

Report to the Legislature's  
Executive Appropriations Committee  
Social Services Appropriations Subcommittee  
Health and Human Services Interim Committee

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Utah Medicaid Waiver Request

Payment and Service Delivery Reform

June 1, 2011



## **Background**

Senate Bill 180, passed during the 2011 Legislative General Session, directed the Utah Department of Health to develop a Medicaid reform proposal to maximize the replacement of the fee-for-service model with one or more risk-based delivery models. The proposal was to include, among other requirements, the following key provisions:

- Restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that maintain or improve recipient health status,
- Restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to maintain or improve their health and use providers who deliver appropriate services at the lowest cost,
- Pay providers for episodes of care rather than individualized services,
- Limit the rate of growth in per-patient-per-month General Fund expenditures for the Medicaid program to the rate of the growth in General Fund expenditures for all other programs,
- Develop the proposal with the input of stakeholder groups representing those who will be affected by the proposal, and
- Submit a written report on the development of the proposal to the Legislature's Executive Appropriations Committee, Social Services Appropriations Subcommittee, and Health and Human Services Interim Committee no later than June 1, 2011.

## **Key Stakeholders Public Working Group Meetings**

In compliance with the requirements of SB 180, the Department convened several working group meetings to discuss key components of the reform proposal. The following is a summary of those meetings.

| <u>Date and Time</u>                       | <u>Primary Discussion Topics</u>              |
|--|---|
| Mar 30 <sup>th</sup> 9:00 AM – 11:00 AM    | General concept summary for the waiver        |
| April 6 <sup>th</sup> 8:30 AM -- 10:00 AM  | Integrating the pharmacy benefit into the ACO |
| April 13 <sup>th</sup> 4:00 PM -- 5:30 PM  | Cost sharing                                  |
| April 20 <sup>th</sup> 3:30 PM -- 5:00 PM  | Capitated rate setting process                |
| April 27 <sup>th</sup> 8:30 AM -- 10:00 AM | Client incentives for healthy behaviors       |
| May 4 <sup>th</sup> 3:30 PM -- 5:00 PM     | Provider assessment and UPL preservation      |
| May 11 <sup>th</sup> 3:30 PM -- 5:00 PM    | Quality Assurance                             |

Additionally, the Department will hold public hearings on the waiver proposal document on June 7, 2011 from 10 AM to 12 PM and on June 9, 2011 from 4 PM to 6 PM.

## **Reform Proposal Introduction and Description**

It is no secret that medical costs continue to rise. In Utah Medicaid, growth rates have exceeded the State's annual revenue growth rate for the past two decades. Accordingly, the State is concerned about the long-term sustainability of the Medicaid program. While Medicaid is a unique entitlement health care program that has various federal mandates and regulations associated with it, much of the increased costs are due to conditions prevailing in the health care industry as a whole. Health care industry costs continue to outpace overall inflation due to many factors, among those is a reimbursement structure that provides financial incentives for overutilization of health care services. In an effort to preserve the long-term viability of the Medicaid program and to establish a standard for better control over increasing costs in health care, the State of Utah is submitting this Medicaid reform proposal that implements payment reforms and more appropriately aligns financial incentives in the health care system. Not only will the financial incentives change, but the quality of health care will be maintained or enhanced.

In the 2011 General Session, the Utah State Legislature passed Senate Bill 180, Medicaid Reform. This new statute provides Utah's Single State Agency, the Department of Health, with overall guidance and direction for creating and submitting this waiver proposal. In addition, it contains provisions that grant Utah Medicaid preferential funding consideration when expenditures are less than appropriated funding or historical growth rate targets. The residual amount is deposited into a newly created "Medicaid Growth Reduction and Budget Stabilization Account" (Stabilization Account). In circumstances in which the amount of general fund growth available for Medicaid and the balance in the Stabilization Account are insufficient to meet the growing needs in the program, then the State would implement service reductions from a prioritized list of health services as has been done in the Oregon Medicaid program.

### **Accountable Care Organizations (ACOs)**

The State of Utah has contracted with managed care organizations under a variety of different contracting arrangements over the past two decades. While the State believes that these contracts have added value in delivering quality care to Medicaid clients in controlling costs over the years, the State also believes that converting these contracts to an Accountable Care Organization (ACO) contract model can better align financial incentives to control costs and to deliver appropriate care to clients. This reform proposal will replace the current Utah Medicaid managed care model with the Utah Medicaid ACO model. The Utah Medicaid ACO model is distinct from the model adopted by the Medicare program. For the purposes of its Medicaid program, the State is willing to consider as an ACO any organization that can (1) manage risk and accept a capitated premium for its services, (2) distribute payments across the continuum of scope of service providers and (3) meet the quality standards required under contract.

The ACO contracts would essentially provide the ACOs with monthly risk-adjusted, capitated payments based on enrollment and create an environment in which the ACOs deliver necessary and appropriate care, while demonstrating that quality of care and access to care are maintained or improved. ACOs would also have more flexibility to distribute payments throughout their network of providers. Rather than reimbursing providers based on the units of service delivered, the ACO could make payments for delivering the necessary care to a group of Medicaid enrollees for a specified period of time. The ACO also could choose to distribute incentive payments through its network of providers when various cost-

containment, quality or other goals are met. By reforming payments at each level of health care delivery, the ACO will better align the incentives for all participating providers.

While an ACO model may at first seem quite similar to a traditional managed care, the key differences are (1) that the ACO payments eliminate the incentives to provide excess care and (2) the contracts will be maintained only if the ACO meets established quality and access criteria.

A centerpiece of the ACO care delivery model is a “Medical Home.” Each Medicaid client would have access to a primary care provider or a group of primary care providers who would deliver care and also coordinate the client’s use of medical services throughout the ACO network of providers. The client would be expected to utilize services within the ACO provider network. Each ACO would create, through contract or employment, a sufficient network of health care providers to deliver the necessary care for the enrolled Medicaid clients. Medicaid clients would be able to select from at least two ACOs at their time of initial program enrollment and have an option once per year of switching health plans during an “open enrollment” period.

### **Risk Adjusted, Capitated Payments**

The State plans to use risk-adjusted, capitated payments for all of its Accountable Care Organization contracts. These payments consist of actuarially certified rates based on major categories of Medicaid eligibility (i.e., children, pregnant women, elderly, etc.) and the severity of illness prevalent in the enrolled population.

Actuarial certification of rates is made by actuaries who calculate historic cost and trend amounts for enrollees’ health care utilization in the various categories of eligibility. These calculations are based on claims and/or encounter data from the providers delivering the care.

The State wants to ensure that after the initial round of actuarial rate setting has been completed for the implementation of this reform, that the resulting capitated rates can serve as the baseline for future years’ reimbursement rates. As a foundational principle of this reform, the State wants to eliminate the incentive for providers to deliver care based on reimbursable or billable services. As a result, the State wants and expects that ACOs and their associated providers will begin delivering care in a manner that will not result in as many billable services being delivered. However, under the current actuarial rate setting process, this could result in ongoing reductions in reimbursement rates. Consequently, the State has worked with its contracted actuaries to develop a data gathering model that will meet the needs of the new ACO structure, while still meeting the relevant rate-setting regulations.

### **Funding and Special Consideration**

In the implementation of this reform proposal, the State is interested in keeping the current provider reimbursement levels intact. There is no interest in reducing the reimbursement levels for providers willing to venture into this new reform proposal with the State. In general, the State envisions retaining the current level of Medicaid funding in the system and realign incentives with the expectation that future program growth will be more comparable with State revenue growth.

One way the State supports current reimbursement levels is a hospital provider assessment. Additionally, the State makes supplemental payments to its teaching hospital. The State wants to make sure that the federal funding associated with these payments is not jeopardized as a result of this reform proposal's use of ACOs. The State will restructure its hospital assessment base and place the majority of the previous quarterly distribution payments into the new ACO capitated rates.

### **Budget Management Strategy**

One of the overall goals of this reform is to bring Medicaid growth more in line with overall State revenue growth. In addition to the reform proposal's conversion to ACO contracts is a budget management strategy that sets specific Medicaid growth targets. Those targets would be linked to long-term State revenue growth figures.

It is the intent of the State that in years when Medicaid's growth was not as high as the targets that the difference would be deposited into the Medicaid Growth Reduction and Budget Stabilization Account. In years when Medicaid growth exceeds general fund growth targets, then the State would like to use a plan similar to that used by the Oregon Medicaid program to reduce benefits on a pre-determined schedule.

### **Out-of Network Payment Limitations**

Another way to reduce health care costs is to place limits on out-of-network charges for Medicaid clients. Currently, when an individual seeks urgent care out of his or her selected managed care network, the treating provider will charge the client's health plan a higher fee. This reform proposal seeks to place limits on such charges for Medicaid clients.

### **ACO Scope of Benefits**

The current Utah Medicaid managed care contracts generally include only inpatient hospital, outpatient hospital, physician services and other ancillary services. Pharmacy, dental, mental health and long-term care services are "carved out" of or excluded from these contracts. The reform proposal looks to include non-behavioral health pharmacy benefits in the ACO benefit package. The State believes that including these pharmacy benefits in the ACO scope of services will better align the incentives of prescribers with the goals of the State.

### **Quality of Care Standards**

Utah Medicaid also intends to maintain quality of care monitoring of the ACOs through the continued use of HEDIS data. The agency will utilize existing processes and procedures which have been established and guided by federal regulation applicable to managed care organizations. In addition, in order to renew a contract authorized under this 1115 Waiver, the ACOs will be required to participate in quality improvement activities and adhere to metrics specific to an ACO as yet to be developed with input from providers and client advocates as coordinated and promulgated by the Utah Department of Health.

### **Individual Accountability and Responsibility**

This proposal seeks to engender an enhanced sense of responsibility and accountability on the part of Medicaid clients. Medicaid clients should participate more in the cost of their health care. The State is interested in replacing archaic limits on Medicaid copayment amounts.

### **Client Incentives**

An important aspect for enhancing physical well-being and reducing service utilization is patient compliance with recommended treatment. Increasing patient compliance results in better outcomes, lower costs and long term stabilization of chronic conditions. This proposal would allow an ACO to offer some incentives that will help increase patient compliance for victims of chronic disease states. Two of these proposed incentives would be (1) limiting or waiving copayments and (2) granting limited cash awards for compliant behavior, which reduces the need for additional service.

### **Premium Subsidy Option**

Under a federal waiver, the State currently offers a health insurance premium subsidy to low-income individuals who are not eligible for Medicaid coverage. Medicaid-eligible individuals do not have the option to enroll in this premium subsidy program. This reform proposal seeks to allow a Medicaid client the option to receive a premium subsidy and purchase a health insurance product through the State's Health Insurance Exchange as an alternative to enrolling in the Medicaid ACO product.

### **Geographic Implementation**

The State currently has three managed care organizations providing services to Medicaid clients in the State's four most populous counties: Salt Lake, Davis, Utah and Weber. The reform proposal looks to implement the ACO contracting model in these same four counties.

### **Implementation Time Frames**

The proposed date for implementation is **July 1, 2012**. This timetable should allow the State and health care providers some planning and implementation time for realigning models of care delivery and updating payment and monitoring systems. Therefore, the State requests timely consideration for this proposal.

### **Goals and Objectives**

The primary goal of this reform proposal is to significantly reduce the rate at which Utah Medicaid expenditures are increasing. Stated another way, reduce the slope of the curve reflecting the rate of increasing expenditures. Similarly, a companion goal is that expenditures under the ACO model would be measurably less than what otherwise would have been by retaining the current system.

Another main goal of the reform is to align incentives in such a way that the delivery patterns move away from billable events and to focus more on patient outcomes and the quality of care.

What the Utah proposal does is incorporate what is working well in the current system, adds new innovative aspects, and modifies the delivery and reimbursement system to conform to the ACO model.