State of Utah

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Governor

GREG BELL
Lieutenant Governor

Utah Department of Health
Executive Director's Office

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December 30, 2010

Members of the Health and Human Services Appropriations Subcommittee
Utah State Capitol
Salt Lake City, UT 84114

Dear Subcommittee Members:

As directed by UCA 26-18-2.3 (5), the Utah Department of Health (Department) submits the following information regarding:

(a) Measures taken to increase efficiencies within Medicaid
(b) Measures taken to increase cost avoidance and cost recovery efforts in Medicaid
(c) Results of efforts to ensure Medicaid program integrity by conducting internal audits

This report contains responses from two different organizational units within the Department. The response to the request regarding increased efficiencies is from the Division of Medicaid and Health Financing. The response to the requests regarding cost avoidance/recovery and internal audits comes from the Office of Internal Audit and Program Integrity. The office was created in November 2009 to increase the independence of both the Department's internal audit function and the Medicaid program integrity unit.

Sincerely,

David N. Sundwall

David N. Sundwall, M.D.
Executive Director

UTAH DEPARTMENT OF HEALTH

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Report to the Health and Human Services Appropriations Subcommittee

Increased Medicaid Program Efficiencies

Prepared by the Division of Medicaid and Health Financing

December 2010

Increased Medicaid Efficiencies

Over the past year, the Division of Medicaid and Health Financing (Division) has implemented many changes to improve the efficiency and effectiveness of the part 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.

Administrative Staff Efficiencies

One of the greatest efficiencies achieved by the Division has been its ability to maintain the administration of the program with the current level of staff while facing significant increases in Medicaid enrollment. Although enrollment increased 11.1 percent this year to 227,325 individuals in November 2010, the Division did not receive any additional funding to handle the increased need for health plan selections, prior authorization requests, or claims processing. In fact, during the first six months of 2010, the Division was operating under a statewide budget reduction ordered by Governor Herbert. During that time, agencies had to cut their total personnel budgets by 3 percent for the year. In order to achieve these savings, the Division offered an early retirement incentive in December 2009 and then often did not fill many of the resulting vacancies, implemented a furlough day in January 2010, and did not fill many other positions when they became vacant.

In July 2010, the Division completed a reorganization effort that began in November 2009 with the removal of the Medicaid program integrity unit and the Medicaid auditors to an independent office at the Department level. Since 2009, the Division has gone from eight to six bureaus and has been able to reduce the corresponding number of bureau directors and secretaries. By leaving these positions unfilled, the Division has been able to reduce its personnel costs over the last six months.

Budget Impacts

Some of the budget cuts taken and revenues budgeted during the 2010 General Session were possible thanks to the savings identified by the Division. The following are budget cuts or increased revenues used in the 2010 Legislative General Session that were the result of improvements identified wholly or in part by efforts of the Division:

- Division staff worked with Department executive management and the Office of the Attorney General to recover $24 million from a drug company for off-label promotion of a drug. *Although $4 million of the award went to legal fees, the remaining $20 million went to the State's General Fund*

- Division staff clarified emergency room billing rules to ensure that claims were only paid at the higher, emergent reimbursement level if the principal diagnosis was emergent.
  Targeted budget reduction – $7,000,000
- Division staff eliminated mailing of remittance advices to Medicaid providers. An additional 3,000 providers now use electronic means to get this information.
  Targeted budget reduction – $214,500
- Division staff reduced mailings of notices to families regarding the need for well child visits.
  Targeted budget reduction – $50,000

Ongoing Efficiency Efforts

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

- 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 2010, the Division added four new drug classes (covering 337 drugs) to the PDL. These drug class additions, combined with savings from existing PDL classes, generated PDL savings totaling over $15 million in state and federal funds.
- In FY 2010, the New Choices Waiver program added 130 new enrollees over its FY 2009 enrollment. Each waiver enrollee is someone who was previously receiving care in a nursing home and now receives services in a less costly environment (often an assisted living facility). The average cost savings per person in this waiver is approximately $14,900 per year. Medicaid cost avoidance this year due to the increased waiver enrollment is $1,937,000 in total funds.
- The Division continues to operate a "Lock In" program for Medicaid clients who demonstrate a pattern of excessive program utilization. The Division restricts these clients to one pharmacy and one prescribing provider.
- The Division operates an Emergency Department Diversion program to redirect clients seeking primary care needs in the Emergency Department of the State's hospitals. Once a client registers an Emergency Department visit with a non-emergent diagnosis on the claim, the Division will contact that individual and help him or her find a primary care provider and educate the client on when Emergency Department utilization is appropriate.

Quicker Managed Care Enrollment

The Division examined the current health plan enrollment process to determine if enrollment into a health plan could be hastened without jeopardizing the Centers for Medicare and Medicaid Services (CMS) mandated educational components of the process. The Division now sends the initial system alert to enrollment staff simultaneously with the "Welcome to Medicaid" letter rather than waiting the ten days allowed for clients to make a plan selection. This change was made effective in June 2010 and

implements a recommendation made by the legislative auditors to accelerate the process of assigning Medicaid clients to a managed care plan. The audit report stated, "To the extent the health plans have favorable contracting agreements, getting recipients into managed care sooner takes advantages of those agreements."

Contracted Services

In 2010, the Department issued three requests for proposals to bring in outside contractors to analyze Medicaid claims. It is expected that these contracts will increase efficiencies by reducing the payments of claims that do not meet Medicaid policy. One contracted service began in December 2010. This vendor reviews claims before they are paid by the Medicaid system. In addition, a second contract has been awarded to a vendor that will conduct an in-depth review of 2008 and 2009 claims, identify potential payment errors, and collect overpayments. Finally, the Department has issued a request for proposals for a third contract where the vendor will provide a new tool for Program Integrity to detect potential fraud, waste, and abuse and may also lead to the outsourcing of certain Program Integrity functions.

Payment Reform

During 2010, the Division spent a substantial amount of time engaged in payment reform efforts. These reform efforts look to change the underlying incentives in the health care system that currently exist for providers to provide excessive health care services. The Division looks to work closely with the Governor's Office and the Legislature to implement these proposals within the next 18 months.

Conclusion

The Division is committed to maintaining its efforts in these areas to ensure the continuation of previously identified efforts to improve efficiency. The Division will also continue to seek out the most effective way to carry out its responsibilities in the future.

ANNUAL REPORT TO THE HEALTH AND HUMAN SERVICE APPROPRIATIONS SUBCOMMITTEE

UTAH DEPARTMENT OF
HEALTH

12/21/2010

Office of Internal Audit

The Office of Internal Audit was established in May 2010 to ensure adequate internal controls are in place and functioning as designed, and effective and efficient policies and procedures are established and followed.

State of Utah

GARY R. HERBERT
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Lieutenant Governor

Utah Department of Health
Office of Internal Audit & Program Integrity

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DEAN EBORN, CPA
Director, Internal Audit & Program Integrity

December 21, 2010

TO: Senator Allen M. Christensen, Representative John Dougall, and the Health and Human Services Appropriations Subcommittee

SUBJECT: 2010 Annual Report for the Department of Health's Office of Internal Audit

Attached is our 2010 annual report to the Health and Human Services Appropriations Subcommittee, in compliance with ***Utah Code*** 26-18-2.3(5). This report shows results from the Department of Health's Office of Internal Audit for fiscal year 2010.

I am available to meet with members of the subcommittee to discuss any item contained in this report and to answer any questions regarding the efforts of this office.

Sincerely,

Dean Eborn, CPA
Director, DOH Office of Internal Audit

cc: President Michael Waddoups
Speaker David Clark
David Sundwall, M.D.
David Patton, Ph.D
Teresa Garrett, RN MS
Michael Hales
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INTRODUCTION

ROLE AND AUTHORITY:

The Office of Internal Audit (OIA or office) is an independent office of program evaluation and review located within the Department of Health (DOH or department) created in May 2010. The purpose of this office is to ensure adequate internal controls are in place and functioning as designed, and effective and efficient policies and procedures are established and followed. The director of the OIA reports to the Executive Director of the department.

STAFF:

Director	Dean Eborn, CPA
Audit Managers	Broc Christensen David Pulsipher, CIA CFE
Program Managers	Alex Yei Kylene Hilton
Audit Staff	David Meadows, JD Doug May, CIA Keith Swenson Les Painter, CPA Robert Kolan, CPA CFE Roger Price Ryan Huntsman Tad Purser
Program Integrity Staff	Brenda Strain, RN Connie Keuffel, RN George Smith, MD John Slade Jordan Davis, RN Kathy Adams Kathy Cordova Leonor Lopez Marian West, RN Randy Draper, MD Robert Miller, MD Sally Valdez, RN Sandi Rue, RN Toni Shepard, RN
Administrative Support	Ann Carrillo

"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..."

- ***Utah Code*** 26-18-2.3(4)

OIA IMPACT

Audits conducted by the internal auditors and program integrity units within the OIA recovered $3.5 million dollars in one-time state and federal Medicaid funds during fiscal year 2010. During the first half of fiscal year 2011, the OIA recovered $1.8 million and questioned an additional $5.2 million in one-time state and federal Medicaid funds. The implementation of OIA recommendations will prevent an estimated $3.6 of unnecessary state and federal funds from being wasted each year.

Internal Audit

Three internal performance audits question $5.2 million in Medicaid costs during the first half of fiscal year 2011, including the state and federal portion. These three audits cited concerns in inappropriate billings, unsubstantiated provider costs, and vaccines. The following table shows the impact of the internal auditors during the last six months.

Complete Audits	Fiscal Year 2010*		Fiscal Year 2011 (to Dec. 2010)	
	One-Time	Ongoing	One-Time	Ongoing
Questioned Costs	N/A	N/A	$5.2 Million	0
Cost Avoidance	N/A	N/A	0	$3.6 Million**
Total	N/A	N/A	**$5.2 Million**	**$3.6 Million**

**OIA began tracking cost avoidance in December 2010.*
***Estimate*

Program Integrity

The program integrity unit of the OIA returned $3.5 million in state and federal funds to the Medicaid program in fiscal year 2010, and has recovered $1.8 million during the first two quarters of fiscal year 2011. The following table shows the impact of the program integrity unit.

Complete Audits	Fiscal Year 2010	Fiscal Year 2011 (to Dec. 2010)
Recoveries	$3.5 Million	$1.8 million
Cost Avoidance*	N/A	N/A
Total	**$3.5 Million**	**$1.8 Million**

**OIA began tracking cost avoidance on 12/14/2010*

INTERNAL AUDITS

Complete Audits	Fiscal Year 2010		Fiscal Year 2011 (to Dec. 2010)	
	Total Reports	Medicaid Audits	Total Audits	Medicaid Audits
Performance Audits	0	0	3	3
Cost Settlements	3	3	1	1
Follow-Up Reviews	0	0	2	2
Total Audits	**3**	**3 (100%)**	**6**	**6 (100%)**

Performance Audits
The office released a performance audit on emergency room and ambulatory surgical center billing on October 25, 2010. This report contained recommendations to correct billing coding errors, reprocess inappropriate billings, and implement a policy to ensure timely implementation of billings changes.

A performance audit of the University of Utah's Healthy Outcomes Medical Excellence (HOME) was completed in December 2010. This audit report recommended that the HOME program substantiate costs in a format that is required by federal regulations and the contract, or repay the Division of Medicaid and Health Financing (division) for the unsubstantiated costs. The audit report also recommends greater coordination between the division and HOME, an audit of HOME fiscal year 2010 costs, and adjustment of HOME prepayments to reflect documented costs.

Two additional internal audits will be completed in early 2011 that address, the Baby Your Baby program and vaccines. The office is also currently undertaking a department-wide risk assessment that will be used to prioritize future internal audits. The initial risk assessment is scheduled to be complete by early 2011. Office staff will re-evaluate department risks on an annual basis.

Cost Settlements
The Utah State Plan requires the office to conduct annual cost settlements with specified providers. Cost settlements are completed for federally-qualified health centers (FQHC), the Utah State Developmental Center, and the Utah State Hospital. The office is also tasked with providing annual financial review oversight over the various mental health centers in Utah.

The office has completed one cost settlement so far in fiscal year 2011, and currently is in the process of conducting three others.

Follow-Up Reviews
The office is committed to following up on all recommendations made to the department by all audit groups in a timely manner. This process has begun with the issuing of report number 2011-03, a follow up of the Legislative Auditors report on *A Performance Audit of Fraud Waste and Abuse Controls in Utah's Medicaid Program*. This follow up report was issued in November of 2010 and stated that 14 of the Legislative Auditor's recommendations are fully implemented and the remaining 11 are in process of full implementation.

PROGRAM INTEGRITY UPDATES AND ACCOMPLISHMENTS

While program integrity staffing has decreased over the last two years due to budget cuts, collections have remained strong. This fiscal year, the program integrity unit has developed 18 key performance measures to assess performance of the unit and of individual employees, issued requests for proposal (RFP) to assist in the medical reviews and purchase a software tool to identify fraud, waste, and abuse, and began reviewing previously unaudited entities.

Performance Measures

Three key performance measures are presented below:

Performance Measure	FY 2010	Est. FY 2011	FY 2011 Minimum Target
State Return on Investment (ROI)	206%	210%	200%
Recoveries per FTE	$437,265	$450,000	$450,000
Closed Cases with Recoveries to Closed Cases Without Recoveries	0.87	1.00	2.00

The following ratios will also be measured starting with fiscal year 2010, as soon as the measurements are validated:

- Federal reviews closed to total cases closed
- Reviews in functional areas to total cases opened
- Total hours and total PERM overtime hours to total amount of PERM hours
- Hours spent working cases to total recoveries
- State/federal recoveries to hours spent on recoveries
- Complete federal reviews to total dollars recovered
- Recoveries due to algorithms to total recoveries
- Cases greater than 12 months
- Completed provider self audits to total recoveries
- Total recoveries to notices of provider education notices sent
- Recurring cases to total dollars collected
- Federal reviews completed to total open cases
- Hotline referrals to total recoveries
- Website referrals to total recoveries
- EOB responses to total cases opened

Return on Investment

The main measurement is a return on investment (ROI) for the program integrity unit. Based on collections for fiscal year 2010, and compared to estimated cost, the unit produced an ROI of 206 percent on collections. For every dollar the State spends on program integrity efforts, the unit returns $2.06.

The investigation of several providers resulted in the discovery of multi-million dollar overpayments. Two most recent examples are a woman's clinic (over $1 million) and medical supply provider (over $4 million). In addition, based on newly developed fraud algorithms, program integrity has also uncovered several large fraudulent billing cases, the most recent case involving a provider who allegedly stole Medicaid ID numbers and sent in false billings. Program integrity has also developed more than 20 new algorithms that generate reports automatically to review for fraud, waste and abuse.

Recovery RFP and FADS RFP

In response to recommendations from the Office of Legislative Auditor and the Bangerter Commission Report, as well as changes to the federal regulations regarding recovery audit contractors, the Department of Health issued two requests for proposal (RFP): (1) an RFP on August 2, 2010 to perform medical reviews and recover as much as possible from certain 2008 and 2009 Medicaid claims, and (2) an RFP on November 15, 2010 to purchase a software tool for identifying potential fraud, waste, and abuse in Medicaid claims. The RFP also includes the option to outsource the medical reviews and recoveries in the Program Integrity Unit.

Medical Review and Recovery Process

All Medicaid claims are now being included in the program integrity medical reviews and recoveries. Until October 12, 2010, Medicaid claims through the Department of Human Services, Indian Health Services, and the Department of Health clinics were excluded from the medical review and recovery process. Hundreds of millions of dollars of Medicaid claims have been excluded from the medical review and recovery process for many years resulting in millions of undetected overpayments. This significant deficiency has now been corrected.