UTAH DEPARTMENT OF HEALTH BUDGET INCREASE SUMMARY - FY 2016 BUILDING BLOCKS

Items included in Governor's Budget

Budget Increase Description	One Time General Fund	Ongoing General Fund	Comments	Federal Funds	Total	FTEs
Early Intervention/Baby Watch	$ 220,000		Caseload growth was funded in FY13 with one-time funding. This request is to provide ongoing funding for a building block already approved by the legislature and the Governor.		220,000	
Health Facility State Licensing Staffing	$ 86,900		One new licensing staff to support survey of assisted living facilities, personal care agencies, psychiatric hospitals and other licensed-only health facilities. More timely inspections of all state licensed facilities.	0	86,900	1.0
Health Facility Certification Staffing	$ 56,000		Nursing Facility Surveyors. Increase budget to support the inspections required to license and certify the increasing numbers of nursing facilities in the state. This meets state licensing and federal Medicare/Medicaid certification requirements.	301,693	357,693	4.0
Prescription Drug Misuse, Abuse, and Overdose Prevention	$ 500,000		Prescription drug abuse has resulted in premature deaths, contributed to significant economic burdens through increased health care costs and substance abuse treatment, and fueled the rise in heroin addictions. Prior program funding of $500,000 resulted in a 27.6% decrease in prescription opioid overdose deaths from 2007 to 2010. Since 2010, there has been no concerted public health effort to address the issue of opioid abuse, misuse, and death.		500,000	
Restore Dental Coverage for Elderly and Persons with Disabilities		$ 3,226,000	Funding to expand dental coverage to include some preventive and restorative procedures, including routine exams, X-rays, cleanings, crown and full dentures for the elderly and persons with disabilities.	7,691,000	10,917,000	
Nursing Home Rates (Hospice)		$ 2,000,000	Ongoing funding to have the State continue the nursing home reimbursement levels established for FY2015.	4,780,800	6,780,800	
MMIS Replacement (One-Time)	$ 3,500,000		One-Time $3.5 million in FY2015. Based on expected deliverables for FY2015.	31,500,000	35,000,000	
Technology Dependent Waiver Waiting List		$ 366,000	FFP: 70% - Funding to enroll 10 additional clients in the Technology Dependent Waiver. There are currently 75 applicants on a waiting list for services, 10 of whom are currently residing in South Davis, Country Life or are inpatient at Primary Children's Hospital. Providing services in the waiver rather than in facilities is a less costly, less restrictive option.	854,000	1,220,000	
ACA Provider Tax		$ 1,016,500	This building block requests ongoing funding to have the State continue the provider payments related to the Affordable Care Act tax.		1,016,500	
Consensus Process will provide funding levels for: FMAP - Mandatory & Optional, Forced Provider Inflation, Caseload Growth, ACO Inflationary Increases, CHIP caseload growth		consensus	Consensus Process will provide funding levels for: FMAP - Mandatory & Optional, Forced Provider Inflation, Caseload Growth, ACO Inflationary Increases, CHIP caseload growth		consensus	
Healthy Utah Savings		$ (4,500,000)	When Utah implements the Healthy Utah Plan, the Department of Health will be able to close the Primary Care Network (PCN) program. This close will result in program savings.		(4,500,000)	
Healthy Utah Service Costs	$ (4,702,900)	$ 19,943,400				
Healthy Utah Administration Increase	$ 200,000	$ 658,500	Implementing Healthy Utah is expected to increase enrollment by over 90,000 members. The department is seeking this increase to cover the related administrative expenses that are beyond the existing operations and budgets.	658,500	1,517,000	

Form 4000 Incremental Budget Change Request

Submit a Form 4000 for each incremental budget change request invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15/ FY 16 Budget Guidelines for instructions).

Agency: 270 Dept of Health

Request Title: Baby Watch Early Intervention One-time Funds Change to Or

Appropriation Code: LFJ Child Development

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	0	0	220,000	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	0	0	
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	Other Source Notes
Total	0	0	220,000	

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
HH Other Charges/Pass Through	0	0	220,000
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	0	0	220,000

Brief Description of Request:

$1,763,700 in on-going and $220,000 in one-time funds (total $1,963,700) were awarded to the Baby Watch Early Intervention Program (BWEIP) in the 2013 General Legislative session. These funds were used for caseload growth. The funding was distributed to 15 local contract providers. The funding enabled the BWEIP to preserve current program eligibility criteria and fund program growth.

The 2014 General Legislature authorized the $220,000 one time funds to continue for SFY15. Request to make these funds on-going.

New FTE	0
Agency Priority	

Describe any legislation that is necessary to implement this request.	NA
How will the proposed change impact QT/OE (if a Success System has not been formally designated, describe generally how this request will influence both quality throughput and operational expenses -- e.g. QT will increase X%, OE will increase Y?)	This request will enable the BWEIP to continue providing services to all children who meet program eligibility. The program is not allowed to maintain a waiting list. If the total amount of funding available for services is not maintained, the number and type of services will be reduced. The number and type of services available is directly related to the quality of child developmental outcomes.
Who are the stakeholders associated with this request? How will they be impacted if the request is funded? How will they be impacted if the request is not funded?	The BWEIP distributes funds to 15 local early intervention program agencies. These agencies provide the early intervention services to children and families. If the state funding is reduced, they will experience a decrease in their budgets. Approximately ninety percent of their budgets are alloted for personnel. Potentially, there could be increased caseloads or loss of jobs for early intervention service providers.

Business Case For Incremental Budget Change Request

Submit a Business Case form and separate justification detail for each incremental budget change request that is not invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15 / FY 16 business case instructions).

Agency: 270 Dept of Health

Request Title: Health Facility State Licensing Staffing

Appropriation Code: LFH Facility Licensure, Certification and Resident Assessment

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	86,910	0	86,910	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	0	0	
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	Other Source Notes
Total	86,910	0	86,910	

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
AA Personnel Services	81,080	0	81,080
BB Travel/In State	2,000	0	2,000
DD Current Expense	2,625	0	2,625
DD Current Expense	1,205	0	1,205
	0	0	0
	0	0	0
Total	86,910	0	86,910

Brief Description of Request:

This request is to provide salary, benefits, and fixed costs for 1 FTE in Health Facility Licensing. This is to provide a surveyor for inspection of state licensed only facilities.
The Bureau will accomplish 25 more inspections per year with increased staff. This one staff person will add to the teams of health professionals that inspect health facilities as a group. The Bureau also expects to be able to respond to licensing complaints in a more timely manner. Complaints are triaged depending on the severity of the issue. Serious complaints need to be investigated within 48 hours. The

Agency Priority:

New FTE: 1

FY 15 / FY 16 BUDGET GUIDELINES

Business Case

Policy and Operational Justification

Budget Request Title: Health Facility State Licensing Staffing
Agency Budget Request Priority:
Brief Description of Budget Change
Increase budget to support the inspections required to license and certify the increasing numbers of health care facilities in the state. This meets state licensing and federal Medicare/Medicaid certification requirements.

Detail on Budget Change Request (respond to the following questions)

1. Background and Problem Definition

a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

The state program does not currently function to the need. The number of health care facilities has increased from 427 in the year 2000, to 880 at the end of 2013. Staffing for licensing inspections has decreased from 8 surveyors in the year 2004 to 3 surveyors currently. State licensing requirements for inspection are not currently being met, as inspections for assisted living facilities have gone from being inspected yearly to every 4-5 years.

b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

The problem is an increase in the number of health care facilities that require inspections for state licensing.

c. What population is being served?

The population is anyone that receives care in licensed health care facilities in the state. This includes the elderly and other vulnerable populations in assisted living, nursing facilities, hospitals, surgery centers, dialysis centers, home health agencies, hospice agencies, personal care agencies and others.

d. Explain why this activity constitutes a proper role of government / what market failure justifies government intervention.

Government is required to ensure the health and safety of patients and residents in health care facilities, and is charged with the licensing process as a way to ensure and enforce health laws.

e. Explain why the state is the proper level of government to handle this issue.

The state is the authority for the licensing of health care facilities – as outlined in the Utah Code 26-21.

f. What other agencies should be involved in dealing with this issue?
N/A

g. How are outcomes expected to change relative to current practice if the item is not funded?

State licensed facilities will not receive timely inspections to ensure the health and safety of patients/residents. There will not be staff to investigate complaints in health care facilities. Currently the Bureau investigates about 100 licensing complaints/yr. The complaints address constituent concerns from improper discharge to abuse issues.

2. QT/OE and SUCCESS Initiative principles

a. How does the budget change request improve the ratio of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

This budget increase will increase the numbers of inspections for health facilities in the state, which will ensure that patients/residents of such facilities will be more protected. The Bureau expects to accomplish 25 more inspections per year with increased staff. This one staff person will add to the teams of health professionals that inspect health facilities as a group. The bureau also expects to be able to respond to licensing complaints in a more timely manner. Complaints are triaged depending on the severity of the issue. Serious complaints need to be investigated within 48 hours. The bureau expects to be able to respond to all serious complaints within time frames. Licensing of health providers requires more adequate staffing to ensure that providers that carry a license are meeting the standards set forth by the state to operate. Outcomes will show increased inspections, which relates to the number of serious citations given during these surveys. This all shows that residents and patients of health care are protected and safe.

b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services) (T), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

There is ongoing and significant growth in the health care industry, particularly in the sector that serves our elderly population (e.g., nursing homes, assisted living facilities, home health care). There has been a 106% increase in these numbers since 2000 without an increase in staffing to support it. Health care will continue to grow in the state as the population grows and demands access to services.

c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings? If savings, are they hard cost savings or foregone costs / cost avoidance?

This request will not generate future costs or savings.

d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

This is the first request in funding for this program since the 1990s. The state should expect to support the licensing and certification needs in the future if they increase, so that current laws can be met.

e. Are the requested additional resources being directed to the control point of the system or somewhere else?

Resources will be directed to the control point of the system. The funding will be directed at staffing.

f. What operational strategy will be put in place to ensure that the activities of the program lead to the desired outcomes?

The state licensing functions will be monitored through the Department of Health to ensure that health facilities receive appropriate inspections to ensure health and safety.

3. Use of Existing Capacity

a. What efforts have been taken to date to maximize the use of existing capacity?

A list of some of the efficiencies the Bureau has made is as follows:

1. Licenses are now issued every two years instead of annually since about 2000;
2. The licensing bureau was combined with health certification in 2004 to streamline administrative functions;
3. Mock surveys for new providers were eliminated in 2004;
4. Follow up to Joint Commission surveys for hospitals was eliminated in 2004;
5. State surveys of hospitals, rural hospitals, home health agencies and surgery centers were eliminated;
6. Pre-license inspections to determine compliance before issuing health facility licenses were eliminated in 2005;

7. Surveys within the provisional period of licensing (first 6 months) to determine compliance for new providers have not been done since 2010;
8. Review of policy manuals prior to licensing was eliminated in 2011;
9. The feasibility study requirement for new health care facility applicants was eliminated in 2011;
10. Some training and consultation is no longer provided for providers;
11. There have been numerous rule amendments to streamline and upgrade rules to match current standards and processes.

b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

Listed above. Many lower priority activities have been eliminated.

c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

None are known

d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to fund this program?

None are known – funding for this program goes directly to staffing to increase surveys for health providers. There are no other sources for funding.

4. Evidence-Based Practice and Evaluation Plans

a. How does this request align with agency's core mission?

The Department of Health promotes and protects the health of consumers in Utah. This program aligns with that goal of protecting the health and safety of consumers of health care services.

b. What is the objective of the program? What is the product or service being produced?
Protection of the health and safety of health care consumers.

c. Precisely what are the expected improvements in outcomes?

There will be more inspections of licensed-only health care providers. This will ensure healthier and safer outcomes for patients and residents in health care facilities.

d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin of error exists in the proposed measurements?

The numbers of state only inspections, licensing, and complaints are tracked every year. The licensing inspections are measured on average time frames by year. The current trend is lengthening the time frames between inspections to about 4.5 years. We track all inspections on a data system and can measure the average time frames between surveys. We also look at the average number of deficiencies cited during inspections. When time frames for inspections lengthen, the average number of deficiencies also rises, putting patients at risk. One other measurement is that of Class I Deficiencies, which are issues that are cited that create an imminent danger to residents/patients. The numbers of Class I deficiencies usually decrease when inspections are more frequent.

e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

The inspection of health care facilities is done throughout the country. Inspection results are documented and proven through national associations such as NARA (National Association of Regulatory Agencies), AHCA (American Health Care Association) and AHFSA (The Association for Health Facility Survey Agencies).

f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

The Department of Health will oversee and evaluate the licensing program to ensure appropriate actions are taken. The Department has an internal audit program that oversees all programs, as well as our own Bureau auditing and reporting systems.

g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

Internal audit will require action steps to show why goals were not met and how to remedy any situation. The program will be accountable for the outcomes.

h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

No – continued oversight of health and safety inspection for health providers ensures that vulnerable patients are safe.

i. For new or untested programs or services

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?

ii. What activities and associated (proximate) measures are available to show progress?

iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?

N/A

5. Timing

a. How long will the program take to implement?

The program is currently implemented; new funding will increase staffing to better meet needs.

b. What steps will be taken to ensure timeliness in implementation?

c. How long will it be before measurable results can be evaluated?

Each year.

6. Funding source

a. If the request is for an allocation of General Fund or Education Fund revenues, what funds / resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

None are known

7. Stakeholders

a. Who are the stakeholders associated with or impacted by this request?

The Bureau of Health Facility Licensing and Certification at the Department of Health. We also work closely with the State Ombudsman, APS, Medicaid Fraud and Control Unit, Medicaid and health facility provider associations. The most important stakeholders are the citizens and their families that utilize health care services in facilities licensed and certified by the department.

b. How will stakeholders be impacted if the request is funded?

Consumers will be better protected. Other agencies will be better supported by more oversight and information regarding the regulation of health care facilities.

c. How will stakeholders be impacted if the request is not funded?

Consumers will have dwindling assurance of the health and safety of health care facilities in the state. They will not be able to have complaints addressed timely or at all. Other agencies will not be supported by our regulatory oversight and information for all health care facilities.

8. Legislation

a. Describe any legislation needed to implement this request.

N/A

Business Case For Incremental Budget Change Request

Submit a Business Case form and separate justification detail for each incremental budget change request that is not invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15 / FY 16 business case instructions).

Agency: 270 Dept of Health

Request Title: Health Facility Certification Staffing

Appropriation Code: LFH Facility Licensure, Certification and Resident Assessment

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	55,943	0	55,943	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	158,639	0	158,639	3252 Fed DOH Title XIX Medicaid
Federal Funds 2	143,054	0	143,054	3256 Fed DOH Community & Family Health Services Grants
Transfers	0	0	0	
Other	0	0	0	
Total	357,636	0	357,636	

Other Source Notes: By providing State General Fund of $55,943, we will receive Federal Match Funds of $301,693. 75/25 Match rate for personnel, travel, and training. 50/50 match rate for other expense.

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
AA Personnel Services	48,648	0	48,648
BB Travel/In State	1,200	0	1,200
CC Travel/Out of State	1,500	0	1,500
DD Current Expense	3,150	0	3,150
EE Data Processing Current Expens	1,445	0	1,445
	0	0	0
Total	55,943	0	55,943

Brief Description of Request:

This request is to provide salary, benefits, and fixed costs for 4 FTE in Health Facility Certification. These are Long Term Care Surveyors. CMS provides Title XVIII, Title XIX funding. State Match must be used for the Title XIX funding. Adding these 4 FTE will allow the Bureau to meet CMS survey requirements.

The bureau completed 56 inspections of nursing facilities in 2013. This number increases to 100 with the staffing proposed in this budget increase. CMS requires that the state average no more than 12.9 months

Agency Priority:

New FTE: 4

FY 15 / FY 16 BUDGET GUIDELINES

Business Case

Policy and Operational Justification

Budget Request Title: Health Facility Survey and Certification Staffing
Agency Budget Request Priority:
Brief Description of Budget Change
Increase budget to support the inspections required to license and certify the increasing numbers of health care facilities in the state. This meets state licensing and federal Medicare/Medicaid certification requirements.

Detail on Budget Change Request (respond to the following questions)

1. Background and Problem Definition

a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

Staffing for the certification of nursing facilities decreased in 2009 from 18 surveyors to 11. The Bureau did not meet federal inspection requirements for nursing facilities for the years between 2010 and 2013. State Match is required for the match portion of Title XIX expenditures of Federal CMS (Centers for Medicare and Medicaid Services) certification of long term care facilities. The Department moved temporary money to the bureau to allow the hiring of 4 additional staff in SFY 2014 to meet federal inspection requirements for Medicare/Medicaid. This money is temporary and will not continue to support the function. Permanent funding is necessary to support the staffing.

b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

The problem is an increase in the number of health care facilities that require inspections for federal Medicare/Medicaid certification, coupled with inadequate budgets from the recession. The Bureau must meet tier requirements as set forth by CMS for Medicare and Medicaid certification of these facilities. If the Bureau fails to meet the requirements, a non delivery deduction is imposed and we will receive a significant loss in our Federal Funding. Also, facilities will not be certified and residents with Medicare and Medicaid would no longer have access to long term care nursing facilities.

c. What population is being served?

Elderly and other vulnerable populations in CMS certified long term Care facilities, including nursing facilities and others.

d. Explain why this activity constitutes a proper role of government / what market failure justifies government intervention.

Government is required to ensure the health and safety of patients and residents in health care facilities. Federal guidelines require timely inspections of all providers that participate in the Medicare and Medicaid programs. Failure to certify these facilities may result in the loss of Medicare and Medicaid funding. The Department of Health is the contracted agent in the state to perform this function, as outlined in section 1864(a) of the Social Security Act.

e. Explain why the state is the proper level of government to handle this issue.

The state is the authority for the licensing of health care facilities – as outlined in the Utah Code 26-21. The state is also the contracted authority with the Centers for Medicare and Medicaid Services (CMS) for the certification of any health providers participating in Medicare and Medicaid programs.

f. What other agencies should be involved in dealing with this issue?

N/A

g. How are outcomes expected to change relative to current practice if the item is not funded?

There will not be staff to investigate complaints in health care facilities. Currently the Bureau responds to approximately 300 complaints in CMS Medicare/Medicaid certified facilities. The complaints address constituent concerns from improper discharge to abuse issues. There will also not be timely inspections of nursing facilities in the state which results in increased violations of health and safety rules and may also result in the loss of Medicare/Medicaid certification due to non delivery reductions of federal funds. The loss of certification would mean that residents would no longer have access to nursing care in the state through nursing facilities, and the state would experience a significant economic impact from the loss of Medicare and Medicaid funds.

2. QT/OE and SUCCESS Initiative principles

a. How does the budget change request improve the ratio of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

This budget increase will increase the numbers of inspections for long term care nursing facilities in the state, which will ensure that patients/residents of such facilities will be more protected. Federal requirements for Medicare/Medicaid do not allow for any variance from the process of certification. To participate in the program, providers must have certification inspections. Outcomes will show increased inspections, which relates to the number of serious citations given during these surveys. This all shows that residents and patients of health care are protected and safe. The bureau completed 56 inspections of nursing facilities in 2013. This number increases to 100 with the staffing proposed in this budget increase. CMS requires that the state average no more than 12.9 months between nursing facility surveys. In 2013, that average for Utah reached 23 months. With the addition of these four staff, the average will be within federal requirements at 12.5 months between surveys.

b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services) (T), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

There is ongoing and significant growth in the health care industry, particularly in the sector that serves our elderly population (e.g., nursing homes, assisted living facilities, home health care). There has been a 10% increase in these numbers since 2000 with a decrease in staffing to support it. Health care will continue to grow in the state as the population grows and demands access to services.

c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings? If savings, are they hard cost savings or foregone costs / cost avoidance?

This request will not generate future costs or savings.

d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

This is the first request in funding for this program since the 1990s. The state should expect to support the licensing and certification needs in the future if they increase, so that current laws can be met. Failure to support this function may result in a significant loss of Medicare and Medicaid funding for the state.

e. Are the requested additional resources being directed to the control point of the system or somewhere else?

Resources will be directed to the control point of the system. The funding will be directed at staffing. The funding for the nursing home surveyors will also draw down federal money to support the program.

f. What operational strategy will be put in place to ensure that the activities of the program lead to the desired outcomes?

The program is held to federal requirements for nursing facility inspections and will continue to be evaluated to those requirements by CMS. CMS performs evaluations of the state certification on a yearly basis. The state licensing functions will be monitored through the Department of Health to ensure that health facilities receive appropriate inspections to ensure health and safety.

3. Use of Existing Capacity

a. What efforts have been taken to date to maximize the use of existing capacity?

The licensing bureau was combined with health certification in 2004 to streamline administrative functions and to decrease costs; and

some training and consultation is no longer provided for health care facilities. Other efficiencies are not possible because Federal CMS requirements for Medicare/Medicaid do not allow for any variance from the process of certification.

b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

Listed above. Many lower priority activities have been eliminated where possible, but there are only a few that relate to the specific process of certifying nursing facilities.

c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to fund this program?

None are known – funding for this program goes directly to staffing to increase surveys for health providers. There are no other sources for funding.

4. Evidence-Based Practice and Evaluation Plans

a. How does this request align with agency's core mission?

The Department of Health promotes and protects the health of consumers in Utah. This program aligns with that goal of protecting the health and safety of consumers of health care services.

b. What is the objective of the program? What is the product or service being produced?

Protection of the health and safety of health care consumers.

c. Precisely what are the expected improvements in outcomes?

There will be continued inspections in certified nursing facilities which will ensure future payment of Medicare and Medicaid funds for qualifying patients in Utah. This will also ensure better outcomes for patients of nursing facilities. The Bureau will be able to meet the tier requirements set forth by CMS.

d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin of error exists in the proposed measurements?

The numbers of inspections are tracked every year. We expect to see the nursing facility inspections remain constant when permanent funding is obtained. This means that the federal requirements will be met. CMS requires that all nursing homes are inspected within a 12.9 month average time frame, with no facility exceeding 15.9 months. This is evaluated every year by the federal CMS office in Denver. We track all inspections on a data system and can measure the average time frames between surveys. We also look at the average number of deficiencies cited during inspections. When time frames for inspections lengthen, the average number of deficiencies also rises, putting patients at risk. One other measurement is that of Class I Deficiencies, which are issues that are cited that create an imminent danger to residents/patients. The numbers of Class I deficiencies usually decrease when inspections are more frequent.

e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

The inspection of health care facilities is done throughout the country. Inspection results are documented and proven through national associations such as NARA (National Association of Regulatory Agencies), AHCA (American Health Care Association) and AHFSA (The Association for Health Facility Survey Agencies).

f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

The federal CMS office in Denver evaluates our program for certification on a yearly basis. Utah is currently in compliance with nursing facility survey objectives, so the permanent funding is needed to maintain this program. The federal officers make occasional site visits to the department to evaluate programs as well as taking info from the federal data systems that we use. We have a written evaluation each year that is sent to the individual program.

g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

Internal audit will require action steps to show why goals were not met and how to remedy any situation. The program will be accountable for the outcomes.

h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

No – continued oversight of health and safety inspection for health providers ensures that vulnerable patients are safe, and that providers can participate in the Medicare and Medicaid programs.

i. For new or untested programs or services

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?
ii. What activities and associated (proximate) measures are available to show progress?
iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?
N/A

5. Timing

a. How long will the program take to implement?
The program is currently implemented; new funding will support increased staffing to meet needs.

b. What steps will be taken to ensure timeliness in implementation?

c. How long will it be before measurable results can be evaluated?
Each year.

6. Funding source

a. If the request is for an allocation of General Fund or Education Fund revenues, what funds / resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

Federal funds are available for the nursing facility inspections as match funding. Medicaid inspections are funded at 75% federal and 25% state for personnel, travel, and training costs. Other current expense costs are funded at a 50/50 match rate.

7. Stakeholders

a. Who are the stakeholders associated with or impacted by this request?

The Bureau of Health Facility Licensing and Certification at the Department of Health. We also work closely with the State Ombudsman, APS, Medicaid Fraud and Control Unit, Medicaid and health facility provider associations. The most important stakeholders are the citizens and their families that utilize health care services in facilities certified by the department.

b. How will stakeholders be impacted if the request is funded?

Consumers will be better protected. Other agencies will be better supported by more oversight and information regarding the regulation of health care facilities.

c. How will stakeholders be impacted if the request is not funded?

Consumers will have dwindling assurance of the health and safety of health care facilities in the state. They will not be able to have complaints addressed timely or at all. Other agencies will not be supported by our regulatory oversight and information for all health care facilities.

8. Legislation

a. Describe any legislation needed to implement this request.

N/A

Business Case For Incremental Budget Change Request

Submit a Business Case form and separate justification detail for each incremental budget change request that is not invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15 / FY 16 business case instructions).

Agency: 270 Dept of Health

Request Title: Prescription Drug Abuse, Misuse, and Overdose Prevention

Appropriation Code: LEJ Health Promotion

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	0	0	500,000	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	0	0	
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	
Total	0	0	500,000	

Other Source Notes:

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
AA Personnel Services	0	0	60,000
BB Travel/In State	0	0	300
CC Travel/Out of State	0	0	4,000
EE Data Processing Current Expens	0	0	80,000
HH Other Charges/Pass Through	0	0	350,000
DD Current Expense	0	0	5,700
Total	0	0	500,000

Brief Description of Request:

Prescription drug abuse has resulted in premature deaths, contributed to significant economic burdens through increased health care costs and substance abuse treatment, and fueled the rise in heroin addictions. Prior program funding of $500,000 resulted in a 27.6% decrease in prescription opioid overdose deaths from 2007 to 2010. Using conservative estimates, evidence supports that with continued, on-going funding, at least 120 Utahn lives would have been saved from preventable drug overdose deaths.

Agency Priority:

New FTE: 1

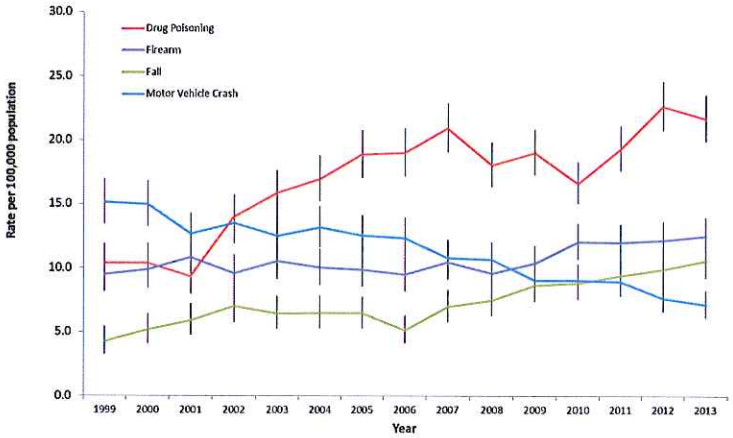
Business Case
Policy and Operational Justification

Budget Request Title: Prescription Drug Abuse, Misuse, and Overdose Prevention
Agency Budget Request Priority:
Brief Description of Budget Change Request: Prescription drug abuse has resulted in premature deaths, contributed to significant economic burdens through increased health care costs and substance abuse treatment, and fueled the rise in heroin addictions. Prior program funding of $500,000 resulted in a 27.6% decrease in prescription opioid overdose deaths from 2007 to 2010. Using conservative estimates, evidence supports that with continued, on-going funding, at least 120 Utahn lives would have been saved from preventable drug overdose deaths.

1. Background and Problem Definition

Currently, Utah ranks 5th in the U.S. for drug poisoning deaths with a rate of 22 per 100,000 population.[i] Drug poisoning deaths are a preventable public health problem and have outpaced deaths due to firearms, falls, and motor vehicle crashes in Utah (Figure 1).[ii] The mission of the Utah Department of Health (UDOH) is to protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles. Drug poisoning death is one of several indicators identified to measure the Health Department's strategic goal of being the healthiest people in the country.

Figure 1: Rate of top injury-related deaths per 100,000 population, Utah, 1999-2013 (age-adjusted)



Every month, 49 Utahns die as a result of a drug poisoning, 82.3% of which are accidental or of undetermined intent, and of these, 74.8% involve opioids.[iii] Utah is particularly affected by prescription opioids and funding to implement a comprehensive public health approach to address this problem is critically needed.

Proposed promising public health approaches to prescription drug overdose prevention and control that target the public, patients, and providers include the following: 1) Strengthening surveillance systems and capacity, 2) Enhancing coordination of and developing targeted patient, public, and provider education programs, 3) Leveraging health information technology to improve clinical care and reduce abuse, and 4) Preventing opioid overdose deaths through naloxone initiatives.

The prescription opioid problem has been well documented over the last decade. History has proven that the private sector is not equipped nor motivated to fully address this public health issue. States with the highest drug overdose death rates, such as Utah, have among the highest sales per capita of prescription opioids. A number of factors have contributed to the increase and widespread availability of prescription opioids. In the early 1990s, physicians were urged to be more attentive in identifying and aggressively treating pain. In addition, the pharmaceutical industry aggressively marketed the use of prescription opioids to providers. Consequently, opioid pain relievers, such as oxycodone and hydrocodone, gained widespread acceptance. Healthcare professionals prescribed opioid pain relievers more frequently as part of patient care. The increase in prescription pain medications resulted in these medicines being kept in home medicine cabinets, resulting in an increased opportunity for theft or misuse. To add to the severity of the prescription opioid problem in Utah, there has been an increase in heroin deaths, which is also an opioid, since 2009.

The UDOH is the most appropriate agency to address this issue and this level of government is critical to seeing improved outcomes for two key reasons: 1) the surveillance and evaluation capacity unique to the Utah Department of Health, and 2) the authority and connections of the UDOH to other stakeholders at the state level.

Collaborating with the following key state agencies will be necessary for implementing a public health approach for prescription drug misuse, abuse, and overdose prevention:

- *Department of Commerce, Division of Occupational and Professional Licensing (DOPL).* The Utah Controlled Substance Database (CSD), housed at DOPL, is used to track and collect data on the dispensing of Schedule II-V drugs by all retail, institutional, and outpatient hospital pharmacies, and in-state/out-of-state mail order pharmacies. The Utah Department of Health Violence and Injury Prevention Program (VIPP) has previously collaborated with DOPL on other data sharing projects and currently has a Memorandum of Understanding detailing UDOH's access and use of the CSD.
- *University of Utah, Utah Poison Control Center (UPCC).* The UPCC works to prevent and minimize adverse health effects from poison exposure through education, service, and research. The UPCC is an important state resource, which provides accurate and up-to-date poison information and toxicology consultation to a variety of audiences, as well as conducts poisoning epidemiology and poison prevention research, including poisoning related to prescription drugs.
- *Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH).* DSAMH is Utah's substance abuse and mental health authority, responsible for overseeing publicly funded prevention and treatment systems. They are uniquely positioned to track treatment and substance abuse trends in the state. Violence and Injury Prevention staff has worked closely with DSAMH to share data to improve surveillance and inform statewide prevention efforts and currently co-chairs the Utah Pharmaceutical Drug Community Project.
- *Commission on Criminal and Juvenile Justice, Utah Substance Abuse Advisory Council (USAAV).* The USAAV was created by the 1990 Utah Legislature for the purpose of coordinating the state's efforts related to substance abuse. The mission of the Council is to provide a unified voice for establishing a comprehensive strategy to combat substance abuse and illegal drug activity.

Without funding, a public health approach to the problem will not be re-established and the death rate will continue to increase; prescription drug overdose death data will not be collected, analyzed, and published; and the Use Only as Directed Public Education Campaign would be limited in its scope and reach, slowing the public education and awareness momentum that has been building throughout the campaign. Furthermore, as a key driver of the problem, providers would not receive the much needed education, training, and tools to adequately educate patients on the risks of prescription drug misuse and abuse, screen their patients for substance abuse, utilize opioids as appropriate and safely to treat pain, use effective medication-assisted therapies in patients with addiction or substance abuse disorders. Naloxone is a rescue medication that can reverse overdoses from heroin or prescription opioids such as oxycodone, hydrocodone, and methadone. Vital training for first responders on the use and administration of naloxone may not be available and without funding, other initiatives such as third party naloxone prescribing and dispensing (someone who is usually a caregiver or a potential bystander to a person who is at risk for overdose) will be difficult to advance, despite the passage of the Naloxone Law (2014 House Bill 119).

Utah's experience has proven that PDO deaths are preventable through targeted interventions and stakeholder coordination. It is vital to re-develop and re-establish a public health approach to prescription drug abuse, misuse, and overdose deaths.

2. QT/OE and SUCCESS Initiative principles

Quality (Q) – The scope and effectiveness of programmatic interventions that target the public, patients, and providers through: 1) strengthened surveillance systems and capacity, 2) enhanced coordination of and developed targeted patient, public, and provider education programs, 3) leveraged health information technology to improve clinical care and reduce abuse, and 4) prevention of opioid overdose deaths through naloxone initiatives. System results will be included as a measure of quality for program effectiveness.

Throughput (T) – Capacity to implement proposed programmatic interventions measured by the number of drug overdose deaths prevented.

Operating Expense (OE) – $500,000 on-going funds.

With an increased and on-going operating expense (OE), we can expect to see increases in the scope and effectiveness of programmatic interventions (Q) and a decrease in the number of drug overdose deaths in Utah (T).

Q=(Scope and effectiveness of programmatic interventions) **T**=(Drug overdose deaths)
OE=Operating Expense

Once funding was eliminated in 2010, Utah struggled to implement coordinated, multi-agency approaches since the capacity to implement successful programmatic interventions decreased. As a result, Utah has seen a 36.8% increase in the rate of prescription opioid deaths from 2010 to 2012. With an increase in the capacity to address the problem, an ongoing decrease in drug overdose deaths is expected.

Prescription drug abuse, misuse, and overdose prevention currently does not have an operating budget and the amount of requested on-going funds is not expected to change in the future. Healthcare savings are expected. The cost of prescription opioid abuse is a substantial burden on healthcare. The total cost of Utah opioid hospitalizations in 2011 was $9.5 million. In 2012, the total cost reached $12 million.

As with many health indicators related to prescription drug misuse, abuse, and overdose, Utah is following the national trend of increasing newborns diagnosed with neonatal abstinence syndrome (NAS), a drug withdrawal syndrome that occurs in newborns exposed to addictive prescription or illicit drugs while in utero. Utah estimates total hospitalization charges associated with newborns (birth to 28 days) exhibiting drug withdrawal symptoms to be almost $10 million in 2011. In comparison, Utah's total hospitalization charges for mothers with drug dependence associated with complicated pregnancies or births was $1.4 million in 2011.

Requested funding is being directed to the control point of the system, which are healthcare providers with a controlled substance license. These providers have been identified as one of the key drivers of the epidemic. Through provider education, training, provider material development for patients, co-prescribing of opioids and naloxone for high risk patients, and the enhancement of clinical tools to improve clinical decision making, providers are in a strategic position to effect change in the prevention of prescription drug abuse, misuse, and overdose deaths. To ensure that the activities of the program lead to the desired outcomes, it will be essential to measure the effectiveness of the health care provider's implementation of activities. This evaluation will assist in identifying gaps and how to best address them so outcomes are reached.

3. Use of Existing Capacity

The UDOH Violence and Injury Prevention Program (VIPP) is keenly aware that a public health partnership with multiple partners is needed to increase the potential for broader impact and mitigate the health burden of prescription drug misuse, abuse, and overdose. However, progress has been hampered by siloed prevention interventions and inadequate coordination among stakeholders, policy makers, and data stewards.

Currently there is no state funding to address the prescription drug problem in Utah. Furthermore, the VIPP is completely funded through federal grants with specific goals and objectives. In the absence of state funding for VIPP activities, there are no lower-priority activities that can be stopped or reduced to free up existing resources for this purpose, nor are there funds that can be redirected to pay for it.

Utah has a well-established problem with prescription opioid misuse, abuse, and overdose[iv,v] and a reputable willingness to respond to identified public health issues.[vi,vii] In response to this crisis, the UDOH has undertaken a series of concurrent actions to continue addressing the issue. When legislatively established funding was available, strategies included educating the general public and medical providers, studying the use of prescription medication in the general population, and working with the state legislature to create legal and regulatory changes. In addition, the UDOH published guidelines for opioid prescribing, and created a partnership with the Controlled

Substances Database (CSD), housed within the Utah Department of Commerce, Division of Occupational and Professional Licensing (DOPL).

Currently, the VIPP has established prescription drug overdose as a program priority and has actively worked to advance efforts to most effectively use resources, collaborate with partners, and prevent prescription drug misuse, abuse, and overdose with limited funding. These efforts include the following:

- *Utah Violence and Injury Prevention Plan.* The Utah Violence and Injury Strategic Plan,[viii] organized by lifespan, is a framework that guides surveillance, partnership building, prevention, and policy development in Utah. Poisoning was identified as an injury priority for Utahns ages 18-64 and as a result, is also a focus area for the Utah Core Violence and Injury Prevention Program (CORE VIPP) funded by the Centers for Disease Control and Prevention (CDC).
- *Prescription Drug Overdose Deaths Reports and Fact Sheets.* Utah is comprised of 62 Utah Small Areas that are determined by population size, political boundaries of cities and towns, and economic similarity. These areas are especially useful for assessing health needs at the community level and targeting programs to those at greatest risk for an injury. Earlier this year, VIPP released its second Violence and Injury Small Area Report.[ix] The report summarizes data on 17 different injury-related topics by Utah Small Areas across the state, including Poisoning Fatalities. This provides partners information to determine critical geographic target areas for each priority. VIPP also publishes an annual indicator report on Drug Overdose and Poisoning Incidents,[x] in addition to a Prescription Pain Medication Deaths in Utah fact sheet,[xi] which assists partners in establishing critical target areas by identifying demographic risk factors to help focus prevention efforts on disparate populations.
- *Data Collection, Surveillance, and Evaluation.* Discontinued funding of prescription drug misuse, abuse, and overdose efforts necessitated the integration of unintentional drug overdose deaths into the Utah National Violent Death Reporting System (UTVDRS), housed in VIPP. This integration into the UTVDRS offers a look at the complete picture of drug overdose deaths in Utah and an opportunity for continuity in data collection. As a result of this effort, Utah was honored with the prestigious Innovative Initiative of the Year Award from the Safe States Alliance. Utah participated in Safe States and the American Public Health Association's Injury and Violence Prevention Program & Policy Evaluation Institute to develop a policy evaluation plan for House Bill 119 Emergency Administration of Opiate Antagonist Act. The Utah Policy Evaluation Team consisted of members from the VIPP, Division of Substance Abuse and Mental Health, Utah Poison Control Center, and the Department of Veterans Affairs Medical Center.
- *Coalition Building.* The Utah Prescription Drug Community Project (UPDCP) is a collaboration of state and local partners in public health, substance abuse prevention, law enforcement, and healthcare with broad aims that include preventing prescription drug misuse, abuse, and overdose deaths and increasing public and prescriber awareness. VIPP was instrumental in reconvening UPDCP and facilitating the development of a comprehensive state plan that addresses prescription drug abuse, misuse, and overdose through public awareness, prescriber education, access to substance abuse treatment programs and community resources, criminal justice, and data and surveillance. VIPP staff currently chairs this coalition.

- *Prescriber Education.* During the 2013 general session, the Utah State Legislature passed Senate Bill 214, Continuing Education for Prescription Drugs, to establish the continuing education requirements for controlled substance prescribers under the Utah Controlled Substances Act. It requires certain controlled substance prescribers to complete at least 3.5 hours of continuing education hours in one or more controlled substance prescribing classes as a requisite for license renewal. In addition, the controlled substance prescribing class should also include all elements of the FDA Blueprint for Prescriber Education under the FDA's Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy (REMS). VIPP staff served on the Project Management Committee with partners from the Division of Occupational and Professional Licensing (DOPL), Utah Medical Association, and health care providers to develop the training modules.
- *Media Campaign.* Initially, the Use Only As Directed media campaign was designed by the UDOH and was authorized and funded by the state legislature from 2008-2009. In 2011, a broader version of the campaign was launched and was funded through federal grant monies from the Utah Commission on Criminal and Juvenile Justice and the Division of Substance Abuse and Mental Health. The expanded effort incorporated community drug take-back events, permanent drop-off boxes, and health care professional education, in addition to the media campaign branding. An evaluation of the Use Only as Directed Media campaign, originated at the Utah Department of Health, found that the campaign may have contributed to a reduction in overdose deaths in Utah.[xii] Use Only as Directed is publicly recognized with an established website and social media presence. VIPP staff serves on the committee to guide campaign messages and strategies.

These combined efforts indicate VIPPs capacity to approach the prescription drug overdose crisis through programmatic and policy efforts. However, the scope and magnitude of programmatic efforts are extremely limited since there is no specific funding for these activities.

4. Evidence-Based Practice and Evaluation Plans

As previously stated, the mission of the UDOH is to protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles. Drug poisoning death is one of several indicators identified to measure the Health Department's strategic goal of being the healthiest people in the country.

As a state experiencing a high rate of drug overdose deaths and ranking 5th across the nation, the goal of the funding request is to reduce the overall burden of prescription drug abuse, misuse, and overdose death in Utah through a re-developed and re-established public health approach without a sunset provision.

The strategies identified to implement this program were adapted from the Utah Pharmaceutical Drug Abuse Prevention Plan, Colorado's Plan to Reduce Prescription Drug Abuse, New Hampshire's Call to Action for Prescription Abuse Prevention, the Office of National Drug Control Policy Prescription Abuse Plan, and the U.S. Department of Health and Human Services Behavioral Health Coordinating Committee, Prescription Drug Abuse Subcommittee "Addressing Prescription Drug Abuse in the United States, Current and Future Opportunities" report.

Goal 1: Strengthen surveillance systems and capacity.
Objective 1.1: Abstract unintentional drug overdose deaths in the Utah Violent Death Reporting System.
Objective 1.2: Enhance and improve use of the controlled substance database as a public health surveillance system.
Objective 1.3: Track naloxone distribution and administration.
Goal 2: Promote public awareness.
Objective 2.1: Leverage DEA's National Take Back Days, International Overdose Awareness Day, National Substance Abuse Prevention Month, National Drug Facts Week, and other events as opportunities to highlight the risks and warning signs of prescription drug misuse, abuse and overdose across Utah.
Objective 2.2: Continue the Use Only as Directed public awareness campaign, including updating and maintaining the website, utilizing social media, PSAs and other media to promote safe use, storage and disposal.
Objective 2.3: Provide an appropriate method of prescription drug disposal in each Utah community.
Goal 3: Increase patient and family education.
Objective 3.1: Convene a Utah Pharmaceutical Drug Community Project subcommittee to focus on patient education activities and messaging and assure they are evidence-based and consistent across agencies.
Objective 3.2: Develop targeted education initiatives, focusing on the addiction risks of medications, signs and symptoms of an overdose, the proper use of Naloxone, the dangers of mixing medications, safe storage and disposal.
Objective 3.3: Develop a high quality patient/family education intervention for pharmacies dispensing opioids.
Goal 4: Develop and promote provider education and training.
Objective 4.1: Partner with stakeholders to develop targeted education and training to meet the needs of all providers and practice settings.
Objective 4.2: Train providers to access the controlled substance database, screen for substance abuse, utilize the Utah Clinical Guidelines on Prescribing Opioids, and identify appropriate medication-assisted therapies for patients with opioid addiction as part of a standard clinical examination and assessment.
Goal 5: Enhance Clinical Practice Tools
Objective 5.1: Explore and implement opportunities to integrate clinical tools and access to the controlled substance database into electronic health records to improve clinical decision-making.
Objective 5.2: Update, expand, and integrate Utah's Clinical Guidelines on Prescribing Opioids into clinical decision support tools, especially in high-risk settings.
Objective 5.3: Develop a referral directory for patients: 1) transitioning from short to long term opioid use, 2) showing signs of addiction while on opioids for pain, and 3) needing chronic pain treatment but at risk for substance abuse.
Goal 6: Enhance Overdose Prevention
Objective 6.1: Partner with first responders to disseminate information on naloxone use and train on naloxone administration
Objective 6.2: Evaluate House Bill 119 Emergency Administration of Opiate Antagonist Act and House Bill 11 Overdose Reporting Amendments

It is expected that the proposed objectives and activities will have the intended effect of reducing prescription drug misuse, abuse, and overdose in Utah. The following logic model shows the short-term, intermediate, and long-term outcomes we expect to achieve:

What is needed?	What are we going to do?	What are our products?	Performance Measures: Short-term	Performance Measures: Intermediate	Performance Measures: Long-term
Funding Staff time Community partners Stakeholders Utah Legislature	Data collected, analyzed, disseminated	Number of brochures, fact sheets, pamphlets, web hits, reports, conference presentations, social media	Increase in data reports to inform prevention efforts	Increase awareness of abuse risks and warning signs	Decrease opioid overdose hospitalizations
	Educate on risks and warning signs, safe use, storage, and disposal	Number of educational materials developed and distributed	Increase in number trained on naloxone use and overdose prevention	Increase proportion of prescribers following guidelines	Decrease deaths due to opioid overdoses
	Develop provider / prescriber materials and training	Number and types of providers and first responders trained	Increase in public awareness exposure	Change in rate of prescribing of opioids per year	
	Training on naloxone use and access for first responders	Number of tools integrated into electronic health records, guidelines updated, referral directory developed and disseminated	Increase in number of providers educated		
	Develop targeted education initiatives with coalition support				
	Enhance clinical decision support tools				

The UDOH has previously achieved remarkable success in prescription drug overdose prevention and control. The problem was first identified in Utah by the Office of the Medical Examiner in 2004. Subsequently, in 2007, UDOH received legislative funding to implement a Prescription Pain Medication Program (PPMP). The collective strategies included five main components: a media campaign targeting high-risk populations, provider education and development of clinical guidelines, community "take-back" events, improvements to the Utah Controlled Substance Database, and targeted law enforcement and prosecution. These activities significantly decreased the adult prescription opioid death rate from 2007 to 2010. Funding for the program was eliminated in 2010, and since that time, overdose deaths have been increasing (Table 1).

Table 1: Count and rate of poisoning deaths in Utah, 2006-2012

Year	Occurrent* Poisoning Deaths	Occurrent* Rx Drug Deaths	Occurrent* Rx Opioid Deaths	Rx Opioid Deaths, UT Residents 18+	Rx Opioid Death Rate per 100,000 UT Residents 18+	95% Confidence Interval
2006	416	308	280	274	15.8	(14.0 - 17.8)
2007	478	371	326	313	17.6	(15.7 - 19.6)
2008	430	321	288	278	15.2	(13.5 - 17.1)
2009	420	306	272	269	14.4	(12.7 - 16.2)
2010	369	278	236	227	11.9	(10.4 - 13.6)
2011	444	306	243	233	12.0	(10.5 - 13.7)
2012	502	323	261	250	12.7	(11.2 - 14.4)

*Occurrent deaths include individuals who were fatally injured in Utah, whether or not they were a resident of Utah.

Data collection efforts will continue, public awareness initiatives will build on the Use Only as Directed Campaign, informatics solutions will be applied, naloxone initiatives explored, and provider education will integrate academic detailing, which involves face-to-face education of prescribers by trained health care professionals. Academic detailing has been studied for over 25 years[xiii] and has been shown to be effective at improving prescribing behavior and though it is primarily used to affect prescribing, it is also used to educate providers regarding other non-drug interventions, such as screening guidelines. An evaluation of Utah's previous efforts of academic detailing has shown success where reductions in inappropriate prescribing were found after the intervention.[xiv]

Several evaluation efforts indicate that Utah Good Samaritan and Naloxone laws will go a long way in decreasing opioid overdose deaths by removing legal barriers to the timely administration

of naloxone and reducing the fear of criminal prosecution when reporting an overdose. New Mexico became the first state to eliminate naloxone administration barriers in 2001. Since then, 22 other states have enacted laws to make it easier for medical professionals to prescribe and dispense naloxone and for lay administrators to use it without the fear of legal repercussions. As a result, at least 188 community-based overdose prevention programs now distribute naloxone and these programs have provided training and naloxone to over 50,000 people resulting in over 10,000 overdose reversals through community-based overdose prevention programs.[xv] Washington state has made efforts in evaluating its Good Samaritan Law; the state found a lack of apparent negative consequences of the law and encourages other states to consider this legislative approach in their plans to prevent prescription drug overdose deaths.[xvi] However, without adequate funding, it will be difficult to educate the public, patients, and providers about these new laws and the benefits that are provided.

The VIPP, who will be responsible for project administration, has been in existence for 30 years and is well respected locally and nationally for its performance in injury prevention program planning, implementation, and evaluation. VIPP has substantial experience in injury surveillance, conducting quality assurance activities, and generating data reports of its findings. Health Code UCA Sec 26-1-30 provides for the release of confidential information from any person, health facility, or other organization to the UDOH for study, with the purpose of reducing morbidity and mortality or for the improvement of health care, without that entity incurring liability. Under Health Code Chapter 26, the VIPP maintains several confidential databases and has a substantial history of timely and accurate collection and analysis of confidential injury surveillance data for drug overdose death, as well as student injury, traumatic brain and spinal cord injury, suicide, child fatality, and domestic violence fatality data. The VIPP has in place highly educated and experienced staff with the capacity to perform program evaluation. The VIPP will collaborate with key program partners to implement an Evaluation and Performance Measurement Plan to demonstrate achievement of identified outcomes and build a stronger evidence base for prescription drug overdose prevention. By focusing on the extent to which the identified goals, objectives, and activities are met and are met in a timely manner, the plan will be instrumental in ensuring continuous program improvement in the event intended objectives are not met. Regular meetings will be held to discuss progress, barriers, and solutions for the proposed objectives and activities, and routine documentation of "lessons learned" will allow the VIPP to feasibly evaluate program progress, effectiveness, and impact.

5. Timing

To implement a comprehensive, public health approach to address prescription drug abuse, misuse, and overdose deaths may take several years. Fortunately, Utah has experience in addressing this issue and can build on previous partnerships to help inform the proposed goals and objectives. To ensure timeliness and accountability in implementation, an overall evaluation and performance measurement plan will be developed that will describe key evaluation questions to be answered, potentially available data sources, how evaluation findings will be used for continuous program and quality improvement, the frequency that evaluation and performance data are to be collected, and how the data will be reported and disseminated. Short-term outcomes can be measured within one year of program implementation, intermediate outcomes within one to three years, and long-term outcomes within three to five years.

6. Funding Source

Currently, two federal grants through a cooperative agreement with the CDC fund prescription drug-related prevention activities in Utah. These grants are very prescriptive in the activities that address the problem and typically don't include implementation efforts for public education and awareness, patient education, provider education, naloxone initiatives, enhancing clinical tools, and data collection.

7. Stakeholders

The VIPP has long-standing, established relationships with key state-level agencies. These relationships will provide Utah the opportunity to coordinate improvement efforts and expand intervention efforts. The stakeholders that may be impacted by this request include the Department of Commerce, Division of Occupational and Professional Licensing, where the Controlled Substance Database (CSD) is housed, the University of Utah, Utah Poison Control Center (UPCC), the Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH) and, the Commission on Criminal and Juvenile Justice, Utah Substance Abuse Advisory Council (USAAV).

If funded, stakeholders may be impacted as a result of: 1) improved access and utilization of the CSD as integration into electronic health records is explored, 2) increased calls to the UPCC as a result of public awareness and education efforts, 3) increased need for substance abuse treatment services through DSAMH, and 4) increased coordination of efforts and a unified strategy across state agencies to address this problem through USAAV.

Without funding, it will be difficult to integrate strategies across key state-level agencies and activities tend to get siloed without a concerted, public health approach to the problem. Resources aren't maximized and streamlined and it is difficult to implement a wide range of programmatic and policy initiatives that would impact the goal of reducing the burden of prescription drug abuse, misuse, and overdose deaths.

8. Legislation

Legislation is not needed to implement this request at this time.

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[i] Centers of Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2011). National Center for Injury Prevention and Control, CDC (producer). [cited 2014 Oct].

[ii] Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health: 199-2013 data queried via Utah's Indicator-Based Information System for Public Health (IBIS-PH) [cited 2014 October].

[iii] Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health: 199-2013 data queried via Utah's Indicator-Based Information System for Public Health (IBIS-PH) [cited 2014 October].

[iv] Porucznik CA, Johnson EM, Sauer B, Crook J, Rolfs RT. Studying adverse events related to prescription opioids: the Utah experience. Pain Med. 2011 Jun;12 Suppl 2:S16-25. PubMed PMID: 21668753. Epub 2011/06/28. eng.

[v] Johnson EM, Lanier WA, Merrill RM, Crook J, Porucznik CA, Rolfs RT, et al. Unintentional prescription opioid-related overdose deaths: description of decedents by next of kin or best contact, Utah, 2008-2009. J Gen Intern Med. 2013 Apr;28(4):522-9. PubMed PMID: 23070654. Pubmed Central PMCID: 3599020.

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Form 4000 Incremental Budget Change Request

Submit a Form 4000 for each incremental budget change request invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15/ FY 16 Budget Guidelines for instructions).

Agency: 270 Dept of Health

Request Title: Dental Coverage for Elderly and People with Disabilities

Appropriation Code: LJE Dental Services

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	0	0	3,226,000	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	0	7,691,000	3252 Fed DOH Title XIX Medicaid
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	Other Source Notes
Total	0	0	10,917,000	

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
HH Other Charges/Pass Through	0	0	10,917,000
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	0	0	10,917,000

Brief Description of Request:

NOTE: THIS REQUEST IMPACTS VARIOUS APPROPRIATION CODES

Studies show that dental benefits are important to ensure good oral and overall health. Oral examinations help detect early signs of nutritional deficiencies and systemic disease.

Utah currently allows all clients on Traditional and Non-traditional Medicaid to receive emergency dental services. These services require the client's condition to have deteriorated to the state of emergency exhibiting symptoms of pain and/or infection

New FTE	0
Agency Priority	1

Describe any legislation that is necessary to implement this request.	None
How will the proposed change impact QT/OE (if a Success System has not been formally designated, describe generally how this request will influence both quality throughput and operational expenses -- e.g. QT will increase X%, OE will increase Y?)	QT Dental procedures are available to the elderly and people with disabilites. Their oral and overall health are improved. More expensive emergency dental services are avoided. OE Requested funds are for pass through dollars to dental providers. As such, these program costs do not affect OE but increase overall services and program costs.
Who are the stakeholders associated with this request? How will they be impacted if the request is funded? How will they be impacted if the request is not funded?	With funding, the elderly and persons with disabilities who qualify for Medicaid will have preventative and restorative dental coverage available. Consequences of Not Fully Funding the Building Block: Medicaid eligible elderly adults and individuals with disabilities continued to have limited access to dental care. Preventative and restorative services are not available. The overall health, self-esteem and employability of these individuals is negatively impacted. Emergency rooms continue to address more acute dental issues resulting in higher costs.

FY 15 / FY 16 BUDGET GUIDELINES

Business Case
Policy and Operational Justification

Budget Request Title: Dental Coverage for Elderly and Persons with Disabilities
Agency Budget Request Priority: 01
Brief Description of Budget Change Request: This building block requests funding to expand dental coverage to include some preventive and restorative procedures, including routine exams, X-rays, cleanings, crowns, and full dentures for the elderly and persons with disabilities.

Detail on Budget Change Request (respond to the following questions)

1. Background and Problem Definition

a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

Although preventative and restorative dental coverage is not currently a benefit covered by Medicaid, providing access to this type of dental care improves the quality of health care the Department can offer members, which is a component of the Department's mission. Utah currently allows all clients on Traditional and Non-traditional Medicaid to receive emergency dental services. These services require the client's condition to have deteriorated to the state of emergency exhibiting symptoms of pain and/or infection before treatment may be rendered. This practice results in many clients ending up with infected gums, decayed teeth and other systemic complications which result in considerable cost.

b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

Providing access to quality preventative and restorative dental care to the elderly and persons with disabilities enrolled in Medicaid programs improves the overall health and employability of these individuals. Expanding coverage may result in potential savings by encouraging beneficiaries to seek care prior to escalating to an emergency, and potentially avoids other services need to address heart disease, diabetes, respiratory disease, pregnancy complications, and nutritional deficiencies.

c. What population is being served?

The elderly and persons with disabilities enrolled in traditional and non-traditional Medicaid programs.

d. Explain why this activity constitutes a proper role of government / what market failure justifies government intervention.

Providing dental coverage is appropriately handled by the government through the Medicaid program. The Department is able to provide this coverage as part of the Medicaid benefit packages available to the demographic described and we are able to offset the cost to the State with federal funds available for the program.

e. Explain why the state is the proper level of government to handle this issue.

Providing dental coverage is appropriately handled at the State level through the Medicaid program, because the Department is able to provide this coverage as part of the Medicaid benefit packages available to the demographic described and we are able to offset the cost to the State with federal funds available for the program.

f. What other agencies should be involved in dealing with this issue?

No other agencies should be involved.

g. How are outcomes expected to change relative to current practice if the item is not funded?

Limited access to dental care, threatens overall health, self-esteem, and employability. Beginning July 1, 2012 Utah allowed all clients on Traditional and Non-traditional Medicaid to receive emergency dental services. These services require the client's condition to deteriorate to the state of emergency exhibiting symptoms of pain and/or infection before treatment may be rendered. This practice results in many clients ending up with infected gums, decayed teeth and other systemic complications which result in considerable cost.

2. QT/OE and SUCCESS Initiative principles

a. How does the budget change request improve the ratio of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

Preventative and restorative dental benefits will be available to the elderly and people with disabilities. This will improve the quality of care available to this Medicaid population, thereby, improving their overall health. The requested funds will be passed through to dental providers for services performed for the specified demographic. Thus, there will be limited impact to operating expense, because the payments to the dental providers will be processed through existing medical reimbursement systems and processes.

b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services) (T), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

The budget change request will improve the quality of services available to a specific Medicaid population and will allow the Department to proactively address dental care before the member's condition becomes emergent. Studies show that dental benefits are important to ensure good oral and overall health. Oral examinations help detect early signs of nutritional deficiencies and systemic disease. The benefits of this program are ongoing.

c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings?

Expanding dental coverage to include preventative and restorative treatment could result in long-term savings by encouraging members to seek care prior to symptoms escalating to an emergency, as preventative dental care is significantly less costly than emergency dental care.

d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

Changes in enrollment in the program with the specified populations can change, as well as rates associated with procedures performed can change, both of which could result in the need for additional funding in the future for this program.

e. Are the requested additional resources being directed to the control point of the system or somewhere else?

The requested resources will be passed through the established reimbursement system to reimburse dental providers for preventative and restorative services provided to the identified population.

f. What operational strategy will be put in place to ensure that the activities of the program lead to the desired outcomes?

Medicaid staff will work closely with providers and dental plans to ensure that changes in allowed coverage are communicated timely and effectively. Also, the Medicaid staff will ensure that Eligibility Specialists understand the change in the coverage and are trained in the eligibility requirements of the program to ensure Medicaid clients are informed of the services available.

3. Use of Existing Capacity

a. What efforts have been taken to date to maximize the use of existing capacity?

This request is to add a dental benefit for the elderly and persons with disabilities, which expands services the Department can provide to the public. No existing Medicaid funds have been targeted to fund this program, as any changes to the current funding mix, would result in cutting Medicaid services in other areas.

b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to fund this program?

There are no legal or other impediments to redirecting funds to this priority. The only known limitation related to this request is that the funding must be state funding, as it will be considered part of the required state match for the federal program.

4. Evidence-Based Practice and Evaluation Plans

a. How does this request align with agency's core mission?

The core mission of the Utah Department of Health is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles. Providing preventative and restorative dental care to the elderly and persons with disabilities improves the Department's ability to prevent avoidable illness as well as improves the Department's ability to assure access to affordable, quality health care.

b. What is the objective of the program? What is the product or service being produced?

The objective of the program expand dental coverage to include some preventive and restorative procedures, including routine exams, X-rays, cleanings, crowns, and full dentures for the elderly and persons with disabilities to improve the overall health and employability of these individuals.

c. Precisely what are the expected improvements in outcomes?

By providing access to preventative oral health services, the rate of oral disease declines which significantly impacts the cost of overall health care. Oral disease contributes to cardiovascular disease, stroke, uncontrolled diabetes, preterm birth weight and other systemic conditions.

d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin of error exists in the proposed measurements?

Emergency dental program costs could decrease as dental issues are addressed as members seek care prior to escalating to an emergency. Also, receiving preventative dental care could relate to reduced costs related to other health care issues because oral disease contributes to cardiovascular disease, stroke, uncontrolled diabetes, preterm birth weight and other systemic conditions. Reduced costs in the emergency dental program will be quantifiable.

e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

There is a vast amount of research that exists surrounding the correlation between oral health and disease prevention. Some studies include but are not limited to: *Oral Health in America: Summary of the Surgeon General's Report* http://www.cdc.gov/oralhealth/publications/factsheets/sgr2000_05.htm; *Oral Health, General Health and Quality of Life, World Health Organization* http://www.who.int/bulletin/volumes/83/9/editorial30905html/en/.

f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

The Medicaid Dental Health Program Manager will perform annual reviews of the program to ensure that utilization of the dental program reduces costs in the emergency dental program.

g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program.

h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program, however, the Department is not requesting that the program be sunset.

i. For new or untested programs or services

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?
The funding request is to provide preventative and restorative dental coverage to the elderly and persons with disabilities enrolled in Medicaid programs. Dental benefits are currently provided to other populations enrolled in Medicaid and dental services were a covered benefit of the Medicaid program for the specified demographic prior to fiscal year 2010.

ii. What activities and associated (proximate) measures are available to show progress?
The funding request is to provide preventative and restorative dental coverage to the elderly and persons with disabilities enrolled in Medicaid programs. Dental benefits are currently provided to other populations enrolled in Medicaid and dental services were a covered benefit of the Medicaid program for the specified demographic prior to fiscal year 2010.

iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?
The funding request is to provide preventative and restorative dental coverage to the elderly and persons with disabilities enrolled in Medicaid programs. Dental benefits are currently provided to other populations enrolled in Medicaid and dental services were a covered benefit of the Medicaid program for the specified demographic prior to fiscal year 2010.

5. Timing

a. How long will the program take to implement?

3 to 6 months

b. What steps will be taken to ensure timeliness in implementation?

1) **Timely filing of modifications to the Medicaid State Plan Amendment and/or Administrative Rule**
2) **Close collaboration with Dental Plans**
3) **Working as an interdisciplinary team to integrate the program into the Medicaid claim adjudication system (MMIS)**
4) **Providers will be notified of impending changes via the Medicaid Information Bulletin (MIB)**

c. How long will it be before measurable results can be evaluated?

It will be at least one year after implementation before meaningful results can be evaluated. Initially, it is expected that utilization of the program will be significantly higher than normal ranges, as members seek treatment for ongoing dental issues that have not been addressed. However, it is expected that the utilization levels will reach a norm after about one year.

6. Funding source

a. If the request is for an allocation of General Fund or Education Fund revenues, what funds / resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

The proposed dental coverage will be included in the benefit plans available to the specified member groups and as such, all state funds will be matched with federal funds at approximately a 70% federal 30% state split.

7. Stakeholders

a. Who are the stakeholders associated with or impacted by this request?

The elderly, individuals with disabilities enrolled in Medicaid programs, and caretakers of the identified populations.

b. How will stakeholders be impacted if the request is funded?

Medicaid members will benefit from expanded dental benefits which will improve their overall health, which will improve their employability and quality of life.

c. How will stakeholders be impacted if the request is not funded?

If unfunded, Medicaid eligible elderly adults and individuals with disabilities continued to have limited access to dental care. The overall health, self-esteem and employability of these individuals are negatively impacted and emergency rooms will continue to address more acute dental issues resulting in higher costs.

8. Legislation

a. Describe any legislation needed to implement this request.

No additional legislation is required to implement the program.

Form 4000 Incremental Budget Change Request

Submit a Form 4000 for each incremental budget change request invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15/ FY 16 Budget Guidelines for instructions).

Agency: 270 Dept of Health

Request Title: Nursing Home Rate Increase (Including Hospice)

Appropriation Code: LHC Nursing Home

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	0	0	2,000,000	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	0	4,780,800	3252 Fed DOH Title XIX Medicaid
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	Other Source Notes
Total	0	0	6,780,800	

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
HH Other Charges/Pass Through	0	0	6,780,800
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	0	0	6,780,800

Brief Description of Request:

NOTE: THIS REQUEST IMPACTS MULTIPLE APPROPRIATION CODES

The Medicaid program requires a strong provider pool to properly service Medicaid clients. The Legislature appropriated $2 million (General Funds) for FY2015 to increase the reimbursement rates for Nursing Homes (HB0002). The funding was moved to one-time funds. This building block requests ongoing funding to have the State continue the nursing home reimbursement levels established for FY2015.

New FTE	0
Agency Priority	2

Describe any legislation that is necessary to implement this request.	None
How will the proposed change impact QT/OE (if a Success System has not been formally designated, describe generally how this request will influence both quality throughput and operational expenses -- e.g. QT will increase X%, OE will increase Y?)	QT The Medicaid program maintains a strong provider pool to properly service Medicaid clients. The state continues funding at the nursing home reimbursement levels established for FY2015. OE Requested funds are for pass through dollars to providers. As such, these program costs do not affect OE but increase overall program costs.
Who are the stakeholders associated with this request? How will they be impacted if the request is funded? How will they be impacted if the request is not funded?	If funded, ongoing pass thru payments to providers will maintain the current (FY2015) level of Nursing Home reimbursements in the Medicaid programs. Consequences of Not Fully Funding the Building Block: If not funded, nursing home (and hospice) providers will have rates reduced by $6.7 million from the FY2015 levels. Financial stress is added to the service delivery system and the important partnership between State and the Medicaid provider pool is weakened.

FY 15 / FY 16 BUDGET GUIDELINES

Business Case
Policy and Operational Justification

Budget Request Title: Nursing Home Rate Increase (including Hospice)
Agency Budget Request Priority: 02
Brief Description of Budget Change Request: This building block requests ongoing funding to have the State continue the nursing home reimbursement levels established for FY2015.

Detail on Budget Change Request (respond to the following questions)

1. Background and Problem Definition

a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

The Medicaid program requires a strong provider pool to properly service Medicaid clients. The current nursing home rates were established for 2015 and the request is to continue the current funding levels ongoing. Maintaining rates at current levels directly relates to improving the quality and availability of health care the Department can offer members, which are components of the Department's mission.

b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

Providing rates for nursing homes and hospice care that are sufficient to ensure high quality care is being provided and maintaining current rates serves to strengthen the provider network for the Medicaid program.

c. What population is being served?

Individuals enrolled in Medicaid programs with health care issues requiring nursing home or hospice care.

d. Explain why this activity constitutes a proper role of government / what market failure justifies government intervention.

According to Utah Code Title 26 Chapter 18 Section 3 (1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

e. Explain why the state is the proper level of government to handle this issue.

Providing funding for currently established rates is appropriately handled at the State level through the Medicaid program, since the rates are Medicaid reimbursement rates and we are able to offset the cost to the State with federal funds available for the program.

f. What other agencies should be involved in dealing with this issue?

No other agencies should be involved.

g. How are outcomes expected to change relative to current practice if the item is not funded?

The request is to continue the FY2015 rates ongoing. If not funded, nursing home (and hospice) providers rates would be reduced by $6.7 million from the FY2015 levels. Financial stress would be added to the service delivery system and the important partnership between State and the Medicaid provider pool is weakened.

2. QT/OE and SUCCESS Initiative principles

a. How does the budget change request improve the ratio of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating

expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

Throughput: The Medicaid program needs to maintain a strong provider pool to properly serve Medicaid clients. Continued funding of reimbursement rates at current levels serves to strengthen these critical relationships.

Operating Expenses: Requested funding will affect program expenses but not operating expenses. The requested funds will be passed through to providers and maintain existing rates are already established in the reimbursement system.

b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services) (T), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

Maintaining funding for current reimbursement rates ongoing will ensure a strong provider pool to service Medicaid clients, thereby, improving the Department's ability to offer access to quality health care. The change will be ongoing.

c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings? If savings, are they hard cost savings or foregone costs / cost avoidance?

The requested funding is a qualitative measure improving the Department's ability to offer access to quality health care. Requested funds will be passed through to providers. As such, these program costs do not affect OE but increase overall program costs.

d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

As the cost of health care increases, there will likely be future requests to fund rate increases for nursing home and hospice care in the future.

e. Are the requested additional resources being directed to the control point of the system or somewhere else?

The requested resources will be passed through the established reimbursement system to reimburse nursing home and hospice care providers for medical services provided.

f. What operational strategy will be put in place to ensure that the activities of the program lead to the desired outcomes?

This funding request is to maintain funding at to providers and is not related to a new program.

3. Use of Existing Capacity

a. What efforts have been taken to date to maximize the use of existing capacity?

This request does not relate to addition of a new program or expansion of an existing program. It is a request for funding to continue reimbursement rates for nursing home and hospice providers at the FY15 levels.

b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to fund this program?

There are no legal or other impediments to redirecting funds to this priority. The only known limitation related to this request is that the funding must be state funding, as it will be considered part of the required state match for the federal program.

4. Evidence-Based Practice and Evaluation Plans

a. How does this request align with agency's core mission?

The core mission of the Utah Department of Health is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles. Providing rates at current levels helps the Department assure access to care and quality of health care.

b. What is the objective of the program? What is the product or service being produced?

The objective of the request is to receive ongoing funding to allow the Department to continue reimbursing nursing homes and hospice care providers at rates established for FY2015, thereby improving the Department's ability to ensure access to quality health care.

c. Precisely what are the expected improvements in outcomes?

Providing rates for nursing homes and hospice care that are sufficient to ensure high quality care is being provided and maintaining current rates serves to strengthen the provider network for the Medicaid program.

d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin of error exists in the proposed measurements?

This request is for funding to allow the Department to continue reimbursing nursing homes and hospice care providers at rates established for FY2015, and it will strengthen the relationship between the providers and the Medicaid program. However, this outcome is more qualitative than quantitative.

e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

This funding was approved as one-time funding during Fiscal Year 2015. We are unaware of an evaluation or data-driven studies associated with the approved funding.

f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program.

g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program.

h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program, however, the Department is not requesting that the program be sunset.

i. For new or untested programs or services

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?

Funding rates at current levels serves to strengthen the relationship between the providers and the Medicaid program, thereby, ensuring that the Department can offer members high quality accessible health care.

ii. What activities and associated (proximate) measures are available to show progress?

This request relates to funding nursing home and hospice rates at current levels, and it will strengthen the relationship between the providers and the Medicaid program. However, this outcome is primarily qualitative and as such related measures will be difficult to quantify.

iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?

This request relates to funding nursing home and hospice rates at current levels, and it will strengthen the relationship between the providers and the Medicaid program. However, this outcome is primarily qualitative and there are no known related studies or research.

5. Timing

a. How long will the program take to implement?

The request is to continue funding to nursing home and hospice services at current levels ongoing. Therefore, the one-time funding for the rates is already implemented, but needs.

b. What steps will be taken to ensure timeliness in implementation?

The program is already implemented, the request is to continue the current funding levels ongoing.

c. How long will it be before measurable results can be evaluated?

This request relates to funding to assist providers with federally mandated taxes associated with the ACA, and it will strengthen the relationship between the providers and the Medicaid program.

6. Funding source

a. If the request is for an allocation of General Fund or Education Fund revenues, what funds / resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

The funding for the reimbursement rates are funded by both state general funds and federal funds at approximately a 70% federal 30% state split.

7. Stakeholders

a. Who are the stakeholders associated with or impacted by this request?

Nursing home providers, hospice care providers, and participants in the Medicaid program receiving hospice and nursing home services.

b. How will stakeholders be impacted if the request is funded?

If the request is funded ongoing, Medicaid recipients will continue to receive quality care at current levels and it will strengthen the provider network for the Medicaid program.

c. How will stakeholders be impacted if the request is not funded?

If not funded, nursing home (and hospice) providers will have rates reduced by $6.7 million from the FY2015 levels. Financial stress is added to the service delivery system and the important partnership between State and the Medicaid provider pool is weakened.

8. Legislation

a. Describe any legislation needed to implement this request.

No additional legislation is required to implement the program.

Business Case For Incremental Budget Change Request

Submit a Business Case form and separate justification detail for each incremental budget change request that is not invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15 / FY 16 business case instructions).

Agency: 270 Dept of Health

Request Title: MMIS Replacement (PRISM) Project Costs

Appropriation Code: LHL Medicaid MIS Replacement

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	0	3,500,000	0	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	31,500,000	0	3252 Fed DOH Title XIX Medicaid
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	
Total	0	35,000,000	0	

Other Source Notes:

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
AA Personnel Services	0	4,330,200	0
DD Current Expense	0	846,000	0
EE Data Processing Current Expens	0	29,823,800	0
	0	0	0
	0	0	0
	0	0	0
Total	0	35,000,000	0

Brief Description of Request:

The legacy Medicaid Management Information System (MMIS) was designed to process paper based claims more than three decades ago. Since then, the health care system has changed dramatically and the reimbursement methodologies are much more complex and require information system flexibility that is not inherent in the legacy MMIS system. Some of the enhanced functionality provided by the new system (PRISM – Provider Reimbursement Information System for Medicaid) is as follows:

• Improved data collection and reporting capability

Agency Priority: 1

New FTE: 0

FY 15 / FY 16 BUDGET GUIDELINES

Business Case

Policy and Operational Justification

Budget Request Title: Medicaid Management Information System (MMIS) Replacement Project
Agency Budget Request Priority: 01
Brief Description of Budget Change Request:
This building block requests $3,500,000 one-time General Fund to cover the projected costs for FY2016, which are based on project deliverables of the contracted vendor.

Detail on Budget Change Request (respond to the following questions)

1. Background and Problem Definition

a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

The legacy Medicaid Management Information System (MMIS) was designed to process paper based claims more than three decades ago and is the current claims processing system for Medicaid. Since then, the health care system has changed dramatically and the reimbursement methodologies are much more complex and require information system flexibility that is not inherent in the legacy MMIS system.

The mission of the Utah Department of Health is to protect the public's health through preventing avoidable illness, injury, disability and premature death/ assuring access to affordable, quality health care; and promoting healthy lifestyles. The replacement of the legacy MMIS claims payment system will ensure the Department of Health has the continued ability to pay providers for services and treatment to the citizens of Utah in line with the mission of the Department of Health.

b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

Utah's existing MMIS system is a mature legacy system rapidly approaching its end of life. It is primarily a mainframe Cobol/VSAM/CICS system implemented nearly 30 years ago. Three decades of changes in the way Utah Medicaid does business have led to numerous patches and creative work-around processes to keep the system operational and the business functioning. With approval of the requested funding the current design, development, and implementation of the MMIS replacement claims processing system will continue.

In March 2008, the State began an extensive project known as the Medicaid Assessment Planning Project (MAPP). The first phase in this project was a MITA State Self-Assessment. Other phases of the MAPP included: developing a gap analysis from the results of the State Self-Assessment, providing an assessment of Utah's capacity to continue to self-administer its MMIS as well as its capacity to oversee a fiscal agent contract, completing a system options cost/benefit analysis. DOH Medicaid with the support from its technical assistance contractor researched a variety of options for meeting its need to upgrade the system support for Medicaid and other health care initiatives. After reviewing these options the Division settled on four viable options based on considerations from existing approaches in other State Medicaid programs and budget and political realities in Utah. These four options were vetted and priced in the State's cost benefit analysis. After reviewing the various alternatives and considering other solutions State Medicaid moved forward with the current MMIS replacement solution which is named PRISM.

c. What population is being served?

Medicaid is a source of health insurance coverage for Utah's vulnerable populations. Medicaid is a state/federal program that pays for medical services for low-income pregnant women, children, individuals who are elderly or have a disability, parents and women with breast or cervical cancer. To qualify these individuals must meet income and other eligibility requirements.

d. Explain why this activity constitutes a proper role of government / what market failure justifies government intervention.

According to Utah Code Title 26 Chapter 18 Section 3 (1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to title XIX of the Social Security Act.

e. Explain why the state is the proper level of government to handle this issue.

Utah Medicaid is the single state agency responsible for the administration of the Medicaid program. The MMIS replacement claims processing system will ensure that the State will have the continued ability to pay medical providers that serve the citizens of Utah.

f. What other agencies should be involved in dealing with this issue?

Multiple agencies are involved in, or will be affected by the MMIS replacement project. The Division of Medicaid and Health Financing has the primary responsibility in replacing the MMIS legacy system. However, The Department of Humans Services, Department of Workforce Services, Office of Recovery Services, Office of Inspector General Medicaid Services, State Attorney General, and over 70 provider types will be impacted by the replacement of the legacy MMIS system.

g. How are outcomes expected to change relative to current practice if the item is not funded?

If not funded, the MMIS replacement project would need to be stopped and the vendor contracts canceled. The State of Utah would have to pay back federal funding that has been used to cover past expenditures for the project. DMHF will be unable to meet Federal mandates in a timely manner. Providers will be required to maintain obsolete systems to interact with Medicaid. This may eventually lead to access to care problems if providers refuse to participate in the Medicaid program. The current 30 year-old system would remain operational for years to come, with increasing system failure risks. The State's CMS advanced planning certification would also be voided.

2. QT/OE and SUCCESS Initiative principles

a. How does the budget change request improve the ratio of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

Enhanced functionality of the MMIS replacement system includes 1) Improved data collection and reporting capability, 2) Enhanced ability to manage and control Medicaid costs, 3) Surveillance and utilization review functions, 4) Ability to process electronic health records, and 5) Ability to electronically exchange data with other state agencies to manage the program more efficiently.

b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services) (T), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

The request for FY2016 funding relates to the design, development, and implementation of a new claims processing system. When the new claims processing system is completed the data processing or throughput capabilities of the new MMIS system will essentially be limitless. The throughput of the MMIS payment is limited by the funding of the State and Federal government.

c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings? If savings, are they hard cost savings or foregone costs / cost avoidance?

One-Time funding adds OE until the replacement system is operational.

d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

This project is expected to continue through SFY 2019. Matching funding is needed for future design, development, and implementation of the project. The total State General Fund portion approved in the CMS advanced planning document and agreed to by the State is $15,507,268.

e. Are the requested additional resources being directed to the control point of the system or somewhere else?

The requested resources are used directly for the design, development, and implementation of the MMIS replacement system.

f. What operational strategy will be put in place to ensure that the activities of the program lead to the desired outcomes?

The MMIS replacement project is monitored by a third party vendor "Cognosante". Cognosante provides an independent party verification and validation of the new system.

3. Use of Existing Capacity

a. What efforts have been taken to date to maximize the use of existing capacity?

While the existing MMIS has served the Utah Medicaid program well, over the past 5 to 10 years it had become increasingly obvious that the system needed a major overhaul or replacement. While the State's IT staff met the challenges of managed care enrollment and the current standard transactions required under HIPPA, the solutions included a significant number of "work-arounds". Rapid changes in technology have nearly exhausted the States options in attempting to keep the current system compliant with ever increasing demands in health care technology. The enhanced approaches to health care delivery afforded by health information technology were unknown when the existing MMIS was designed.

b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to fund this program?

The State has certified to CMS in an advanced planning document that required matching State General Funds needed for Federal Funds Participation are available to fund the MMIS Replacement project through SFY 2019. The State is also signed a contract with CNSI, the main developer on the project.

4. Evidence-Based Practice and Evaluation Plans

a. How does this request align with agency's core mission?

The mission of the Utah Department of Health is to protect the public's health through preventing avoidable illness, injury, disability and premature death/ assuring access to affordable, quality health care; and promoting healthy lifestyles. The replacement of the legacy MMIS claims payment system will ensure the Department of Health has the continued ability to pay providers for services and treatment to the citizens of Utah in line with the mission of the Department of Health.

b. What is the objective of the program? What is the product or service being produced?

The objective of the MMIS replacement project is to design, develop, and install a state of the art Medicaid claims processing and payment system. The new system will allow the flexibility to adapt to the ever changing health care environment.

c. Precisely what are the expected improvements in outcomes?

Improvements in the new Medicaid claims processing system include the following:

- **Improved data collection and reporting capability.**
- **Enhanced ability to manage and control Medicaid costs.**
- **Surveillance and utilization review functions.**
- **Ability to process electronic health records.**

- **Ability to electronically exchange data with other state agencies to manage the program more efficiently.**

d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin of error exists in the proposed measurements?

CMS will certify the new claims processing system after the design, development, and implementation is complete. The State has also contracted with Cognosante an independent verification and validation vendor to ensure that the new system will be in compliance with CMS requirements. The outcomes of the MMIS replacement project will be quantifiable. Measures of success include the timely and accurate processing of provider claims.

e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

The core of the CNSI solution has been successfully implemented in both Washington and Michigan. Both States passed CMS certification with no significant findings. CMS certification includes evaluation of system functionality using the criteria published in the Medicaid Information Technology Architecture (MITA) Maturity Model.

f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

CMS auditors, State OIG auditors, State internal auditors, and other stakeholders perform regular evaluations of the MMIS claims processing system. The evaluation of the claims processing tests accuracy of payments, testing of State and Federal funds match, provider Medicaid eligibility, variance analysis, fraud detection, and other audit procedures.

g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

CMS regulations and payment methods do change over time, which can affect the claims processing and procedures. The benefit of the replacement MMIS system includes modern technologies and programming language that enable efficient and effective programming changes to comply with CMS and State mandates. The claims processing system will be updated with needed improvements and updates as necessary.

h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

The State is in contract with CNSI (the main developer replacement system). The deliverables performed by CNSI are reviewed by State MMIS employees and an independent contractor before payment is made. The program cannot be sunset without significant paybacks to the federal government.

i. For new or untested programs or services

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?

The PRISM MMIS Replacement System is being implemented in multiple releases. Release 1 includes an updated website and a new online eligibility look-up tool for provider verification of the patient's coverage and eligibility. Release 2 includes an executive dashboard tracking metrics of system performance. These releases were implemented during 2014. Release 3 is scheduled for fall of 2015 and includes on online portal for provider enrollment and a new system to support CMS payments to providers and hospitals for Electronic Health Records. The final Release includes all the remaining functionality including claims payment will follow approximately 18 months later. The State will complete the CMS Certification Process and knowledge transfer to State employees through SFY 2019.

ii. What activities and associated (proximate) measures are available to show progress?

The State uses Microsoft Project and SharePoint to track tasks and milestones for the project. The work plan contains thousands of tasks. The CNSI contract is based on State acceptance of more than 200 specific deliverables which document successful complete of the tasks to complete the project. The approved deliverables and payment amounts are available to show progress.

iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?

Day to day management of the MMIS Replacement Project is led by an Integrated Project Management Office (IPMO) with participation from DOH, DTS, CNSI and Cognosante. The IPMO follows the best practices of the Project Management Institute including formal Risk and Issue tracking. The MS Project work plan includes all contract deliverables and decomposes the tasks to complete each deliverable.

5. Timing

a. How long will the program take to implement?

The first 2 releases of system functionality were implemented in 2014. Release 3 is scheduled for fall of 2015 and the final release will go live approximately 18 months later. CMS requires several months of system stabilization and operation before they will schedule their formal certification team. After successful certification, the CNSI contract requires 12 months of mentoring before the system is turned over to the State. We anticipate the turnover will occur approximately 24 months after the final release goes live.

b. What steps will be taken to ensure timeliness in implementation?

The MS Project work plan includes dates for tasks, milestones, and deliverables. The work plan is monitored by the IPMO and actively updated using a rolling wave approach with revisions based on the projects previous performance. Formal corrective action plans are created for significant deviations.

c. How long will it be before measurable results can be evaluated?

As noted above, the first 2 releases are already implemented and are managed by the PRISM Operations Group. The formal evaluation of the complete project will occur during the CMS certification approximately 12 months after Release 4.

6. Funding source

a. If the request is for an allocation of General Fund or Education Fund revenues, what funds / resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

The funding source is 90% federal funds and 10% state funds or 75% federal funds and 25% state funds depending on the expense type.

7. Stakeholders

a. Who are the stakeholders associated with or impacted by this request?

Stakeholders of the MMIS replacement project include: Medicaid clients, Medicaid Providers, State of Utah Medicaid, and auditors of the Medicaid program.

b. How will stakeholders be impacted if the request is funded?

Clients will receive the appropriate services, providers will receive the correct reimbursement, and the DOH will prudently spend the Medicaid budget to fulfil its mission to the State of Utah.

c. How will stakeholders be impacted if the request is not funded?

If not funded, the MMIS replacement project would need to be stopped and the vendor contracts canceled. The State of Utah would have to pay back federal funding that has been used to cover past expenditures for the project. DMHF will be unable to meet Federal mandates in a timely manner. Providers will be required to maintain obsolete systems to interact with Medicaid. This may eventually lead to access to care problems if providers refuse to participate in the Medicaid program. The current 30 year-old system would remain operational for years to come, increasing system failure risks. The State's advanced planning certification is voided.

8. Legislation

a. Describe any legislation needed to implement this request.

Medicaid is requesting $3,500,000 in State General Fund for State Fiscal Year 2016. The appropriation will be used as State match to acquire the matching Federal Funds.

Business Case For Incremental Budget Change Request

Submit a Business Case form and separate justification detail for each incremental budget change request that is not invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15 / FY 16 business case instructions).

Agency: 270 Dept of Health

Request Title: Technology Dependent Waiver Capacity Expansion

Appropriation Code: LJB Home & Community Based Waivers

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	0	0	366,000	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	0	854,000	3252 Fed DOH Title XIX Medicaid
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	
Total	0	0	1,220,000	

Other Source Notes:

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
HH Other Charges/Pass Through	0	0	1,220,000
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	0	0	1,220,000

Brief Description of Request:

Funding requested to enroll 10 additional clients in the Technology Dependent Waiver. There are currently 75 applicants on a waiting list for services, 10 of whom are currently residing in South Davis, Country Life or are inpatient at Primary Children's Hospital. Providing services in the waiver rather than in facilities is a less costly, less restrictive option.

Agency Priority:

New FTE:

FY 15 / FY 16 BUDGET GUIDELINES

Business Case

Policy and Operational Justification

Budget Request Title: TECHNOLOGY DEPENDENT WAIVER CAPACITY EXPANSION (Ongoing Funding FY2016)
Agency Budget Request Priority: 01
Brief Description of Budget Change Request:

Funding requested to enroll 10 additional clients in the Technology Dependent Waiver. There are currently 75 applicants on a waiting list for services, 10 of whom are currently residing in South Davis, Country Life or are inpatient at Primary Children's Hospital. Providing services in the waiver rather than in facilities is a less costly, less restrictive option.

Detail on Budget Change Request (respond to the following questions)

1. Background and Problem Definition

a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

This program provides unique home and community-based services to a limited number of eligible individuals who would otherwise require placement in a certified nursing facility to receive Medicaid coverage for their care and services. Allowing 10 additional children to participate in the program will reduce the number of children with special health care needs waiting for services or being serviced out of their own homes in nursing facilities or in hospitals. Clients are provided with less restrictive option settings for less cost. This relates to the Department of Health core mission of providing a quality health care to Medicaid clients.

b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

Enrolling an additional 10 clients into the Technology Dependent Waiver will allow children with special health care needs to be served in their homes with their families. It is a less costly alternative to serving the children in nursing facilities or hospitals.

c. What population is being served?

Children with significant and complex medical conditions (for example, children who are dependent on ventilator and tracheostomy technologies).

d. Explain why this activity constitutes a proper role of government / what market failure justifies government intervention.

The type of services provided in the Technology Dependent Waiver are not covered or are partially covered by private insurance.

e. Explain why the state is the proper level of government to handle this issue.

Utah Department of Health is the single state agency responsible for the administration of the Medicaid program [UCA 26:18(3)]. The Medicaid 1915(c) waiver authority allows the state to provide these services to a limited population, as defined by the state, who would otherwise receive the services in nursing facilities or hospitals. Waiver services are a less costly alternative.

f. What other agencies should be involved in dealing with this issue?

The Department of Health Division of Medicaid and Health Financing and Division of Family Health and Preparedness, Children with Special Health Care Needs.

g. How are outcomes expected to change relative to current practice if the item is not funded?

If not funded, applicants will continue to wait for waiver services or will receive services in the more costly nursing facility or hospital settings.

2. QT/OE and SUCCESS Initiative principles

a. How does the budget change request improve the ratio of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

Enrolling an additional 10 clients into the Technology Dependent Waiver will allow children with special health care needs to be served in their homes with their families. It is a less costly alternative to serving the children in nursing facilities or hospitals.

b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services) (T), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

Increasing waiver capacity by 10 clients would be ongoing.

c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings? If savings, are they hard cost savings or foregone costs / cost avoidance?

This is an increase in program costs but does not increase OE.

d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

The funding request is to admit 10 additional children into the waiver on an ongoing basis. This request would not result in additional budget requests beyond the requested ongoing funding.

e. Are the requested additional resources being directed to the control point of the system or somewhere else?

The requested additional resources are directed to the control point.

f. What operational strategy will be put in place to ensure that the activities of the program lead to the desired outcomes?

The 1915(c) waiver document would be amended to increase the number of waiver slots by 10.

3. Use of Existing Capacity

a. What efforts have been taken to date to maximize the use of existing capacity?

The waiver is currently at the authorized capacity.

b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

There are no lower-priority activities to discontinue that would free up resources for this purpose.

c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

There are no savings in other mandatory programs that can be used to fund this waiver expansion.

d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to fund this program?

No.

4. Evidence-Based Practice and Evaluation Plans

a. How does this request align with agency's core mission?

The project aligns with the mission of providing access to quality, cost effective health care for eligible Utahns.

b. What is the objective of the program? What is the product or service being produced?

To expand home and community based services to children with special health care needs in the most cost effective, least restrictive way.

c. Precisely what are the expected improvements in outcomes?

To expand services in the waiver, rather than in facilities, is a less costly, less restrictive option.

d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin of error exists in the proposed measurements?

The desired outcome will be achieved when the 10 slots are filled. Program enrollment will be evidence of the desired outcome.

e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

The program has been in operation for more than 20 years. It is well documented that serving these children in home and community based services are the least costly alternative and they allow children to remain with their families.

f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

The state is required to complete an annual CMS 372 report to document that waiver services costs are less than what would have been spent if the participant had received the services in a nursing facility or hospital.

g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

The program would need to be re-evaluated to determine why waiver services were more costly than facility based services. In the 20 year history of the program, this has not occurred.

h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

No.

i. For new or untested programs or services

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?

N/A – This not a new program.

ii. What activities and associated (proximate) measures are available to show progress?

N/A (not a new program)

iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?

N/A (not a new program).

5. Timing

a. How long will the program take to implement?

State will submit waiver amendment to increase the number of waiver slots. CMS has 90 days to review and approve the amendment.

b. What steps will be taken to ensure timeliness in implementation?

Upon confirmation of available funding, State will immediately submit waiver amendment to CMS.

c. How long will it be before measurable results can be evaluated?

Individuals will be enrolled upon CMS approval of waiver amendment.

6. Funding source

a. If the request is for an allocation of General Fund or Education Fund revenues, what funds / resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

There are no other funds available. General funds are required in order to draw the federal Medicaid funds.

7. Stakeholders

a. Who are the stakeholders associated with or impacted by this request?

The stakeholders associated with this request are families and children with special health care needs, who are dependent on ventilator and tracheostomy technologies and service providers.

b. How will stakeholders be impacted if the request is funded?

Stakeholders will be positively impacted by this request as 10 more clients are accepted onto this waiver in a less restrictive, more cost effective manner.

c. How will stakeholders be impacted if the request is not funded?

Families will have to make a determination about placing their child out of their homes in order to receive needed services.

8. Legislation

a. Describe any legislation needed to implement this request.

No legislation needed.

Business Case For Incremental Budget Change Request

Submit a Business Case form and separate justification detail for each incremental budget change request that is not invited by GOMB. Completed forms should be saved and uploaded to the Google Budget Site (see FY 15 / FY 16 business case instructions).

Agency: 270 Dept of Health

Request Title: Affordable Care Act (ACA) Provider Tax

Appropriation Code: LHD Managed Health Care

source of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing	Sources
Unrestricted Funds	0	0	1,832,900	1000 (GF) General Fund Unrestricted
Restricted Funds 1	0	0	0	
Restricted Funds 2	0	0	0	
Dedicated Credits 1	0	0	0	
Dedicated Credits 2	0	0	0	
Federal Funds 1	0	0	4,381,200	3252 Fed DOH Title XIX Medicaid
Federal Funds 2	0	0	0	
Transfers	0	0	0	
Other	0	0	0	Other Source Notes
Total	0	0	6,214,100	

use of funds	FY 15 One-Time	FY 16 One-Time	FY 16 Ongoing
HH Other Charges/Pass Through	0	0	6,214,100
	0	0	0
	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	0	0	6,214,100

Brief Description of Request:

The federal Affordable Care Act (ACA) requires a tax on Medicaid and CHIP providers to help fund the federal costs of the ACA. The act allows for federal participation if the states reimburse providers for these added costs. HB0002 of the Utah 2014 General Session provided one-time funding to providers for FY2015 to help address the impacts of the provider tax required by ACA.

This building block requests ongoing funding to have the State continue the provider payments related to the ACA tax.

Agency Priority:

New FTE:

FY 15 / FY 16 BUDGET GUIDELINES

Business Case
Policy and Operational Justification

Budget Request Title: ACA Provider Tax
Agency Budget Request Priority: 03
Brief Description of Budget Change Request: This building block requests ongoing funding to have the State continue the provider payments related to the ACA tax.

Detail on Budget Change Request (respond to the following questions)

1. Background and Problem Definition

a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

The federal Affordable Care Act (ACA) requires a tax on Medicaid providers to help fund the federal costs of the ACA. The ACA allows for federal participation if the states reimburse providers for these added costs. HB0002 of the Utah 2014 General Session provided one-time funding to providers for FY2015 to help address the impacts of the provider tax required by ACA. Offering assistance to providers to help offset the impact of the ACA tax relates to improving the quality and the availability of health care that the Department can offer members, both of which are components of the Department's mission.

b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

The ACA requires a tax on Medicaid providers to help fund the costs associated with the ACA. Providing assistance to providers to defray the costs of the ACA serves to strengthen the relationship between the providers and the Medicaid program, thereby, ensuring that the Department can offer members high quality accessible health care.

c. What population is being served?

Enrolled providers of the Medicaid program.

d. Explain why this activity constitutes a proper role of government / what market failure justifies government intervention.

According to Utah Code Title 26 Chapter 18 Section 3 (1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

e. Explain why the state is the proper level of government to handle this issue.

Providing funding to providers to help offset the costs of ACA is appropriately handled at the State level. The ACA allows federal participation if the states reimburse providers for these added costs.

f. What other agencies should be involved in dealing with this issue?

No other agencies should be involved.

g. How are outcomes expected to change relative to current practice if the item is not funded?

The request is to continue providing assistance to providers to minimize the tax burden of the ACA ongoing. If not funded, providers bear a ($6.9 million) greater financial impact as a result of the ACA.

2. QT/OE and SUCCESS Initiative principles

a. How does the budget change request improve the ratio of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

The Medicaid program needs to maintain a strong provider pool to properly serve Medicaid clients. Continued funding to minimize the tax burden to providers as a result of the ACA serves to strengthen these critical relationships. Requested funds will be passed through to providers. As such, these program costs do not affect OE but increase overall program costs.

b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services) (T), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

Maintaining funding for provider ACA tax assistance ongoing will ensure a strong provider pool to service Medicaid clients, thereby, improving the Department's ability to offer access to quality health care. The change will be ongoing.

c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings? If savings, are they hard cost savings or foregone costs / cost avoidance?

The requested funding is a qualitative measure improving the Department's ability to offer access to quality health care. Requested funds will be passed through to providers. As such, these program costs do not affect OE but increase overall program costs.

d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

The request is to provide funding to assist providers with the mandated taxes associated with the ACA. There are no foreseen future budget cost pressures related to this request. However, at the federal level changes may be made to the ACA requirements, which could affect the tax requirements for providers.

e. Are the requested additional resources being directed to the control point of the system or somewhere else?

The requested resources will be passed through the established reimbursement system to providers to offset the federal ACA tax burden.

f. What operational strategy will be put in place to ensure that the activities of the program lead to the desired outcomes?

N/A – this is funding to continue providing assistance to providers to offset the mandated tax requirements of the ACA and is not related to a new program.

3. Use of Existing Capacity

a. What efforts have been taken to date to maximize the use of existing capacity?

N/A - This request does not relate to addition of a new program or expansion of an existing program. It is a request for funding to continue providing assistance to providers to offset the costs of the ACA.

b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

Medicaid would need to cut services to State citizens / Medicaid clients to free up existing resources.

d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to fund this program?

There are no known legal or other impediments to redirecting funds to this priority. The only known limitation related to this request is that the funding must be state funding, as it will be considered part of the required state match for the federal program.

4. Evidence-Based Practice and Evaluation Plans

a. How does this request align with agency's core mission?

The core mission of the Utah Department of Health is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles. Providing assistance with provider taxes associated to the ACA helps the Department assure access to care and quality of health care.

b. What is the objective of the program? What is the product or service being produced?

The objective of the request is to receive funding to allow the Department to continue assisting providers with taxes associated with the ACA, thereby improving the Department's ability to ensure access to quality health care.

c. Precisely what are the expected improvements in outcomes?

Providing assistance to providers to defray the costs of the ACA serves to strengthen the relationship between the providers and the Medicaid program, thereby, ensuring that the Department can offer members high quality accessible health care.

d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin of error exists in the proposed measurements?

This request relates to funding to assist providers with federally mandated taxes associated with the ACA, and it will strengthen the relationship between the providers and the Medicaid program. However, this outcome is more qualitative than quantitative.

e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

This funding was approved as one-time funding during Fiscal Year 2015. We are unaware of an evaluation or data-driven studies associated with the approved funding.

f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program.

g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program.

h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

The Department is requesting ongoing funding for this program. Future evaluations of the program may be performed by policy makers to determination the effectiveness of the program, however, the Department is not requesting that the program be sunset.

i. For new or untested programs or services

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?

Providing assistance to providers to defray the costs of the ACA serves to strengthen the relationship between the providers and the Medicaid program, thereby, ensuring that the Department can offer members high quality accessible health care.

ii. What activities and associated (proximate) measures are available to show progress?

This request relates to funding to assist providers with federally mandated taxes associated with the ACA, and it will strengthen the relationship between the providers and the Medicaid program. However, this outcome is primarily qualitative and as such related measures will be difficult to quantify.

iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?

This request relates to funding to assist providers with federally mandated taxes associated with the ACA, and it will strengthen the relationship between the providers and the Medicaid program. However, this outcome is primarily qualitative and there are no known related studies or research.

5. Timing

a. How long will the program take to implement?

The request is to continue funding approved in FY2015 to assist providers with taxes related to the ACA ongoing. Therefore, the program is already implemented, but needs ongoing funding.

b. What steps will be taken to ensure timeliness in implementation?

N/A – the program is already implemented, the request is to continue the current funding ongoing.

c. How long will it be before measurable results can be evaluated?

This request relates to funding to assist providers with federally mandated taxes associated with the ACA, and it will strengthen the relationship between the providers and the Medicaid program. However, this outcome is primarily qualitative, as opposed to quantitative.

6. Funding source

a. If the request is for an allocation of General Fund or Education Fund revenues, what funds / resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

The funding for the provider tax is funded by both state general funds and federal funds at approximately a 70% federal 30% state split.

7. Stakeholders

a. Who are the stakeholders associated with or impacted by this request?

Enrolled Medicaid providers.

b. How will stakeholders be impacted if the request is funded?

If the request is funded ongoing, Medicaid recipients will continue to receive quality care at current levels and it will strengthen the provider network for the Medicaid program.

c. How will stakeholders be impacted if the request is not funded?

If not funded, providers will bear a $6.9 million tax burden as a result of the ACA and the important partnership between State and the Medicaid provider pool is weakened.

8. Legislation

a. Describe any legislation needed to implement this request.

No additional legislation is required to implement the program.