MEDICAID REVIEW; STATUS OF RECOMMENDATIONS

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SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
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ISSUE BRIEF

SUMMARY

This brief identifies the 19 recommendations not fully implemented from the 42 recommendations from the Medicaid Review report (http://www.le.state.ut.us/interim/2010/pdf/00000295.pdf), presented at the January 28, 2010 meeting of the Health and Human Appropriations Subcommittee. This brief includes three suggested performance measures the Legislature may want to track. Additionally, this brief summarizes the implementation status of all 42 recommendations.

DISCUSSION AND ANALYSIS

Savings From Recommendations Implemented

The table below shows the total $(11,705,100) annual General Fund savings and cost avoidance from recommendations implemented thus far:

Annual Ongoing General Fund Savings		
Recommendation	**Savings**	**Cost Avoidance (annual)**
Outpatient hospital and ambulatory center services reimbursements at historical rates	$ (4,394,600)	$ (1,492,500)
Increased recoveries for fraud, waste, & abuse	$ (5,818,000)	
Total	**$ (10,212,600)**	**$ (1,492,500)**

Recommendations for Performance Measures

The Legislature may be interested in tracking the following items as performance measures:

1. **Clients in Managed Care** – The Legislative Auditors made several recommendations in recent audits to expand the number of Medicaid clients being served by managed care plans.
2. **Days to Sign up for Managed Care** – The Legislative Auditors made the following recommendation: "We recommend that Utah Medicaid review methods of accelerating the process of assigning Medicaid recipients to a managed care plan (Report 2010-01, page 24, http://le.utah.gov/audit/10_01rpt.pdf)."
3. **General Fund Cost in Allocation Model for Eligibility Workers** – The Legislative Auditor's Report 2009-19 (http://le.utah.gov/audit/09_19rpt.pdf) provided several suggestions for improving the cost allocation model for eligibility workers with the Department of Workforce Services and the impact on General Fund.

Nineteen Recommendations Not Fully Implemented

The table below details the 19 recommendations not fully implemented from the Medicaid Review report. Of these 19, ten recommendations have been partially implemented.

Recommendation	Done?	Next Steps if Further Action Desired	Notes
Allow for psychotropic or anti-psychotic drugs to be on the Preferred Drug List	No	Statutory change	
Program Integrity access to the controlled substance database	Partial	Statutory change	May want to consider allowing inquiries by provider.
Same service same price	Partial	Legislative action	May want to consider paying same price between ambulatory surgical centers and outpatient hospital for the same services
Allow immunosuppressive drugs on the Preferred Drug List Program	No	Statutory change	
Study return on investment for Medicaid Fraud Control Unit	No	Legislative action	
Report on recommendations to expand waivers	Partial	Legislative action	
Annual follow up on "A Performance Audit Of Fraud, Waste, and Abuse..."	Partial	Legislative action	First year follow up done. What about future years?
Annual follow up on "A Performance Audit of Utah Medicaid Managed Care"	Partial	Legislative action	First year follow up done. What about future years?
Annual follow up on "A Performance Audit of DWS Eligibility..."	Partial	Legislative action	First year follow up done. What about future years?
Increase public awareness fraud reporting	No	Legislative action	
meeting of all provider groups & list of changes for the federal government	Partial	Legislative action	
Expansions in the areas of collections	No	Legislative action	
Review of Medicaid statute	No	Legislative action	
Explore moving away from fee-for-service payments to pay for quality	No	Legislative action	
Further study consolidating and/or better coordinating the Medicaid program	Partial	Legislative action	
Studying lessons from Medicare	No	Legislative action	
Identify a budgeting method to remove the double counting	No	Legislative action	
changes to revenue and expenditure reporting	Partial	Legislative action	
clearly track total administrative seed revenues	Partial	Legislative action	

In addition to the nineteen recommendations mentioned above, the following report requested by the Legislature has not been received as of January 16, 2011: “The Legislature intends that the Department of Workforce Services report to the Office of the Legislative Fiscal Analyst the feasibility of allowing non-state entities working with low income individuals to submit the required information for Medicaid and other public programs eligibility via online methods by December 31, 2010 (HB 2, Item 157, 2010 General Session).”

Status of Each of the 42 Recommendations

The list below includes all of the 42 recommendations from the Medicaid Review report (http://www.le.state.ut.us/interim/2010/pdf/00000295.pdf) in four groups (policy changes, new reporting requirements, areas for additional research in coming sessions, and administrative budget structure changes) and their implementation status in *italics*.

Policy Changes - Status of Recommendations

1. Direct the Department of Health via statute to change their reimbursement methodology as soon as possible away from paying a percentage of billed charges for outpatient hospital and ambulatory center services reimbursements. The levels of reimbursement should be set at historical levels similar to what is being paid to other service providers.

Implemented. Moving to historical rate levels was implemented via appropriations with $4,394,600 ongoing General Fund reductions starting in FY 2011. The Department of Health reports: "In March 2010, the Department of Health reduced the percent of billed charges it was paying for these services in order to set payments back to historical levels. The Department estimates that it will be able to achieve the targeted reductions from the appropriations change." Based on FY 2010 spending on ambulatory surgical centers and outpatient hospitals and the FY 2009 Governor recommended inflationary increase of 4.12% for these two services, the State is cost avoiding $1,492,500 annually from moving away from paying a percentage of billed charges.

2. Remove $5,818,000 ongoing General Fund and $14,404,000 federal funds from Medicaid services in FY 2012 to match potential savings found from improved fraud recoveries discussed in the Legislative Auditor General's "A Performance Audit Of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program." Additionally, appropriate $3,386,800 one-time General Fund in FY 2011 to provide for a phased-in implementation.

Implemented via appropriations. The Department of Health in December 2010 began doing additional pre-editing of medical claims with the help of a contractor. The Department of Health reports: "The Department has also brought in a contractor to do a focused review of paid claims from 2008 and 2009 and to collect any overpayments. In addition, the Department of Health has issued a request for proposals (RFP) for a new fraud and abuse detection system. It is estimated that the system will be in place by September 2011. Depending on the results of the evaluation of the responses to the RFP, the Department may also select a vendor to review claims after payment and to collect any overpayments."

3. Change UCA 26-18-4.2 to allow for psychotropic or anti-psychotic drugs to be considered for the Preferred Drug List.

Not implemented.

4. The "(Legislative Auditor General) recommend(s) that the Legislature consider the merits of extending access of the controlled substance database to (the Bureau of Program Integrity). If access is granted, (the Bureau of Program Integrity) should develop and institute controls to ensure providers are billing

Medicaid correctly and that prescriptions are appropriate in regards to frequency and dosage (2009 Medicaid audit, page 40)."

Partially implemented. HB 186 "Controlled Substance Database Revisions" passed in the 2010 General Session and provides the Department of Health access to the controlled substance database. From page 6 of the Legislative Auditor General's "A Follow-up of Utah's Medicaid Implementation of Audit Recommendations" (http://le.utah.gov/audit/10_14rpt.pdf) it states: "Legislative Amendments made to the controlled substance database now allows Program Integrity to obtain information by individual. Future tests may show a need to also give Program Integrity the ability to obtain information by provider."

5. In statute change the fee-for-service payment system to be the same for services regardless of who the provider is. Explore paying the lowest price for a service to all providers. If pricing cannot be fixed, then explore requiring a client to use an ambulatory surgical center for approved services before using a hospital unless prior authorization is approved.

Partially implemented. The following intent language was included in HB 2: "The Legislature intends that the Department of Health establish a Medicaid outpatient fee schedule for each of the following types of facilities: rural hospitals, urban hospitals, and ambulatory surgical centers. The first twenty-five percent of the new fee schedule should be implemented no later than July 1, 2010. Fifty percent should be implemented no later than October 1, 2010. Seventy-five percent should be implemented no later than January 1, 2011. The project should be completed by July 1, 2011." A next possible step would be to pay the same price for the same service regardless if it is received in an ambulatory surgical center or outpatient hospital setting.

6. Change statute to remove the requirement to have CHIP providers have two hospital networks. Instead, focus requirements on sufficient access and coverage.

Implemented. HB 461 "Children's Health Insurance Program" passed during the 2010 General Session and made this change.

7. Allow immunosuppressive drugs, used to prevent organ rejection, to be placed on the Preferred Drug List Program.

Not implemented.

8. Require the Department of Health via intent language to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee its plans for a Medicaid Management Information System replacement. The presentation should include the full array of options for which parts of claims processing are performed by State vs contracted workers. Consider funding a portion of this request beginning in FY 2011 in a separate line item.

Implemented. The following intent language was included in HB 2: "The Legislature intends that the Department of Health report to the Office of the Legislative Fiscal Analyst by July 1, 2010 its plans for a Medicaid Management Information System replacement. The presentation should include the full array of options for which parts of claims processing are performed by State vs contracted workers." The Department of Health submitted the required report on time. The Department of Health presented the required reports on August 17,

2010 to the Executive Appropriations Committee. For additional information please see the audio link at http://le.utah.gov/av/smil?int=168850 and the report at http://health.utah.gov/medicaid/stplan/LegReports/HB2%20MMIS%20System%20Replacement%20Options.pdf.

9. Require the Department of Health via intent language to report to the Executive Appropriations Committee the responses to the request for proposals for the Medicaid Management Information System replacement.

Implemented. The following intent language was included in HB 2: "The Legislature intends that the Department of Health report quarterly to the Office of the Legislative Fiscal Analyst on the status of replacing the Medicaid Management Information System replacement beginning September 30, 2010. The reports should include, where applicable, the responses to any requests for proposals." The following link is to the most recent quarterly report http://health.utah.gov/medicaid/stplan/LegReports/HB2%20MMIS%20Quarterly%20Report.pdf.

10. Consider providing more access points to clients applying for Medicaid eligibility (allow local health departments and non-profit groups who work with low income individuals to help complete applications for their clients for Medicaid).

Implemented. The following intent language was included in HB 2: "The Legislature intends that the Department of Workforce Services report to the Office of the Legislative Fiscal Analyst the feasibility of allowing non-state entities working with low income individuals to submit the required information for Medicaid and other public programs eligibility via online methods by December 31, 2010." As of January 16, 2011, this report has not been received.

11. Consider a statutory change requiring all unused funds that are associated with the Medicaid program in the Department of Workforce Services and the Department of Human Services to be deposited into the Medicaid General Fund Restricted Account at year end.

Implemented. HB 397 "Medicaid Program Amendments" passed in the 2010 General Session and made this change effective FY 2012.

12. Study the return on investment for resources provided to the Attorney General's Medicaid Fraud Control Unit. Study the feasibility of increased recoveries if the unit is provided with more resources.

Not implemented. During the 2010 General Session the recommendation became item 157 in the Master Study Resolution (SJR 15). Item assigned to the Health and Human Services Interim Committee. This committee did not discuss this item.

13. Require internal Health auditors to do audits at least in proportion to their Medicaid funding, which is currently about one-third.

Implemented. HB 459 "Health Amendments" passed in the 2010 General Session and made this change. The results of these internal audits are reported in Appendix B at the end of this report.

New Reporting Requirements - Status of Recommendations

1. Change statute to require the Department of Health to report annually to the Health and Human Services Appropriations Subcommittee on how they are meeting their statutory mandates to be more efficient and effective.

Implemented. HB 459 "Health Amendments" passed in the 2010 General Session and made this change. This report is included in the report in Appendix B at the end of this report.

2. The "(Legislative Auditor General) recommend(s) that (the Bureau of Program Integrity) report annually to the Legislature and Governor on their cost avoidance and cost recovery efforts (2009 Medicaid audit, page 56)." This could be accomplished via intent language.

Implemented. HB 459 "Health Amendments" passed in the 2010 General Session and made this change. From July 2009 through December 2010, the Department has recovered $5.3 million total funds and estimates an annual cost avoidance of $3.6 million total funds. The 2010 report is included as Appendix B at the end of this report.

3. Change statute to require the Departments of Health, Human Services, and Workforce Services to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee before reapplication of Medicaid waivers. The report should include an analysis of costs and benefits as well as recommendations on whether or not to expand enrollment and/or end the waiver.

Partially implemented. HB 459 "Health Amendments" passed in the 2010 General Session and made a change to reporting requirements to include reapplication of waivers. Two waivers have been renewed since the passage of this legislation: (1) Community Supports for Individuals with Intellectual Disabilities and (2) Individuals Aged 65 and Older (Aging). The statutory change did not include an analysis of costs and benefits nor a recommendation on whether or not to expand enrollment in the waiver. The report from the agency on waiver reapplications is included as Appendix A.

4. Require a report annually via intent language from the Department of Health on the implementation of "A Performance Audit Of Fraud, Waste, and Abuse Controls in Utah's Medicaid Program" to be presented to the Health and Human Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.

Partially implemented. The first follow up report by the Legislative Auditor General is entitled "A Follow-up of Utah's Medicaid Implementation of Audit Recommendations" and can be found at http://le.utah.gov/audit/10_14rpt.pdf. Additional follow up work will not be undertaken unless requested by the Legislature. Future follow up work would need to be coordinated with other audit requests.

5. Require a report annually via intent language from the Department of Health on the implementation of "A Performance Audit of Utah Medicaid Managed Care" to be presented to the Health and Human Services Appropriations Subcommittee. Additionally, require the report to include the differences in

cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.

Partially implemented. The first follow up report by the Legislative Auditor General is entitled "A Follow-up of Utah's Medicaid Implementation of Audit Recommendations" and can be found at http://le.utah.gov/audit/10_14rpt.pdf. Additional follow up work will not be undertaken unless requested by the Legislature. Future follow up work would need to be coordinated with other audit requests.

6. Require a report annually via intent language from the Department of Workforce Services on the implementation of "A Performance Audit of DWS Eligibility Determination Services" to be presented to the Commerce and Workforce Services Appropriations Subcommittee. Additionally, require the report to include the differences in cost/savings to the State from implementing the recommendations. These reports should continue until all recommendations have been satisfactorily implemented.

Partially implemented. The Health and Human Services Appropriations Subcommittee made a motion to request the Legislative Auditors to do annual verification audits until all the recommendations had been satisfactorily completed. The Legislative Auditors did their standard follow up report in December 2010. They will report the following as part of their annual report: "Department of Workforce Services (DWS) management, who allocated $125 million in fiscal year 2009, should do more to increase cost allocation accuracy. An increased emphasis on timely responses will improve cost allocation accuracy and could have saved the state over $500,000 in fiscal year 2009. DWS recently freed up $16.1 million in state funds by using third-party in-kind contributions as part of the state's TANF obligation. We believe the Legislature should determine how these funds should be used. DWS could save the state over $530,000 by eliminating four underutilized buildings. Three additional buildings should be downsized to save the state additional funds. ***Results of Follow-Up:*** *Nineteen recommendations were made; twelve have been implemented, two partially implemented, four are in process and one was not implemented. The one recommendation not implemented is for the Legislature to determine how to appropriate the above-mentioned $16.1 million."*

Additional follow up work will not be undertaken unless requested by the Legislature. Future follow up work would need to be coordinated with other audit requests.

7. Require a report via intent language from the Department of Workforce and the Department of Health on how they have addressed the problems found by the Utah State Auditor. After reviewing the results of the FY 2009 audit, the Legislature may want to consider requesting the auditors to check the status of this problem more frequently than the current annual basis.

Implemented. HB 2 from the 2010 General Session included the following intent language: "The Legislature intends that the Utah State Auditor report to the Legislative Fiscal Analyst by December 31, 2010 on how the Departments of Health and Workforce Services have addressed problems found by the Utah State Auditor in their FY 2008 and FY 2009 audits." The State Auditor referenced its annual report as its response to the intent language above. The report on the Department of Health can be found at http://www.sao.utah.gov/_finAudit/rpts/2010/10-21.pdf. The report on the Department of Workforce Services can be found at http://www.sao.utah.gov/_finAudit/rpts/2010/10-38.pdf.

8. Beginning December 1, 2010, require a combined, unified annual report from the Departments of Health, Workforce Services and Human Services to the Executive Appropriations Committee or Health and Human Services Appropriations Subcommittee that shows how all Medicaid appropriations are being spent for administration and services in the prior fiscal year. For December 1, 2011, expand the coordinated reporting requirement to include non-State entities providing services via contracts. This report will help enable coordination of funding and policy decisions.

Implemented. The Executive Appropriations Committee assigned the following in-depth budget review to the Governor's Office of Planning and Budget at its April 6, 2010 meeting: "Medicaid Program Coordination – to study the consolidation or improved coordination of the Medicaid program by the Department of Health, the Department of Human Services, and the Department of Workforce Services. The coordination study shall include a format for a combined, unified annual report from the three departments, and any other state agency receiving Medicaid funds, to the Executive Appropriations Committee showing how all Medicaid appropriations were spent in the prior fiscal year. Additionally, study shall be made for potential options for coordinated reporting from those performing final expenditures via contract." The "Medicaid Consolidated Report" section of Governor's Office of Planning and Budget's report is included at the end of this report as Appendix F. The full report can be viewed online at http://www.health.utah.gov/medicaid/pdfs/annual_report2010.pdf .

9. Require the Department of Health to gather reports from local health departments. The reports should include at a minimum: (1) explain why local health departments are not using all of the State match provided and their county match for the Early Periodic Screening, Diagnosis and Treatment Program for Utah Medicaid and (2) where the unmatched grant money has been used.

Not Implemented. Upon further investigation, it would appear that this report is not needed.

10. Require a report via intent language from the Departments of Health, Human Services, and Workforce Services on how they will increase public awareness of their fraud reporting systems and encourage the public to report Medicaid fraud.

Not implemented. During the 2010 General Session the recommendation became item 125 in the Master Study Resolution (SJR 15). Item assigned to the Health and Human Services Interim Committee. This committee did not discuss this item.

11. Direct the Department of Health and Public Health Employee's Program (PEHP) via intent language to provide a report to the Legislature on ideas learned by PEHP that could be applied in Medicaid and a time frame for carrying out those proposals.

Implemented. HB 2 from the 2010 General Session included the following intent language: "The Legislature intends that the Public Employees' Health Program (PEHP) provide a report to the Legislative Fiscal Analyst by December 31, 2010 on ideas learned by PEHP that could be applied to Medicaid." This reported is included at the end of this brief as Appendix D.

Areas for Additional Research in Coming Sessions - Status of Recommendations

1. Direct the Department of Health via intent language to report by October 1, 2010 on reimbursement options for pharmaceutical drugs that would give the State more control over inflationary increases and/or move away from a reimbursement based on Average Wholesale Price.

Implemented. HB 2 from the 2010 General Session included the following intent language: "The Legislature intends that the Department of Health report by October 1, 2010 to the Office of the Legislative Fiscal Analyst on reimbursement options for pharmaceutical drugs that would give the State more control over inflationary increases and/or move away from a reimbursement based on Average Wholesale Price." This report is included at the end of this brief as Appendix E and is available online at http://health.utah.gov/medicaid/stplan/LegReports/Medicaid%20AWP%20Replacement%20Option%20Report.pdf and http://health.utah.gov/medicaid/stplan/LegReports/Rx%20Exec%20Sum%20and%20White%20Paper%20FINAL1.pdf.

2. Convene a meeting of all provider groups to recommend which level of government and which type of providers should administer which portions of Medicaid. Additionally, make a list of recommended changes to the Medicaid program to present to the federal government.

Partially implemented. During the 2010 interim a survey was conducted of the following groups: State agencies, Medicaid providers, advocates, and existing Medicaid committees. For the results of this survey please see the Issue Brief entitled "Medicaid Survey Results."

3. Revisit the role and efficiency of the Office of Recovery Services in the Department of Human Services. Direct the Departments of Health, Human Services, and Workforce Services via intent language to develop a list of options for expansions in the areas of collections (such as requiring insurers to share benefit information for all medical assistance recipients to increase collections and cost avoidance).

Not implemented. During the 2010 General Session the recommendation became item 130 in the Master Study Resolution (SJR 15). Item assigned to the Health and Human Services Interim Committee. This committee did not discuss this item.

4. Review Medicaid statute for clarification in assigned responsibilities, desired policy direction, and agency interactions. Consider raising all the statutes relating to Medicaid from chapter level in statute to a separate title and consolidate all related statute beneath that title.

Not implemented. During the 2010 General Session the recommendation became item 128 in the Master Study Resolution (SJR 15). Item assigned to the Health and Human Services Interim Committee. This committee did not discuss this item.

5. Further study consolidating and/or better coordinating the Medicaid program for the agencies involved (Health, Workforce Services, and Human Services).

Partially implemented. The Executive Appropriations Committee assigned the following in-depth budget review to the Governor's Office of Planning and Budget at its April 6, 2010 meeting: "Medicaid Program Coordination –

to study the consolidation or improved coordination of the Medicaid program by the Department of Health, the Department of Human Services, and the Department of Workforce Services. The coordination study shall include a format for a combined, unified annual report from the three departments, and any other state agency receiving Medicaid funds, to the Executive Appropriations Committee showing how all Medicaid appropriations were spent in the prior fiscal year. Additionally, study shall be made for potential options for coordinated reporting from those performing final expenditures via contract." This report is included at the end of this report as Appendix C. The Legislature may want to look at this issue more to search for more ideas for consolidation and coordination.

6. Explore contracting for direct Medicaid providers for primary care services. Direct the Department of Health to issue a Request for Information for direct contracting for primary care services and report on results to the Health and Human Services Appropriations Subcommittee by February 1, 2011.

Implemented. HB 397 "Medicaid Program Amendments" passed in the 2010 General Session and implemented this recommendation.

7. Explore moving away from fee-for-service payments to pay for quality.

Not implemented. During the 2010 General Session the recommendation became item 115 in the Master Study Resolution (SJR 15). Item assigned to the Health and Human Services Interim Committee. This committee did not discuss this item.

8. Direct the Department of Health to study the feasibility of a three-year pilot project with medical homes within their existing budget. During the third year of the pilot, the Department of Health shall report to the Legislature with recommendations for expansion or termination of the pilot project. Direct the Department of Health via intent language to study the five recommendations from the Henry J. Kaiser Foundation September 2009 report on Medicare and give options for implementation in the Medicaid program in a report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee by February 1, 2011.

***Medical homes** - Implemented. HB 397 "Medicaid Program Amendments" passed in the 2010 General Session and implemented the recommendation. This report is included as Appendix G at the end of this report.*

***Studying lessons from Medicare** - not implemented. During the 2010 General Session the recommendation became item 126 in the Master Study Resolution (SJR 15). Item assigned to the Health and Human Services Interim Committee. This committee did not discuss this item.*

Administrative Budget Structure Changes - Status of Recommendations

1. Direct the Department of Health via intent language to report incomes sources in Medicaid to the Legislature annually by major income type. Additionally, direct the Department of Health to work with the Division of Finance to identify a tracking method for all revenues to the Medicaid program that will also reflect expenditures in the expenditure reports provided to the Legislature wherever feasible.

Partially implemented. The subcommittee made a motion for the chairs to write a letter directing the Department of Health to provide the detail mentioned above. This letter was mailed in February 2010. The

Department of Health reports: "The Utah Statistical Report of Medicaid and CHIP issued December 30, 2010, contains income sources by major income type (See Figure 5 and Table 2, page 13)." The page with number 13 on it in Appendix F is where this table can be found.

2. Direct the Department of Health to work with the Division of Finance to identify a way to clearly track total administrative seed revenues annually beginning with the FY 2011 budget.

Partially implemented. The subcommittee made a motion for the chairs to write a letter directing the Department of Health to provide the detail mentioned above. This letter was mailed in February 2010. The Department of Health reports: "The Department is in discussions with the Division of Finance to develop unique transfer codes for State agency seed monies. The Department is also requesting the Division of Finance establish additional dedicated credit coding to identify seeded funding for Mental Health entities and the University Hospital."

3. Add two budget programs in Health Care Financing entitled "DWS Seeded Services" and "Other Seeded Services" detailing the seeded money the Department of Health gives for Medicaid to DWS and other entities.

Implemented. Implemented via appropriations, see http://le.utah.gov/lfa/reports/cobi2011/LI_LGA.htm.

4. Identify a budgeting method to remove the double counting in Medicaid due to transfers between the Department of Health and other State agencies (situation not unique to Medicaid).

Not implemented. During the 2010 General Session the recommendation became item 113 in the Master Study Resolution (SJR 15). Item assigned to the Health and Human Services Interim Committee. This committee did not discuss this item.

5. Add a budget program in the Medicaid budget entitled "Medicaid Non-service Expenses" and move costs from non-service categories to this budget program.

Implemented. Implemented via appropriations, see http://le.utah.gov/lfa/reports/cobi2011/LI_LJA.htm.

6. Make mental health inpatient hospital a separate program within the Medicaid Optional Services line item. This may help highlight the difference between optional and mandatory and contrast with the capitated mental health costs that we are paying.

Implemented. Implemented via appropriations, see http://le.utah.gov/lfa/reports/cobi2011/LI_LJA.htm.

7. Make Crossover Services, Hospice Care Services, and Medical Supplies their own budget program within the Medicaid service line items (Medicaid Mandatory Services and Medicaid Optional Services).

Implemented. Implemented via appropriations, see http://le.utah.gov/lfa/reports/cobi2011/LI_LJA.htm and http://le.utah.gov/lfa/reports/cobi2011/LI_LHB.htm.

8. Move primary care grants statute UCA 26-18 Part 3 out of the Medicaid chapter of statute.

Implemented. HB 397 "Medicaid Program Amendments" passed in the 2010 General Session and made this change.

9. Add another budget program to break out the detail for services through Select Access (not managed care) and the 2 managed care networks.

Implemented. Implemented via appropriations with a new budget program entitled "State-run primary care case management," see http://le.utah.gov/lfa/reports/cobi2011/LI_LHB.htm.

10. Move the Bureau of Program Integrity through appropriations from part of Medicaid administration (Health Care Financing) to a budget program within the Executive Director's Office line item.

Implemented. Implemented via appropriations. Beginning FY 2011, funding for the Bureau of Program Integrity is part of the budget program entitled "Internal Audit and Program Integrity," which is part of the Executive Director's Office line item, see http://le.utah.gov/lfa/reports/cobi2011/LI_LAA.htm.

LEGISLATIVE ACTION

The Subcommittee has at least the following options:

1. Do nothing.
2. Take further action on items not fully implemented.
3. Direct State agencies to track up to three of the suggested performance measures.
4. Some combination of #2 and #3 above.

APPENDIX A - REPORT ON WAIVER RE-APPLICATIONS

State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health
Executive Director's Office

David N. Sundwall, M.D.
Executive Director

Michael Hales
Director, Medicaid and Health Financing

June 30, 2010

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

Dear Subcommittee Member:

The Centers for Medicare and Medicaid Services (CMS) requires the Utah Department of Health to update its State Plan for Medicaid when the State makes changes to the program. Notification of these changes has historically been sent to members of the Executive Appropriations Committee. During the 2010 Legislative General Session, the Legislature passed HB 262, which now directs these notices be sent to members of the Health and Human Services Appropriations Subcommittee.

Additionally, the Legislature passed HB 459, which directs the Department to submit a notice of a waiver extension. This letter will accomplish both requirements for all activity since the 2010 Legislative Session.

Amendments to State Plan and Rate Changes

There are several State Plan Amendments resulting from budget adjustments and federal eligibility policy changes. Here is a summary of all submissions with additional detail following on subsequent pages:

- Rural Area Access to Pain Management Services of a Primary Care Physician
- Treatment of Census Takers and Burial Fund Clarification
- Retroactive Period Effective Date
- Eligibility Conditions and Requirements
- Rural Disproportionate Share Hospital (DSH) Payments
- Inpatient Hospital Assessment and Adjustments to Private Hospitals
- Medical Education and Supplemental State Teaching Hospital Payments
- Ambulatory Surgical Centers
- Outpatient Hospital Payments
- Transportation Services
- Estate Recovery
- Cost Sharing Exemption
- Quality Improvement Incentive
- Crossover Payments
- Estimated Acquisition Cost

Rural Area Access to Pain Management Services of a Primary Care Physician

The Department has transmitted State Plan Amendment – Pain Management, which will increase access to pain management services in rural areas by allowing a primary care physician the option to devise a pain management plan to carry out treatment for a patient. These changes allow physicians in rural areas of the state to provide services and a treatment plan for patients who suffer from chronic pain.

In the previous pain management program, the Department limited services to pain management specialists who formulated the management plan and turned patient management over to the primary care physician.

This change allows a pain medicine specialist the option to continue as the patient's pain medicine physician after devising the patient's treatment plan. It also further simplifies and clarifies billing codes and procedures to reimburse clinical psychologists and psychiatrists that participate in pain management.

There is no anticipated cost increase or cost shift to more expensive services.

Utah Treatment of Census Takers and Burial Fund Clarification

The Department has transmitted State Plan Amendment – Utah Treatment of Census Takers and Burial Fund Clarification. This amendment excludes the earned income that some Medicaid recipients may receive if they are employed as temporary census takers. In addition, this amendment clarifies how the state treats burial funds if the person removes the funds from an excluded burial fund account.

The Department of Health has submitted this amendment so that wages of temporary census workers that were previously excluded for everyone except the medically needy will apply to all Medicaid groups. These temporary census workers may work for a few months during the year of the census. This allows Medicaid recipients an incentive to receive work experience for a few months without disrupting their eligibility for Medicaid benefits.

There is no anticipated cost increase for this change.

Retroactive Period Effective Date

The Department has transmitted State Plan Amendment - Retroactive Period Effective Date. This amendment changes the effective date of Medicaid eligibility to the first day of the third month before the date of application.

This change brings the State into compliance with federal requirements to determine the effective date of Medicaid eligibility for the retroactive period. This amendment will provide clients additional time to apply for retroactive coverage.

There is no anticipated cost increase associated with this change.

Eligibility Conditions and Requirements

The Department has transmitted State Plan Amendment – Eligibility Conditions and Requirements. The purpose of this change is to match the resource limits for the Medicare cost sharing programs to the limits used by the Medicare Part D Low-Income Subsidy program, as required in the Social Security Act.

Page 22 of Attachment 2.6-A is amended to indicate that the new resource limits for the Medicare cost sharing programs meet the federal requirements found under Section 1905(p)(1)(C) of the Social Security Act. This amendment also specifies that the new resource limits apply to Qualifying Individuals.

It is anticipated this change will increase general fund expenditures by $51,280 for FY 2011.

Rural Disproportionate Share Hospital (DSH) Payments

The Department has transmitted State Plan Amendment – Rural Disproportionate Share Hospital (DSH) Payments. This amendment allows for a DSH payment pool for qualifying rural hospitals. This will allow amounts available to rural providers to be pooled and distributed to rural facilities above their individual annual "cap," but still subject to the uncompensated care cost limits for each facility.

This State Plan change does not change the amount of DSH dollars available from the Centers for Medicare and Medicaid Services (CMS). The allocation of the allotted amount is changed. Rural hospitals may qualify for a greater amount of DSH if other rural hospitals cannot maximize their allotment, but the overall DSH pool remains constant (i.e., all Utah hospitals, urban and rural can only be paid up to the allotment for the state). The total DSH pool will not be increased (i.e., any increase that the rural hospitals receive will necessarily mean that the urban DSH pool will be reduced by the same amount). This is a yearly allotment received by the state from CMS.

There is no anticipated cost increase associated with this change.

Inpatient Hospital Assessment and Adjustments to Private Hospitals

The Department has transmitted State Plan Amendment – Inpatient Hospital Assessment and Adjustments to Private Hospitals. This amendment adds new language to the State Plan for inpatient hospital supplemental payments to private hospitals. This amendment preserves and improves access to inpatient hospital services in private hospitals. This action does not change coverage or benefits to Medicaid enrollees. This change provides supplemental payments to private hospitals for inpatient services up to the upper payment limit gap for private hospitals. The Department is implementing the Hospital Provider Assessment Act as outlined in Senate Bill 273 from the 2010 General Session of the Utah State Legislature. This action is in accordance with 42 CFR 447.272 and establishes quarterly supplemental payments to private hospitals. These payments are to preserve and improve access to inpatient hospital services in private hospitals for the period January 1, 2010, through June 30, 2013.

There is no general fund impact resulting from this amendment as all match funds will be provided through the hospital assessment.

Medical Education and Supplemental State Teaching Hospital Payments

The Department has transmitted State Plan Amendment – Medical Education and Supplemental State Teaching Hospital Payments. This change updates the direct graduate medical education payment methodology, removes the indirect medical education payments and replaces them with supplemental

state teaching hospital payments. There is no estimated federal budget impact because there is no net change in payments. This is due to the fact that the GME payments are not anticipated to change as a result of this SPA.

The supplemental teaching hospital payments effectively replace the indirect medical education payments of the past. Consequently, there is no anticipated cost increase associated with this change.

Ambulatory Surgical Centers

The Department has transmitted State Plan Amendment –Ambulatory Surgical Centers. This change updates the percentage of charges paid to these facilities and also establishes fixed fee pricing for certain procedures. It also moves away from percentage of charges reimbursement on July 1, 2010. This amendment only addresses the "Surgical Centers" section of the State Plan. It is anticipated that annual provider payments will decrease by $1,188,000 in State and Federal funds as a result of this change.

Outpatient Hospital Payments

The Department has transmitted State Plan Amendment – Outpatient Hospital Payments. This amendment updates the percentage of charges paid to outpatient hospitals and reduces the percentage of charges reimbursement amounts. It also adds supplemental payments to state and other government-owned facilities. It also incorporates other minor changes.

This change will reduce total expenditures by $10,889,500.

Transportation Services

The Department has transmitted State Plan Amendment – Transportation Services. The purpose of this change is to update citations referenced from the Utah Administrative Code and to list the federal statute that requires the Department of Health to ensure necessary transportation for Medicaid recipients. This change, therefore, amends Attachment 3.1-D to clarify and update citations from the Utah Administrative Code, and lists the federal statute (42 CFR 431.53) that requires the Department of Health to ensure necessary transportation for Medicaid clients. It is also amended to change the word "insure" to "ensure" to be more consistent with the federal statute.

There is no anticipated cost increase associated with this change.

Estate Recovery

The Department has transmitted State Plan Amendment – Estate Recovery. This amendment requires states to exempt Medicare cost sharing benefits paid under the Medicare Savings Programs from estate recovery after death. CMS requires this amendment from all states.

It is anticipated this change will result in additional general fund expenditures of $113,400 for FY 2011.

Cost Sharing Exemption

The Department has transmitted State Plan Amendment – Cost Sharing Exemption. This amendment includes American Indians as a group that is exempt from copayment requirements. This

exemption is in accordance with the provisions of the American Recovery and Reinvestment Act of 2009. This amendment does not provide any new services for Medicaid clients. It does, however, eliminate out-of-pocket copayment expenses to American Indians who receive Medicaid services through Indian health programs.

This amendment does not result in any increase or decrease in payment to Medicaid providers because the Department will reimburse them the full amount for services to cover the cost of the exemption.

There is no impact to the Department budget because services for American Indians are covered entirely by federal funds.

Quality Improvement Incentive

The Department has transmitted State Plan Amendment – Quality Improvement Incentive. The purpose of this amendment is to continue quality incentive programs for nursing facilities in state fiscal year 2011 and to make other clarifications.

This amendment does not provide any new services and it does not affect the budget. Furthermore, this amendment does not affect overall payments to the nursing facility industry or to ICF/MR providers and does not change the services that nursing facility residents already receive.

Crossover Payments

The Department has transmitted State Plan Amendment – Crossover Payments. This amendment removes the Medicaid payment rate of 80% for Qualified Medicare Beneficiary (QMB) Only providers to comply with state budget shortfalls and required budget cuts. This amendment does not provide any new services and it results in a savings to the budget of approximately $4,400 in FFY 2010 and $16,400 in FFY 2011. QMB Only providers will see a decrease in total provider payments.

Estimated Acquisition Cost

The Department has transmitted State Plan Amendment – Estimated Acquisition Cost. This amendment decreases the estimated acquisition cost of medications upon which reimbursement is based. The estimated acquisition cost for prescription drugs will be reduced from Average Wholesale Price (AW) minute 15 percent to AWP minus 17.4 percent.

This will result in a decrease in payment to providers. This change is being made in accordance with budget cuts and will reduce projected annual expenditures by approximately $3,700,000 in total funds.

New Waivers

The Department did not apply for any new waivers during this reporting period.

Waiver Renewals

Home and Community-Based Services waiver renewals

The Centers for Medicare and Medicaid Services (CMS) require the Department of Health to renew each of its 1915(c) Home and Community Based Service (HCBS) waivers every five years. The following waivers required renewal: the New Choices Waiver, the Waiver for Individuals Aged 65 or Older (Aging Waiver) and the Community Supports Waiver for Individuals with Intellectual Disabilities and Related Conditions (Community Supports Waiver).

The HCBS waivers offer an array of services in a person's home or other community-based setting as an alternative to receiving services in a nursing facility or intermediate care facility for individuals with mental retardation (ICF/MR).

NEW CHOICES WAIVER:

The following modifications were made to the waiver renewal application: The Community Transition, Chore, and Professional Medication Monitoring service definitions were modified and the number of participants the waiver is authorized to serve was increased from 1,000 to 1,200. Because this waiver only serves individuals who come directly from nursing facilities, serving additional clients on the waiver does not result in additional costs, it results in cost reduction, because immediately prior to coming on to the waiver, the individuals were receiving Medicaid nursing facility services. The Department estimates that the average annual cost per waiver client will be approximately $22,584 per year. Prior to enrolling in the New Choices Waiver, these clients were residing in nursing facilities and had an average annual cost per client of $44,660.

AGING WAIVER:

The following modifications were made to the waiver renewal application: Three new services were added including Community Transition, Personal Budget Assistance, and Financial Management and minor modifications were made to seven existing service definitions. The Department estimates that the average annual cost per waiver client will be approximately $13,762 per year. This waiver is an alternative to nursing facility services which have an average annual cost of $51,315 per client.

COMMUNITY SUPPORTS WAIVER:

The following modifications were made to the waiver renewal application: The Professional Medication Monitoring service definition was modified and clarifications were made to the fair hearing process. The Department estimates that the average annual cost per waiver client will be approximately $36,221 per year. This waiver is an alternative of an ICF/MR which has an average annual cost of $75,363 per client.

1115 Demonstration Waiver

The Department has submitted a request to renew the Primary Care Network 1115 Demonstration Waiver for an additional three years. In addition the Department has resubmitted a request to amend this demonstration in order to allow the State to assist individuals in their purchase of private health insurance.

This 1115 waiver was originally created in 2002 as a statewide demonstration in order to obtain federal Medicaid matching funds to cover certain able-bodied adults who are not eligible for Medicaid state plan services. The demonstration seeks to increase health care coverage without increasing costs by

shifting some resources from parents on Medicaid to populations that currently have no health care coverage. As part of this demonstration over 18,000 adults receive basic, preventive care through the Primary Care Network (PCN).

In October 2006 the demonstration was amended to offer assistance to children and adults with payment of premiums for employer-sponsored health insurance through Utah's Premium Partnership for Health Insurance (UPP). In December 2009 another amendment allowed UPP to provide premium assistance to children and adults for coverage obtained under the provisions of the Consolidated Omnibus Reconciliation Act of 1986 (COBRA). Renewing the waiver will allow the Department to continue the PCN and UPP programs through June 30, 2013.

Renewal of the waiver will continue state and federal expenditures as they have been for FY 2011.

Waiver Amendments

1115 Demonstration Waiver

In addition to the request for renewal the Department is resubmitting a request to amend the waiver to expand UPP to provide subsidies for the purchase of individual policies. This action was originally requested in 2008 but CMS has not acted on the request. Therefore the Department is resubmitting this amendment along with the renewal request.

Through the amendment uninsured individuals and families that do not have access to employer-sponsored health insurance or COBRA continuation coverage will benefit from these changes. Enrollment in UPP is limited by available funding. In 2006 the Legislature appropriated funding to cover 1,000 adults on this program. This appropriation of $267,500 in General Fund combined with some existing funding for PCN and federal matching funds will cover program expenditures. Enrollment in UPP can be closed once the 1,000 slots for adults have been filled. Therefore these amendments will not require additional appropriations. To the extent these amendments increase enrollment up to the 1,000 slots, the amount of General Fund and federal funds used by UPP will increase. The increase will reduce the amount of unspent appropriated UPP funds, which in prior years has lapsed into the Medicaid Restricted account.

Please let me know if you have any questions. My number is 801-538-6689.

Sincerely,

Michael T. Hales, Director
Division of Health Care Financing

Enclosures

APPENDIX B - ANNUAL EFFICIENCY, COST AVOIDANCE, AND INTERNAL AUDITING REPORT FOR MEDICAID

ANNUAL REPORT TO THE HEALTH AND HUMAN SERVICE APPROPRIATIONS SUBCOMMITTEE

UTAH DEPARTMENT OF HEALTH

12/21/2010

Office of Internal Audit

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

State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health
Office of Internal Audit & Program Integrity

David N. Sundwall, M.D.
Executive Director

W. DAVID PATTON, PH.D
Chief Operating Officer

DEAN EBORN, CPA
Director, Internal Audit & Program Integrity

December 28, 2010

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

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

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

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

Sincerely,

Dean Eborn

Dean Eborn, CPA
Director, DOH Office of Internal Audit

cc: President Michael Waddoups
Speaker David Clark
David Sundwall, M.D.
David Patton, Ph.D
Teresa Garrett, RN MS
Michael Hales
Russ Franson
Stephen Jardine
Clifford Strachen

UTAH DEPARTMENT OF HEALTH

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Telephone 801-538-6123 • Facsimile 801-538-6382 • *www.health.utah.gov*

Table of Contents

INTRODUCTION

ROLE AND AUTHORITY:

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

STAFF:

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

"The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, fraud, waste, abuse, and cost recovery..."

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

OIA IMPACT

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

Internal Audit

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

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

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

***Estimate*

Program Integrity

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

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

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

INTERNAL AUDITS

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

Performance Audits

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

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

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

Cost Settlements

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

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

Follow-Up Reviews

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

PROGRAM INTEGRITY UPDATES AND ACCOMPLISHMENTS

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

Performance Measures

Three key performance measures are presented below:

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

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

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

Return on Investment

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

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

Recovery RFP and FADS RFP

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

Medical Review and Recovery Process

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

APPENDIX C - GOPB MEDICAID REPORT

MEDICAID

Report to the Utah State Legislature by the Governor's Office of Planning and Budget

Coordination & Reporting Study

Clifford Strachan, Analyst
David Walsh, Analyst
Nancy Grisél, Analyst
Stephen J. Coleman, Analyst

EXECUTIVE SUMMARY

The Governor's Office of Planning and Budget (GOPB) received a request from the Legislative Management Committee pursuant to UCA 63J-1-701, to perform an in-depth review of Medicaid Program Coordination. Specifically, focus has been requested in the following areas:

1. Study the consolidation or improved coordination of the Medicaid program by the Department of Health, the Department of Human Services, and the Department of Workforce Services.

2. Present a format for a unified annual report from the three departments, and any other state agency receiving Medicaid funds.

3. Include options for coordinated reporting from those performing final expenditures via contract.

RECOMMENDATIONS

Consolidation/Coordination

The departments of Health and Workforce Services have proactively collaborated to address some of the issues with Medicaid eligibility and service delivery. Great strides have been made to streamline communication, improve the policy change process, and align policies across all programs wherever possible. The results of their efforts are detailed in this report.

1. GOPB recommends that the departments continue their efforts to collaborate on Medicaid process improvement. Specifically, efforts should focus on improvements that:

    - Increase departmental accountability for Medicaid funding and expenditures;
    - Restructure policy development processes to improve integration among departments, while recognizing the needs within each department;
    - Provide clear delineation of roles and responsibilities;
    - Optimize audit procedures;
    - Ensure compliance with state and federal requirements;
    - Redirect or eliminate excess capacity;
    - Result in less rework;
    - Reduce errors; and,
    - Provide professional, timely, and accurate service delivery to the citizens of Utah.

2. GOPB recommends that the departments establish a target date by which these efforts will be completed.

Annual Report

3. GOPB recommends the Department of Health (DOH) be responsible for collecting data and publishing a unified annual report on Medicaid and Children's Health Insurance Program (CHIP) expenditures. All other State agencies receiving or expending Medicaid funds, including the Department of Human Services (DHS), the Department of Workforce Services (DWS), the University of Utah, and the Attorney General, should designate senior finance personnel to cooperatively participate with DOH's Division of Medicaid and Health Financing in producing this annual report.

4. GOPB recommends that DOH, with the cooperation of other entities receiving or expending Medicaid funds, shall deliver the abovementioned report to GOPB and the Chairs of the Executive Appropriations Committee by December 31, for the prior fiscal year.

5. GOPB recommends that report should be expanded to include Medicaid expenditures by contracted providers.

Contents

INTRODUCTION

The Governor's Office of Planning and Budget received a request from the Legislative Management Committee pursuant to UCA 63J-1-701, to perform an in-depth review of Medicaid Program Coordination. Specifically, focus has been requested in the following areas:

1. Study the consolidation or improved coordination of the Medicaid program (Title XIX) by the Department of Health, the Department of Human Services, and the Department of Workforce Services.

2. The coordination study shall include a format for a unified annual report from the three departments, and any other state agency receiving Medicaid funds to the Executive Appropriations Committee, showing how all Medicaid appropriations were spent in the prior fiscal year.

3. Study shall be made for potential options for coordinated reporting from those performing final expenditures via contract.

With cooperation from Departments of Health (DOH), Human Services (DHS), and Workforce Services (DWS), the Attorney General, and the University of Utah, the Governor's Office of Planning and Budget (GOBP) examined the current status of Medicaid program coordination and reporting. In this document, GOPB makes recommendations pertaining to consolidation, improved coordination, and reporting.

This document includes a preview of report information to be provided pursuant to the recommendations made here. It details Medicaid programs and appropriations as spent in the prior fiscal year (FY2010). GOPB's efforts to obtain this information have already improved the process of coordinated reporting as GOPB has directed the Division of Medicaid and Health Financing to expand its annual report to include both Medicaid and Children's Health Insurance Program (CHIP) and to include and make clear the expenditure of Medicaid funds through all state agencies. Information in this report will be included in DOH's annual report entitled, "Utah Statistical Report of Medicaid and CHIP: State Fiscal Year 2010" expected in December 2010. Further, DOH, DHS, DWS, and GOPB are working together to expand the report to include coordinated reporting for local health departments and other entities receiving Medicaid funds.

This report begins with a discussion of consolidation and coordination issues and presents recommendations. It then addresses Medicaid reporting and the need to consolidate reporting of Medicaid and CHIP expenditures providing a snapshot of program expenditures. Finally, the study includes a preview of the type and form of information to be provided in a unified annual report on Medicaid and CHIP expenditures.

The preview of the unified report provides overviews of Medicaid and CHIP, descriptions of programs and State agencies delivering or administering services, guidelines for eligibility, benefits, services and programs, and expenditure data pertaining to administration and operation of Medicaid and CHIP. The Appendix includes a glossary of terms, a description of Utah's Medicaid waiver programs, and a comparison of adult Medicaid programs.

RECOMMENDATIONS

Consolidation/Coordination

1. GOPB recommends that the departments continue their efforts to collaborate on Medicaid process improvement. Specifically, efforts should focus on improvements that:

    - Increase departmental accountability for Medicaid funding and expenditures;
    - Restructure policy development processes to improve integration among departments, while recognizing the needs within each department;
    - Provide clear delineation of roles and responsibilities;
    - Optimize audit procedures;
    - Ensure compliance with state and federal requirements;
    - Redirect or eliminate excess capacity;
    - Result in less rework;
    - Reduce errors; and,
    - Provide professional, timely, and accurate service delivery to the citizens of Utah.

2. GOPB recommends that the departments establish a target date by which these efforts to optimize Medicaid processing will be completed, understanding that continual improvement will occur after that date.

Annual Report

3. GOPB recommends DOH be responsible for collecting data and publishing a unified annual report on Medicaid and CHIP expenditures. All other State agencies receiving or expending Medicaid funds, including the DHS, the DWS, the University of Utah, and the Attorney General, should designate senior finance personnel to cooperatively participate with DOH's Division of Medicaid and Health Financing in producing this annual report.

4. GOPB recommends that DOH, with the cooperation of other entities receiving or expending Medicaid funds, shall deliver the abovementioned report to GOPB and the Chairs of the Executive Appropriations Committee by December 31, for the prior fiscal year.

5. GOPB recommends that the unified annual report should be expanded to include Medicaid expenditures by contracted providers.

MEDICAID PROGRAM CONSOLIDATION/COORDINATION

Background

In 1965 Congress enacted Social Security Amendments which created the Medicaid (Title XIX) program. Utah began its Medicaid program for acute and long term care in 1966. DOH is designated as the single State agency responsible for making state applications to the federal government for all Medicaid funding and Medicaid-related programs. The department also administers CHIP (Title XXI).

Programs and services for Medicaid are delivered by DOH, DHS, and a myriad of contracted providers including University of Utah Hospitals, local health organizations, not-for-profit and for-profit entities. The Office of the Attorney General also receives Medicaid funding to investigate and prosecute Medicaid fraud and abuse.

In 2007 the Utah State Legislature transferred the Medicaid eligibility determination (funding and workers) function from the Department of Health to the Department of Workforce Services to consolidate all eligibility determination staff.

The total State of Utah FY2010 Medicaid expenditures amounted to $1.9 billion.

Consolidation/Coordination

The issue of consolidating various aspects of Medicaid processes has been raised in various forums. Under the existing framework of Medicaid processing, funding and expenditures are difficult to track. Financial reporting among the various departments involved in Medicaid is disparate. Comprehensive expenditure reporting is based on general budgeting categories that fail to provide clarity about who is paying for services and who is providing them. The complexity of the Medicaid program, combined with the diversity of agencies either administering the program or delivering services, and compounded by the vast financial resources involved, make simplifying the processes a logical suggestion. Solutions are often framed by frustration with current processes but tempered by the overarching desire to be more efficient.

Many valid suggestions have been put forth. Among them is Governor Herbert's *Utah Advisory Commission to Optimize State Government* recommendation that the Departments of Health and Workforce Services implement an interagency initiative to better coordinate policy.

More specific suggestions have been made by various interested parties:

- *Audit Functions:* Identify one department responsible for edit and audit activities for medical eligibility programs.
- *Policy Development:* Assign DWS ownership of the medical eligibility policy development process with DOH owning the final approval of that policy as the single State agency.
- *Medical Review Board (MRB):* Integrate the separate processes within the DWS and DOH as related to the medical eligibility determination for Disability Medicaid when the applicant has not yet been approved for Social Security Disability.
- *Medical Eligibility Determinations:* Consolidate all medical eligibility determinations into one department.

- *Provider Access Points:* Inter-connect the service options housed in each department for providers to obtain information.

- *Customer Access Points:* Inventory all access points available to customers in each department and assess abilities to integrate them.

Any proposal to improve Utah's Medicaid processes must consider the constraints imposed in statute by CMS, wherein DOH is bound by edit and audit requirements and regulations concerning policy development and delegation of authority.

Responsibilities of the Single State Agency

As the single State agency designated by Federal Regulations CFR 431.10, DOH is ultimately responsible for all aspects of Medicaid and is prohibited from delegating its authority to those other than its own officials. The following are requirements to which the Medicaid agency must adhere:

> Authority of the single State agency. In order for an agency to qualify as the Medicaid agency, the agency must not delegate, to other than its own officials, authority to:
>
> 1. Exercise administrative discretion on the administration or supervision of the [Medicaid State] plan, or
>
> 2. Issue policies, rules and regulations on program matters.
>
> 3. The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance or similar action by other offices or agencies of the State.
>
> 4. If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency. (42 CFR 431.10)

Recent Efforts to Improve Service Delivery

Recognizing the need for process improvement, DWS and DOH proactively sought a solution for inefficiencies that could be addressed easily. As a result of interdepartmental "Kaizen Process Improvement" exercises, DWS and DOH have already identified and implemented many procedural improvements, including:

- DOH medical policy staff participates in monthly meetings with DWS food stamp, financial and child care policy staff with the goal of aligning policies across all programs where possible;
- DOH works closely with DWS to coordinate the release of policy to ensure DWS has the ability to train the medical eligibility workers prior to policy implementation;
- DOH policy staff meets monthly with DWS program staff to ensure they clearly understand the policy changes and are able to train the DWS eligibility workers on the correct policy;
- DWS program staff has the ability to contact a DOH policy specialist directly regarding questions on specific areas of policy; and,
- DOH, DWS and electronic Resource Eligibility Product (eREP) staff meet at least monthly to coordinate policy changes that may affect eREP programming.

These are important first steps toward attaining better communication, greater efficiency, and improved accuracy. Further efforts to improve Medicaid processes should address departmental accountability for expenditures, performance, and efficiency. An improvement in one process that creates problems in other processes is not an

acceptable solution. Any organizational change that is undertaken should be done only after a complete business analysis has been performed.

The largest challenge to improving many individual processes is that it be done in a way that will lead to *overall* improvement in the way Utah manages Medicaid. All suggestions worth considering should lead to:

- Increased department accountability for Medicaid funding and expenditures;
- Increased access to usable real time Medicaid expenditure data;
- Increased accuracy in determining both program and services eligibility;
- Most efficient use of resources;
- Increased responsiveness by implementing policy changes accurately and in a more timely manner;
- Improved ability to manage all change, but especially federal health care reform;
- Shared mission statement and goals relating to Medicaid among departments;
- Increased customer satisfaction;
- Mutual commitment to continual improvement;
- Improved interagency cooperation and collaboration; and,
- Improved, more efficient service delivery.

Annual Report

Tracking Medicaid is a complex undertaking. In a report titled "Medicaid Review" presented at the January 28, 2010 meeting of the Health and Human Services Appropriations Subcommittee, the Legislative Fiscal Analyst (LFA) discussed the administration of Medicaid:

> All Medicaid money is administered by the Department of Health. As per federal requirements, all funding for Medicaid must flow through the Department of Health and be governed by a memorandum of understanding for all functions performed by other entities whether State, non-profit, for profit, local government, etc. About 83% of the medical services are provided by any willing provider who bills Medicaid directly. The other 17% of medical services are provided through two contracted health plans who handle the billing and case management services of their clients.
>
> For all Medicaid services in State government in FY2009, the Department of Health directly administered 73% of the total. The second largest player in Medicaid is the Department of Human Services which provides services to its qualifying aged, disabled, and foster care clients and represents 15% of total spending in the State. Other providers, who provide matching money to receive federal funds, make up the other 12% of Medicaid services. (LFA, Medicaid Review, 2010, p.13)

The report recommended *"a unified annual report"* from state agencies "that shows how all Medicaid appropriations are being spent for administration and services in the prior fiscal year." (p.13). It further recommended expanding the requirement to non-state agencies, which is addressed later in this GOPB report.

Complexities include the State's classification of Medicaid services as mandatory or optional. The report states, "The line dividing mandatory and optional services is occasionally blurred by the fact that some optional services are mandatory for specific populations or in specific settings." Another is the seeded match or "seed" money required to receive federal funds. Counties, for example, "use their appropriation from the State, together with county match to participate in the Medicaid program" (p.16). There is a need for improved reporting.

GOPB has been working with DOH, DHS, and DWS to streamline reporting of Medicaid funds. Primarily, these agencies track Medicaid fund usage as follows:

1. FINET – The State's financial program tracks revenues and expenditures from an accounting perspective by specific line item, but does not give detailed program information.

2. CMS – The Utah Medicaid Program, operated by the Utah Department of Health, is responsible for the submission of quarterly reports to the Centers for Medicare and Medicaid Services (CMS) detailing total federal and state expenditures under Medicaid-authorized programs. Approximately 60 percent of all Medicaid expenditures are conducted through entities performing services to the State, within the parameters of the Medicaid program.

3. MMIS – DOH uses the Medicaid Management Information System (MMIS) to track expenditures from a programmatic perspective. Data collected are used to determine statistically the use of Medicaid funds. DOH has initiated a significant upgrade to the MMIS function to better track and use data pertaining to Medicaid.

   The MMIS replacement will benefit the Medicaid program in numerous ways. The updated, modern technology will provide enhanced ability to:

   a. Administer different, more flexible benefit plans;
   b. Interact and communicate with providers and recipients;

c. Pay claims at a line level, providing the ability to more accurately pay claims and track payments throughout the adjudication process, as well as more accurate accounting and reporting of payments;
d. Provide the flexibility to implement newer payment policies and do so in a timelier manner;
e. Analyze program quality and program trends;
f. Increase the use of more efficient electronic processes such as prior approvals; and,
g. Be flexible and timely in responding to changes in law and regulation.

DOH is statutorily required to report on various programs participating in Medicaid or CHIP, however, there has been no requirement to report on the entirety of Medicaid in Utah. The following programs require reports to the legislature and are summarized in Table 1:

1. Medicaid 340 Drug Program – The Bureau of Coverage and Reimbursement Policy (BCRP) reports on the department's progress towards implementing an expansion of the use of the 340B drug pricing program by community health centers.

2. Preferred Drug Lists – BCRP reports savings to the Medicaid program resulting from the use of the preferred drug list.

3. CHIP – Bureau of Managed Health Care (MHC) reports annually on its evaluation of the program's performance.

4. Health Insurance Benefit Design – This report covers the activities of the PCN program. MHC reports on numbers covered, claims experienced, cost shifted, agreements combining public with private coverage, and employer-based coverage that increase benefits.

5. This report covers the activities of the Capital Primary Care Network (PCN) program, which operates with Medicaid funding.

6. Drug Utilization Review Board reports annually the activities of the board, effectiveness, reach, fiscal impact, and other data respecting the Drug Utilization Review program.

Table 1: Required DOH Medicaid Reports

Report	*DOH Reporting entity*	*Statutory Report Date*	*To whom?*	*UCA citation*	*Date enacted*
Medicaid 340B Drug Program	Bureau of Coverage and Reimbursement Policy	Initial report by May 21, 2008; thereafter quarterly	Health and Human Services (HHS) Interim & Appropriations Committees	26-18-12	2008 (sunsets July 1, 2013)
Preferred Drug List	Bureau of Coverage and Reimbursement Policy	Before November 10, 2010	HHS Interim & Appropriations Committees	26-18-2.4	Amended 2009
Children's Health Insurance Program	Bureau of Managed Health Care	Before November 1 each year	HHS Interim Committee	26-40-109	Amended 2001
Health Insurance Benefit Design	Bureau of Managed Health Care	Before November 15 each year	HHS Interim Committee	31A-22-633	Amended 2005
Drug Utilization Review Board	Bureau of Coverage and Reimbursement Policy	Before December 1 each year	Report to US Dept. Health and Human Services; copy to Legislative leadership and others	26-18-103	Amended 2008

DOH has for several years produced an annual report of Medicaid, but only from DOH's perspective. GOPB has determined that this statistical report is an appropriate starting point to meet the request made by the legislature for unified annual reporting, but the report should be expanded to coordinate reporting from those performing final expenditures via contract.

Working with DOH, DHS, and DWS, GOPB has initiated expansion of the existing report format to include all State agencies receiving Medicaid funding. DOH's normal timeline has been to deliver the annual report late in the calendar year. DOH is targeting December 2010 for the first expanded version of this report.

GOPB has included in this study many of the elements to be found in the combined annual report. The report will also be expanded to include a section on CHIP.

Finally, the legislature requested potential options for coordinated reporting from those performing final expenditures via contract. State agencies provide the majority of their services via third party entities, such as local health departments, local substance abuse authorities, local mental health authorities, school districts and numerous private providers. The primary sources of data for the reporting of Medicaid expenditures under contract on the State's behalf are: Department of Health, the Department of Human Services, the University of Utah, and those entities performing contract expenditures.

GOPB has included sample reports that detail expenditures by department, entity, and at the contract level. While data for the first two reports are readily available, the third report would require extensive staff time by the State and the third party contractor.

PREVIEW OF THE FY2010 UNIFIED ANNUAL REPORT OF MEDICAID AND CHIP

Medicaid Overview

Medicaid and Medicare are two government programs that provide services to specific groups of people in the United States. Although the two programs are very different, they are both managed by the CMS.

Medicare is a social insurance program that serves more than 44 million enrollees (as of 2008). The program costs approximately $432 billion nationally, or 3.2 percent of GDP, in 2007.

Medicaid is a social welfare (or social protection) program that serves about 40 million people nationally and costs about $330 billion, or 2.4 percent of GDP, in 2007. Together, Medicare and Medicaid represent 21 percent of the FY2007 federal budget.

The Division of Medicaid and Health Financing (DMHF), within the Department of Health, administers the Medicaid program, authorized by Title XIX of the Social Security Act. With State and federal resources, DMHF provides funding for medical services to needy individuals and families throughout the State.

Expenditures for Medicaid are made by: Department of Health, Department of Human Services, Department of Workforce Services, University of Utah, and the Attorney General. In addition, the Department of Health passes funding through to local government and other providers. The Governor's Office of Planning and Budget reviewed expenditure data from these five state agencies.

Figure 1 shows all Medicaid expenditures for FY2010. Program expenditures totaled $1,885,648,300. Expenditures for mandatory services comprised the largest portion of total expenditures (46%) followed by optional services (26%). Specific detail is shown for both service expenditures and administrative expenditures. Administrative expenses accounted for $101.7 million, or six percent of the total Medicaid-related expenditures. Figure 2 shows Medicaid funding by funding source. Federal funds comprise the largest share at 67 percent of total funding. The Department of Health has also identified in the Consolidated Report, the category of service expenditures for FY2010 as well as the portion of the General Fund which is seeded to other state agencies and local governments.

Table 2 shows Medicaid funding by source and type of service. In FY2010 federal funds provided the largest share of funds for both mandatory and optional services, totaling $1.4 billion. General Funds provided $279.8 million.

Table 3 shows Medicaid expenditures by type of service. Inpatient hospital services incurred the largest share of mandatory services ($283,321,300) while Pharmacy incurred the largest portion of optional services ($170,059,100).

Figure 1: Medicaid Funding and Expenditures FY2010

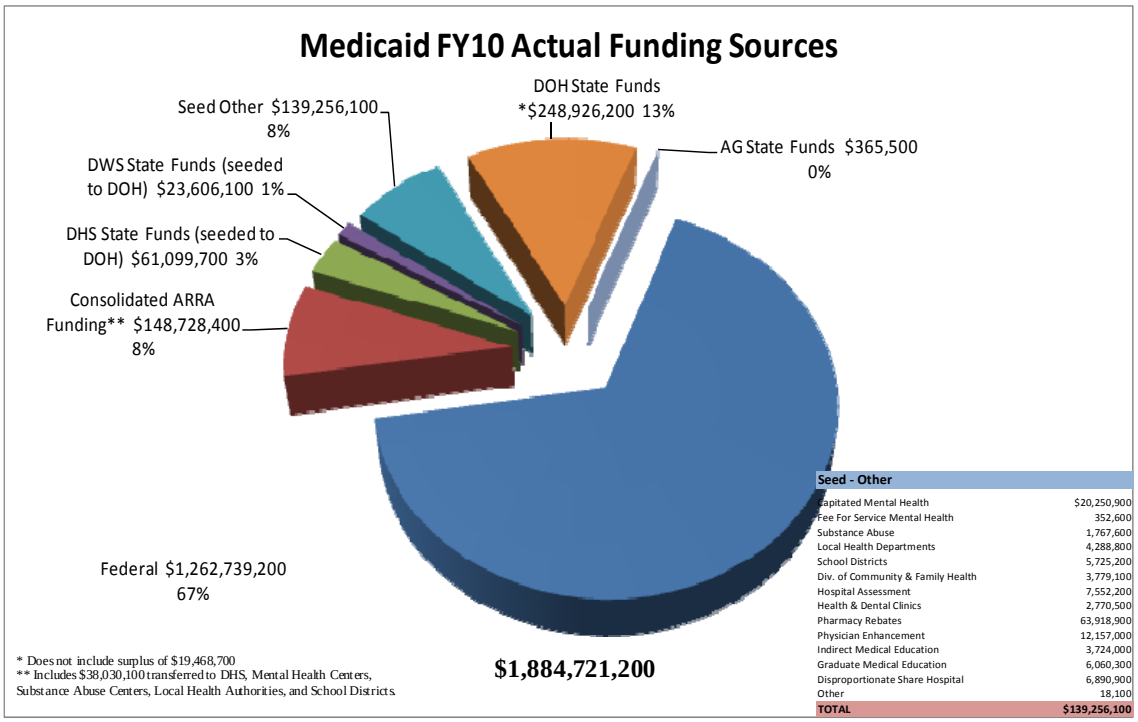

Figure 2: Medicaid Consolidated Expenditures FY2010

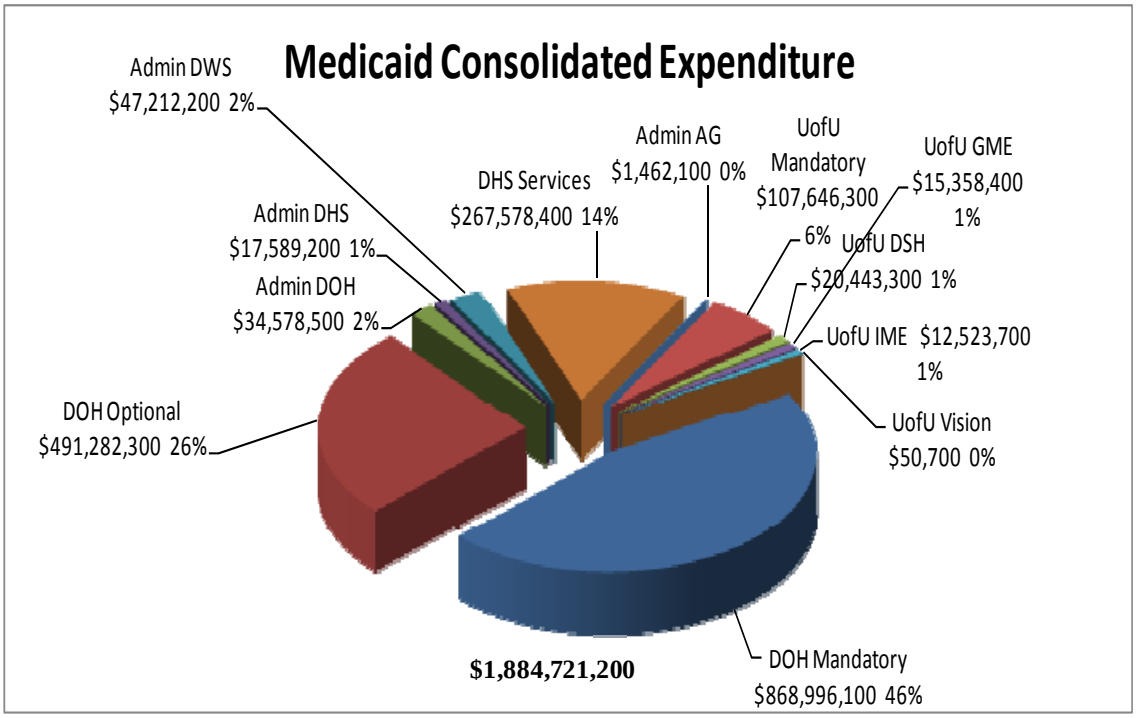

Table 2: MEDICAID REVENUE FY2010

Medicaid Revenues FY2010

Mandatory	Inpatient Hospital	Nursing Home	Contracted Health	Physician Services	Outpatient Hospital	Other	TOTAL
General Fund	$44,035,100	$1,969,200	$39,579,500	$16,684,800	$22,297,300	$28,386,200	$152,952,100
Federal Funds	223,072,800	127,134,400	185,851,800	75,775,500	96,767,000	65,776,800	$774,378,300
Dedicated Credits	7,552,200	0	0	428,800	0	1,737,800	$9,718,800
Restricted Revenue	8,320,500	16,236,000	0	0	0	0	$24,556,500
Transfers	125,100	7,400	558,200	127,100	182,500	3,006,500	$4,006,800
Beginning Balance	20,123,500	(3,340,900)	(1,854,000)	(1,380,900)	(3,341,600)	(2,883,900)	$7,322,200
Closing Balance	(19,464,800)	15,903,600	10,087,900	3,088,400	3,592,100	(8,343,900)	$4,863,300
Lapsing Balance	(443,100)	(712,500)	0	0	0	0	($1,155,600)
Subtotal	**$283,321,300**	**$157,197,200**	**$234,223,400**	**$94,723,700**	**$119,497,300**	**$87,679,500**	**$976,642,400**

Optional	Pharmacy	HCB Waiver	Capitated MH Services	Buy in/out	Dental Services	ICF / MH	Vision Care	Other	TOTAL
General Fund	$36,645,600	$1,028,200	($7,167,000)	$10,291,100	$6,729,100	$2,049,000	$681,700	($11,177,200)	$39,080,500
Federal Funds	72,264,400	126,255,200	133,679,200	24,702,500	25,330,300	67,612,600	1,561,000	131,128,700	$582,533,900
Dedicated Credits	63,918,900	0	18,660,300	0	0	0	0	8,574,500	$91,153,700
Restricted Revenue	76,000	0	0	0	0	1,654,300	0	0	$1,730,300
Transfers	146,300	28,958,800	8,653,500	0	28,900	10,442,400	3,800	29,530,800	$77,764,500
Beginning Balance	7,134,800	4,025,000	2,229,500	(2,069,100)	(3,176,200)	(921,200)	(187,900)	(6,050,200)	$984,700
Closing Balance	(10,126,900)	(2,526,600)	5,893,000	3,349,200	2,488,900	3,618,000	23,100	11,394,500	$14,113,200
Lapsing Balance	0	0	0	0	0	(124,000)	0	0	($124,000)
Subtotal	**$170,059,100**	**$157,740,600**	**$161,948,500**	**$36,273,700**	**$31,401,000**	**$84,331,100**	**$2,081,700**	**$163,401,100**	**$807,236,800**

	Services	Admin	TOTAL
General Fund	$192,032,600	$3,617,600	$195,650,300
Federal Funds	1,356,912,200	54,555,400	1,411,467,600
Dedicated Credits	100,872,500	2,242,900	103,115,400
Restricted Revenue	26,286,800	350,000	26,636,800
Transfers	81,771,300	39,090,300	120,861,600
Beginning Balance	8,306,900	493,500	8,800,400
Closing Balance	18,976,500	492,200	19,468,700
Lapsing Balance	(1,279,600)	0	(1,279,600)
Subtotal	**$1,783,879,200**	**$100,841,900**	**$1,884,721,200**

Table 3: MEDICAID EXPENDITURES FY2010

Medicaid Expenditures FY2010

Mandatory	DOH	DHS	University of Utah	DWS	AG	Mandatory
Inpatient Hospital	$242,315,000	$0	$41,006,300	$0	$0	$283,321,300
Nursing Home	157,197,200	0	0	0	0	157,197,200
Contracted Health Plan Services	201,111,200	0	33,112,200 *	0	0	234,223,400
Physician Services	69,308,500	0	25,415,200	0	0	94,723,700
Outpatient Hospital	111,527,100	0	7,970,200	0	0	119,497,300
Other Mandatory Services	87,537,100	0	142,400	0	0	87,679,500
Subtotal	$868,996,100	$0	$107,646,300	$0	$0	**$976,642,400**

Optional	DOH	DHS	University of Utah	DWS	AG	Optional
Pharmacy	$170,059,100	$0	$0	$0	$0	$170,059,100
Home & Community Based Waivers	59,800	157,680,800	0	0	0	157,740,600
Mental Health Services	105,649,900	56,298,600	0	0	0	161,948,500
Buy In / Out	36,273,700	0	0	0	0	36,273,700
Dental Services	31,401,000	0	0	0	0	31,401,000
Intermediate Care Facilities	31,531,000	52,800,100	0	0	0	84,331,100
Vision Care	2,031,000	0	50,700	0	0	2,081,700
Other Optional Services	114,276,800	798,900	0	0	0	115,075,700
Disproportionate Share Hospital	0	0	20,443,300	0	0	20,443,300
Graduate Medical Education	0	0	15,358,400	0	0	15,358,400
Indirect Medical Education	0	0	12,523,700	0	0	12,523,700
Subtotal	$491,282,300	$267,578,400	$48,376,100	$0	$0	**$807,236,800**

Administrative	$34,578,500	$17,589,200	$0	$47,212,200	$1,462,100	**$100,842,000**
TOTAL EXPENDITURES	$1,394,856,900	$285,167,600	$156,022,400	$47,212,200	$1,462,100	**$1,884,721,200**

*Does not include $54,489,100 that is expended by Healthy-U contracted provider program to other Utah health care systems.

MEDICAID ELIGIBILITY, BENEFITS, SERVICES, AND PROGRAMS

Eligibility for Medicaid: Federal Guidelines

Each state sets its own Medicaid eligibility guidelines. The program is geared towards low-income individuals, but eligibility also depends on other factors such as age, pregnancy status, disability status, other assets, or citizenship.

States must provide Medicaid services for individuals who fall under certain categories of need in order to receive federal funds. For example, the State is required to provide coverage to certain individuals who receive federally assisted income maintenance payments and similar groups who do not receive cash payments. Other groups that the federal government considers categorically needy and who are eligible for Medicaid include:

- Children under age 6 whose family income is at or below 133 percent of the Federal Poverty Level (FPL);
- Pregnant women with family income below 133 percent of the FPL;
- Supplemental Security Income recipients;
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act;
- Special protected groups such as individuals who lose cash assistance due to earnings from work or from increased Social Security benefits;
- Children born after September 30, 1983 who are under age 19 and in families with incomes at or below the FPL; and,
- Certain Medicare beneficiaries.

States may also choose to provide Medicaid coverage to other similar groups who share some characteristics with those stated above but are more broadly defined. These include:

- Infants up to age 1 and pregnant women whose family income is not more than the state-determined percentage of the FPL;
- Certain low-income and low-resource children under the age of 21;
- Low-income institutionalized individuals;
- Certain aged, blind, or disabled adults with incomes below the FPL;
- Certain working-and-disabled persons with family income less than 250 percent of the FPL;
- Some individuals infected with tuberculosis;
- Certain uninsured or low-income women who are screened for breast or cervical cancer; and,
- Certain medically needy persons, allowing States to extend Medicaid eligibility to persons who would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State.

Medicaid does not provide medical assistance for all poor persons. It is estimated that about 60 percent of America's poor are not covered by the program.

Eligibility for Medicaid: State of Utah Guidelines

Eligibility determinations for the Medicaid program are made by DWS or, to a limited extent, DHS. There are 30 types of Medicaid, each with varying eligibility requirements, including household income.

Categories of Assistance

- Children - Individuals under age 19;
- Adults in families which include their children;
- Pregnant women;
- Disabled Individuals - Individuals who have been determined disabled by Social Security;
- Aged Individuals - Individuals age 65 of age or older;
- Blind Individuals - Individuals of any age who meet Social Security's criteria for statutory blindness;
- Women with breast or cervical cancer;
- Medicare cost-sharing programs for those who receive Medicare; and,
- Primary Care Network - Individuals who do not meet criteria for any of the above listed groups, ages 19-64.

Medicaid Benefits

Medicaid benefits vary from person to person, depending on differences in:

- Age;
- Pregnancy status; and,
- Category of assistance.

Differences in benefits include:

- Individuals who do not meet citizenship requirements but meet all other eligibility requirements can qualify for coverage of emergency services;
- PCN covers only primary care services; and,
- Individuals who are not pregnant or are not a child may have co-payment or cost-sharing requirements.

Income and asset tests are primary factors in determining eligibility. The Medicaid program must provide medical services to categorically needy individuals. Many categorically needy optional groups and medically needy individuals are covered in Utah as a state option. Medically needy individuals have enough income to meet basic living costs, but are unable to afford vital medical care.

MEDICAID PROGRAMS: UTAH

Mandatory

Medicaid mandatory services include the following:

- Emergency transportation;
- Family planning services;
- Federally qualified health centers;
- Home health services;
- Inpatient hospital services;
- Laboratory and x-ray services;
- Medical supplies (including specialized wheelchairs);
- Outpatient hospital services;
- Physician services;
- Pregnancy-related services;
- Rural health clinics;
- Nursing facilities;
- Specialized nursing; and,
- Well child care.

Optional

Medicaid optional provides the following optional services:

- Ambulatory surgical;
- Case management;
- Dental;
- Dialysis;
- Early intervention;
- Eye examinations and eyeglasses;
- Hospice;
- Interpretive services;
- Mental health;
- Non-emergency transportation;
- Intermediate care facility/mentally retarded;
- Optometry;
- Personal care services;
- Pharmacy;
- Physical therapy;
- Podiatry; and,
- Occupational therapy.

Medicaid Waivers

The Social Security Act allows states to waive government-mandated requirements which pertain to Medicaid under certain circumstances. When a state uses this tool, it is known as a "Medicaid waiver." Medicaid waivers are designed to allow states more flexibility in providing health care options to their citizens, allowing states to save money and patients to have more freedom of choice. Sections 1115, 1915(b), and 1915(c) contain specific information about different types of Medicaid waivers and how they work. Currently, Utah operates waivers out of each of the sections listed above. For consumers, the most common type of waiver is the 1915(c). This waiver promotes the use of community-based services as an alternative to institutionalized care. If a patient is deemed suitable for institutionalization due to psychiatric illness, developmental disability, or chronic disease, the patient or the patient's advocates can request a 1915(c) waiver to get access to community-based care, allowing the patient to remain at home rather than needing to reside in an institution.

If the application for the waiver is approved, the patient will have access to home health care and other health care services which originate in the community. Medicaid may pay the patient an allowance to cover medical care, or it may pay specific providers, depending on the state and the situation.

Patients often benefit from a 1915(c) Medicaid waiver because the waiver allows patients to select their own health care providers and it empowers patients to make choices about where and when they receive care. Advocates for people with developmental disabilities in particular have taken advantage of the Medicaid waiver program to encourage community-based care for people who would otherwise be institutionalized, arguing that staying in the community is better for the patient. Medicaid waivers also allow people to receive skilled nursing care at home, and provide access to other services which would normally be limited under the Medicaid statutes.

An 1115 Medicaid waiver allows states to waive rules for demonstration and pilot studies. These waivers are provided on the grounds that additional research and the development of advanced health care techniques can give patients access to better care, and possibly save money in the long term by creating alternatives to traditional care. In Utah, all non-traditional Medicaid, PCN and Utah's Premium Partnership (UPP) small programs are provided under 1115 waivers.

1915(b) waivers are used by states to limit freedom of choice, allowing states to enroll patients in special managed care programs which may not be available across the state and thereby creating a situation in which patients can have access to special services.

For a more detailed description of Medicaid waiver, see Appendix II

MEDICAID EXPENDITURES

MEDICAID PROGRAM EXPENDITURES

Historical Expenditures

The State of Utah has witnessed a consistent rise in Medicaid expenditures during the last ten years. Concern arises pertaining to the State's ability to maintain this rate of growth in the program. Federal health care reform adds to this concern as planned expansion of the program would see a substantial rise in the numbers of those seeking services under the program. While the cost of Medicaid expansion will be borne by the federal government for an initial period, there is a liability to the State, for a small percentage during the initial period of rollout of the given expansion, with no cap following the initial period.

Table 4 shows State and federal funding from FY2002 through FY2010, excluding administrative costs. State Medicaid administrative service expenditures fell from $475 million in FY2009 to $427 million in FY2010, for a ten percent reduction. This reduction in State expenditures is a result of increased federal funding from the American Recovery and Reinvestment Act (ARRA) of 2009. Caseload for the same period increased from 341,720, or by 7.5% as shown in Table 5. Since 2002, Medicaid caseload has increased by 79.0 percent.

Table 4: Medicaid Expenditures FY2002 through FY2010

Medicaid Expenditure

	State Expenditure	Federal Expenditure	Total Expenditure*
2002	$332,203,100	$668,686,900	**$1,000,890,000**
2003	$335,064,500	$765,098,100	**$1,100,162,600**
2004	$358,929,200	$915,450,200	**$1,274,379,400**
2005	$433,149,900	$964,057,300	**$1,397,207,200**
2006	$490,599,600	$1,027,531,200	**$1,518,130,800**
2007	$502,426,600	$983,726,400	**$1,486,153,000**
2008	$486,080,900	$1,091,822,500	**$1,577,903,400**
2009	$475,053,100	$1,248,242,200	**$1,723,295,300**
2010	$426,967,100	$1,356,912,100	**$1,783,879,200**

*Does not include admin costs or AG expenditures

Table 5: Medicaid Caseload FY2002 - FY2010

Medicaid Caseload

	Clients served
2002	190,879
2003	210,751
2004	263,313
2005	280,116
2006	349,237
2007	349,444
2008	274,859
2009	317,758
2010	341,720

Average Member Months

The most accurate method of estimating caseload is to calculate the average number of individuals enrolled per month, or average member months. This number more closely reflects the number of people on the Medicaid program during any given month of the year. Table 6 shows the average member months from FY2002 to FY2010. Average member month caseload increased from 217,974 in 2009 to 243,819 in 2010—an increase of 11.9 percent—while average member month expenditures fell by 7.5 percent from $7,906 to $7,316, over the same period.

Table 6: Average Member Months Caseload and Expenditures

Medicaid Enrollees		
Year	Avg Member Months	Per-Enrollee Per-Average Member Months
2002	102,130	$9,800
2003	116,297	$9,460
2004	128,919	$9,885
2005	142,878	$9,779
2006	202,222	$7,507
2007	199,274	$7,458
2008	198,271	$7,958
2009	217,974	$7,906
2010	243,819	$7,316

Client Count

Another way to determine the number of Medicaid clients is to count the number of persons who actually receive services. This number can also yield useful information. This figure does not account for the number of services that were received. In other words, a person who uses one service one time is counted equally as a person who uses multiple services during the same year.

MEDICAID FUNDING BY AGENCY, OFFSETS TO EXPENDITURES, & CONTRACT SERVICE PROVIDER

STATE ENTITIES RECEIVING MEDICAID FUNDING

Department of Health

DOH was created in 1981 to protect the public's health by preventing avoidable illness, injury, disability and premature death; assure access to affordable, quality healthcare; promote healthy lifestyles; and monitor health trends and events.

Table 7 shows Medicaid expenditures by the Department of Health by mandatory and optional services, and by administrative costs. Mandatory Medicaid services comprised the largest share of Medicaid services expenditures (64 percent) compared to optional services which comprised 36 percent. Administrative expenditures were $35 million, or 2.5 percent of total DOH Medicaid expenditures. This amount does not include eligibility determination, which is done by the Department of Workforce Services.

In FY2010 DOH total budget was about $2.2 billion. Total Medicaid expenditures were $1.4 billion, or about 65 percent of the DOH total budget.

Table 7: FY2010 DOH Medicaid Expenditures

Department of Health		
Services Expenditures - Actual		
Mandatory		***Percent of Total***
Inpatient Hospital	$242,315,000	18%
Nursing Home	157,197,200	12%
Managed Care	201,111,200	15%
Physician Services	69,308,500	5%
Outpatient Hospital	111,527,100	8%
Other Mandatory	87,537,100	6%
TOTAL Mandatory	**$868,996,100**	**64%**
Optional		
Pharmacy	$170,059,100	13%
HCB Waivers	59,800	<1%
Capitated MH	105,649,900	8%
Buy In/Out	36,273,700	3%
Dental Services	31,401,000	2%
ICFMR	31,531,000	2%
Vision Care	2,031,000	<1%
Other Optional	114,276,800	8%
TOTAL Optional	**$491,282,300**	**36%**
Total Service Expenditure DOH	$1,360,278,400	100%
Administrative Expenditures - Actual		
Responsibilities: Claims payment, rate setting, cost settlement, contracting, prior authorization of services, waiver management, client plan selection.		
Personnel services	$16,255,300	46%
Travel - In State	32,000	<1%
Travel - Out of State	16,000	<1%
Current Expense	5,189,300	17%
Contractual	5,109,200	15%
DTS	7,976,700	23%
Total Admin Expenditure DOH	$34,578,500	100%
TOTAL	**$1,394,856,900**	
Total DOH Budget	**$2,152,577,000**	
Medicaid, as a % of overall budget	**65%**	

* The amount shown for Medicaid service expenditures does not include funds sent to the University of Utah and the Department of Human Services.

Divisions and bureaus within DOH, that affect services within the Medicaid expenditures, are as follows:

Division of Medicaid and Health Financing

Division of Medicaid and Health Financing (DMHF) is responsible for the management and administration of the Medicaid program within the State of Utah.

The administration of Medicaid is accomplished through the DMHF and six bureaus. The Division Director administers and coordinates the program responsibilities delegated to develop, maintain and administer the Medicaid program. Contract development and monitoring, staff training and development, and inventory control are coordinated by the division.

Bureau of Financial Services

Objectives and responsibilities include monitoring, coordinating and facilitating DMHF's efforts to operate economical and cost-effective medical assistance programs. The bureau is responsible for coordinating and monitoring federally mandated quality control systems, budget forecasting and preparation, appropriation requests, legislative presentations, monitoring program and administration expenditures, collecting pharmacy rebates, federal reporting, collecting the nursing home and hospital assessments, data analysis and publishing the annual report.

Bureau of Managed Health Care

Objectives and responsibilities include providing Medicaid clients with a choice of health care delivery programs in order to enable them to use Medicaid benefits properly. It also provides oversight of the CHIP, PCN, and the UPP programs. This bureau monitors the performance of the capitated prepaid mental health program under Medicaid and operates the early periodic screening, diagnosis, and treatment program that provides well-child health care.

Bureau of Long-Term Care

Objectives and responsibilities include promoting quality, cost-effective long-term care services that meet the needs and preferences of Utah's low-income citizens.

Bureau of Medicaid Operations

Objectives and responsibilities include the oversight and accurate timely processing of claims submitted for covered services on behalf of eligible beneficiaries and the training of providers regarding allowable Medicaid expenditures and billing practices.

General responsibilities include processing and adjudication of medical claims, publishing all provider manuals, being the single point of telephone contact for information about client eligibility, claims processing, and general questions about the Medicaid program.

Bureau of Coverage and Reimbursement Policy

Objectives and responsibilities include policy formulation, interpretation, and implementation planning. This responsibility encompasses scope of service, eligibility, and reimbursement policy for Utah's Medicaid program and the Home and Community-Based Services Waiver (HCBS). In addition to implementation planning for newly adopted policy, the bureau is responsible for short- and long-range planning.

Bureau of Eligibility Policy

Objectives and responsibilities include oversight and processing eligibility determinations for the Medicaid program; Interpreting federal regulations; writing Medicaid eligibility policy, providing timely disability decisions based on Social Security Disability criteria; and monitoring the accuracy and timeliness of the Medicaid program by reviewing eligibility determinations under guidance from CMS.

Office of Internal Audit

The Office of Internal Audit is responsible for the integrity of the Medicaid program. Among its responsibilities, the office:

1. Ensures that the Medicaid agency has a method for identifying, investigating and collecting all provider referrals for fraud or suspected fraud cases; ensure the agency has a method of verifying with recipients whether services billed by providers were received; ensure that all disclosure of information by providers and fiscal agents is monitored;
2. Ensures that services are sufficient in amount, duration and scope to achieve their purpose; ensure that services are medically necessary; assess the quality of services;
3. Ensures that all services under the state plan requiring a prior authorization are completed on time and accurately and if denied, that all rights to appeal for the recipient and providers are preserved;
4. Provides for the limitation on Medicaid Contractor's liability to carry out a contract under the Medicaid Integrity Program; and,
5. Ensures the Medicaid Agency has an established and accepted method for the Payment Error Rate Measurement by CMS.

Department of Human Services

The Department of Human Services was created in 1990 under UCA 62A-1-102 to provide direct and contracted social services to persons with disabilities, children and families in crisis, juveniles in the criminal justice system, individuals with mental health or substance abuse issues, vulnerable adults, and the aged

Table 8 shows Medicaid expenditures by the Department of Human Services by category of service and funding source as well as administrative costs. The largest portion of services funds was expended on people with disabilities—over $153 million in federal funds and $36 million from the General Fund—and accounts for over 70 percent of total DHS services expenditures. Administrative costs were $17.6 million, or 6.2 percent of total Medicaid expenditures by DHS. *Personnel* was the largest component of expenditures at $11.2 million.

In FY2010 DHS total budget was $676 million, of which $285 million was expended on Medicaid, or about 43 percent of the total DHS budget.

Table 8: FY2010 DHS Medicaid Expenditures

Department of Human Services				
Service Expenditures - Actual	*Federal Funds*	*State Funds*	*TOTAL*	*Percent of Total*
Child & Family Services	$30,013,700	$7,594,100	$37,607,800	14%
Juvenile Justice System	15,143,700	3,547,100	18,690,800	7%
Substance Abuse & Mental Health	15,129,200	3,504,600	18,633,800	7%
People With Disabilities	153,002,100	36,166,800	189,168,900	71%
Aging & Adult Services	2,560,100	917,000	3,477,100	1%
Total Services Expenditures DHS	**$215,848,800**	**$51,729,600**	**$267,578,400**	**100%**
Expenditures include amounts paid directly by DOH to providers who serve DHS clients.				
Administrative Expenditures - Actual				
Personnel Services			$11,262,800	64%
Travel - In State			64,300	<1%
Travel - Out of State			500	<1%
Current Expense			2,064,200	12%
DTS			1,856,900	11%
Pass-through			692,700	4%
Indirect costs			1,647,800	9%
Total			**$17,589,200**	**100%**
TOTAL			**$285,167,600**	
Total DHS Budget			**676,920,600**	
Medicaid, as a % of overall budget			**42%**	

Divisions within the Department of Human Services, which affect services within the Medicaid expenditures, are as follows:

Division of Services for People with Disabilities

The mission of the Division of Services for People with Disabilities is to promote opportunities and provide support for persons with disabilities to lead self-determined lives.

Division of Child and Family Services

The mission of the Division of Child and Family Services (DCFS) is to protect children at risk of abuse, neglect, or dependency. The division does this by working with families to provide safety, nurturing, and permanence. The division partners with the community in this effort.

Division of Substance Abuse and Mental Health

The division is responsible for ensuring that substance abuse and mental health services are available statewide. A continuum of substance abuse services that includes prevention and treatment is available for adults and youth. The goal is to ensure that treatment is available for adults with serious mental illness and for children with serious emotional disturbance. Services are offered statewide through 13 local authorities who either provide services or contract with private providers.

Office of Recovery Services

The division serves children and families by promoting independence through responsible parenthood and ensures public funds are used appropriately, which reduces costs to public assistance programs. Office of Recovery Services works with parents, employers, federal, state and private agencies, professional associations, community advocates, the legal profession and other stakeholders and customers. The office works within the bounds of state and federal laws and limited resources to provide services on behalf of children and families in obtaining financial and medical support through locating parents, establishing paternity and support obligations, and enforcement of those obligations when necessary.

The office provides services to reimburse the State for costs of supporting children placed in its care and/or custody. Financial and medical support are obtained by locating parents, establishing paternity and support obligations, and enforcing those obligations when necessary. The office also collects medical reimbursement from responsible third parties to reimburse the State and avoid additional Medicaid costs.

Division of Aging and Adult Services

The division provides leadership and advocacy pertaining to issues that impact older Utahns, and serves elderly and disabled adults needing protection from abuse, neglect or exploitation. The Division of Aging and Adult Services (DAAS) offers choices for independence by facilitating the availability of a community-based independent living in both urban and rural areas of the State. The division encourages citizen involvement in planning and delivering services.

Child Protection Ombudsman

The Child Protection Ombudsman investigates consumer complaints regarding DCFS, and assists in achieving fair resolution of complaints, promoting changes that will improve the quality of services provided to the children and families of Utah, and building bridges with partners to effectively work for the children of Utah.

Office of Fiscal Operations

The office establishes sound fiscal practices which provide useful information, and maintains reliable program and fiscal controls.

Office of Public Guardian

This office provides court-ordered guardian and conservator services to incapacitated adults who are unable to make basic daily living or medical decisions for themselves. The office provides training and education to health and social services professionals as well as the general public on the services available and appropriate criteria to look for in

determining alternatives to court ordered public guardianship/conservatorship is available. The office conducts intake and assessment for court petition process.

Office of Services Review

The Office of Services Review assesses whether the Division of Child and Family Service is adequately protecting children and providing appropriate services to families. The office accomplishes this by conducting in-depth reviews of practice, identifying problem areas, reporting results and making recommendations for improvement to the division. The office performs similar functions for other divisions and offices in the department.

Utah State Hospital

Utah State Hospital is a 24-hour inpatient psychiatric facility which serves people who experience severe and persistent mental illness. It has the capacity to provide active psychiatric treatment services to 359 patients (including a five-bed acute unit). The hospital serves all age groups and all geographic regions of the State.

Division of Juvenile Justice Services

The Division of Juvenile Justice Services (JJS) serves youth offenders with a comprehensive array of programs, including home detention, secure detention, day reporting centers, case management, community alternatives, observation and assessment, long-term secure facilities, transition, and youth parole. Juvenile Justice Services is a division within the Department of Human Services but has been assigned to the Executive Offices and Criminal Justice Appropriations Subcommittee for Legislative oversight. Prior to FY2004, it was known as the Division of Youth Corrections.

JJS is responsible for all youth offenders committed by the State's Juvenile Court for secure confinement or supervision and treatment in the community. JJS also operates receiving centers and youth services centers for non-custodial and non-adjudicated youth.

Programs within the Division of Juvenile Justice Services include:

- Administration;
- Early Intervention Services;
- Community Programs;
- Correctional Facilities;
- Rural Programs; and,
- Youth Parole Authority, the JJS equivalent to the Board of Pardons and Parole.

Department of Workforce Services

The Department of Workforce Services was created in 1997, per UCA 35A-1-103(1), to provide employment and support services to customers to improve their economic opportunities. Costs of the Department of Workforce Services for the Eligibility Services Division are computed by taking a random moment time sample. On a quarterly basis, eligibility workers in the department record the time they spent on fourteen public assistance programs. Total costs are allocated to the various programs based on the percent of time derived from the sample.

Table 9 shows Medicaid administrative expenditures by the Department of Workforce Services by cost type and funding source. Administrative costs totaled $47.2 million, or 3 percent of the DWS total budget of $1.6 billion.

Table 9: FY2010 DWS Medicaid Expenditures

Department of Workforce Services				
Administrative Expenditures - Actual	**Federal Funds**	**State Funds**	**TOTAL**	**Percent of Total**
Direct costs	$1,369,900	$1,369,900	$2,739,800	6%
Allocated costs	22,236,200	22,236,200	44,472,400	94%
Total Admin Expenditures DWS	**$23,606,100**	**$23,606,100**	**$47,212,200**	**100%**
Does not include year-end closing entries made by DWS.				
Total DWS Budget			**1,583,937,500**	
Medicaid, as a % of overall budget			**3%**	

Divisions and budget areas within the Department of Workforce Services are as follows:

Eligibility Services Division

The division was created in 2009 to centralize the State's public assistance eligibility process using eREP to process applications. The division determines eligibility for the Medicaid, CHIP, and other federal and state public assistance programs.

Eligibility for the different medical programs varies depending upon the program. Some major elements of consideration include: income level, assets, and the presence of dependents in the home. Generally, those who receive coverage must submit documentation annually to confirm continued eligibility.

Medical Programs

Medical Programs is a specific budget area at DWS and includes Medicaid eligibility, CHIP, PCN, and UPP. The entire eligibility component of these programs was transferred from DOH to DWS in FY2008. Prior to that, DWS conducted about 40 percent of all eligibility determinations. General administration and oversight of the programs are still conducted within the Department of Health.

Medical Programs are funded by General Fund and federal funds for Medicaid, CHIP, PCN and UPP. DWS receives funding to provide eligibility determinations within each of the programs. Actual payments to providers are made by DOH.

Medical Programs Performance Measures

Program performance is measured by several mechanisms. Federal regulation requires that a decision be made on a medical application within 45 days following the date of application and 90 days for Disabled Medicaid. However, federal policy allows extensions for the applicant to provide proof of eligibility. DWS has established a timeliness benchmark of 30 days for its internal processes, similar to other DWS-administered programs such as Food Stamps.

Approximately 28 percent of their time is related to the Medicaid program. As shown in Table 9, only six percent of the costs are direct, while 94 percent are allocated based on the random moment time study.

Office of the Attorney General

Program: Criminal Prosecution

The Criminal Prosecution Program consists of five divisions of which two, criminal justice and investigations are responsible for investigation and prosecution of Medicaid fraud within the State. Table 10 shows Medicaid administrative expenditures by category and funding source. Of the $1.5 million in total expenditures, over $1 million (74 percent) is spent on personnel services. Total Medicaid expenditures comprise 3 percent of the Office of the Attorney General's budget.

Table 10: FY2010 Office of the Attorney General Medicaid Expenditures

Attorney General

Administrative Expenditures - Actual	*Federal*	*State Funds*	*Total*	*Percent of Total*
Personnel Services	$807,400	$269,200	$1,076,600	74%
Travel	3,700	1,200	4,900	<1%
Supplies	7,200	2,400	9,600	1%
Contractual	67,000	22,300	89,300	6%
Other	21,700	7,200	28,900	2%
Indirect Costs	189,600	63,200	252,800	17%
Totals	**$1,096,600**	**$365,500**	**$1,462,100**	**100%**

Total AG Budget	**49,595,000**
Medicaid, as a % of overall budget	**3%**

Currently the Attorney General's office has ten full-time positions assigned to the Medicaid Fraud Unit. Table 11 shows that, during FY2010 there were 113 new investigations opened and nearly $30 million collected as a result of the efforts of this unit.

Table 11: Medicaid Fraud Unit Performance FY2003 – FY2010

Medicaid Fraud Unit Performance FY2003-FY2010

Criminal Justice Division - Medicaid Fraud	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
New Investigations	105	142	138	134	49	104	115	113
Patient funds investigations		38	38	45	22	17	9	11
Abuse and neglect investigtions		64	55	46	13	63	67	54
Provider fraud investigations		40	45	43	14	24	39	48
Investigations Closed	52	95	54	76	24	92	92	69
Pre-filing diversions		3	1	2	3	0	2	0
Number Convicted	19	11	7	14	3	9	8	13
Trainings provided		16	24	11	5	14	6	5
Number of persons trained		5,615	7,922	622	100	311	285	151
Restitution Ordered	$625,830	$2,379,904	$3,413,952	$487,865	$1,828,680	$2,655,293	$3,798,144	$591,084
Civil Recoveries						$4,768	$699,825	$1,119,776
Criminal Recoveries								$47,921
Global Settlements								$28,599,334

University of Utah Medical Center

Table 12: FY2010 University of Utah Hospital Medicaid Expenditures

University of Utah (Hospital & Clinics)		
Service Expenditures - Actual		
Mandatory Services	***TOTAL***	***Percent of Total***
Inpatient services	$41,006,300	26%
Contracted health plan services	33,112,200	21%
Physician services	25,415,200	16%
Outpatient hospital	7,970,200	5%
Other mandatory services	142,400	<1%
TOTAL	$107,646,300	69%
Optional Services		
Vision care	$50,700	<1%
Disproportionate Share Hospital (Seeded by the U)	20,443,300	13%
Graduate Medical Education (Realigned in FY2011 to a U-UPL calc.)	15,358,400	10%
Indirect Medical Education (Eliminated in FY2011 to a U-UPL calc.)	12,523,700	8%
TOTAL	$48,376,100	31%
Total Services Expenditures	**$156,022,400**	**100%**
Total University Budget (Hospital & Clinics)	**876,000,000**	
Medicaid, as a % of overall budget	**18%**	

The University of Utah is involved in three Medicaid program areas:

1. Inpatient Disproportionate Share Hospital – These funds come from finite federal allocation to states and are used to pay "safety net" hospitals that serve a disproportionate share of Medicaid and uninsured patients. The funds are intended to offset some of the hospitals costs in serving these clients.

2. Inpatient Graduate Medical Education (GME) – These funds offset some of the costs of residency programs that serve Medicaid clients. The funds cannot be used for academic programs but are used to cover some of the patient care costs associated with the care provided by residents. These funds are mainly matched by the University and are subject to the calculated Upper Payment Limit (UPL) authorized by CMS.

3. Inpatient Indirect Medical Education (IME) – These funds help offset some of the clinical care costs of residency programs that serve Medicaid clients. All of the IME funds are matched by the University and are subject to the calculated UPL as authorized by CMS. Like GME funds, these funds cannot be used for academic programs.

Table 12 shows where the University of Utah expends Medicaid funds in FY2010. Expenditures for mandatory services comprise 69 percent of all University Hospital Medicaid expenditures, while optional services comprise the remaining 31 percent. Of mandatory services, the single largest expenditure is $41 million for inpatient services or 26% of all Medicaid expenditures. In total, the $156 million expended on Medicaid represents 18 percent of the University of Utah Hospital's total FY2010 budget. This table does not include $54,489,100 that is expended by 'Healthy U' contracted provider program to other Utah healthcare systems.

Offsets to Medicaid Expenditures

In FY2010 a total of $1.9 billion (State and federal resources) was expended for Medicaid in the State of Utah. Every effort is made by the various State agencies who receive Medicaid funding to offset these expenditures and thereby decrease the total resources allocated to Medicaid. In FY2010 a total of $344,758,900 was was used to offset Medicaid expenditures. These offsets are described below and detailed in Table 13.

1) Co-payments - Medicaid clients are required to pay a portion of the cost for some of the services they receive. For example, clients pay $3 per prescription up to a maximum of $15 per month. Total co-payments collected in FY2010 amounted to $6,130,500.

2) Third party liability - Services a Medicaid client receives can sometimes be billed to a third party provider such as Medicare. The Office of Recovery Services (ORS) also collects monies from these third parties. In FY2010 $236,579,400 was collected or charged from/to third parties.

3) Pharmacy rebates - Pharmacy retailers offer volume discount rebates to DOH. In FY2010 DOH received $63,918,900 in pharmacy rebates.

4) Spenddown income - If a potential Medicaid client's exceeds the eligibility threshold, they have the option to spend down (or pay part of) their income in order to become eligible for Medicaid. In FY2010 Medicaid clients spent down $5,256,400.

5) Primary Care Network premiums - Adults must pay a premium, up to $50, to be eligible for this program. In FY2010 a total of $440,000 was collected.

6) Estate recoveries - ORS has the responsibility to collect monies from estates when a Medicaid recipient over the age of 55 dies and a revocable trust existed. In FY2010 ORS recovered $2,666,700 from estates.

7) Criminal and civil recoveries from the Attorney General Medicaid Fraud Unit - The Medicaid Fraud Unit in the Attorney General's Office, collects criminal and civil penalties as a result of fraud and abuse that they investigate and prosecute. In addition, the Attorney General receives global settlements from class action lawsuits. In FY2010 a total of $29,767,000 was collected from these three sources.

Table 13: FY2010 Expenditures Offset

Expenditure Offsets - FY2010 Actual

Category Of Service	Co-Payment	Third Party Liability	Rebates	ORS Spenddown Recovery	Premiums	Criminal / Civil Recoveries	TOTAL
Inpatient Hospital Services, General	$594,000	$77,793,000	$0	$0	$0	$0	$78,387,000
Inpatient Hospital Services, Mental	0	(14,400)	0	0	0	0	(14,400)
Outpatient Hospital Services, General	254,600	31,011,900	0	0	0	0	31,266,500
Nursing Facility II (NF II)	0	5,000	0	0	0	0	5,000
Nursing Facility III (NF III)	0	34,000	0	0	0	0	34,000
Nursing Facility I (NF I)	0	19,823,000	0	0	0	0	19,823,000
Home Health Services	0	5,576,900	0	0	0	0	5,576,900
Personal Care	0	100	0	0	0	0	100
Substance Abuse Treatment Services	0	25,400	0	0	0	0	25,400
Independent Lab and/or X-Ray Servic	1,900	550,500	0	0	0	0	552,400
Ambulatory Surgical Services	2,400	1,113,000	0	0	0	0	1,115,400
Contracted Mental Hlth Services	0	7,600	0	0	0	0	7,600
Mental Health Services	0	1,530,000	0	0	0	0	1,530,000
Rural Health Clinic Services	0	283,600	0	0	0	0	283,600
ESRD Kidney Dialysis Services	0	7,654,700	0	0	0	0	7,654,700
Pharmacy	4,460,800	4,298,600	63,918,900	0	0	0	72,678,300
Medical Supply Services	3,000	6,947,100	0	0	0	0	6,950,100
Occupational Therapy	1,000	76,000	0	0	0	0	77,000
Medical Transportation	0	5,041,200	0	0	0	0	5,041,200
Specialized Nursing Services	0	559,500	0	0	0	0	559,500
Well Child Care (EPSDT) Services	0	859,400	0	0	0	0	859,400
Physician Services	494,500	31,959,600	0	0	0	0	32,454,100
Federally Qualified Health Cntrs	7,800	126,300	0	0	0	0	134,100
Dental Services	173,500	3,008,500	0	0	0	0	3,182,000
Pediatric/Family Nurse Practioners	22,400	315,400	0	0	0	0	337,800
Psychologist Services	0	248,300	0	0	0	0	248,300
Physical Therapy Services	12,500	871,300	0	0	0	0	883,800
Speech and Hearing Services	0	54,900	0	0	0	0	54,900
Podiatry Services	7,500	675,800	0	0	0	0	683,300
Vision Care Services	12,100	310,100	0	0	0	0	322,200
Optical Supply Services	0	60,300	0	0	0	0	60,300
Osteopathic Services	82,300	1,861,200	0	0	0	0	1,943,500
QMB-Only Services	0	2,666,000	0	0	0	0	2,666,000
Chiropractic Services	200	57,100	0	0	0	0	57,300
Group Pre/Postnatal Education	0	500	0	0	0	0	500
Nutritional Assessment Counseling	0	200	0	0	0	0	200
New Choices Waiver Services	0	600	0	0	0	0	600
Primary Care Network premiums	0	0	0	0	440,000	0	440,000
Recoveries from Attorney General	0	0	0	0	0	29,767,000	29,767,000
Estate Recoveries	0	0	0	0	0	2,666,700	2,666,700
Spenddown Collections	0	0	0	5,256,400	0	0	5,256,400
ORS Collections	0	31,187,200	0	0	0	0	31,187,200
TOTAL	**$6,130,500**	**$236,579,400**	**$63,918,900**	**$5,256,400**	**$440,000**	**$32,433,700**	**$344,758,900**

OPTIONS FOR EXPENDITURE REPORTING: CONTRACTORS

State agencies provide the majority of their services via third party entities, such as local health departments, local substance abuse authorities, local mental health authorities, school districts and numerous private providers.

There are three primary sources of data for reporting Medicaid expenditures under contract on the State's behalf: Department of Health, the Department of Human Services, and those entities performing contract expenditures.

The following reports could be used to provide the legislature detailed expenditures at the contract level. While data for the first two reports are more readily available, the third report would require extensive staff time for both the State and third party contractors. Confidence levels would be low regarding consistency, comparability, and reliability for this type of reporting. Large swings may exist depending on how narrowly or broadly the providers identify their costs. The LFA Provider Study performed during the 2007 Interim demonstrates concerns regarding this type of reporting (only 3% of information requested from providers was useable). Analysis would be required to determine the fiscal impact of generating this report. The cost and effort to obtain this type of reporting would likely outweigh any benefit achieved.

Report 1: Top 25 Providers by Expense Volume

Top 25 Providers by Expense
Medicaid Report

Name	Category Of Service	Reimbursement Amount	Claims	Av. Cost per Claim
Name	Managed Care Organization	$0	0	$0
Name	Inpatient Hospital	0	0	0
Name	Managed Care Organization	0	0	0
Name	Local Mental Health Services	0	0	0
Name	Inpatient Hospital	0	0	0
Name	Inpatient Hospital	0	0	0
Name	Inpatient Hospital	0	0	0
Name	Intermediate Care Facilities for Mental Retarded (ICMR)	0	0	0
Name	Local Mental Health Services	0	0	0
Name	Inpatient Hospital	0	0	0
Name	Intermediate Care Facilities for Mental Retarded (ICMR)	0	0	0
Name	Home and Community Based Waiver Services	0	0	0
Name	Managed Care Organization	0	0	0
Name	Inpatient Hospital	0	0	0
Name	Outpatient Hospital	0	0	0
Name	Home and Community Based Waiver Services	0	0	0
Name	Home and Community Based Waiver Services	0	0	0
Name	Inpatient Hospital	0	0	0
Name	Outpatient Hospital	0	0	0
Name	Local Mental Health Services	0	0	0
Name	Outpatient Hospital	0	0	0
Name	Home and Community Based Waiver Services	0	0	0
Name	Inpatient Hospital	0	0	0
Name	Outpatient Hospital	0	0	0
Name	Local Mental Health Services	0	0	0
TOTAL		**$0**	**0**	**$0**

Report 2: Top 5 Providers by Service Category

Top 5 Providers within Service Category
Medicaid Report

Service	Provider Name	Reimbursement Amount	Claims	Av. Cost per Claim
Inpatient Hospital				
	Name	$0	0	$0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Subtotal	**$0**	**0**	**$0**
Outpatient Hospital				
	Name	$0	0	$0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Subtotal	**$0**	**0**	**$0**
Pharmacy				
	Name	$0	0	$0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Subtotal	**$0**	**0**	**$0**
Long Term Care Services				
	Name	$0	0	$0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Subtotal	**$0**	**0**	**$0**
Home and Community Based Waiver Services				
	Name	$0	0	$0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Subtotal	**$0**	**0**	**$0**
Physician Services				
	Name	$0	0	$0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Name	0	0	0
	Subtotal	**$0**	**0**	**$0**
TOTAL		**$0**	**0**	**$0**

Report 3: Medicaid Expenses as a Percentage of Contract Services

Medicaid Expenditures

Revenue		Percentage of Total
Medicaid	0	%
Other State Fundings	0	%
Other Revenue Sources	0	%
TOTAL	*0*	%
Expenses		
Personnel	0	%
Admin	0	%
Programming Costs	0	%
Building & Maintenance	0	%
Other	0	%
TOTAL	0	%
TOTAL	**$0**	**%**

*Provider Type (Local Health Dept., Local School District, Loca

CHIP

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

DOH manages CHIP through the Division of Medicaid and Health Finance, the same division that manages Utah's Medicaid Program. All eligibility actions are handled through DWS. CHIP is a state-sponsored, health insurance plan for uninsured children whose parents' income is less than 200 percent of the FPL. In 2010 this limit is $44,100 for a family of four.

Since being signed into law in 1998, CHIP has covered more than 212,000 Utah children, making it possible for them to get preventive care to stay healthy and medical services when they get sick or injured.

Table 14: FY2010 CHIP Expenditures

CHIP		
Service Expenditures - Actual	***TOTAL***	***Percent of Total***
Capitated Managed Health Care		
PEHP	$36,708,100	48%
Molina	21,278,600	28%
Immunization services	477,100	1%
Dental Services	9,933,700	13%
Other Services	361,800	0%
Total CHIP Services	**$68,759,300**	**89%**
UPP Services	**$599,600**	**1%**
Total Service Expenditures	**$69,358,900**	**90%**
Administrative Expenditures		
DOH	3,086,000	4%
DWS	4,556,700	6%
Total Administrative Expenditures	**$7,642,700**	**10%**
TOTAL	**$77,001,600**	**100%**

In accordance with UCA 26-40-106, CHIP benefits were actuarially equivalent in FY2010 to benefits received by enrollees in Select Health's Small Business Account plan which is the commercial plan with the largest enrollment in the State. In FY2010 CHIP contracted with two HMO plans to provide medical services, Molina and the Public Employee's Health Plan (PEHP). All dental services were provided through PEHP's dental plan.

Table 14 shows that in FY2010 CHIP spent $69,358,900 on health plan premiums and $7,642,700 on administration. The majority of the administrative costs are for eligibility determinations made by DWS. With an average monthly enrollment of 42,006 in FY2010, the average cost per child was $1,833 per year, or $153 per month.

CHIP receives approximately 80 percent of its funding from the federal government under Title XXI of the Social Security Act with the other 20 percent coming from state matching funds. From FY2001 to FY2007, state funds came exclusively from the proceeds of the Master Settlement Agreement between the State and tobacco companies. From FY2008 to FY2010 the state funding also included an appropriation from the General Fund.

Eligibility and Enrollment

As required by House Bill 326 of the 2008 General Session, CHIP does not close enrollment and continuously accepts new applications. Applications for CHIP and Utah's Premium Partnership for Health Insurance (UPP) can be submitted through the mail, in-person, and online. A simplified renewal form and process has been implemented to reduce unnecessary barriers for the families being served.

Basic eligibility criteria:

- Gross family income cannot exceed 200 percent of the FPL ($44,100 for a family of four).
- The child must be a resident of the state of Utah and a US citizen or legal alien.
- The child must be 18 years of age or younger.
- The child must be uninsured and not eligible for Medicaid.
- CHIP children are enrolled in the program for a twelve-month period.

CHIP contracted with two health plans—Molina and Public Employees Health and Dental—in FY2010 to provide medical service for enrollees.

Enrollment Statistics

Figure 3 shows CHIP enrollment from July 2007 through July 2010. Over that period, total CHIP enrollment increased from 28,429 to 40,755—an increase of more than 43 percent. Increases in caseload have slowed over time, however, increasing 24 percent in FY2008, 15 percent in 2009 and almost no increase in 2010.

Figure 3: CHIP Enrollment

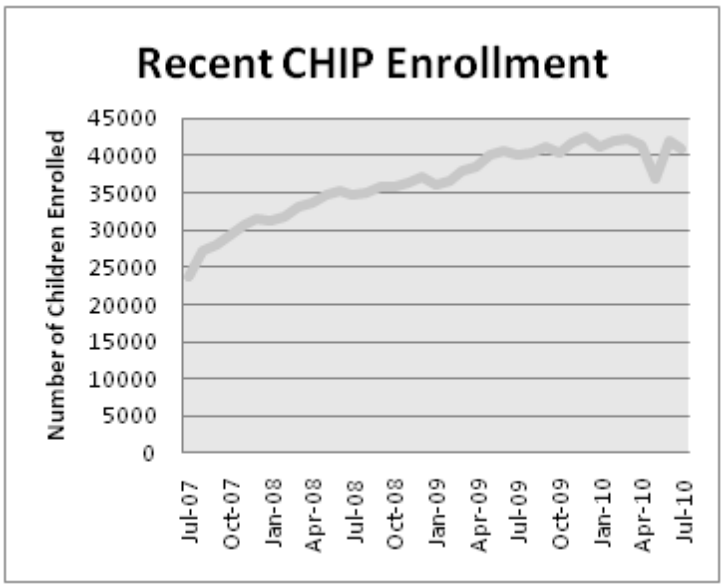

Table 15 shows CHIP enrollment by ethnicity, race, age, and income. Most CHIP recipients (42 percent) are in families having less than 100 percent of the FPL. Thirty-seven percent live in families with incomes between 101-150 percent of the FPL. The remaining 21 percent live in households with incomes between 151 and 200 percent of FPL.

Table 15: CHIP Enrollment

Sixty-nine percent of CHIP children are residents of Davis, Salt Lake, Weber, and Utah counties. Thirty-one percent are residents of other counties.

Enrollment (as of Aug 2010)	
Ethnicity	
Non-Hispanic	29,995
Hispanic	10,465
Race	
White	37,159
Multiple Races	1,673
Asian	648
Native American/Alaska Native	488
Black	472
Native Hawaiian/Pacific Islander	413
Age	
Less than 10	20,837
10 to 19	20,016
Income	
Less than 100% FPL	17,286
101% to 150% FPL	14,958
151% to 200% FPL	8,615

There have been, historically, some minor discrepancies based on blank fields for these designations when completed by clients.

Utah's Premium Partnership for Health Insurance (UPP)

In an effort to create private health insurance opportunities for individuals who qualify for CHIP, DOH obtained federal approval to offer families the ability to purchase their employer-sponsored health insurance rather than enroll their children in CHIP. Beginning November 1, 2006, qualified families were eligible to receive a rebate when they purchased health coverage through their work. In addition, qualified families also receive a rebate if they purchase dental coverage through their work. If the family does not purchase dental coverage for their children through their work, the children can be enrolled in CHIP dental coverage, which is provided through PEHP in FY2010. Those rebates are currently $120 per child per month for medical coverage and an additional $20 per child per month for dental coverage.

In August 2010 there were 393 children enrolled in UPP. Of the 393 enrollees, 321 received both the medical and dental subsidy and 72 received the medical subsidy and enrolled in the CHIP dental plan.

In December 2009 UPP was given approval by the Centers for Medicare and Medicaid Services to help low-income individuals and families pay for their COBRA coverage. New families, either COBRA-eligible or already enrolled in COBRA, may qualify to receive up to $150 per adult each month and up to $140 per child each month to help subsidize their monthly COBRA premium payment.

APPENDICES

APPENDIX I

Glossary

XIX: Title XIX: Title XIX of the Social Security Act requires states to establish Medicaid programs to provide medical assistance to low income individuals and families. Within broad federal rules, each state decides eligible coverage groups, eligibility criteria, covered services, payment levels, and administrative and operating procedures.

Aid Categories: A designation under which a person may be eligible for medical assistance.

Arrears: The amount of money owed to a state or to a Non-IV-A participant that was not paid when due.

BMC: Bureau of Medical Collections. The ORS program collects medical reimbursement from responsible third parties to both reimburse and avoid state Medicaid costs.

Capitation: A reimbursement method where the contractor is paid a fixed amount (premium) per enrollee per month.

Category of Assistance: A group of aid categories consisting of clients with similar Medicaid eligibility. Examples include Aged, Blind and Disabled.

Category of Service: A group of services that are provided by a common provider. Examples include Inpatient Hospital, Outpatient Hospital and Physician Services.

CHIP: The Children's Health Insurance Program is a state health insurance plan for children. Depending on income and family size, working Utah families who do not have other health insurance may qualify for CHIP.

CIC: Children in Care. The program within ORS which provides services to reimburse the state for costs of supporting children placed in its care and/or custody, by obtaining financial and medical support, through locating parents, establishing paternity and support obligations and enforcing those obligations when necessary.

Clawback Payment: Federally required payments to the Medicare program that began in 2006 to cover the pharmacy needs of Medicare clients that were also eligible for Medicaid.

CMS: Centers for Medicare and Medicaid Services. A federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

CSS: Child Support Services. The ORS program which provides services on behalf of children and families in obtaining financial and medical support. Child support services also include locating parents and establishing paternity.

DOH: Utah Department of Health

DHS: Utah Department of Human Services.

DWS: Utah Department of Workforce Services.

Eligibles: Individuals who have been certified to participate in the Utah State Medicaid Program.

FTE: Full-time equivalent staff.

Managed Health Care: A system of health care organizations that contract with Medicaid to provide medical and mental health services to Medicaid clients.

Medicaid Restricted Account: The General Fund Restricted Account created to hold any general funds appropriated to the Department of Health for the State plan for medical assistance or for the Division of Health Care Financing that are not expended in the fiscal year for which the general funds were are appropriated and which are not designated as nonlapsing. Unused State funds associated with the Medicaid program from DWS and DHS and any penalties imposed or collected under various statutes shall be deposited. See UCA 26-18-402 for more detail.

Nursing Care Facilities Account: Proceeds from the assessment imposed by Section UCA 26-35a-104 which shall be deposited in the restricted account to be used for the purpose of, and to the extent authorized by federal law, to obtain federal financial participation in the Medicaid program**.**

OCSE: The Federal Office of Child Support Enforcement.

Order: A legal document that specifies the amount of money owed by a participant or the enforceable duty of the participant.

ORS: The Office of Recovery Services, located in the Utah Department of Human Services. ORS houses the IV-D agency, as well as the Bureau of Investigations and Collections, Bureau of Medical Collections and the Bureau of Collections for Children in Care.

ORSIS: The Office of Recovery Services Information System. ORSIS is the comprehensive computer system used in ORS.

Participating Provider: A provider who submitted a bill to the Utah State Medicaid Program for payment during the fiscal year.

PCN: Primary Care Network is a health plan administered by DOH. It covers services administered by a primary care provider. Applications are accepted during open enrollment period and federal requirements give preference to parents over people without children.

Recipients (Clients): The unduplicated number of eligibles who had paid claim activity during a specific time period. This count is unduplicated by category of service as well as in total.

Seed: State funds appropriated to agencies outside the Division of Medicaid and Health Financing that are transferred to the Utah Department of Health in order to draw down the federal match for Medicaid activities that occur within those other agencies.

Spenddown Money: Clients that have too much income to qualify for Medicaid can spend down their income if they have qualifying medical expenses that bring their net income to Medicaid levels.

TANF: The federal block grant program Temporary Assistance for Needy Families, which succeeds the Aid to Families with Dependent Children program. In Utah, this program is known as "FEP", Family Employment Program.

TPL: Third Party Liability. Individuals or entities who have financial liability for medical costs of Medicaid recipients.

Trends: A measure of the rate at which the data is changing. Trends are calculated by the least squares method based on the past twelve months of date up to and including the current month.

UAPA: Utah Administrative Procedures Act

Unduplicated Count: Recipients who are counted only once regardless of whether they used one or more categories of service or are covered by one or more categories of assistance.

Units of Service: A measure of the medical service rendered to a client. The unit of measure of a service unit will vary with the type of claim. For example, the service unit for an inpatient hospital claim is days of stay, while the service unit for a dental claim is procedures.

USDC: Utah State Development Center

Waiver: The waiving of certain Medicaid statutory requirements which must be approved by CMS.

Welfare Reform: New federal requirements as a result of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996.

APPENDIX II

Utah Medicaid Waivers

Waiver programs currently in effect in the State of Utah:

Waiver Type 1115

Primary Care Network (PCN)

PCN is a health plan offering services from primary care providers. The federal government requires that more parents be enrolled than adults without children. Since 2002, Waiver Type 1115 has enabled funding for Nontraditional Medicaid (average 21,000 adults annually), PCN (19,000 adults, and Utah's Premium Partnership for Health Insurance (UPP) (over 200 adults and 500 children annually). Funding for adults is through Title XIX (Medicaid). Children are funded through Title XXI (CHIP).

Waiver Type 1915b

(i) Choice of Health Care Delivery Program & Hemophilia Disease Management Program

This program grants operating authority to allow Medicaid to require Traditional Medicaid clients living in Davis, Salt Lake, Utah, and Weber counties to select a health plan that provides services in accordance with the program's waiver. In addition, this is the operating authority to allow Medicaid to contract with a Utah licensed pharmacy for the provision of anti-hemolytic factors to Utah's Medicaid clients with hemophilia.

(ii) Prepaid Mental Health Plan

This waiver allows Medicaid to mandatorily enroll most Title XIX recipients in 27 counties in this plan. Contracted mental health centers provide services covered under the waiver on an at-risk capitation basis.

Waiver Type 1915c

(i) Technology Dependent, Medically Fragile

This program offers the choice of home and community-based alternatives for technology dependent, medically fragile individuals with complex medical conditions, who would otherwise require placement in a Medicaid enrolled Nursing Facility to obtain needed services (the costs of which would be borne by Medicaid). The waiver operates statewide, and serves a maximum of 120 recipients at any point in time.

This program permits the State to furnish an array of home and community-based services (in addition to Medicaid State plan services) necessary to assist technology dependent individuals with complex medical needs to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by the Medicaid agency and the Division of Family Health and Prevention (also under the umbrella of the Single State Medicaid Agency). The Medicaid agency provides the State matching funds for this program.

(ii) Community Supports Waiver

This program serves over 4,400 individuals with intellectual disabilities in home and community-based setting as an alternative to institutional care in an Intermediate Care Facility for People with Mental Retardation (ICF/MR). The Operating Agency is DHS, Division of Services for People with Disabilities.

This program's primary focus is to provide services to children and adults with intellectual disabilities. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for services provided in an intermediate care facility for people with mental retardation (ICF/MR). The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

(iii) Aging Waiver

This program serves nearly 600 individuals over the age of 65 in home and community-based settings as an alternative to institutional care in a nursing facility. The Operating Agency is DHS, Division of Aging and Adult Services.

This program's primary focus is to provide services to elderly individuals in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Aging and Adult Services, provides for the day-to-day operation and the state funding of this program.

(iv) Acquired Brain Injury Waiver

This program serves approximately 100 individuals with acquired brain injuries in home and community-based settings as an alternative to institutional care in a nursing facility. The Operating Agency is DHS, Division of Services for People with Disabilities.

This program's primary focus is to provide services to adults who have suffered acquired brain injuries. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

(v) Physical Disabilities Waiver

This program serves approximately 120 individuals with physical disabilities in home and community-based settings as an alternative to institutional care in a nursing facility. The Operating Agency is DHS, Division of Services for People with Disabilities.

This program's primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual's own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

(vi) New Choices Waiver

This program serves approximately 800 people who were nursing facility residents immediately prior to enrolling in the waiver. The program provides services to these individuals in home and community-based settings as an alternative to institutional care in a nursing facility. The Operating Agency is the State Medicaid Agency.

The purpose of this waiver is to assist individuals who are currently residing in nursing homes to have the option to move back into a community-based setting and receive their Long Term Care services in that setting rather than in a nursing home.

APPENDIX III

Adult Medicaid Programs

Comparison of Adult Medicaid Programs – July 2009
****A provider can refuse to see you, if you do not pay your co-pay. ****
*** This chart may change at anytime***

Benefit	Traditional Medicaid - usually 18 years or older	Non-Traditional Medicaid - usually 19 years or older	PCN- Fee for Service - 19 years or older
Out of Pocket Maximum	* **Pharmacy** $15 per month **Inpatient** $220 per year **Physician & Outpatient** $100 per year	$500 per calendar year per person	$1000 per calendar year per person (up to $50 enrollment fee not included)
Dental	***Not covered***	***Not covered***	10% co-pay - limited benefits
Emergency Room	* no co-pay. $6 co-pay for non-emergency use of the ER.	*no co-pay. $6 co-pay for non-emergency use of the ER.	$30 co-pay per visit - See PCN Member Guide for limitations
Family Planning	**Office visit** - no co-pay **Pharmacy** - no co-pay *See current OTC list*	**Office visit** - no co-pay **Pharmacy** - no co-pay *See current OTC list* *Implants and patches are not covered*	**Office visit** - $5 co-pay per visit **Pharmacy** - refer to pharmacy benefit , *See current OTC list* *Implants and sterilization not covered*
Inpatient Hospital	*$220 co-pay yearly for non-emergency stays	$220 co-pay each non-emergency stay	Not a covered service
Lab	no co-pay	no co-pay	Lab - 5% co-pay if Medicaid allowed amount over $50
Medical Equipment & Supplies	no co-pay	no co-pay	10% co-pay for covered services
Mental Health	no co-pay at prepaid Mental Health Center	no co-pay - limited benefit *30 annual inpatient, 30 annual outpatient visits*	Not a covered service
Occupational and Physical Therapy	no co-pay	$3 co-pay - *limited to a combined 10 visits per year*	Not a covered service
Office Visit & Outpatient	***Outpatient** - $3 co-pay per visit **Office visit** - $3 co-pay per visit	**Outpatient** - $3 co-pay **Office visit** - $3 co-pay per visit - *no co-pay for preventative care or immunizations*	**Outpatient** - not covered **Office visit** - $5 co-pay per visit - *Pregnancy related services not covered*
Pharmacy	*$3 co-pay per prescription limited to $15 monthly *Review process for more than 7 prescriptions per month* *Limited over-the-counter drug coverage*	$3 co-pay per prescription *Review process for more than 7 prescriptions per month* *Limited over-the-counter drug coverage*	*Limited to 4 prescriptions per month* **Generic** - $5 co-pay **Brand Name** - co-pay is 25%
Transportation	no-co-pay	no co-pay - *limited to emergency transportation*	no co-pay - *limited to emergency transportation*
Vision Services	Optometrist – no co-pay for annual eye exam Ophthalmologist - $3.00 co-pay for annual eye exam Glasses not covered	Annual coverage limited to $30.00 for a medically necessary eye exam *Glasses not covered*	$5.00 co-pay for annual exam *Glasses not covered*
X-Ray	no co-pay	no co-pay	X-ray - 5% co-pay if Medicaid allowed amount over $100

* **American Indians, pregnant women and children are excluded from co-pays.** In addition to Traditional Medicaid benefits, pregnant women and children will receive dental, vision and chiropractic benefits.

Other insurance or Medicare may affect co-pay and co-insurance.

APPENDIX D - IDEAS LEARNED BY PEHP THAT COULD BE APPLIED TO MEDICAID

December 30, 2010

Mr. Jonathan Ball

Legislative Fiscal Analyst

State of Utah

Dear Mr. Ball:

In accordance with House Bill 2 from the 2010 General session, Public Employees Health Program (PEHP) submits this report on strategies employed by PEHP that may be applicable to the State Medicaid program in improving their cost control and management efforts.

Specifically, the excerpt from House Bill 2 reads:

> The Legislature intends that the Public Employees' Health Program (PEHP) provide a report to the Legislative Fiscal Analyst by December 31, 2010 on ideas learned by PEHP that could be applied to Medicaid.

PEHP is not intimately familiar with the federal and state regulations and rules under which Medicaid operates. Consequently, some of our observations and suggestions may not be practical or even feasible for Medicaid to adopt. Likewise, we recognize that Medicaid has undergone recent performance audits by the Legislative Auditor General and that our observations and suggestion may be redundant with the results of those audits. We anticipate your office, in cooperation with the Legislative Auditor General and Medicaid management, will be able to assess the value of our observations and suggestions.

Our report does not include detailed discussions of our processes, including the vendor products we use. Should our observations and suggestions appear useful to Medicaid's operations, we would be pleased to discuss in more detail and would make available our management team for such discussions.

Sincerely,

Jeffrey L. Jensen

PEHP Director

Report by Public Employees Health Program

to the Legislative Fiscal Analyst

on Ideas Learned that May be Applicable to Medicaid

FRAUD, WASTE AND ABUSE

- PEHP runs a report based on diagnosis codes which identify potential Third Party Liability (TPL) claims. The report is run weekly for the prior week claim payments, and is reviewed by the TPL technician. If a claim is judged to be a potential TPL claim, the member is sent a questionnaire asking questions related to the accident. When a TPL injury is identified, the TPL Specialists open a database with all pertinent information. A follow-up is performed every 30 days to ensure PEHP is included when settlement is made. PEHP researches potential third-party liability issues with automobile and homeowners insurance claims by accessing the National Insurance Crime Bureau's Insurance Services Office (ISO) claims network to determine if subrogation is warranted. (The ISO database records all property & casualty and workers compensation claims.) If warranted, a PEHP team pursues reimbursement.

- Overpayments less than $10.00 are not pursued as they are not cost-effective.

- PEHP uses analytical tools that assess the appropriateness of invoices and automatically denies claims if recommended by the application. We use a McKesson product on the front end of the claims process and HealthCare Insight on adjudicated (but before payment is made) claims. Using the products in tandem permits us to assess differences in those recommendations, and affords us the ability to select the desired payment policies and compare the output of one tool to the other.

- PEHP is addressing the overutilization caused by our members who are "doctor shopping". We focus on members who obtain multiple narcotic prescriptions from multiple providers. PEHP's doctor shopping program uses an analytical tool called Impact Pro to identify suspected drug seekers. The member's providers are contacted with a full prescription history so that they may modify their prescribing patterns as appropriate. Also, the member is required to sign an agreement which designates a single provider who can write narcotic prescriptions for that member.

- As a corollary to members exhibiting "doctor shopping" behavior, PEHP conducts analyses of our prescription data to identify providers that may have unusual prescribing patterns, especially when it involves narcotic pain medication.

- PEHP has found value in having our fraud, waste and abuse team work closely with our claims operations, clinical services and provider relations departments in order to facilitate their investigations. We believe the Medicaid Fraud Control Unit may not be part of the Department of Health.

UTILIZATION AND CASE MANAGEMENT

- PEHP controls unnecessary utilization of high-end medical services with an integrated process that includes:
    - Pre-notification of a hospital stay so we can perform
        - Utilization review for medical necessity of a continued hospital stay and/or further treatment, and, in the event of potentially catastrophic situation,
        - Case management by nurses working with treating physicians and family to coordinate care for complex or high-dollar cases to achieve the best outcome with the prudent use of resources.
- McKesson Interqual is a leased application which is used as an objective database to validate the decisions of the case managers and utilization managers.
- PEHP employs a “continuum of care” approach called Care Management. This is a full-time, integrated team effort which provides benefits support in the areas of wellness, pre-disease status, disease management, and case management. The integration of Care Management gives PEHP the ability to encourage clinical intervention in members with deteriorating health.

PHARMACY MANAGEMENT

- Formulary Management, PEHP has
    - Created a Pharmacy and Therapeutics Committee to advise on appropriate prescription drugs for our Utah-based drug formulary
    - Established a closed formulary that allows PEHP to require prior authorization or to exclude from coverage medications that do not offer clinical advantage over lower cost alternatives

- Created pre-authorization criteria on medications that are high cost, have off-label use, require previous trial of other medications, and require special monitoring
- Created a quantity level program that minimizes the chance of overutilization, waste and abuse and
- Required step therapy for multi-source medications (brand name medication where a generic equivalent is available).

- PEHP is constantly auditing our third-party pharmacy benefit manager for contract compliance (e.g., drug utilization reviews, rebates, pricing guarantees, quantity levels, refill-too-soon)

PROVIDER RELATIONS

- PEHP has strengthened our credentialing criteria that governs who is eligible to participate in the network by including more thorough reviews of current and past histories of:
  - DOPL (Department of Public Licensing) actions
  - Malpractice history
  - Sexual misconduct allegations
  - Health care fraud
  - Crimes
- PEHP has created a coordinated process to review providers with unusual claims practices
  - The review process brings together representatives from Provider Relations, Fraud & Abuse, and Benefits Review
  - The process includes a method to identify suspicious claims activity, review claims to substantiate or clear the providers of inappropriate billing, and recommends actions to be taken against the provider based upon the results of the review

CLAIMS AUDIT AND MANAGEMENT

- PEHP performs internal and external audits of adjudicated claims with the dual goal of correcting processing errors before payment is made, as well as providing training for our claims processors. Our auditing of claims includes the following:
    - Editing by McKesson software upon receipt
    - Adjudication of the claim
    - Auditing by Health Care Insight using their proprietary software and their nurses
    - Review by PEHP claims supervisors
- Our audit processes are highly efficient and we are most willing to share our work flow with Medicaid staff as appropriate.

APPENDIX E - REIMBURSEMENT OPTIONS FOR PHARMACEUTICAL DRUGS IN MEDICAID

Report to the
Office of Legislative Fiscal Analyst

Reimbursement Options for Pharmaceutical Drugs: Replacing Average Wholesale Price

in compliance with HB 2 Intent Language

Prepared by the Division of Medicaid and Health Financing

October 1, 2010

UTAH DEPARTMENT OF HEALTH

EXECUTIVE SUMMARY

Average wholesale price (AWP) has been the basis of calculating pharmaceutical pricing and reimbursement for many years. Lawsuits filed, beginning in 2003, have challenged the use of AWP as an inflated benchmark costing government and insurance health plans millions. A final ruling in 2008 ended litigation and mandated a five percent rollback in the basis of AWP, and national pricing compendia agreed to cease publishing AWP in September 2011.

Until recently, the search for a suitable replacement for AWP has largely centered around academic discussions of the merits of the various other pricing benchmarks that are in common use within the industry. In late 2009 and early 2010, the National Association of State Medicaid Directors (NASMD) along with the American Medicaid Pharmacy Administrators Association (AMPAA) began dialogue with the states to produce a white paper focused on this issue. The purpose of the white paper can be viewed as three-fold:

1. Provide an understanding to major stakeholders of the issues involved with pharmaceutical pricing
2. Emphasize the need for CMS to adopt a leading role in the effort to identify and advocate a suitable, nationwide pricing metric for pharmaceutical pricing
3. Raise the awareness of all stakeholders to the problems facing them in the absence of a single, nationally viable AWP replacement

The white paper was submitted to the Centers for Medicare and Medicaid Services (CMS) in July of 2010. In the wake of this submission, two states, Alabama and Oregon, submitted state plans to CMS outlining differing approaches for identifying an Actual Acquisition Cost (AAC) and the cost of dispensing, through the use of survey tools. CMS has approved the Alabama plan, but is cautious about all 50 states undertaking similar measures since provisions in the Medicaid laws and the Affordable Care Act (ACA) provide for retail pricing surveys by CMS.

The intent language of H.B. 2 directs that the Department of Health:

> …report on …reimbursement options for pharmaceutical drugs that would give the State more control over inflationary increases and/or move away from a reimbursement based on Average Wholesale Price…

The main issue surrounding AWP is the unknown and inconsistent margins built into the price. This particular issue is believed to be the concern and focus of the information sought. Accordingly, this report will focus on efforts to replace AWP as a basis for Medicaid reimbursement.

Introduction

State and federal agencies have struggled for years over appropriate levels of reimbursement for pharmaceutical products purchased by their respective programs. Indeed, the current Medicaid program involving rebates from manufacturers came as a result of those concerns. Even with these efforts, however, a pricing system based on transparent pricing has eluded all attempts at transparency. There are simply too many purchasers and purchaser types, too many discounts and discount types, and too many negotiable and negotiated scenarios for a manufacturer to have a single price for all business transaction types. Attempts to limit pricing benchmarks to certain types of sales have only resulted in multiple benchmarks, thus raising confusion and ending in frustrated systems. After years of experimentation with different manipulations of the various benchmarks, litigation over the use of AWP leaves all stakeholders facing the same inevitable conclusion: AWP must be replaced. It also leaves all stakeholders facing the same question: What to replace it with and how?

Replacing AWP - options

Left in the wake of a discarded AWP are approximately seven or more different pricing benchmarks including:

- Average Sales Price (ASP)
- Average Manufacturer Price (AMP)
- Best Price (BP)
- Wholesale Acquisition Cost (WAC)
- Nominal Pricing (NP)
- 340b
- Federal Upper Limit pricing (FUL)

Except for FULs, these benchmarks are all manufacturer derived and reported to CMS. Each has a role in some federal regulation. Each also has potential application as well as unique problems. Their definitions, merits, faults, and differences however are not within the scope of this report. These, for the most part, are treated exceptionally well in the NASMD white paper, and the reader is referred to Attachment 1 for that information.

State Plans and pricing methodology

In addition to pricing benchmarks, other pricing tools have resulted as a direct result of the manipulations previously mentioned. Some are the result of regulation. Others from dissatisfaction with available tools. Among these are:

- Estimated Acquisition Cost (EAC)
- Actual Acquisition Cost (AAC)
- Maximum Allowable Cost (MAC)

In contrast to the benchmarks mentioned above, these tools are within the scope of state regulation and except for AAC, have their relationship and application defined in some way by those general benchmarks.

State Plans are required by federal regulation to stipulate the methodology a state uses to determine reimbursement. Federal regulation (42 CFR 447.512) requires that a state base its reimbursement on EAC and allows each state the leeway to derive EAC, but it must be described in the State Plan (42 CFR 447.518). Historically, states have begun with AWP as the starting point for EAC derivations. Any change in the methodology requires the state to file a State Plan Amendment (SPA) with CMS, which then must be approved by CMS for the change to qualify for federal financial participation.

Pricing methodologies are scrutinized by CMS to ensure they satisfy federal requirements that reimbursements are adequate to guarantee access and scope of coverage. Reimbursement methodologies that result in too many providers choosing not to participate limit access to coverage for beneficiaries. On the other hand, methodologies that result in excessive payments, as determined by CMS, are not acceptable either. Speaking at the Western Medicaid Pharmacy Administrators (WMPAA) conference on September 28, 2010 CMS officials stated that any SPAs changing the basis for pharmacy reimbursement methodology from EAC to AAC would be carefully reviewed, and more specifically any such SPA would have to include a new, validated cost-of-dispensing survey upon which dispensing fees are based. The reasoning given for this position is rooted in the fact that most payers' dispensing fees have historically been artificially low due to the hidden margins provided by the use of AWP as a pricing benchmark. CMS is committed to corrections in both pricing methodology and dispensing fees in light of the call to eliminate AWP. Changes proposed through SPAs must be carefully approached.

State efforts to replace AWP

State Medicaid Agencies have been reluctant to rush into pricing methodology changes for their Medicaid programs because of the national white paper effort. CMS accepted the NASMD white paper and agrees that it would not be in the best interest of the states or the federal program to have multiple pricing metrics in use. This is especially true since, as the white paper establishes, a reliable alternative is not obvious. The various state Medicaid agencies would be best served if a single basis were established for use by all. This is underscored by requirements in the Medicaid laws (SSA 1927(f)) and the ACA that provide for retail pricing surveys. CMS has stated these surveys are in process. The intent of CMS is to provide pricing information on a monthly basis (Joe Fine, CMS, 9/28/2010).

In spite of the white paper initiative, two states - Alabama and Oregon, have initiated SPAs to switch their pricing methodology from an AWP-based reimbursement (EAC) to an AAC-based method. The SPA from Alabama has been approved and goes into effect October 1, 2010. Alabama initiated an ambitious effort to involve all pharmacy groups and associations as well as other providers and manufacturers in the process. In the end, pharmacies volunteered to provide invoice pricing to the state agency survey vendor every 6 months. Alabama also conducted through the same vendor an extensive cost-of-dispensing survey that resulted in an increase in its dispensing fee from $5.40 to $10.64.

Oregon has undergone a similar process of stakeholder involvement and SPA submission. The difference in the Oregon plan, however, is a plan for a tiered dispensing fee based on pharmacy prescription volume. The tiers will range from $10.14 to $15.00, and pharmacies not participating in the surveys will automatically receive the lowest dispensing fee (current dispensing fee is $3.50). The Oregon SPA has yet to be approved. Both states have been working since the beginning of this year to implement their respective programs.

From confidential information shared by states that have contracts with the vendor involved with both of the Alabama and the Oregon surveys as well as information from Alabama and Oregon, vendor services for survey and maintenance operations can cost from $170,000 to $360,000 per year depending on the package of services provided in the contract.

Summary

The call for the elimination of AWP as a pricing meter for Medicaid pharmacy programs is escalating, aided by the cessation of its publication by national pricing compendia in 2011. The lack of a suitable alternative, as well as CMS interest in state activities over replacement methodologies suggest, that a cautious approach be adopted in the pursuit of establishing an appropriate replacement to AWP. While a measure of urgency is acknowledged, the state is not without groundwork in identifying and implementing a change in Medicaid pricing methodology.

Recommendation

Adopt a price benchmark based on actual average acquisition cost data. This, as noted in the NASMD White Paper (emphasis added):

> …most clearly fulfills legal and practical requirements… However, obtaining a valid source of acquisition cost information will require strict definitions, legal reporting obligations, and the identification of a data gathering and reporting process – Using true average cost data complies most literally with federal law and, with a reasonable dispensing fee, is both equitable and legally defensible. **Its development, however, may require: changes in state and federal law, the imposition of reporting obligations on wholesalers, pharmacies, or manufacturers**; Medicaid State Plan Amendments; and a revised process for price reporting, ideally one that was coordinated among groups of states if not all states.

APPENDIX F - COMBINED, UNIFIED ANNUAL REPORT ON MEDICAID EXPENDITURES (PAGES 12 TO 25)

Full Report Available at http://www.health.utah.gov/medicaid/pdfs/annual_report2010.pdf.

Medicaid Consolidated Report

All Medicaid money is administered by the Utah Department of Health (UDOH). As per federal requirements, all funding for Medicaid must flow through the Department of Health and be governed by a memorandum of understanding for all functions performed by other entities whether State, non-profit, for profit, local government, etc.

Programs and services for Medicaid are delivered by UDOH, the Department of Human Services (DHS), the Department of Workforce Services (DWS), and a myriad of contracted providers including University of Utah Hospitals, local health organizations, not-for-profit and for-profit entities. The Office of the Attorney General also receives Medicaid funding to investigate and prosecute Medicaid fraud and abuse.

This consolidated report section shows how Medicaid appropriations are being spent for administration and services by the following departments: UDOH, DHS, DWS, University of Utah, and the Attorney General. In addition, UDOH passes funding through to local government and other providers. The Governor's Office of Planning and Budget reviewed expenditure data from these five state agencies.

Figure 5 shows Medicaid funding by funding source. Federal funds comprise the largest share at 67 percent of total funding. UDOH has also identified in the Consolidated Report, the category of service expenditures for SFY 2010, as well as the portion of the General Fund which is seeded to other state agencies and local governments.

Figure 6 shows all Medicaid expenditures for SFY 2010. Program expenditures totaled $1,885,648,300. Expenditures for mandatory services comprised the largest portion of total expenditures (46 percent), followed by optional services (26 percent). Specific detail is shown for both service expenditures and administrative expenditures. Administrative expenses accounted for $101.7 million, or six percent of the total Medicaid-related expenditures.

Table 3 shows Medicaid funding by source and type of service. In SFY 2010 federal funds provided the largest share of funds for both mandatory and optional services, totaling $1.4 billion. General Funds provided $279.8 million.

Table 4 shows Medicaid expenditures by type of service. Inpatient hospital services incurred the largest share of mandatory services ($283,321,300), while Pharmacy incurred the largest portion of optional services ($170,059,100).

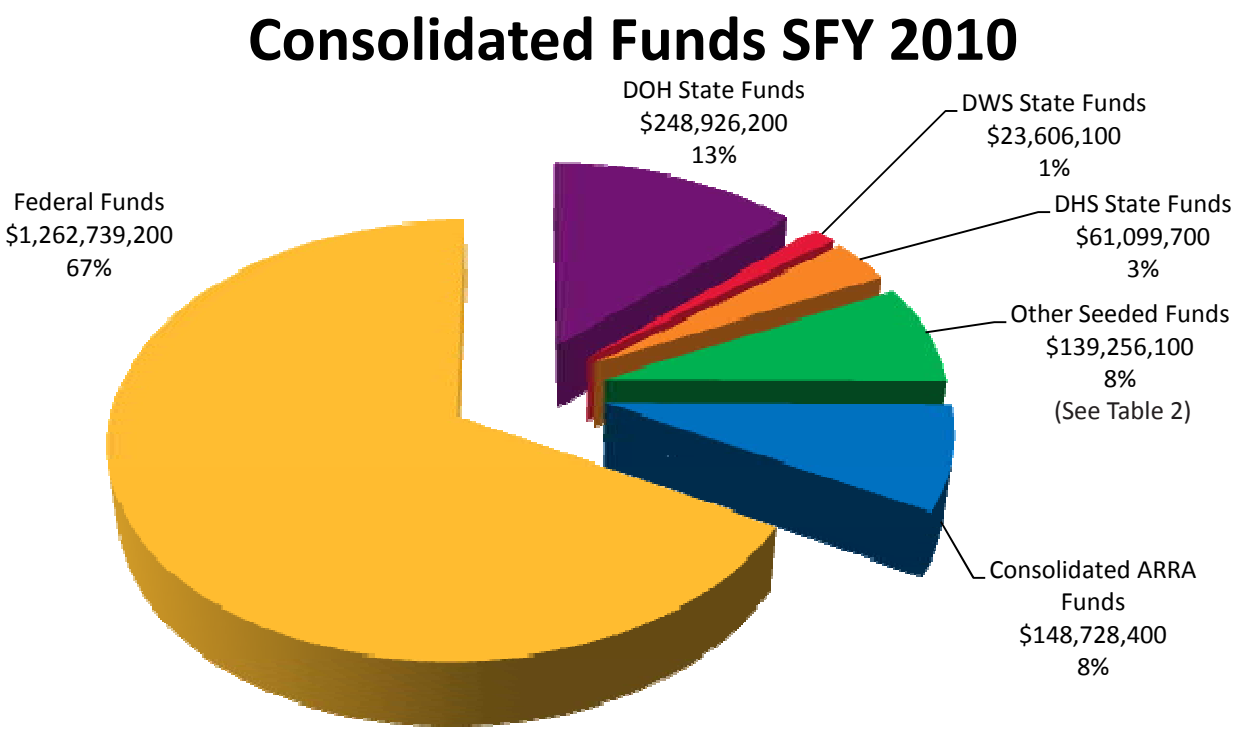

Figure 5

Other Seeded Funds	
Capitated Mental Health	$20,250,900
Fee-For-Service Mental Health	$352,600
Substance Abuse	$1,767,600
Local Health Departments	$4,288,800
School Districts	$5,725,200
Div. of Community & Family Health	$3,779,100
Hospital Assessment	$7,552,200
Health & Dental Clinics	$2,770,500
Pharmacy Rebates	$63,918,900
Physician Enhancement	$12,157,000
Indirect Medical Education (IME)	$3,724,000
Graduate Medical Education (GME)	$6,060,300
Disproportionate Share Hospital	$6,890,900
Other	$18,100
Total	$139,256,100

Table 2

Consolidated Medicaid Revenues SFY 2010

Mandatory	LHB	LHC	LHD	LHE	LHF	LHG	Total
General Fund	$44,035,100	$1,969,200	$39,579,500	$16,684,800	$22,297,300	$28,386,200	$152,952,100
Federal Funds	$223,072,800	$127,134,400	$185,851,800	$75,775,500	$96,767,000	$65,776,800	$774,378,300
Dedicated Credits	$7,552,200	$0	$0	$428,800	$0	$1,737,800	$9,718,800
Restricted Revenue	$8,320,500	$16,236,000	$0	$0	$0	$0	$24,556,500
Transfers	$125,100	$7,400	$558,200	$127,100	$182,500	$3,006,500	$4,006,800
Beginning Balance	$20,123,500	($3,340,900)	($1,854,000)	($1,380,900)	($3,341,600)	($2,883,900)	$7,322,200
Closing Balance	($19,464,800)	$15,903,600	$10,087,900	$3,088,400	$3,592,100	($8,343,900)	$4,863,300
Lapsing Balance	($443,100)	($712,500)	$0	$0	$0	$0	($1,155,600)
	$283,321,300	$157,197,200	$234,223,400	$94,723,700	$119,497,300	$87,679,500	$976,642,400

Optional	LJA	LJB	LJC	LJD	LJE	LJF	LJG	LJH	Total
General Fund	$36,645,600	$1,028,200	($7,167,000)	$10,291,100	$6,729,100	$2,049,000	$681,700	($11,177,200)	$39,080,500
Federal Funds	$72,264,400	$126,255,200	$133,679,200	$24,702,500	$25,330,300	$67,612,600	$1,561,000	$131,128,700	$582,533,900
Dedicated Credits	$63,918,900	$0	$18,660,300	$0	$0	$0	$0	$8,574,500	$91,153,700
Restricted Revenue	$76,000	$0	$0	$0	$0	$1,654,300	$0	$0	$1,730,300
Transfers	$146,300	$28,958,800	$8,653,500	$0	$28,900	$10,442,400	$3,800	$29,530,800	$77,764,500
Beginning Balance	$7,134,800	$4,025,000	$2,229,500	($2,069,100)	($3,176,200)	($921,200)	($187,900)	($6,050,200)	$984,700
Closing Balance	($10,126,900)	($2,526,600)	$5,893,000	$3,349,200	$2,488,900	$3,618,000	$23,100	$11,394,500	$14,113,200
Lapsing Balance	$0	$0	$0	$0	$0	($124,000)	$0	$0	($124,000)
	$170,059,100	$157,740,600	$161,948,500	$36,273,700	$31,401,000	$84,331,100	$2,081,700	$163,401,100	$807,236,800

	Services	Admin *	Total
General Fund	$192,032,600	$3,617,700	$195,650,200
Federal Funds	$1,356,912,200	$54,555,400	$1,411,467,600
Dedicated Credits	$100,872,500	$2,242,900	$103,115,400
Restricted Revenue	$26,286,800	$350,000	$26,636,800
Transfers	$81,771,300	$39,090,300	$120,861,600
Beginning Balance	$8,306,900	$493,500	$8,800,400
Closing Balance	$18,976,500	$492,200	$19,468,700
Lapsing Balance	($1,279,600)	$0	($1,279,600)
	$1,783,879,200	$100,841,900	$1,884,721,200

- Administrative Revenues include the Office of the Attorney General revenues and do not include revenues from non-Medicaid Federal grants.

Table 3

Consolidated Medicaid Expenditures SFY 2010

Mandatory	DOH	DHS	U of U	DWS	AG	Total
Inpatient Hospital	$242,315,000	$0	$41,006,300	$0	$0	$283,321,300
Nursing Home	$157,197,200	$0	$0	$0	$0	$157,197,200
Contracted Health Plan Services	$201,111,200	$0	$33,112,200	$0	$0	$234,223,400
Physician Services	$69,308,500	$0	$25,415,200	$0	$0	$94,723,700
Outpatient Hospital	$111,527,100	$0	$7,970,200	$0	$0	$119,497,300
Other Mandatory Services	$87,537,100	$0	$142,400	$0	$0	$87,679,500
Subtotal	$868,996,100	$0	$107,646,300	$0	$0	$976,642,400

Optional	DOH	DHS	U of U	DWS	AG	Total
Pharmacy	$170,059,100	$0	$0	$0	$0	$170,059,100
Home & Community Based Waivers	$59,800	$157,680,800	$0	$0	$0	$157,740,600
Mental Health Services	$105,649,900	$56,298,600	$0	$0	$0	$161,948,500
Buy In / Out	$36,273,700	$0	$0	$0	$0	$36,273,700
Dental Services	$31,401,000	$0	$0	$0	$0	$31,401,000
Intermediate Care Facilities	$31,531,000	$52,800,100	$0	$0	$0	$84,331,100
Vision Care	$2,031,000	$0	$50,700	$0	$0	$2,081,700
Other Optional Services	$114,276,800	$798,900	$0	$0	$0	$163,401,100
Disproportionate Share Hospital	$0	$0	$20,443,300	$0	$0	$0
Graduate Medical Education	$0	$0	$15,358,400	$0	$0	$0
Indirect Medical Education	$0	$0	$12,523,700	$0	$0	$0
Subtotal	$491,282,300	$267,578,400	$48,376,100	$0	$0	$807,236,800

Administrative	DOH	DHS	U of U	DWS	AG	Total
	$34,578,500	$17,589,200	$0	$47,212,200	$1,462,100	$100,842,000

Total Expenditures	DOH	DHS	U of U	DWS	AG	Total
	$1,394,856,900	$285,167,600	$156,022,400	$47,212,200	$1,462,100	$1,884,721,200

- Note that for this report Home & Community Based Waivers does not include New Choice Waiver and Technology Waiver. New Choice Waiver is included in Other Optional Services. The Technology Waiver spans many service categories including Mandatory Services.

Table 4

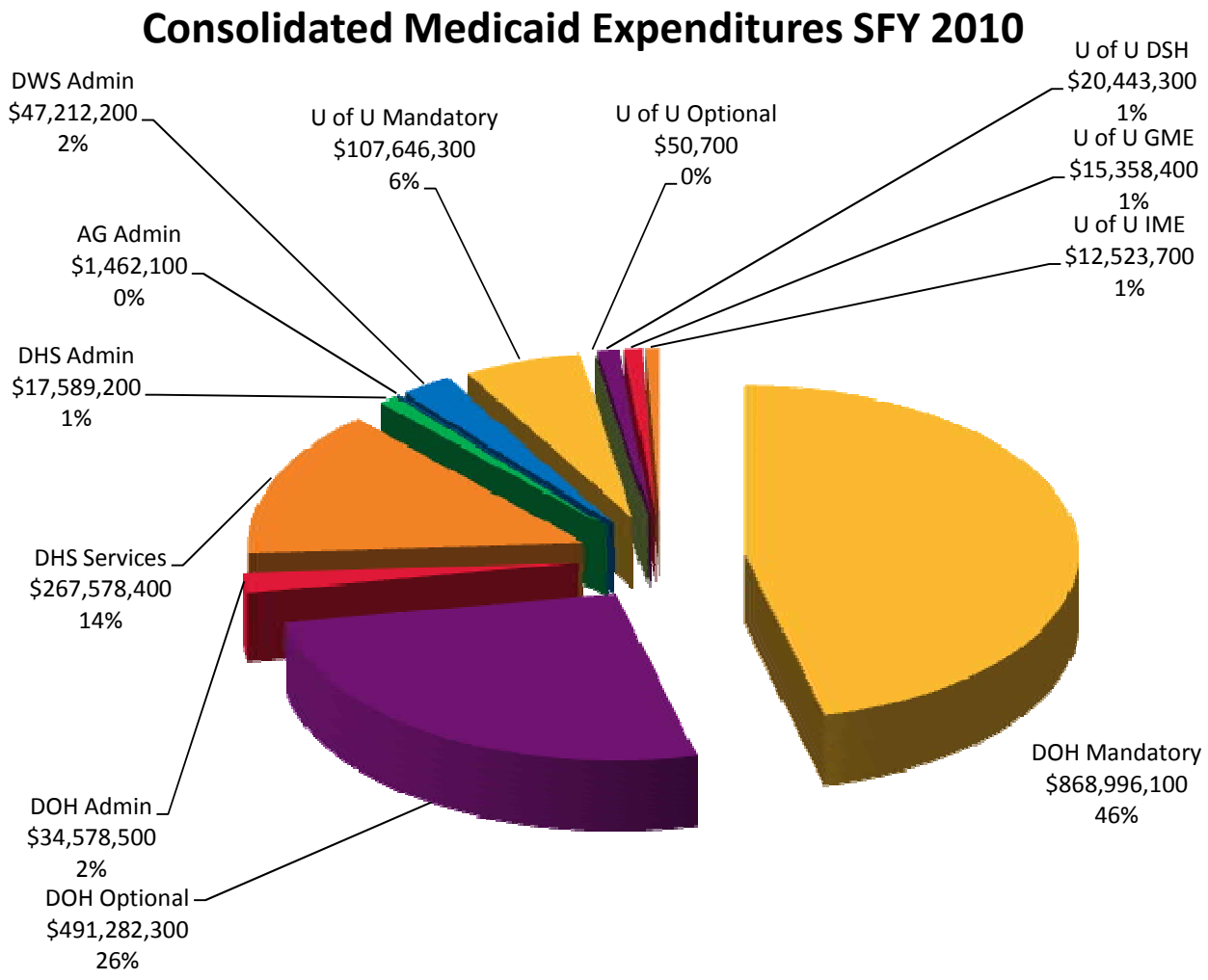
Consolidated Medicaid Expenditures SFY 2010
DWS Admin
$47,212,200
2%
U of U Mandatory
$107,646,300
6%
U of U Optional
$50,700
0%
U of U DSH
$20,443,300
1%
U of U GME
$15,358,400
1%
U of U IME
$12,523,700
1%
AG Admin
$1,462,100
0%
DHS Admin
$17,589,200
1%
DHS Services
$267,578,400
14%
DOH Admin
$34,578,500
2%
DOH Optional
$491,282,300
26%
DOH Mandatory
$868,996,100
46%

Figure 6

Utah Department of Health
Division of Medicaid and Health Financing

The Utah Department of Health (UDOH) was created in 1981 to protect the public's health by preventing avoidable illness, injury, disability and premature death; assure access to affordable, quality health care; promote healthy lifestyles; and monitor health trends and events.

See the Division of Medicaid and Health Financing (DMHF) Overview on page 2 of this report for a breakdown of the bureau responsibilities within the UDOH/DMHF. Table 5 shows Medicaid expenditures by mandatory and optional services, and by administrative costs. Mandatory Medicaid services comprised the largest share of Medicaid services expenditures (64 percent) compared to optional services, which comprised 36 percent. Administrative expenditures were $35 million, or 2.5 percent of total Medicaid expenditures. This amount does not include eligibility determination, which is done by DWS. Please note that HCBS Waivers in Table 5 do not include the New Choices Waiver or Technology Waiver (see note for Table 4).

In SFY 2010 UDOH/DMHF total budget was about $2.2 billion. Total Medicaid expenditures were $1.4 billion, or about 65 percent of the total budget. Table 5 shows SFY 2010 UDOH/DMHF Medicaid Expenditures.

Utah Department of Health / Division of Medicaid and Health Financing			
Services Expenditures - Actual			
Mandatory			***Percent of Total***
Inpatient Hospital	$	242,315,000	18%
Nursing Home	$	157,197,200	12%
Managed Care	$	201,111,200	15%
Physician Services	$	69,308,500	5%
Outpatient Hospital	$	111,527,100	8%
Other Mandatory	$	87,537,100	6%
TOTAL Mandatory	**$**	**868,996,100**	**64%**
Optional			
Pharmacy	$	170,059,100	13%
HCB Waivers	$	59,800	<1%
Capitated HM	$	105,649,900	8%
Buy In/Out	$	36,273,700	3%
Dental Services	$	31,401,000	2%
ICF/MR	$	31,531,000	2%
Vision Care	$	2,031,000	<1%
Other Optional	$	114,276,800	8%
TOTAL Optional	**$**	**491,282,300**	**36%**
Total Services Expenditures UDOH/DMHF	**$**	**1,360,278,400**	**100%**
Administrative Expenditures - Actual			
Responsibilities:			
Claims payment, rate setting, cost settlement, contracting, prior authorization of services, waiver management, client plan selection.			
Personnel Services	$	16,255,300	46%
Travel - In State	$	32,000	<1%
Travel - Out of State	$	16,000	<1%
Current Expense	$	5,948,600	17%
Contractual	$	5,109,200	14%
DTS	$	7,976,700	23%
Total Administrative Expenditures UDOH/DMHF	**$**	**35,337,800**	**100%**
TOTAL	**$**	**1,395,616,200**	
TOTAL UDOH/DMHF Budget		**$2,152,577,000**	
Medicaid, as a % of overall budget		**65%**	

Table 5

Department of Human Services

The Department of Human Services (DHS) was created in 1990 under UCA 62A-1-102 to provide direct and contracted social services to persons with disabilities, children and families in crisis, juveniles in the criminal justice system, individuals with mental health or substance abuse issues, vulnerable adults, and the aged.

Table 6 shows Medicaid expenditures by DHS by category of service and funding source as well as administrative costs. The largest portion of services funds was expended on people with disabilities - over $153 million in federal funds and $36 million from the General Fund - and accounts for over 70 percent of total DHS services expenditures. Administrative costs were $17.6 million, or 6.2 percent of total Medicaid expenditures by DHS. Personnel expense was the largest component of expenditures at $11.2 million.

In SFY 2010 DHS total budget was $676 million, of which $285 million was expended on Medicaid, or about 43 percent of the total DHS budget.

Table 6 illustrates the DHS Medicaid Expenditures for SFY 2010.

Department of Human Services					
Services Expenditures - Actual	**Federal Funds**	***State Funds***	**TOTAL**		**Percent of Total**
Child & Family Services	$ 30,013,700	$ 7,594,100	$ 37,607,800		14%
Juvenile Justice System	$ 15,143,700	$ 3,547,100	$ 18,690,800		7%
Substance Abuse & Mental Health	$ 15,129,200	$ 3,504,600	$ 18,633,800		7%
People with Disabilities	$ 153,002,100	$ 36,166,800	$ 189,168,900		71%
Aging & Adult Services	$ 2,560,100	$ 917,000	$ 3,477,100		1%
Total Services Expenditures DHS	**$ 215,848,800**	**$ 51,729,600**	**$ 267,578,400**		**100%**
Expenditures include amounts paid directly by UDOH to providers who serve DHS clients.					
Administrative Expenditures - Actual					
Personnel Services	$ 5,631,400	$ 5,631,400	$ 11,262,800		64%
Travel - In State	$ 32,150	$ 32,150	$ 64,300		<1%
Travel - Out of State	$ 250	$ 250	$ 500		<1%
Current Expense	$ 456,600	$ 1,607,600	$ 2,064,200		12%
DTS	$ 928,450	$ 928,450	$ 1,856,900		11%
Pass-through	$ 346,350	$ 346,350	$ 692,700		4%
Indirect Costs	$ 823,900	$ 823,900	$ 1,647,800		9%
Total Admin Expenditures DHS	**$ 8,219,100**	**$ 9,370,100**	**$ 17,589,200**		**100%**
TOTAL	**$ 224,067,900**	**$ 61,099,700**	**$ 285,167,600**		
TOTAL DHS Budget	**$676,920,600**				
Medicaid, as a % of overall budget	**42%**				

Table 6

Divisions within DHS, which affect services within the Medicaid expenditures, are as follows:

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES - The mission for the Division is to promote opportunities and provide support for persons with disabilities to lead self-determined lives.

DIVISION OF CHILD AND FAMILY SERVICES - The mission of the Division of Child and Family Services (DCFS) is to protect children at risk of abuse, neglect, or dependency. The Division does this by working with families to provide safety, nurturing, and permanence. The Division partners with the community in this effort.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH - The Division is responsible for ensuring that substance abuse and mental health services are available statewide. A continuum of substance abuse services that includes prevention and treatment is available for adults and youth. The goal is to ensure that treatment is available for adults with serious mental illness and for children with serious emotional disturbance. Services are offered statewide through 13 local authorities who either provide services or contract with private providers.

OFFICE OF RECOVERY SERVICES - The Office of Recovery Services (ORS) serves children and families by promoting independence through responsible parenthood and ensures public funds are used appropriately, which reduces costs to public assistance programs. ORS works with parents, employers, federal, state and private agencies, professional associations, community advocates, the legal profession and other stakeholders and customers. The Office works within the bounds of state and federal laws and limited resources to provide services on behalf of children and families.

The Office provides services to reimburse the State for costs of supporting children placed in its care and/or custody. Financial and medical support is obtained by locating parents, establishing paternity and support obligations, and enforcing those obligations when necessary. The Office also collects medical reimbursement from responsible third parties to reimburse the State and avoid additional Medicaid costs.

DIVISION OF AGING AND ADULT SERVICES - The Division provides leadership and advocacy pertaining to issues that impact older Utahns, and serves elderly and disabled adults needing protection from abuse, neglect, or exploitation. The Division offers choices for independence by facilitating the availability of a community-based independent living in both urban and rural areas of the state. The Division encourages citizen involvement in planning and delivering services.

CHILD PROTECTION OMBUDSMAN - The Child Protection Ombudsman investigates consumer complaints regarding DCFS, and assists in achieving fair resolution of complaints, promoting changes that will improve the quality of services provided to the children and families of Utah, and building bridges with partners to effectively work for the children of Utah.

OFFICE OF FISCAL OPERATIONS - The Office establishes sound fiscal practices, which provide useful information, and maintains reliable program and fiscal controls.

OFFICE OF PUBLIC GUARDIAN - The Office provides court-ordered guardian and conservator services to incapacitated adults who are unable to make basic daily living or medical decisions for themselves. The Office provides training and education to health and social services professionals, as well as the general public on the services available and appropriate criteria to look for in determining alternatives to court ordered public guardianship/conservatorship is available. The office conducts intake and assessment for court petition process.

OFFICE OF SERVICES REVIEW - The Office of Services Review assesses whether DCFS is adequately protecting children and providing appropriate services to families. The Office accomplishes this by conducting in-depth reviews of practice, identifying problem areas, reporting results and making recommendations for improvement to DCFS. The Office performs similar functions for other divisions and offices in the department.

UTAH STATE HOSPITAL - Utah State Hospital is a 24-hour inpatient psychiatric facility which serves people who experience severe and persistent mental illness. It has the capacity to provide active psychiatric treatment services to 359 patients (including a five-bed acute unit). The hospital serves all age groups and all geographic regions of the state.

DIVISION OF JUVENILE JUSTICE SERVICES - The Division of Juvenile Justice Services (JJS) serves youth offenders with a comprehensive array of programs, including home detention, secure detention, day reporting centers, case management, community alternatives, observation and assessment, long-term secure facilities, transition, and youth parole. JJS is a division within DHS but has been assigned to the Executive Offices and Criminal Justice Appropriations Subcommittee for Legislative oversight. Prior to SFY 2004, it was known as the Division of Youth Corrections.

JJS is responsible for all youth offenders committed by the State's Juvenile Court for secure confinement or supervision and treatment in the community. JJS also operates receiving centers and youth services centers for non-custodial and non-adjudicated youth.

Programs within the Division of Juvenile Justice Services include:

- Administration
- Early Intervention Services
- Community Programs
- Correctional Facilities
- Rural Programs
- Youth Parole Authority, the JJS equivalent to the Board of Pardons and Parole

Department of Workforce Services

The Department of Workforce Services (DWS) was created in 1997, per UCA 35A-1-103(1), to provide employment and support services for customers to improve their economic opportunities. Costs of DWS for the Eligibility Services Division are computed by taking a random moment in time sample. On a quarterly basis, eligibility workers in the Department record the time they spent on fourteen public assistance programs. Total costs are allocated to the various programs based on the percent of time derived from the sample.

Table 7 shows Medicaid administrative expenditures by DWS by cost type and funding source. Administrative costs totaled $47.2 million, or 3 percent of the DWS total budget of $1.6 billion.

Table 7 shows the DWS Medicaid Expenditures for SFY 2010.

Department of Workforce Services									
Administrative Expenditures - Actual		**Federal Funds**		**State Funds**		**TOTAL**	**Percent of Total**		
Direct Costs	$	1,369,900	$	1,369,900	$	2,739,800	6%		
Allocated Costs	$	22,236,200	$	22,236,200	$	44,472,400	94%		
Total Admin Expenditures DWS	**$**	**23,606,100**	**$**	**23,606,100**	**$**	**47,212,200**	**100%**		

Does not include year-end closing entries made by DWS.

TOTAL DWS Budget	**$1,583,937,500**
Medicaid, as a % of overall budget	**3%**

Table 7

Divisions and budget areas within DWS are as follows:

ELIGIBILITY SERVICES DIVISION - The Division was created in 2009 to centralize the State's public assistance eligibility process using eREP to process applications. The Division determines eligibility for the Medicaid, CHIP, and other federal and state public assistance programs.

Eligibility for the different medical programs varies depending upon the program. Some major elements of consideration include: income level, assets, and the presence of dependents in the home. Generally, those who receive coverage must submit documentation annually to confirm continued eligibility.

MEDICAL PROGRAMS - Medical Programs is a specific budget area at DWS and includes Medicaid, CHIP, PCN, and UPP eligibility. The entire eligibility component of these programs was transferred from UDOH to DWS in SFY 2008. Prior to that, DWS conducted about 40 percent of all eligibility determinations. General administration and oversight of the programs are still conducted within UDOH.

Medical Programs are funded by General Fund and Federal Funds for Medicaid, CHIP, PCN and UPP. DWS receives funding to provide eligibility determinations within each of the programs. Actual payments to providers are made by UDOH.

MEDICAL PROGRAMS PERFORMANCE MEASURES - Program performance is measured by several mechanisms. Federal regulation requires that a decision be made on a medical application within 45 days following the date of application and 90 days for Disability Medicaid. However, federal policy allows extensions for the applicant to provide proof of eligibility. DWS has established a timeliness benchmark of 30 days for its internal processes, similar to other DWS administered programs, such as Food Stamps.

Approximately 28 percent of DWS time is related to the Medicaid program. As shown in Table 8, only six percent of the costs are direct, while 94 percent are allocated based on the random moment time study.

Office of the Attorney General

The Criminal Prosecution Program consists of five divisions of which two, criminal justice and investigations are responsible for investigation and prosecution of Medicaid fraud within the State. Table 8 shows Medicaid administrative expenditures by category and funding source. Of the $1.5 million in total expenditures, over $1 million (74 percent) is spent on personnel services. Total Medicaid expenditures comprise three percent of the Office of the Attorney General's budget.

Currently the Attorney General's office has ten full-time positions assigned to the Medicaid Fraud Unit. During SFY 2010 there were 113 new investigations opened and nearly $30 million collected as a result of the efforts of this unit.

Table 8 shows the Office of the Attorney General Medicaid Expenditures for SFY 2010.

Attorney General								
Administrative Expenditures - Actual		**Federal Funds**			**State Funds**		**TOTAL**	**Percent of Total**
Personnel Services	$	807,400	$	269,200	$	1,076,600	74%	
Travel	$	3,700	$	1,200	$	4,900	<1%	
Supplies	$	7,200	$	2,400	$	9,600	1%	
Contractual	$	67,000	$	22,300	$	89,300	6%	
Other	$	21,700	$	7,200	$	28,900	2%	
Indirect Costs	$	189,600	$	63,200	$	252,800	17%	
Total	**$**	**1,096,600**	**$**	**365,500**	**$**	**1,462,100**	**100%**	
TOTAL AG Budget		**$49,595,000**						
Medicaid, as a % of overall budget		**3%**						

Table 8

University of Utah Medical Center

The University of Utah is involved in three Medicaid program areas:

INPATIENT DISPROPORTIONATE SHARE HOSPITAL - These funds come from finite federal allocation to states and are used to pay "safety net" hospitals that serve a disproportionate share of Medicaid and uninsured patients. The funds are intended to offset some of the hospitals costs in serving these clients.

INPATIENT GRADUATE MEDICAL EDUCATION (GME) - These funds offset some of the costs of residency programs that serve Medicaid clients. The funds cannot be used for academic programs but are used to cover some of the patient care costs associated with the care provided by residents. These funds are mainly matched by the University and are subject to the calculated Upper Payment Limit (UPL) authorized by CMS.

INPATIENT INDIRECT MEDICAL EDUCATION (IME) - These funds help offset some of the clinical care costs of residency programs that serve Medicaid clients. All of the IME funds are matched by the University and are subject to the calculated UPL as authorized by CMS. Like GME funds, these funds cannot be used for academic programs.

Table 9 shows where the University of Utah expends Medicaid funds in SFY 2010. Expenditures for mandatory services comprise 69 percent of all University Hospital Medicaid expenditures, while optional services comprise the remaining 31 percent. Of mandatory services, the single largest expenditure is $41 million for inpatient services or 26 percent of all Medicaid expenditures. In total, the $156 million expended on Medicaid represents 18 percent of the University of Utah Hospital's total SFY 2010 budget. This table does not include $54,489,100 that is expended by 'Healthy U' contracted provider program to other Utah health care systems.

Table 9 illustrates the University of Utah Hospital Medicaid Expenditures for SFY 2010.

University of Utah (Hospital & Clinics)			
Service Expenditures - Actual			
Mandatory		**TOTAL**	***Percent of Total***
Inpatient Services	$	41,006,300	26%
Contracted Health Plan Services	$	33,112,200	21%
Physician Services	$	25,415,200	16%
Outpatient Hospital	$	7,970,200	5%
Other Mandatory Services	$	142,400	<1%
TOTAL Mandatory	**$**	**107,646,300**	**69%**
Optional			
Vision Care	$	50,700	<1%
Disproportionate Share Hospital *(Seeded by the U)*	$	20,443,300	13%
Graduate Medical Education *(Realigned in FY2011 to a U-UPL calc.)*	$	15,358,400	10%
Indirect Medical Education *(Eliminated in FY2011 to a U-UPL calc.)*	$	12,523,700	8%
TOTAL Optional	**$**	**48,376,100**	**31%**
Total Services Expenditure	**$**	**156,022,400**	**100%**

TOTAL University of Utah Budget (Hospital & Clinics)	**$876,000,000**
Medicaid, as a % of overall budget	**18%**

Table 9

Offsets to Medicaid Expenditures

In SFY 2010 a total of $1.9 billion (state and federal resources) was expended for Medicaid in the State of Utah. Every effort is made by the various State agencies that receive Medicaid funding to offset these expenditures and thereby decrease the total resources allocated to Medicaid. In SFY 2010 a total of $344,758,900 was used to offset Medicaid expenditures. These offsets are described below and detailed in Table 10.

Co-payments - Medicaid clients are required to pay a portion of the cost for some of the services they receive. For example, clients pay $3 per prescription up to a maximum of $15 per month. Total co-payments collected in SFY 2010 amounted to $6,130,500.

Third Party Liability - Services a Medicaid client receives can sometimes be billed to a third party provider such as Medicare. The Office of Recovery Services (ORS) also collects monies from these third parties. In SFY 2010, $236,579,400 was collected or charged from/to third parties.

Pharmacy Rebates - Pharmacy retailers offer volume discount rebates to UDOH. In SFY 2010 UDOH received $63,918,900 in pharmacy rebates.

Spenddown Income - If a potential Medicaid client exceeds the eligibility threshold, they have the option to spenddown (or pay part of) their income in order to become eligible for Medicaid. In SFY 2010, Medicaid clients spent down $5,256,400.

Primary Care Network (PCN) Premiums - Adults must pay an annual premium, up to $50, to be eligible for this program. In SFY 2010 a total of $440,000 was collected.

Estate Recoveries - ORS has the responsibility to collect monies from estates when a Medicaid recipient over the age of 55 dies and a revocable trust existed. In SFY 2010, ORS recovered $2,666,700 from estates.

Criminal and Civil Recoveries From the Attorney General Medicaid Fraud Unit - The Medicaid Fraud Unit in the Attorney General's Office collects criminal and civil penalties as a result of fraud and abuse that they investigate and prosecute. In addition, the Attorney General receives global settlements from class action lawsuits. In SFY 2010 a total of $29,767,000 was collected from these three sources.

Expenditure Offsets - FY 2010 Actual							
Category of Services	**Co-Payment**	**Third Party Liability**	**Rebates**	**ORS Spenddown Recovery**	**Premiums**	**Criminal/Civil Recoveries**	**TOTAL**
Inpatient Hospital Services, General	$ 594,000	$ 77,793,000	$ -	$ -	$ -	$ -	$ 78,387,000
Inpatient Hospital Services, Mental	$ -	$ (14,400)	$ -	$ -	$ -	$ -	$ (14,400)
Outpatient Hospital Services, General	$ 254,600	$ 31,011,900	$ -	$ -	$ -	$ -	$ 31,266,500
Nursing Facility II (NF II)	$ -	$ 5,000	$ -	$ -	$ -	$ -	$ 5,000
Nursing Facility III (NF III)	$ -	$ 34,000	$ -	$ -	$ -	$ -	$ 34,000
Nursing Facility I (NF I)	$ -	$ 19,823,000	$ -	$ -	$ -	$ -	$ 19,823,000
Home Health Services	$ -	$ 5,576,900	$ -	$ -	$ -	$ -	$ 5,576,900
Personal Care	$ -	$ 100	$ -	$ -	$ -	$ -	$ 100
Substance Abuse Treatment Services	$ -	$ 25,400	$ -	$ -	$ -	$ -	$ 25,400
Independent Lab and/or X-ray Services	$ 1,900	$ 550,500	$ -	$ -	$ -	$ -	$ 552,400
Ambulatory Surgical Services	$ 2,400	$ 1,113,000	$ -	$ -	$ -	$ -	$ 1,115,400
Contracted Mental Health Services	$ -	$ 7,600	$ -	$ -	$ -	$ -	$ 7,600
Mental Health Services	$ -	$ 1,530,000	$ -	$ -	$ -	$ -	$ 1,530,000
Rural Health Clinic Services	$ -	$ 283,600	$ -	$ -	$ -	$ -	$ 283,600
ESRD Kidney Dialysis Services	$ -	$ 7,654,700	$ -	$ -	$ -	$ -	$ 7,654,700
Pharmacy	$ 4,460,800	$ 4,298,600	$ 63,918,900	$ -	$ -	$ -	$ 72,678,300
Medical Supply Services	$ 3,000	$ 6,947,100	$ -	$ -	$ -	$ -	$ 6,950,100
Occupational Therapy	$ 1,000	$ 76,000	$ -	$ -	$ -	$ -	$ 77,000
Medical Transportation	$ -	$ 5,041,200	$ -	$ -	$ -	$ -	$ 5,041,200
Specialized Nursing Services	$ -	$ 559,500	$ -	$ -	$ -	$ -	$ 559,500
Well-Child Care (EPSDT) Services	$ -	$ 859,400	$ -	$ -	$ -	$ -	$ 859,400
Physician Services	$ 494,500	$ 31,959,600	$ -	$ -	$ -	$ -	$ 32,454,100
Federally Qualified Health Centers	$ 7,800	$ 126,300	$ -	$ -	$ -	$ -	$ 134,100
Dental Services	$ 173,500	$ 3,008,500	$ -	$ -	$ -	$ -	$ 3,182,000
Pediatric/Family Nurse Practitioners	$ 22,400	$ 315,400	$ -	$ -	$ -	$ -	$ 337,800
Psychologist Services	$ -	$ 248,300	$ -	$ -	$ -	$ -	$ 248,300
Physical Therapy Services	$ 12,500	$ 871,300	$ -	$ -	$ -	$ -	$ 883,800
Speech and Hearing Services	$ -	$ 54,900	$ -	$ -	$ -	$ -	$ 54,900
Podiatry Services	$ 7,500	$ 675,800	$ -	$ -	$ -	$ -	$ 683,300
Vision Care Services	$ 12,100	$ 310,100	$ -	$ -	$ -	$ -	$ 322,200
Optical Supply Services	$ -	$ 60,300	$ -	$ -	$ -	$ -	$ 60,300
Osteopathic Services	$ 82,300	$ 1,861,200	$ -	$ -	$ -	$ -	$ 1,943,500
QMB-Only Services	$ -	$ 2,666,000	$ -	$ -	$ -	$ -	$ 2,666,000
Chiropractic Services	$ 200	$ 57,100	$ -	$ -	$ -	$ -	$ 57,300
Group Pre/Postnatal Education	$ -	$ 500	$ -	$ -	$ -	$ -	$ 500
Nutritional Assessment Counseling	$ -	$ 200	$ -	$ -	$ -	$ -	$ 200
New Choices Waiver Services	$ -	$ 600	$ -	$ -	$ -	$ -	$ 600
Primary Care Network Premiums	$ -	$ -	$ -	$ -	$ 440,000	$ -	$ 440,000
Recoveries from Attorney General	$ -	$ -	$ -	$ -	$ -	$ 29,767,000	$ 29,767,000
Estate Recoveries	$ -	$ -	$ -	$ -	$ -	$ 2,666,700	$ 2,666,700
Spenddown Collections	$ -	$ -	$ -	$ 5,256,400	$ -	$ -	$ 5,256,400
ORS Collections	$ -	$ 31,187,200	$ -	$ -	$ -	$ -	$ 31,187,200
TOTAL	**$ 6,130,500**	**$ 236,579,400**	**$ 63,918,900**	**$ 5,256,400**	**$ 440,000**	**$ 32,433,700**	**$ 344,758,900**

Table 10

APPENDIX G - MEDICAL HOME FEASIBILITY REPORT

Report to the Health and Human Services Appropriations Subcommittee

Medical Home Demonstration Project Feasibility

Prepared by the Division of Medicaid and Health Financing

December 2010

UTAH DEPARTMENT OF HEALTH

EXECUTIVE SUMMARY

This report is submitted in response to the requirement in H.B. 397 passed by the 2010 Legislature:

"By December 31, 2010, the department shall: determine the feasibility of implementing a three year patient-centered medical home demonstration project in an area of the state using existing budget funds: and report the department's findings and recommendations under Subsection (13)(a)(i) to the Health and Human Services Appropriations Subcommittee."

Medical Home – Defined

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). See Appendix A for a detailed definition.

Feasibility

The question of the feasibility of implementing a patient-centered medical home within existing budget funds was presented to the Medical Care Advisory Committee (MCAC) in May, 2010. The committee consists of a variety of medical professionals, payers and medical service providers. At the direction of the MCAC a subcommittee was formed to study the issue. Staff from the Division of Medicaid and Health Financing worked with the group to determine a course of action. The group considered the fact that the Centers for Medicare and Medicaid Services (CMS) is funding demonstration projects under the Medicare program to determine the cost effectiveness of the medical home model. The group determined that without additional funding, and given the many components of a medical home, it would not be feasible to launch a medical home demonstration within existing funding. Rather, it would be most effective for Medicaid to participate in the Children's Medical Home Demonstration Project that is funded through the Children's Health Insurance Program Reauthorization Act (CHIPRA).

Utah Children's Medical Home Demonstration

Utah is one of ten states to receive a quality demonstration grant under section 401(d) of the Children's Health Insurance Program Reauthorization Act (CHIPRA). The total 5-year funding award is $10,277,361. The Utah Children's Medical Home Demonstration is a key grant activity. The project description is included in Appendix B.

Accountable Care Organizations

The Division has been working closely with legislators to develop a plan to implement payment reform by moving away from the current structure to a model where care is delivered through Accountable Care Organizations (ACO.) The medical home construct is a key component of the Accountable Care Organization model. The only way that a medical home demonstration would be feasible would be in a scenario in which payment reform would be involved.

Course of Action:

- The Division of Medicaid and Health Financing will support the Utah Children's Medical Home Demonstration and report the findings to the Legislature.
- The Division of Medicaid and Health Financing will continue to work with legislators on payment reform efforts that have a medical home component.

Introduction

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). See Appendix A for additional information.

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Feasibility

Since 1996 Utah has required all Medicaid recipients in Salt Lake, Weber, Davis and Utah counties to enroll in a managed care organization. Only those living in a nursing facility or hospital are excluded from this requirement. Medicaid operates a voluntary primary care case management program in the remaining twenty-five counties. The Medicaid agency contracts with local health departments to educate Medicaid clients on the importance of having a regular source of medical care rather than relying on emergency departments. The local health departments enroll Medicaid clients with a medical provider willing to act as their primary care provider. In some rural counties, 87 percent of Medicaid clients are enrolled with a primary care provider. Other counties have few providers willing to accept Medicaid and enrollment is much lower. On average, 60 percent of rural Medicaid clients are enrolled with a primary care provider.

While some states claim huge savings from changing from a fee-for-service program to a medical home model the same saving would not be available in Utah's program because most Medicaid clients are enrolled in a managed care arrangement. The savings were realized when the model shifted from fee-for-service to managed care in 1996. Utah demographics are very different as well. Other states have higher smoking rates – Utah has the lowest smoking rate in the nation. Utah's population is the youngest in the nation. The vast majority of Utah Medicaid clients are children. All these differences must be taken into account when determining the feasibility of implementing a medical home approach. The area that offers the most possibility is to focus on children – and in particular children with special health care needs. Ensuring that children with chronic health care conditions have a true medical home where necessary care is provided and coordinated to eliminate unnecessary care may result in better quality care and reduced costs.

The question of the feasibility of implementing a three year patient-centered medical home demonstration project within existing budget funds was presented to the Medical Care Advisory Committee (MCAC) in May, 2010. The committee consists of a variety of medical professionals, payers and medical service providers. At the direction of the MCAC a subcommittee was formed to study the issue. Staff from the Division of Medicaid and Health Financing worked with the group to determine a course of action.

The group discussed the fact that in order to launch a three year medical home project the Division would need to find providers that would be willing to take on the additional responsibilities and services required to serve patients in a medical home model. The group reviewed the principles of the medical home model including the expectation that each patient has a personal physician, the physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, care is coordinated and integrated and quality and safety are woven through all aspects of care. The cost of delivering care within these principles is not reimbursed through the current fee for service model and is not included in the current Medicaid budget. Physicians want support for the cost of implementing a medical home model as demonstrated by the fact that some physicians groups are approaching commercial payers to make the case that it is in the best interest of payers to fund the upfront additional practice costs because ultimately medical expenses will be reduced. The key question considered by the group was would it be feasible to add the services integral to a medical home model and have that effort result in medical expense savings?

Although early evidence indicates that over time medical homes reduce hospital admissions, and therefore medical expense, there is no assurance the medical home model would produce guaranteed savings within three years. An additional consideration is that since 60 percent of Utah Medicaid clients in rural counties are enrolled with a primary care provider and most clients in urban counties are enrolled with a managed care organization the savings opportunity from implementing a medical home model might not be as great as if there were no existing medical expense reduction efforts in place.

However, the workgroup acknowledged the great value in the medical home model and continued to consider how the Medicaid program could participate in a medical home demonstration project. Several workgroup members were aware that work is underway in Utah to develop and evaluate

medical homes for children with special health care needs. That is, Utah is one of ten states to receive a quality demonstration grant under section 401(d) of the Children's Health Insurance Program Reauthorization Act (CHIPRA.) The total five year funding award is $10,277,361. The Utah Children's Medical Home Demonstration is a key grant activity. The five year grant will fund the expense of transforming twelve primary care practices by adding the care coordination and other services necessary to function as a medical home. The grant will also pay for evaluation of the entire effort. The project includes commercial payers and Medicaid is a key participant in the project.

Based on review of all these factors the MCAC workgroup concluded it would not be prudent to assume there would be sufficient medical expense savings to fund the expense of adding the services necessary for a medical home demonstration project within current budget limits. It also would not be likely providers would be willing to take on the burden of establishing a medical home model without additional reimbursement for their efforts. Therefore is would not be feasible to launch a three year medical home demonstration project within existing budget funds.

However, the group recognized that funding does exist to test the medical home concept for children with special health care needs. The group recommend that Medicaid focus efforts on supporting the activities of the Utah Children's Medical Home Demonstration.

Utah Children's Medical Home Demonstration (UCMHD)

Can we improve the health of Utah's children while spending less on their healthcare? Can providers, payers, and families work together to meet the dual challenges of healthcare that is too expensive and outcomes that reflect gaps in quality, equity, and engagement?

The **Children's Healthcare Improvement Collaboration (CHIC)** is a four year demonstration of the medical home model of care and innovative approaches to compensating clinicians and supporting quality improvement and care coordination. The demonstration will be supported by the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstrations grant and funding from insurers of children in Utah through the multi-payer demonstrations group established by the Utah Legislature's Health Reform Task Force. For a complete description of the project see Appendix B.

Accountable Care Organizations

What would be the circumstances in which it would be possible to include the medical home construct within existing budget funds? The answer likely resides with the Accountable Care Organization (ACO) concept. The Division has been working closely with legislators to develop a plan to implement payment reform by moving away from the current structure to a model where care is delivered through Accountable Care Organizations. A report issued by the Deloitte Center for Health Solutions states "accountable care organizations (ACOs), a method for integrating local physicians with other members

of the health care system and rewarding them for controlling costs and improving quality, have the potential to drive payment reform in the public and private health care sectors."

According to the New England Journal of Medicine "an ACO will not succeed without a strong foundation of high-performance primary care." In other words medical homes are a necessary component of a successful ACO.

The ACO provides the opportunity for providers to deliver care in a manner that is not tied to fee-for-service reimbursement. This means that providers may choose to alter the service delivery model to include items such as telehealth visits and case management services while also developing other innovative, cost-effective and efficient ways to deliver care. The ACO reimbursement method will reward providers for eliminating unnecessary care and meeting quality objectives. If implementation of the medical home construct occurs within the overall payment reform effort it is the most likely scenario where the model will be successfully implemented.

Course of Action:

- **The Division of Medicaid and Health Financing will support the Utah Children's Medical Home Demonstration Project and report the findings to the Legislature.** As evidenced by the Utah Children's Medical Home Demonstration Project implementing and evaluating medical homes for children with special health care needs is expensive and resource intensive. The Division of Medicaid and Health Financing should support the project and provide periodic reports to the Legislature on the progress and ultimate outcomes.
- **The Division of Medicaid and Health Financing will continue to work with legislators on payment reform efforts that have a medical home component.** The medical home concept is a key component of Accountable Care Organizations. The Division should continue to work with legislators to restructure the way Medicaid pays for health care by moving to a model where care is delivered through Accountable Care Organizations.

Appendix A

Joint Principles of the Patient Centered Medical Home

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

February 2007

Introduction

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

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- Evidence-based medicine and clinical decision-support tools guide decision making

- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
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- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:

American Academy of Family Physicians
http://www.futurefamilymed.org

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians:
http://www.acponline.org/advocacy/?hp

American Osteopathic Association
http://www.osteopathic.org

Appendix B

Proposal for a

Utah Children's Medical Home Demonstration

from the Children's Healthcare Improvement Collaboration (CHIC)

CHIC's Utah partners include:

- Utah Department of Health
  - Division of Medicaid and Health Financing
  - Office of Healthcare Statistics
- University of Utah
  - Department of Pediatrics
    - Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ)
    - Medical Home Portal (www.medicalhomeportal.org)
  - Department of Biomedical Informatics
- Intermountain Healthcare
  - Primary Children's Medical Center's Pediatric Continuum of Care Managers program
  - Institute for Health Care Delivery Research
- *HealthInsight*
- Utah Family Voices

Executive Summary – Utah Children's Medical Home Demonstration

Can we improve the health of Utah's children while spending less on their healthcare?

The **Children's Healthcare Improvement Collaboration (CHIC)*** proposes collaborating with insurers and the Utah Health Reform Task Force on a 4-year multi-payer demonstration of quality improvement (QI), the medical home model, and innovative payment strategies, aimed at improving children's healthcare and outcomes and decreasing overall costs. The demonstration will involve 30-40 primary care pediatricians and four pediatric subspecialty practices. Interventions will include:

- Central support for measurement-driven practice-based QI and care coordination (CC)
  - Medical Home Coordinators 'embedded' in pediatric practices to develop and support practice teams in QI, CC, and implementing other elements of medical home and family-centered care
  - Practice coaches to guide and support QI efforts and share lessons learned across practices
  - Parent Partners in each practice to advise on policies/processes and assist other families to connect with needed services and supports
- Practice compensation to enable practices to build QI infrastructure and systems, support needed incremental staff, improve access to care, and provide services that are not currently compensated, such as electronic visits, care conferences, and population management

A 5-year CHIPRA Quality Demonstrations grant, awarded to Utah Medicaid in 2010, will cover most of the central support and project evaluation costs. Practice compensation and remaining central costs will be supported by the multi-payer demonstration. The practice compensation will enable both primary care and subspecialty practices to make needed investments and experiment with novel approaches to care. These costs will be split among payers by market share of insured children – see *Projected Costs* on page 8 for detail. Practices will budget these funds and be accountable for their appropriate use and for performance and outcomes measures. In years 3- 4, a portion of documented savings in overall costs of care (formula to be developed) will be shared with participating practices.

Evaluation measures will be developed with payers, participating practices, and the Task Force. They will address access, utilization/costs, quality of care, clinical outcomes, and patient/family experience. A robust evaluation will be supported by a set of resources that is unique to this project, including:

- Utah All-Payer Claims Database (APCD), enabling comparisons to 'virtual' control practices
- Independent evaluation by the Institute for Healthcare Delivery Research
- National evaluation supported by the grant agency[†]
- *HealthInsight*'s EHR Measure Calculator, to extract clinical/quality data from practice EHRs
- QI TeamSpace, a quality improvement project collaboration and data reporting system
- Potential to use prospectively recruited control practices to compare a range of measures

Practices will be selected in December 2010 from among those that respond to a 'request for applications,' using criteria[‡] that will include level of commitment and proportion of patients insured by Medicaid. Project staff will be hired and trained to enable implementation in March 2011. Periodic data and interim evaluation reports will guide ongoing adjustments in project strategies and practice compensation. The interventions will continue through November 2014 (3½ years).

Lessons learned in the demonstration and its evaluation will inform ongoing healthcare reform in Utah and may guide insurers in compensation design and provider contracting. Sustainability of this approach to QI and medical home will depend on the balance between the costs of a mature practice support system and demonstrated improvements in healthcare cost, access, quality, and outcomes. We expect that systems like this will be critical to the success of evolving healthcare delivery/payment structures, such as accountable care organizations (ACO).

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* CHIC's major partners include the Utah Medicaid program, the University of Utah's Utah Department of Pediatrics and Pediatric Partnership to Improve Healthcare Quality, *HealthInsight*, Intermountain Healthcare's Institute for Healthcare Delivery Research and Pediatric Continuum of Care Managers program, and Utah Family Voices.