LFA LEGISLATIVE FISCAL ANALYST

HB 397 & HB 459 FOLLOW UP

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
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ISSUE BRIEF

SUMMARY

This issue brief summarizes the implementation of the 13 changes from House Bills 397 "Medicaid Program Amendments" and 459 "Health Amendments" from the 2010 General Session by the various agencies effected. This brief is for informational purposes only and no action is required.

DISCUSSION AND ANALYSIS

House Bills 397 "Medicaid Program Amendments" and 459 "Health Amendments" from the 2010 General Session mandated changes that impacted the Departments of Health, Human Services, and Workforce Services. The 13 changes made as well as implementation by each agency is detailed below.

Department of Health

1. Nonlapsing authority for Medicaid funds through FY 2011 – this extends by one year prior nonlapsing authority granted in FY 2009 and FY 2010 in order to comply with requirements of the federal stimulus or *American Reinvestment and Recovery Act*. In FY 2010, the department retained $17.5 million in nonlapsing spending authority from this provision.
2. Conduct internal audits at least in proportion to Medicaid funding for internal auditors – in FY 2011 through December 31, 2010 the Department has completed 6 Medicaid audits. The completed audits looked at an emergency room and ambulatory surgical center, University of Utah's Healthy Outcomes Medical Excellence, follow up reviews to Legislative Audit recommendations, as well as conducting cost settlements. The audits in progress are looking Baby Your Baby and vaccines.
3. By December 31st each year, report on the following (a copy of the report is available at http://health.utah.gov/medicaid/stplan/LegReports/HB%20459%20Medicaid%20Efficiencies%202010%20Annual%20Report.pdf):
    a. Increased efficiencies
    b. Cost avoidance
    c. Cost recovery
    d. Results of internal auditing efforts
4. Expand reporting requirement to Legislative Executive Appropriations Committee or the Social Services Appropriations Subcommittee regarding waivers to include renewing or extending an existing waiver. Thus far this has impacted 3 waivers. For the remainder of FY 2011 and FY 2012 this will affect 1 waiver.
5. Issue and report by February 1, 2011 to the Social Services Appropriations Subcommittee on a request for information for direct contracting of primary medical services. This report is available at http://health.utah.gov/medicaid/stplan/LegReports/Medicaid%20Primary%20Care%20Services%20RFI%20Summary%20Report%202-1-11.pdf and is included in this report as Appendix A. The following is a quote from the report:
    a. "Given that neither response to the RFI included information on a contract amount or service delivery model for a primary care program and that both responses proposed alternatives, the Department concludes that pursuing a separate primary care program is not feasible at this time.

The Department will consider and incorporate some of the other suggestions from the responses in its planned conversion to Accountable Care Organization contracts."

6. Determine the feasibility of conducting a medical home model experiment within existing budgets. By December 31, 2010 report to this committee on the feasibility of conducting a three year pilot (a copy of the report is available at http://health.utah.gov/medicaid/stplan/LegReports/Medical%20Home%20Feasibility%20Report%20December%2030%202010.pdf and can be found on pdf page 119 of the Issue Brief entitled "*Medicaid Review Status of Recommendations*" available at http://le.utah.gov/interim/2011/pdf/00000180.pdf). By December 31, 2012, the Department shall report to this committee on the feasibility of expanding and continuing this medical home pilot project. The following are some quotes from the report:
   a. "**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."
   b. "**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."
7. Allows the Department of Health to apply for federal permission to implement health opportunity accounts for currently eligible Medicaid clients (if and when federal law changes to permit a health opportunity account program).
8. Changes to the purposes that the General Fund Restricted - Nursing Care Facilities Account may be used for. Specifically, the fund may be used to pay for the higher reimbursement costs for hospice costs directly related to that portion of the daily rate caused by the nursing home assessment. The hospice cost change replaced General Fund in the amount of $245,900 in FY 2010 and $983,400 ongoing beginning in FY 2011. Additionally, the limitation to what of the 3% for administration can be used for was removed. This administrative change replaced $197,200 ongoing General Fund beginning in FY 2010 with General Fund Restricted money.

Department of Human Services

1. Nonlapsing authority for Medicaid funds through FY 2011 - this provides that nonlapsing authority comply with requirements of the federal stimulus or *American Reinvestment and Recovery Act*. The department anticipates retaining $0 in FY 2011.
2. Requirement to deposit unused Medicaid funds in the General Fund Restricted – Medicaid Restricted Account. The same funds retained by the agency in FY 2011 discussed above in item 1 will go the General Fund Restricted – Medicaid Restricted Account beginning in FY 2012. Statute also says that the money in this account may be used to expand medical assistance coverage to low income persons not traditionally covered by Medicaid.
3. A requirement for the department to report to the Health and Human Services (HHS) Appropriations Subcommittee no later than December 31, 2010 regarding: 1) changes made by the division or the department beginning July 1, 2010 that effect the Medicaid program, a waiver under the Medicaid program, or an interpretation of Medicaid services or funding, that relate to care for children and youth

in the custody of the Division of Child and Family Services (DCFS) or the Division of Juvenile Justice Services (DJJS), 2) the history and impact of these changes, 3) the department's plans for addressing the impact of any changes, and 4) ways to consolidate administrative functions within the Department of Human Services, the Department of Health, the Division of Child and Family Services, and the Division of Juvenile Justice Services to more efficiently meet the needs of children and youth with mental health and substance disorder treatment needs.

The Department of Human Services made its report to the HHS Appropriations Subcommittee at its November 18, 2010 meeting. DCFS representatives provided a brief history of its recent loss of approximately $18 million in federal Medicaid funding and the impact on both contract providers and DCFS administration associated with the loss. The changes required affect residential services, not basic foster care. In its efforts to re-engineer the service delivery model and determine how best to implement the changes, DCFS stated it was working to minimize the fiscal impact, but most importantly reduce the negative impact to children and families.

DCFS officials related the additional administrative burdens as well as the costs and additional requirements placed on contract providers. Along with outlining these difficulties, DCFS also described several positive impacts resulting from the changes including: 1) viewing the significant loss of federal Medicaid funding as an opportunity to look at its entire system and how it might be improved, 2) increasing accountability from the new requirements to *unbundle* the old residential rate and requiring providers now bill separately for the various services rendered, 3) reemphasizing the DCFS philosophy, which the division pointed out was consistent with research, that over time most children have better outcomes in home-like settings, 4) providing increased emphasis on evidence-based treatments to allow children to move more quickly back into home-like settings from residential placements, 5) implementing a new emphasis to provide supplemental supports to children and youth in home-like settings enabling them to function in the community, and 6) reviewing quarterly high needs children and youth to ensure appropriate placement decisions.

DCFS also described five functions it has developed as a result of these changes:

1. DCFS and DJJS have established consistent programmatic requirements for contract providers of these services
2. DCFS and DJJS established a process to have interagency client reviews In partnership with the Division of Substance Abuse and Mental Health (DSAMH) and community mental health centers – particularly for the children and youth that have very specialized needs and services
3. DCFS and DJJS developed a model to evaluate the need and intensity of treatment which now provides for better consistency
4. DCFS, in conjunction with other agencies, developed a request for proposal (RFP) enabling contractors to submit a single proposal for combined agencies rather than one proposal for each agency
5. DCFS, DJJS, and DSAMH, in conjunction with Medicaid quality assurance, are developing a new audit plan to coordinate audits between these agencies to ensure the requirements are consistently applied.

Department of Workforce Services

1. Nonlapsing authority for Medicaid funds through FY 2011 - this provides nonlapsing authority comply with requirements of the federal stimulus or *American Reinvestment and Recovery Act*. The department anticipates retaining $0 in FY 2011.

2. Requirement to deposit unused Medicaid funds in the General Fund Restricted – Medicaid Restricted Account. The same funds retained by the agency in FY 2011 discussed above in item 1 will go the General Fund Restricted – Medicaid Restricted Account beginning in FY 2012. Statute also says that the money in this account may be used to expand medical assistance coverage to low income persons not traditionally covered by Medicaid.

APPENDIX A – DIRECT CONTRACTING FOR PRIMARY CARE SERVICES

Report to the Social Services Appropriations Subcommittee

Medicaid Primary Care Services

Request for Information

Summary of Responses

Prepared by the Division of Medicaid and Health Financing

February 1, 2011

Introduction

This report is submitted in response to the following language in H.B. 397 2nd Substitute passed by the 2010 Legislature:

"In order to determine the feasibility of contracting for direct Medicaid providers for primary care services, the department shall: (a) issue a request for information for direct contracting for primary services that shall provide that a provider shall exclusively serve all Medicaid clients: (i) in a geographic area; (ii) for a defined range of primary care services; and (iii) for a predetermined total contracted amount; and (b) by February 1, 2011 report to the Health and Human Services Appropriations Subcommittee on the response to the request for information under Subsection (12)(a)."

Current Delivery System

Utah's Medicaid service delivery system currently utilizes three different methods: fee-for-service, managed care and premium assistance. In the rural service area (non-Wasatch Front), the vast majority of Utah's Medicaid clients are enrolled in the fee for service program.

Request For Information (RFI)

In November 2010, the Department of Health, Division of Medicaid and Health Financing (Department) issued a *Request for Information (RFI) for Medicaid Primary Care Services*. The RFI listed the primary care services to be offered to Medicaid clients, the co-insurance and co-payment amounts allowed under Medicaid and the number of Medicaid clients enrolled by county and by type of Medicaid program. The RFI then asked responders to (1) specify in which county or group of counties it was willing to offer the primary care services, (2) specify if it planned to target specific Medicaid enrollees (i.e., children, pregnant women, etc.) or cover the entire Medicaid population in that geographic region and (3) identify a contract amount for which it was willing to provide the above services. Additionally, the Department solicited comments and suggestions on alternatives to the proposed program.

The Department received responses from two entities: Molina Healthcare of Utah and UnitedHealthcare. Neither of the responders provided a response to the specific questions in the RFI: who they proposed to cover, where they would offer services and what contract amount they would require for the primary care services. Rather, both responders provided comments or suggestions on alternative options. The key points by each responder are summarized below.

Summary of Key Points in RFI Responses

Responder #1: The first responder believes that a separate Medicaid Primary Care Services program is not the best approach. For this responder, expanding Medicaid Managed Care is a better model. The responder indicated the following:

- ***Problems with a Separate Primary Care Program:*** A separate Medicaid Primary Care services approach would likely consist of multiple provider groups managing the primary care needs of members through separate non-standardized software systems. It would also lack a core operational unit responsible for oversight of all healthcare services and data analysis.
- ***Benefits of an Expanded Managed Care Model:*** A Medicaid managed care model would be a better model than the primary care services approach because, unlike the Primary Care Services model, the managed care model provides consistent access to providers for members, complete care coordination and community health education services, and the ability to control costs system-wide. Managed care would be a better approach because an integrated health plan has better quality of care due to better continuity and coordination of care, better management of the appropriate location for care, and an integrated software system.
- ***A Managed Care Model Must Provide the Seven Essential Components of a Medical Home as described by Rittenhouse (2008).***

    1. A personal physician
    2. Physician-directed medical practice by a multi-disciplinary team
    3. Whole person orientation
    4. Coordinated/ integrated care
    5. Quality and safety
    6. Improved access to care
    7. Payment reform that values primary care

Responder #2: The second responder believes that Patient Centered Medical Homes (PCMH) provide a good foundation for coordinated primary care services. The second responder also offered the following ideas for Utah's Primary Care Program:

- Size and scale matter: to ensure success of the program, limit the number of entities awarded contracts

- Identify, qualify, and support a comprehensive network of medical homes
- Identify individuals with chronic conditions as early as possible
- Coordinate care efficiently
- Improve physician-patient communication while educating and supporting patients

Summary

Given that neither response to the RFI included information on a contract amount or service delivery model for a primary care program and that both responses proposed alternatives, the Department concludes that pursuing a separate primary care program is not feasible at this time. The Department will consider and incorporate some of the other suggestions from the responses in its planned conversion to Accountable Care Organization contracts.