A Performance Audit of Capitation Payments Made after the Death of Medicaid Members

Report Number A2022-01

February 13, 2023

Utah Office of
Inspector General

Gene Cottrell
Inspector General

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To: Department of Health and Human Services

Please see the attached report, **A Performance Audit of Capitation Payments Made after the Death of Medicaid Members**, (Report A2022-01). An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 7 of this report.

Sincerely,

Gene D. Cottrell
Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Sen. Jacob Anderegg, Social Services Appropriations Subcommittee, Senate Chair
Rep. Raymond Ward, Social Services Appropriations Subcommittee, House Chair
Jon Pierpont, Chief of Staff, Office of Governor Spencer Cox
Sen. J. Stuart Adams, President of the Utah Senate
Rep. Brad Wilson, Speaker of the Utah House of Representatives
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PREFACE

In the 2021 General Session, the Utah State Legislature passed H.B. 365 *State Agency Realignment* transitioning the Utah Department of Health (UDOH) and the Department of Human Services into a single agency, the Department of Health and Human Services (DHHS). According to the transition plan, all functions of the two departments merged with the exception of "a small piece of Medicaid (eligibility quality control and review of eligibility adjudications) [which moved] from UDOH to the Department of Workforce Services (DWS), the department responsible for Medicaid eligibility determinations for the state."[1] Prior to the completion of this audit, the consolidation became official on July 1, 2022. Accordingly, use of UDOH in this report refers to the State Medicaid Agency prior to July 1, 2022.

[1] Social Services Realignment Transition Plan. (2021). Accessed September 13, 2022. https://sites.google.com/utah.gov/hhsplan/updates/transition-plan.

EXECUTIVE SUMMARY

Utah Medicaid contracts with Accountable Care Organization (ACO), Utah Medicaid Integrated Care (UMIC), Dental, Transportation, Prepaid Mental Health Plan, and Substance Use Disorder contractors to provide services to eligible Medicaid members. The contractors receive monthly per enrollee capitation payments. According to federal law, the State may only make capitation payments for Medicaid-eligible enrollees. Medicaid eligibility ends on the date an individual dies. The Utah Office of Inspector General (UOIG) initiated this audit based on a data query showing capitation payments issued after death (see Figure 1 pg. 6).

Audit Objectives:

- Determine if Utah Medicaid made unallowable capitation payments after the death of Medicaid members.
- Determine how Utah Medicaid receives and records reports of death.
- Determine if Utah Medicaid documents the basis for discontinuing assistance when a Medicaid member dies.
- Determine if Utah Medicaid's ACO and UMIC contracts require contractors to report excess capitation payments.

Audit Findings:

1. Utah Medicaid did not regularly identify and recover capitations paid after the death of Medicaid members.
2. Utah Medicaid did not always stop issuing capitation payments after the death of Medicaid members.
3. Contracts did not consistently require ACOs to report excess capitation payments.

Utah Medicaid has procedures to identify and reverse capitations paid after death. System defects, reports not working as designed, and inaccurate and incomplete data compromised the performance of Utah Medicaid's procedures for detecting and remediating capitations paid after death. These impediments resulted in waste in the form of Utah Medicaid paying unallowable capitations on behalf of deceased Medicaid members. During the 3-year audit period, UOIG identified approximately $1.5 million in unrecovered overpayments. UOIG recommends that DHHS recover overpayments not yet recovered, increase oversight, and strengthen existing procedures to reduce the possibility of future unallowable and unrecovered capitation payments after death.

Both Utah Medicaid and Department of Workforce Services receive reports of death. Utah Medicaid records dates of death in the Medicaid Management Information System (MMIS) as required by the Centers for Medicare and Medicaid (CMS). When terminating eligibility, DWS eligibility workers document the reason in accordance with federal law and the State Medicaid Plan.

Contracts with the UMIC plans require reporting of excess capitation payments, which is consistent with federal law. The contracts with the four ACOs omitted the federal requirement for a six-month period. UOIG recommends that DHHS evaluate its current contract amendment process.

INTRODUCTION

BACKGROUND

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. Utah Admin. Code R414-1-3 designates DHHS the single state agency responsible to administer or supervise the administration of the Utah Medicaid Program in accordance with federal and state law. At the federal level, CMS is responsible for regulation and federal oversight of the state programs. Together, the state and federal government fund Utah Medicaid at rates determined by the federal medical assistance percentage (FMAP).

Medicaid programs must comply with federal requirements such as delivering covered services to specific populations. To meet the needs and budget of each state, federal law allows states to expand services and populations covered. States may also apply to CMS to waive certain federal requirements. Due to these flexibilities, Medicaid programs are complex and unique to each state.

Two Primary Payment and Delivery Models

Most states, including Utah, use two primary delivery and payment approaches to administer Medicaid programs: fee-for-service (FFS) and managed care. Under a fee-for-service model, providers bill Medicaid directly for each covered service provided to a Medicaid member. Managed care models involve the state contracting with healthcare organizations to provide services to Medicaid members. The state pays contractors a fixed dollar amount each month per enrolled Medicaid member. Contractors receive these monthly capitation payments regardless of how many services members receive each month.

Managed Care Programs

A significant change in the state's Medicaid delivery system took place after Senate Bill 180, *Medicaid Reform*, unanimously passed in 2011. The bill directed UDOH to replace large portions of the state's FFS delivery model with a risk-based managed care delivery model. Accordingly, UDOH contracted with four risk-based ACOs to provide physical health services in the four most populated counties of Utah.[2] The goals of ACO contracting are "to maintain quality of care and improve health outcomes for Medicaid members, as well as control costs by keeping the Medicaid cost growth rate from

> "Utah's goals for using ACOs are to maintain quality of care and improve health outcomes for Medicaid members, as well as control costs by keeping the Medicaid cost growth rate from exceeding the State General Fund growth rate."
>
> Utah Medicaid & Chip Annual Report, 2018

[2] In 2015, enrollment expanded to include Box Elder, Cache, Davis, Wasatch, Morgan, Rich, Salt Lake, Summit, Tooele, Washington, Weber, Iron, and Utah counties.

exceeding the State General Fund growth rate."[3] Delivery of physical health services through the ACOs started on January 1, 2013. Utah Medicaid enrolls eligible members in a separate Prepaid Mental Health Plan (PMHP) for behavioral health services.

Recently, Utah Medicaid implemented UMIC as a delivery system for Adult Expansion Medicaid members in five counties.[4] Unlike the ACO delivery system, UMIC enrollees receive physical and mental health services through the integrated managed care plan. By providing physical and mental health services through the same plan, Utah Medicaid's aim is to give rise to "the best health outcomes for members while managing the costs of services." Utah Medicaid started enrollment members in UMIC plans on January 1, 2020.

Beginning in September of 2013, Utah Medicaid started enrolling eligible members in dental managed care plans. Utah Medicaid currently contracts with two managed care dental plans to provide dental services to pregnant members and children eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Utah Medicaid Uses Capitation Payment Methodology for other Medicaid Services

Utah Medicaid provides non-emergency medical transportation "to ensure necessary transportation of recipients to and from providers of medical services."[5] Non-emergency medical transportation services are for members to receive Medicaid covered services from Medicaid providers. The state provides transportation through various modes including Utah Transit Authority (UTA) bus passes, paratransit bus service, grant, contracted service, and personal mileage reimbursement. The state's contracted transportation service is for members who live outside UTA's service area and do not have access to a vehicle. The transportation contractor receives a fixed capitation payment each month per enrolled Medicaid member.

Medicaid Eligibility Determinations

As the single state agency, DHHS is responsible for determining eligibility for individuals applying for or receiving Medicaid services under the State Plan. DHHS delegates this responsibility to the Department of Workforce Services (DWS), as allowed under federal and state law. Once delegated, the DHHS "must exercise appropriate oversight over eligibility determinations" and ensure that DWS "[c]omplies with all relevant Federal and State laws, regulations and policies, including, but not limited to, those related to the eligibility criteria."[6] A Memorandum of Agreement (MOA) between the single state agency and DWS formalizes the delegation of Medicaid eligibility determinations to DWS.

Medicaid is one of the numerous temporary support services for which DWS provides eligibility services. DWS uses a system called the Electronic Resource and Eligibility Product (eREP) for case management, support service determination and benefit issuance. eREP is a rules-based web application. DWS eligibility workers (eligibility workers) use eREP to

[3] Annual Report Utah Medicaid & CHIP. (2018). Accessed August 11, 2022. https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/MedicaidAnnualReport_2018.pdf.
[4] Davis, Salt Lake, Utah, Washington, and Weber counties.
[5] Utah Medicaid State Plan, Attachment 3.1-D. Accessed September 26, 2022. https://medicaid.utah.gov/stateplan/spa/A_3-01-D.pdf.
[6] State Organization and General Administration, 42 CFR 431.10(c). https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-part431.pdf.

record actions like Medicaid eligibility determinations and changes. Federal regulation, the State Medicaid Plan, and Medicaid policy all require maintenance of records that contain, among other things, the basis for discontinuing Medicaid assistance such as the death of a member.

Many Systems Support the Administration of the Medicaid Program

Among the systems that support the administration of Utah's Medicaid Program, MMIS is the primary management system and federal law requires its use. MMIS supports Medicaid operations and many business functions such as claims processing, payment, collecting data, and monitoring utilization. Part 11 of the State Medicaid Manual outlines system requirements including minimum data elements for MMIS systems. One data element that must be present is the date of a member's death after receipt of an official notice.

Utah Medicaid is in the process of replacing Utah's MMIS with a new system. The aim of the multi-year replacement project is to modernize the state's system and increase functionality. Utah named the new system the Provider Reimbursement Information System for Medicaid (PRISM). Prior to the release of this report, Utah Medicaid announced an implementation date change extending the go-live date for PRISM by 3 months to April 3, 2023.

Coronavirus Disease 2019 (COVID-19) Public Health Emergency

The COVID-19 public health emergency (PHE) has affected many aspects of the Medicaid program including eligibility maintenance. In January of 2020, the U.S. Secretary of Health and Human Services (HHS) declared COVID-19 a PHE. Shortly after, the President declared the outbreak a national emergency beginning on March 1, 2020. As one of the many responses to the PHE, Congress passed the Families First Coronavirus Response Act (FFCRA) in March of 2020. Under the Act, states and territories are eligible to receive enhanced Medicaid federal funding during the PHE. One of the requirements to receive the 6.2 FMAP increase is—with limited exceptions—to continue Medicaid coverage for members enrolled as of March 18, 2020 or later until the end of the PHE. The exceptions to the maintenance of eligibility requirements include death, voluntary termination, and permanently moving out of state.

> Exceptions to maintenance of eligibility requirements during the public health emergency include death, voluntary termination, and permanently moving out of state.

In December of 2022 Congress passed the Consolidated Appropriations Act, 2023 (CAA). This new law changes the maintenance of eligibility requirements contained in FFCRA. Under CAA, expiration of the maintenance of eligibility requirements and 6.2 FMAP increase are no longer linked to the end of the PHE. Instead, the maintenance of eligibility requirements will end on March 31, 2023 and the temporary FMAP increase will gradually reduce and end on December 31, 2023.

Maintenance of eligibility requirements were in place during the last 19 months of the audit scope.

The Utah Office of Inspector General

Under the authority of Utah Code § 63A-13-201, UOIG is an independent entity operating within the Department of Government Operations to fulfill its mission of protecting taxpayer dollars. UOIG's statutory responsibilities include inspecting and monitoring the state Medicaid program's expenditure of federal and state funds; identifying potential or actual fraud, waste, or abuse in the state Medicaid program; and auditing, inspecting, and evaluating the functioning of Utah Medicaid for the purpose of making recommendations to the Legislature and Utah Medicaid to ensure the Medicaid program is managed in the most efficient and cost effective manner possible.[7]

Testing program controls is an essential element of identifying waste in the Medicaid program. Utah law defines waste as the act of using or expending a resource carelessly, extravagantly, or to no purpose. Waste includes activities that do not constitute abuse or necessarily involve a violation of law; and relates primarily to mismanagement, an inappropriate action, or inadequate oversight.[8]

Increase in Capitations Paid

UOIG initiated this audit based on a data query that showed unrecovered capitation payments issued after death. The query showed an increase of capitation payments starting in 2019 (see Figure 1).

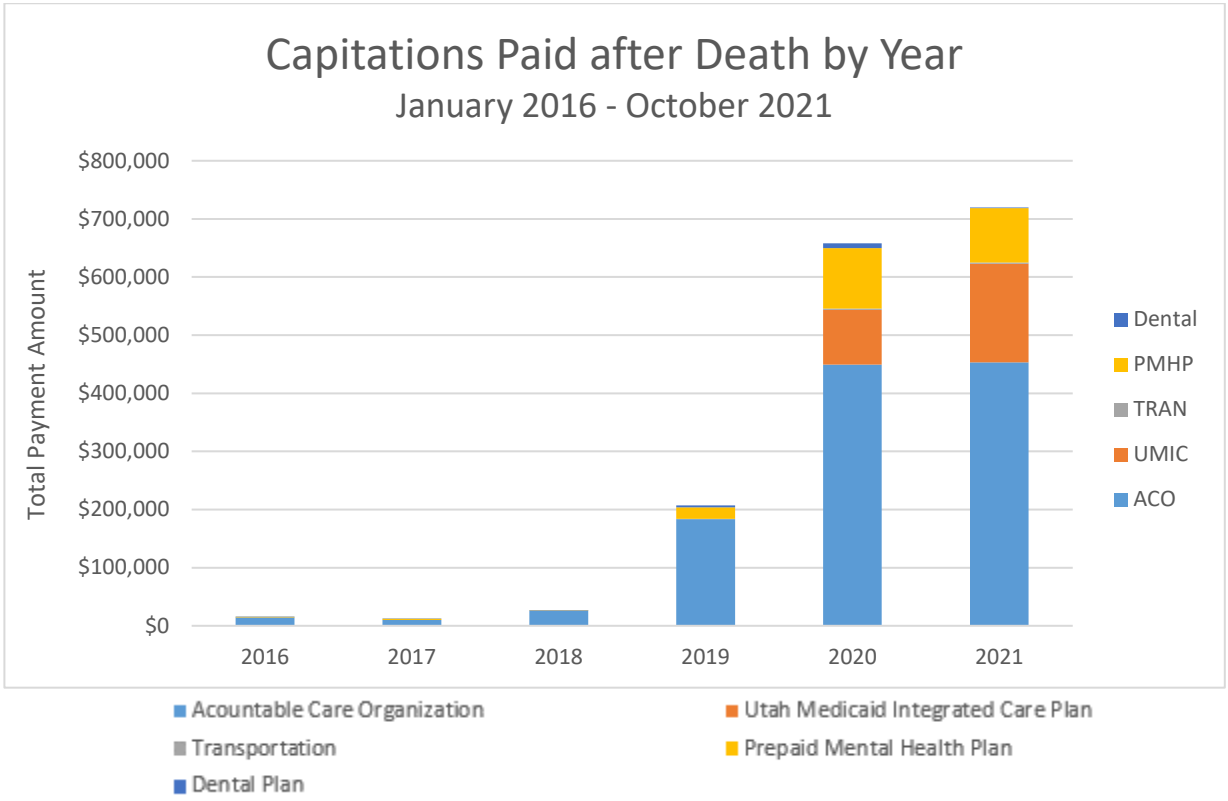


Figure 1 *Source: UOIG Data Query*

[7] Duties and Powers of Inspector General and Office, Utah Code § 63A-13-202. https://le.utah.gov/xcode/Title63A/Chapter13/63A-13-S202.html?v=C63A-13-S202_2022050420220504

[8] Definitions, Utah Code § 63A-13-102(13). https://le.utah.gov/xcode/Title63A/Chapter13/63A-13-S102.html?v=C63A-13-S102_2022050420220701

OBJECTIVES AND SCOPE

Audit Objectives:

- Determine if Utah Medicaid made unallowable capitation payments after the death of Medicaid members.
- Determine how Utah Medicaid receives and records reports of death.
- Determine if Utah Medicaid documents the basis for discontinuing assistance when a Medicaid member dies.
- Determine if Utah Medicaid's ACOs and UMICs contracts require contractors to report excess capitation payments.

Audit Scope:

The scope of the audit covered capitations paid to managed care and transportation contractors from September 1, 2018 through September 30, 2021.

METHODOLOGY

To carry out the audit objectives, UOIG conducted fieldwork between September of 2021 and September of 2022.

To identify capitation payments made after the death of Medicaid members, UOIG obtained Office of Vital Records and Statistics death records and Medicaid member information from the Utah Medicaid Data Warehouse (Data Warehouse). UOIG used social security numbers to match Medicaid members with the death records. UOIG also obtained capitation coverage dates and capitation payments made on behalf of matching Medicaid members. The results include capitation payments made to ACO; dental plan contractors; prepaid mental health plan and substance use disorder services contractors; Utah Medicaid integrated care plan contractors; and transportation contractors.

UOIG used MMIS to review 11,440 capitation payments made on behalf of 3042 Medicaid members with a date of death recorded in the Data Warehouse. To resolve conflicting date of death information, UOIG's eligibility specialist used eREP to search for death certificates or to verify death information as reported by the Social Security Administration (SSA). For members with four or more months of capitation payments after death, UOIG's eligibility specialist reviewed eREP to gain an understanding of actions taken by eligibility workers as well as actions performed automatically at a system level. Additionally, in certain reviews, the audit team used the Medicaid Managed Care System (MMCS) to compare date of death and eligibility information with the data in MMIS.

UOIG also:

- Reviewed applicable federal and state statutes, state administrative rules, and related policy and procedures.
- Reviewed applicable reports.

- Requested and examined the ACO and UMIC contracts in place during the audit scope. The contract review focused on the federal reporting of excess capitations requirement.
- Conducted interviews of Utah Medicaid, Department of Workforce Services, and Department of Technology Services (DTS) staff.

CONCLUSION

During the three-year audit period, Utah Medicaid made capitation payments to managed care and transportation contractors on behalf of deceased Medicaid members. UOIG identified approximately $1.5 million in unrecovered capitation overpayments. This waste occurred because of the eREP system defect; MMCS allowing for enrollment in transportation and PMHP plans after death; a surveillance and utilization report not working as designed; and inaccurate eligibility information.

Federal law and Section 4.7 of the State Plan require that Utah Medicaid maintain or supervise the maintenance of records documenting the basis for discontinuing Medicaid assistance. UOIG observed that while eligibility workers did not always follow through with the necessary actions to terminate eligibility after death successfully, they appropriately documented the basis for discontinuing Medicaid eligibility in eREP. The documentation complies with federal law and the State Plan. The eREP notes capture the date, time, and name of the user that entered the record.

To support program integrity, federal law requires that the state, through its contracts, ensure that managed care entities report to the state excess capitation payments within 60-days of identification. During the period, the state's contracts with the four UMIC contractors complied with this federal law. For a six-month period, the state's contracts with the four ACO contractors did not include the federal requirement to report excess capitation payments.

To receive federal funding, state Medicaid programs are required to use and maintain a MMIS. CMS provides guidelines for system requirements. One of the minimum data requirements is a member's date of death after the state receives an official notice of death. Once eligibility workers enter a date of death in eREP, the dates appear in real-time in MMIS.

Since UOIG began work on the audit, Utah Medicaid has taken timely corrective action to repair the eREP system defect and the broken surveillance and utilization report.

FINDING 1 — Utah Medicaid did not Regularly Identify and Recover Capitations Paid after the Death of Medicaid Members

When a Medicaid member dies, Utah Medicaid and state departments have active roles in the processes that follow.

Department of Technology Services
Utah Medicaid utilizes Surveillance and Utilization Reports (SURS) in its procedure to identify members that have died and remediate overpayments that occurred after death. The automated SURS reports generate at regular intervals using data from the Medicaid Data Warehouse. DTS is responsible for ongoing maintenance of the reports as directed by Utah Medicaid.

Office of Managed Healthcare
The Office of Managed Healthcare (OMHC) receives the weekly SURS-009 report, which lists Medicaid members that have died. The report matches names, dates of birth, and social security numbers to data from the Office of Vital Records and Statistics. Each week, typically on Mondays, OMHC forwards the SURS-009 report to DWS by email. OMHC also receives and sends DWS intermittent reports of death from multiple sources including the managed care contractors and nursing homes.

According to standard operating procedure (SOP), when OMHC determines that a name incorrectly appears on the SURS-009 report, OMHC sends the member information to a Research Consultant in the Bureau of Financial Services (BFS) for exclusion from future SURS reports. UOIG learned that OMHC's current practice is to enter the name on an exception list connected to the query and output of future SURS-009 reports. The current version of the SOP has not been updated to reflect this change.[9]

Department of Workforce Services
DWS receives reports of death from a number of sources including Utah Medicaid, SSA, nursing homes, and family members. OMHC emails the weekly SURS-009 report to a designated DWS Program Specialist. The Program Specialist manually transfers the report to a spreadsheet shared by a team of eligibility workers in Google Drive. Using the shared Google spreadsheet allows multiple users to access the report at the same time. The team enters dates of death from the report in eREP matching name, date of birth, and social security number. DWS reports any discrepancies to OMHC.

Utah Medicaid uses both an automated and manual process to recover capitations paid after the death of members. The recovery process relies on information in MMCS and a weekly surveillance and utilization report. During the audit period, MMCS did not consistently receive information from DWS required to initiate the automated process to identify and reverse overpayments. Additionally, the manual process did not take place routinely.

[9] The SOP version tracking indicates that the policy has not been updated since Utah Medicaid implemented the SOP in October of 2017.

Contracts with the ACO and UMIC contractors establish that Utah Medicaid "shall recoup any payment paid to the Contractor which was paid in error. Such error may include human or mechanical error on either part of the Contractor or the Department. Errors can include but are not limited to, lack of eligibility or computer error." According to federal law, "[c]apitations payments may only be made by the State and retained by the MCO, PIHP or PAHP for Medicaid-eligible enrollees."[10] Deceased individuals are not eligible for Medicaid.

eREP Defect

In January of 2019, the state started a large project to modernize the state's eligibility system, eREP. The project transferred eREP from the Curam framework to open source product and other technologies. The multiyear project consisted of phased implementation with portions of the new system released on a monthly basis.

Along with benefit issuance, case management and many other business functions, DWS uses eREP to record and document information. Two items recorded in eREP are dates of death and eligibility decisions. DWS reports both items to DHHS nightly.

In September of 2021, UOIG contacted Utah Medicaid about capitations paid after death. Utah Medicaid promptly researched the issue and discovered that the nightly file transfer to Utah Medicaid did not always include every date of death. Utah Medicaid reported the deficiency to DWS. Research revealed a system error introduced during the switch from Curam to the new software product. This system defect resulted in eREP reporting dates of death in narrow circumstances. Instead of reporting every date of death entered, eREP only reported when a date of death changed from one date to a different date.

When Utah Medicaid receives dates of death from DWS, the dates load into MMCS. The entry of the dates of death starts an automated capitation recovery process in MMCS. First, MMCS enters the date of death as the end date for managed care enrollment and Medicaid eligibility. The system then performs a check for any capitations paid after the date of death and recovers overpayments.

Although eligibility workers were updating dates of death in eREP, the defect resulted in incomplete information in the nightly files DWS sent to Utah Medicaid. The files did not include every date of death entered by eligibility workers. Consequently, the automated recovery process in MMCS did not start and overpayments went undetected.

Shortly after Utah Medicaid discovered indications of the eREP system error, DTS inspected the system and identified the source of the error. DTS released the defect fix in the regularly scheduled November 2021 release, which was part of the phased implementation of the new eREP system. According to Utah Medicaid and DWS, eREP is working well since the November release.

CAP-6 Report

DHHS utilizes SURS reports in its procedure to remediate overpayments that occur after a member's death. The reports support Utah Medicaid's procedure to recover overpayments

[10] Managed Care, 42 CFR 438.3(c)(2). https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-part438.pdf.

for capitations paid after a member's death. To identify capitations made after a member's death, DHHS uses the SURS-006 report. Staff commonly refer to this report as the CAP-6 report.

The CAP-6 report prompts OMHC staff to start the manual process in MMCS. The manual process is required for dates of death that do not post to MMCS during the automated process. After manually entering the date of death, the process closely follows the steps in the automated process. An OMHC employee checks for any capitations paid after the date of death and recovers any overpayments. Next, the employee enters the date of death as the end date for Medicaid eligibility. Unlike the automated process, the end date for health plan enrollment is the last day of the month, not the date of death. The last step employees take is deleting any eligibility that DWS issued for months following the date of death.

Between 2019 and October of 2021, no names appeared on the CAP-6 report. Although the reports were generating and reporting on schedule, the reports were blank and did not contain any data. Shortly after UOIG contacted OMHC about capitation payments continuing after death, OMHC notified DTS that the CAP-6 was reporting no names. Research revealed that the CAP-6 report was not working as designed. DTS identified the coding error and corrected the coding in October of 2021.

Managed care and transportation contractors received approximately $1.5 million in capitation payments made after the death of Medicaid members that Utah Medicaid did not detect or recover (see Appendix A for more details). The eREP system defect and CAP-6 report error contributed to waste in the form of capitations paid after the death of 3011 Medicaid members.

Since the beginning of the audit, Utah Medicaid has taken steps to recover at least $357,000 of the $1.5 million in unallowable capitation payments.

Recommendations

UOIG recommends that DHHS:

1.1 Recover unallowable capitation payments made on behalf of deceased Medicaid members during and after the audit scope.

1.2 Determine a baseline of typical numbers reported on the SURS-006 and SURS-009 reports for ongoing trend analysis to support early detection of impediments to Utah Medicaid's procedures for recovering unallowable capitations made on behalf of deceased Medicaid members.

1.3 Develop a process to aid timely detection of incomplete or erroneous files from DWS, which could include determining a baseline for the typical number of dates of death reported by DWS in the nightly file to support ongoing monitoring.

1.4 Review and update SOP, including the Remediating Overpayments for Claims/Encounters that Occurred after a Member's Death SOP, to reflect current business practices, responsibilities, and actions taken.

1.5 Establish a regular ongoing process to review SOP, after implementation, to reflect changes to business practices, responsibilities, and actions taken.

1.6 Document, distribute, and train staff on any new or amended procedures stemming from action taken in response to Recommendations 1.2, 1.3, 1.4, and 1.5.

1.7 Coordinate with DWS and DTS to determine if it is possible to automate the process of emailing, uploading and processing date of death information instead of manually performing these tasks.

FINDING 2 — Utah Medicaid Did Not Always Stop Issuing Capitation Payments after the Death of Medicaid Members

UOIG identified members with unallowable capitations paid after a reported death and an automated or manual recoupment process. After posting a date of death, MMCS allowed for re-enrollment of deceased individuals in Medicaid. Based on a programming error in MMCS and incorrect eligibility information from DWS, Utah Medicaid re-enrolled deceased individuals in transportation, and PMHP managed care plans.

Federal law provides that states may only make capitation payments for Medicaid eligible enrollees. The rules of Utah Admin. Code Rule R414-308-6(2)(f) provide that Medicaid eligibility ends on the date the individual dies. The PHE provisions of Utah Admin. Code Rule R414-308-11(1)(b) reiterate that Medicaid benefits "may only continue through the date of the beneficiary's death." Finally, the MOA between UDOH and DWS states that DWS shall correctly determining eligibility and "[c]orrectly maintain eligibility for all Medical Assistance programs."

Medicaid Managed Care System

In the fall of 2021, Utah Medicaid discovered that in certain circumstances MMCS allows for capitation payments to issue on behalf of deceased individuals. The safeguard to prevent capitations from issuing after MMCS received dates of death from DWS failed and allowed payments to the transportation contractor. Although the system previously terminated Medicaid eligibility and dis-enrolled the deceased person from health plans, the system allowed for re-enrollment in health plans and payment of capitations regardless of the presence of a date of death in the system. To repair the safeguard, Medicaid submitted Division Operations Tracker (DOT) number 113702 to DTS in December of 2021.

During the audit fieldwork, UOIG detected capitation payments made to the PMHP managed care contractors on behalf of deceased members. UOIG inquired about the unallowable payments in March of 2022. OMHC updated the DOT to include research and repairs to ensure that PMHP capitations do not pay after MMCS receives a date of death from DWS. As of the date of this report, DTS has not completed work on the DOT.

Inaccurate Eligibility from DWS

As discussed previously, Utah Medicaid receives daily files from DWS containing dates of death and eligibility information. The information populates in MMCS nightly. UOIG observed multiple instances of Medicaid eligibility incorrectly continuing to issue or starting to re-issue for numerous months after a confirmed date of death. In these cases, after sending dates of death in the nightly files, DWS subsequently sent nightly files showing the same deceased individuals as eligible for Medicaid.

Many factors contributed to eligibility remaining open or re-opening after eligibility workers entered a date of death in eREP. UOIG frequently observed multiple overlapping factors on cases. While the factors listed below may appear minor if viewed individually, the cumulative impact of the factors contributed to the unallowable payment of capitations after reported death dates.

Eligibility Workers not following Eligibility Policy

In some cases after posting a date of death in eREP, eligibility workers incorrectly left Medicaid eligibility open. Examples of notes in eREP include, "we are not closing any Medicaid programs at this time due to Covid 19" and "set task to monitor program and close at the end of the PHE if contact is not reinstated." After learning of a death, eligibility workers did not always take action to end Medicaid eligibility on the date the individual died. Eligibility policy specifically addressing the PHE states that death is an exception to eligibility maintenance during the PHE.

Eligibility Workers Neglected to Place Household Member(s) on a New Case

When an individual dies and they have a spouse and/or children, DWS procedure requires action to ensure benefits issue correctly for the remaining household members. Opening a new case for the remaining household members is required in some situations. Eligibility workers not opening new cases or neglecting to remove deceased persons from households resulted in improper continuation of Medicaid eligibility for deceased individuals.

Eligibility Workers Mistakenly Thought the System Would Close Medicaid Eligibility

UOIG observed that after entering a date of death in eREP, eligibility workers did not always take additional steps to manually close Medicaid eligibility. Typical examples from the worker notes in eREP include, "case will close," "will let RV [review] go out…RV is due and will let case close," and "updated PID[11] when the review is complete, her benefits should end." Without action to manually close Medicaid eligibility, eREP continued to issue eligibility for deceased individuals. In a meeting with UOIG, DWS management explained that there has been confusion about which parts eligibility workers complete manually, and which parts eREP handles.

eREP Did Not Exclude Individuals after Death

eREP allowed Medicaid eligibility to issue for individuals with a date of death entered in eREP. DWS explained in a meeting with UOIG that since DTS fixed the eREP system defect identified in the fall of 2021, DWS has not heard of further instances of eligibility issuing for deceased individuals. According to DWS, eREP looks for a date of death and if there is one, it will exclude the person.

Incorrect Closure Reason

When Medicaid eligibility closes, eligibility workers manually enter notes in eREP documenting the basis for ending assistance. A closure reason is generated automatically by the system or manually entered by the eligibility worker. System generated closures rely on information entered and actions taken by eligibility workers. When certain actions—such as reassessment of benefits—are omitted, the system generated closure reason will incorrectly be something other than death. During the audit scope, eREP automatically re-opened eligibility as part of PHE eligibility maintenance for cases without death as the system generated or manually selected closure reason.

[11] PID refers to the Medicaid member's personal identification. Eligibility workers click on the member's PID number in eREP to access the member's Person Home Page. The Person Home Page is used to update personal evidence such as address, phone number, and date of death.

eREP Overrode Eligibility Decisions

DWS uses two functions in eREP as part of their normal processes: Forced Evidence and Reassessment (FEAR) and Due Process Month. Ordinarily DWS issues a Due Process Month to extend benefits for one to two months to allow time to complete an eligibility review or provide proper notice of an agency decision. DWS uses FEAR for emergency eligibility issuance, when the programming in eREP is not working properly or not yet programmed. Both functions override the rules in eREP and ignore any reasons for ineligibility.

DWS has used FEAR and Due Process Month during the PHE to continue Medicaid coverage for members as part of the maintenance of eligibility requirements. The exceptions to the maintenance of eligibility requirements are death, voluntary termination, and permanently moving out of state. Use of the FEAR and Due Process Month functions overrode deceased eligibility decisions. In some circumstances eREP continued to override and issue eligibility month after month, when eligibility previously closed due to death.

DWS management monitors Medicaid cases issued during the PHE where the system is ignoring the ordinary eligibility rules to comply with PHE maintenance of eligibility requirements. The monthly monitoring report does not include data on exceptions to the maintenance of eligibility requirements such as dates of death.

When DHHS identifies eligibility errors, DWS receives notice through the Request for Action (RFA) process. DHHS sends RFA reports with a significant number of errors directly to DWS management. The DWS Program and Training Medical Team receives RFA reports with individual cases. DWS reviews the RFA and takes appropriate action to resolve the eligibility errors. The two departments agreed to the following in the MOA:

> DOH and DWS will track the issues sent through the RFA process to determine trends. DOH and DWS will review the trends at least quarterly at the Medical Quarterly Meeting, as described in Section 9.4, to identify training issues.[12]

Between August of 2020 and September of 2022, UDOH and DWS did not hold Medical Quarterly Meetings (MQMs) due to a lack of agenda items or conflicts as the merger of UDOH and the Department of Human Services took place. The MQM is one of the core meetings identified in the MOA to prioritize and maintain.[13]

CAP-6 Report

The capitations incorrectly paid after death—due to issues such as incorrect eligibility or the MMCS system error—would ordinarily appear on the SURS-006 report. As discussed in Finding 1, the report was not working as designed between 2019 and October of 2021. The re-enrollment of deceased individuals in healthcare plans and the associated overpayments went undetected due to the CAP-6 report not working as designed.

[12] Medical Assistance Operating Agreement (2017). Article 12.2.4.
[13] Medical Assistance Operating Agreement (2017). Article 4.9.1.

When names appear on the CAP-6 report, Utah Medicaid sends the report to DWS. According to the MOA between DHHS and DWS, eligibility errors must be resolved within five business days. DWS relies on the eligibility error reporting from Utah Medicaid and does not currently generate an internal report showing instances of Medicaid eligibility issuing after death.

Utah Medicaid acts on the eligibility information received from DWS. During the audit scope, Utah Medicaid received files from DWS indicating that deceased individuals were eligible for Medicaid. An undetected system defect allowed Utah Medicaid to re-enroll deceased individuals to receive transportation, and PMHP managed care services. Unallowable capitation payments were made to transportation, and PMHP contractors, resulting in waste. Utah Medicaid did not detect or recover the unallowable payments made months after a known death because the CAP-6 surveillance and utilization report was not working.

Recommendations

UOIG recommend that DHHS:

2.1 Establish a plan to evaluate the functionality of MMCS and MMIS processes that will transfer to the new PRISM system such as posting dates of death; the automated recoupment process; and date of death validation before enrollment in managed care plans or transportation and payment of capitations.

2.2 Take action to review and prioritize adequate oversight of eligibility determinations and provide assurance that DWS is compliant with federal and state laws, regulations, and policies requiring that eligibility be maintained accurately in accordance with 42 CFR 431.10(c).

2.3 Review eligibility policies related to the death of Medicaid members for completeness and clarity; including provisions specific to public health emergencies.

2.4 Coordinate with DWS to review procedures related to the death of Medicaid members to ensure the procedures adequately implement policy, clearly state responsibilities, and provide detailed guidance on required actions.

2.5 Coordinate with DWS to distribute and provide adequate training to eligibility workers on policies and procedures reviewed in response to Recommendation 2.3 and 2.4.

2.6 Coordinate with DWS and DTS to ensure that eREP programming is in place and working to prevent Medicaid eligibility from issuing for individuals with a date of death entered in the system.

2.7 Coordinate with DWS to implement proactive monitoring of Medicaid eligibility issued after death as part of DWS's agreement with DHHS to correctly maintain eligibility for all Medicaid Assistance programs. Such ongoing monitoring could include DWS generating a report of Medicaid eligibility cases issued after death.

FINDING 3 Contracts Did Not Consistently Require the ACO Contractors to Report Excess Capitation Payments

Utah Medicaid contracts with health plans to provide services to eligible Medicaid members living in certain counties. During the audit scope, Utah Medicaid contracted with four ACO health plans and four Utah Medicaid Integrated Care plans. The contract period for the four ACO health plans is January 1, 2018 through December 31, 2022, and the contract period for the four UMIC plans is January 1, 2020 through December 31, 2024.

Federal law states that contracts between the State Medicaid Agency and each Managed Care Entity (MCE) must ensure that the MCE contractors report to the State, within 60 calendar days, when they have identified capitation payments in excess of the amounts specified in the contract.[14]

Between the execution of the four ACO contracts and September of 2021, the parties signed eight contract amendments. The contracts properly required that each ACO contractor report to the State within 60 calendar days any capitation payments it identifies that exceed the amounts specified in the contract. However, two of the eight contract amendments did not include this required provision.

For a six-month period, between January 1, 2019 and July 1, 2019, Utah Medicaid did not meet federal requirements. The contracts between Utah Medicaid and the four ACO contractors did not require the ACOs to report excess capitation payments within 60 calendar days of identification.

Importantly, in subsequent contract amendments, Utah Medicaid included the reporting requirement in the ACO contracts in place during the audit scope.

During the time period reviewed, the UMIC contracts and contract amendments required the contractors to report excess capitation payments in compliance with the federal law.

Recommendations

UOIG recommends that DHHS:

3.1 Evaluate its current contract amendment process to identify ways to strengthen the process to ensure that all federal requirements are included in each contract amendment.

3.2 Document and distribute to staff any new or amended procedures, desk aids, or forms created in response to Recommendation 3.1.

[14] Managed Care, 42 CFR § 438.608(c)(3). https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-part438.pdf.

Observation 1 — Unaddressed Changes in Circumstance Delayed Eligibility Determinations

UOIG observed that eligibility workers did not always take action on eligibility changes reported to DWS. Unlike the eligibility factors discussed in Finding 2, in these cases eligibility workers postponed entering dates of death in eREP as well as termination of Medicaid eligibility. Utah Medicaid enrolls members in managed care plans, and pays capitations and fee-for-service claims based on eligibility information from DWS. When Utah Medicaid receives dates of death from DWS, Utah Medicaid uses the information to identify and recover capitations paid after death.

Medicaid members and caretakers of members are responsible to report changes in circumstance that may affect eligibility. During fieldwork, UOIG identified cases where family members or caregivers reported the death of a Medicaid member to DWS. In some cases, eligibility workers took no action requiring that family member or caregiver provide proof of the death before entering the date of death and terminating eligibility.

Prior to the PHE, eligibility workers did not always act when the department received returned mail with no forwarding address. Policy in place during the audit scope instructs eligibility workers to send written denial or closure notice when the post office returns mail with no forwarding address.[15] Eligibility Workers did not send notice or take action to start the process of terminating Medicaid eligibility.

[15] Eligibility policy includes a special rule for Medicaid members on general delivery method for mail. The case examples noted in this observation were not on general delivery for mail.

Other Matters

During the audit fieldwork, UOIG identified areas of risk outside the audit scope. To accomplish UOIG's mission of protecting taxpayer dollars by identifying fraud, abuse, waste risks and vulnerabilities in the State Medicaid Program, the UOIG Planning Committee meets regularly to review and prioritize reported problems, concerns, and areas of risk. UOIG made note of each of the areas of risk listed below, and may pursue them separately in a future audit, investigation, inspection, evaluation, or review.

Fee for Service Claims

Although FFS claims were not part of the audit scope, UOIG—at the request of Utah Medicaid—generated a data query to review FFS claims. The query showed $67,905.73 in FFS claims paid after the death of Medicaid members between September of 2018 and September of 2021(see Appendix B). More analysis would be required to determine if the FFS claims were unallowable. FFS claims submitted directly to Utah Medicaid for services that took place after the death of a Medicaid member could indicate improper, abusive, or fraudulent billing.

Contract Management

In reviewing the ACO and UMIC contracts for the federal requirements, UOIG identified a potential contract weakness. The contract and contract amendment effective dates were regularly prior to the execution dates. The number of dates between the effective date and signature ranged from 1 to 464 days. The state may limit its ability to enforce contracts and contract amendments by allowing the effective dates to precede the execution date.

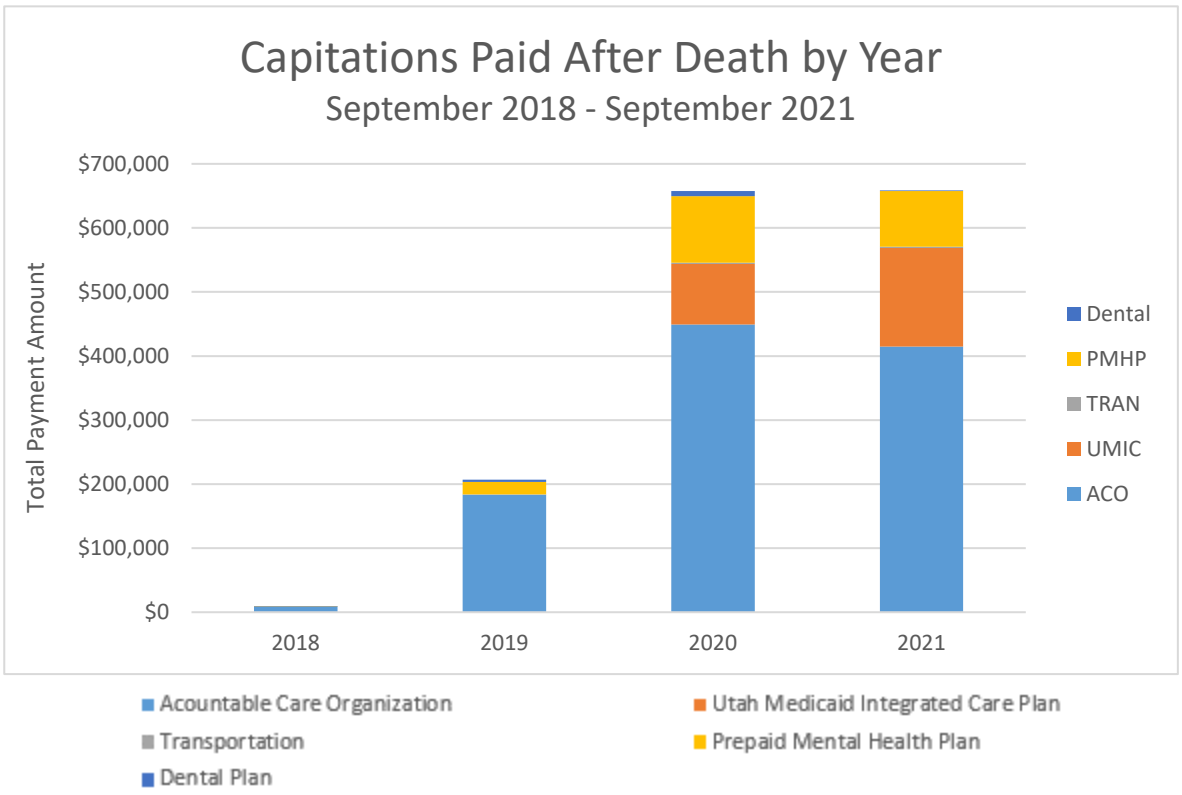
Similarly, UDOH and DWS signed the Medical Assistance Operating Memorandum of Agreement in May and June of 2017, over 4 years after the agreed service period started. The MOA covers a 20-year service period from April 1, 2013 to March 31, 2033.

Invalid Data in Systems

UOIG observed that systems did not detect invalid data. In one instance, MMIS, MMCS, and eREP allowed for entry of a date of death that preceded the member's date of birth. Although the date of death was in the correct format, the systems did not detect the date as out of range. In another example, eREP allowed for entry of an impossible date of death. Detection of invalid data ensure data accuracy and supports the subsequent business processes.

Appendix A: Capitations Paid after Death

The figure below depicts capitations paid after death between September 1, 2018 and September 30, 2021 by contractor type. The vertical bars show the total capitations paid.

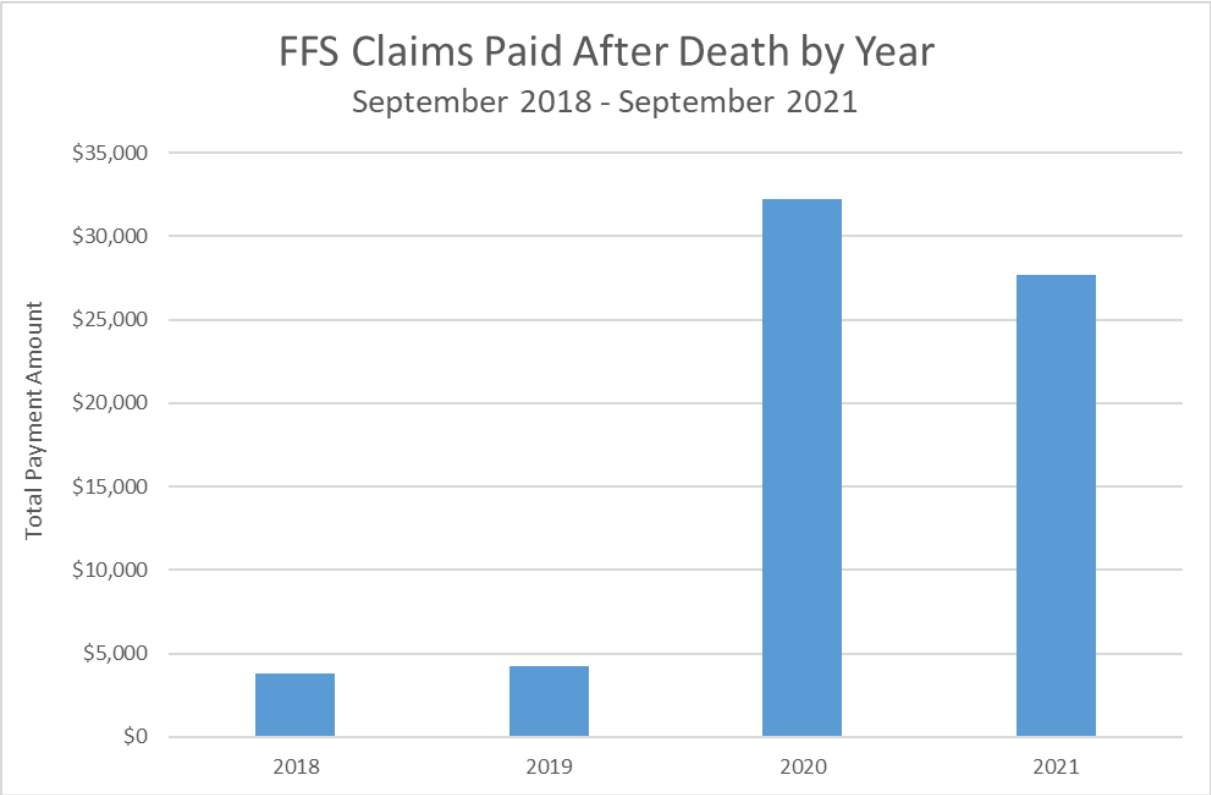


Source: UOIG Data Query

Appendix B: FFS Claims Paid after Death

The figure below depicts fee-for-service claims paid after death between September 1, 2018 and September 30, 2021. The vertical bars show the total amounts paid.

Note: FFS claims were not part of UOIG's audit scope. More analysis would be required to determine if the FFS claims were unallowable.



Source: UOIG Data Query

GLOSSARY

Acronym	Term/Definition
ACO	Accountable Care Organization
BFS	Bureau of Financial Services
CAA	Consolidated Appropriations Act, 2023
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
	Data Warehouse *Data repository containing claims, utilization, costs, member eligibility, dates of death, provider enrollment, and other information for data query and reporting.*
DHHS	Utah Department of Health and Human Services
DOT	Division Operations Tracker *Tracking component in MMCS used by Utah Medicaid and DTS to document and submit research requests, modifications, and changes requests for multiple systems.*
DTS	Department of Technology Services
DWS	Department of Workforce Services
	Eligibility Worker *Employees of the Department of Workforce Services who determine eligibility for Medicaid.*
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
eREP	Electronic Resource and Eligibility Product *Utah's eligibility system used for case management, eligibility determination an issuance.*
FEAR	Forced Evidence and Reassessment *Forced eligibility function within the eREP system.*
FFCRA	Families First Coronavirus Response Act
FMAP	Federal Medical Assistance Percentage

HHS	U.S. Department of Health and Human Services
MCE	Managed Care Entity
MMCS	Medicaid Managed Care System
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
MQM	Medical Quarterly Meeting
OMHC	Office of Managed Healthcare
PHE	Public Health Emergency
PID	Personal Identification
PMHP	Prepaid Mental Health Plan *Managed care plan that covers impatient and outpatient mental health services and outpatient substance use disorder services.*
PRISM	Provider Reimbursement Information System for Medicaid
RFA	Request for Action
SOP	Standard Operating Procedure
SSA	Social Security Administration
SURS	Surveillance and Utilization Reports
UDOH	Utah Department of Health
UMIC	Utah Medicaid Integrated Care
UOIG	Utah Office of Inspector General
UTA	Utah Transit Authority
	Waste *The act of using or expending a resource carelessly, extravagantly, or to no purpose. Waste includes activity that does not constitute abuse or necessarily involve a violation of law; and relates primarily to mismanagement, an inappropriate action, or inadequate oversight.*

MANAGEMENT RESPONSE

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

March 7, 2023

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Inspector General Cottrell:

On behalf of the Department of Health and Human Services, thank you for the opportunity to respond to the audit titled *A Performance Audit of Capitation Payments Made after the Death of Medicaid Members (A2022-01)*. I appreciate the effort and professionalism of you and your staff in this review. The final product reflects a significant effort and time of the DHHS staff collecting information for OIG review, answering questions, and planning changes to improve the program. This audit and its responses will result in a better, more efficient program.

DHHS agrees with the recommendations in this report. DHHS is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Jennifer Strohecker (Mar 10, 2023 13:31 MST)

Jennifer Strohecker, PharmD, BCPS
Medicaid Director
Director, Division of Integrated Healthcare

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Response to Recommendations

Finding 1: *Utah Medicaid did not Regularly Identify and Recover Capitations Paid after the Death of Medicaid Members*

Recommendation 1.1

UOIG recommends that DHHS recover unallowable capitation payments made on behalf of deceased Medicaid members during and after the audit scope.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will recover unallowable capitation payments made on behalf of deceased Medicaid members. Any capitation payments that cannot be recovered through available means by DHHS will be referred to the UOIG for recovery as appropriate.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 1.2

UOIG recommends that DHHS determine a baseline of typical numbers reported on the SURS-006 and SURS-009 reports for ongoing trend analysis to support early detection of impediments to Utah Medicaid's procedures for recovering unallowable capitations made on behalf of deceased Medicaid members.

Department Response:

DHHS partially agrees with this recommendation.

What: DHHS will review available data sources after the PRISM go-live to determine the best sources for information that can provide this trend information. It is unclear whether the SURS-006 and SURS-009 will exist or exist in their current form after go-live and so DHHS will need to conduct that evaluation before committing to use those two reports for this purpose.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 1.3

UOIG recommends that DHHS develop a process to aid timely detection of incomplete or erroneous files from DWS, which could include determining a baseline for the typical number of dates of death reported by DWS in the nightly file to support ongoing monitoring.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will develop a process to aid timely detection of incomplete or erroneous files from DWS.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 1.4

UOIG recommends that DHHS review and update SOP, including the Remediating Overpayments for Claims/Encounters that Occurred after a Member's Death SOP, to reflect current business practices, responsibilities, and actions taken.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will review and update the Remediating Overpayments for Claims/Encounters that Occurred after a Member's Death SOP, to reflect current business practices, responsibilities, and actions taken.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 1.5

UOIG recommends that DHHS establish a regular ongoing process to review SOP, after implementation, to reflect changes to business practices, responsibilities, and actions taken.

Department Response:

DHHS agrees with this recommendation.

What: DHHS establish a regular ongoing process to review the Remediating Overpayments for Claims/Encounters that Occurred after a Member's Death SOP after implementation, to reflect changes to business practices, responsibilities, and actions taken.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 1.6

UOIG recommends that DHHS document, distribute, and train staff on any new or amended procedures stemming from action taken in response to Recommendations 1.2, 1.3, 1.4, and 1.5.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will document, distribute, and train staff on any new or amended procedures stemming from action taken in response to Recommendations 1.2, 1.3, 1.4, and 1.5

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 1.7

UOIG recommends that DHHS coordinate with DWS and DTS to determine if it is possible to automate the process of emailing, uploading and processing date of death information instead of manually performing these tasks.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will coordinate with DWS and DTS to determine if it is possible to automate the process of emailing, uploading and processing date of death information instead of manually performing these tasks.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Finding 2: *Utah Medicaid Did Not Always Stop Issuing Capitation Payments after the Death of Medicaid Members*

Recommendation 2.1

UOIG recommends that DHHS establish a plan to evaluate the functionality of MMCS and MMIS processes that will transfer to the new PRISM system such as posting dates of death; the automated recoupment process; and date of death validation before enrollment in managed care plans or transportation and payment of capitations.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will establish a plan to evaluate the functionality of MMCS and MMIS processes that transferred to the new PRISM system such as posting dates of death; the automated recoupment process; and date of death validation before enrollment in managed care plans or transportation and payment of capitations.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 2.2

UOIG recommends that DHHS take action to review and prioritize adequate oversight of eligibility determinations and provide assurance that DWS is compliant with federal and state laws, regulations, and policies requiring that eligibility be maintained accurately in accordance with 42 CFR 431.10(c).

Department Response:

DHHS agrees with this recommendation.

What: With the merger of Health and Human Services in 2022, DHHS no longer has staff able to review DWS eligibility on a larger scale. DHHS will ask DWS' Performance Review Team (PRT) to conduct an off-cycle audit of eligibility where Medicaid members have died.

When: Any off-cycle audit would need to occur after the calendar year 2023 when the current MEQC pilot audit concludes.

Contact: Jeff Nelson, Director, Office of Eligibility Policy, jeffnelson@utah.gov

Recommendation 2.3

UOIG recommends that DHHS review eligibility policies related to the death of Medicaid members for completeness and clarity; including provisions specific to public health emergencies.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will continue to provide oversight to ensure eligibility policy is clear for DWS eligibility workers.

When: July 1, 2023

Contact: Jeff Nelson, Director, Office of Eligibility Policy, jeffnelson@utah.gov

Recommendation 2.4

UOIG recommends that DHHS coordinate with DWS to review procedures related to the death of Medicaid members to ensure the procedures adequately implement policy, clearly state responsibilities, and provide detailed guidance on required actions.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will continue to provide oversight to ensure DWS eligibility procedures are clear for DWS eligibility workers.

When: July 1, 2023

Contact: Jeff Nelson, Director, Office of Eligibility Policy, jeffnelson@utah.gov

Recommendation 2.5

UOIG recommends that DHHS coordinate with DWS to distribute and provide adequate training to eligibility workers on policies and procedures reviewed in response to Recommendation 2.3 and 2.4.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will work with DWS to provide updated training for eligibility workers. Due to the unwinding of continuous eligibility, the Division will need additional time to work with DWS to train staff appropriately.

When: July 1, 2024

Contact: Jeff Nelson, Director, Office of Eligibility Policy, jeffnelson@utah.gov

Recommendation 2.6

UOIG recommends that DHHS coordinate with DWS and DTS to ensure that eREP programming is in place and working to prevent Medicaid eligibility from issuing for individuals with a date of death entered in the system.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will work with eREP to ensure that proper programming is in place or that any required changes required are considered and implemented.

When: October 1, 2023

Contact: Jeff Nelson, Director, Office of Eligibility Policy, jeffnelson@utah.gov

Recommendation 2.7

UOIG recommends that DHHS coordinate with DWS to implement proactive monitoring of Medicaid eligibility issued after death as part of DWS's agreement with DHHS to correctly maintain eligibility for all Medicaid Assistance programs. Such ongoing monitoring could include DWS generating a report of Medicaid eligibility cases issued after death.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will help DWS to develop and implement a report to help monitor and prospectively look for errors related to eligibility issued after death.

When: January 1, 2024

Contact: Jeff Nelson, Director, Office of Eligibility Policy, jeffnelson@utah.gov

Finding 3: *Contracts Did Not Consistently Require the ACO Contractors to Report Excess Capitation Payments*

Recommendation 3.1

UOIG recommends that DHHS evaluate its current contract amendment process to identify ways to strengthen the process to ensure that all federal requirements are included in each contract amendment.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will evaluate its current contract amendment process to identify ways, if necessary, to strengthen the process to ensure that all federal requirements are included in each contract amendment.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

Recommendation 3.2

UOIG recommends that DHHS document and distribute to staff any new or amended procedures, desk aids, or forms created in response to Recommendation 3.1.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will document and distribute to staff any new or amended procedures, desk aids, or forms created in response to Recommendation 3.1.

When: September 30, 2023

Contact: Gregory Trollan, Director, Office of Managed Healthcare, gtrollan@utah.gov

EVALUATION OF MANAGEMENT RESPONSE

UOIG appreciates the response provided by DHHS to this audit. Based on its response, DHHS is taking measures to address the audit findings.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

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UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services will protect taxpayer dollars by identifying fraud, abuse, and waste risk and vulnerabilities in the State Medicaid Program and by taking action to mitigate or eliminate those risks.

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