Report to the Social Services Appropriations Subcommittee

Increased Medicaid Program Efficiencies

December 2017

UTAH DEPARTMENT OF HEALTH

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.*
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> *(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.*
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> *(5) The department shall, by December 31 of each year, report to the Health and Human Services Appropriations Subcommittee regarding:*
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> *(a) measures taken under this section to increase:*
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> *(i) efficiencies within the program; and*
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> *(ii) cost avoidance and cost recovery efforts in the program; and*
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> *(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 Medicaid program. 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.

Performance Metrics

The Division continues to meet with individual work teams within each bureau and the Director's Office to develop performance metrics and use these to promote ongoing improvement efforts. For instance, the Buyout program in the Bureau of Eligibility Policy purchases private health insurance for some members to offset potential high Medicaid costs. The Buyout team has developed a measurement system that captures the number and outcomes of buyout referrals from the Department of Workforce Services. Our data gauges the extent to which these referrals lead to buyout, and evaluates the cost savings of this effort. The data for CY2017 YTD finds that for every dollar we invest in buying private insurance, we offset $1.68 in expenditures (a return on investment of 68%), with an average cost savings of $710 per case. Further, we recently refined the referral process to reduce the number of inappropriate referrals we receive and increase the ratio of cases that lead to appropriate and successful

buyout. This has reduced the number of referrals by approximately 22%, giving team members more time to evaluate appropriate referrals and make timely buyout decisions.

Elimination of Unnecessary Prior Authorization Criteria

Throughout FY 2017, Medicaid policy staff have identified several prior authorization requirements on medications and medical procedures that no longer warranted this intervention. The prior authorization criteria may have become outdated due to new medical research, new safety data, or new generic medications being available. In some cases, it has been determined that post utilization review rather than prior authorization would be better. By eliminating the unnecessary prior authorization criteria, the Division has minimized the workload on providers and also has allowed the existing Division staff to shift their time and efforts to other projects.

Preferred Drug List

In FY 2017, the Preferred Drug List (PDL) was expanded to include psychotropic drugs. The addition of this drug class resulted in general funds savings of over $1.8 million. This amount is on top of the $17.5 million in General Fund savings achieved through the PDL that has been in place for other Medicaid drugs.

Provider Enrollment

With the phased implementation of the new PRISM system, the Division has experienced increased efficiency in provider enrollment. Previously, providers enrolled using a manual paper process, which required a significant amount of staff time. The new system is designed to enable providers to enroll electronically, which has decreased the amount of time it takes to process provider applications. Achieving these effeciencies has been critical to help the Division absorb expanded mandates from the federal government regarding provider enrollment and recredentialing.

Emergency Services Program for Non-Citizens

The Division has created a new template for providers who submit claims under the Emergency Services Program for Non-Citizens. Prior to the creation of the template, the Division would receive submissions that were not uniform or that were missing key identifying information. The new template has allowed the Division to process claims in a more timely and efficient manner. Delays in processing these claims have been reduced.

Medical Review Board

The Medical Review Board determines disability for Medicaid applicants. During the year, the Division was able to decrease the number of days it takes to make disability determinations by over 90% by reprioritizing workloads and making other process improvements. This improvement means that applicants have less of a wait to find out regarding Medicaid's decision on their disability request.

Medically Complex Children's Waiver (MCCW) Service Cost Savings/Avoidance

The availability of the MCCW allowed other governmental entities, such as school districts (local education authorities (LEAs)), to maximize their state dollars to draw down federal Medicaid funds for required services. For example, because school-based services are reimbursable by Medicaid, the LEAs only needed to pay the state matching funds rather than the entire cost for medical services provided to children enrolled in the MCCW. The state portion of the funding for these services ($307,330) is provided by LEAs and does not result in expenditures to the MCCW General Fund appropriation. Drawing down the additional federal Medicaid funds resulted in $714,680 in overall state fund savings/cost avoidance for these entities.

Ongoing Efficiency Efforts

The Division continues to operate a restriction program for Medicaid clients who demonstrate a pattern of excessive program utilization, including individuals who inappropriately utilize Emergency Departments (ED). When a pattern of misuse is identified, the Division will contact that individual and assign/restrict the Medicaid client to a primary care provider and one pharmacy. The Division will also provide education to the client regarding proper utilization of Medicaid benefits, proper utilization of EDs and alternatives such as urgent care clinics. Medicaid ACOs are responsible to also conduct reviews of their members under the direction and oversight of the Division. In 2017, the Division/ACO conducted case reviews on 1,019 individuals. There are currently 995 individuals in the restriction program as a result of Medicaid benefit misuse or abuse.

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 2017, OIA performed and reported an audit of Medicaid non-medical transportation services, which is a component of the New Choices Waiver program. This purpose of the audit was to determine whether the Division had adequate controls over non-medical transportation billings. The report identified areas where the Division could strengthen internal controls. The Division has taken steps to implement OIA's recommendations and continues to make improvements to program oversight.

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.