

**Utah State Legislature
Social Services Appropriations Subcommittee**

**Implementation of SUCCESS Framework
A Report Prepared by the Department of Health
February 12, 2015**

Current Department of Health SUCCESS Projects:

- Medicaid Accountable Care Organizations – Page 1
- Medicaid Operations (Suspended Claim Review) – Page 3
- Medicaid Operations (Provider Application Processing) – Page 4
- Environmental Quality Laboratory Testing – Page 6
- Baby Watch Early Intervention Services – Page 8
- Issuance of Vital Record Certificates – Page 9

EVALUATION of the MEDICAID ACCOUNTABLE CARE ORGANIZATIONS

Medicaid Accountable Care Organizations (ACOs) were implemented within the four Wasatch Front counties on January 1, 2013. For Medicaid enrollees who live in Utah County, Salt Lake County, Davis County, or Weber County, ACO enrollment is mandatory. Medicaid enrollees who reside outside of those counties may elect to participate in an ACO, if a health plan is available in the area. Four health plans are available: SelectHealth, Molina Healthcare of Utah, Healthy U, and HealthChoice. Approximately 275,000 Utahns are enrolled in Medicaid; ACO enrollment is roughly 70 percent of total.

Measuring ACO Performance

Language contained in S.B.180 (2011 General Session) sets the expectation that the Medicaid ACO model will “limit the rate of growth in per-patient-per-month General Fund expenditures for the program to the rate of growth in General Fund expenditures for all other programs.” The objective is to shift the focus from paying for activity to paying for outcomes and reduce the rate of escalation in the Medicaid cost trend.

In addition to monitoring program costs, Medicaid management will monitor quality using the Healthcare Effectiveness Data and Information Set (HEDIS), and patient satisfaction with Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data. HEDIS measures are available at: <https://health.utah.gov/myhealthcare/reports/hedis/>
To review CAHPS measures go to: <https://health.utah.gov/myhealthcare/reports/cahps/2013/>

Evaluation of ACO Cost – Per Member Per Month (PMPM)

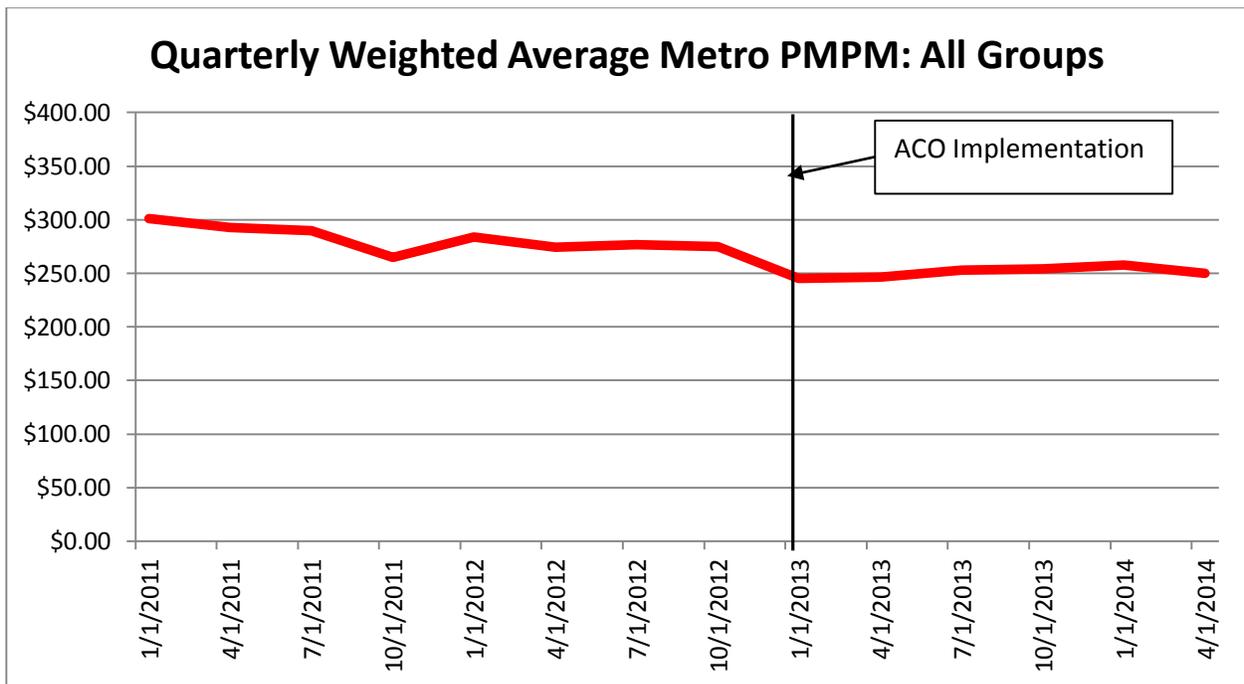
A Medicaid ACO cost analysis is currently in process. The analysis includes a PMPM evaluation of claims expenditures for these Categories of Aid:

- Children Age 1-18
- Newborn/Infant
- Adult
- Aged
- Blind and Disabled
- Pregnant Women

Cost Evaluation Methodology

- Calculate cost on a Per-Member-Per-Month (PMPM) basis as follows:
 - Group 1: Wasatch Front Fee-for-Service (FFS) enrollment for CY 2010-CY2012
 - Group 2: FFS enrollment outside of the Wasatch Front for CY2010-CY2012
 - Group 3: Wasatch Front ACO enrollment for CY2013
 - Group 4: FFS enrollment outside the Wasatch Front for CY2013
- Exclude costs for mental health care, nursing home services, and dental services
- Include cost of mental health drugs
- Include ACO administrative costs and estimated UDH FFS administrative costs
- Time periods are based on dates of service, rather than date of payment
- Acuity and utilization patterns will differ between urban rural populations

Aggregate PMPM data gathered for the Medicaid Categories of Aid included in the study, are displayed in the graph below. The analysis suggests that overall Medicaid costs are dropping for Wasatch Front enrollees (Metro) in absolute terms, as well as relative to historic cost trends.



IMPROVING TURNAROUND TIME OF MEDICAID CLAIMS SUSPENDED FOR REVIEW

The Bureau of Medicaid Operations is responsible for review and adjudication of claims that are suspended from the normal weekly claim cycle. Suspended claims do not meet pre-established criteria for auto-adjudication. The SUCCESS focus is to improve the timeliness of handling suspended claims, while maintaining a high level of accuracy.

Scope of Work

The Medicaid Management Information System (MMIS) auto-adjudicates approximately 98 percent of fee-for-service claims submitted for reimbursement by Medicaid providers. Average monthly claim volume is approximately 524,400. Of that monthly number, about 10,500 are put into a suspense file. Of the 10,500 average suspended claims, approximately 8,600 require intervention by a trained Claim Technician for manual adjudication.

Application of the SUCCESS Framework to Claim Adjudication Timeliness

The Medicaid Operations Management Team has adopted and applied SUCCESS principles and tools to evaluate and document workflow, including a Throughput Operating System (TOS) Map, a Functional Assessment of Speed and Time (FAST) Diagram, a Cumulative Flow Diagram, and an Interference Diagram. QT and OE variables have been defined, and a baseline dataset is in development.

QT/OE Defined

- T = Volume of adjudicated claims
- Q1 = Timeliness of claims processed
- Q2 = Accuracy of claims processed
- OE = In development

Claims audit for accuracy

Suspended claims that are manually adjudicated are audited periodically for accuracy. The most recent audit, completed in February 2015, resulted in confirmation that 87% percent of claims were adjudicated correctly. Audit results are used to identify staff training needs.

Performance Improvement

The backlog of suspended claims currently rests at an unprecedented two claim cycles (two weeks). Historically, the volume of suspended claims has backed up for eight to 12 cycles.

Bureau management has evaluated options and implemented process improvements that will maintain the current high level of service. The best results over the long haul will be achieved by reducing multitasking and devoting larger blocks of time to uninterrupted claim processing. The specific tactics that have contributed to achieving higher levels of performance are:

- Consolidated customer service teams – provided training across all claim types
- Dedicated staff to specialized workload
- Assessed staff skills and assign workload accordingly
- Initiated “peer-to-peer” mentoring
- Modified telephone shifts to allow more “protected” processing time

IMPROVING TURNAROUND TIME FOR PROVIDER APPLICATION PROCESSING

The Bureau of Medicaid Operations is responsible for credentialing health care providers for participation with the Utah Medicaid Program. The scope of work includes the fee-for-service panel and Accountable Care Organizations. The SUCCESS focus is to improve the efficiency of provider application processing to bring the backlog of pending applications current and maintain a high level of high service.

About the Medicaid Provider Panel

Currently, 31,900 health care providers are enrolled with the Utah Medicaid Program, although in any given year, approximately 7,000-8,000 practitioners actually bill for services provided to Medicaid enrollees. Of the 31,900 total enrolled providers, 29,200 are licensed to practice within the state of Utah.

In addition to new enrollments, Medicaid credentialing work load is affected by other variables:

- Medical school graduation
- New requirements mandated by the Affordable Care Act
- Accountable Care Organization enrollment requirements
- Enrollment requirements of the PRISM Medicaid Management Information System

Impact of Affordable Care Act

As a result of the Affordable Care Act (ACA), State Medicaid programs are now required to conduct mandatory site visits for certain provider types. Additionally, all providers enrolled prior to March 25, 2011 must revalidate their enrollment information every three or five years (again, depending on provider type). The re-credentialing process requires that providers submit a new Provider Agreement, Ownership Disclosure Form, and applicable Licensure.

Background checks are conducted on potential Medicaid providers, as well as medical business owners, and managers. ACA has expanded the number of databases that are accessed during the application review. The process involves checking national databases for information:

- Verify billing and practice location addresses
- Confirm licensure
- Verify tax identification numbers
- Verify Medicare enrollment status
- Review potential issues related to waste, fraud, and abuse
- Review reports of illegal or unethical behavior or activity
- Confirm student loans are in good standing

Current Processes and Backlog of Work

Current enrollment processes are largely manual. Providers submit a completed enrollment application, and provide copies of licenses, and other required documentation, such as Medicare certification, Ownership Disclosure, Medicaid Provider Agreement. The completed application packet (application and supporting documentation) is faxed or mailed to the Medicaid office for review and processing. More contemporary, electronic business practices are in development with the new Medicaid Management Information System. Throughout most of 2014, the backlog of pending applications stayed relatively constant at 12 week. It does not make sense to devote resources to automate current processes in the legacy system, but an extended 12 week backlog is not acceptable.

Application of the SUCCESS Framework to Provider Application Processing

The Medicaid Provider Enrollment Team has adopted and applied SUCCESS tools to their workflow, including a Throughput Operating System (TOS) Map, a Functional Assessment of Speed and Time (FAST) Diagram, a Cumulative Flow Diagram, and an Interference Diagram. QT and OE variables have been defined, and a baseline dataset is in development.

QT/OE Defined

- T = Volume of processed applications
- Q = Timeliness of processed applications
- OE = In development

Performance Improvement

The provider enrollment workload is a “moving target.” Process improvement techniques have been implemented that focus on reducing multitasking and devoting larger blocks of staff time to uninterrupted application processing. These process improvements have reduced the backlog of pending provider applications from 12 weeks to six weeks. Additional gains are expected.

Some specifics are:

- Re-assessed team priorities. Divert staff resources from telephones to application processing, while maintaining telephone service at an acceptable level
- Redistributed some clerical functions to other team members
- Assess staff skill level and accuracy levels – target job-specific training
- New team assignments – re-energize team; new outlook and perspectives

IMPROVING TIMELINESS OF ENVIRONMENTAL TESTING SERVICES

The Utah Public Health Laboratory is a scientific laboratory that provides public health testing that is timely, accurate, and cost efficient. The Lab is divided into four testing sections: Environmental Chemistry, Forensic Toxicology, Infectious Diseases, and Newborn Screening. Although all Lab Sections are adopting process improvement to varying degrees, the SUCCESS focus is Environmental Chemistry.

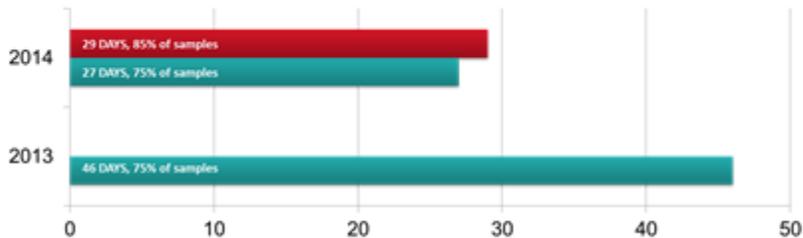
The Environmental Chemistry Lab is further subdivided into Inorganic testing (phosphates/nitrates), Organic testing (pesticides), and Metals testing (mercury, copper, lead,). The primary customer is the Utah Department of Environmental Quality.

QT/OE Defined

- T = Volume of tests, weighted by cost (fee schedule)
- Q1 = Proficiency Scores
- Q2 = Timeliness of test completion
- OE = Total lab direct operating expense, plus an allocation for overhead

AFTER A YEAR OF OBSERVATION

- Real Time Operational Data Reviewed Weekly
 - LEAD TIME by (a) testing, (b) data review, (c) reporting
 - % of samples meeting Service Level Agreement (46 days)



Performance Improvement

To a certain degree, speeding up processing does not necessarily equate to positive outcomes in a laboratory setting. Scientific protocol must be followed to ensure quality and accuracy of testing. That being stated, there are areas where the Lab can improve processing and reporting turnaround times, and ultimately service to customers. The key to improving Environmental Chemistry performance has been to review the entire system, from the time samples are delivered to the Lab to the time data package reporting is released to the customer. The bottom line for Environmental testing is – simple changes yield big results. Some of the specific tactics implemented:

- Modifying work shifts to ensure instrument warm-up and cool-down times are optimized
- Eliminate batching of data package reporting to customers
- General awareness of and visibility to performance data

IMPROVING THE VALUE PROVIDED BY THE BABY WATCH EARLY INTERVENTION PROGRAM

The Baby Watch Early Intervention Program (BWEIP) provides services for children from birth to age three who have disabilities or delays in development. The program is available throughout the state to the family of a qualifying child. Infants and toddlers enter the program at a variety of ages and they and their families are served in the program for varying lengths of time. The BWEIP endeavors to maximize the time a child and their family spends in the program receiving successful interventions in order to increase the likelihood of the child's growth and development.

Some of the services available include:

- A full assessment of a child's current development and health status
- Service coordination among the team, the family providers, programs, and agencies
- Strategies to address family concerns, priorities, and resources
- Family training services in conjunction with occupational therapy, physical therapy, speech language therapy, etc.

Measurement of Child Growth and Development

Children's developmental progress during the time they are receiving program services is determined through a child outcomes rating scale when they enter and again when they exit the program. Progress is only determined for children if they have received at least six months of early intervention services. The entry and exit scores determine the type of progress the child has made in the following areas:

- Positive social-emotional skills (including social relationships)
- Acquisition and use of knowledge and skills (including early language/communication)
- Use of behaviors to meet their needs

Future Project – Focus on infants and toddlers from disadvantaged backgrounds:

- Increase the rate of functioning in the area of social-emotional skills
- Increase the percentage of children who receive at least 6 months of early intervention service

EXPANDING TECHNOLOGY IN VITAL RECORDS AND STATISTICS

During SFY2014, the State Vital Records Office issued 79,322 copies of birth certificates and 13,589 death certificate copies. Copies of birth records may be requested online through the State’s Secure Internet Link for Vital Events Records (SILVER) system. Of the 79,322 birth records issued by the State, 24,623 (31 percent) were requested online. Local Health Departments also issue vital record certificates. Comparative data are shown in the following table:

Certificates Issued (SFY 2014)

	State	LHD	Total
Birth Record	79,322	109,093	188,415
Death Record	13,589	126,934	140,523
Total	92,911	236,027	328,938

SUCCESS Focus

The SILVER system is more than a decade old. In addition to utilizing more contemporary technology, the site needs an upgrade to “look” and “feel.” The replacement system for SILVER will also allow for online requests for death certificates, in addition to birth records. There is opportunity to improve the efficiency of the State Vital Records Office by increasing the number of vital record certificates that are requested online.