

# Report to the Social Services Appropriations Subcommittee

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## Increased Medicaid Program Efficiencies

December 2018



## **Statutory Requirement**

As first required by House Bill 459 (2010), the Utah Department of Health (Department) submits this response to comply with the following statutory requirement in UCA 26-18-2.3:

*Division responsibilities -- Emphasis -- Periodic assessment.*

*(4) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, fraud, waste, abuse, and cost recovery.*

*(5) The department shall, by December 31 of each year, report to the Social Services Appropriations Subcommittee regarding:*

*(a) measures taken under this section to increase:*

*(i) efficiencies within the program; and*

*(ii) cost avoidance and cost recovery efforts in the program; and*

*(b) results of program integrity efforts under Subsection (4).*

## **Increased Medicaid Efficiencies**

Over the past year, the Division of Medicaid and Health Financing (Division) within the Department has implemented many changes to improve the efficiency and effectiveness of the areas of the Medicaid program it manages. In addition to the efficiencies it has identified on its own, the Division has also worked with many partners (including legislative auditors, its legislative fiscal analyst, and the federal government) to identify other potential improvements and then implement those changes. Some of these efficiencies have produced budget savings, others have resulted in cost avoidance, and others have created improved operating processes for the Medicaid program.

Here are examples of some of the increased efficiencies achieved this year:

### ***Medicaid Buyout Program***

The Division's Medicaid Buyout program purchases private health plans when someone is Medicaid eligible, has other health insurance available, and would save the Medicaid program money. After reviewing the claims paid data, the Medicaid Buyout team recognized the need to transition Buyout eligible members (with few exceptions) from managed care plans to the Fee for Service Network. This change significantly increased Medicaid's average net savings of \$0.14 for every Buyout dollar spent in

2017 to \$4.75 in 2018 YTD. In the 3<sup>rd</sup> quarter of 2018 alone, Buyout saved Medicaid from spending \$6.70 for every Buyout dollar spent, amounting to over \$850,000 in cost savings.

### ***Prior Authorization Cross Training***

In the past, prior authorization reviewers were specialized to perform authorizations for specific programs. The Division cross trained its authorization staff to be able to review and authorize any request received. In the short term, there was an expectation of a slight increase in turn-around time for prior authorizations. However, contrary to expectations, the turn-around time actually decreased despite an increase in the volume of prior authorization requests.

### ***Interpretive Services***

When the Division receives a bill for interpretive services, it has to determine manually if the individual is eligible for Medicaid or CHIP, if there was a qualifying service performed on the date of the interpretive service, and if the individual is enrolled in an Accountable Care Organization (ACO), a Prepaid Mental Health Plan (PMHP) or a Capitated Dental Plan. The Division worked with one of the interpretive providers who provides invoices in an electronic format and developed a system to intake the electronic invoice, automatically determine eligibility, search for a qualifying service, and check ACO, PMHP, and Dental Plan enrollment. This process has greatly sped up the procedure for processing an interpretive services invoice. The Division is now working toward automating this process for all interpretive providers willing to invoice in an electronic format.

### ***Standardization of GRAMA Requests***

The Division implemented a SharePoint process to route and track Government Records Access and Management Act (GRAMA) requests. This process included a peer review once the request was fulfilled and prior to delivery. This process has sped up the overall GRAMA request process and has helped to improve the quality of data provided for such requests.

### **Internal Audits of the Medicaid Program**

The Office of Inspector General for Medicaid Services (OIG) was created in July 2011. Many audit positions related to Medicaid were moved from the Department to the OIG to staff that office. As a result, among other responsibilities, the OIG is to audit, inspect, and evaluate the functioning of the Division to ensure that the Medicaid program is managed in the most efficient and cost-effective manner possible. The OIG is directed to issue its own reports to the Legislature on its efforts.

Despite the loss of staff in 2011, the Department has continued to operate its own Office of Internal Audit (OIA). Responsibilities for the OIA are broader than just Medicaid and include performing internal audits and reviewing grants issued by the Department.

During 2018, OIA performed an audit titled *Medicaid Health Financing Provider Enrollment Compliance*. This purpose of the audit was to determine whether the Division was complying with federal provider re-credentialing requirements for moderate and high risk providers. The report identified areas where the Division could strengthen internal controls related to re-credentialing. The Division has implemented OIA's recommendations.

### **Conclusion**

The Department is committed to improving the Medicaid program. It is the Department's goal to employ healthcare delivery and payment reforms that improve the health of Medicaid clients while keeping expenditure growth at a sustainable level. The Department will maintain previously identified efforts to improve efficiency as they continue to save the State tens of millions of dollars each year. In addition, the Department will continue to seek out the most effective way to carry out its responsibilities in the future.