REQUIRED REPORTS – DEPARTMENT OF HEALTH

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: RUSSELL FRANDSEN

ISSUE BRIEF

SUMMARY

This Issue Brief provides information regarding five reports currently required to be given to the Social Services Appropriations Subcommittee by the Department of Health. This brief also includes a list of 12 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. "During this past year, the face-to-face and phone education has been standardized and streamlined, reducing the amount of time for each orientation. As a result, more orientations are scheduled and more Medicaid eligible individuals are educated each month. Last fiscal year, the Division provided education to 68,441 Medicaid and 20,344 CHIP eligible individuals."
   b. "Medicaid eligibility verification is also available to providers through the Medicaid Interactive Voice Response (IVR) system. In June 2013, system access was expanded to be available 24/7. The volume of eligibility inquiries through the IVR has increased by 13 percent. Not all provider offices are equipped to verify beneficiary eligibility through the HIPAA 5010 Standard. Expanding the IVR hours of operation creates an efficiency by allowing access to eligibility data during regular business hours and after hours, without having to speak to a technician."
   c. "In FY 2013, the Division added 13 new drug classes to the PDL. As a result of the Division's use of the PDL, Medicaid saved $44.5 million total funds ($13 million general fund) in FY 2013."
   d. "There are currently 762 individuals in the "Lock In" program. Of these, 70.6 percent are enrolled in managed care. Approximately .3 percent of all Medicaid clients are in the "Lock In" program."
2) **Implementation of Improved Provider Payment Controls** – UCA 26-18-604 directs that the Department of Health report annually on its recovery of improper payments to providers in its Medicaid program. The report is Appendix B. Below are some quotes from the report:
   a. "Lower Limb Medical Supplies – The OIG identified Medicaid payments that were beyond the defined limits for Lower Limb medical supplies. The OIG recommended that the Department establish an internal control mechanism that would edit and check for the frequency of lower limb orthosis billings, consistent with current policy. The OIG estimated a recovery amount of $94,300. Status: Medicaid will work with the identified providers to properly resubmit and reprocess these claims to recover the over payments. The requested controls will be established for these payments."
3) **Medicaid State Plan Amendments** – UCA 26-18-3 directs the Department to report to the Social 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 C, which represent all the reports submitted since the 2012 General Session through December 2013.
4) **Tobacco Prevention and Control in Utah** - UCA 51-9-203(3) requires the Department of Health to report on reviews conducted of programs that received tobacco money funding. This report is available at http://www.tobaccofreeutah.org/pdfs/tpcpfy13report.pdf. The following are some quotes from the report:

a. "Recent increases in smoke-free policies and subsequent declines in cigarette smoking have led to the development of a growing number of alternative tobacco or nicotine products. These products, which include electronic cigarettes, hookahs, and dissolvable tobacco, are marketed as safe and "cool". Increasing use of these products, especially among youth, is alarming since long-term health risks are unknown and nicotine addiction caused by these products may serve as a gateway to cigarette smoking. To continue to reduce the burden of tobacco use in Utah, a sustained commitment to effective tobacco prevention and cessation interventions is needed."

b. "Since 2001, TPCP-funded quit services, the Utah Tobacco Quit Line (1.800.QUIT.NOW) and UtahQuitNet.com, have served more than 100,000 tobacco users."

c. "As a result of the Recovery Plus Partnership between the TPCP and the Division of Substance Abuse and Mental Health (DSAMH), all of Utah's publicly-funded substance abuse and mental health clinics (serving 17,000 clients) adopted tobacco-free campus policies and integrated tobacco cessation into treatment protocols."

d. "The TPCP partnered with businesses, health plans, and healthcare providers to form the Utah Tobacco Prevention Task Force, which promotes comprehensive tobacco-free policies and works to increase access to cessation services in business and healthcare settings."

5) **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/2013AutismTreatmentAccount.pdf and is Appendix D. The following are quotes from the report:

a. "A total of 35 children have been served during the first year of the pilot. After initial enrollment, five children discontinued services (parents moved out of state, child near typical development, parent withdrew) and 9 new children were enrolled, including some that have been in the program for less than 6 months. The time period for service duration needed to assess outcomes was determined to be at least six months. Assessment data are available for 28 children who received at least 6 months of continuous service."

b. "Vineland II is an assessment of an individual's daily functioning that may be used in educational and clinical diagnostic evaluations of developmental delays, in developmental evaluations of young children, for progress monitoring, and for program planning. Results from the Vineland II indicate significant improvements in ATA [Autism Treatment Account] participants' communication, daily living skills, socialization, motor skills, and adaptive behaviors."

c. "The [Behavioral Assessment System for Children]-2 (completed by both parents and teachers) indicates the efficacy of ATA-funded services in improving social, emotional, behavioral, and adaptive functioning outcomes for children with ASD [Autism Spectrum Disorders]. Both parents and teachers indicated a decrease (an improvement) in the Behavioral Symptoms Index (BSI), or overall score, which measures the level of behavioral problems. Teachers indicated an increase in the Adaptive Skills Composite, indicating more positive behaviors. The change in both measures indicates improvement"

Other Department of Health Reports That May be of Interest

1) **Utah Department of Health Strategic Plan 2013 – 2016 -** the Department of Health identifies the following four strategic goals: (1) healthiest people, (2) health in health reform, (3) transform Medicaid, and (4) a great organization. The full report is available at http://health.utah.gov/about/documents/StrategicPlan_2014print.pdf

2) **Annual Financial Audit (FY 2013) -** of the Department of Health by the Utah State Auditor. This report is available at http://financialreports.utah.gov/saoreports/2013/13-09DOH-ml.pdfHealth,Departmentof.pdf.

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 report is available at http://le.utah.gov/interim/2013/pdf/00003603.pdf.

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 Department combined this report with #2 on page 1 entitled "Implementation of Improved Provider Payment Controls."
    a. The Department notes: "As reported in 2012, all five recommendations have been implemented by the Division."

5) **Implementation of Federal Health Care Reform** – UCA 63M-1-2505.5 requires any agency before implementing any part of federal health care reform to report to one of three legislative committees. The letters received from the Department of Health from February 2013 through December 2013 are included as Appendix E.
    a. Most of the changes reported had to with mandatory eligibility changes for Medicaid and the Children's Health Insurance Program.

6) **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 2012 report is available at http://health.utah.gov/medicaid/stplan/LegReports/StateOfUtahDURAnnualReport2012.pdf. Below is some information from the report:
    a. "Utah Medicaid has a contract with the University of Utah's Drug Regimen Review Center (DRRC). The DRRC reviews Utah Medicaid clients who have high drug utilization and drug costs...The goal is to reduce waste, duplication, and unnecessary prescription utilization…For the State fiscal year 2012, the DRRC program achieved over $958,108 in savings by assisting physicians to reduce the number of prescriptions that could cause potential adverse drug reactions, or eliminate unnecessary and/or duplicate prescriptions."
    b. "In Federal fiscal year 2012 the DUR Board discussed fourteen issues over nine meetings, placing new prior authorization requirements on two different drugs, removing prior authorization requirements from three different drugs, altering prior authorization criteria for two different drugs, and adding quantity limits on two different drug products."

7) **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 report is available at http://www.tobaccofreeutah.org/pdfs/tpcpfy13report.pdf. Below are some quotations from the report:
    a. "In FY13, 2,345 Medicaid clients gained access to tobacco cessation services and counseling through a collaborative effort between Medicaid and TPCP"
    b. "Nearly 1,600 pregnant women on Medicaid and 895 low-income or uninsured tobacco users received free counseling and tobacco cessation prescriptions during FY13."
    c. "155 publicly-funded substance abuse and mental health treatment facilities and 4 hospitals or clinics adopted policies to protect Utahns from secondhand smoke."

8) **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 2013 $786,200 in grants served 31,200 individuals. The FY 2013 report is available at http://health.utah.gov/legislativereports/PrimaryCareGrants2013.pdf.

9) **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.

10) **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 December 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.

11) **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/2013legislativereport.pdf. Below is a quote from the report:

    a. "[Office of Health Disparities Reduction] successfully addressed the infant mortality problem among the two Utah racial groups with the highest infant mortality rates, reducing the African American/Black infant mortality rate from 8.4/1,000 births in 2004-2007 to 7.6/1,000 in 2008-2011 and reducing the Pacific Islander infant mortality rate by nearly half, from 7.4/1,000 births in 2004-2007 to 3.6/1,000 in 2008-2011. Strategies included the first-ever statewide surveillance study of Pacific Islanders in the continental United States, new health promotion videos in English, Samoan, and Tongan featuring African American and Pacific Islander Utahns, and culturally appropriate health promotion and health care referral programs implemented in partnership with ethnic community based organizations."

12) **National Putative Father Registry** - UCA 26-2-3 requires that during the 2013 interim the state registrar shall report to the Health and Human Services Interim Committee on the feasibility of partnering with the public legal notice website to create a national putative father registry. The state registrar reported on June 19, 2013 to the interim committee. A link to the audio of that presentation is here http://utahlegislature.granicus.com/MediaPlayer.php?view_id=2&clip_id=9650&meta_id=434003.

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 2013

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 stakeholders (including auditors, the Legislative Fiscal Analyst's Office, 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.

Implementation of Accountable Care Organizations (ACO)

In response to concerns that the Utah Medicaid growth rates exceeded the State's annual revenue growth rate for the past two decades and concerns about the long-term sustainability of the Medicaid program, Senate Bill 180, Medicaid Reform, was passed during the General Legislative Section in 2011. In part, the Bill requires that:

"The Department shall develop a proposal to amend the state plan for the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models."

In order to maximize replacement of the fee-for-service delivery model, Senate Bill 180 provides some specific goals and guidance:

1. Restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate service at the lowest cost that maintains or improves recipient health status. The Legislation included:

(a) Identifying evidence-based practices and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost;

(b) Paying providers for packages of services delivered instead of entire episodes of illness;

(c) Rewarding providers for delivering services that make the most positive contribution to maintaining and improving a recipient's health status;

(d) Using providers that deliver the most appropriate services at the lowest cost; and

2. Restructure the program to bring the rate of growth in Medicaid more in line with the overall growth in General Funds.

3. Restructure the program's cost sharing provisions and add incentives to reward recipients for personal efforts to maintain and improve their health status.

To achieve these goals, effective January 2013, the Division implemented Accountable Care Organizations (ACO). There are four ACOs currently operating on behalf of Medicaid: HealthChoice Utah, Healthy U, Molina Healthcare of Utah, and SelectHealth Community Care. Currently, 64.5 percent of all Medicaid beneficiaries are enrolled in an ACO.

The goals of the ACO delivery and payment reform model are to maintain quality of care and improve health outcomes for Medicaid beneficiaries and to control costs by keeping the Medicaid cost growth rate from exceeding the state General Fund growth rate. All ACO contracts are full-risk, capitated contracts and therefore require the ACO to assume the risk for all health care costs for their enrollees. The Division contracts with a nationally recognized actuarial firm to develop ACO reimbursement rates paid to the ACOs, which must be actuarially certified and approved by CMS.

Implementation of Dental Managed Care Plans for Dental Services along the Wasatch Front

Pursuant to HB 256 (2011 General Session), the Division issued a request for proposal to "bid out Medicaid dental benefits" based on the following criteria:

- ability to manage dental expenses;
- proven ability to handle dental insurance;
- efficiency of claim paying procedures;
- provider contracting, discounts, and adequacy of network; and
- other criteria established by the Department.

Full dental benefits are only available to pregnant women, children up to age 18 and to disabled, non-pregnant 19 and 20 year olds.

After careful consideration of cost and access to care, the Division awarded contracts to Delta Dental and Premier Access for the Wasatch Front only. Dental managed care plans were implemented September 1, 2013.

Streamlined Plan Enrollment and Client Education

When a Medicaid beneficiary is required to enroll in a managed care plan, a Health Program Representatives (HPR) assists the individual with the plan choice and education regarding the Medicaid benefits and the appropriate use of the program. Education and plan choice are handled during face-to-face orientation classes, as well as over the phone. During this past year, the face-to-face and phone education has been standardized and streamlined, reducing the amount of time for each orientation. As a result, more orientations are scheduled and more Medicaid eligible individuals are educated each month. Last fiscal year, the Division provided education to 68,441 Medicaid and 20,344 CHIP eligible individuals.

In addition, the Division began using a shorter, more streamlined approach for the plan enrollment process that results in Medicaid beneficiaries being enrolled in a managed care plan faster. Finally, the Division is working on an online Medicaid orientation, including a YouTube video, to allow individuals to access these education materials at any time.

Nursing Home Resident Assessment

Medicaid pays for the long-term care of individuals in nursing facilities, if those individuals meet specific criteria. For many years, the registered nurses that review admissions to nursing facilities were part of the Division of Family Health and Preparedness (DFHP) within the Department. In July 2013, the Medicaid nursing facility prior authorization function was moved from DFHP to the Division of Medicaid and Health Financing. The nurses were moved to the same organizational unit where prior authorizations for other Medicaid services are completed. As a result, nursing staff that complete the nursing facility prior authorizations are now in close proximity to the remainder of Medicaid's clinical staff. This provides the opportunity for a broader group of clinical staff to consult on complex cases, thus increasing the efficiency of the nursing home resident assessment process.

Real-Time Eligibility Inquiry Access

The Division opened real-time eligibility inquiry access to providers. This resulted from implementation of the HIPAA 5010 Standard that allows providers to electronically check a patient's eligibility for Medicaid and confirm benefits. When an inquiry is received, the Medicaid Management Information System (MMIS) returns a response within 20 seconds. This improves efficiency by giving medical providers the ability to electronically verify benefit eligibility of Medicaid recipients.

Medicaid eligibility verification is also available to providers through the Medicaid Interactive Voice Response (IVR) system. In June 2013, system access was expanded to be available 24/7. The volume of

eligibility inquiries through the IVR has increased by 13 percent. Not all provider offices are equipped to verify beneficiary eligibility through the HIPAA 5010 Standard. Expanding the IVR hours of operation creates an efficiency by allowing access to eligibility data during regular business hours and after hours, without having to speak to a technician.

Provider Access Portal

In February 2013, the Division, working in partnership with Goold Health Systems, implemented a provider access portal. The portal is a component of the pharmacy point-of-sale system. Physicians may utilize the portal to submit an electronic prior authorization for certain medications, check eligibility for benefits, review drug history online and submit a prescription to fill. The portal improves efficiencies by giving medical providers access to resources through one electronic pathway.

Improve Workflow Processes

In 2013, SharePoint was deployed to all Medicaid staff as a tool to more efficiently perform day-to-day tasks by automating business processes and allowing employees to collaborate with each other electronically. Medicaid has worked closely with the Department, specifically with the DOH Financial Officer, in order to develop and deploy several workflows, automate manual processes, as well as greatly improve efficiencies and minimize errors. Examples of these workflows include fiscal notes, travel forms, purchase forms, and contract processing. In addition, Medicaid leverages the capabilities of SharePoint for managing Legacy MMIS enhancement projects such as ICD-10 and T-MSIS and monitoring all contracting activities for the new MMIS replacement project.

Enhancements to the Legacy MMIS System

In 2013, the Division and the Department of Technology Services (DTS) made a commitment to improve collaboration and transparency for enhancements to the Legacy MMIS, data and system security, and CMS required projects. These collaborative efforts have enabled DTS to focus its energy on development and programming—leading to more deadlines being met and an increased number of enhancements moving into production.

New Medicaid Cards

The Division and the Department of Workforce Services (DWS) have been working together to produce a new Medicaid eligibility card. In 2013, the work has focused on the design of the new card and a web portal that will give timely eligibility and coverage information to both providers and recipients. The group continues to meet regularly and work on the specifics of this new concept, as well as look for efficiencies within the process.

Ongoing Efficiency Efforts

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

- The Medicaid claims process includes a code-editing module designed to identify and deny payment for inappropriate or incorrect medical claim procedure coding. The module, branded as "Convergence Point" is a proprietary product, developed by Verisk Health. The claim savings yielded by this product amounted to $2,195,197 for the twelve month period ending November 30, 2013.
- 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 2013, the Division added 13 new drug classes to the PDL. As a result of the Division's use of the PDL, Medicaid saved $44.5 million total funds ($13 million general fund) in FY 2013.
- The Division continues to operate a "Lock In" program for Medicaid clients who demonstrate a pattern of excessive program utilization or who abuse the use of Medicaid benefits. The Division uses criteria and surveillance of claims to identify clients who should be placed in "Lock In." The criteria take into consideration use of multiple pharmacies and/or providers, as well as frequent use of emergency departments (ED) for non-emergent reasons. The Division restricts these clients to one pharmacy and one prescribing provider. In addition, the Division provides education to clients on appropriate use of EDs and alternatives to ED use. There are currently 762 individuals in the "Lock In" program. Of these, 70.6 percent are enrolled in managed care. Approximately .3 percent of all Medicaid clients are in the "Lock In" program.

Internal Audits of the Medicaid Program

The Office of Internal Audit (OIA) initiated seven Medicaid audits to identify and resolve fraud, waste and abuse. Four are complete and three are in process. The table below identifies these audits.

#	Audit #	Title	Status (as of December 16)
1	OIA-13-24	Medicaid Supplemental Payments	Report issued in May
2	OIA-13-27 OIA-13-34	Medicaid Pharmacy Point-of-Sale Medicaid GHS (Pharmacy) Business Associate Agreement	2 Reports Issued in September Reporting necessitated 2 separate reports
3	OIA-13-31	Controls Over the Medicaid Autism Waiver	Report issued in October
4	OIA-14-01	Performance Audit of the CMS 64 Report	Finalizing Report
5	OIA-14-02	Performance Audit of UUMG	Memo issued in September
6	OIA-14-04	Medicaid MMIS Change Management Process	Drafting Report
7	OIA-14-10	Review of the CMS 21 Report	Fieldwork

1. The Supplemental Payments audit reviewed three supplemental payments (Disproportionate Share; Graduate Medical Education; and Outpatient Upper-Payment Limit) the purpose was to review process for controls and review the calculations for accuracy.

2. Goold Health Service (GHS) is a third-party vendor that initiates and adjudicates Medicaid pharmacy claims. This audit was separated into two parts and each part was reported individually:

a) The OIA reviewed claims to determine whether eligibility, payment amount and data retention followed prescribed practices.

b) The OIA also reviewed the Business Associate Agreement (BAA) between Medicaid and GHS. The BAA is a contract that establishes the required relationship for the sharing of HIPAA-regulated claim data. The OIA reviewed the contract and associated controls.

3. Medicaid started processing claims for the Autism Waiver this year. The OIA reviewed the process and electronic claims for accuracy and performance.

4. Medicaid reports quarterly expenditures to the Federal Government to receive the federal funds match (CMS 64 report). The OIA reviewed the process and calculations for accuracy and controls. As of the date of this report, the fieldwork has been finalized and an exit conference is scheduled.

5. The OIA reviewed the supplemental payment for the University of Utah Medical Group (UUMG). After performing planning and analysis, the OIA concluded the area to be low risk and did not pursue an audit. A memo was issued which included the decision to not pursue an audit.

6. The OIA performed an information technology audit of the Department of Technology Services' (DTS) change management processes over the Medicaid claims software (MMIS). Change management is the process an information technology (IT) group performs when making changes (fixes or updates) to software. As of the date of this report, fieldwork is concluded and the report is being drafted.

7. The Children's Health Insurance Program (CHIP) reports quarterly to CMS to receive its federal funds match (CMS 21 Report). Similar to the 64 report, the OIA is reviewing the process and calculations for accuracy and controls. As of the date of this report, the OIA is performing fieldwork.

In addition to the audits identified above, the OIA loaned a staff member to the Department full-time, for three months, to provide technical assistance to improve the IT security for "covered entities" (a HIPAA term designating organizations that must keep information secure as they retain protected health information). Duties focused on Medicaid and areas of the Department that support Medicaid.

Conclusion

The Department is committed to 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 efficiencies 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 - IMPLEMENTATION OF IMPROVED PROVIDER PAYMENT CONTROLS

Report to the Social Services Appropriations Subcommittee

Implementation of Improved Provider Payment Controls

Prepared by the Division of Medicaid and Health Financing

December 17, 2013

Background

This report is submitted in compliance with UCA 26-18-604 which states in part:

> (2) Each year, the division shall report the following to the Social Services Appropriations Subcommittee:
>
> (a) incidents of improperly used or paid Medicaid funds and medical or hospital assistance funds;
>
> (b) division efforts to obtain repayment from providers of the funds described in Subsection (2)(a);
>
> (c) all repayments made of funds described in Subsection (2)(a), including the total amount recovered; and
>
> (d) the division's compliance with the recommendations made in the December 2010 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of Legislative Auditor General.

Identification of Improper Payments

A. Status update of certain items from last year's report:

Sleep Studies – Controls should be properly set to avoid inappropriate overpayments to sleep study providers. The OIG estimates that this could save $17,000 per year.

Status Reported in 2012 – The Department and DTS are working toward an implementation date of October 31, 2012 for the programming. Once the programming is complete, the Department will look to recover inappropriately paid amounts.

Current Status – The programming has been completed and the controls are now in place to avoid inappropriate overpayments. The division is in the process of reexamining past payments for potential recovery.

Wheel Chairs – Programming was not in place to support a new policy before it was put into effect. The OIG estimated savings of the policy change is $32,000 annually.

Status Reported in 2012 – When programming is put into place, the OIG will make the recoveries.

Current Status – The programming has been completed and the OIG is in the process of recovering $34,414.

B. FY2013 Identified Improper Payments

Lower Limb Medical Supplies – The OIG identified Medicaid payments that were beyond the defined limits for Lower Limb medical supplies. The OIG recommended that the Department establish an internal control mechanism that would edit and check for the frequency of lower limb orthosis billings, consistent with current policy. The OIG estimated a recovery amount of $94,300.

Status: Medicaid will work with the identified providers to properly resubmit and reprocess these claims to recover the over payments. The requested controls will be established for these payments.

OIG and Other Collections – The Office of Inspector General (OIG) prepares a separate annual report identifying OIG and MFCU collections for improper Medicaid payments. The OIG FY2013 annual report dated September 25, 2013 was submitted to the Governor and the Legislative Executive Appropriations Committee.
The report is available at: www.oig.utah.gov/Annual_Report_OIG_2013.pdf

Compliance with 2010 Performance Audit of Utah Medicaid Provider Cost Control

[(See UCA 26-18-604(2)(d)]: The Legislative Auditor General issued Report #2010-16, A Performance Audit of Utah Medicaid Provider Cost Control in December 2010. There were five specific recommendations to the Department of Health, Division of Medicaid and Health Financing (Department). As reported in 2012, all five recommendations have been implemented by the Division.

APPENDIX C – MEDICAID STATE PLAN AMENDMENTS

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

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

December 20, 2013

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:

Primary Care Network 1115 Demonstration Waiver

CMS has agreed to renew Utah's 1115 waiver through December 31, 2014. As a condition of renewal, CMS is requiring the State to make several changes to the waiver consistent with requirements of the Affordable Care Act. The maximum income level to be eligible for the Primary Care Network program is reduced from 150% FPL to under 100 % FPL. In addition, co-payments for both the Primary Care Program and the Non-traditional Medicaid program must be changed to be the same as co-payments for traditional Medicaid. Additionally, the Department will no longer be able to charge an annual enrollment fee for the program.

Home Health Services

The Department has transmitted a State Plan Amendment to clarify the provision of home health services.

This amendment updates the definition of home health services, clarifies services and limitations, updates references, and reorganizes home health information.

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

UTAH DEPARTMENT OF
HEALTH

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • *www.health.utah.gov*

Physical Therapy and Occupational Therapy

The Department has transmitted a State Plan Amendment to clarify the provision of physical therapy and occupational therapy services.

This amendment updates, clarifies and reorganizes physical therapy and occupational therapy services for eligible Medicaid recipients.

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

Physician Fee Schedules

The Department has transmitted a State Plan Amendment to clarify coding procedures for Medicaid providers.

This amendment updates and clarifies coding information in the State Plan by removing extraneous information that more appropriately exists in other administrative systems.

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

Inpatient Hospital Payments

The Department has transmitted a State Plan Amendment to clarify payment procedures for inpatient hospital services.

This amendment updates payment procedures for Diagnosis Related Groups (DRGs), updates reimbursement to hospitals for the Shaken Baby Syndrome Project, and clarifies reimbursement to hospitals for patients who are readmitted within 30 days of discharge.

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

Outpatient Hospital

The Department has transmitted a State Plan Amendment to remove certain requirements for outpatient hospitals. This amendment removes the requirement for outpatient hospitals to complete the Title XIX section of the Medicare Cost Report, removes the requirement to calculate and use a Medicaid cost to charge ratio (CCR), and removes the requirement to

complete an annual reconciliation of Critical Access Hospital's medical claims to 101% of costs.

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

Dental Services Access

The Department has transmitted a State Plan Amendment to better define how dentists can qualify for the enhanced payment rate used to increase client access to dental services.

This amendment facilitates client access to dental services by requiring dental providers in the urban counties of Utah, who wish to be reimbursed at the enhanced rate, to sign an agreement to see 100 or more clients during a one-year period.

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

MAGI-Based Eligibility Groups

The Department has transmitted a State Plan Amendment to implement modified adjusted gross income (MAGI) requirements for eligibility groups under the Affordable Care Act (ACA).

This amendment includes the tax-rule requirement to determine household composition and countable income for families with dependent children, pregnant women and children under age 19. It also adds coverage for children who age-out of foster care to allow them to receive Medicaid until age 26, and removes the asset test for parents, caretaker relatives, children under age 19, and for pregnant women. It further increases income limits for children and streamlines the eligibility process with the designation of income options, single state agency delegation, state residency regulations, citizenship regulations, and options for presumptive eligibility.

The Department estimates a total cost of about $6,663,700 to implement this change, but there is no cost shift to more expensive services for Medicaid recipients and their families.

Eligibility Process

The Department has transmitted a State Plan Amendment to implement the MAGI eligibility process for eligibility groups under ACA.

This amendment streamlines applications, application renewals, coordination for enrollment, and eligibility agreements for the eligibility process.

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

MAGI Income Methodology

The Department has transmitted a State Plan Amendment to implement MAGI income methodology for eligibility groups under ACA.

This amendment allows the option to count pregnant women as themselves and the number of expected unborn children for both their household determination and the household determination of their other family members. The eligibility agency will use current monthly income and will prorate reasonably predictable future income. Actual cash support provided to a tax dependent, who is not the spouse or child of the tax payer, will be countable.

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

Single State Agency

The Department has transmitted a State Plan Amendment to implement the delegation process for eligibility groups under ACA.

This amendment, therefore, addresses the delegation process for appeals and determinations in single state agencies.

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

State Residency

The Department has transmitted a State Plan Amendment to implement residency requirements for eligibility groups under ACA.

This amendment, therefore, affirms residency regulations for the State agency and also addresses interstate agreements and temporary absence.

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

Citizenship and Immigration Status

The Department has transmitted a State Plan Amendment to implement citizenship requirements for eligibility groups under ACA.

This amendment, therefore affirms citizenship regulations, specifies reasonable opportunity options, and specifies policy options related to immigrant eligibility.

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

MAGI Eligibility & Methods (CHIP)

The Department has transmitted a State Plan Amendment to implement MAGI eligibility requirements and methods for CHIP eligibility groups under ACA.

This amendment sets the MAGI income standards for all covered groups in separate CHIP that include the categories of targeted low-income for pregnant women and children, conception to birth, deemed newborns, public employee coverage for pregnant women and children, dental only coverage, MAGI income methodology, and spenddowns.

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

Establish 2101(f) Group (CHIP)

The Department has transmitted a State Plan Amendment to implement a new CHIP coverage group under Title XXI to comply with new ACA requirements.

This amendment establishes a new coverage group for children who lose Medicaid eligibility as a result of discontinuation of disregards.

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

Eligibility Process (CHIP)

The Department has transmitted a State Plan Amendment to implement the MAGI eligibility process for CHIP eligibility groups under ACA.

This amendment streamlines the CHIP application, updates the screening and enrollment process, updates the renewal process, and specifies the eligibility process through screening by other insurance affordability programs.

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

Non-Financial Eligibility (CHIP)

The Department has transmitted a State Plan Amendment to implement non-financial eligibility requirements for CHIP under ACA.

This amendment specifies the requirements for non-financial eligibility that include the categories of residency, citizenship, social security number, substitution of coverage, premium lock-outs, other eligibility standards, continuous eligibility, and presumptive eligibility for pregnant women and children.

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

Non-Emergency Medical Transportation

The Department has transmitted a State Plan Amendment to update the provision of Non-Emergency Medical Transportation (NEMT).

This amendment, therefore, updates NEMT to a brokerage provider model and terminates the 1915(b)(4) NEMT Waiver. It also clarifies services and limitations, updates references, and reorganizes transportation services information. It also updates the effective date of rates for NEMT brokerage provider services to January 1, 2014.

The Department does not anticipate any costs to result from this shift to a brokerage provider model, which is cost effective to the Department and allows a greater number of Medicaid clients to participate in the Medical Transportation Program. Furthermore, this amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Dental Services and Extended Services to Pregnant Women

The Department has transmitted a State Plan Amendment to clarify the availability of dental services and extended services to pregnant women.

This amendment, therefore, clarifies the availability of emergency dental services to non-pregnant clients and to non-EPSDT clients. It also clarifies the availability of extended services to pregnant women by specifying the numerous health care professionals who are qualified to provide perinatal care coordination services.

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

State Disregard of Income and Resources

The Department has transmitted a State Plan Amendment to disregard all income and resources.

This amendment neither increases nor decreases Medicaid eligibility. Nonetheless, it allows a child to continue Medicaid eligibility by disregarding all income and resources of the child when there is a State adoption assistance agreement in effect.

The Department does not anticipate any costs to result from this amendment, and the amendment does not affect annual appropriations. Furthermore, it does not create a cost shift to more expensive services for Medicaid recipients and their families.

Pharmacy Services

The Department has transmitted a State Plan Amendment to comply with pharmacy-related provisions of the Affordable Care Act.

This amendment removes coverage restrictions on barbiturates, benzodiazapines and smoking cessation drugs for Medicaid recipients, and covers these drugs under the Medicare Part D program.

The Department anticipates total annual savings of about $298,400 with the shift of coverage for these drugs to the Medicare Part D program.

This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

340B Dispensing Fee

The Department has transmitted a State Plan Amendment to implement a 340B drug dispensing

fee. This amendment, therefore, amends the Special Category Fees list of the State Plan to incorporate this dispensing fee, which is determined to be consistent with surveys, in-house studies of dispensing fee costs, national and regional data, and economic trends and conditions.

The 340B drug program reimburses for drugs dispensed to eligible clients of 340B covered entities. Because these drugs are discounted to the extent that expenses normally satisfied under traditional dispensing fees are not adequately covered, these changes should not have an impact on total annual expenditures.

This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

1915-(b) Non-Emergency Medical Transportation Waiver

The Department submitted a request for a temporary extension of Utah's Non-Emergency Transportation (NEMT) waiver program through January 31, 2014. Per guidance from CMS the NEMT program may operate under State Plan Authority, rather than waiver authority. Therefore rather than renewing the existing waiver, the state will transition the program effective February 1, 2014.

1915(c) Home and Community-Based Waiver Amendment

The Department submitted an amendment to the Medicaid Autism Waiver. The waiver is being amended to modify the number of unduplicated recipients from 400 to 320 to accurately reflect the number of individuals served.

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

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 28, 2013

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:

Psychologist Services

The Department has transmitted a State Plan Amendment to clarify the provision of psychology services.

This amendment specifies services available to Medicaid recipients who meet the criteria set forth in the amendment. These services include psychological evaluation and testing for individuals who exhibit intellectual disabilities, developmental disabilities or related conditions, and psychological evaluation for individuals with a condition that requires chronic pain management services.

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

Reimbursement for Physician and Anesthesia Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for physician and anesthesia services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • www.health.utah.gov

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Optometry Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for optometry services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Speech Pathology Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for speech pathology services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Audiology Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for audiology services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Chiropractic Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for chiropractic services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Eyeglasses Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for eyeglasses services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Clinic Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for clinic services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Physical Therapy and Occupational Therapy

The Department has transmitted a State Plan Amendment to update the effective date of rates for physical therapy and occupational therapy to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Rehabilitative Mental Health Services

The Department has transmitted a State Plan Amendment to update the effective date of rates for rehabilitative and mental health services to July 1, 2013. This amendment is based on the existing State Plan requirement to annually rebase pricing of physician codes.

The Department anticipates this update to be budget neutral. This amendment does not affect annual appropriations 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 payment pool for direct graduate medical education (GME) in response to a request by the Utah Medical Education Council.

This amendment updates cost report information, updates the percentage allocation to each eligible hospital for medical education payments, and consolidates payment methodology for the upper payment limit.

The Department does not anticipate any budget impact because there is no net change in payments. This is due to the fact that GME payments are not anticipated to substantially vary from current levels as a result of this amendment.

This amendment does not affect annual appropriations and there is no cost shift to more expensive services for Medicaid recipients and their families.

Quality Improvement Incentive

The Department has transmitted a State Plan Amendment to update quality incentive programs for nursing facilities and intermediate care facilities for persons with intellectual disabilities (ICFs/ID). This amendment also adds a new program in State Fiscal Year 2014 and beyond to sweep any remaining amounts from the QII2 program.

The Department anticipates an annual increase of about $743,600 as a result of this amendment.

There is no cost to Medicaid recipients and facilities that qualify for the incentive will increase their revenue and improve nursing facility services for recipients and their families.

Preadmission Screening by Categorical Determination

The Department has transmitted a State Plan Amendment to implement a new template for the section on Preadmission Screening and Resident Review (PASRR).

This amendment will allow the State to add the Short Stay Categorical Determination as a new category type. This new category allows an individual who suffers from an acute physical illness in a community setting to be admitted directly to a nursing facility for a short stay to stabilize the illness.

The Department does not expect an increase in total annual expenditures as a result of this amendment. This amendment does not affect annual appropriations or create costs to Medicaid recipients and their families.

Podiatric Services

The Department has transmitted a State Plan Amendment that broadens client access to podiatric services through a provision that allows podiatrists to perform services within their scope of license to all categorically and medically needy recipients.

There is no impact to the state budget because the increase in revenue for podiatrists comes from the same appropriation of funds that general practitioners continue to receive for podiatric services.

This amendment only increases client access to podiatric services and there is no cost shift to Medicaid recipients and their families.

Outpatient Hospital Supplemental Payments

The Department has transmitted a State Plan Amendment to clarify outpatient hospital supplemental payments.

The purpose of this change is to clarify which hospital cost reports are used, what utilization trend is used, what Medicaid claims information is used and that critical access hospital cost amounts will include appropriate inflation and utilization trending.

The Department estimates that these updates will not result in changes to Federal Financial Participation. Furthermore, there is no cost shift to Medicaid recipients and their families.

Crossover Payments

The Department has transmitted a State Plan Amendment which clarifies that Medicaid, as a payor of last resort, utilizes third-party payment methodology for crossover claims of Medicare beneficiaries.

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

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

April 18, 2013

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 statutory reporting requirements of UCA 26-18-3(3)(a), the Department is submitting the following summary of recent program changes:

<u>Supplemental Payments to Participating Non-State Government-Owned Nursing Facilities</u>

The Department has transmitted a State Plan Amendment that proposes a new supplemental payment program for nursing facilities owned by a non-state government entity.

This program will allow non-state government-owned nursing facilities to receive supplemental Medicaid payment adjustments and will provide Medicaid recipients better access to services.

The adjustment will not exceed the upper payment limit (UPL) and the calculation for the gap will be the difference between the UPL and payments made to participating facilities.

The Department anticipates an increase in annual expenditures; however, the increase is funded by the non-state government entities providing the non-federal (state) share of the expenditures. There is no General Fund impact due to this change.

<u>Nursing Facility Preadmission Screening and Resident Review</u>

The Department is transmitting a State Plan Amendment that clarifies the types of Preadmission Screening and Resident Review Level II Evaluations that may be made as "Categorical Determinations". This change is being made based on technical guidance provided by the Centers for Medicare and Medicaid Services.

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • *www.health.utah.gov*

1915(c) Home and Community-Based Waiver Renewal and Amendments

The Department submitted the five-year renewal of the Medically Fragile/Technology Dependent Waiver. The current waiver expires June 30, 2013. The submission includes the following changes: (a) Updates some technical financial eligibility requirements; (b) Allows two additional services to be provided under a Self-Directed Services model; (c) Implements critical incident reporting requirements; and (d) Updates terminology and two service descriptions.

The Department is also submitting amendments to the Medicaid Autism Waiver, the Community Supports Waiver, the Acquired Brain Injury Waiver and the Physical Disabilities Waiver.

- The Medicaid Autism Waiver is being amended, based on legislative clarification, to modify program eligibility to serve children from a child's second birthday until the end of the child's sixth year. This change will be effective May 1, 2013.
- The Community Supports, Acquired Brain Injury and Physical Disabilities Waivers are being amended to: (a) Update waiver admission requirements to comply with S.B. 259 *Amendments to Disability Waiting List*; and (b) Reduce the number of unduplicated waiver slots to better align the projections with actual utilization. These changes will be effective July 1, 2013.

1915(b) Non-Emergency Medical Transportation Waiver

The Non-Emergency Medical Transportation (NEMT) 1915 (b)(4) Waiver expires June 30, 2013. We are currently submitting the waiver renewal request through the CMS waiver portal and requesting a five-year renewal. We are now allowed the longer time period because the waiver includes services to Medicare/Medicaid Dual Eligibles.

This waiver provides recipients with non-emergency medical transportation to Medicaid providers for Medicaid covered services. To qualify, the recipient must be eligible for Traditional Medicaid and not have access and/or the ability to use a personal vehicle, bus transportation or paratransit services. The waiver serves the entire state and is a door-to-door service.

1915(b) Prepaid Mental Health Plan Waiver

The Department submitted an amendment to the Prepaid Mental Health Plan Waiver for mental health services to include San Juan County. Until this change, San Juan County was one of only two counties not participating in the Prepaid Mental Health Plan Waiver.

This means that Medicaid recipients in San Juan County will be required to obtain inpatient and outpatient mental health services through the San Juan Counseling Center. This change, however, does not apply to Medicaid recipients who are American Indians and receive these services from Indian health care providers.

The proposed effective date of this change is July 1, 2013.

1915(b) Dental Choices Waiver

Pursuant to HB 256, 2011 General Session, the Department issued a Request for Proposal (RFP) to provide dental services through dental managed care plans. A new waiver was submitted to require mandatory enrollment in a dental plan for Medicaid recipients (children and pregnant women) in Weber, Davis, Salt Lake and Utah Counties.

This change, however, does not apply to Medicaid recipients who are American Indians and receive these services from Indian health care providers.

The waiver would be effective starting July 1, 2013.

Please let me know if you have questions about any of these changes to the State Plan and waivers.

Sincerely,

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

APPENDIX D – AUTISM TREATMENT ACCOUNT ADVISORY COMMITTEE

Report to:

Utah Department of Health Executive Director
Health and Human Services Interim Committee
Social Services Appropriations Subcommittee

Autism Treatment Account Pilot Program

Prepared by the:
Utah Department of Health, Autism Treatment Account Advisory Committee

November 2013

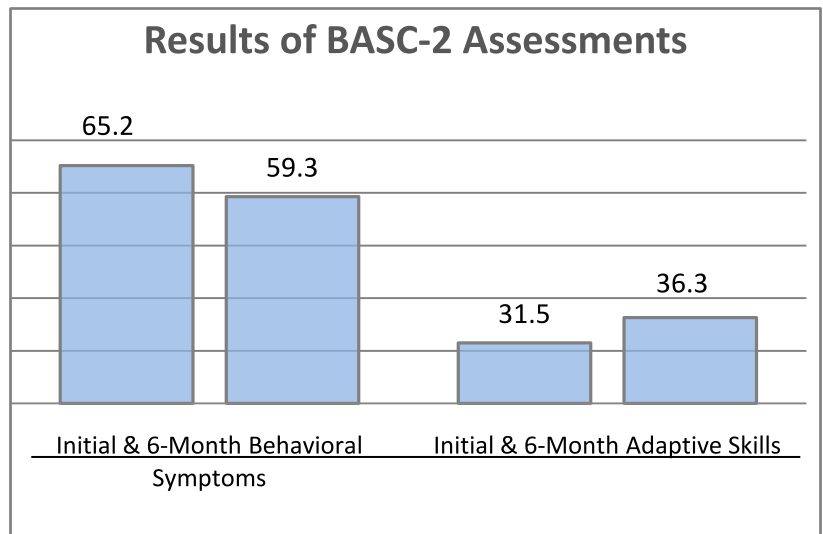
Executive Summary

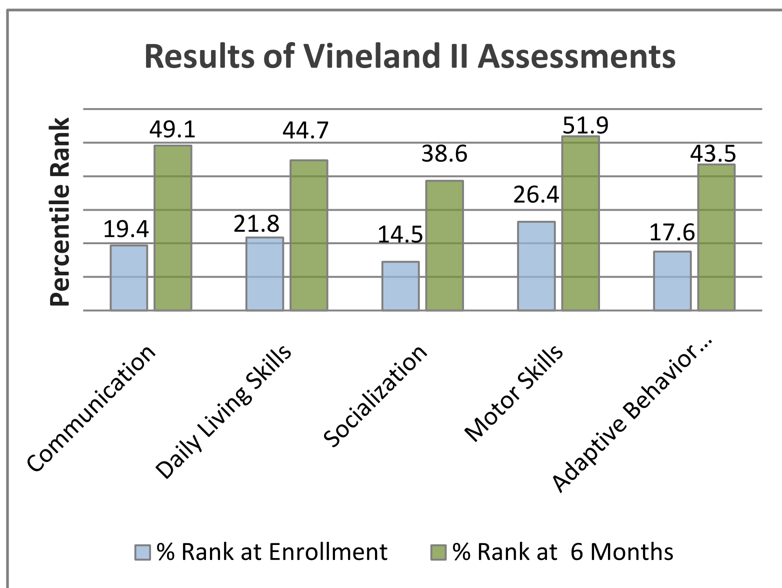
With the passage of HB272 in the 2012 Legislative Session, an autism-services pilot was created. The pilot was divided into three sub-pilots. The Autism Treatment Account (ATA) is one of the sub-pilots. The ATA serves children with autism spectrum disorders, 2 to 7 years of age. Through the ATA, the Utah Department of Health contracts with four Applied Behavioral Analysis (ABA) providers. A total of 35 children received services during the first year of the pilot. Assessment data are available for 28 children who received at least six months of continuous therapy.

Outcomes and Effectiveness

Participating children were assessed at enrollment prior to services being initiated and again after receiving 6 months of services.

The Behavioral Assessment System for Children, Second Edition (BASC-2) was used to assess the social, emotional, behavioral, and adaptive functioning of participating children. The outcomes for children receiving services demonstrate that ATA funded therapy resulted in positive decreases in behavioral problems (Behavioral Symptoms, where a score above 60 is a concern) and increases in positive behaviors (Adaptive Skills, where a score below 40 is a concern). The change in both measures indicates improvement.





The Vineland II: Parent/Caregiver Survey Interview (Vineland II) was used to assess the communication, daily living skills, socialization, motor skills, and adaptive behavioral functioning of participating children. The outcomes for children receiving services were positive and demonstrate that services provided resulted in positive increases in all domains.

Autism Treatment Account Pilot Program Report

Purpose of Report

This report is submitted in response to the following language from HB272 passed by the 2012 Legislature:

"Not later than November 30 of each year, the [Autism Treatment Account Advisory] committee shall provide a written report summarizing the activities of the committee to:

(i) the executive director of the department;

(ii) the Legislature's Health and Human Services Interim Committee; and

(iii) the Legislature's Social Services Appropriations Subcommittee.

(b) The report under Subsection (8)(a) shall include:

(i) the number of children diagnosed with autism spectrum disorder who are receiving services under this chapter;

(ii) the types of services provided to children under this chapter; and

(iii) results of any evaluations on the effectiveness of treatments and services provided under this chapter."

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 7 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 seven years of age with Autism Spectrum Disorders (ASD).
  - Funding was appropriated by the state to the ATA for $1M for the 2 year pilot program.
- 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."
  - Private donations of $750,000 from Intermountain Healthcare ($500,000) and Zions Bank ($250,000) have been received
- 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 during the first year of the pilot program:

- 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. The committee members serve on a rotation and 2 new members were appointed in November 2013 by the Governor to replace Peter Nicholas and Leeann Whiffen. The new members are Natalie Roth, PhD and Melanie Hall, mom of a child with autism.

Autism Treatment Account: FY2013 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 ATA 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 are used to provide a child who has a diagnosis of ASD, and who is at least two years of age but younger than seven years, with services that utilize applied behavior analysis (ABA) and other proven effective therapies per national standards.
- All services provided include at least:
    1. ABA 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. Ability to reach children in rural and underserved areas of the state through use of telehealth; and
    3. Methods to engage family members in the treatment process.

The RFA resulted in contracts with four ASD therapy providers. Providers selected:: Alternative Behavior Strategies, Inc.; Amy Peters Therapy Services, LLC; Autism Therapy Services LLC; and Kids on the Move, Inc.

Number of children with ASD who are receiving services

A total of 35 children have been served during the first year of the pilot. After initial enrollment, five children discontinued services (parents moved out of state, child near typical development, parent withdrew) and 9 new children were enrolled, including some that have been in the program for less than 6 months. The time period for service duration needed to assess outcomes was determined to be at least six months. Assessment data are available for 28 children who received at least 6 months of continuous service. Enrolled children met the established criteria: family is a resident of Utah; child is between 2 and 6 years of age (this was amended to 7 years of age); can receive at least 6 months of service; has a diagnosis of Autism Spectrum Disorder; and family agrees to the provision of ABA services and family involvement activities.

The 28 children included:

- 92% male
- Mean age at time of enrollment: 45.6 months (3.8 years)
- 72% received services in-home setting, 4% used videoconferencing
- Videoconferencing was used in 18% of homes to provide treatment supervision by a BCBA
- 21% rural

Types of services provided to children

All children received a baseline assessment prior to beginning services and had a treatment plan developed which is updated regularly. The treatment plans generally consist of the identification of the problems/concerns, a statement of the treatment goal or objective, a strategy by which the goal will be achieved and the criteria to be used to measure progress. The parents actively collaborated in the development of the treatment plan and in monitoring progress. The plans are reviewed at least every three months or sooner if appropriate. Progress or lack of progress is recorded, and the plan is revised as necessary. After receiving six months of services, the assessments were repeated to determine progress and identify directions for next steps in the ABA services. Properly certified and / or supervised personnel who are employees or contractors of the provider provide the ABA services. The amount of progress cannot be compared across children as each child's treatment plan contains unique goals designed to address the behavioral needs of the individual child. Videoconferencing (Skype, Facetime, Telehealth) was used to provide Board Certified Behavior Analyst (BCBA) supervision and support to 22 ABA tutors and 1 BCBA candidate. The cost effective method of supervision increased access to ABA services for 15 ATA children.

To August 31, 2013, participating children have received 14,038 hours in direct services (one-on-one ABA instruction). The average number of direct service hours (per child) in a month is 54 hours, with an average of 13.5 hours per week.

Results of evaluations on the effectiveness of treatment and services provided

The Utah Department of Health issued a request for proposals using the Utah State Purchasing system. Utah State University (USU) Center for Persons with Disabilities was selected to conduct the evaluation of the ATA. All providers submitted data to USU as required in their contract. Complete results of the evaluation are available upon request.

Each of the four ATA providers submitted copies of the Vineland II Adaptive Behavior Scales (Vineland II) and Behavioral Assessment System for Children, Second Edition (BASC-2) instruments as they were completed during the initial assessment and after receiving six months of ABA services to the evaluation team.

Vineland II is an assessment of an individual's daily functioning that may be used in educational and clinical diagnostic evaluations of developmental delays, in developmental evaluations of young children, for progress monitoring, and for program planning.

- Results from the Vineland II indicate significant improvements in ATA participants' communication, daily living skills, socialization, motor skills, and adaptive behaviors.

The BASC-2 (completed by both parents and teachers) indicates the efficacy of ATA-funded services in improving social, emotional, behavioral, and adaptive functioning outcomes for children with ASD.

- Both parents and teachers indicated a decrease (an improvement) in the Behavioral Symptoms Index (BSI), or overall score, which measures the level of behavioral problems. Teachers indicated an increase in the Adaptive Skills Composite, indicating more positive behaviors. The change in both measures indicates improvement.
- On individual measures, both parents and teachers indicate a decrease in the child's atypicality. (Atypicality is a term used to describe when a person performs behaviors that differ from their peers.) Parents indicated positive changes, indicating improvement, in hyperactivity, depression, attention problems, social skills, activities of daily living, and functional communication. Teachers also noted a decrease in aggressive behaviors.
- These results indicate the delivery of ABA services through ATA is leading to positive behavioral outcomes in children with ASD.

Family involvement and perception. After approximately 6 months of service, all families participating in the ATA program were asked to respond to a brief online survey regarding their experience in the ATA program and the impact of the ABA services for their child. The evaluation team designed the survey which was reviewed and revised by the ATA Advisory Committee and the ABA providers. To ensure confidentiality, the link to the electronic survey was distributed by each provider to each family with their own confidential identifier. As a result, the evaluation team did not have access to participants' names. The participating families were informed that their individual responses would not be shared with their ABA provider. Twenty families responded to the survey and 16 completed it.

Family involvement is a critical component of the ATA program. Families responding to the survey indicated that they observed their child's treatment / therapy an average of 6.73 hours per week and had participated in training sessions an average of 2 hours per week and 2.95 hours per week in meetings with the provider team. Participation in parent training sessions averaged 4.47 hours per week. Parents working independently with their child averaged 11.2

hours per week. Although not all providers offered each of these elements, families were actively engaged in the ABA process.

Family perceptions of child change.

Are services provided making a difference with:

	Strongly disagree	Disagree	Agree	Strongly agree
Your understanding of how to support and interact with your child?	0%	0%	44%	56%
Your child's development?	0%	0%	12.5%	87.5%

Please rate your opinion of your child's improvement on:

	No improvement	Somewhat improved	Improved	Greatly improved
Language development	0%	12.5%	25%	62.5%
Behavior targets	0%	0%	18.75%	81.25%

The families rated the value of the information that they had received from their service provider as valuable (87.5%) or useful (12.5%). The training they received from their provider was rated as valuable by 87.5% of the families; useful by 7% and not useful by 7%. All families indicated that they were comfortable or very comfortable in participating in the treatment of their child.

Family comments

Families were given the opportunity to provide their thoughts, both positive and negative, regarding their child's ATA program. Selected representative comments include the following:

- "We are very proud of the progress our son has made since he's been in the ABA program. We see continuous improvement from him and this program has given us hope for the future. This program has been a dream come true and we are very blessed to be a part of this program. "
- "The ABA program has been life changing for us and especially our son! He is now communicating, answering simple questions and requests, he doesn't run away, he has great behavior and is now teachable! I honestly didn't know if we would ever reach him, but we have, and his chances of being integrated into society as an adult if he keeps doing ABA are way higher, and we are so happy about this! We now have hope!"

- "Our child's program is doing an excellent job. We have seen so much progress in just a little over six months. When our child began the program, he could say less than ten words and would go weeks without saying anything. We could not take him to public places, like restaurants or shopping, and we would often have to intervene to stop him from attacking others. He could not sit in a chair or be still. Now, we cannot even count the words he can say and sign. He is fine in public places and his attacks on others have decreased significantly. He can even sit still for several minutes. Our child's program is working miracles with our son."

Several challenges were noted which included:

- "One thing I wish the program had was peer interaction, because that is one of my son's greatest weaknesses. But luckily my son will be starting preschool for kids with special needs through the school district, along with his ABA, and this should hopefully help that tremendously. Also I think the program should continue longer than 2 years. I know it would be tremendously helpful if it at least continued until the child is 7 or 8 years old."
- "The downside of in-home therapy has been that the personal and professional lines were blurred and often overstepped by the tutor, as well as me (the mother), out of politeness. Although the benefits have been good for my autistic son, there were too many downsides in the end and I would only continue the therapy in an out-of-home setting."

Cost of providing ABA services through ATA:
From July 2012 through August 31, 2013, the total expenditures of the ATA Program:

Total expenditures:	$719,836
Contractual costs to ABA providers:	$663,224 (comprise 92% of all funds expended)
UDOH administrative costs:	$ 56,612 (comprise 8% of all funds expended)

Of the $663,224 contractual costs to ABA providers, direct service expenses comprised $430,027, or approximately 65%. Clinical administrative (non-direct) costs (Assessments/Coordination/Supervision/Tools) account for $233,197, or approximately 35% of the contractual costs.

Resulting system improvements
In February 2013, following the implementation of the ATA program, the 4 ABA providers noted early changes in expanding the state's capacity to serve young children with ASD:

- New BCBA candidates in Price, St. George, two each in Ogden, Park City, Lehi
- New direct care staff (35) all enrolled in Board Certification programs in Salt Lake, Summit, Weber, Davis, Utah, Carbon, Tooele
- The U of U opened a BCBA credentialing program
- A new professional group for behavior analysts was established
- The number of direct care providers increased, thereby increasing access to ABA services

The four ATA service providers also responded to an electronic survey, in August 2013, regarding the impact of the ATA on their community and other programs. They indicated that the program has opened a dialogue with communities and increased capacity of the systems to provide care. Quotes included:

“Care has transitioned and generalized across community members and stakeholders.”

“The program has provided a treatment option that was previously not available in the community. This program has also led to collaborative relationships with schools and clinics. Several agencies have asked us to come and present information to their staff. The longer the program has gone the more communication there has been between school programs and home programs.”

“Some of the benefits of the ATA within our organization are an increased capacity to serve kids in our area. I hired more staff and can now not only serve the ATA well kids but also others who come along. Through collaboration with other ATA providers we have learned how to better utilize video supervision. This has improved the amount of dose supervision we can provide to some of our clients who are more distant.”

“The ability to supervise tutors using virtual technology has allowed us to work with more clients. Using virtual technology has also enabled us to reach clients in rural areas who otherwise have no ability to access specialized services.”

“We have also been able to reach out to families in need in rural communities when this wasn't an option before. As we've opened up therapy in a specific rural area. We have been able to train 2 ABA tutors who are now in that area.”

Lessons learned:

1) Children enrolled were older than the recommended treatment start age of 2-3 years. The average age of ATA children being 45.6 months.
2) The stipulation in provider contract for number of hours of therapy per child needs to be evaluated. Hours of treatment should be based on results of assessment. In the current system, each provider estimated the number of hours that a child would receive services and then found they were limited if the child required therapy beyond the estimated projection.
3) To increase usability of evaluation data submitted by the providers, a standard protocol and training should be developed for each evaluation instrument for providers.
4) Families engaged in the ABA process to a much greater degree than nationally recommended level of 20%.
5) Families may be unaware of coverage by their insurance plans. A few families that applied for the ATA were identified to already have insurance coverage for ABA

Evaluation team comments on the overall impact of the ATA on children, families, and the system of services:

The evaluation team from USU reviewed, aggregated, and analyzed the child data and the treatment plans. Based on the 6-month results, the children participating in the ATA program made noticeable progress as indicated by scores on the Vineland II and the BASC-2. Treatment plans also documented achieved goals.

Families are clearly pleased with the changes they have seen in their child's behavior, social skills, and language development. Their comments are almost entirely positive in nature, and are supported by the analysis of the outcome measures. It is the opinion of the evaluation team that the ATA program is having a positive impact on the enrolled families including their ability to participate with their child in community activities and interact with family and friends.

The ATA program has already made positive changes to the service systems in Utah. The use of virtual technology for supervision purposes, training more direct service personnel, extending services into rural areas, and reaching underserved populations are all enhancing the capacity of the service systems.

APPENDIX E - IMPLEMENTATION OF FEDERAL HEALTH CARE REFORM

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

September 6, 2013

Members of the Executive Appropriations Committee, the Health Reform Task Force, and the Business and Labor Interim Committee
State Capitol
Salt Lake City, Utah 84114

Dear Committee Member:

In accordance with the reporting requirements of Utah Code Title 63M-1-2505.5, the Department of Health (Health) submits this report on an item from federal health care reform that is scheduled to be implemented.

Enhanced Funding for Medicaid Eligibility Systems Operation and Maintenance

For the Medicaid program, the Centers for Medicare and Medicaid Services (CMS) has provided 90 percent federal matching funds to states for the design and development of new or improved Medicaid eligibility determination systems to accommodate the new Affordable Care Act (ACA) modified adjusted gross income (MAGI) rules and to coordinate coverage with the federally facilitated individual marketplace (FFM).

On February 6, 2013, we notified you about work that needed to be done to the State's existing eligibility system (eREP) in order to meet the requirements of the ACA. After the February letter, the State reached an agreement with CMS on how exchanges would function in Utah and we were able to better define how eREP would need to interact with the FFM and data hub. On June 13, 2013, we sent a second notification to you defining additional eligibility system enhancements needed to meet the requirements of ACA. All changes being made are encompassed by the mandatory changes to Medicaid and CHIP eligibility and do not include changes that would implement an optional Medicaid expansion to new adult groups.

In addition to these mandatory changes to eligibility systems, states may also receive 75 percent federal match for maintenance and operations, in the context of eligibility determinations. Historically, these eligibility determination functions have been matched at a 50 percent rate. In our state, the Department of Workforce Services (DWS) performs these functions for Medicaid. DWS will not need to change its current cost allocation methodologies, but CMS approval of this enhanced funding request will allow certain eligibility determination-related costs to be matched at the enhanced 75 percent Federal Financial Participation (FFP).

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • *www.health.utah.gov*

---

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Title II of Public Law 111-148, part of ACA, requires numerous changes to the Medicaid and CHIP eligibility determination processes. Title I, Subtitle E has requirements for interaction between the Medicaid and CHIP agency and the health insurance exchange.

2) Whether the reform provision has any state waiver or options

In June 2012, the Supreme Court ruled that states have the option to expand Medicaid to cover adults age 19 through 64 up to 133 percent of poverty. However, the Supreme Court's decision did not provide states with the opportunity to opt out of other mandatory changes to Medicaid and CHIP eligibility. Health is not aware of any waivers that are available for the mandatory changes to Medicaid and CHIP eligibility that will be addressed through this amendment.

Utah does not have to seek the enhanced 75 percent FFP. It could continue to receive 50 percent FFP for eligibility determination functions.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

In addition to the mandatory changes to Medicaid and CHIP eligibility requiring a MAGI-based eligibility determination methodology, ACA requires a coordinated and streamlined eligibility and enrollment process for Medicaid, CHIP, and advance premium tax credits/cost sharing reductions to purchase coverage on the FFM. Generally, by October 1, 2013, individuals will be able to apply for coverage using a "single, streamlined application" which may be submitted online, by telephone, through the mail, or in person to DWS or the FFM. Individuals will provide their income and other eligibility information which will be verified primarily through state and private electronic data and potentially other information accessed through the federal data services hub. If the FFM assesses that an application is likely Medicaid or CHIP eligible, the application will need to be transferred to DWS. If DWS determines that an application is not Medicaid or CHIP eligible and is likely eligible for tax credits, then DWS will need to transfer the application to the FFM.

Receipt of the enhanced 75 percent FFP is conditioned on states meeting a series of system requirements. Some of these requirements include:

- State eligibility system being compliant with the CMS defined Seven Standards and Conditions
- State eligibility system capability to make MAGI-based eligibility decisions
- State eligibility system ability to accept the ACA single streamlined application
- State eligibility system functionality to coordinate with the FFM starting October 1, 2013

Utah is currently on track to meet the above criteria by October 1, 2013 and is eligible to request the enhanced 75 percent FFP.

---

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

If the State adopts the mandated ACA changes, individuals that apply for Medicaid and CHIP will be impacted. Individuals will be able to apply online through DWS and eREP will be programmed to determine their Medicaid and CHIP eligibility based on the new ACA-determined requirements. Individuals that apply through the FFM and are assessed to be Medicaid or CHIP will be sent to DWS for eligibility determination. Individuals impacted include parents and caretaker relatives, pregnant women and children under age 19. Currently these groups constitute about 120,000 cases on Medicaid and CHIP.

If Utah does not seek the enhanced 75 percent FFP, it would continue to receive 50 percent FFP for eligibility determination functions.

5) What is the cost to the state or citizens of the state to implement the federal reform provision

No additional costs have been identified from those stated in the previous letters sent on February 6, 2013 and June 7, 2013. There are no additional projected costs as the state's current cost allocation methodologies will not change. If CMS approves the enhanced 75 percent FFP for eligibility determination functions, there will be savings to the state because of the reduced requirement for state match.

6) Consequences to the state if the state does not comply with the federal reform provision

The State of Utah could lose significant federal funding for its Medicaid and CHIP programs if CMS decided to disallow federal payments because eligibility determinations in Utah were not conducted according to federal law. If all Medicaid and CHIP payments are disallowed, the State could lose approximately $1.4 billion in federal funds each year.

If Utah does not seek the enhanced 75 percent FFP, it would continue to receive 50 percent FFP for eligibility determination functions and would not be able to reduce its state match on those functions.

---

7) The impact, if any, of the ACA requirements regarding:
  a) the state's protection of a health care provider's refusal to perform an abortion on religious or moral grounds as provided in Section 76-7-306; and
  b) abortion insurance coverage restrictions provided in Section 31A-22-726

The changes proposed by this amendment do not impact Medicaid or CHIP benefits or payments to providers. There does not appear to be any impact related to abortions.

Please let me know if you have any questions on the implementation of this item from federal health care reform.

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

August 22, 2013

Members of the Executive Appropriations Committee, the Health Reform Task Force, and the Business and Labor Interim Committee
State Capitol
Salt Lake City, Utah 84114

Dear Committee Member:

In accordance with the reporting requirements of Utah Code Title 63M-1-2505.5, the Department of Health (Health) submits this report on an item from federal health care reform that is scheduled to be implemented.

Mandatory Changes to Medicaid and Children's Health Insurance Program (CHIP) Eligibility

On February 6, 2013 and June 13, 2013, we notified you about the work that needed to be done on the State's existing eligibility system (eREP) in order for eREP to be able to determine eligibility in compliance with the requirements of the Affordable Care Act (ACA). The purpose of this letter is to notify you that we plan to amend the Medicaid and CHIP State Plans and revise the Medicaid and CHIP Administrative Rules in order to implement certain eligibility requirements of the ACA. These changes give the State of Utah the authority to determine Medicaid and CHIP eligibility following the new ACA rules.

Changes in the State Plan include the following:

- Moving to Modified Adjusted Gross Income (MAGI) based methodology for determining income and household size;
- Converting current income limits to account for the loss of income disregards; and
- Selecting income limits used to determine the MAGI Medicaid categorical groups of parent/caretaker relative, pregnant women, and children.

Changes in the Administrative Rules include the following:

- Allowing an electronic interface of data with the Federally Facilitated Marketplace (FFM); and
- Allowing the use of electronic data sources.

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • *www.health.utah.gov*

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Title II of Public Law 111-148, part of ACA, requires numerous changes to the Medicaid and CHIP eligibility determination processes. Title I, Subtitle E has requirements for interaction between the Medicaid and CHIP agency and the FFM.

2) Whether the reform provision has any state waiver or options

Health is not aware of any waivers that are available for the mandatory changes to Medicaid and CHIP eligibility that will be addressed through these amendments and rules. When an option was available, the state has generally selected eligibility options based on the following criteria:

- Align rules and processes with other programs (e.g., Food Stamps, Child Care, General Assistance, etc.),
- Maintain current Medicaid or CHIP eligibility groups and income levels, and
- Determine eligibility in a manner similar to the way it is done today.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

The ACA requires a coordinated and streamlined eligibility and enrollment process for Medicaid, CHIP, and advance premium tax credits/cost sharing reductions to purchase coverage on the FFM. Generally, by October 1, 2013, individuals will be able to apply for coverage using a "single, streamlined application" which may be submitted online, by telephone, through the mail, or in person to the Department of Workforce Services (DWS) or the FFM. Individuals will provide their income and other eligibility information which will be verified primarily through state and private electronic data and potentially other information accessed through the federal data services hub. If the FFM assesses that an application is likely Medicaid or CHIP eligible, the application will need to be transferred to DWS for actual Medicaid or CHIP eligibility determination. If DWS determines that an application is not Medicaid or CHIP eligible and is likely eligible for tax credits, then DWS will need to transfer the application to the FFM.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

If the State adopts these provisions, individuals that apply for Medicaid and CHIP will be impacted. Individuals will be able to apply online through DWS will be programmed to determine their Medicaid and CHIP eligibility based on the new ACA-determined requirements. Individuals that apply through the FFM and are assessed to be Medicaid or CHIP will be sent to DWS for eligibility determination. Individuals impacted include parents and caretaker relatives, pregnant women and children under age 19. Currently these groups constitute about 120,000 cases on Medicaid and CHIP. If these provisions are not implemented, the State might have to use a contingency plan to accept Medicaid and CHIP applications – possibly relying on paper applications that would later need to be keyed into eREP.

---

5) What is the cost to the state or citizens of the state to implement the federal reform provision

ACA requires that states remove Medicaid asset tests for parents and caretaker relatives, pregnant women and children under age 19. In addition, income eligibility for children ages 6 to 18 years old will increase from 100 percent federal poverty level (FPL) to 133 percent FPL. Health estimates that the impact of these mandatory changes will be $17.4 million in General Fund. The state has budgeted $15.6 million for FY 2014 to cover these costs and any costs of currently eligible individuals enrolling in the program.

6) Consequences to the state if the state does not comply with the federal reform provision

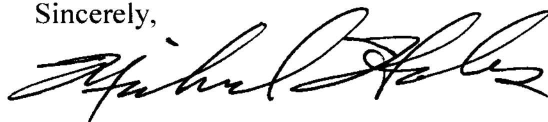
The State of Utah could lose significant federal funding for its Medicaid and CHIP programs if CMS decided to disallow federal payments because eligibility determinations in Utah were not conducted according to federal law. If all Medicaid and CHIP payments are disallowed, the State could lose approximately $1.4 billion in federal funds each year.

7) The impact, if any, of the ACA requirements regarding:
a) the state's protection of a health care provider's refusal to perform an abortion on religious or moral grounds as provided in Section 76-7-306; and
b) abortion insurance coverage restrictions provided in Section 31A-22-726

The changes proposed by this amendment do not impact Medicaid or CHIP benefits or payments to providers. There does not appear to be any impact related to abortions.

Please let me know if you have any questions on the implementation of this item from federal health care reform.

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 13, 2013

Honorable Members of the Executive Appropriations Committee, the Health System Reform Task Force and the Business and Labor Interim Committee
State Capitol
Salt Lake City, Utah 84114

Dear Honorable Committee Member:

In accordance with the reporting requirements of Utah Code Title 63M-1-2505.5, the Department of Health (Department) submits this report on an item from federal health care reform that is scheduled to be implemented.

Mandatory Changes to Medicaid Eligibility

On February 6, 2013, the Department notified you about work that needed to be done to the State's existing eligibility system for public assistance programs (eREP) in order to meet the requirements of the Affordable Care Act (ACA). Because sufficient detail was not available in February and certain decisions regarding exchanges had not been made by the State, the original request did not cover the required connections that eREP must make with the federally facilitated individual marketplace (FFM). The purpose of this letter is to notify you that we plan to amend the original federal funding request submitted to the Centers for Medicare and Medicaid Services (CMS).

In the original request, the Department of Health, together with the Department of Workforce Services (DWS), and the Department of Technology Services (DTS) requested enhanced Federal Financial Participation (FFP) from CMS in order to make ACA-required changes to eREP. The changes included the development and use of a Modified Adjusted Gross Income (MAGI) methodology, which will enable the system to make Medicaid and Children's Health Insurance Program (CHIP) eligibility decisions based on the new requirements established by the ACA. The changes are limited to ACA-mandated changes to Medicaid and CHIP eligibility and do not include any changes that would implement an optional Medicaid expansion to new adult groups.

To accomplish the changes, DWS/DTS will need to move eREP from the proprietary platform that was originally used to create the system to an open source code that will allow greater flexibility in revising and customizing eligibility determination rules. The system will need data interfaces with new sources (including the Federal data hub) and will need to be able to integrate that information into the eligibility determination process. The application and renewal process for Medicaid and CHIP will need to be revised. DWS will need to make changes to its communications and contact center phone systems.

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • *www.health.utah.gov*

Through the proposed amendment to our original federal funding request, Health, DWS, and DTS will modify eREP's Customer Portal system (myCase). This enhancement will include the following:

- modifications to existing myCase solutions to support increased volumes and electronic interfaces;
- an online single, streamlined application;
- a system and methodology to integrate "paper" applications; and
- modifications to support online change reporting and program re-certifications.

These changes will enable the system to gather the necessary data and information to make Medicaid and CHIP eligibility decisions based on ACA requirements. This amendment also covers integration of data and process modifications to other systems and processes impacted by these changes to myCase.

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Title II of Public Law 111-148, part of ACA, requires numerous changes to the Medicaid and CHIP eligibility determination processes. Title I, Subtitle E has requirements for interaction between the Medicaid and CHIP agency and the health insurance exchange.

2) Whether the reform provision has any state waiver or options

In June 2012, the Supreme Court ruled that states have the option to expand Medicaid to cover adults whose ages are between 19 through 64 and whose family income is under 133 percent of the federal poverty level. However, the Supreme Court's decision did not provide states with the opportunity to opt out of other mandatory changes to Medicaid and CHIP eligibility. Health is not aware of any waivers that are available for the mandatory changes to Medicaid and CHIP eligibility that will be addressed through this amendment.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

In addition to the mandatory changes to Medicaid and CHIP eligibility described in our February 6 letter, the ACA requires a coordinated and streamlined eligibility and enrollment process for Medicaid, CHIP, and advance premium tax credits/cost sharing reductions to purchase coverage on the FFM. Generally, by October 1, 2013, individuals will be able to apply for coverage using a "single, streamlined application" which may be submitted online, by telephone, through the mail, or in person to DWS or the FFM. Individuals will provide their income and other eligibility information which will be verified primarily through state and private electronic data and potentially other information accessed through the federal data services hub. If the FFM assesses that an application is likely Medicaid or CHIP eligible, the application will need to be

transferred to DWS. If DWS determines that an application is not Medicaid or CHIP eligible and is likely eligible for tax credits, then DWS will need to transfer the application to the FFM.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

If the State adopts these provisions, individuals who apply for Medicaid and CHIP will be impacted. Individuals will be able to apply online through DWS and eREP will be programmed to determine their Medicaid and CHIP eligibility based on the new ACA-determined requirements. Individuals who apply through the FFM and are assessed to be Medicaid or CHIP will be sent to DWS for eligibility determination. Individuals impacted include parents and caretaker relatives, pregnant women and children under age 19. Currently these groups constitute about 120,000 cases on Medicaid and CHIP. If these provisions are not implemented, the State might have to use a contingency plan to accept Medicaid and CHIP applications – possibly relying on paper applications that would later need to be keyed into eREP.

5) What is the cost to the state or citizens of the state to implement the federal reform provision

DWS, DTS, and Health estimate the cost to implement this amendment and the original provisions in the February 6 letter will be approximately $21.0 million in total funds – $18.5 million in federal funds and $2.5 million in state funds. This represents an increase of $3.9 million in total funds – $3.3 million in federal funds and $0.6 million in state funds – from what was listed in the February 6 letter.

No additional state appropriations are being requested for the changes to eREP – current state match dollars will be extended by moving staff from work where 50 percent of their costs are funded by the federal government to this project where 90 percent of their costs will be funded by the federal government. The departments will then use the match savings to help backfill positions to cover existing workload during the course of this project.

6) Consequences to the state if the state does not comply with the federal reform provision

The State of Utah could lose significant federal funding for its Medicaid and CHIP programs if CMS decided to disallow federal payments because eligibility determinations in Utah were not conducted according to federal law. If all Medicaid and CHIP payments are disallowed, the State could lose approximately $1.4 billion in federal funds each year.

7) The impact, if any, of the ACA requirements regarding:

a) the state's protection of a health care provider's refusal to perform an abortion on religious or moral grounds as provided in Section 76-7-306; and

---

b) abortion insurance coverage restrictions provided in Section 31A-22-726

The changes proposed by this amendment do not impact Medicaid or CHIP benefits or payments to providers. There does not appear to be any impact related to abortions.

Please let me know if you have any questions on the implementation of this item from federal health care reform.

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

February 6, 2013

Members of the Executive Appropriations Committee, the Health Reform Task Force, and the Business and Labor Interim Committee
State Capitol
Salt Lake City, Utah 84114

Dear Committee Member:

In accordance with the reporting requirements of Utah Code Title 63M-1-2505.5, the Department of Health (Health) submits this report on items from federal health care reform that are scheduled to be implemented.

Mandatory Changes to Medicaid Eligibility

Health, Workforce Services (DWS), and Technology Services (DTS) are requesting enhanced Federal Financial Participation (FFP) from the Centers for Medicare and Medicaid Services (CMS) to enhance the State's existing eligibility system (eREP). This enhancement will include the development of a Modified Adjusted Gross Income (MAGI) methodology, which will enable the system to make Medicaid and Children's Health Insurance Program (CHIP) eligibility decisions based on the requirements established by federal health care reform. This enhancement encompasses the mandatory changes to Medicaid and CHIP eligibility and does not include changes that would implement an optional Medicaid expansion to new adult groups.

To accomplish this system enhancement, DWS/DTS must move eREP from the proprietary platform that was originally used to create the system to an open source code that will allow greater flexibility in revising and customizing eligibility determination rules. The system will need data interfaces with new sources (including the Federal data hub) and will need to be able to integrate that information into the eligibility determination process. The application and renewal process for Medicaid and CHIP will need to be revised. DWS will need to make changes to its communications and contact center phone systems.

1) **Specific federal statute or regulation that requires the state to implement a federal reform provision**

   Title II of Public Law 111-148, the Affordable Care Act (ACA), requires numerous changes to the Medicaid and CHIP eligibility determination processes. Title I, Subtitle E has requirements for interaction between the Medicaid and CHIP agency and the health insurance exchange (either the federal exchange or an approved state exchange.)

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • *www.health.utah.gov*

---

2) Whether the reform provision has any state waiver or options

In June 2012, the Supreme Court ruled that states have the option to expand Medicaid to cover adults age 19 through 64 up to 133 percent of poverty. However, the Supreme Court's decision did not provide states with the opportunity to opt out of other mandatory changes to Medicaid and CHIP eligibility. Health is not aware of any waivers that are available for the mandatory changes to Medicaid and CHIP eligibility.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

The mandatory changes to eligibility mostly affect parents and caretaker relatives, pregnant women, and children under age 19 for both Medicaid and CHIP, but a few changes affect all eligibility groups. These changes will be implemented in eREP, as well as through policies and procedures, and include:

- Removing the asset test for certain eligibility groups
- Increasing the income limit for children age 6 through 18 to 133 percent of poverty
- Applying MAGI when determining income eligibility for certain eligibility groups by using federal tax rules regarding income and household size
- Increasing the age limit for children aging out of foster care to age 26
- Using a single streamlined application process and transferring information to and from the health insurance exchange
- Using electronic verification, including verification through the federal data hub

These changes need to be in place by October 1, 2013 in order to provide benefits by January 1, 2014.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

Individuals impacted include parents and caretaker relatives, pregnant women and children under age 19. Currently these groups constitute about 120,000 cases on Medicaid and CHIP. The number of individuals affected would be higher because there are often multiple individuals on a single case and because additional families will gain eligibility for these programs based on the mandated changes to eligibility. Failure to implement these changes would mean individuals who could be eligible in the future for Medicaid or CHIP based on the new eligibility rules would not be able to receive those services.

---

5) What is the cost to the state or citizens of the state to implement the federal reform provision

DWS, DTS, and Health estimate the cost to implement these provisions will be approximately $17.1 million in total funds – $15.2 million in federal funds and $1.9 million in state funds. No additional state appropriations are being requested for the changes to eREP – current state match dollars will be extended by moving staff from work where 50 percent of their costs are funded by the federal government to this project where 90 percent of their costs will be funded by the federal government. The departments will then use the match savings to help backfill positions to cover existing workload during the course of this project.

6) Consequences to the state if the state does not comply with the federal reform provision.

The State of Utah could lose significant federal funding for its Medicaid and CHIP programs if CMS decided to disallow federal payments because eligibility determinations in Utah were not conducted according to federal law. If all Medicaid and CHIP payments are disallowed, the State could lose approximately $1.4 billion in federal funds each year. If CMS chose to disallow payments only for the groups most impacted by the law (parents and caretaker relatives, pregnant women and children under age 19), the State would lose approximately $0.6 billion in federal funds each year.

Enhanced Payments to Physicians for Medicaid Services

Regulations issued by CMS require state Medicaid programs to pay certain qualified providers at the current Medicare rates for various evaluation and management (E&M) and Vaccines for Children (VFC) codes starting January 1, 2013 through December 31, 2014. These enhanced payments will be funded with a 100 percent federal match for the portion of this reimbursement that exceeds the state Medicaid rates that were in place as of July 1, 2009 for the codes specified.

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Please see the following sections in the Code of Federal Regulations (CFR):
42 CFR 438.6, 42 CFR 438.804, 42 CFR 441.600, 42 CFR 441.605, 42 CFR 441.610, 42 CFR 441.615, 42 CFR 447.400, 42 CFR 447.405, 42 CFR 447.410, and 42 CFR 447.415

2) Whether the reform provision has any state waiver or options

There is no state waiver or option for this provision.

---

3) Exactly what the reform provision requires the state to do, and how it would be implemented

In order to qualify for these enhanced payments, Medicaid providers must self-attest they meet one of the following criteria:

1. They have a specialty designation of family medicine, general internal medicine, or pediatric medicine.
2. They have a subspecialty within those designations as recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS).
3. As part of that attestation they must specify that they either are currently Board certified in an eligible specialty or subspecialty and/or that 60 percent of their Medicaid codes for the prior year were for the E&M codes (99201 – 99499) and vaccine administration codes (90460, 90461, 90471, 90472, 90473 or their successor codes) specified in the regulation.

Within the guidelines set forth through this regulation, Utah Medicaid is proposing a State Plan amendment to make quarterly lump sum payments to qualifying fee-for-service providers or current managed care plans for the difference between the current Utah Medicaid and Medicare rates.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

Only physicians who qualify and self-attest to a specialty designation of family medicine, general internal medicine, pediatric medicine or who have a subspecialty recognized by the ABMS, AOA, or ABPS will be impacted by the adoption of this federal reform provision. It is unclear at this time if the enhanced payments to the physicians will result in additional physicians providing Medicaid services and thereby increasing client access to physicians.

5) What is the cost to the state or citizens of the state to implement the federal reform provision

These enhanced rates are paid with 100 percent federal funds. There will be no additional General Fund cost to implement these enhanced rates. In fact, it is anticipated that compliance with this provision will result in some General Fund savings for two calendar years (2013 and 2014) since the State has been paying the General Fund match on inflationary increases that have been added to physician rates since July 1, 2009.

6) Consequences to the state if the state does not comply with the federal reform provision.

Unknown. No consequences were stated when the CFRs for these rates were released.

Concurrent Hospice Care for Children

Under a new provision in the ACA, children will be able to elect hospice care without losing access to other Medicaid services.

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Please see Section 2302 of the ACA.

2) Whether the reform provision has any state waiver or options

There is no state waiver or option for this provision.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

Under the law, the State will assure that voluntary election of hospice care will not constitute a waiver of any of the child's rights to be provided with services or to have payment made for services that are related to the treatment of the child's terminal condition. The law will be implemented by modifying currently existing hospice payment edits within the Medicaid claims payment system, MMIS. These edit modifications will allow payment of all Medicaid services children receive, rather than the previous policy of allowing only coverage of palliative services once a person elected the hospice benefit.

As a result of this provision, skilled nursing facilities that provide complex care to children in hospice will be reimbursed 100 percent of the amount the facility would have been paid had the child not elected to enroll in hospice. To implement the change to the nursing facility payment, Health intends to submit a State Plan Amendment and an administrative rule amendment.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

Children with terminal conditions, their families and service providers will be impacted by this provision. Parents of children with terminal conditions will not have to choose between palliative care for their children and having access to the remaining Medicaid services. Under this provision the child will have access to both types of services. Medicaid providers will be reimbursed for services the child receives whether the services are palliative or treatment based.

---

5) What is the cost to the state or citizens of the state to implement the federal reform provision

Health estimates the annual General Fund cost to implement nursing facility reimbursement change will be approximately $4,000 per individual. Health estimates approximately four individuals per year would utilize the services. Because hospice enrollees have not previously been able to receive hospice care and other treatments simultaneously, it is difficult to predict the number of terminally ill children who may elect to receive the hospice benefit and access additional treatment concurrently. It is estimated that Medicaid would have incurred the majority of the treatment costs regardless, because parents would likely not have elected the hospice benefit for their child in the past.

6) Consequences to the state if the state does not comply with the federal reform provision.

In terms of enforcement, the consequences are unknown. No consequences were stated in Section 2032 of the ACA. The consequence for children could be that families may not choose to enroll their child in hospice care if they do not have the option to continue to receive additional treatment services.

Please let me know if you have any questions on the implementation of these items from federal health care reform.

Sincerely,

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