Report to the Social Services Appropriations Subcommittee

Increased Medicaid Program Efficiencies

December 2013

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.*
>
> *(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 Health and Human 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 stakeholders (including auditors, the Legislative Fiscal Analyst's Office, 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.

Implementation of Accountable Care Organizations (ACO)

In response to concerns that the Utah Medicaid growth rates exceeded the State's annual revenue growth rate for the past two decades and concerns about the long-term sustainability of the Medicaid program, Senate Bill 180, Medicaid Reform, was passed during the General Legislative Section in 2011. In part, the Bill requires that:

"The Department shall develop a proposal to amend the state plan for the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models."

In order to maximize replacement of the fee-for-service delivery model, Senate Bill 180 provides some specific goals and guidance:

1. Restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate service at the lowest cost that maintains or improves recipient health status. The Legislation included:

(a) Identifying evidence-based practices and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost;

(b) Paying providers for packages of services delivered instead of entire episodes of illness;

(c) Rewarding providers for delivering services that make the most positive contribution to maintaining and improving a recipient's health status;

(d) Using providers that deliver the most appropriate services at the lowest cost; and

2. Restructure the program to bring the rate of growth in Medicaid more in line with the overall growth in General Funds.

3. Restructure the program's cost sharing provisions and add incentives to reward recipients for personal efforts to maintain and improve their health status.

To achieve these goals, effective January 2013, the Division implemented Accountable Care Organizations (ACO). There are four ACOs currently operating on behalf of Medicaid: HealthChoice Utah, Healthy U, Molina Healthcare of Utah, and SelectHealth Community Care. Currently, 64.5 percent of all Medicaid beneficiaries are enrolled in an ACO.

The goals of the ACO delivery and payment reform model are to maintain quality of care and improve health outcomes for Medicaid beneficiaries and to control costs by keeping the Medicaid cost growth rate from exceeding the state General Fund growth rate. All ACO contracts are full-risk, capitated contracts and therefore require the ACO to assume the risk for all health care costs for their enrollees. The Division contracts with a nationally recognized actuarial firm to develop ACO reimbursement rates paid to the ACOs, which must be actuarially certified and approved by CMS.

Implementation of Dental Managed Care Plans for Dental Services along the Wasatch Front

Pursuant to HB 256 (2011 General Session), the Division issued a request for proposal to "bid out Medicaid dental benefits" based on the following criteria:

- ability to manage dental expenses;
- proven ability to handle dental insurance;
- efficiency of claim paying procedures;
- provider contracting, discounts, and adequacy of network; and
- other criteria established by the Department.

Full dental benefits are only available to pregnant women, children up to age 18 and to disabled, non-pregnant 19 and 20 year olds.

After careful consideration of cost and access to care, the Division awarded contracts to Delta Dental and Premier Access for the Wasatch Front only. Dental managed care plans were implemented September 1, 2013.

Streamlined Plan Enrollment and Client Education

When a Medicaid beneficiary is required to enroll in a managed care plan, a Health Program Representatives (HPR) assists the individual with the plan choice and education regarding the Medicaid benefits and the appropriate use of the program. Education and plan choice are handled during face-to-face orientation classes, as well as over the phone. During this past year, the face-to-face and phone education has been standardized and streamlined, reducing the amount of time for each orientation. As a result, more orientations are scheduled and more Medicaid eligible individuals are educated each month. Last fiscal year, the Division provided education to 68,441 Medicaid and 20,344 CHIP eligible individuals.

In addition, the Division began using a shorter, more streamlined approach for the plan enrollment process that results in Medicaid beneficiaries being enrolled in a managed care plan faster. Finally, the Division is working on an online Medicaid orientation, including a YouTube video, to allow individuals to access these education materials at any time.

Nursing Home Resident Assessment

Medicaid pays for the long-term care of individuals in nursing facilities, if those individuals meet specific criteria. For many years, the registered nurses that review admissions to nursing facilities were part of the Division of Family Health and Preparedness (DFHP) within the Department. In July 2013, the Medicaid nursing facility prior authorization function was moved from DFHP to the Division of Medicaid and Health Financing. The nurses were moved to the same organizational unit where prior authorizations for other Medicaid services are completed. As a result, nursing staff that complete the nursing facility prior authorizations are now in close proximity to the remainder of Medicaid's clinical staff. This provides the opportunity for a broader group of clinical staff to consult on complex cases, thus increasing the efficiency of the nursing home resident assessment process.

Real-Time Eligibility Inquiry Access

The Division opened real-time eligibility inquiry access to providers. This resulted from implementation of the HIPAA 5010 Standard that allows providers to electronically check a patient's eligibility for Medicaid and confirm benefits. When an inquiry is received, the Medicaid Management Information System (MMIS) returns a response within 20 seconds. This improves efficiency by giving medical providers the ability to electronically verify benefit eligibility of Medicaid recipients.

Medicaid eligibility verification is also available to providers through the Medicaid Interactive Voice Response (IVR) system. In June 2013, system access was expanded to be available 24/7. The volume of

eligibility inquiries through the IVR has increased by 13 percent. Not all provider offices are equipped to verify beneficiary eligibility through the HIPAA 5010 Standard. Expanding the IVR hours of operation creates an efficiency by allowing access to eligibility data during regular business hours and after hours, without having to speak to a technician.

Provider Access Portal

In February 2013, the Division, working in partnership with Goold Health Systems, implemented a provider access portal. The portal is a component of the pharmacy point-of-sale system. Physicians may utilize the portal to submit an electronic prior authorization for certain medications, check eligibility for benefits, review drug history online and submit a prescription to fill. The portal improves efficiencies by giving medical providers access to resources through one electronic pathway.

Improve Workflow Processes

In 2013, SharePoint was deployed to all Medicaid staff as a tool to more efficiently perform day-to-day tasks by automating business processes and allowing employees to collaborate with each other electronically. Medicaid has worked closely with the Department, specifically with the DOH Financial Officer, in order to develop and deploy several workflows, automate manual processes, as well as greatly improve efficiencies and minimize errors. Examples of these workflows include fiscal notes, travel forms, purchase forms, and contract processing. In addition, Medicaid leverages the capabilities of SharePoint for managing Legacy MMIS enhancement projects such as ICD-10 and T-MSIS and monitoring all contracting activities for the new MMIS replacement project.

Enhancements to the Legacy MMIS System

In 2013, the Division and the Department of Technology Services (DTS) made a commitment to improve collaboration and transparency for enhancements to the Legacy MMIS, data and system security, and CMS required projects. These collaborative efforts have enabled DTS to focus its energy on development and programming—leading to more deadlines being met and an increased number of enhancements moving into production.

New Medicaid Cards

The Division and the Department of Workforce Services (DWS) have been working together to produce a new Medicaid eligibility card. In 2013, the work has focused on the design of the new card and a web portal that will give timely eligibility and coverage information to both providers and recipients. The group continues to meet regularly and work on the specifics of this new concept, as well as look for efficiencies within the process.

Ongoing Efficiency Efforts

The Department also has several ongoing projects that have generated increased savings and efficiencies for the Medicaid program this year.

- The Medicaid claims process includes a code-editing module designed to identify and deny payment for inappropriate or incorrect medical claim procedure coding. The module, branded as “Convergence Point” is a proprietary product, developed by Verisk Health. The claim savings yielded by this product amounted to $2,195,197 for the twelve month period ending November 30, 2013.
- Each year the Division works with its Pharmacy and Therapeutics (P&T) Committee to determine if additional drug classes should be added to Medicaid’s Preferred Drug List (PDL). In FY 2013, the Division added 13 new drug classes to the PDL. As a result of the Division’s use of the PDL, Medicaid saved $44.5 million total funds ($13 million general fund) in FY 2013.
- The Division continues to operate a “Lock In” program for Medicaid clients who demonstrate a pattern of excessive program utilization or who abuse the use of Medicaid benefits. The Division uses criteria and surveillance of claims to identify clients who should be placed in "Lock In." The criteria take into consideration use of multiple pharmacies and/or providers, as well as frequent use of emergency departments (ED) for non-emergent reasons. The Division restricts these clients to one pharmacy and one prescribing provider. In addition, the Division provides education to clients on appropriate use of EDs and alternatives to ED use. There are currently 762 individuals in the “Lock In” program. Of these, 70.6 percent are enrolled in managed care. Approximately .3 percent of all Medicaid clients are in the "Lock In" program.

Internal Audits of the Medicaid Program

The Office of Internal Audit (OIA) initiated seven Medicaid audits to identify and resolve fraud, waste and abuse. Four are complete and three are in process. The table below identifies these audits.

#	Audit #	Title	Status (as of December 16)
1	OIA-13-24	Medicaid Supplemental Payments	Report issued in May
2	OIA-13-27 OIA-13-34	Medicaid Pharmacy Point-of-Sale Medicaid GHS (Pharmacy) Business Associate Agreement	2 Reports Issued in September Reporting necessitated 2 separate reports
3	OIA-13-31	Controls Over the Medicaid Autism Waiver	Report issued in October
4	OIA-14-01	Performance Audit of the CMS 64 Report	Finalizing Report
5	OIA-14-02	Performance Audit of UUMG	Memo issued in September
6	OIA-14-04	Medicaid MMIS Change Management Process	Drafting Report
7	OIA-14-10	Review of the CMS 21 Report	Fieldwork

1. The Supplemental Payments audit reviewed three supplemental payments (Disproportionate Share; Graduate Medical Education; and Outpatient Upper-Payment Limit) the purpose was to review process for controls and review the calculations for accuracy.

2. Goold Health Service (GHS) is a third-party vendor that initiates and adjudicates Medicaid pharmacy claims. This audit was separated into two parts and each part was reported individually:

a) The OIA reviewed claims to determine whether eligibility, payment amount and data retention followed prescribed practices.

b) The OIA also reviewed the Business Associate Agreement (BAA) between Medicaid and GHS. The BAA is a contract that establishes the required relationship for the sharing of HIPAA-regulated claim data. The OIA reviewed the contract and associated controls.

3. Medicaid started processing claims for the Autism Waiver this year. The OIA reviewed the process and electronic claims for accuracy and performance.

4. Medicaid reports quarterly expenditures to the Federal Government to receive the federal funds match (CMS 64 report). The OIA reviewed the process and calculations for accuracy and controls. As of the date of this report, the fieldwork has been finalized and an exit conference is scheduled.

5. The OIA reviewed the supplemental payment for the University of Utah Medical Group (UUMG). After performing planning and analysis, the OIA concluded the area to be low risk and did not pursue an audit. A memo was issued which included the decision to not pursue an audit.

6. The OIA performed an information technology audit of the Department of Technology Services' (DTS) change management processes over the Medicaid claims software (MMIS). Change management is the process an information technology (IT) group performs when making changes (fixes or updates) to software. As of the date of this report, fieldwork is concluded and the report is being drafted.

7. The Children's Health Insurance Program (CHIP) reports quarterly to CMS to receive its federal funds match (CMS 21 Report). Similar to the 64 report, the OIA is reviewing the process and calculations for accuracy and controls. As of the date of this report, the OIA is performing fieldwork.

In addition to the audits identified above, the OIA loaned a staff member to the Department full-time, for three months, to provide technical assistance to improve the IT security for "covered entities" (a HIPAA term designating organizations that must keep information secure as they retain protected health information). Duties focused on Medicaid and areas of the Department that support Medicaid.

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 efficiencies 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.