

Utah's Medical Program Eligibility HB174



A Cooperative Effort of
Southern Utah University and Utah State University

March 2012

Ryan M. Yonk PhD & Roberta Q. Herzberg PhD

Utah's Medical Program Eligibility – HB174

Final Report

Prepared by Principle Investigators:

Ryan M. Yonk PhD
Southern Utah University
Department of Political Science and Criminal Justice
351 W University Blvd
GC 406M
435-586-7961

Roberta Q. Herzberg, PhD
Utah State University
Department of Political Science
0725 Old Main Hill
Logan Utah 84322-3565
435-797-1307

Student Researcher Assistants:

Kristen Dawson
Kayla Harris
Amy McIff
Neal Mason
Rhett Busk
Nicholas Hilton
Heidi Eysser
Mathew Coates

Table of Contents

Summary of Recommendations	1
Section One – Introduction	9
Section Two – Current Status of Medical Eligibility Determination	11
Section Three – Privatization	21
Section Four – Cross State Comparisons	25
Section Five – Governance	39
Appendices	46

Summary of Recommendations

Understanding the status of the eligibility processes in Utah's medical assistance programs requires an understanding of the purposes, procedures, goals, rules, and practices of both the programs themselves as well as the philosophical orientation of the agencies involved in the process of determining the eligibility of recipients.

Our approach to analysis is that of the economist. We are interested in the costs and benefits of programmatic changes, rules, and approaches and attempt to judge the relative efficiencies of policies using these approaches. Using this approach provides policy makers, both inside the agencies and in the oversight bodies, with the ability to draw policy conclusions on the basis of these comparisons rather than simply trusting a recommendation from any single source.

With this goal in mind we suggest a test of efficiency, or the costs and benefits of any particular aspect of the eligibility program, that relies on a definition of efficiency expanded beyond the monetized costs and benefits of a particular program. We consider monetized concerns, but, we also evaluate quality, access, and other non-monetized costs and benefits that are of interest to policy makers, program recipients and the taxpaying citizens of the state of Utah in order to evaluate the questions of medical program eligibility.

Background of the Study

In 2007, the previously fragmented eligibility process for health, social services, and employment assistance was consolidated in the Department of Workforce Services (DWS). As a result, medical assistance eligibility moved to DWS while service and policy oversight remained with the Department of Health. The transition offered the prospect for overall savings from reduced duplication and greater ease for clients, but initial years were marked by higher eligibility case cost and high levels of error as eligibility employees learned the new parts of the merged system. These levels peaked in 2009-2010 and have recently been transitioning down to earlier rates.

We are hopeful that the trend since 2010, in fact, is the continued pattern going forward. But, legislative concerns about these transition levels, and/or a desire to consider other private options, resulted in the call for an analysis of the process in the form of HB174. HB174 requires that the Department of Health (DOH), as lead agency, along with the Department of Workforce Services, the Department of Human Services (DHS), and the Privatization Policy Board (PPB), 'study' eligibility of state medical assistance programs, along with the potential for privatization in those eligibility programs.

To meet the legislative intent of HB174, the agencies cooperatively developed a scope of work under the assumption that the completion of “an unbiased, thorough, and valid study” of the full scope of options for determining eligibility was necessary to fully meet the requirements of HB174. These recommendations are the product of that study.

From our analysis (presented in our final report), we make four recommendations to increase the efficiency of the eligibility determination process in Utah’s medical assistance programs.

1. Increased cooperative governance over medical program eligibility between the Department of Workforce Services and the Department of Health.
2. Continued exploration of future opportunities to contract with the private sector for medical program eligibility, including efforts for regulatory relief from the federal government to enhance Utah options.
3. Ongoing internal and external oversight of the eligibility process.
4. Ongoing evaluation of the current institutional arrangements for making eligibility determinations.

1. *Increased Cooperative Governance over medical program eligibility between the Department of Workforce Services and the Department of Health.*

The core of our recommendations and the bulk of our observations of the system for determining eligibility lead us to conclude that to achieve widespread efficiency, both in monetized costs and in quality, DWS and DOH must cooperatively govern the eligibility determination inside Utah’s medical assistance programs.

We arrive at this conclusion in part due to the complex nature of federally funded medical assistance programs and the requirements of those programs to provide services to those who are eligible. Attempting to make eligibility decisions outside the larger service delivery system is likely to produce results that are neither as cost effective nor as accurate as they might be with closer coordination.

This reality is illustrated further by the current institutional arrangement of medical assistance delivery in the state of Utah. Currently DOH is the agency responsible to CMS for ensuring that federal funds are expended accurately and that service delivery is consistent with the federal rules for each program. DWS acts much like a contractor, whose contract is focused on eligibility determination. These arrangements necessitate a close working relationship to provide governance for these important and expensive programs for the State.

Our suggestion in this regard is further reinforced by the wealth of literature on the problems that develop when multiple agencies attempt to independently administer portions of programs without engaging with the other responsible agencies in a holistic process of governance. We suggest that DWS and DOH work together to establish a

formal mechanism for interagency cooperation in the governance of eligibility processes. We believe that this attempt, of necessity, will require the establishment of processes, institutions, and policies that are not currently in existence within either agency.

It is our belief that the establishment of these processes, institutions, and policies can be created through a concerted and coordinated effort by both agencies and, in particular, the Executive Directors and their teams. Further, we expect that the explicit sharing of expertise, expectations, and evaluations can ensure that the current efficiency gains be maintained and expanded, and that new efficiencies can be found.

Our analysis of the eligibility processes for Utah's medical assistance programs found no common set of benchmarks for either cost or quality that was being used by all of the involved parties. There were varying measures and benchmarks by agency, by the state auditors, and by federal regulators.

We found during our discussions with DWS a general benchmarking standard that was focused on to ensure that applicants were placed into the right program if eligible. The state auditors and DOH expressed a similar desire to focus on the correct decisions throughout the process but each focused on different decision points and expressed concerns over 'error' in differing ways. These approaches while useful are substantially different than the PERM or MECQ standards imposed by federal regulators.

This lack of consistency across the agencies and regulators has exacerbated and likely increased the transition costs of consolidating eligibility with other programs into the DWS. It has further created some confusion between agencies, as well as for this study, because no clear standards have been consistently articulated that function across state agencies.

Having a common set of measures and corresponding benchmarks is necessary to ensuring that the cooperative governance of these programs and the corresponding increases in efficiency can occur. We find some value in each of the articulated mechanisms for measuring quality and cost but the lack of a common language renders each approach far less useful than a single common approach would be.

It is our recommendation that the agencies (DWS and DOH and other agencies as necessary) in cooperation with the state auditors, articulate a common approach to measuring cost and error in medical program eligibility. These measures and their corresponding benchmarks can then be used to evaluate the efficiency of eligibility processes, policies, and institutions.

2. *Continued exploration of opportunities to contract with the private sector within medical program eligibility.*

Our overall analysis does not suggest that privatization of eligibility determination is likely to yield substantial increases in efficiencies and carries potential risk of additional transition costs. Therefore, we do not recommend large-scale privatization

of eligibility determination in Utah's medical programs at this time. Despite this general recommendation, we believe and DWS has suggested in their HB174 report, that portions of the eligibility process could potentially be accomplished by contracting with the private sector. These attempts have the potential to increase efficiency in the system, where possible.

Our recommendation is that through the process of cooperative governance, and with consultation from the Privatization Policy Board, the agencies continually review the mechanics of eligibility decision-making and consider whether contracting for private sectors services could improve efficiency. We further suggest that periodically the agencies consult directly with the PPB and review processes identified as having potential for contracting or privatization.

3. Ongoing internal and external oversight of the eligibility process.

We find those charged with carrying out the eligibility process are moving to find greater efficiencies in the process, but the progress has been slow. Work Force Services has added value for consumers by consolidating processes and has restructured to use employees more efficiently. Despite these positive gains, the error rates have remained high and costs per case are still higher than those under the earlier Department of Health accounting.

Until additional evidence is collected, there is no way to determine whether this is the new, more permanent trend or instead, is simply a short term response to recent scrutiny and focus. As such, we think it is important that an ongoing oversight process be put in place to monitor continued improvement. A well-developed internal process housed within the two agencies is best capable of addressing this need. This system of cooperative governance could bring those with greatest knowledge together to maintain focus on improving problems of the past.

Moreover, the consolidation brought two somewhat different service perspectives together – the movement to employment and off programs from DWS, and the positive commitment to cover all possible eligible citizens from health and CMS. Reconciling these differences could improve eligibility performance on medical assistance programs going forward. The requirement that both perspectives be included will create a stronger approach than either process separately, but only if a better process of communication and responsibility is developed. We recommend that the Directors of the two Agencies work out the decision structure between them. This coordination is essential to ensure that gains in one area are not resulting in increased costs or problems somewhere else in the system.

In order to reinforce the new process, we further recommend continued legislative oversight or an external check process to work out continued challenges between the approaches and resolve conflicts when contradictions emerge. Systemic checks by legislators on the long-term trend towards efficiency will help ensure continued efficiency, particularly as the state faces the increased expectations of the ACA reforms. Reports on the error rate and costs per case should be reported regularly –

biannual or annually – until the legislature is convinced that all possible efficiencies have been achieved and are sustainable over the long run.

4. *Ongoing evaluation of the current institutional arrangements for making eligibility determinations.*

As part of the continued evaluation process, we recommend that a periodic analysis of the institutional responsibilities be included using a holistic approach. We recognize that the state stands to gain from linking previously distinct processes, as do the clients who are served by this process. But, there is no reason to assume those gains will be spread evenly across all programs. Improvements in one area may result in higher costs in another or a greater propensity to error. Such a change may still be justified, but it is critical to keep all possible arenas in mind, so that accountability and gains are evaluated using the same calculus. If the state benefits overall from a decision process that results in higher costs in Medicaid, for example, then that can be justified, but the Medicaid program should not be judged by those offsetting costs. Considering individual programs apart from a process intended to be consolidated may confound the policy process. Finding a method for evaluating them in context, with consistent measures and all relevant parties will permit a more accurate picture of overall efficiencies.

Section One – Introduction

Understanding the status of the eligibility processes in Utah’s medical assistance programs requires an understanding of the purposes, procedures, goals, rules, and practices of both the programs themselves as well as the philosophical orientation of the agencies involved in the process of determining the eligibility of recipients.

Throughout this report we rely heavily on data provided by the agencies directly involved in the eligibility processes. As such, we have relied on the representation of the agencies with regards to the data being well defined, correctly represented, and generally accurate. We find some discrepancies between the agencies interpretation, presentation, and measurement of some areas of interest, but in general we believe the provided data is consistent across the two agencies and that discrepancies can likely be explained through different collection processes. Where we do find discrepancies between the data provided, we rely on the primary data over any secondary interpretation wherever possible to provide the most accurate information available to us.

Our approach to this analysis is one used by economists; we are interested in the costs and benefits of the programmatic changes, rules, and approaches and attempt to judge the relative efficiencies of policies using these approaches. The approach provides policy makers both inside the agencies and in the oversight bodies with the ability to draw policy conclusions on the basis of these comparisons, rather than simply trusting a recommendation from any single source.

With this goal in mind we suggest a test of efficiency, or the costs and benefits of any particular aspect of the eligibility program, that relies on a definition that is expanded beyond the monetized costs and benefits of a particular program and instead is focused on those monetized concerns but also on quality, access, and other non-monetized costs and benefits that are of interest to policy makers, program recipients, and the taxpaying citizens of the state of Utah. We will use this broad calculus in mind as we consider potential options for the state moving forward.

Background of the Study

In the 2011 legislative session the Utah Legislature passed HB174. This legislation requires that the Department of Health, as lead agency, along with the Department of Workforce Services, the Department of Human Services, and the Privatization Policy Board ‘study’ eligibility of a variety of state medical assistance programs and investigate the potential for privatization in those eligibility programs.

To meet the legislative intent of HB174, the agencies involved cooperatively developed a scope of work under the assumption that the completion of “an unbiased, thorough, and valid study” of the full scope of options for determining eligibility in five categories of medical assistance programs was necessary to fully meet the requirements of the legislature.

To accomplish this goal, we (Southern Utah University with the cooperation of scholars from Utah State University) contracted with the Department of Health for the completion of the study. In what follows, we present the results of our analysis of the eligibility systems for (1) The State Medicaid Program, (2) Utah Children's Health Insurance Program (CHIP), (3) Primary Care Network, (4) Utah Premium Partnership, and (5) other medical assistance programs administered by the state.

Utah Health Assistance Programs

The state of Utah offers several different types of health assistance programs for low-income individuals and families, administered by the Department of Health and the Department of Workforce Services. While there are a number of sub-category offerings, the four primary assistance programs are Medicaid, the Children's Health Insurance Program (CHIP), Primary Care Network (PCN), and the Utah Premium Partnership (UPP). Descriptions and requirements for each program are outlined below.

For each of the medical assistance programs, a specific application form is used. If an applicant wishes to concurrently apply for other public assistance in addition to medical programs such as food stamps, financial assistance, or childcare, a multi-program application may be used. Applications for Medicaid and CHIP are accepted year-round; applications for PCN and UPP are accepted only during open enrollment periods. The form takes approximately twenty-five minutes to complete and can be submitted electronically, in person at a DWS office, via fax, or by mail. The Department of Health also offers several resources for applicants and program recipients to help them find the right plan and understand the services available to them. Most resources from each agency are available online, but in-person advisors or 'Health Program Representatives' are available at DWS locations as well.

DWS describes the process a client would experience as follows:

When a customer submits an application online, they are given a confirmation number and instructions to call in for an appointment. Applications received online are automatically registered and assigned a case owner in our eREP system and reminder notification is scheduled to be sent to the customer (if the customer does not call in within a specified time.) An image of the application is available for the Eligibility Specialist to view in eREP within just a few minutes of submission. Medical-only applicants are not instructed to call in, as an interview is not required for medical services.

When a customer submits a paper application, the application is faxed to a central location. The software associated with this fax number automatically sends the document to an imaging software queue. Staff assigned to work this queue pull up the imaged application and register the application in eREP and assign to an Eligibility Specialist. In Employment Centers, customers are given

instructions on how to call in for an interview, and associated time frames for expedited services (specific to the SNAP program).

The customer is able to make an 800 call anywhere in the state and choose the interview option on the phone system. The call is placed into a queue staffed by Eligibility Specialists. The Eligibility Specialist answers the call and completes an interview for services. Questions and clarifications are asked of the customer. If the Eligibility Specialist identifies the application as one for specialized programs, they use the specialized interview checklist to ask additional questions specific to the program. The Eligibility Specialist will tell the customer which verifications are needed to process the case and also educates the customers on timeframes, processes, benefit usage, recertification requirements, change reporting, etc.

The Eligibility Specialist will process the case for expedited services (if eligible), send notification to the customer on verifications required and either keep the application, or transfer the application to a specialized team for processing. If all verifications are received to process the application and the application will remain with the Eligibility Specialist who completed the interview, the application will be processed as soon as possible.

The customer submits verifications requested either by mail, fax or drop-off in one of the DWS Employment Centers. The verifications are imaged into the document imaging system and the Eligibility Specialist is notified when the verifications are received. The Eligibility Specialist will review the verifications to ensure they are complete. If additional information is needed, the Eligibility Specialist will notify the customer (by phone, mail or on-line) of additional verifications required. Otherwise, the Eligibility Specialist will process the application and send notification of decision to the customer.

Recertifications

Customers receive notification at the end of the month prior to their last month of benefits (either through US Postal Service or online that a recertification is due. Customers may log in to myCase (on-line customer service portal) to complete their recertification online, or they may complete the paper recertification form and submit in the same manner as applications above.

The Eligibility Specialist will process the recertification in the same manner as above, requesting additional verifications or completing the recertification, if all documentation is on file. Medical cases do NOT need an actual

recertification completed, the Eligibility Specialist may review the case and/or contact the customer and recertify the medical program without a formal recertification (form or online) being submitted.

Interim Changes

Customers can report interim changes in household circumstances by mail (form 475 Change Report Form), phone or online through myCase. The Eligibility Specialist will be notified that a change is received and will take action on the change (either by updating information in eREP and notifying the customer of changes in benefit/program) or by requesting additional verification. Once the verification is received by the customer, the Eligibility Specialist will review the information, make appropriate changes in eREP and notify the customer of any change in benefit/program. Some changes reported online through myCase automatically update information in eREP and do not require additional documentation to be sent in by the customer.

Case Status/General Questions

The preferred method for customers to check the status of their case and/or application is by viewing their myCase account. Customers may also utilize online chat from myCase or by calling into the ESD phone system. Eligibility Specialists are assigned to a queue specific for case questions or status questions. General questions may be answered in the same manner, with the addition of viewing a FAQ section in myCase.

Submitting Documentation

Requested documentation may be submitted by mail, fax or drop off in one of our Employment Centers. Mailed and faxed documentation goes directly to our Imaging Operations Center. For drop-off documentation, the Employment Centers along the Wasatch Front have twice-daily courier service to our Imaging Operations Center. The rural centers may either fax to Imaging Operations or directly image documents.

myCase

myCase is an online customer portal which is an additional and preferred resource for eligibility customers. myCase allows customers to see benefit amounts, case status, receipt of documentation, make payments, chat online with Eligibility, complete applications, reviews and changes online, view

notices (requires opting in to paperless), set notification preferences (email, text message), receive answers to general questions via FAQ's, download needed forms, etc. Information on myCase is viewable 24/7. In terms of available functionality, the myCase system leads the nation and is constantly benchmarked by other states.

During our analysis, we relied on this representation of the client's experience without providing independent confirmation. We include in Appendix One application requirements and a full outline of the enrollment requirements for each program.

Section Two – A Tale of Two Processes: The Unfolding of Current Medical Eligibility Determination

We view the recent history of eligibility determination by dividing it into two distinct periods in terms of performance. The initial stage of transition from 2007-2009 when the agencies, at the direction of the legislature, sought to consolidate the eligibility processes to create a “One Stop Shop” approach to medical, employment and social services under the direction the Department of Workforce Services. The most recent stage, 2010 to present, includes a fully implemented process that should be transitioning towards regularized and efficient eligibility decisions. We use the year of 2010 as a dividing point not only because it represents the turn towards improved performance, but also because it marks the beginning of some new decision agreements between the agencies and restructuring of DWS to achieve additional efficiency gains. To fully understand the performance under each era, we identify key processes and performance in greater detail for each period below.

Era of transition (2007-2009)

In 2007, under legislative mandate, full control of the eligibility determination processes for the four major medical assistance programs were transferred from the Bureau of Eligibility Services in the Department of Health to the Department of Workforce Services¹. The goal of this legislative mandate was to improve efficiency in a system where the dual eligibility of many recipients caused substantial duplication in determination efforts between the two agencies. Further, the legislature sought to develop a single contact point for recipients to reduce confusion and improve customer service at the point of contact.

A further complication developed from the way in which eligibility determination processes were divided between the two agencies. Prior to 2007 all cases deemed ‘medical only’ were managed within DOH, while cases which had dual eligibility for other social welfare programs (food stamps, TANF, etc...) as well medical assistance program eligibility were managed by DWS. This division of labor resulted in the transfer of cases between the agencies on a regular basis, with some cases moving across the agencies multiple times each year as the mix of eligible services for each recipient changed.

Common to all these proposed changes was a goal of substantially increased efficiency in the eligibility determination process both for the state and for the recipient. Achieving this goal, however, would require a substantial transition process. In such a situation, our expectation would be that increased efficiency would likely be achieved only with non-trivial costs in a transition marked by employees who must be retrained, systems to be reevaluated, new tasks to be added, and policies modified to match the new approach.

¹ Medical Assistance to Children in Foster Care was included in the consolidation of the eligibility program.

The Costs of Transition

Transition costs of this sort are common to nearly all large-scale transitions in both the private and public sectors. Further costs were expected as a large number of Bureau of Eligibility Services (BES) employees were to be integrated in DWS and employee duplication across the agencies eliminated. To avoid the large psychic costs that come with shrinking any organization, DWS approached this task from a longer time horizon, but that implied savings would unfold more slowly

An additional set of costs comes from the historical mission and goal of the Division of Workforce Services as it relates to its earlier mission, as well as the traditional mission of the Department of Health. DWS notes its mission shift as follows:

“Prior to DWS, employment and training programs were separated across several state agencies, and completely disconnected from traditional public assistance programs—to the individuals who could most benefit from employment services. DWS effectively developed an “employment-first” culture, and was able to manage program policy and operations in this direction. Consolidating the entire medical program caseload better connects individuals to services they need to increase their economic standing, thereby reducing the need to depend on assistance.” (DWS HB174 Sec. 1, page 1).

Ultimately this notion of the mission of the agency is not entirely consistent with the goals and purposes of the medical assistance programs. Working out how a program with a notion of positive or presumptive eligibility, could be integrated into a program that focused so clearly on ‘employment-first’, and had relied on a negative or non-presumptive eligibility approaches created some conflict during this initial period of consolidation.

The costs of the transition can be seen clearly both in the increased cost of eligibility per enrolled recipient and in the error rates over this period. In fact DWS rightly notes that:

“...that soon after the 2007 consolidation of medical cases [into DWS], medical program costs did increase... (DWS HB 174 Sec. 3, p. 3).

Cost Per Enrolled Individual

The costs of eligibility per enrollee rose from \$134.75 in 2007, the final year of dual eligibility determination, to \$229.85 in 2008 and to a maximum cost of \$248.46 in 2009 the final year in this period of transition² This consistent increase in costs is indicative of an increased cost of doing business during the transition, rather than a normal lag where fixed costs cannot immediately be reduced to mirror enrollment changes. Table 2.1 details the six-year trend of enrollment, enrollment change, total

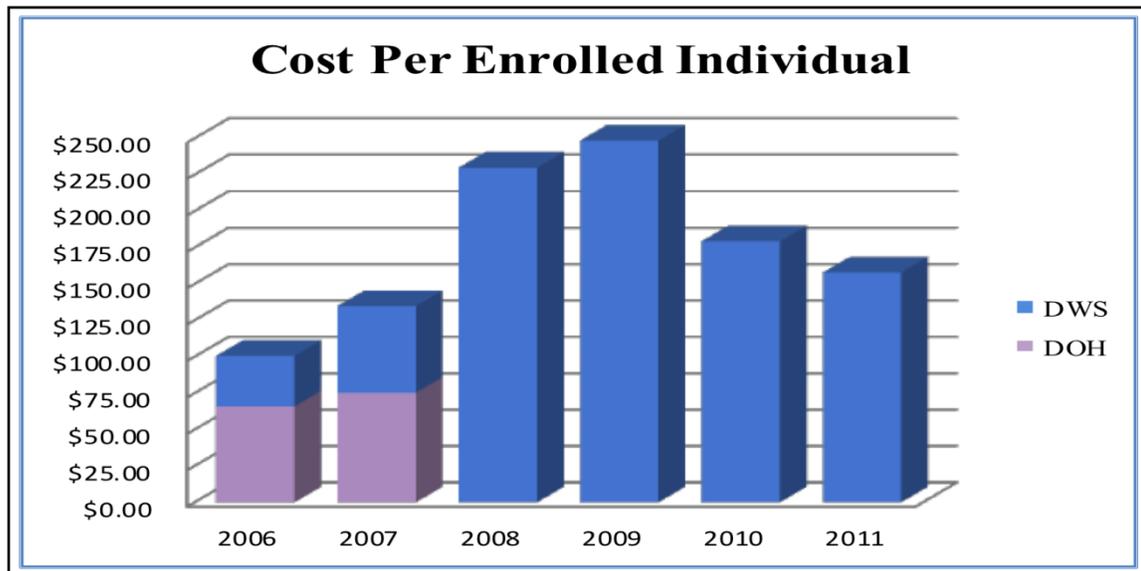
eligibility expenditures, and the costs per enrolled individual. We further note that the 2010-current period illustrates a dramatic reduction in the cost per enrolled individual that seems to reverse the trends and illustrates our contention that the increased costs are potentially the result of the transition rather than ongoing increased costs of doing business in DWS³.

Table 2.1
Medical Eligibility Determination Claiming Review

SFY	Avg. Medical Enrollment *	% Enrollment Change	Eligibility Determination Expenditures	Cost Per Enrolled Individual
2006	224,926		\$22,623,464.45	\$100.58
2007 ⁴	208,302	-7.39%	\$28,068,553.69	\$134.75
2008	210,080	0.85%	\$48,287,473.31	\$229.85
2009	235,808	12.25%	\$58,589,256.82	\$248.46
2010	265,465	12.58%	\$47,578,117.49	\$179.23
2011	289,262	8.96%	\$45,662,653.87	\$157.86

Figure 2.1 illustrates the overall trend in eligibility costs per enrolled individual during our initial period. From the base year of 2006 to the height of the transition in 2009 these costs increased by nearly two and a half times before seeing the beginning of a reduction which if it continue over the longer term appears likely to bring cost down to more traditional levels.

Figure 2.1



³ Costs increased for FY 2007 because of the transition of clients to eREP as enrollment was decreasing.

These increased costs were noticed by CMS and, following the transition, CMS reduced the costs for the purpose of calculating federal payment for the eligible services. Table 2.2 illustrates those reductions.

**Table 2.2
2007-2009 Cost Per Enrolled Individual Actual and Revised**

FY	Avg. Medical Enrollment	% Enrollment Change	Eligibility Determination Expenditures	Cost Per Enrolled Individual	Revised Cost per Enrolled Individuals
2007	208,302		\$29,658,893.00	\$142.38	\$142.38
2008	210,080	0.85%	\$48,287,473.31	\$229.85	\$149.50
2009	235,808	12.25%	\$58,589,256.82	\$248.46	\$156.98

In FY 2008 the revised cost CMS calculated as appropriate using its standards was 65.04% of the actual cost. FY 2009 the revised costs were 63.18% of the actual costs. These reductions by CMS indicate that costs during this period were above the level that they viewed as appropriate and would pay given the historical costs of determination.

DWS identifies one of the key factors that they believe was driving increased costs -- the development of the eREP system. eRep is an inter-agency application program that attempts to integrate information held by DWS, DOH, as well as the Department of Human Services and to manage cases in a number of programs inside each agency. Utah’s medial assistance programs are among those that were integrated into the system. The costs of developing and implementing this cross agency database were substantial and could represent a portion of the increased costs. If this is the case we should expect that the costs per enrolled individual should decrease substantially after the program is implemented. DWS describes the eREP systems as:

“A rules based system that determines eligibility for multiple public assistance programs based on requirements and the interdependencies that exist with other programs.”

An imaging system providing a paperless, all electronic case management system

Automated data interfaces with other state and federal agencies

Financial institution interfaces for electronic benefit payments directly to customer accounts

Correspondence system that merges and compiles multiple program notices for the same household reducing mailing costs” (DWS HB174 Report Sec. 2, page7).

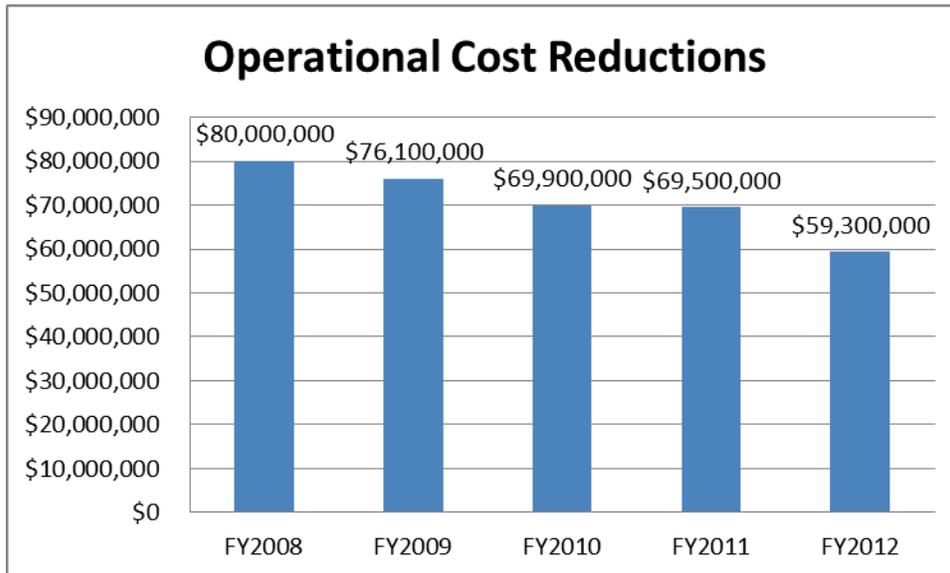
DWS further notes that the eRep system was also designed to provide a customer interface that would allow recipients to navigate the initial and ongoing

eligibility process using a web-based program known as MyCase. DWS describes MyCase as allowing recipients to “... interact directly with the system—saving worker time and effort” (DWS HB174 Report Sec. 2, page 7).

While Medical Assistance Program costs were increasing during this era, DWS was beginning to identify cost savings in other parts of their operation that could serve as an offset to the rising medical eligibility costs. As they note:

DWS has realized the following operational cost reductions over the last five state fiscal years:

*FY2008 \$80.0 million
FY2009 \$76.1 million
FY2010 \$69.9 million
FY2011 \$69.5 million
FY2012 \$59.3 million (forecast)*



The above shows a net reduction in costs of \$20.7 million, representing a net reduction of 26 percent. In addition, IT costs were reduced by another \$4.0 million, while facility costs were reduced by \$1.9 million.

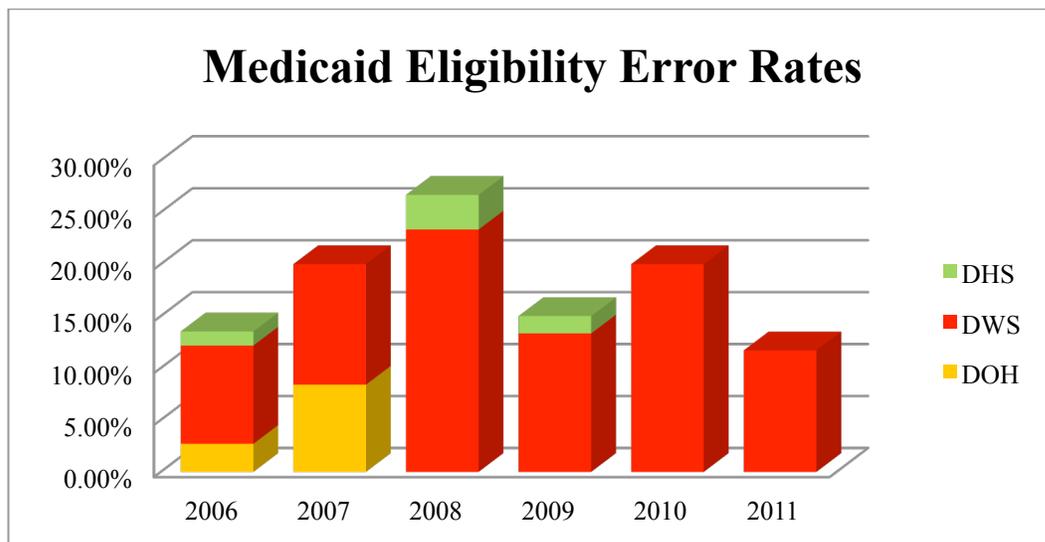
The majority of these savings are the result of staff reductions. As previously indicated, the economies of scale associated with the formation of the DWS Eligibility Services division resulted in a total decrease in 97 full-time equivalent (FTE) workers. It should also be noted that all these reductions in labor force were managed through normal attrition—there was no involuntary reduction in force.

Eligibility Error

In addition to increased costs per enrollee in medical assistance programs, the period from 2007-2009 also saw increased error in eligibility performance. As in the case of additional costs, increases in error were to be expected as retraining, retooling, and new policies were developed. However, the levels of error reported have yet to return to pre-transition rates, suggesting that continuing issues may remain.

At the start of the transition period under dual determination the medicaid eligibility rate found by the state auditors spiked from thirteen percent in 2007 to a combined error rate of twenty percent in 2008 and further increases to twenty three percent in 2009. This escalation is illustrated by Figure 2.2.

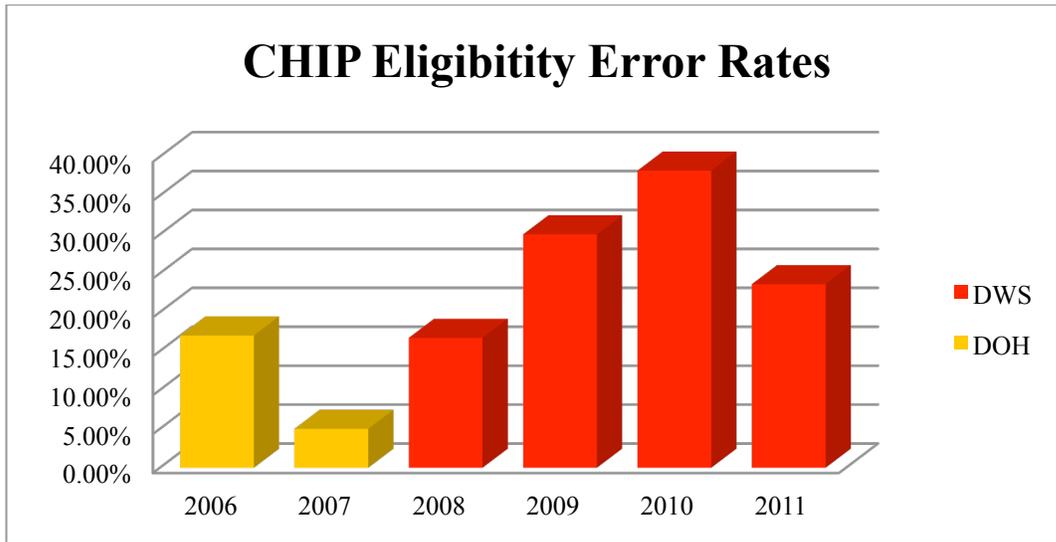
Figure 2.2



The Children's Health Insurance Program saw a similar but more pronounced increase in error over the same period. At the start of the transition period, 2007, the state auditors found an error rate of five percent⁴. This was the final year of BES determinations for this program under DOH. Starting in 2008 and continuing through 2010 error rates increased dramatically beginning at nearly seventeen percent and jumping to thirty percent in 2009, and further escalating to thirty eight percent in 2010. These trends are illustrated in Figure 2.3.

⁴ It should be noted that 2006 saw an error rate of seventeen percent similar to the 2008 number indicating the transition costs were delayed in CHIP until 2008.

Figure 2.3



Illustrating Transition Costs

As was expected, the costs of transitioning eligibility determinations are clearly illustrated in the results of the state audits across the period. These costs, while expected, should not be ignored, but rather need to be considered within the larger context of how the agencies involved in the governance of the programs interact, establish policy, and attempt to rectify the increased costs.

Our analysis of this period indicates a number of factors that likely exacerbated the increased costs and error rates during the 2006-2009 and into the 2010 period. First, we note that this period was a time of increasing demand for medical program services. The intensification of the recession, and the change in presidential administrations meant larger numbers of applicants, and ultimately enrollees in the programs. Table 2.3 illustrates this increase. The period saw an increase of nearly twenty five thousand recipients on average through the year. Meeting this new demand, before employees were familiar with all that was needed could increase cost and error.

Table 2.3
Average Medical Enrollment Change

SFY	Avg. Medical Enrollment	% Enrollment Change
2007	208,302	
2008	210,080	0.85%
2009	235,808	12.25%
2010	265,465	12.58%
2011	289,262	8.96%

A second factor impacting the cost side could be due to the restructuring of the staff in DWS and BES. To facilitate the transition it was necessary for DWS to both integrate former BES employees into DWS and bring them up to speed on Agency policies while simultaneously training current DWS eligibility workers in medical program eligibility. Both of these realities are likely to reduce the efficiency of the eligibility process during transition. Like any new task, navigating the process of medical program eligibility and integrating into DWS requires a learning curve that in the face of the other factors was steeper than might have been expected.

One final observation could explain potential problems -- policy was in flux in both DOH and DWS with regards to eligibility and their inter-agency relationship during this period. DWS illustrates this reality:

“Once all the entire eligibility caseload was consolidated into DWS in 2007, the infrastructure DWS developed could support all medical programs. However, from an operational perspective, eligibility in DWS remained under the authority of five separate regional areas. This resulted in different business process and disparity with workload equity.” (DWS HB174 Sec. 1, page 1).

DWS also highlights this flux as they initiated the fundamental reorganization undertaken in 2009 which they describe as being one of the largest in the agencies history. One of the core features of that reorganization was:

“...consolidate[ing] all eligibility functions into one statewide Eligibility Services Division (ESD). This new division formed under several key tenants- statewide standardized eligibility processes, reduced eligibility costs, expanded technology and increased service levels to customers. Consolidating eligibility proved successful with significant savings and a reduction of 97 staff in the first year. In that same timeframe, the Department facilitated an efficient transition to eREP (Electronic Resource & Eligibility Product). This was all accomplished during historic increases in workload due to the recession. Utah is one of only a handful of states that was able to effectively implement an eligibility rules-based system without a significant decrease in operational performance.” (DWS HB174 Sec. 1, page 2).

2010 Through the Current Period

The period starting in 2010 has shown substantial improvement across most of the key indicators and the trend lines as both error and cost are adjusting downward. This trend seems to indicate to us that the period from 2007-2009 was in fact a transition period and not a permanent increase in both cost and error.

Cost Per Enrolled Individual

The costs of eligibility per enrollee dropped from \$248.46 in 2009 the final year of the transition period to \$179.23 in 2010. The most current available cost figure

is \$157.86 per enrollee, this is however the last data available for our study and might not reflect the complete cost. Table 2.4 details the six-year trend of enrollment, enrollment change, total eligibility expenditures, and the costs per enrolled individual. As we noted above, the 2010-current period illustrates a reverse in the trends and illustrates our contention that the increased costs are potentially the result of the transition, rather than ongoing increased costs of doing business in DWS⁵.

**Table 2.4
Medical Eligibility Determination Claiming Review**

SFY	Avg. Medical Enrollment	% Enrollment Change	Eligibility Determination Expenditures	Cost Per Enrolled Individual
2006	224,926		\$22,623,464.45	\$100.58
2007 ⁶	208,302	-7.39%	\$28,068,553.69	\$134.75
2008	210,080	0.85%	\$48,287,473.31	\$229.85
2009	235,808	12.25%	\$58,589,256.82	\$248.46
2010	265,465	12.58%	\$47,578,117.49	\$179.23
2011	289,262	8.96%	\$45,662,653.87	\$157.86

As Table 2.4 illustrates above, using 2009 as a base year, the cost trends show consistent decreases in the cost per enrolled individual for the three-year period.

As noted above, the increased costs of the transition period were noticed by CMS and a corresponding reduction in the payment allowed occurred in the post transition period. As cost rates improved, we saw a corresponding reduction in the CMS's revision of the allowed costs. Table 2.5 illustrates those reductions for the post transition period where data is available.

**Table 2.5
2009-2011 Cost Per Enrolled Individual Actual and Revised**

FY	Avg. Medical Enrollment	% Enrollment Change	Eligibility Determination Expenditures	Cost Per Enrolled Individual	Revised Cost per Enrolled Individuals
2009	235,808		\$58,589,256.82	\$248.46	\$156.98
2010	265,465	12.58%	\$47,578,117.49	\$179.23	\$164.83

During the transition period CMS indicated that only an average of sixty-four percent of the actual costs per enrolled individual were historically appropriate. The post transition period has data from a single year with a much higher percentage of

⁵ We also note that the manner in which cost per enrolled individual was calculated may have changed in the transition between agencies.

⁶ Costs increased for FY 2007 because of the transition of clients to eREP as enrollment was decreasing.

actual cost considered appropriate within CMS guidelines. In 2010 CMS indicated that ninety-one percent of the actual costs were appropriate. While CMS indicated that costs during this year were above the level that they viewed as appropriate, the difference was much lower than during the transition period.

Eligibility Error

As we note above we find that 2007-2009 saw increased error in eligibility. As with increased costs, increases in error were likely to occur as retraining, retooling, and new policies were developed. In the 2010 to the current period, we have not seen the same consistent reduction in eligibility error that we saw in costs reduction. However there is some evidence that the small increase in 2010 over 2009 is an aberration and that the 2011 reduction may continue in future years.

Efficiencies beyond Error or Per Enrollee Cost

While we have primarily focused on two measures of efficiency a number of other factors are of interest and should be carefully considered. We present information provided by DWS to illustrate those efficiencies. We include this information primarily because they represent outcomes that are important to State policy makers beyond those directly tied to eligibility.

Costs and Reductions in Full Time Employees (FTE's)

DWS in their HB174 report notes that the agency overall has seen significant cost reductions. These reductions were both requested by the legislature and internally identified. Indeed the expenditures in medical programs have consistently dropped year over year from 55.2 million dollars in FY 2009 to 44.2 dollars in FY 2011 and are expected to further drop in FY 2012 (HB 174 Sec. 3, page 3).

They further note that

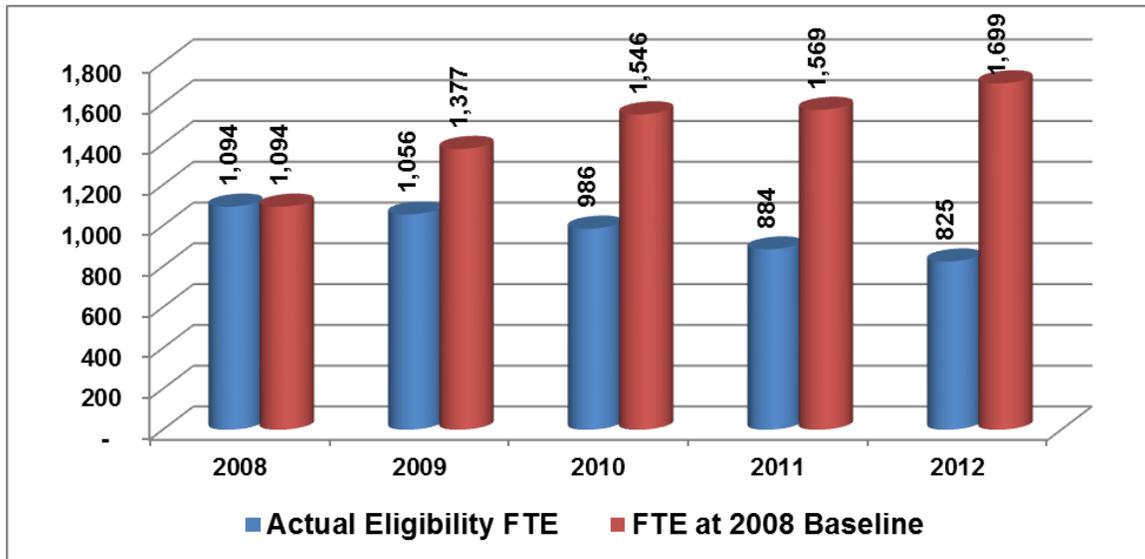
“[their chart indicates]... a net reduction in costs of \$20.7 million, representing a net reduction of 26 percent. In addition, IT costs were reduced by another \$4.0 million, while facility costs were reduced by \$1.9 million.

DWS further illustrates that:

“The majority of these savings are the result of staff reductions. As previously indicated, the economies of scale associated with the formation of the DWS Eligibility Services division resulted in a total decrease in 97 full-time equivalent (FTE) workers. It should also be noted that all these reductions in labor force were managed through normal attrition—there was no involuntary reduction in force.” (HB 174 Sec. 3, page 1).

Because the transition and post-transition periods have seen increasing enrollments, it is key to note that a reduction in FTE's is not just a reduction from the status quo levels from pre-transition period, but also a reduction in what potentially could have been required. Using FY 2008 as a base, Figure 2.4 indicates how many employees could have been utilized as case numbers rose.

Figure 2.4
Estimated Eligibility Workers Needed Compared to Actual Employed



Conclusions

As we note, we are optimistic that the 2007-2009 period can properly be identified as a period where increased costs and increased error resulted from the transition between agencies, systems, and approaches. We find consistent evidence that costs of transition have been real and substantial. This period saw more error and higher costs in eligibility determination than the previous period or the period since. These transition costs, however, appear to have peaked in 2009 or 2010 and are beginning to return to pre-transition levels. While this is a positive sign, we cannot be certain that the trend will continue indefinitely. We, therefore, conclude that the DWS, DOH, and the Legislature should pay close attention to ensure that our belief that the transition period has ended is in fact correct.

Section Three — Privatization

HB 174's primary goal was the evaluation of privatization potential inside the Medicaid eligibility system. This central, legislatively-mandated goal provided clear direction as to the core questions that needed to be answered in the course of completing this study. To address the question of privatization, we take a two-fold approach. First we identify particular areas that might be privatized within the medial program eligibility determination systems. Second, we turn to the question of practical privatization in an attempt to illustrate that what can be done, isn't necessarily what should be done.

True privatization is the complete transfer of governmental programs, functions, or responsibilities to the private sector with the stated goal of no future government involvement. We note that because medical programs are provided through a federalist agreement, where the federal and state government share responsibility, ending all governmental involvement resulting in true privatization is not possible in these programs. We instead take as our standard for privatization the more common approach of contracting out particular functions to the private sector with government still holding ultimate responsibility for the program and function. This approach is commonly called privatization and this somewhat less stringent definition is what we refer to throughout this report.

We therefore ask if there are particular functions, systems, materials, or processes associated with Medical eligibility that could be contracted for in the private market. Answering this question requires that we address two key issues: first whether the function identified is statutorily allowed to be provided by a private entity; and second, whether there is a vender in the private market who is capable of providing the service at comparable levels to governmental employees.

Statutory Limitations

The medical programs identified here are joint federal and state programs. Both federal and state laws, with a central federal statute, govern them. Because these programs are substantively linked to each other, the most restrictive requirements regarding privatization will necessarily govern the administration of the program. Known as regulatory spillover in the policy and economic literature, this phenomenon occurs in circumstances where related or connected programs face differential regulatory regimes. Because of this multi-level governance, a single program may have fewer regulatory requirements, however, if it is connected to a different program with stricter requirements, then stricter requirements must be followed.

This notion is of particular interest within medical program eligibility because recipients may be eligible for differing programs based on their criteria and the highest priority to the managing agencies is to place the recipient in the correct program(s). Thus, because the programs are linked in the above manner, the process of determining eligibility is governed under the most statutorily- intense guidelines.

The medical program that appears to govern questions of privatization is Medicaid. The relevant statute comes from Title XIX of the Social Security Act and from 42 CFR Part 432 subpart A 432.

“Subpart A—General Provisions:

§ 432.1 Basis and purpose. This section prescribes regulations to implement section 1902(a)(4) of the Act, which relates to a merit system of State personnel administration and training and use of sub professional staff and volunteers in State Medicaid programs. Section 1903(a) defines rates of FFP for Medicaid staffing and training costs. It also prescribes regulations, based on the general administrative authority in section 1902(a)(4), for State training programs for all staff.”

The statute indicates that a merit employee must make the actual determination decision for Medicaid enrollment. There are, however, few other restrictions on what private contractors may complete in the process. Given this set of limitations, we have identified four areas in medical eligibility that private contractors could play a substantial and increased role.

1. Initial Application and Processing
2. Enrollment Services
3. Oversight Operation
4. Appeals

These areas have a wide variety of tasks that range from the initial greeting of potential consumers to application processing, digitization, storage, processing, compiling, review, appeals handling, etc. Indeed the number of possible tasks under the governing statute for Medicaid is large. In our analysis we found contracted services in each of the four areas that were providing a wide variety of services to various states. Those services are discussed in some detail below.

While we can identify many possible areas for privatization, in Utah’s ‘One Stop Shop’ approach, there is the problem which creates a second area of regulatory spillover. Instead of being limited to the rules of medical programs, DWS must comply with the most restrictive rules of any of the programs included in the joint determination system. The program with the most restrictive privatization rules is not Medicaid; instead it is the Food Stamps Program that has essentially banned privatization of any substantive function in its eligibility determination systems. Because we believe that the ‘One Stop Shop’ approach is a substantial efficiency gain for the state and for recipients, the regulatory spillover from the Food Stamps Program is an intransigent impediment.

This resistance within foods stamps became apparent in November 2009 when USDA Under Secretary Kevin Concannon issued a memorandum regarding the use of for-profit organizations in eligibility determination. That notification stated, “Based on the evidence, we do not regard these projects as successfully furthering the purpose of the (SNAP) Program. We do not support furtherance of such projects, and believe they put public funds and our clientele at risk.” Indicating little willingness by USDA to

engage with privatization, Concannon further stressed that, “To be clear, we believe that the outsourcing of key application processing duties to for-profit organizations is an unwise use of State and Federal resources that undermines Program accountability.”

Given these restrictions, if the unified process is to be maintained, there is little or no practical opportunity to privatize, even though there may be room in the medical program statutes to do so. We believe that the medical programs could be done independently but the efficiency gains of the unified system in Utah would be in jeopardy. Losing those gains would likely outweigh the benefits of privatizing in the medical programs.

While we currently cannot identify a positive outcome in terms of efficiency from severing the programs and privatizing portions of the medical eligibility systems, we would encourage DWS, DOH, and other state entities to work with USDA and the other agencies which govern these programs to allow more room for privatized options in the future. Further, because the USDA policy is not statutorily determined, but is rather a decision by the Under Secretary, we continued our investigation into possible market opportunities. In our investigation, we found a number of private agencies whose business area was in providing eligibility services in public medical programs and we provide a brief review of where, what, and how those agencies provide service below. We should note that because there has been no RFP we do not, and cannot, provide a cost analysis of private services compared to the current system.

The Current Market State of Privatized Medical Program Eligibility Services

Currently twenty-eight states across the nation (including Washington D.C.) employ some manner of a private Medicaid support system. In addition, thirteen states employ a third party program for the implementation of their CHIP programs. Privatization through third parties has several major upsides for the improvement of the current national healthcare system.

As individual states begin the process of the implementing the Affordable Care Act in 2014, there arise some serious budgetary and logistical problems. For example in Utah it is estimated that between 2014 and 2019 there will occur a 4.3 percent increase in Medicaid spending and \$2.9 million in additional spending. Utah ranks 7th in the United States in projected spending increases as a result of the ACA provisions and there is an estimated 51.9 percent increase in enrollment by 2019. These statistics coupled with the fact that healthcare spending ranks as the third highest expenditure (six percent) in Utah's overall budget, suggests that moving forward, there is even greater pressure to discover every efficiency possible.

Perhaps the greatest advantage of using third party providers is the fact that it will effectively lighten the load placed upon state employees and state agencies. Most of the shift from State to private employees would occur in such services as personal customer assistance, application and renewal of services, and enhanced use of technology to reduce the need for manual labor.

When directly used in the administration of Medicaid, third party companies provide several services that supply some distinct advantages for the expansion that is expected in Medicaid. Some of the states using these third parties include, California, Colorado, and Georgia. The expertise of these private companies led to successful results that include, but aren't limited to, determining eligibility and handling renewals for millions of people, providing education and enrollment services to two-thirds of the Medicaid managed care population in states that allow enrollment brokers, providing over fifty million new enrollments and reinstatements and delivering upwards of fifty million enrollment packets to individuals applying or re-enrolling.

Another major goal in the implementation of a third party in the Medical system is the simplification of the application process for benefits. Traditionally the application processes, as well as the claim systems have been far too complicated and time consuming and it places a large strain on state agencies and employees. The move to a more privatized system of Medicaid eligibility could certainly lead to the simplification of the application process because private companies sought to avoid the costly and complicated process that has long been associated with the traditional Medicaid program.

In short, the privatization of the SSA and Medicaid system displays numerous upsides that range from the simplification of the application process, to the lightening of government workloads, and finally to the decreased role of government in the healthcare industry in a time that has seen dramatic increase in the control government wields. While Private contractors provide a variety of technical improvements, DWS notes that they have moved to processes that offer virtually all of the same services so little added benefit might be gained. As shown in this table from their report on HB174:

DWS Comparison of service availability in-House versus private contractor

Private Sector Vendor Offering	DWS System
Technology-Enhanced Work Processes	
Convert all paper-based documents into electronic images through high production scanners and imaging software	Yes
Handle incoming faxes in purely electronic fashion by transferring them to an imaging database (as opposed to printing them)	Yes
Link all electronic images to the cases to which they pertain (the images can be accessed as groups or individually)	Yes
Automatic routing of documents through electronic work queues or assignments	Yes
Data entry through split or dual screens in which data fields are presented alongside the images containing the required information	Yes

Bar codes on missing information or follow-up correspondence enables the documents that are returned to be automatically linked to the appropriate case	Yes
Forms recognition and OCR/ICR processing to automatically populate application screens	Yes
Rapid data entry to accelerate data capture activities	Yes
Use of integration tools to integrate across disparate systems	Yes
Data matching to ease applicant and renewing family burden and increase overall program accuracy and integrity	Yes
Vital records or social security data matches to validate Citizenship	Yes
Medicaid/CHIP data match to eliminate dual enrollment	Yes
Income tax agency or employment data bases to confirm income	Yes
Multi-Channel Access to Services	
Applications, renewals, and health plan enrollment choices over the web or using an Integrated Voice Response (IVR) phone system	Yes-on-line
Online and IVR responses to commonly-asked questions or standard inquiries	Yes-on-line
Online and IVR tools to help screen people for possible eligibility (to limit the number of obviously ineligible people who apply)	Yes-on-line
Electronic signatures	Yes
Downloadable forms and brochures	Yes
Provider or health plan searches that can be customized by geographic area, health care need, enrollee language preference, or type of service	DOH function
Online and IVR premium and enrollment fee payment options	Yes
Multiple choices for electronic payment (debit card, credit card, electronic check, automatic withdrawal)	Yes
Outbound dialer for automated calls to people with incomplete renewals or applications or delinquent payments	No*
Application that encompasses all the requirements for multiple public health insurance programs	Yes
The application can also include requirements for other means-tested programs such as TANF and/or Food Stamps	Yes
Centralized Processing	Yes
Intake and verification of applications, renewals, and changes at a single processing location	Yes
Administrative tasks such as mail intake, data entry, or handling of complaints are assigned to groups of workers	Yes

trained and very efficient in those tasks (this contrasts with a case management model in which a single worker handles all the tasks related to a particular case)	
Standardized and optimized business processes	Yes
Cross-trained workers enable work to be shifted among tasks based on volume-driven work patterns	Yes
Technology solutions that automate common tasks are more feasible because of economies of scale	Yes
Business process modeling and improvement	Yes

Conclusion

Our analysis suggests that there is potential opportunity for privatized functions in **medical** eligibility programs. So long as the actual determination of eligibility comes from a merit employee of the state, most other functions can be privatized as indicated by the DWS table comparing a private contractor with their own activities. Further, we find a robust market for these services across the county that could produce privatized options for Utah. Despite these possibilities, we also note that because of the institutional arrangement of Utah's system which links multiple health and social service programs, regulatory spillover from other programs restricts these options substantially. Indeed, because Food Stamps and Medical programs eligibility are jointly conducted in Utah, the restrictions placed by USDA on Food Stamps eligibility prohibit privatization of any substantive function at this time. Given this limitation and our belief that the 'One Stop Shop' approach to these programs is a substantial efficiency gain for Utah, we believe there is little current opportunity to privatize. Instead, we strongly recommend that DWS and DOH continue to review privatization options, but make no further action on that front at this time.

Section 4- Cross State Comparisons

It is challenging to evaluate the error rate and cost efficiency rate for the programs under review in a comparative context for a number of reasons. First, the measures available across states—PERM, MEQC, and overall administrative budgets—do not lend themselves to comparisons because of issues of sample, size of state, and overall health costs in the state. For example, if we examine the PERM rate for Utah in its latest PERM cycle (2010), we note that it is in the top third of the states evaluated for that year, but the rate is relatively low when compared with the internal state audit figures presented to the legislature. Determining which figure is a more accurate measure depends on interpretation about the methodology used in each. With the small number of cases used in PERM and the impact a single bad case may have on the figure, it is a rate that should be used comparatively only with great caution.

Second, the change in federal administration during this period of evaluation led to some changes in interpretation and application that could impact Utah (for example, what to do with self-reported income as documentation and how these changes will count as documentation errors going forward, especially with respect to denials). Certainly, errors of any kind should be minimized, but the consequence of the errors, and the type of error on which to focus will depend on interpretations coming from the federal agencies that will measure it.

Third, as you might imagine, state policy makers and bureaucrats are hesitant to provide any information on the record that could be used to show them or their state in a bad light. Thus, obtaining accurate and comparable information directly from the states without a regulatory requirement to give information, results in selection bias that makes interpretation of that data limited at best. Thus, while we would like a detailed analysis of states comparable to the Utah state audit report data used above, we are left with aggregate data and the earlier measures discussed above.

Finally, we were asked to do an analysis of the cost efficiency of the eligibility process of the medical assistance programs in Utah, but as noted above, that process now is intertwined with the eligibility process for several other programs. Measuring cost and accuracy in one part of the program without evaluating the positive and/or negative impacts on other programs, would give only a partial picture with respect to overall benefit to the state. In our analysis, Utah is the only state that consolidates all of these programs together (although some states are close and others are trending in this direction as they utilize new online technologies). As a result, DWS's argument that full comparisons are impossible at this point is credible and any comparisons should be evaluated in that context.

Given all of these concerns, comparative analysis should only be used to provide a general impression to the legislature and the agencies on the relative

performance of Utah's eligibility process, where Utah is in terms of future requirements of health reform, and overall whether there is a risk relative to federal compliance. We will report national trends and suggest where Utah places only in general terms (i.e.—above the national average, etc.)

National Measures of Error

Payment Error Rate Measurement, or PERM, is the primary measure used by the federal government (CMS) to evaluate state performance in administering Medicaid and medical assistance programs. According to CMS, the PERM process has four phases: Sampling, Eligibility Reviews, Payment Reviews, and Error Rate Calculation. States perform their own eligibility reviews according to State and Federal eligibility criteria. States measure Medicaid and CHIP separately and must review both active and negative cases. Negative cases are all cases denied or terminated from the programs. The eligibility component produces its own error rates for each of the following rates: Active Case Error Rate, Negative Case Error Rate, and Active Case Payment Error Rate. The eligibility payment error rate from each state is included into the national program error rate with FFS and managed care error rates.

The PERM audit operates with a three-year cycle, with approximately 1/3 of the states included in each year. Utah was in the first whole analysis for all Medicaid FFS, Managed Care, and Eligibility samples drawn in 2007, and just repeated with the 2010 sample (reported November 2011). Established in the Improper Payment Information Act of 2002, and amended in IPERA in July 2010, PERM is just beginning its second round of measurement in the states. As such, it is difficult to draw definitive conclusions. However, performance to date does suggest an overall trend and points to areas that potentially pose problems and deserve greater attention.

National error rates as represented by CMS

Table 4.1

Annual Medicaid Error Rates

Year PERM Cycle	Overall	FSS	Managed Care	Eligibility
2007 Cycle 1-FY 2006	--	4.7%	--	--
2008 Cycle 2-FY 2007	10.5%	8.9%	3.1%	2.9%
2009 Cycle 3-FY 2008	8.7%	2.6%	0.1%	6.7%
2010 Cycle 4-FY 2009	9.0%	1.9%	0.1%	7.6%
2011 Cycle 5-FY 2010	6.7%	3.6%	0.5%	4.0%

Utah error measured 8.5 percent overall during its most recent PERM evaluation (FY 2010), with eligibility errors comprising just over half, at 4.5 percent of sampled results. This level placed Utah in the highest third of states when considering rates of error as measured by PERM. Again, we should not over interpret these levels as cross state comparisons can be impacted by a number of features in the relatively small sample associated with any single state. State officials frequently express concern with PERM because a single significant error in the small sample can translate into an overly negative result. Similarly, as federal policymakers caution,

"State error rates vary due to multiple factors related to differences in how States implement and administer their programs. The PERM findings should be considered in the context of these differences and operational realities. We provide each State their specific error rates and data analysis reports to develop corrective actions designed to reduce major error causes and to identify trends in errors or other factors for purposes of reducing improper payments. Due to the variation of States' sizes, overall program variations, and ways in which a states error rates impact the national rate, we do not encourage comparisons based solely on PERM." (CMS, 2012)

As such, we do not think the recent PERM error level in Utah poses the basis for policy action, but in combination with other factors, the error level suggests that Utah continue to monitor eligibility error levels to evaluate the agencies.

An additional change in federal procedures that could impact future audits is the possibility of consolidating PERM and MEQC procedures. Under the CHIP reauthorization of 2010, CMS agreed to permit states to substitute the traditional MEQC process for the PERM process or vice versa, but only where states were using traditional MEQC and not a pilot program. Since Utah operates with a pilot MEQC, we must continue to offer both measures or receive a waiver. However, this increased flexibility suggests a change in regulatory environment that Utah should pursue.

Under both MEQC and PERM, the state must operate in accordance with the policy's sampling methodology, review procedures, reporting forms, and other requirements specified by CMS. Each state authorized audit team selects statistical samples of both active and negative case actions. They review each case in the sample to identify eligibility errors and any claims pertaining to each active case to identify erroneous payments resulting from ineligibility. They then determine whether recipient liability was understated or overstated and whether third-party liability claims are evident in processing errors. States must also conduct a field investigation to evaluate and correct errors. To note the importance of error in the national process and consider where Utah fits in that arena, we turn to a more detailed consideration of the national context.

Error has been especially problematic in medical assistance programs nationally and given the high spending possible in these programs; the consequence of such error translates into large levels of waste. Five of the top ten error rates in federal programs are associated with health services and they account for most of the losses at the national level. According to the OMB, documentation errors have proven to be the most frequent cause of error among newly measured programs and are among the first to be resolved once recognized. However, the remaining causes of program error (e.g., verification or authentication) prove to be much more difficult to remediate. (*OMB, Improving the Accuracy of Federal Payments, 2009*). In Utah, documentation errors are a serious problem in early audits and the improvements are just beginning.

The focus on documentation errors over the history of PERM implies that otherwise correct decisions that are simply missing documentation count against a State. In the most recent reevaluations of this process, Executive Order 13520 – Reducing Improper Payments (November 20, 2009) and CHIPRA in 2010, the Obama Administration reset the rules regarding documentation requirements to permit recent self-declarations unless other evidence contradicts that declaration. Since many past errors in Utah and other states were a function of missing documentation, this rule change could reduce overall error going forward, but might enhance the possibility for errors associated with denials.

A second procedural relaxation adopted by CMS permits families to be considered collectively as a case instead of separating out each individual in a family. These rule changes offer states greater flexibility and should imply reduced error levels, but it also implies a greater emphasis on erring on the side of inclusion in programs. This emphasis may create a greater division with DWS's perspective for other social assistance programs. As such, we believe it is important to maintain the focus on such measures to ensure the pattern of continued improvement in Utah.

CMS is required to report out-year error reduction targets for Medicaid based on a three-year average, or rolling rate, reflecting all states measured. The targets for the national error rate reduction plan are in Table 4.2.

Table 4.2
Error Reduction Rate Targets

Nov 2010 AFR (actual)	Nov 2011 AFR	Nov 2012 AFR	Nov 2013 AFR
9.4%	8.4%	7.4%	6.4%

In order to reach this level, we can assume that CMS will be focused on states with continuing high levels of error. As such, it is important that Utah policymakers continue to follow the recent trend and respond quickly if the level of error starts climbing again.

As the following sample tables constructed by OMB show for 2008, the average number of errors is highest in eligibility decisions, but the costs of those errors are small relative to the costs of other errors. Moreover, they find that most errors fall into the category of documentation and may not pose the significant impact assumed by citizens when they hear high error rates reported. As federal rules now reduce the requirements for documentation, overall error rates can be expected to fall nationally (as we have observed in the latest PERM report). If Utah faces special problems that suggest continued high rates, this could invite additional scrutiny to search for a more fundamental cause of the error problem here.

Table 4.5
2008 Types of Error By Category

Error Type Descriptions	Number of Payment Errors	% of Total Number of Errors
Insufficient Documentation	309	39.8%
No Documentation	244	31.4%

Number of Units Error	91	11.7%
Procedure Coding Error	57	7.3%
Diagnosis Coding Error	26	3.4%
Medically Unnecessary Service	18	2.3%
Policy Violation	15	1.9%
Administrative/Other	15	1.9%
Unbundling	1	0.1%
Total	776	100%

The passage of CHIPRA in 2010 prevented CMS from continuing with their ongoing CHIP error measurements. As such, recent national CHIP error rates will not be reported until the 2013 cycle. Despite this lack of recent CHIP error context, we know that the pattern prior to the passage of CHIPRA suggests error rates in CHIP are higher than in Medicaid, with a national rate of 14.7 in 2009. In Utah, error in CHIP also runs higher than other medical assistance programs.