiscal years. In other programs, overpayment calculations are limited to a 12-month span, requiring less work for benefit accuracy analysts.

If calculations of medical overpayments caused by agency error are necessary, the time period should be consistent with other programs.

The extensive time requirement also increases the complexity of calculations. Medicaid policy 825-5.1(1) states that the analyst must “use the rules in effect for each month of the overpayment period to calculate the amount of the overpayment or understatement of liability.” Therefore, the further an analyst must go back to calculate an overpayment, the more policy changes that must be considered. For example, the two longest overpayment periods were 8 and 21 years, which required analysts to apply multiple old policy provisions to calculate the overpayment amount.

Considering that other programs’ agency error overpayments are eligible for collection, requiring additional months of information for medical overpayments that are not eligible for collection seems illogical. Based on the need for these overpayment calculations, the DOH should consider aligning overpayment calculations for medical programs with other programs’ policies regarding agency errors.

Recommendations

1. We recommend that the Eligibility Services Division develop a process that tracks the impact of individual worker initiatives and case review changes to clarify the benefits from improvement initiatives.
2. We recommend that the Department of Health reconsider whether tracking and calculating medical overpayments caused

by agency error is necessary. Based on their evaluation, one of the following should occur:

- The Department of Health should collaborate with Department of Workforce Services and the Office of the Inspector General on how to estimate the costs of benefits paid to ineligible recipients if calculations are discontinued, or
- The Department of Health should consider aligning the time period considered in overpayment calculations for agency errors in medical programs with other benefit programs.

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Chapter IV

Eligibility Card Process

Needs to Be Updated

Utah is the only state in its region that provides a monthly, eligibility identification paper card to their Medicaid recipients. The five other states in the same region as Utah have provided a one-time eligibility identification card to their recipients for about the past 10 years. We contacted some other states outside of Utah's region; they also have relied on a one-time eligibility identification card for several years. If Utah updated its process to provide recipients with a one-time card rather than a monthly paper card, the state could save card distribution costs of \$1.27 to \$1.39 million per year.

In comparison with other states, Utah has been slow to implement a one-time Medicaid identification card. The primary reason given for this slow implementation—rather than providing a one-time identification card and having providers utilize current eligibility verification options—is that the Department of Health (DOH) has been focusing on its partnership with the state's insurance community. An insurance workgroup has been focusing on developing standardized health benefit plan cards (cards with a new verification option) in accordance with *Utah Code 31A-22-636*. For several years, the Utah Health Insurance Network (UHIN) workgroup has been developing standardized protocols and working through technology barriers to establish a single, standardized system to comply with statute. However, we believe that Medicaid could have been providing recipients with a one-time identification card, and providers could use the three existing eligibility verification options.

Utah has been slow to implement a one-time, plastic Medicaid identification card.

Distributing a Monthly Eligibility Card Is Expensive

In Utah, all eligible Medicaid recipients receive a monthly eligibility paper card to serve as proof of eligibility. It is a costly process to mail all recipients an eligibility card each month. By providing recipients with a one-time, plastic eligibility card, the state can save between \$1.27 and \$1.39 million per year. Other states

Delays in switching to a one-time card are attributed to the UHIN workgroup discussion of how to implement standardized health benefit cards.

moved to a one-time, plastic eligibility card several years ago to reduce the costs of providing a monthly paper card.

Delays in switching to a one-time card are attributed to the UHIN workgroup discussion of how to implement standardized health benefit cards. Medicaid reports that this process could be completed by 2013. However, Medicaid could have already been distributing one-time identification cards and providers could use the three existing eligibility verification options to verify Medicaid eligibility. If the standardization process is not completed by 2013, Medicaid should move ahead and distribute one-time identification cards.

Paper Cards Provide Timely Proof of Eligibility

All eligible recipients for Utah Medicaid benefits receive an eligibility card each month. The Department of Workforce Services (DWS) prints paper cards with the recipients' eligibility and personal information and mails the documents to all Medicaid recipients monthly. In 2011, an average of 248,000 recipients received eligibility documents each month.

The main reason for the current eligibility document process is to provide timely proof of eligibility to providers.

The main reason for the current eligibility document process is to provide timely proof of eligibility to providers. Medicaid eligibility is determined on a month-to-month basis in Utah. A recipient can show the eligibility card to providers as evidence of eligibility for medical benefits. If a recipient becomes ineligible for Medicaid benefits, then the eligibility card will not be sent to the recipients for future months.

One weakness of the current eligibility document process is that eligibility can change anytime during a month. If it is determined that a recipient is no longer eligible for benefits during the month, the now ineligible recipient still possesses an eligibility card for the entire month. Medicaid would be required to pay providers those claims costs for that month because the recipient had a valid eligibility card. While this situation occurs rarely, it is a disadvantage of the current process.

Eligibility Card Costs Can Be Reduced

It is a costly process to mail all recipients an eligibility card each month. We compared the annual cost to provide recipients with a

monthly, paper eligibility card to the estimated cost to provide recipients with a one-time, plastic eligibility card. Figure 4.1 shows that the state could save about \$1.27 to \$1.39 million per year by utilizing a one-time card process.

The state could save between \$1.3 to \$1.4 million per year by utilizing a one-time card process.

Figure 4.1 Potential Identification Card Annual Savings. A one-time card costs more per card, but is only distributed one-time to each recipient.

Description	Cost per Card	Annualized Amounts
Monthly Eligibility Card Costs	\$ 0.546	\$ 1,624,800
High Estimate of ID Card Costs	1.44	357,100
Annual Savings (Low Estimate)		\$ 1,267,700
Monthly Eligibility Card Costs	\$ 0.546	\$ 1,624,800
Low Estimate of ID Card Costs	0.94	233,108
Annual Savings (High Estimate)		\$ 1,391,701

Source: Legislative Auditor Analysis

The cost per card stated in Figure 4.1 is the total cost of the card; this includes labor and the cost of materials and printing, as well as the cost of envelopes, stuffing, and postage. The actual cost of a one-time, plastic eligibility card will depend on the rate DOH can procure. We obtained rates from other states and provided the highest rate and the lowest rate in this estimate. The state may be able to realize additional savings if it can procure a lower rate.

Other States Do Not Provide a Monthly Eligibility Card. We contacted the five other states (Montana, North Dakota, South Dakota, Wyoming, and Colorado) within the same region as Utah. All five states provide Medicaid recipients with a one-time, plastic, eligibility card, and have done so for about 10 years. The main reason given by other states for updating their card process was to save the costs of distributing monthly paper cards.

All other states that we contacted provide a one-time, plastic, eligibility card.

The eligibility card in many other states has a magnetic strip that allows providers to electronically verify Medicaid eligibility. The only exception is Colorado, which provides a magnetic strip on its card that does not have a system in place so that providers can verify eligibility. In Colorado providers use a web portal or call Colorado Medicaid to verify eligibility.

The eligibility card in many other states has a magnetic strip that allows providers to electronically verify eligibility.

Medicaid Could Have Already Been Distributing One-Time Identification Cards

In Utah providers have three different avenues for checking patient eligibility:

- They can call the DOH directly and speak with someone to verify eligibility.
- They can access the Medicaid eligibility computer system to verify eligibility through the phone system.
- They can execute an electronic transaction through UHIN to verify eligibility.

The electronic transaction avenue has about a two-hour delay in verifying eligibility. The verification system was not designed for an open-face inquiry. A script has to be written to process an inquiry. The DOH reports that by the fall of 2012, the electronic transaction through UHIN will be upgraded to real-time and will not involve a delay in giving providers eligibility verification. Through the electronic transaction avenue, a provider will receive more information about the recipient than just eligibility verification, such as the recipient's Medicaid plan and the copayment amount.

Focus Has Been on Implementing Standardized Health Benefit Cards

Several years ago, the workgroup, which includes Medicaid staff, was given the responsibility to discuss and improve electronic data interchange between insurance payers and providers and other health-related administrative functions. The workgroup has been focusing on *Utah Code 31A-22-636*, which requires (as of the 2009 General Session) Utah's insurance community to standardize health benefit plan cards.

The workgroup is considering adding a magnetic strip on the eligibility card, or inserting an electronic chip in the card to help providers verify eligibility. This verification process would be similar to the process in other states that we contacted. However, providers would need the electronic readers for the cards. In other states, providers were required to pay for the card readers, if they wanted to use that avenue to verify eligibility. The cost of card readers varies

DOH reports that by the fall of 2012, the electronic verification transaction process will be upgraded to real-time for providers.

Statute requires the Utah's insurance community to standardize health benefit plan cards.

In some states, providers were required to pay for card readers, if they wanted to use that avenue to verify eligibility.

depending on the type of reader, but card readers could cost between \$300 and \$400.

As part of this project, and in addition to standardizing the eligibility card among insurance payers, the workgroup has been determining how insurance payers, including Medicaid, will need to modify payer systems to meet the needs of a standardized system. Providers will also need to modify their electronic medical record systems to communicate with the eligibility verification system. In other states, providers were required to make modifications to their systems, if they wanted to use the card reader verification system. According to Medicaid, with the upgrading of its eligibility verification system to real-time this year, Medicaid identification cards could be implemented as early as 2013.

Cards Can Be Distributed Without A Card-Reader Verification Process

While UHIN has been working on standardizing health benefit cards, Medicaid could still have been saving costs by providing a one-time identification card to recipients, rather than a monthly paper card, much like Colorado's system. Since DOH reports the electronic transaction through UHIN will be real-time by the fall 2012, providers could use the current eligibility verification options to verify eligibility and compare the information provided on the identification card to accurately identify the recipient and their Medicaid benefits.

If the eligibility card did not have a magnetic strip, the cards would be only slightly less expensive to produce. Two quotes from companies for plastic cards without magnetic strips averaged about \$0.86 per card. This would save an additional \$20,000 per year above the \$1.39 million estimate.

**When standardizing
eligibility cards,
providers may need to
modify their computer
systems.**

**One-time Medicaid
identification cards
could be distributed to
recipients while still
allowing providers' use
of the current eligibility
verification options.**

Recommendation

1. We recommend that the Medicaid program provide Medicaid recipients with a one-time, plastic eligibility card.

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Agency Response

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State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Department of Workforce Services

KRISTEN COX
Executive Director

GREGORY B. GARDNER
Deputy Director

JON S. PIERPONT
Deputy Director

June 11, 2012

John M. Schaff, CIA
Auditor General
Office of the Legislative Auditor General
W315 Utah State Capitol Complex
P.O. Box 145315
Salt Lake City, UT 84114

Mr. Schaff:

The Utah Department of Workforce Services' response to "A Performance Audit of Medicaid Eligibility" (Report No. 2012-07) is attached.

I would like to thank the Office of the Legislative Auditor General and staff, specifically Tim Osterstock, Wayne Kidd, and Tim Bereece, for their professionalism and flexibility in conducting this audit. I would also like to thank the Office of the Legislative Auditor General for its acknowledgement and recognition that Medicaid is being managed "better than in previous audits." DWS has been diligent in our efforts to improve quality, efficiency, and service to our customers and your recognition is appreciated.

If you have any questions or need additional information, please contact Dale Ownby, Associate Director, Eligibility Services Division, at (801) 526-9889 or downby@utah.gov.

Sincerely,

Kristen Cox
Executive Director

Performance Audit of Medicaid Eligibility – RESPONSES
DWS Eligibility Services Division (ESD)
June 11, 2012

Page 16, bottom paragraph:

While the new myCase application process appears promising, the project was developed without a formal planning document that includes project outcomes. Instead, DWS and DTS staff work collaboratively as the project develops to define what the application will and will not do. We recommend that DWS report to the Legislature regarding the project outcomes of reducing the number of multiple PIDs. Reporting the outcomes may also provide solutions to address the multiple PID problem identified in other systems that use the PID for recipient identification.

DWS Response:

DWS and DTS utilized an “agile approach” in developing the myCase online application process. Agile is a formal software development practice recognized by the software development community at large, and has become a standard practice in those communities. It is relatively new for Utah state government, but is widely used in the private sector. DWS procured services from a certified expert to train both DTS and DWS staff in Agile tools and their applications. Outcomes were documented and tested in the following areas: hardware and architecture, customer devices, performance, support, testing, user acceptance, customer guide and training, helpdesk documentation and training, installation to production, operator’s guide and disaster recovery.

Recommendation:

We recommend that DWS regularly report to the Legislature on the progress of achieving its goal to reduce multiple PIDs.

DWS Response:

DWS is willing to regularly report to the Legislature our progress in reducing duplicate PIDs.

Prior to the new online application launching in May 2012, most PIDs were created manually with worker intervention. This methodology was error-prone. With the new online application in production, the methodology for searching and identifying existing PIDs has changed. A customer is required to enter a social security number or case number to continue with the online application process. eREP then interfaces with Utah’s master customer directory (electronic warehouses identifying information from eREP, PACMIS, UWORKS, USSDS, ORSIS and SAFE computer systems). If the social security number is known to the customer directory, the customer and case are registered using the identified PID. If the customer does not enter their social security number or case number, they are directed to print a paper application. In these circumstances, an ESD employee will follow the process as they have in the past. As with any computer matching technology, the match is

dependent upon the quality of the data which is input into the system. If the customer or eligibility specialist transposes numbers in a social security number, date of birth, etc., there is a possibility of a duplicate PID being created. With the new process, DWS expects to see progress in reducing duplicate PIDs.

DTS regularly runs reports which identified exact match duplicate PIDs and potential duplicate PIDs. DTS is able to delete the duplicate if there have been no involvements (approval or denial of benefits) in eREP. If the PID has had involvements, they are set by DTS as duplicates so they are identified as such in the system. If the duplicate PID is shared with another agency (i.e. Office of Recovery Services), the other agency is notified and a hierarchy methodology is used to determine which PID is optimal for all agencies to use.

As of May 31, 2012, there are a total of 1,048,320 PIDs known to eREP. The estimate of 2,300 actual duplicates equates to 0.2% of the total PID universe being identified as duplicates. Although we acknowledge that duplicate PIDs are problematic, and must be corrected, we feel that the percentage of duplicates to total PIDs is very small.

Recommendation:

We recommend that the Eligibility Services Division develop a process that tracks the impact of individual worker initiatives and case review changes to clarify the benefits from improvement initiatives.

DWS Response:

We agree that implementing concurrent or overlapping initiatives can make it challenging to determine individual initiative benefits. DWS has been utilizing Theory of Constraints (TOC) to identify opportunities for efficiencies by isolating bottlenecks and resolving or eliminating those items that lead to inefficiency. Fortunately (or unfortunately), this frequently moves the bottleneck to a different area of our process(es). This continual improvement requires us to be nimble and utilize human and technological talent to achieve quality throughput. We primarily focus on the results or outcomes to indicate success.

TOC principles are relatively new to state government, but have been widely utilized in the private sector with great success. DWS has found that using these management tools, focusing on key outcomes is our indicator of success. Looking at the Eligibility Services Division (ESD) Throughput Operating System (TOS) that was put in place in early 2011 as a guide to streamline our processes, ESD has clear and key objectives: reduce costs, increase volume and quality, sustain or improve service levels and decrease days to decision. These are the same goals that were set and achieved by ESD. ESD has several initiatives in place to meet these goals: pay for performance, improved quality tools, new business processes, staff training and system enhancements. As with all of our initiatives, DWS' data and reporting systems allow DWS and ESD to identify specific outputs and corresponding impacts on division, team, and individual worker performance.

Using the TOC principles, ESD is able to adapt quickly to fluctuating business needs, constraints, and policy changes. This flexibility is something new and quite innovative for state government.

Recommendation:

We recommend that the Department of Health reconsider whether tracking medical overpayments caused by agency error is necessary. Based on their evaluation, one of the following should occur:

- The Department of Health should collaborate with the Department of Workforce Services and the Office of the Inspector General on how to estimate the costs of benefits paid to ineligible recipients if calculations are discontinued, or
- The Department of Health should consider aligning the time period considered in overpayment calculations for agency errors in medical programs with other benefit programs.

DWS Response:

Although this item is addressed to the Department of Health, DWS is supportive of the recommendation and either alternative. The first option is preferable, and DWS will work with the Department of Health and the Office of Inspector General in developing a methodology to track costs.

Recommendation:

We recommend that the Medicaid program provide Medicaid recipients with a one-time, plastic eligibility card.

DWS Response:

Although this item is addressed to the Department of Health, DWS is supportive of this recommendation. DWS will work with the Department of Health to plan and support implementation of the new medical card, when ready.



Utah Department of Health Executive Director's Office

W. DAVID PATTON, Ph.D.
Executive Director

ROBERT T. ROLFS, M.D., MPH
Deputy Director
State Epidemiologist

MICHAEL HALES, MPA
Deputy Director, Medicaid and Health Finance

State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

May 30, 2012

Mr. John M. Schaff, CIA
Legislative Auditor General
W315 Utah State Capitol Complex
PO Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Schaff:

Thank you for the opportunity to review and to respond to the Department of Health sections of your legislative audit titled "A Performance Audit of Medicaid Eligibility" (Report No. 2012-07). We will also review the remainder of the report once it is made available to us upon the public release of the report.

We in the Department of Health appreciate the work performed by you and your staff in the review of Medicaid eligibility. As the focus of the audit was primarily on the work performed in the Department of Workforce Services (DWS), we had more limited interactions with your staff than we have had during previous audits focused on activities at the Department of Health. However, we commend your staff for their professionalism and cooperative efforts as we worked with them and discussed the findings related to the Department of Health.

In regard to the specific recommendations for the Department of Health, here are our responses:

Recommendation: *We recommend that the Department of Health reconsider whether tracking and calculating medical overpayments caused by agency error is necessary.*

Agency Response: The Department agrees with the recommendation and will reconsider the calculation of overpayments caused by agency error. Our preliminary review of this issue is that it is still important to know what the error rate is for overpayments related to agency error so that efforts can be made to reduce the error. However, we do believe there is flexibility in how the calculation of the error is made and will commit to finding a less burdensome way to calculate the amount.

Recommendation: *We recommend that the Medicaid program provide Medicaid recipients with a one-time, plastic eligibility card.*

Agency Response: The Department agrees with the recommendation. The Department has been working collaboratively with legislators, providers and the Utah Health Information Network (UHIN) to create an electronic plastic eligibility card with "swipe card" technology to replace the current Medicaid eligibility benefit paper document.

Since the current Medicaid eligibility document contains so much information that is used by providers, such as the Medicaid benefit package (traditional, non-traditional, or Primary Care Network), the mental health network, the physical health network and cost containment efforts such as a provider lock-in, Medicaid has wanted to ensure that all of that information would continue to be available to providers with any new plastic eligibility card. Part of the ability to support such an electronic plastic eligibility card is the ability to support real-time eligibility inquiries by providers. The Department is currently working with Department of Technology Services (DTS) programmers to upgrade the current claims payment system so it can support a real-time eligibility inquiry. Once this programming is completed, Medicaid will be in a position to begin converting to an electronic plastic eligibility card. We anticipate being able to achieve this in calendar year 2013.

We look forward to working with you to ensure that our implementation plan is consistent with the intent of your recommendations. Since the Department of Health is the Single State Agency for Medicaid in Utah, we will also work with DWS to ensure their compliance with any issues that your report may have raised in relation to how they have been carrying out their Medicaid functions.

Again, we thank you for your time and efforts in performing this program review and the resulting recommendations for improvement. We look forward to discussing the report and the recommendations with the Audit Subcommittee.

Sincerely,



W. David Patton, Ph.D.
Executive Director