REQUIRED REPORTS – DEPARTMENT OF HEALTH

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: RUSSELL FRANDSEN

ISSUE BRIEF

SUMMARY

This Issue Brief provides information regarding 10 reports currently required to be given to the Social Services Appropriations Subcommittee by the Department of Health. This brief also includes a list of 16 other reports given to the Legislature but not specifically to the Social Services Appropriations Subcommittee, that may be of interest. This brief is for informational purposes only and requires no Legislative action.

DISCUSSION AND ANALYSIS

Department of Health's Reports That are Required by Statute

1) **Medicaid Efficiency, Cost Avoidance, and Internal Auditing Report** – UCA 26-18-2.3 requires an annual report by December 31st. The report is Appendix A. The following are some quotes from the report:
    a. "Before the pilot began, the Provider Enrollment Unit had six staff who processed approximately 275 regular applications per month on average. As a result of the efficiencies obtained through this pilot, the Division was able to redirect one of the six staff to another area. In a recent month, the unit was able to process 592 regular applications with just five staff. This jump in productivity has had a positive impact for providers as well. Before the pilot, it often took four to six weeks before a provider's application was processed. Now these applications are processed within a week, often within several days."
    b. "Due to the success of the Provider Enrollment Pilot, the Division has started a second pilot with its Medical Review Board Unit. This unit processes applications from individuals that are seeking a disability determination from Medicaid (often while they are waiting for a disability determination from Medicare)."
    c. "In FY 2012, the Division added 18 new drug classes to the [Preferred Drug List]. As a result of the Division's use of the [Preferred Drug List], Medicaid saved $34 million in FY 2012."
    d. "In 2012, the Division conducted case reviews on 2,098 individuals. There are currently 677 individuals in the "Lock In" program as a result of Medicaid benefit misuse or abuse…the Division sent 16,563 education letters and provided one-on-one education to 1,920 individuals. An additional 336 individuals are in the "Lock In" program as a result of Emergency Department Diversion efforts."
    e. "Providers that billed 1.75 standard deviations or more above the mean for their provider type were submitted to OIG for review of medical charts to determine appropriateness of coding. A total of 65 providers were submitted to OIG."
2) **Medicaid State Plan Amendments** – UCA 26-18-3 directs the Department to report to the Health and Human Services Appropriations Subcommittee when beginning or changing waivers, Medicaid State Plan, or rate changes that require public notice. There are three reports included as Appendix B, which represent all the reports submitted since the 2012 General Session through December 2012.
3) **Committee to Evaluate Health Policies and to Review Federal Grants** – UCA 26-1-4 requires an annual report by November 30th on the work done by a local health department and Department of Health consultation committee, which coordinate the sharing of federal grants between the Department of Health and local health departments. This report is Appendix C and is available at

http://health.utah.gov/legislativereports/2012GovernanceProgressReport.pdf. The tables showing the shared grant funding between the Department of Health and local health departments are pages 2 and 3 of the Budget Brief entitled "*Local Health Departments.*" Below is a quote from the report:

a. "During the 2012 calendar year the Governance Committee has reviewed 99 grants. 55 were approved for submission and 44 were exempted from review. To date, 50 of these grants have received a notice of award for funding."

4) **Tobacco Settlement Restricted Account** – UCA 51-9-201 directs all agencies receiving funds from the Tobacco Settlement Restricted Account to provide a report on program activities by September 1 of each year. The Department of Health receives money from this account and combines this report with Children's Health Insurance Program report discussed as #7 further below under the other reports section.

5) **Tobacco Prevention and Control in Utah** - UCA 51-9-203(3) requires the Department of Health to report on all programs and campaigns that received tobacco money funding. This report is available at http://www.tobaccofreeutah.org/pdfs/tpcpfy12report.pdf. The following are some quotes from the report:

a. "In FY 2012, 4,000 Medicaid clients gained access to tobacco cessation services and counseling through a collaborative effort between Medicaid and [Tobacco Prevention and Control Program]."

b. "358 Intermountain Medical Group clinics and 12 other hospitals and clinics implemented policies to protect Utahns from secondhand smoke."

c. "In addition, 8 outdoor recreation venues and 4 worksites passed tobacco-free policies."

d. "2,371 new smoke-free units were listed in the [Tobacco Prevention and Control Program]'s Smoke-free Apartment and Condominium Statewide Directory."

e. "Utah has seen a 58% decline in per capita cigarette consumption since 1990."

6) **Expansion of 340B drug pricing programs** – UCA 26-18-12 requires quarterly progress reports on expanding the use of 340B drug pricing programs within the Medicaid program. This report is Appendix D. The following are some quotes from the November 21, 2012 report:

a. "While follow-up with CMS has occurred almost quarterly…practical implementation and further pursuit of this SPA has declined as a result of other Medicaid pharmacy priorities (e.g., ACO's) that have a direct impact on this initiative."

b. "The feasibility of expanding disease management into other disease states will be greatly reduced if clients along the Wasatch front become part of an ACO in the future. This may impact the willingness of 340B providers to bid for other disease management programs (lacking economies of volume)."

7) **Assistance to Persons with Bleeding Disorders** – UCA 26-47-103-(5)(b) requires an annual report on the grant program for persons with bleeding disorders. In FY 2012, $200,000 in grants served 57 individuals. This report is Appendix E. The most recent report is available at http://health.utah.gov/primarycare/pdfs/BleedingDisordersFactSheet.pdf.

8) **Kurt Oscarson Children's Organ Transplant Fund** – UCA 26-18a-3(5) states that there shall be an annual report, "Regarding the programs and services funded by contributions to the trust account." The report indicates that in FY 2012 $52,979 was collected from tax returns and used to help five families with the

financial costs of their children's organ transplants. This report is Appendix F and is also available at http://health.utah.gov/legislativereports/Kurt%20Oscarson%202012.pdf.

9) **Organ Donation Contribution Fund** -UCA 26-18b-101(2)(c) requires annual report on the activities on the fund. The report indicates that in FY 2012 the fund received $84,331 from voluntary donations through motor vehicle license registrations that were used to promote organ donation. This report is Appendix G and is also available at http://health.utah.gov/legislativereports/OrganTransplantFund2012.pdf.

10) **Autism Treatment Account Advisory Committee** – UCA 26-52-202 requires an annual report on the activities of the Autism Treatment Account Advisory Committee. The report is available at http://health.utah.gov/legislativereports/2012AutismTreatmentAccountReport.pdf and is Appendix H. The following are quotes from the report:

    a. "A private donation of $500,000 from Intermountain Healthcare has been received."

    b. "Contracts negotiated with the four providers: To provide 79 weeks of therapy based on the state appropriation of $1 million. Not less than 15 children have been randomly selected, evaluated, and are in the early phases of therapy planning."

Other Department of Health Reports That May be of Interest

1) **Implementation of Improved Provider Payment Controls** – UCA 26-18-604 directs that the Department of Health report annually by September 1st on its recovery of improper payments to providers in its Medicaid program. The report is available at http://health.utah.gov/medicaid/stplan/LegReports/HHSInterimReport-HB77-August_31_2012.pdf. Below are some quotes from the report:

    a. "Of the 313 high-dollar outpatient service claims that the State agency claimed for payments it made to providers during this period, 201 were allowable. For the remaining 112 high-dollar outpatient service claims, providers reported incorrect charges and could not provide documentation to support that some of the outpatient services were provided. This resulted in overpayments totaling $373,932 ($276,800 Federal share, $97,132 State share)."

    b. "There are circumstances in which wheel chair providers are not complying with a new Medicaid payment policy. The policy limits payments to a contracted 12-month period. Programming was not in place to support the new policy before it was put into effect. The estimated savings of the policy change is $32,000 per year."

2) **Annual Financial Audit (FY 2012)** - of the Department of Health by the Utah State Auditor. This report is available at http://www.sao.utah.gov/_finAudit/rpts/2012/12-22.pdf. The Budget Brief entitled *"Executive Director's Operations"* includes a discussion of some of the findings from the audit.

3) **Medicaid's Inspector General** - "The inspector general shall provide the report described in Subsection (1) to the Executive Appropriations Committee of the Legislature and to the governor on or before October 1 of each year. The inspector general shall present the report described in Subsection (1) to the Executive Appropriations Committee of the Legislature before November 30 of each year." (HB 84 - http://le.utah.gov/~2011/htmdoc/hbillhtm/hb0084s04.htm) The audio of the presentation to the Executive Appropriations Committee, presented on September 18, 2012, is available at http://utahlegislature.granicus.com/MediaPlayer.php?view_id=2&clip_id=1863&meta_id=61735.

4) **Implementation Status of Medicaid Audit** - UCA 26-18-604 directs that the Department of Health report annually by September 1 on the status of implementing recommendations from the "Performance Audit of Utah Medicaid Provider Cost Control" by the Office of Legislative Auditor General and the repayment of funds from providers. This report is available at

http://health.utah.gov/medicaid/stplan/LegReports/HHSInterimReport-HB77-August_31_2012.pdf. Below are some quotes from the report:

a. "The Department entered into a contract with Goold Health Systems (GHS) in late 2010 to replace and manage a prescription point-of-sale (POS) system. In 2011, the Department determined it would be cost effective to use the contract with GHS to provide prescription cost data."

b. "Of the 313 high-dollar outpatient service claims that the State agency claimed for payments it made to providers during this period, 201 were allowable. For the remaining 112 high-dollar outpatient service claims, providers reported incorrect charges and could not provide documentation to support that some of the outpatient services were provided. This resulted in overpayments totaling $373,932 ($276,800 Federal share, $97,132 State share)."

5) **Drug Utilization Review Board** – UCA 26-18-103 requires an annual report to legislative leadership on the activities and results from work by the board. The federal FY 2011 report is available at http://health.utah.gov/medicaid/stplan/LegReports/StateOfUtahDURAnnualReport2011.pdf. Below is some information from the report:

a. The top three warnings totaled over 45,000 instances in tracked categories came from therapeutic duplication, drug disease conflict, and above maximum pediatric dose.

b. $2,430,700 estimate of net savings from the policies established by the Drug Utilization Review Board.

6) **Cancellation of Request for Proposals for Medicaid Dental Services** - "If the division cancels the request for proposals [for dental services] under Subsection (6)(a), the division shall report to the Health and Human Services Committee regarding the reasons for the decision" (HB 256 - http://le.utah.gov/~2011/bills/hbillenr/hb0256.pdf). The Department is going forward with contracting for services, so there will be no report. The Department issued a new request for proposal with a close date of January 29, 2013.

7) **Children's Health Insurance Program (CHIP)** – UCA 26-40-109(2) instructs the Department of Health to report annually on its evaluation of the performance measures for CHIP. CHIP has both performance objectives and core performance measures. This report is available at http://health.utah.gov/medicaid/stplan/LegReports/CHIP_Annual_Report_2012.pdf. The following are some quotes from the report regarding meeting those objectives and measures:

a. "In FY 2012, Utah's CHIP program now has the highest cost sharing of any CHIP program in the country."

b. "86.5% of parents surveyed said they 'Always' or 'Usually' got timely care."

c. "89% of all CHIP enrollees had one or more visits with a primary care practitioner in 2011."

d. "92.81% rated their personal doctor or nurse as 8, 9, or 10"

8) **Primary Care Network** – UCA 31A-22-633 requires an annual report from the Department of Health to the Health and Human Services Interim Committee on the Primary Care Network. The following link - http://health.utah.gov/medicaid/stplan/LegReports/2012%20PCN%20Annual%20Report.pdf has the FY 2012 report. Below are some quotations from the FY 2012 report:

a. "The average monthly enrollment in (Primary Care Network) was 15,487."

b. "Total PCN claims were $17,777,592."

   c. "In FY 2011, the Department received 1,935 referrals for specialty care and arranged 744 specialty care visits."

9) **Cigarette Tax Restricted Account** – UCA 59-14-204 directs all agencies receiving funds from the Cigarette Tax Restricted Account to provide a report on program activities by September 1 of each year. The Department of Health receives money from this account and combines the report with the Tobacco Prevention and Control in Utah discussed above.

10) **Primary Care Grant Program** – UCA 26-10b-105 requires an annual report on the implementation of the grant program for primary care services. In FY 2012 $757,700 in grants served 29,800 individuals. The most updated report is available at http://health.utah.gov/primarycare/pdfs/PrimaryCareGrantsFactSheet.pdf.

11) **Emergency Medical Services Five Year Strategic Plan** – this report goes to the Judiciary, Law Enforcement, and Criminal Justice Interim Committee. This report is available at http://health.utah.gov/ems/about/strategic_plan.pdf. The report includes 15 goals with timelines for improving the Emergency Medical Services System in Utah.

12) **Rural Residency Physician Training Program** – UCA 63C-8-106 directs the Medical Education Council to report annually by November 30th to the Health and Human Services Interim Committee on the implementation status of a pilot project to put physicians into rural residency programs. The pilot project is scheduled to sunset July 1, 2015. This report is available at http://www.utahmec.org/uploads/files/76/Rural-Report-2007-2012.pdf. The following is a quote from this report:

   a. "Since 2007, the Utah Medical Education Council (UMEC, www.utahmec.org) has sponsored 463 clinical rotations for 387 health care students in the rural and underserved areas of Utah. This initiative was created to attract and retain health care providers in Utah, specifically to the rural and underserved areas. These rotations provide students with a chance to experience and see firsthand rural life and practice, thereby improving chances of these students returning to rural Utah for practice."

   b. "Students participating in this program include medical residents (36%), pharmacy students (22%), physician assistant (PA) students (20%), medical students (11%), dental residents (7%), and advanced practice registered nurses (APRN) (3%)."

13) **Standards for the Electronic Exchange of Clinical Health Information** – UCA 26-1-37 directs the Department of Health to reports to the Health and Human Services Interim Committee annually by October 15 on the use of standards for the electronic exchange of health information. This report is available at http://health.utah.gov/legislativereports/CHIEAnnualReportforLegislature_2012.pdf.

14) **Testing for Suspected Suicides** – UCA 26-4-28 requires an annual report from the Department of Health to the Health and Human Services Interim Committee by November 30 regarding the types of substances found in people suspected to have died of suicide or suspected suicide. The Department reports that of the 532 suicides investigated by the Medical Examiner in FY 2012, 198 had some substances/drugs in their body at the time of death. This report is available at http://health.utah.gov/legislativereports/2012SuicideToxicologyReport.pdf.

15) **Abortion Informed Consent Material Penetration** – UCA 76-7-305.7 directs the Department of Health to report annually to the Health and Human Services Interim Committee after July 31 regarding specific information for abortions. The Department reports that there were 0 of the 3,172 abortion patients that were excused by a physician from receiving the required information in FY 2012. This report is available at http://health.utah.gov/legislativereports/InformedConsent.pdf.

16) **Office of Health Disparities Reduction Annual Report** - UCA 26-7-2 directs that the Office of Health Disparities Reduction annually report to the Legislature on its activities and accomplishments. The full report is available at http://health.utah.gov/disparities/AboutCMH/2012legislativereport.pdf. Below are some quotations from the report:

   a. "[Office of Health Disparities Reduction] conducted a statewide surveillance study of Utah Pacific Islander health, the first study addressing mainland Pacific Islanders in the United States. New research methods and data from the study will be disseminated nationwide through a peer-reviewed journal (the Journal of Public Health Management and Practice)."

   b. "[Office of Health Disparities Reduction] partnered with local clinics to screen Utahns for health problems and initiate treatment. Of approximately 800 people screened, about 100 were Pacific Islanders."

Additional Resources

- http://health.utah.gov/legislativereports/index.html
- http://health.utah.gov/medicaid/stplan/legisrept.htm

APPENDIX A – INCREASED MEDICAID PROGRAM EFFICIENCIES

Report to the Social Services Appropriations Subcommittee

Increased Medicaid Program Efficiencies

December 24, 2012

Statutory Requirement

As first required by House Bill 459 (2010), the Utah Department of Health (Department) submits this response to comply with the following statutory requirement in UCA 26-18-2.3:

> *Division responsibilities -- Emphasis -- Periodic assessment.*
>
> *(4) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, fraud, waste, abuse, and cost recovery.*
>
> *(5) The department shall, by December 31 of each year, report to the Health and Human Services Appropriations Subcommittee regarding:*
>
> *(a) measures taken under this section to increase:*
>
> *(i) efficiencies within the program; and*
>
> *(ii) cost avoidance and cost recovery efforts in the program; and*
>
> *(b) results of program integrity efforts under Subsection (4).*

Increased Medicaid Efficiencies

Over the past year, the Division of Medicaid and Health Financing (Division) within the Department has implemented many changes to improve the efficiency and effectiveness of the areas of the Medicaid program it manages. In addition to the efficiencies it has identified on its own, the Division has also worked with many partners (including legislative auditors, its legislative fiscal analyst, and the federal government) to identify other potential improvements and then implement those changes. Some of these efficiencies have produced budget savings, others have resulted in cost avoidance, and others have created improved operating processes for the Medicaid program.

Accountable Care Organizations

On June 30, 2011, the Division submitted an 1115 Waiver Request to the federal government to transform the way Utah operates its Medicaid program in the four Wasatch Front counties (Salt Lake, Weber, Davis and Utah). Through the waiver, the Division attempted to slow the growth of Medicaid costs while preserving the quality of care provided to clients. Three of the request's major goals are to:

- Restructure the program's provider payments to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that maintain or improve recipient health status.
- Pay providers for episodes of care rather than for each service.

- Restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to maintain or improve their health and use providers who deliver appropriate services at the lowest cost.

The proposal would replace the current Utah Medicaid fee-for-service/managed care model with the Utah Medicaid Accountable Care Organization (ACO) model along the Wasatch Front. The new contracts would essentially provide the ACOs with monthly risk-adjusted, capitated payments based on enrollment. The ACOs would then create an environment in which they deliver necessary and appropriate care, while demonstrating that quality of care and access to care are maintained or improved.

The ACOs would also have more flexibility to distribute payments to their network of providers. Rather than reimbursing providers based on the units of service delivered, the ACO could make payments for delivering the necessary care to a group of Medicaid enrollees for a specified period of time. The ACO could also choose to distribute incentive payments through its network of providers when various cost-containment, quality or other goals are met.

Unfortunately, the federal government denied three of the five changes sought in the State's waiver request:

- Allow the State to charge slightly higher copays for some services (e.g., charging $5 for physician visits and $25 for an emergency department visit) – **DENIED** [Requires change in federal law or change in CMS interpretation of federal law]
- Allow the State to use a prioritized list of services when implementing cuts during budget shortfalls (i.e., the lowest priority services would be cut first). This request was modeled after the approved practice in Oregon's Medicaid. – **DENIED**
- Allow clients to have the option to receive premium assistance for enrolling in their employer's health plan (or COBRA plan) rather than receiving direct coverage through Medicaid – **DENIED**
- Allow the State to encourage plans to change their reimbursement to providers away from the traditional fee-for-service arrangement – **APPROVED**
- Allow the ACOs to offer incentives to clients when the clients complete certain healthy behavior activities – Originally **DENIED** then **APPROVED**

Despite the denial of several requests, the Division has worked to implement the requests that were approved. On January 1, 2013, Medicaid clients in Weber, Davis, Salt Lake, and Utah counties will begin receiving services through an ACO. By moving health plans to capitated payments and enhancing quality measures in their contracts, it is expected that the change will increase the effectiveness and efficiency of the Medicaid program in these counties.

Emergency Dental Services

Due to budget cuts in previous years, non-pregnant adults on Medicaid have had no dental coverage. Many Medicaid clients seek emergency dental services in Utah's emergency rooms due to a lack of coverage in more appropriate settings. However, emergency rooms are an expensive source of treatment for Medicaid clients to find relief from tooth pain.

With the support of legislative intent language, Medicaid notified providers that the following limited Emergency Dental Services would be available to non-pregnant adults beginning July 1, 2012:

- A limited oral evaluation;
- Dental x-ray, first film;
- Dental x-ray, each additional film, if needed;
- Tooth extraction;
- Surgical tooth extraction; and
- Incision and drainage of abscess

Between July 1, 2012 and the end of November 2012, Medicaid received and paid 849 emergency dental claims under the new Emergency Dental Services program. These claims totaled $104,035 in provider reimbursement, for an average of $122.54 per visit.

By comparison, hospital emergency department visits for acute dental services averaged $987.61 for the same period of time.

The Medicaid Emergency Dental Services program has provided better access to a more appropriate care setting and is a less costly alternative to emergency department visits. Assuming all of these clients would have received care in an emergency department, the total estimated savings for the first five months of the program are $734,444.

Prepayment Edits

In FY 2011, the Division implemented an additional prepayment editing tool through a contract with Bloodhound Incorporated (now Verisk). The editing tool was an enhancement to the existing rules within the Medicaid Management Information System (MMIS) that detect errors in Medicaid provider billing.

Bloodhound's ConVergence Point product incorporates correct coding principles and industry accepted standards and guidelines to identify appropriate coding for provider billing and reimbursement. The ConVergence Point product edits Medicaid's Professional and Outpatient Facility claims on a weekly basis, prior to final adjudication. With this additional computer support, claim edits are applied more consistently. Some individualized customization to the product has been built into the tool to more fully support Medicaid policy.

Implementation of the tool has resulted in more appropriate payment for services. Since December 2010, the Division has realized over $5.1 million in reduced Medicaid payments from this tool.

Pay for Performance

In FY 2012, the Division implemented a Pay for Performance Pilot in its Provider Enrollment Unit, which processes applications from doctors and other medical providers that want to treat Medicaid clients. The unit checks the applicant information against federal exclusion databases and then enrolls eligible providers in the program. The Pay for Performance Pilot rewards staff when they complete a high volume of work while still maintaining a high level of quality. Pilot incentive awards are paid out once a month. The maximum earning potential per employee/per calendar year is $8,000 (per state policy).

Before the pilot began, the Provider Enrollment Unit had six staff who processed approximately 275 regular applications per month on average. As a result of the efficiencies obtained through this pilot, the Division was able to redirect one of the six staff to another area. In a recent month, the unit was able to process 592 regular applications with just five staff.

This jump in productivity has had a positive impact for providers as well. Before the pilot, it often took four to six weeks before a provider's application was processed. Now these applications are processed within a week, often within several days.

Due to the success of the Provider Enrollment Pilot, the Division has started a second pilot with its Medical Review Board Unit. This unit processes applications from individuals that are seeking a disability determination from Medicaid (often while they are waiting for a disability determination from Medicare). Initial experience with the Medicaid Review Board Pilot has shown an increase in the number of applications being processed by the unit. The pilot is still being fine tuned to make sure it appropriately matches bonuses with high volume/high quality work.

Ongoing Efficiency Efforts

The Department also has several ongoing projects that have generated increased savings and efficiencies for the Medicaid program this year.

- Each year the Division works with its Pharmacy and Therapeutics (P&T) Committee to determine if additional drug classes should be added to Medicaid's Preferred Drug List (PDL). In FY 2012, the Division added 18 new drug classes to the PDL. As a result of the Division's use of the PDL, Medicaid saved $34 million in FY 2012.
- In FY 2012, the New Choices Waiver program added 158 new enrollees over its FY 2011 enrollment. Each waiver enrollee is someone who was previously receiving care in a nursing home and now receives services in a less costly environment (often an assisted living facility).

The average cost savings per person in this waiver is approximately $15,200 per year. Medicaid cost avoidance this year due to the increased waiver enrollment is $2.4 million in total funds.

- The Division continues to operate a "Lock In" program for Medicaid clients who demonstrate a pattern of excessive program utilization. The Division restricts these clients to one pharmacy and one prescribing provider. In 2012, the Division conducted case reviews on 2,098 individuals. There are currently 677 individuals in the "Lock In" program as a result of Medicaid benefit misuse or abuse.
- The Division operates an Emergency Department Diversion program to redirect clients seeking primary care needs in the Emergency Department of the State's hospitals. Once a client registers an Emergency Department visit with a non-emergent diagnosis on the claim, the Division will contact that individual and help him or her find a primary care provider and educate the client on when Emergency Department utilization is appropriate. In 2012, the Division sent 16,563 education letters and provided one-on-one education to 1,920 individuals. An additional 336 individuals are in the "Lock In" program as a result of Emergency Department Diversion efforts.

Internal Audits of the Medicaid Program

The Office of Inspector General for Medicaid Services (OIG) was created in July 2011. Many audit positions related to Medicaid were moved from the Department to the OIG to staff that office. As a result, among other responsibilities, the OIG is to audit, inspect, and evaluate the functioning of the Division to ensure that the Medicaid program is managed in the most efficient and cost-effective manner possible. The OIG is directed to issue its own reports to the Legislature on its efforts.

Despite the loss of staff in 2011, the Department has continued to operate its own Office of Internal Audit (OIA). Responsibilities for the OIA are broader than just Medicaid and include performing internal audits and reviewing grants issued by the Department.

The OIA had two direct audits of Medicaid to identify and resolve fraud, waste and abuse. The first audit focused on the claims cycle for Nursing Homes and the second audit focused on providers' billing of evaluation and management (E&M) codes.

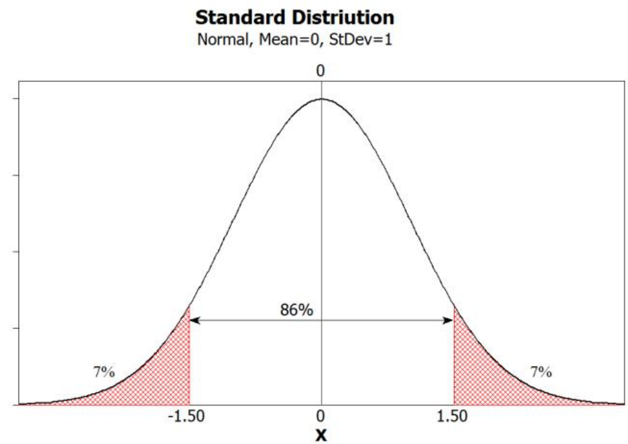
The Nursing Home audit report was issued on June 15, 2012. The life cycle of Nursing Home claims was reviewed. The purpose was to evaluate the adequacy of policies, procedures, and internal controls within the Utah Medicaid Nursing Home Program and to make recommendations regarding potential efficiencies. The OIA compared all (323) approved daily nursing home rates for Calendar Year (CY) 2011 developed by the Division's Bureau of Coverage and Reimbursement Policy with the master file to ensure rates were correctly posted. OIA then compared all (over 100,000) reimbursed nursing home claims for CY 2011 with authorized daily rate amounts.

The Medicaid E&M code analysis report was issued on August 21, 2012. The purpose of the review was to analyze Medicaid billing patterns to identify providers who have excessively high billing patterns. The

review covered claims with date of service during the period July 1, 2010, through June 30, 2012. A total of 2,374 providers with 1 million E&M claims were analyzed. Providers were compared with other providers having a similar provider type and specialty code. Providers that billed 1.75 standard deviations or more above the mean for their provider type were submitted to OIG for review of medical charts to determine appropriateness of coding. A total of 65 providers were submitted to OIG. Providers that billed between 1.5 and 1.75 standard deviations above the mean for their provider type were sent a letter indicating how they bill compared with the average billing pattern. The letter indicates that we will monitor billing patterns going forward. A total of 45 providers were sent a letter. Graphs and charts below are provided to assist the reader in understanding the nature of the work.

The table and chart below shows coverage in terms of a standard deviation measurement of a normal distribution:

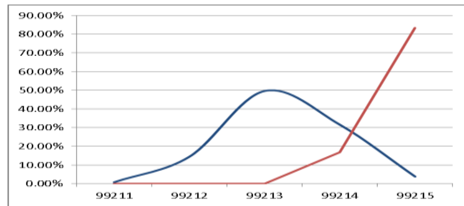
Standard Deviation From Average	Population Coverage
1.0	68%
1.5	86%
2.0	95%
3.0	99.7%



Provider Type: Group Practice

Category of Service: Vision Care

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99211	34	0.75%	0	0.00%	-0.75%	(0.20)
99212	649	14.40%	0	0.00%	-14.40%	(0.73)
99213	2234	49.56%	0	0.00%	-49.56%	(1.38)
99214	1421	31.52%	29	16.67%	-14.86%	(0.22)
99215	170	3.77%	145	83.33%	79.56%	6.73
	4,508	100.00%	174	100.00%		

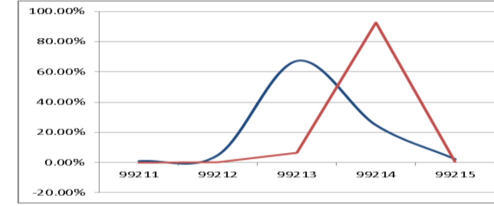


(Provider 6.7 standard deviations above average)

Provider Type: Group Practice

Category of Service: Specialized Nursing

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99211	228	0.94%	0	0.00%	-0.94%	(0.19)
99212	1215	5.00%	1	0.28%	-4.72%	(0.40)
99213	16326	67.23%	23	6.52%	-60.72%	(1.28)
99214	5980	24.63%	327	92.63%	68.01%	1.75
99215	533	2.20%	2	0.57%	-1.63%	(0.31)
	24,282	100.00%	353	100.00%		

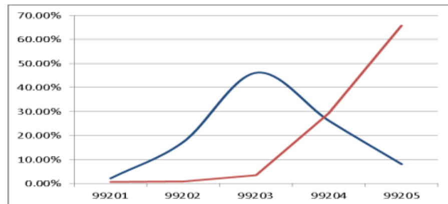


(Provider 1.75 standard deviations above average)

Provider Type: Group Practice

Category of Service: Physician Services

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99201	1961	2.21%	2	0.63%	-1.58%	(0.16)
99202	15440	17.37%	3	0.94%	-16.43%	(0.57)
99203	41012	46.14%	11	3.46%	-42.68%	(0.99)
99204	23275	26.18%	93	29.25%	3.06%	(0.06)
99205	7203	8.10%	209	65.72%	57.62%	2.00
	88,891	100.00%	318	100.00%		

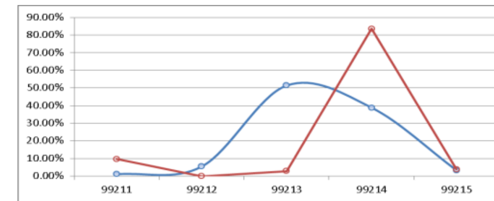


(Provider 2.0 standard deviations above average)

Provider Type: Group Practice

Category of Service: Physician Services

CPT Code	Medicaid Claims Population	Medicaid Average Billing	Your Claims	Your Average Billing	Difference from Medicaid	# Std. Dev.
99211	8789	1.07%	45	9.72%	8.65%	1.29
99212	44796	5.43%	0	0.00%	-5.43%	(0.53)
99213	423662	51.38%	13	2.81%	-48.58%	(1.34)
99214	320113	38.82%	387	83.59%	44.76%	1.53
99215	27143	3.29%	18	3.89%	0.60%	(0.15)
	824,503	100.00%	463	100.00%		



(Provider 1.5 standard deviations above average)

OIA performed audits and provided services that affected Medicaid in an indirect manner.

OIA performed a cash audit of the three dental clinics and three medical clinics run by the Department of Health. These facilities are subsidized by Medicaid. The cash audits included cash collected at the front office and cash payments received by mail.

OIA performed six provider audits of the vaccines for children (VFC) program. This program is paid with Medicaid funds. These audits review controls of providers who administer vaccines to children designated as low-income.

OIA loaned a staff member to the Department full-time for three months to provide technical assistance to improve the I.T. security for "covered entities" (a HIPAA term designating organizations that must keep information secure as they retain protected health information). This staff member will continue to be on loan for the first three months of calendar year 2013. Duties focused on Medicaid and areas of Department that support Medicaid.

Two members of our staff performed Medicaid Cost Reviews for six months. These reviews determine various providers' Medicaid costs to ensure provider costs are valid per federal regulations (Pub. 15). Providers reviewed include nursing homes, private hospitals, state hospital, and mental health providers.

Conclusion

The Department is committed to continually improving the Medicaid program. It is the Department's goal to employ healthcare delivery and payment reforms that improve the health of Medicaid clients while keeping expenditure growth at a sustainable level. The Department will maintain previously identified efforts to improve efficiency as they continue to save the State tens of millions of dollars each year. In addition, the Department will continue to seek out the most effective way to carry out its responsibilities in the future.

APPENDIX B – MEDICAID STATE PLAN AMENDMENTS

State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

March 30, 2012

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Honorable Subcommittee Members:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of UCA 26-18-3(3)(a), the following is a summary of recent changes.

Presumptive Eligibility for Children

The Department has transmitted a State Plan Amendment that allows presumptive eligibility for individuals who are under 19 years of age if a qualified entity determines that they are eligible.

This amendment specifies that the Divisions of Child and Family Services or Juvenile Justice Services are qualified to determine presumptive eligibility and specifies when the presumptive eligibility period begins and ends based on when an individual files a Medicaid application.

This amendment also requires that the application be completed and signed by the child's parent or other representative and requires that the application contain other identifying information.

The Department estimates an annual cost to the state budget of about $72,656 to result from this amendment, but also expects savings to result for Medicaid recipients who become presumptively eligible. This action should be the final step in the State's obtaining approval for the CHIPRA bonus payment, subject to CMS approval. The Department's actions are consistent with the following intent language from House Bill 2 from the 2012 General Session:

The Legislature intends that the Department of Health, in conjunction with the Department of Workforce Services and the Department of Human Services, use part of their appropriations to pursue obtaining CHIPRA Performance Bonuses if the Department of Health determines that it would be in the best financial interest of the state.

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Provider Screening and Enrollment

The Department has transmitted a State Plan Amendment to assure that it complies with provider verification and enrollment procedures. The State Plan Amendment is simply an attestation that the Department is in compliance with the requirements.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Waiver Amendment – Physical Health

The Department has submitted an amendment to the 1915(b) Freedom of Choice Waiver for Utah's Choice of Health Care Delivery and Hemophilia Disease Management Program to allow a new health plan, Health Choice Utah, to enter into a contract to provide services to Medicaid enrollees in Salt Lake and Davis counties.

Waiver Amendment – Mental Health

The Department has submitted an amendment to the 1915(b) Prepaid Mental Health Plan (PMHP). Historically, Medicaid recipients have been enrolled in the PMHP for rehabilitative services for mental health disorders, while outpatient rehabilitative services for substance use disorders have been reimbursed by Medicaid on a fee-for-service basis. Effective 7/1/2012, these recipients will receive needed outpatient rehabilitative services for substance use disorders through the PMHP capitation program as well.

Home and Community Based Waiver Amendments

The Department has submitted three home and community based waiver amendments to CMS. The amendments are for the Community Supports, New Choices and Technology Dependent waivers. The collective purpose of these three amendments is to incorporate quality improvement updates, revise references within each waiver to reflect name and contact information changes, and revise cost estimates of waiver services.

The Department also substituted all instances of the term Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) with the term Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). ICF/ID is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under Federal law.

In addition to these global changes to all three waivers, each amendment also included waiver specific adjustments.

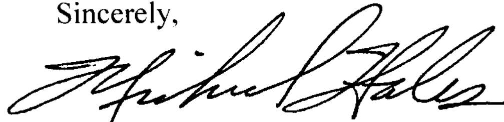
The ***Community Supports Waiver*** amendment modifies the routine group respite service. Previously, routine group respite was only available through the Self-Administered Service (SAS) model. The amendment adjusts this service so that it may now be offered through agency based providers.

The ***New Choices Waiver*** amendment includes increasing the limit of clients served annually from 1200 to 1400, reducing the minimum age requirement from 21 to 18 years of age, and expanding special targeting criteria to take account of individuals who at the time of application are receiving assisted living facility services on an extended stay basis of 180 days or greater or have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility.

The proposed effective date of the waiver amendments is retroactive to July 1, 2011. All three amendments are pending CMS approval. There is no anticipated cost increase to the Community Supports or Technology Dependent waivers associated with the amendments. There is an annual increased cost of $350,766 in state funds to increase the number of clients on the New Choices Waiver. This cost is offset by the savings achieved from transitioning the clients out of nursing facilities and into the New Choices Waiver. The full HCBS waiver amendment application for each waiver can be reviewed by visiting the following site: http://health.utah.gov/ltc/

Please let me know if you have any questions on any of these State Plan and waiver changes. You can reach me at 801- 538-6689.

Sincerely,



Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing

State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

June 29, 2012

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Honorable Subcommittee Members:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of Subsection 26-18-3(3)(a), the following is a summary of recent changes.

Home and Community Based Waiver Update

New Application Submission - June 2012

The 2012 General Legislative Session passed H.B. 272, Pilot Program for Autism Spectrum Disorder Services. This bill required Medicaid to draft and submit a home and community based waiver application to CMS by July 1, 2012. The waiver was submitted earlier today. The *Medicaid Autism Waiver* is a 2-year pilot program that is intended to serve approximately 200 children ages 2 through 5 years. The bill appropriated $4.5 million to implement this pilot: $1.5 million was transferred from Department of Human Services, Division of Child and Family Services and $3 million was designated from the fiscal year 2012 Medicaid Optional Services appropriation as one-time, non-lapsing funds.

Upon submission of the application, CMS typically has 90 days to review the request. The Medicaid Autism Waiver's anticipated effective date is October 1, 2012.

Additional information about the waiver and the full application can be found at:
http://health.utah.gov/autismwaiver/

1115 Waiver Amendment

On May 29, 2011, the Division submitted an amendment to the 1115 Primary Care Network Demonstration Waiver, pursuant to H.B. 144 S4, 2012 General Session of the Utah State Legislature. The amendment requests approval to raise the eligibility income level for adults in Utah's Premium Partnership Program (UPP) from 150% of the federal poverty level (FPL) to 200% of the FPL. The requested effective date of this amendment is July 1, 2012.

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Reimbursement for Physician and Anesthesia Services

The Department has transmitted a State Plan Amendment that updates the frequency of rebasing for physician and anesthesia services and clarifies the methodology for making supplemental payments for physicians employed by the University of Utah Medical Group.

The proposed change requires the physician fee schedule to be updated annually using current relative value units and a budget neutral conversion factor to establish rates. It also proposes annual updates to the anesthesia fee schedule and a 12 % enhancement for rural anesthesia providers.
The Department anticipates an increase of $157,700 to the budget as a result of the enhancement for rural anesthesia providers.

Please note that the Legislature appropriated $2,543,300 (total funds) to increase rates for physician services; however, this SPA addresses the rebasing of rates which is a budget neutral exercise and the addition of a rural enhancement for anesthesiologists as noted above.

There is no cost shift to more expensive services for Medicaid recipients and their families as a result of this amendment.

Quality Improvement Incentive

The Department has transmitted a State Plan Amendment that updates and continues quality incentive programs for nursing facilities and Intermediate Care Facilities for Persons with Intellectual Disabilities in future State Fiscal Years and makes other clarifications.

This amendment continues quality incentive programs by updating the incentive period to be July 1st through May 31st of each state fiscal year. It also specifies the calculation of the upper bound dollar limit of the incentives. Quality incentive programs include improvements to patient shower facilities, security systems, windows, software, and dining.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Medical Education Payments

The Department has transmitted a State Plan Amendment that updates the direct graduate medical education payment pool for 2013.

This amendment rewords the payment amount and time period for the payment pool so the Department does not have to update it each year.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Federally Qualified Health Centers

The Department has transmitted a State Plan Amendment to clarify alternative payment methods for federally qualified health centers (FQHCs).

This amendment clarifies that a FQHC must calculate only covered beneficiary charges when it calculates the Ratio of Beneficiary Charges to Total Charges Applied to Allowable Cost as part of its agreement with the federal government.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Dental Services

The Department has transmitted a State Plan Amendment to restore limited emergency dental services to non-pregnant clients and to non-EPSDT clients in accordance with mandates set forth in the 2012 General Session of the Utah Legislature.

This change provides limited services that include diagnostic exams, X-rays, incision and drainage of abscess, and extractions for erupted teeth.

The Legislature directed through Intent Language that the Department fund the cost of covering emergency dental services for adults on Medicaid within existing appropriations up to $250,000 in general fund for FY 2013. That is approximately $832,224 in total funds to restore these limited dental services. The Department anticipates that increased costs to the dental program will be offset by savings through fewer emergency room visits.

The policy change is an attempt to eliminate the cost shift to more expensive emergency department services. This change will create out-of-pocket savings for non-pregnant and non-EPSDT clients who receive limited emergency dental services.

Disproportionate Share Hospital Payments

The Department has transmitted a State Plan Amendment to allow non-government hospitals that have the support of a government entity (e.g., Special Services District, County government) for the non-federal match dollars to participate in Disproportionate Share Hospital Payments (DSH) payments.

This amendment adds verbiage to allow rural private hospitals that were government-owned as of January 1, 2011, to be eligible for DSH payments under the State Plan.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Home Health Services

The Department has transmitted a State Plan Amendment to update the effective date of home health rates from July 1, 2007, to July 1, 2012 to reflect additional appropriations by the Legislature for this service. The Department estimates an annual cost of about $400,000 (general funds) in SFY 2013 as a result of this change. This amendment will increase provider payments for home health services and thus preserve recipient access to home health services.

Reimbursement for Optometry Services, Speech Pathology Services, Audiology Services, Chiropractic Services, Eyeglasses Services, Physical Therapy and Occupational Therapy, and Rehabilitative Mental Health Services

The Department will transmit State Plan Amendments (SPAs) for each of the services listed above to update the effective date of the agency's rates to July 1, 2012. These updates are in accordance with changes to Section D – Physician Services, and are companion filings to the SPA that describes reimbursement for physician and anesthesia services.

Please note that the Legislature appropriated $2,543,300 (total funds) to increase rates for physician services. In some cases, the providers noted in these amendments bill using the same codes as physicians and, as a result, will recognize reimbursement changes to those shared codes. An estimate of those changes is as follows: SPA for Optometry Services $23,600; SPA for Speech Pathology Services $50; SPA for Audiology Services $550; SPA for Chiropractic Services $8,500; SPA for Eyeglasses Services $70; SPA for Clinic Services $160; SPA for Physical Therapy and Occupational Therapy $380; and SPA for Rehabilitative Mental Health Services $490.

In addition, the Department's transmittal SPA for Clinic Services will propose a rebasing of rates to a percentage of Medicare's rates effective October 1, 2012.

There is no cost shift to more expensive services for Medicaid recipients and their families as a result of these amendments.

Please let me know if you have any questions on these changes to the State Plan and on the waiver update.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing

State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

October 1, 2012

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Subcommittee Member:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of Subsection 26-18-3(3)(a), the following is a summary of recent changes.

Nursing Facility Evacuation Payments

The Department has transmitted a State Plan Amendment that defines the payment process for evacuated nursing facility residents during a declared disaster. This is a continuity of operations provision of the Medicaid State Plan that will allow the Department to reimburse for care provided to evacuated nursing home residents in a declared disaster.

The Department does not anticipate any costs to result from this amendment because this change does not affect overall payments to the nursing facility industry or to providers of intermediate care facilities for persons with intellectual disabilities (ICF/IDs).

Further, there is no cost shift to more expensive services for Medicaid recipients and their families.

1915(b) Choice of Health Care Delivery Program & Hemophilia Disease Management Program

Amendment Submission - September 2012

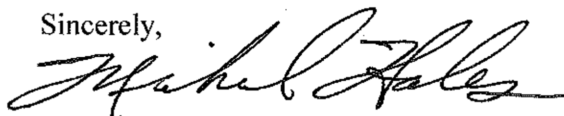
Senate Bill 180 passed during the 2011 General Legislative Session. This bill required the Department of Health to develop a proposal to modify the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models. As previously reported, the Department prepared an 1115 waiver request that was not approved in its entirety by the Centers for Medicare and Medicaid Service (CMS). Since the provisions CMS denied were the ones requiring an 1115 waiver, CMS instructed the Department to use a 1915(b) waiver as the mechanism to implement the payment reform.

This waiver amendment provides for four full-risk capitated health plans in Weber, Davis, Salt Lake and Utah counties effective January 1, 2013. The state will no longer provide for a non-risk plan or

primary care case management plan in these four counties. The plans offered will be Select Health, Molina Healthcare of Utah, Healthy U and HealthChoice of Utah. In addition, effective January 1, 2013, these four plans will assume responsibility for the administration of the Medicaid pharmacy benefit for Medicaid recipients enrolled in their plan. Upon submission of this amendment, CMS has 90 days to review the request.

Please let me know if you have any questions on the change to the State Plan or the waiver amendment.

Sincerely,



Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing

APPENDIX C – COMMITTEE TO EVALUATE HEALTH POLICIES AND TO REVIEW FEDERAL GRANTS

26-1-4 Report: Utah Department of Health and the Local Health Departments - Allocation of public health resources and federal grant funding

1. Governance Structure and Meetings

The Utah Department of Health (UDOH) and the state's 12 local health departments manage as required by UAC 26-1-4, a committee consisting of three local health officers and three department representatives including the Executive Director of UDOH " to evaluate health policies and to review federal grants." The Committee referred to as the Governance Committee or Governance reviews all UDOH proposed and current grant funding and activities. Governance meetings are conducted bi-monthly and held on the first and third Monday of each month at 11:30 a.m. in the Cannon Health Building. All meetings are posted in compliance with Utah's Open and Public meetings laws and posted on the state's Open and Public Meetings Website. The Committee conducted annual Open and Public meetings training and discussed the option of opening the meetings to electronic participation by the public. After a review with the Assistant Attorney General, it was determined to allow Committee members to join the meetings electronically.

2. Number of Grants Reviewed

During the 2012 calendar year the Governance Committee has reviewed 99 grants. 55 were approved for submission and 44 were exempted from review. To date, 50 of these grants have received a notice of award for funding.

3. Policy and Issue Resolution

The Governance Committee is a mechanism through which local and state public health leadership can work for consensus on statewide policy development and resolution to programmatic issues. To assure state and local processes were working, the Committee extensively reviewed the following grants: Collaborative Chronic Disease, Health, Promotion and Surveillance-Diabetes Control, Healthy Communities, Tobacco Prevention Core, National Cancer Prevention and Control Program, Utah Basic Implementation of HDSPP- Heart Disease and Stroke, Arthritis, Utah Colon Cancer Screening, Utah Wisewoman Program, Prevention and Public Health Fund: Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance, Maternal, Infant and Early Childhood Home Visiting Program, Prevention Block Grant, Supporting Evidence Based Home Visitation, Maternal and Child Block Grant, and the HIV Prevention Projects. All of the grants that were reviewed in this process were approved to be submitted in calendar year 2012.

4. Governance Grant Proposal and Funding Review Process

UDOH (www.health.utah.gov/governance) website was created to provide all pertinent proposed grant information to the Governance Committee, all 12 local health departments and the public. This information provides transparency for the UDOH grant writing and application process. All 12 local health departments have designated staff that receive this information and in turn can make a determination as to how they will participate in the grant writing process. A new review process to include local staff in the early stages of the grant writing process or the Grant Application Planning Process (GAPP) was undertaken by the Committee this year.

Approved by the Committee 11/19/2012 (Final)

APPENDIX D – EXPANSION OF 340B DRUG PRICING PROGRAMS

Report to the Health and Human Services Interim Committee and Social Services Appropriations Subcommittee

Expansion of 340B Drug Pricing Programs

Volume 19

Prepared by the Division of Medicaid and Health Financing

November 21, 2012

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H.B. 74 –Expansion of State Medicaid 340B Drug pricing program

The 2008 Legislature directed the State Medicaid agency to expand program use of savings under the 340B drug pricing program. Specifically, the Department of Health shall determine:

- The feasibility of developing and implementing one or more 340B pricing programs for a specific disease, similar to the hemophilia disease management program;
- Whether the 340B program results in greater savings for the department than other drug management programs for the particular disease. The Department shall report regarding:
    - Potential cost savings to the Medicaid program from the expansion of use of the 340B program;
    - Amendments and waivers necessary to implement increased use of 340B pricing;
    - Projected implementation of 340B pricing programs;
- The Department shall work with the Association for Utah Community Health to identify and assist community clinics that do not have 340B drug pricing programs to determine whether:
    - Patients of the Community Health Center would benefit from establishing a 340B drug pricing program on site or through a contract pharmacy;
    - The Community Health Center can provide 340B drug price savings to the Health Center's Medicaid patients

Previous versions of this report have provided explanations and descriptions of program requirements, limitations, expectations, and obstacles. Attention should be directed to these earlier versions for information concerning those details.

Feasibility of Additional Disease Management Programs

Designing a disease management program and securing approval from the Centers for Medicare and Medicaid Services (CMS) presents challenges. Program staff submitted a final draft State Plan Amendment (SPA) to the Denver Regional CMS office in May of 2010 for review. The SPA included six disease states: hemophilia, multiple sclerosis, cystic fibrosis, rheumatoid arthritis, hepatitis C, and Crohn's disease. That draft was reviewed by CMS in both the Regional and the Central CMS offices and received a tentative approval.

With the passage of Health Care Reform, CMS expressed some uncertainty surrounding the best method for implementing an expanded disease management program. At various points in the past, CMS separately asked that the State consider:

- Medical Homes provisions contained in the legislation as a vehicle for implementing the proposed disease management program,
- implementing solely through a State Plan amendment,

- eliminating the need for a1915(B)(4) Waiver,
- giving enhanced attention to the cost effectiveness requirements of a waiver,
- altering the need for a request for proposal, and
- consulting with the Indian tribes prior to approval being granted.

Following additional discussions between the state and CMS, CMS determined that many of its suggestions were not feasible. CMS provided the state with a request for additional information and ultimately decided that three processes are needed along with tribal consultation:

1. A request for proposal (RFP),
2. A 1915(B)(4) Waiver, and
3. The cost effectiveness portion of the waiver.

CMS does not have a template for this waiver type as they have never approved one like this before. The template provided needs to be extensively adapted to this situation and CMS has to collaborate on that requirement.

While follow-up with CMS has occurred almost quarterly since that submission, practical implementation and further pursuit of this SPA has declined as a result of other Medicaid pharmacy priorities (e.g., ACO's) that have a direct impact on this initiative.

Senate Bill 180 in the 2011 Utah Legislative General Session

With the passage of Senate Bill 180 in the 2011 Utah Legislative General Session, Medicaid prepared and submitted an 1115 Waiver application to CMS which, if approved, will convert the existing managed care model to one of Accountable Care Organizations (ACOs). The ACOs are anticipated to include most pharmacy services. ACOs will operate in the four Wasatch Front counties. Individuals in rural areas will continue to be served under the fee-for-service model. Mental health therapeutic classes of drugs (e.g., atypical anti-psychotics, psychotropic drugs) have been excluded from the waiver request and subsequent ACO management.

Various components for handling the pharmacy benefit portion of the ACO model have been discussed with the ACOs as well as CMS. Aspects relating to claims processing, data transfer, and Medicaid regulation compliance must be configured. Accommodation of the Mental Health benefit presents challenges for the ACOs, Medicaid, and future 340B drug program parameters. For example, some ACOs desire to use 340B acquired drugs for their pharmacy benefit. A mental health carve-out means that utilization tracking has to be separate for those drugs that are provided as 340B, those that are not provided as 340B, and those that are not provided though the ACOs.

The Deficit Reduction Act of 2005 requires Medicaid to collect rebates on physician administered drugs even when provided under Managed Care Organizations. The Affordable Care Act of 2010 requires Medicaid to collect rebates on all pharmaceuticals provided under Managed Care Organizations.

In the future, providing Medicaid pharmaceutical care through an ACO model along the Wasatch Front would greatly reduce the population base for expansion of 340B drug pricing programs under fee-for-

service. In all cases, Medicaid is still required to track and report utilization to ensure that required rebates are collected. Consequently, new ACOs will have mandatory utilization reporting requirements.

The feasibility of expanding disease management into other disease states will be greatly reduced if clients along the Wasatch front become part of an ACO in the future. This may impact the willingness of 340B providers to bid for other disease management programs (lacking economies of volume).

The state has been working with CMS to obtain approval of the 1115 Waiver request titled *Utah Medicaid Payment and Service Delivery Reform*. CMS denied the original 1115 Waiver application, but said that portions of the initial submission could be done through a 1915(b) Waiver as a Managed Care Organization. The state is working through changes to the 1915(b) Waiver for the physical health portion of the business and Medicaid staff are also working with CMS on a separate 1915(b) Waiver for disease management.

Potential Cost Savings

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals. Significant savings on pharmaceuticals may be seen by those provider entities that participate in this program. The 340B program is operated under the jurisdiction of the Office of Pharmacy Affairs (OPA). A component of the Health Resources and Services Administration (HRSA), of the U.S. Department of Health and Human Services (HHS), the Office of Pharmacy Affairs has three primary functions:

1. Administration of the 340B Drug Pricing Program, through which certain federally funded grantees and other safety net health care providers may purchase prescription medication at significantly reduced prices.
2. Development of innovative pharmacy services models and technical assistance, and
3. Service as a federal resource about pharmacy.

In all of its activities, OPA emphasizes the importance of comprehensive pharmacy services being an integral part of primary health care. Comprehensive pharmacy services include:

- patient access to affordable pharmaceuticals,
- application of "best practices"
- efficient pharmacy management, and
- the application of systems that improve patient outcomes through safe and effective medication use.

The interest that HRSA (a sister agency to CMS under HHS) maintains in Medicaid 340B programs stems from the fact that all parties involved must take strict measures to ensure that drug manufacturers are not exposed to a “double” rebate and that 340B purchased drugs are not provided to patients who do not qualify as a patient of the 340B participating facility (note: the simple act of filling a prescription at a 340B facility is not sufficient to establish that relationship). Medicaid drug expenditures are entitled to a manufacturers rebate back to Medicaid. Drugs reimbursed to a 340B covered provider entity under the OPA program are prohibited from being subject to any rebate.

All savings to Medicaid from implementing a 340B based program come entirely from the providers. Additional revenues from the 340B program were intended to help 340B providers offset losses resulting from the high volumes of discounted and free medical services provided to the uninsured and underinsured, which volumes qualify them for participation in the program. A change requiring 340B providers to fill prescriptions and bill Medicaid at 340B cost pricing requires providers to share all of their savings with Medicaid and would essentially eliminate that revenue, thus discouraging provider participation. Therefore, it becomes important to find a means to maintain provider interest.

340B pricing information is not accessible directly to Medicaid, as this information is considered proprietary. Cost savings were originally calculated based on estimated 340B prices. Bill Von Oehson, president and general counsel of "The 340B Coalition," a national organization of safety net Disproportionate Share Hospitals (DSH) based in Washington D.C. maintains that 340B prices are on average AWP (Average Wholesale Price) minus 49 percent. The actual price varies by drug product. There is little question that potential cost savings exist. Those savings are not always easily calculated given the constraints of the system, such as 340B requirements, CMS approvals, and availability of willing contractors. Medicaid delayed revising savings calculations pending the outcome of CMS review of the 1115 Waiver application, and continues to do so as development and implementation of the 1915(b) ACO waiver proceed.

Necessary Amendments and Waivers

There are several distinct components for the 340B program. The medical component pertains to pharmaceutical services provided in a physician's office setting (e.g., hospital clinics, community clinics). The point-of-sale (POS) component pertains to prescriptions obtained through a pharmacy. A third component, referred to as disease management, is administered through a POS setting with some medical services also provided.

In previous reports, the Division has addressed the third component, expansion of the current 340B Disease Management program, which includes the management of additional disease states. As reported under the section addressing feasibility, the Division, has, in the past, involved itself in negotiations with CMS to finalize a SPA, waiver, and RFP for disease management. The Division included the disease management expansion program as part of the original 1115 Waiver request titled *Utah Medicaid Payment and Service Delivery Reform*. The value of a Medicaid disease management program with an ACO model running in the state will be limited to the non-ACO catchment areas of the state. Pursuit of disease management under remaining fee-for-service contracts is being revisited, especially since the serviceable populations are located in sparsely populated rural counties.

Projected implementation of 340B programs

Fill-and-Bill and Buy-and-Bill at 340B Pricing

Previous reports have detailed the opportunities and obstacles for implementing "fill-and-bill" and "buy-and-bill" arrangements with providers (please refer to previous reports for more detail).

Negotiations with hospital providers and other 340B covered entities continue in hopes of obtaining additional savings. Although the net gain is less than a full 340B discount, the net result will be additional savings to the Medicaid program and preserving interest in the program by the participating 340B providers.

To aid in this process, Utah Medicaid commissioned a dispensing fee survey. The survey will provide Medicaid with the information necessary to establish a specific 340B dispensing fee. Dispensing fee differentials are likely to be identified, and the state plans to submit a State Plan Amendment to CMS for approval of any new proposed dispensing fees. The State has secured a vendor and the survey is underway and anticipated to be completed in the near future. With information from the dispensing fee survey, Medicaid will begin negotiations with 340B entities in order to have the pharmacy 340B providers fill-and-bill at 340B pricing. Medicaid would put an edit in the claims payment system to ensure those providers are billing at 340B costs and that those claims are not included in the rebate invoicing program.

Disease Management

The process through which Freedom of Choice Waivers are approved by CMS has proven to be lengthy. Such was the case with the original hemophilia program. Given the pace of the CMS approval process, the efforts required to submit a 1915(b) Waiver application, and resulting changes to the disease management model presented by the ACO waiver (e.g., smaller population base), it is difficult to estimate a completion date for expansion of the disease management program.

Association for Utah Community Health

The Association for Utah Community Health (AUCH) is an organization of 340B qualifying community health centers, federally qualified health centers, and family planning clinics. There are 29 covered entities in the AUCH organization. AUCH pharmacies charge 340B clients the cost of the 340B drugs plus a five dollar co-pay, providing a great benefit to their patients. Medicaid patients of the 340B AUCH providers do not use the 340B program and, in fact, are sensitive as to whether 340B purchased drugs are used since using 340B drugs would change their co-pay (Traditional Medicaid clients may not pay copays greater than three dollars).

A 340B covered entity by definition buys 340B drugs for use in the facility. All covered entities provide 340B purchased medications, at least in the physicians' offices, whether or not pharmacy services are available onsite or through a contracted pharmacy. Most AUCH members have onsite pharmacies or have a contracted pharmacy. Presently, covered entities can elect whether or not they will choose to fill-and-bill with 340B purchased drugs for their Medicaid patients. To date, two have elected to do so.

Past negotiations with the AUCH organization focused on methods to make obtaining medications attractive for the Medicaid client while maintaining the revenue for the covered entity. Similar to other 340B providers, as stated previously, the contracted pharmacy retailers providing services to 340B AUCH clients have also voiced discontent with participation unless reimbursement issues (e.g., higher dispensing

fees or co-pays) are addressed. Results from the dispensing fee survey should help resolve those concerns. A cost settlement approach has not been discussed with the AUCH organization since coordination of the required programming among the covered entity, the contracted pharmacy, and the Medicaid agency is beyond the scope of their systems and resources at this time. AUCH has indicated to Medicaid that its organization of covered entities will, however, work towards fill-and-bill participation pending satisfactory resolution of reimbursement issues such as an increase in the current dispensing fee.

APPENDIX E – ASSISTANCE TO PERSONS WITH BLEEDING DISORDERS

Office of Primary Care and Rural Health
Assistance for People with Bleeding Disorders
Updated September 28, 2012

Function

The Office of Primary Care and Rural Health continues to be a resource for Utah's rural, multi-cultural, and underserved communities. The Office works with communities that need assistance in conducting needs assessments, recruiting health care professionals, identifying sources of funding, and implementing other projects related to decreasing disparity and increasing access to primary health care.

Program Description

The Assistance for People with Bleeding Disorders Program is set up to assist persons with bleeding disorders with the cost of obtaining hemophilia services or the cost of insurance premiums for coverage of hemophilia services.

Utah Code Annotated, 26-47, authorizes the Assistance for People with Bleeding Disorders Program.

Key Facts

Eligible individuals are persons with a bleeding disorder:

a. Whose health insurance coverage either:
   1) Excludes coverage for hemophilia services;
   2) Exceeded their health insurance plan's annual maximum benefits;
   3) Exceeded their annual or lifetime maximum benefits payable under Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act; or
   4) Has health insurance coverage available under either private health insurance, Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, Utah mini COBRA coverage under Section 31A, 22-722, or federal COBRA coverage, but the premiums for that coverage are at or greater than 7.5 percent of the person's annual adjusted gross income.

b. Who is low income;
   1) Is without health insurance, including CHIP and Medicaid, or
   2) Is without health insurance that covers hemophilia services, or
   3) Is without health insurance that covers a particular hemophilia service.

c. Who *Resides in the State of Utah.*

d. Are low income defined as including individuals at or below the 200 percent of poverty level as established annually by the Department of Health and Human Services and published annually.

e. Eligibility means an application received from an individual, or their family member, who meets the criteria established in Utah Code Annotated, Section 26-47-103 (1)(b), and that individual's health insurance is at or greater than 7.5 percent of the individual's adjusted gross income.

f. Target population is any individual residing in the State of Utah who has been diagnosed by a health care professional with a bleeding disorder.

g. Underinsured are individuals with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay; and/or individuals which:
   1) are unable to afford health insurance;
   2) are denied paid health care from work;
   3) are denied full coverage plans from work;
   4) have health insurance plans which only cover the worker and not the family or extended family; and/or
   5) have insurance plans with unreasonably high deductibles or co-insurance.

h. Uninsured are individuals who lack public or private insurance.

Appropriation

The Utah Legislature annually appropriated $250,000 for the Assistance for People with Bleeding Disorders Program since State Fiscal Year 2005. During the State Fiscal Year 2011 Utah Legislative session the appropriation was changed to $200,000.

Intent Language

The Utah Legislature has annually included intent language for the Assistance for People with Bleeding Disorders Program allowing up to $50,000 be considered non-lapsing.

ASSISTANCE FOR PEOPLE WITH BLEEDING DISORDERS HISTORY

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013 estimated	Cumulative
Rural Served	15	18	24	15	11	6	9	14	112
Urban Served	21	29	31	38	32	54	48	36	289
Total Served	36	47	55	53	43	60	57	50	401
GOAL	50	50	50	50	50	50	50	50	400
Expenditures	$167,540	$170,500	$386,960	$213,669	$228,200	$234,500	$200,000	$200,000	$1,801,369

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APPENDIX F – KURT OSCARSON CHILDREN'S ORGAN TRANSPLANT FUND

THE KURT OSCARSON CHILDREN'S ORGAN TRANSPLANT FUND
November 2012

The Kurt Oscarson Children's Organ Transplant Fund was established in 1992 (UCA 26-18a) to provide financial support for children who require organ transplants and to promote organ donor awareness. A five-member committee oversees this restricted fund, which is funded through "check-off donations" on the Utah State Income Tax Form. Authority to make expenditures from the fund is granted by an appropriation from the Legislature. The committee may award financial assistance to eligible families through interest-free loans. The committee establishes the terms of repayment, which may include a waiver of the loan repayment. The committee works actively with families to help them secure other financial assistance as well as referring families to other agencies for support services. The committee has also approved expenditures to encourage organ donation. (Lack of donors is a greater problem than actually paying for the transplants.) Utah code requires the committee to make an annual report to the Appropriations Subcommittee.

During the 2012 Fiscal year, $52,979 was collected through the tax check-off on the Utah State Tax Form. The fund assisted 5 new transplant recipients (children under the age of 18 years) with transplant related expenses totaling $14,817. In addition, the committee worked toward promoting organ donation awareness through Intermountain Donor Services. A total of $45,000 was expended for promotion and awareness purposes in FY11 leaving a year-end balance of $116,336.

Below is a summary of current and historical data:

Fiscal Period	Revenue Collected From Tax Returns	Donor Promotion Expenses	Medical Assistance Expenses	Fund Balance Year End	Number Families Assisted
Fiscal Year 2012	$52,979	$45,000	$14,817	$116,336	5
Prior 3 yr Average	**$56,062**	**$46,610**	**$23,791**	**$130,227**	**5.3**
Fund 20 year History	$1,383,517	$703,141	$564,040	$116,336	106

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APPENDIX G – ORGAN DONATION CONTRIBUTION FUND

THE ORGAN DONATION CONTIBUTION FUND

November 2012

The Organ Donation Contribution Fund was established in 2002 (UCA 26-18b) to promote and support organ donation, assist in maintaining an organ donation registry, and provide donor awareness education. The fund receives revenue from voluntary donations collected with motor vehicle registrations and driver licenses. A committee of five members administers and approves expenditures from the fund. This committee also administers the Oscarson Children's Transplant Fund. Authority to make expenditures from the fund is granted by an appropriation from the Legislature.

During the 2012 Fiscal year, $84,331 in donations was collected through the Motor Vehicle and Driver License registrations, from which $16,866 was reimbursed to the Divisions of Motor Vehicles (DMV) and Driver's License (DDL) for collection expenses. Expenditures of $81,150 were made to Intermountain Donor Services for donor promotion services leaving a year-end balance of $38,703 as of June 30, 2012

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Below is a summary of current and historical data:

Fiscal Period	Revenue Collected from Motor Vehicle License Registration	Less: Collection Expenses	Donor Promotion Expenses	Fund Balance Year End
Fiscal Year 2011	$84,331	$16,866	$81,150	$38,703
Prior 3 yr Average	$83,795	$16,759	$82,807	$54,932
Fund 10 yr History	$914,013	$176,159	$699,151	$38,703

APPENDIX H – AUTISM TREATMENT ACCOUNT ADVISORY COMMITTEE

FY 2012 Report to Legislature
Autism Treatment Account

Overview

The Autism Treatment Account (ATA):

- Established in March 2010 by the Utah Legislature with the passage of House Bill 311.
- Revised during the 2012 legislative session.
    - HB 272 created a pilot program to provide services for children ages 2 to 6 years through three mechanisms;
        - 1) a Medicaid Waiver,
        - 2) PEHP insured, eligible children, and
        - 3) the Autism Treatment Account.
- A restricted special revenue account for the receipt and expenditure of funds to be used for assistance in funding services and therapy to eligible Utah children less than 6 years of age with Autism Spectrum Disorders (ASD).
- The account may also accept "gifts, grants, donations, and bequests of real property, personal property, or services, from any source, or any other conveyance that may be made to the account from private sources, interest and other earnings derived from the account money."
- Funding was appropriated by the state to the ATA for $1M for the 2 year pilot program.
- A private donation of $500,000 from Intermountain Healthcare has been received
- A donation is pending from another organization.
- Administered by the Executive Director of the Utah Department of Health
    - Staff support from the Bureau of Children with Special Health Care Needs (CSHCN), in the Division of Family Health and Preparedness.

Autism Treatment Account Advisory Committee

The legislation established the Autism Treatment Account Advisory Committee

- Purpose of committee is to recommend how funds should be managed and expended.

The six Governor-appointed members serving on the committee:

- Harper Randall, MD (representing Utah Department of Health),
- Peter Nicholas, PhD (providing expertise in treatment of ASD),
- Paul Carbone, MD (pediatrician specializing in ASD),
- Leeann Whiffen (family member),
- Cheryl Smith (family advocate/president of the Autism Council of Utah), and
- Jeffrey Skibitsky (a board certified behavioral analyst).

Cheryl Smith is the current chair as selected by the ATA Advisory Committee.

Autism Treatment Account: Recent Activities

The ATA Advisory Committee was charged with creating a rule to govern administration of the funds. This rule includes:

- qualification criteria and procedures for selecting children who may qualify for assistance from the account,
- qualifications, criteria, and procedures for evaluating the services and providers to include in the program, and
- provisions to address and avoid conflicts of interest that may arise in relation to the committee's work.

- The proposed rule went through the rulemaking process and became effective July 30, 2012.

The Autism Treatment Account Advisory Committee and the Utah Department of Health determined that the most efficient and effective way to provide therapy for children under HB272 was to issue a request for grant application (RFA).

- The purpose of the RFA was to enter into contracts with qualified providers or organizations to provide services eligible under *UCA 26-52 (http://le.utah.gov/UtahCode/section.jsp?code=26-52)*.
- Account monies will be used to provide a child who has a diagnosis of ASD, and who is at least two years of age but younger than six years, with services that utilize applied behavior analysis and other proven effective therapies per national standards.
- All services provided will include at least:
  1. Applied behavior analysis therapy provided by or supervised by a board certified behavior analyst or a licensed psychologist with equivalent university training and supervised experience who is working toward board certification in applied behavior analysis;
  2. Willingness to collaborate with existing telehealth networks to reach children in rural and underserved areas of the state; and
  3. Methods to engage family members in the treatment process.

The RFA resulted in contracts with four ASD therapy providers.

- During the open enrollment period for application of eligible children with these providers, 68 applications were received.

Contracts negotiated with the four providers:

- To provide 79 weeks of therapy based on the state appropriation of $1 million.
- Not less than 15 children have been randomly selected, evaluated, and are in the early phases of therapy planning.
- In addition, a donation was received from Intermountain Healthcare and contracts were amended to provide services to seven additional children.
- A donation from another organization is expected to be forthcoming shortly after the beginning of 2013 and it is anticipated that contracts will then be amended to provide services to three additional children.
- As children age out of treatment (become 6 years of age), as outlined by UCA 26-52, additional children from the pool of applications will be considered for enrollment for therapy.
- During open enrollment, one provider identified four children who qualified for ABA therapy services covered by their insurance carrier.

The ATA Program is administered at less than the allowable administrative costs of 9% as outlined in HB272.

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Submitted: November 29, 2012