



MEDICAID REVIEW; STATUS OF RECOMMENDATIONS

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
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ISSUE BRIEF

SUMMARY

At the January 28, 2010 meeting of the Health and Human Services Appropriations Subcommittee, members heard 42 recommendations (<http://www.le.state.ut.us/interim/2010/pdf/00000295.pdf>) for improving Medicaid. This brief reviews the status of those recommendations, including the fifteen that are not fully implemented. The brief suggests three new Medicaid performance measures: clients in managed care; days to sign-up for managed care; and allocation of eligibility worker costs to the General Fund. The brief also recommends putting reporting requirements in statute.

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.

Fifteen Recommendations Not Fully Implemented

The table below details the 15 recommendations not fully implemented from the Medicaid Review report. Of these 15, nine recommendations have been partially implemented.

Recommendations the Legislature May Want to Pursue Further			
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	
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	
Combined, annual report on Medicaid	Partial	Statutory change	
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?
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	
Studying lessons from Medicare	No	Legislative action	
Changes to revenue and expenditure reporting	Partial	Legislative action	
Clearly track total administrative seed revenues	Partial	Legislative action	

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.

Additionally, the Legislature passed the following intent language in SB 2: "The Legislature intends that the Department of Health report by October 1, 2011 to the Office of the Legislative Fiscal Analyst on reimbursement alternatives for inpatient hospital outlier payments that would give the State more control over inflationary increases and/or move away from a reimbursement based on billed charges. The report also shall explain the measures the Department takes to verify the validity of outlier claims. This report should include a report on any other reimbursements based on billed charges that totaled over \$1,000,000 total funds in FY 2011 and options for moving away from paying as a percentage of billed charges." The report is Appendix A.

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." "The Department of Health received no valid responses to its RFP. As a result, the Fraud and Abuse Detection System will not be in place by September 2011. The requirements for this system are being included in the core MMIS (Medicaid Management Information System) replacement project."

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)."

Implemented. HB 186 "Controlled Substance Database Revisions" passed in the 2010 General Session and HB 358 "Access to Controlled Substance Database Revisions" passed in the 2011 General Session provides the Department of Health access to the controlled substance database.

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. HB 2 from the 2010 General Session included the following intent language: "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." SB 3 from the 2011 General Session included the following intent language: "The Legislature intends that when the Department of Health moves to Medicare-like outpatient payment methodologies beginning July 1, 2011 that hospital outpatient payments not be stopped or held pending adoption of this new methodology but rather that payments continue at the current rate until the department fully implements this new payment methodology so that no payment disruptions occur." 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 Social 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. HB 2 from the 2010 General Session included the following intent language: "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. SB 2 from the 2011 General Session included the following intent language: "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, 2011. 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_2011-10-01.pdf.

The Department of Health presented on this topic to the Executive Appropriations Committee on September 20, 2011 (<http://le.utah.gov/av/smil?int=200623>).

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. HB 2 from the 2010 General Session included the following intent language: "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." The Department of Workforce Services did not provide a report in response to this intent language. SB 2 from the 2011 General Session included the following intent language: "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, 2011." This report is Appendix B.

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 2011 General Session the recommendation became item 150 in the Master Study Resolution (HJR 24). Item assigned to the Health and Human Services Interim Committee. As of October 11, 2011, this committee had no plans to discuss this item during the 2011 Interim.

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 C in the following report

<http://le.utah.gov/interim/2011/pdf/00000180.pdf>.

New Reporting Requirements - Status of Recommendations

1. Change statute to require the Department of Health to report annually to the Social 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 Appendix B in the following report <http://le.utah.gov/interim/2011/pdf/00000180.pdf>.

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 Appendix B in the following report <http://le.utah.gov/interim/2011/pdf/00000180.pdf>.

3. Change statute to require the Departments of Health, Human Services, and Workforce Services to report to the Executive Appropriations Committee or the Social 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 Appendix A in the following report <http://le.utah.gov/interim/2011/pdf/00000180.pdf>.

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 Social 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 Social 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. The Legislature included the following intent language in SB 2 from the 2011 General Session: "The Legislature intends that the Department of Health provide a report to the Office of the Legislative Fiscal Analyst by December 1, 2011 on the status of implementing recommendations from the following audits: (1) A Performance Audit of Utah Medicaid Provider Cost Control and (2) A Follow-up of Utah's Medicaid Implementation of Audit Recommendations. The items to be followed up on would be less to the extent that an Independent Medicaid Inspector General is established and takes over the responsibility for implementation of some recommendations. The report would not be needed if a follow up audit is prioritized for the Legislative Auditor General by July 1, 2011." 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.

The Health and Human Services Interim Committee has plans to hear a follow up report on this topic at its October 19, 2011 meeting.

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 Social 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 Social 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 reported the following: "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."*

The Legislature included the following intent language in SB 2 from the 2011 General Session: "The Legislature intends that the Department of Workforce Services provide a report to the Office of the Legislative Fiscal Analyst by December 1, 2011 on the status of implementing recommendations from the A Performance Audit of DWS Eligibility Determination Services. The report would not be needed if a follow up audit is prioritized for the

Legislative Auditor General by July 1, 2011.” 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.

The Legislative Auditor General is currently auditing the Department of Workforce Services’ Medicaid eligibility process with the following scope: “to determine if the application process is appropriately approving recipients for Medicaid benefits.” The Legislative Auditor General might complete this audit by February 2012.

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 Social 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.

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.” The “Medicaid Consolidated Report” section of Governor’s Office of Planning and Budget’s report is Appendix F in the following report <http://le.utah.gov/interim/2011/pdf/00000180.pdf>. The full report can be viewed online at http://www.health.utah.gov/medicaid/pdfs/annual_report2010.pdf. The Governor’s Office of Planning and Budget’s presented this report to the Executive Appropriations Committee on November 16, 2010 (<http://le.utah.gov/av/smil?int=179853>).

The Analyst recommends that this reporting requirement be put into statute. The report can be used to see the size of Medicaid statewide.

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.

Implemented. The Legislature included the following intent language in SB 2 from the 2011 General Session: "The Legislature intends that the Departments of Health, Human Services, and Workforce Services report to the Office of the Legislative Fiscal Analyst by November 1, 2011 on how they will increase public awareness of their fraud reporting systems and encourage the public to report Medicaid fraud."

Additionally, the Legislature included the following intent language in SB 2 from the 2011 General Session: "The Legislature intends the Department of Health and the Department of Workforce Services study the cost and benefits of potentially using additional tools for provider screening, asset verification, and beneficiary screening and report back recommendations for further action to the Office of the Legislative Fiscal Analyst by September 1, 2011." This report is Appendix C.

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 Appendix D in the following report <http://le.utah.gov/interim/2011/pdf/00000180.pdf>.

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 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" available at <http://le.utah.gov/interim/2011/pdf/00000179.pdf>. The Legislature included the following two intent language statements in SB 2 from the 2011 General Session: (1) "The Legislature intends that the Departments of Health, Human Services, Workforce Services, and the Medicaid Fraud Control Unit report to the Office of the Legislative Fiscal Analyst by July 1, 2011 on how they will coordinate their response to the 34 recommendations within the State's control from State agencies contained in the issue brief entitled Medicaid Survey Results (<http://le.utah.gov/interim/2011/pdf/00000179.pdf>). Additionally, these agencies shall report by December 1, 2011 on specific plans of action or reasons for not acting on the 34 recommendations so that the Legislature may decide what additional action may be needed." and (2) "The Legislature intends that the Departments of Health, Human Services, Workforce Services, and the Medicaid Fraud Control Unit report to the Office of the Legislative Fiscal Analyst by January 1, 2012 on plans to follow up feasible recommendations that could be implemented from the 945 comments from the public in the issue brief entitled Medicaid Survey Results (<http://le.utah.gov/interim/2011/pdf/00000179.pdf>). This report will allow the Legislature to decide what additional action may be needed."

The chairs of the Social Services Appropriations Subcommittee sent a letter in February 2011 to the federal government and Utah's Congressional Delegation with thirteen recommendations for change in the Medicaid program. This letter came as a response to a motion passed by the Social Services Appropriations Subcommittee on February 15, 2011. This letter is Appendix D.

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 2011 General Session the recommendation became item 110 in the Master Study Resolution (HJR 24). Item assigned to the Health and Human Services Interim Committee. As of October 11, 2011, this committee had no plans to discuss this item during the 2011 Interim.

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 2011 General Session the recommendation became item 113 in the Master Study Resolution (HJR 24). Item assigned to the Health and Human Services Interim Committee. As of October 11, 2011, this committee had no plans to discuss this item during the 2011 Interim.

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

Implemented. The Social Services Appropriations Subcommittee plans to discuss this issue at its October 20, 2011 meeting. Additionally, 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 Appendix C in the following report <http://le.utah.gov/interim/2011/pdf/00000180.pdf>.

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 Social Services Appropriations Subcommittee by February 1, 2011.

Implemented. HB 397 "Medicaid Program Amendments" passed in the 2010 General Session and implemented this recommendation. The report from the Department of Health is Appendix E.

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

Implemented. The Legislature passed SB 180 Medicaid Reform in the 2011 General Session with the goal to develop a Medicaid model to "restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that compared to services delivered before implementation of the proposal, maintain or improve recipient health status" and "maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models."

Additionally, the Legislature passed the following intent language as part of SB 2 in the 2011 General Session: "The Legislature intends that if SB 180 Medicaid Reform passes, the Department of Health shall issue requests for information and report back a summary of the results to the Office of the Legislative Fiscal Analyst by four months prior to providing services via new contracts."

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 Social 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 Appendix G in the following report <http://le.utah.gov/interim/2011/pdf/00000180.pdf>.

Studying lessons from Medicare - not implemented. During the 2011 General Session the recommendation became item 116 in the Master Study Resolution (HJR 24). Item assigned to the Health and Human Services Interim Committee. As of October 11, 2011, this committee had no plans to discuss this item during the 2011 Interim.

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. Full implementation includes making the annual budget submission include this detail.

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).

Implemented. The Legislative Fiscal Analyst presented some options to the Executive Appropriations Committee at its meeting on June 14, 2011. The full report, Treatment of Medicaid Transfers in State Budgeting, is available at <http://le.utah.gov/interim/2011/pdf/00001060.pdf>.

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 and statute. For FY 2011, funding for the Bureau of Program Integrity was 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. In the 2011 General Session, the Legislature passed HB 84 Office of Inspector General of Medicaid Services, which made Program Integrity independent of the Department of Health.

LEGISLATIVE ACTION

The Subcommittee has at least the following options:

1. Do nothing.
2. Take further action on items not fully implemented, including putting a requirement in statute for a coordinated reporting requirement.
3. Direct State agencies to track up to three of the suggested performance measures.
4. Some combination of #2 and #3 above.

APPENDIX A - MOVING AWAY FROM REIMBURSEMENT BASED ON BILLED CHARGES

Report to the Office of the Legislative Fiscal Analyst

Reimbursement Alternatives for Inpatient Hospital Outlier Payments

Prepared by the Division of Medicaid and Health Financing

September 30, 2011



EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed in Senate Bill 2, lines 868 through 878, by the 2011 Legislature:

The Legislature intends that the Department of Health report by October 1, 2011 to the Office of the Legislative Fiscal Analyst on reimbursement alternatives for inpatient hospital outlier payments that would give the State more control over inflationary increases and/or move away from a reimbursement based on billed charges. The report also shall explain the measures the Department takes to verify the validity of outlier claims. This report should include a report on any other reimbursements based on billed charges that totaled over \$1,000,000 total funds in FY 2011 and options for moving away from paying as a percentage of billed charges.

Reimbursement Alternatives for Inpatient Hospital Outlier Payments That Would Give the State More Control

Staff researched several states and Medicare for outlier payment methodologies. All states researched pay a percent of charges when the outlier threshold is reached. The difference across programs relates primarily to how the claim is determined to have exceeded the threshold, and what percent of charges is paid.

Some states (MS, OK, PA, WA, OH, KY, and RI) determine whether the threshold is exceeded by estimating the costs of the claim, based on the hospital specific cost-to-charge ratio (CCR), and determining whether the costs exceed the base payment by a specified threshold. If the costs exceed the base payment by the predetermined threshold, some percentage of the estimated costs is paid.

Other states (NJ and TX), determine whether the threshold is exceeded by comparing total charges to the base payment. If the charges exceed the base payment by the predetermined threshold, they pay some percentage of charges based on the hospital specific CCR, and any other applicable reduction factors the state may have.

In some states (TX and PA), payment may also be made when the length of stay exceeds a predetermined outlier threshold. These generally pay a per diem that is set by using the average per diem rate (base DRG payment / avg. length of stay) and applying some adjustment factor to that amount. Texas does not allow for both a cost outlier and a length of stay (LOS) outlier payment. Pennsylvania, on the other hand, does allow for both simultaneously.

Some states (MS and RI) have a LOS outlier system in place only for inpatient hospital mental health related claims. In these cases, the LOS outlier payments take the place of the cost outlier payments.

Additionally, Medicare determines if the charges exceed the predetermined threshold and pays a percent of charges based on the hospital specific CCR.

Administrator	Method
Mississippi	Pays 50% of costs exceeding base DRG payment when costs exceed outlier threshold
Oklahoma	Pays % of costs (based on hospital CCR) above outlier threshold
Pennsylvania (Costs)	Pays 100% of costs when costs exceed 150% of DRG base payment
Pennsylvania (LOS)	Pays 60% of per diem DRG rate when LOS exceeds LOS outlier threshold
Texas (Costs)	Pays 70% of charges exceeding outlier threshold
Texas (LOS)	Pays 70% of per diem DRG rate when LOS exceeds LOS outlier threshold
Washington	Pays 100% of costs when costs exceed 175% of DRG base payment
Ohio	Pays 100% of costs when costs exceed outlier threshold
New Jersey	Pays % of charges (based on hospital CCR) above outlier threshold
Kentucky	Pays 80% of costs exceeding the outlier threshold
Rhode Island	Pays 60% of costs above Base DRG Payment when costs exceed outlier threshold
Medicare	Pays % of charges (based on hospital CCR) above outlier threshold

Explanation of Measures the Department Takes to Verify the Validity of Outlier Claims

Inpatient claims are reviewed by Program Integrity within the Office of Inspector General for Medicaid Services. Following are some pertinent provision in Rule:

R414-1-12. Utilization Review.

- (1) The Department conducts hospital utilization review as outlined in the Superior System Waiver in effect at the time service was rendered.
- (2) The Department shall determine medical necessity and appropriateness of inpatient admissions during utilization review by use of InterQual Criteria, published by McKesson Corporation.
- (3) The standards in the InterQual Criteria shall not apply to services in which a determination has been made to utilize criteria customized by the Department or that are:
 - (a) excluded as a Medicaid benefit by rule or contract;
 - (b) provided in an intensive physical rehabilitation center as described in Rule R414-2B; or
 - (c) organ transplant services as described in Rule R414-10A.

In these exceptions, or where InterQual is silent, the Department shall approve or deny services based upon appropriate administrative rules or its own criteria as incorporated in the Medicaid provider manuals.

R414-1-14. Utilization Control

(2) The Department may request records that support provider claims for payment under programs funded through the Department. These requests must be in writing and identify the records to be reviewed. Responses to requests must be returned within 30 days of the date of the request. Responses must include the complete record of all services for which reimbursement is claimed and all supporting services. If there is no response within the 30 day period, the Department will close the record and will evaluate the payment based on the records available.

A report on any other reimbursements based on billed charges that totaled over \$1,000,000 total funds in FY 2011

Aside from the outlier payments for inpatient hospital stays, the only other Medicaid reimbursement methodology paying more than \$1 million in FY 2011 was outpatient hospital reimbursement. As has been directed in previous legislative intent language, the Department of Health converted to a prospective payment system for outpatient hospital payments in FY 2012, but that had not been completed prior to the close of FY 2011.

APPENDIX B - NON-STATE ENTITIES HELPING SUBMIT INFORMATION FOR MEDICAID



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

**Department of
Workforce Services**

KRISTEN COX
Executive Director

GREGORY B. GARDNER
Deputy Director

JON S. PIERPONT
Deputy Director

Jonathan Ball
Office of the Legislative Fiscal Analyst
State Capitol Complex
House Building, Suite W310
Post Office Box 145310
Salt Lake City, UT 84114

September 23, 2011

Mr. Ball,

Please accept this report in response to the following intent language contained in S.B. 2 of the 2011 general session, which reads as follows:

"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, 2011."

It is our pleasure to inform the legislature that not only is this type of third-party access feasible, it is in fact already in production and will be available for third-party use by the end of December, 2011.

Specifically, third-party representatives for our public assistance customers will be able to access a customer's case through our online portal known as MyCase. This will allow a third-party representative to submit information, documents, verifications and otherwise determine what is needed to help the customer complete or maintain his or her services.

Clearly, this can only happen if the third-party representative has obtained the appropriate release from the customer, and we are presently working on the language and method through which the release can be given. We are happy to demonstrate the program at completion.

Kind regards,

Geoffrey T. Landward
General Counsel, DWS

APPENDIX C - ADDITIONAL TOOLS FOR SCREENING CLIENTS AND PROVIDERS

Report to the Office of the Legislative Fiscal Analyst

Assessment of Additional Tools for Medicaid Provider Screening, Asset Verification and Beneficiary Screening

Prepared by

The Utah Department of Health and the Utah Department of Workforce Services

September 1, 2011



Background

As required by intent language in Senate Bill 2 from the 2011 Legislative General Session, the Department of Health (UDOH) and the Department of Workforce Services (DWS) submit this report on the costs and benefits of using additional tools for provider screening, asset verification, and beneficiary screening. This report provides recommendations for further action in these areas.

PROVIDER SCREENING

As required by federal law, UDOH already conducts extensive provider screening, including checking federal exclusion databases and information at the Division of Occupational and Professional Licensing (DOPL). One option for additional provider screening is for UDOH to contract with a vendor to screen all existing providers against its databases and identify problems or potential problems that may not have been identified through existing UDOH searches. Another option is for UDOH to contract on an ongoing basis with a vendor so that UDOH staff can use the vendor's databases to search for additional information about providers.

One-Time Data Match

Under this option, UDOH would send its entire current provider list to the vendor. The vendor would compare the Utah Medicaid providers to its databases for deaths, criminal histories, bankruptcies, loss of professional licenses, etc. The vendor would flag any providers if concerning information was found. UDOH would then follow up on these concerns to determine if action was needed against the provider.

One vendor, LexisNexis, is currently working on a statewide contract with the State's Division of Purchasing and General Services (State Purchasing). LexisNexis asserts that the Medicaid one-time provider data match could be carried out under this statewide contract once it is established.

UDOH has met with LexisNexis several times to find out if the vendor would be willing to perform a database match on a sample of Medicaid providers. Last week, UDOH received a proposal from LexisNexis that included an option for a free trial of the one-time match on a sample of providers. By looking at the actual information provided in the sample, UDOH would be able to determine potential savings that might occur if the match were run across the entire list of Medicaid providers.

Recommendations for further action:

- Determine with State Purchasing if a statewide contract with LexisNexis can be used for a one-time data match on Medicaid providers.
- Obtain a price from LexisNexis for running the entire list of Medicaid providers against their databases, if the contract can be used to conduct the Medicaid provider match.
- Provide LexisNexis with Medicaid provider information and obtain from LexisNexis a sample list of providers with concerning information, if the contract can be used to conduct the Medicaid provider match. UDOH staff will follow up on flagged providers and determine cost savings and any other benefits from the sample.
- Perform a cost-benefit analysis to determine if the savings merit the cost of paying LexisNexis for a match against all Medicaid providers, if the contract can be used to conduct the Medicaid provider match.

Ongoing Database Checks

One vendor in this area, LexisNexis, granted UDOH's Provider Enrollment staff and Program Integrity staff (now located in the Office of Inspector General of Medicaid Services) a complimentary 30-day trial to use and evaluate its product for provider screening. This product claimed to streamline and simplify the current background screening processes that UDOH staff complete prior to enrolling any providers in the Utah Medicaid program. By obtaining access to LexisNexis databases, UDOH hoped this product would allow for timelier and better provider enrollment decisions.

During the 30-day trial period in June 2011, UDOH staff performed 305 searches on new provider applications, as well as existing providers. The searches were done to verify and check sanctions, disciplines, license information, criminal history, National Provider Identifier (NPI) number and, as needed, Social Security Numbers (SSNs).

During the trial period, UDOH staff found the following:

- Some providers did not show their NPI number
- The NPI numbers did not reflect whether it was a type 1 or type 2 NPI
- The disciplinary actions found on a provider's license were general and not as detailed as UDOH needs
- The SSN was not found due to the provider using its Tax ID number

Although UDOH staff saw some value from the product during the trial, they felt that the information would need to be more current and have more detailed sanction information to add value to the process. Without the real-time information, staff members still have to check additional databases to obtain the needed information. Another concern was that if UDOH staff relied on the LexisNexis tool, they may unwittingly enroll providers who have recent disciplinary action not yet available in the LexisNexis database and who should be excluded from enrollment with Utah Medicaid as a provider because of those disciplinary actions.

Overall, UDOH is concerned about the cost effectiveness of this product. Although some time could be saved, a charge per search would be quite costly and have a large impact on an already strained administrative budget. Ongoing access to the databases would cost several hundred thousand dollars a year. UDOH's Provider Enrollment staff already use a systematic approach for collection and verification of a provider's professional qualifications. The review includes relevant training, licensure, certification, and/or registration to practice in a healthcare field, and academic background, as well as an assessment of whether the provider meets certain criteria relating to professional competence and conduct. The databases that Utah Medicaid currently uses for the credentialing process help the staff evaluate the qualifications of providers who provide care to Medicaid clients. This process is completed before a practitioner is accepted for participation in Utah Medicaid.

Recommendations for further action:

- Do not continue use of the LexisNexis tool after the pilot because the additional costs of the tool on a charge-per-search basis do not appear justified.
- Perform a cost-benefit analysis to determine the merit of contracting with LexisNexis for ongoing services, if the one-time match of Medicaid providers on a sample basis proves productive and the statewide contract can be used for ongoing database match services,.

ASSET VERIFICATION

House Bill 256 from the 2011 Legislative General Session established the following asset verification option in law:

(3) (a) The department may enter into an agreement with a financial institution doing business in the state to develop and operate a data match system to identify an applicant's or enrollee's assets that:

(i) uses automated data exchanges to the maximum extent feasible; and

(ii) requires a financial institution each month to provide the name, record address, Social Security number, other taxpayer identification number, or other identifying information for each applicant or enrollee who maintains an account at the financial institution.

(b) The department may pay a reasonable fee to a financial institution for compliance with this Subsection (3), as provided in Section 7-1-1006.

(c) A financial institution may not be liable under any federal or state law to any person for any disclosure of information or action taken in good faith under this Subsection (3).

(d) The department may disclose a financial record obtained from a financial institution under this section only for the purpose of, and to the extent necessary in, verifying eligibility as provided in this section and Section 26-40-105.

The law also specified that this asset verification process would only be put in place if grant funds were available. UDOH approached the Robert Wood Johnson Foundation to see if existing grant funds could be used for this project. The foundation has tentatively approved this project. UDOH and DWS have been meeting to develop appropriate policy and procedures related to this project.

The proposed Asset Verification System (AVS) would electronically identify accounts held by Medicaid clients at participating financial institutions. AVS will be developed in house, utilizing a batch interface with participating financial institutions throughout Utah. AVS is expected to identify existing assets that go unreported by the client, which will reduce error rates and improve fraud prevention efforts.

A monthly batch file will be sent to the participating financial institutions requesting account information on identified Medicaid clients. Upon receipt of the batch file from the financial institution, account information will be loaded. Account information will compare current account information in eREP and notify the eligibility worker of new asset information reported. The worker will request the client validate the information and provide verification as needed.

UDOH and DWS expect that this verification process will be in place by July 1, 2012, as required by state law.

Recommendation for further action:

- Continue development of AVS as authorized by House Bill 256 (2011) and implement by July 1, 2012.

BENEFICIARY SCREENING

The State has designated UDOH as Utah's Medicaid "Single State Agency," which means it is the state agency accountable to the federal government for all aspects of the Medicaid program. DWS, through an interagency contract with UDOH, performs all Medicaid eligibility determinations. As part of the DWS process for making the eligibility determinations, workers conduct extensive beneficiary screening through the eFIND system. A search is conducted upfront using the eFIND system when a customer applies or recertifies for Medicaid. eFIND contains many data sources including, but not limited to; social security income, child support income, unemployment compensation, wage data through the Work Number and UI quarterly wages, citizenship, motor vehicles, etc.

DWS recently implemented automation of three data sources from eFIND, in conjunction with the online recertification process. These three data sources are automatically populated to the eREP system, which is used to determine eligibility for Medicaid.

In the future, DWS plans to implement automation of additional data sources available in eFIND, to the eREP system. This automation would involve directly populating the available data to eREP anytime there is an update to the data, without a worker having to request the data through eFIND. This ensures the data is correctly used to determine eligibility.

One-Time Data Match

As with provider screening, UDOH and/or DWS could contract with a vendor to run additional matches through the vendor's databases. These could be done on a one-time basis to identify the potential for additional data elements to be used in ongoing screening efforts and eventually incorporated into eFind and eREP. The vendor would flag any cases where outlying information was found and UDOH and DWS would use this sample information to explore the applicability, costs and feasibility of incorporating these screening elements into the upfront eligibility processes at the time of application or recertification.

As discussed in relation to provider screening, one vendor, LexisNexis, is currently working on a statewide contract with the State's Division of Purchasing and General Services (State Purchasing). LexisNexis asserts that the Medicaid client data match could be carried out under this statewide contract once it is established.

Recommendations for further action:

- Pursue the planned automation of eFIND data to the eREP system to ensure accurate data is used in eligibility determinations.
- Determine with State Purchasing if a statewide contract with LexisNexis can be used for a one-time data match on Medicaid clients.

- Obtain a price from LexisNexis for running a sample of or the entire list of current Medicaid clients against their databases, if the contract can be used to conduct the Medicaid client match.
- Provide LexisNexis with Medicaid client information and obtain from LexisNexis a sample list of clients with concerning information, if the contract can be used to conduct the Medicaid client match. UDOH and DWS staff will follow up on flagged cases to determine cost savings and other any other ongoing benefits from incorporating the data matches into ongoing eligibility determination processes.
- Perform a cost-benefit analysis to determine if the savings merit the cost of paying LexisNexis for a match against all Medicaid clients, if the contract can be used to conduct the Medicaid client match. If the one-time match of Medicaid clients on a sample basis proves productive and the statewide contract can be used for ongoing database match services, perform a cost-benefit analysis to determine the merit of contracting with LexisNexis for ongoing services for beneficiary screening.

APPENDIX D – LETTER TO FEDERAL GOVERNMENT WITH SUGGESTED CHANGES FOR MEDICAID



Utah State Legislature

Senate • Utah State Capitol Complex • 320 State Capitol
PO Box 145115 • Salt Lake City, Utah 84114-5115
(801) 538-1035 • fax (801) 538-1414

House of Representatives • Utah State Capitol Complex • 350 State Capitol
PO Box 145030 • Salt Lake City, Utah 84114-5030
(801) 538-1029 • fax (801) 538-1908

<http://le.utah.gov>

February 16, 2011

Cindy Mann, Director
Center for Medicaid and State Operations (CMS)

Dear Ms. Mann,

On February 15, 2011, the Social Services Appropriations Committee of the Utah State Legislature approved a motion that a letter be sent to the Director of the Center for Medicaid and State Operations (CMS) recommending CMS consider changes to Medicaid at the federal level. Following is a list of nine suggestions from the state of Utah:

- [Centers for Medicare & Medicaid Services] should develop a core [Medicaid Management Information System] technology and make it available to states.
This would:
 - a. Improve efficiency in determining eligibility for programs and services
 - b. Reduce complexity of the system
 - c. Increase fraud detection and improve accountability measures
 - d. Provide uniform interpretation of programs and services across states
- 1115 waiver submissions and amendments should be subject to a standard timeline for approval.
- 1915(b) and 1915(c) waivers should have a uniform renewal period of three years.
- States should be granted the flexibility of running a combined 1915(b)(c) waiver.
- The federal look back period of five years on the divesting of assets prior to qualifying for Medicaid should also take into account the amount of assets transferred.
- The institutional bias for long-term care services should be eliminated.
- Federal limits on client cost sharing should have some inflationary escalator.
- The Disproportionate Share Hospital (DSH) payments should be equalized across states based on a per capita formula.
- The provision of a Medicaid Health Opportunity Account (HOA) should provide a better model to meet the needs of healthy Medicaid clients.

Please see the attached pages for details about these suggestions. Thank you for your consideration.

Sincerely,

Senator Allen Christensen, Senate Chair
Social Services Appropriations Committee

Representative David Clark, House Chair
Social Services Appropriations Committee

Suggested Changes Outside the State’s Control – 13 Suggestions for the Federal Medicaid Program

1. **“Federal CMS Medicaid policy is error-prone**, due to its complexity. For example, long-term care and waiver programs are very involved, as are determinations involving self-employment; there is significant documentation and verification around expenses, income, self-employment ledgers, etc. Cases could also include detail about assets, spousal deeming and review of trusts.” (Workforce Services)
2. **“Guidance from federal partners, like CMS, can be vague. Too much flexibility allows variation in interpretation—both among state agencies and across states—and can create error and result in inconsistency across regional offices.** Communication between medical programs and the coordination of policy has improved, but still poses notable challenges. One challenge is the sharing of information in relation to data agreements with third parties, since across the nation there are differences between states. While DWS and DOH attempt to align eligibility and services between programs like CHIP and Medicaid, there are instances when that is problematic, or even impossible. Furthermore, nuances promulgated by federal agencies are difficult to navigate. For example, although both DWS and DOH agree an interview is the best way to obtain information from a customer to accurately determine their eligibility, CMS doesn't "require" an "interview."” (Workforce Services)
3. **“1115 waiver submissions and amendments should be subject to a standard timeline for approval by CMS and have an appeals process like other Medicaid waivers.”** (Health)
4. **“1915(b) and 1915(c) waivers should have a uniform renewal period of three years, rather than the (b) waivers be renewed for two years and the (c) waivers being extended for three years.”** (Health)
5. **“States should be granted the flexibility of running a combined 1915(b)(c) waiver without having to operate the combined waiver parts as two separate waivers.”** (Health)
6. **“The federal look back period of five years on the divesting of assets prior to qualifying for Medicaid should also take into account the amount of assets transferred.”** (Health)
7. **“The institutional bias for long-term care services should be eliminated.”** (Health)
8. **“Federal limits on client cost sharing should have some inflationary escalator to at least keep pace with medical inflationary costs.”** (Health)
9. **“CMS should develop a core MMIS [Medicaid Management Information System] technology and make it available to states. States would then need to customize their individual systems to meet their needs. This could save the federal and state government millions of dollars by not having each state procure its own MMIS.”** (Health)
10. **“The Disproportionate Share Hospital (DSH) payments should be equalized across states based on a per capita formula.”** (Health)
11. **“The provision of a Medicaid Health Opportunity Account (HOA) could provide a better model to meet the needs of healthy Medicaid clients. These individuals would become better users of the health care**

- system because they would need to shop for services based on price and quality. This would allow them to have their needs met while on Medicaid, but also prepare them for dealing with the health care system after leaving the Medicaid program. This would require a change in federal law.” (Health)
12. “While all areas of the Medicaid program may be subject to abuse, the area that is most likely to be abused is clients’ use of Medicaid services when they have the **means in their family to pay for the services themselves**. This can take on many different forms and in many cases may be legal under the Medicaid rules: parents allowing a child to enroll on Medicaid for a baby delivery when the parents could pay for it, elderly clients divesting assets to children so Medicaid will pay for their long-term care services, and the inability of the State to recover on an estate after both spouses have passed and all dependent children are living outside the home.” (Health)
 13. “Individuals, including family members who **defraud vulnerable adults including aging parents is a growing problem**. Formerly the MFCU prosecuted these offenses. However OIG has disallowed this practice under grant rules. Increased prosecution of theft from vulnerable adults, particularly financial exploitation which renders the vulnerable adult without resources to care for themselves or pay for their long term care needs is a serious issue that needs to be addressed. The MFCU receives complaints on a weekly basis about this problem. By intentionally and fraudulently reducing aging parents, neighbors, relatives to poverty, Medicaid ends up with the obligation to pay for the long term care needs of these individuals when other assets are available to defray those costs.” (Medicaid Fraud Control Unit)

Sources for Agency Survey:

- State agency responses to an April 6, 2010 letter from the Speaker of the House and the President of the Senate requesting ideas to improve Utah Medicaid. The letter asked the following six questions:
 1. In your professional opinion, what areas of Medicaid could be improved?
 2. What are we doing now that is working well and should be expanded? What are we doing now that is not working well?
 3. How effectively are our current service models serving the needs of Medicaid clients? What service models would better serve the needs of Medicaid clients?
 4. What improvements should be made to better deliver and/or administer Medicaid services in the state?
 5. How could the coordination of oversight responsibilities be improved? How could we limit the administrative burden required?
 6. In your opinion which area of the Medicaid program is most abused?

State Agency Contacts:

Health - Michael Hales, Deputy Director 801-538-6689

Workforce Services - Kristen Cox, Director 801-526-9210

Medicaid Fraud Control Unit - Robert Steed, Director 801-281-1258

APPENDIX E - 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.